## CHAPTER 12 – MEDICAL CARE

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VETERANS SUFFERING FROM MALIGNANT NEOPLASM

Provision exists in Repatriation legislation for male and female veterans to receive a wide range of treatment for malignant neoplasms at the expense of the Department of Veterans’ Affairs, even though they may not be in receipt of a pension nor have any other entitlement to treatment from the department. Approval may also be given for investigation to be carried out where firm diagnostic proof of cancer is not available, but reasonable clinical opinion is that cancer is the most likely diagnosis.

Any enquiries regarding a patient’s eligibility for treatment of malignant neoplasm or investigation of suspected malignant neoplasm should be directed either in writing to the Deputy Commissioner, GPO Box 3994, Sydney or by telephone as follows:

Patient’s surname begins with the letters A to GIK - phone 9290-7704
Patient’s surname begins with the letters GIL to NIB - phone 9290-7630
Patient’s surname begins with the letters NIC to Z - phone 9290-7601

Should a doctor wish to discuss clinical aspects of a case with a Departmental Medical Officer, the correct telephone numbers are:

<table>
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<th>Number</th>
</tr>
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<tr>
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<td>9290-7474</td>
</tr>
<tr>
<td>GILNIB</td>
<td>9290-7636</td>
</tr>
<tr>
<td>NICZ</td>
<td>9290-7348</td>
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In normal circumstances, it is expected that treatment in the metropolitan area will be carried out at the Repatriation General Hospital, Concord, or through departmental facilities. However, where specialised treatment cannot be carried out at Concord Hospital or where the patient is undergoing a course of treatment at a public hospital, authority may be given for the treatment to be carried out at the public hospital at departmental expense. Except in emergency circumstances, responsibility cannot be accepted for expenses incurred without the Department’s approval.

MODIFICATIONS TO VENTILATORS - FITTING OF NON-RETURN VALVE BETWEEN VENTILATOR AND NEBULIZER

A potential hazard exists where modifications have been undertaken to Bird pressure-cycling ventilators, and probably exists with other brands of ventilators. The modification is usually undertaken to allow higher levels of positive end-expiratory pressure (PEEP) to be employed with these pressure-cycling ventilators and consists of the placement of a non-return valve between the ventilator and the nebulizer. This valve isolates the patient from the ventilator pressure-sensing diaphragm and also causes the ventilator pressure manometer to indicate a pressure lower than that being applied to the patient’s lungs. The potential danger arises in the event of failure of the ventilator to cycle inspiration off due to a leak or partial disconnection between the ventilator and non-return valve. This would lead to a continuing flow of gas into the patient’s lungs from the nebulizer jet causing extreme high pressure with lung damage or cardiac arrest.

The Bird Corporation has agreed to package each 5537 check-valve with the following warning affixed:

“Caution: Do NOT INSTALL in any patient breathing circuit designed to deliver patient circuit pressure feedback to a pressure-cycled ventilator.”
This warning obviously applies to all pressure-cycled ventilators in which there is a gas flow to the nebulizer during normal use, if they are dependent on feedback from the patient’s circuit for their proper function. The warning can and should be given a much broader interpretation, namely, that any change in the design of a medical device should be carefully engineered and tested under all operating conditions before it is applied to a patient.

The most satisfactory means of overcoming this problem will vary, depending on other details of circuit design and the requirement for a nebulizer. If the clinician involved in the management of patients on ventilators has any doubt as to the suitability of a proposed modification, it is recommended that he or she discuss the modification with Dr John Lawrence at Prince of Wales Hospital (telephone 9399-0111).

The above should be brought to the attention of all those hospital personnel involved in the use and maintenance of ventilators, including staff of respiratory and intensive care units, anaesthetic department and respiratory technicians, etc.


PURPOSE

The NSW Health Prevention of Falls and Harm from Falls among Older People: 2011-2015 Policy describes the actions that NSW Health, including the NSW Department of Health, Local Health Districts, Ambulance Service, and Clinical Excellence Commission, will undertake between 2011 to 2015 to support prevention of falls and fall-related harm among older people.

Falls are a significant cause of potentially avoidable harm to older people. There is strong evidence that falls can be prevented. The Policy aims to reduce the incidence and severity of falls among older people and reduce the social, psychological and economic impact of falls on individuals, families and the community.

The Policy sets out actions for falls prevention in three key domains: health promotion, NSW Health clinical services and NSW Health residential aged care services (multi-purpose services and State Government Residential Aged Care Facilities). The Policy seeks to promote a comprehensive, systemic approach to falls prevention within NSW Health.

MANDATORY REQUIREMENTS

Each Local Health District will maintain a Falls Prevention Management Committee with senior representation and will develop a falls prevention implementation plan which aligns with the Prevention of Falls and Harm from Falls among Older People Policy. Population Health Services and Local Health Districts will implement falls prevention initiatives as identified in their plan and Chief Executives will provide a six-monthly update on activity and progress to the NSW Department of Health (section 5).

Nine areas of action for NSW Health are described in the Policy (section 3):

1. Provide, or arrange for, screening, assessment and management of falls risk factors among older people presenting to NSW Health services following a fall, or at high risk of falls, in accordance with best practice guidelines.
2. Minimise the risk of falls occurring within NSW Health facilities, and minimise the risk of injury should a fall occur, by implementing the recommendations from best practice guidelines for falls prevention.

3. Implement best practice in management of falls risk for older people residing in NSW Health residential aged care services (such as multi-purpose services and State Government Residential Aged Care Facilities).

4. Support provision of appropriate exercise programs for older people at risk of falls and promote uptake of these programs.

5. Provide older people and their families and carers with information about action they can take to reduce the risk of falls and injury from falls.

6. Support healthy, active ageing by continuing support for healthy lifestyles and for effective management of chronic disease.

7. Consider and respond to specific information and service needs of special groups within the population, including Aboriginal people, people from Culturally and Linguistically Diverse backgrounds, people experiencing socio-economic disadvantage, people living in remote areas, people with cognitive impairment, people with a disability and people living in residential aged care facilities.

8. Identify opportunities to promote best practice in falls prevention within external organisations and external providers of health and aged care.

9. Support the conduct and dissemination of research to advance falls prevention Policy and practice.

Section 4 of the Policy describes specific strategies to be undertaken within each of the nine action areas and the lead and supporting parties for each action.

IMPLEMENTATION

Section 5 describes the governance for implementation of the Policy. The Population Health Division, NSW Department of Health will lead statewide health promotion initiatives and work with Population Health Services to support regional health promotion services to implement such initiatives. Population Health Services will receive funding from the Department of Health for Falls Prevention Coordinators. The Health System Quality, Performance and Innovation Division and Strategic Development Division will lead work in clinical settings, in conjunction with the Clinical Excellence Commission. The Clinical Excellence Commission will receive funding from the NSW Department of Health for a program of work to support Local Health Districts in implementation of the 2009 Australian Commission on Quality and Safety in Health Care falls prevention best practice guidelines in NSW Health clinical settings (including community based services, hospitals, the ambulance service, multi-purpose services and State Government Residential Aged Care Facilities) and contribute to statewide Policy and program development in clinical settings. The NSW Department of Health acknowledges that this Policy is introduced at a time of reform in the Health system and accordingly the establishment of governance arrangements and implementation planning to support this Policy will take place after 1 July 2011.

The document can be downloaded at
INCIDENT MANAGEMENT POLICY (PD2014_004)


PURPOSE

The purpose of this policy is to provide direction to health services regarding the management of both clinical and corporate incidents, including the provision of appropriate feedback to patients, families/support persons and clinicians, and the sharing of lessons learned to prevent patient harm. This policy describes a statewide system for managing clinical and corporate incidents in order that health practitioners, managers and staff respond effectively to them.

MANDATORY REQUIREMENTS

Each NSW Health entity is required to have in place a system to manage incidents based on the following principles:

- **Openness about failures** – incidents are reported and the incident acknowledged without fear of inappropriate blame. Patients and their families/support persons are offered an apology and told what went wrong and why.

- **Emphasis on learning** – the system is oriented towards learning from mistakes and consistently employs improvement methods for achieving this.

- **Obligation to act** – the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit.

- **Accountability** – the limits of individual accountability are clear, individuals understand when they may be held accountable for their actions.

- **Just culture** – individuals are treated fairly.

- **Appropriate prioritisation of action** – action to address problems is prioritised and resources directed to those areas where the greatest improvements are possible.

- **Cooperation, collaboration and communication** – teamwork is recognised as the best defence of system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

IMPLEMENTATION

All Staff are responsible for:

- Notifying all incidents identified using the Incident Information Management System (IIMS).
- Commencing and/or participating in the open disclosure process as appropriate.
- Participating in the investigation of incidents as required.
- Participating in the implementation of recommendations arising from the investigation of incidents.
- Encouraging colleagues to notify incidents that have been identified.

Local Health Districts and Special Health Networks are responsible for

- Ensuring staff are trained in incident management (including IIMS) and able to investigate incidents and action recommendations.
- Ensuring an effective incident management system is in place for investigating and actioning recommendations for all incidents.
• Ensuring that there is timely notification of incidents to the Minister’s Office, Director General, Deputy Director General and the Strategic Relations and Communications Branch of the MoH by submitting a Reportable Incident Brief (RIB) as required and notifying by telephone if urgent attention is required.
• Ensuring that there is timely notification to NSW Treasury Managed Fund (TMF) of all incidents that have the potential to become claims.
• Ensuring the monitoring and rating of all risks identified from incident investigation and analysis as per the NSW Health Risk Management - Enterprise-Wide Policy and Framework (PD2015_043).
• Reporting all Severity Assessment Code (SAC) 1 incidents to the MoH within 24 hours or the next business day.
• Ensuring processes are in place to manage clinical RIBs in accordance with this policy to protect statutory privilege under Section 23 of the Health Administration Act 1982.
• Conducting privileged Root Cause Analysis (RCA) on clinical SAC1 incidents, and other incidents when deemed appropriate, in accordance with Part 2, Division 6C of the Health Administration Act 1982.
• Conducting a detailed investigation of all corporate SAC 1 incidents.
• Where a privileged RCA has been conducted, providing RCA reports to the MoH within 70 calendar days of notification of the incident in IIMS.
• Providing a report on key findings from corporate SAC 1 investigations to the MoH within 70 calendar days.
• Taking local action to ensure appropriate incident management and preventing recurrence of incidents.
• Reporting of trended incident data and outcomes of RCAs and Corporate SAC 1 investigations to relevant groups within health services.
• Ensuring appropriate resources are available for effective incident management and patient safety initiatives.
• Implementing policies and local practices that support staff and encouraging an environment where incident notification and active management of incidents is fostered.
• Contributing to statewide improvements as required.

Clinical Excellence Commission (CEC) is responsible for
• Reviewing clinical incidents and investigation reports.
• Providing advice to the system in response to specific queries about clinical incident management, and in response to analysis of clinical incidents.
• Providing advice and regular reports to the MoH on clinical quality, patient safety issues and trends and lessons learned from the clinical incident management process.
• Disseminating lessons learned from clinical incident management.
• Providing advice to the MoH on strategies to minimise clinical system errors across the state.
• Developing State-wide policies and strategies in relation to patient safety and health care quality.
• Identifying education needs emerging from clinical incident management.

NSW Ministry of Health (MoH) is responsible for
• Ensuring health services have systems in place to report, investigate and implement the actions necessary to prevent clinical and corporate incidents, protect patient safety and improve clinical quality.
• Establishing and maintaining systems to monitor and manage incidents reported to the MoH.
• Receiving and viewing notifications about clinical and corporate SAC1 health care incidents.
• Reviewing advice and reports provided by the CEC on analysis of trends from RCAs and issues arising from all clinical incident (SAC) categories.
• Providing advice to the Minister for Health on issues of public concern and media or public attention.
• Providing an appropriate statewide response to new risks as they are identified.

1. INTRODUCTION

1.1 Aim

The aim of the Incident Management Policy Directive is to:

a. Ensure a consistent and coordinated approach to incident management including the identification, notification, investigation and analysis of incidents resulting in appropriate action.
b. Allow the lessons learned to be shared across the whole health system.
c. Ensure Health Services establish processes that comply with the legal aspects of both clinical and corporate incident management.
d. Establish standard approaches to both clinical and corporate incident management including the establishment of performance indicators to monitor compliance.

1.2 Scope

This Policy Directive

a. Applies to all incidents that occur in the health system.
b. Provides guidance on the difference between clinical and corporate incidents and the key elements of the different approaches required.
c. Is applicable to clinical staff and non-clinical staff.
d. Describes roles and responsibilities in the incident management process.
e. Articulates mandated reporting requirements from legal and policy perspectives.
f. Defines the timeframes within which incidents, and the results of the investigation of these incidents, are to be reported.
g. Identifies the state-level processes for aggregation, analysis, learning and action on incidents.
h. Outlines other policy and legislated incident reporting requirements.

For the purposes of this policy, the term “Health Services” refers to Public Health Organisations including Statutory Health Corporations and Affiliated Health Organisations, and the Ambulance Service of NSW.

Compliance with this Policy Directive is mandatory for all Health Service staff.

1.3 Associated Documents

This Policy Directive is to be read in conjunction with the Incident Management Policy Statement and other policies relating to incident management (Appendix A).

1.4 Key Definitions

The following terms are used in this document

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<th>Definition</th>
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<td>Actual SAC</td>
<td>The rating applied to each incident when it is reviewed by a manager. Further management of the incident is based on this confirmed rating.</td>
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<tr>
<td>Apology</td>
<td>A key aspect of open disclosure is saying sorry or offering an apology to the patient and their family/carer following an incident. An apology is an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, whether or not the apology admits or implies an admission of fault in connection with the matter.</td>
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**Classification**
The process for capturing relevant information about an incident to ensure the complete nature of the incident, including causative and contributory factors from a range of perspectives, is documented and understood.

**Clinical Excellence Commission (CEC)**
A Board governed statutory health corporation established under the *Health Services Act* (section 41). It builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. Under the Act, a statutory health corporation is established to enable certain Health Services and support services to be provided within the State other than on an area/local health district basis.

**Clinical Governance Unit**
The Clinical Governance Unit (CGU) has the role of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the Patient Safety and Clinical Quality 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.

**Clinical Risk Action Group (formerly Clinical Risk Review Committee/Reportable Incident Review Committee)**
The NSW Health Clinical Review Action Group (CRAG) is responsible for examining and monitoring serious clinical adverse events reported to the MoH via Reportable Incident Briefs and ensuring that appropriate action is taken. The Committee analyses information reported to it on specific incidents, identifies issues relating to morbidity and mortality that may have statewide implications and provides strategic direction and advice on policy development to effect health care system improvement. The workings of this Committee are subject to special statutory privilege under section 23 of the *Health Administration Act 1982.*

**Clinician**
a health practitioner or Health Service provider of any profession regardless of whether the person is a registered health practitioner.

**Complaint**
A complaint is
1. An expression of dissatisfaction that may have one or more associated issues.
2. A concern that provides feedback regarding any aspect of service that identifies issues requiring a response.

A complaint may, for example be about policies, procedures, employee conduct, provision of information, quality of communication or treatment, or quality, access to or promptness of service. Complaints do not include requests for services or information or explanation of policies or procedures or industrial matters between Health Services and unions. Complaints may be made, for example, in person, by telephone, letter, survey and in some cases through the media.

**Hazard**
A source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.

**Health Service**
Refers to Public Health Organisations including Statutory Health Corporations and Affiliated Health Organisations, and the Ambulance Service of NSW.

**IIMS**
The NSW Health Incident Information Management System¹.

**Incident**
Any unplanned event resulting in, or with the potential for, injury, damage or other loss. This includes a near miss.

**Incident category**
Grouping of incidents in the incident management system, for example clinical, staff, visitor/contractor incidents, property, security, hazard incidents and complaints.

**Incident Investigation**
The management process by which underlying causes of undesirable events are uncovered².

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¹ The Incident Information Management System (IIMS) incorporates the Advanced Incident Management System (AIMS®) software application as its underlying database.

### 12. Medical Care

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<th>Incident Management</th>
<th>A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and steps are taken to prevent similar occurrences.</th>
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<tr>
<td>Incident type</td>
<td>The core issues of the incident such as a fall or medication error. There can be more than one type of incident associated with each registered incident.</td>
</tr>
<tr>
<td>Local Health Districts (LHDs)</td>
<td>Bodies corporate constituted under section 17 Health Services Act 1997 that are principally concerned with the conduct of public hospitals and health institutions and the provision of Health Services to residents within a designated geographic area.</td>
</tr>
<tr>
<td>Minimum Dataset</td>
<td>The minimum amount of information to be captured for the incident notification to be considered completed in the incident management system. It refers to the datasets associated with the incident type selected.</td>
</tr>
<tr>
<td>Near miss</td>
<td>Any event that could have had adverse consequences but did not. An arrested or interrupted sequence where the incident was intercepted before causing harm e.g. an incorrect medication added to an infusion but not administered.</td>
</tr>
<tr>
<td>Notifier</td>
<td>Any member of staff of the NSW health system who enters information into the incident management system of an incident or near miss, for any incident category. Consumers may notify an incident via the complaints process.</td>
</tr>
<tr>
<td>Notification</td>
<td>The process of entering or documenting data about an incident or near miss for any of the incident categories into the incident management system.</td>
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<td>Open Disclosure</td>
<td>The process of communicating with a patient and/or their support person about a patient related incident.</td>
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<td>Registered user</td>
<td>An authorised person nominated by the health district/network/service with registered access to the incident management system.</td>
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<td>Reportable Incident</td>
<td>An incident requiring a RIB. This includes both clinical and corporate SAC 1 incidents and also any matter that requires direct notification to the MoH under existing legislative reporting requirements or policy directive. See section 3 of this policy.</td>
</tr>
<tr>
<td>Reportable Incident Brief (RIB)</td>
<td>The method for reporting defined health care incidents to the MoH. The RIB process encompasses clinical and corporate incidents. Clinical RIBs are created for the purpose of authorised investigation and research and are privileged under the Health Administration Act 1982.</td>
</tr>
<tr>
<td>Root Cause Analysis (RCA)</td>
<td>A method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process yields recommended actions directed at the prevention of a similar occurrence.</td>
</tr>
<tr>
<td>SAC 1 Reportable Incident</td>
<td>An incident occurring in the health system that must be reported to the MoH. All clinical SAC 1 incidents require an RCA.</td>
</tr>
<tr>
<td>Severity Assessment Code (SAC)</td>
<td>A numerical score applied to an incident based predominantly on its consequence. Its prime purpose is to direct the level of investigation required for a particular event (Appendix A).</td>
</tr>
<tr>
<td>Significant Patient Risk</td>
<td>A significant risk is one where there is a high probability of a substantial and demonstrable adverse impact. In each case a significant risk will be sufficiently serious to warrant an immediate response to reduce the risks to patients. This may include interventions or changes to systems, clinical care or clinical practice. <a href="http://www.safetyandquality.gov.au/publications/advisory-a1301-notification-of-significant-risk/">http://www.safetyandquality.gov.au/publications/advisory-a1301-notification-of-significant-risk/</a></td>
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<td>Specialty Health Networks</td>
<td>Statutory health corporations constituted under section 41 Health Services Act that are specialty network governed pursuant to section 52F Health Services Act 1997.</td>
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<tr>
<td>Support Person</td>
<td>An individual identified by the patient as a nominated recipient of the information regarding their care. This may include the patient’s family members, partner, carer or friends. In cases of dispute between the patient’s family members, partner or carer and/or friends about who should receive information the patient’s wishes should be paramount. Where a patient is unable to give consent, the next person responsible under the Guardianship Act 1987 should be approached.</td>
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12. MEDICAL CARE

1.5 Acronyms

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CE</td>
<td>Chief Executive</td>
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<td>CEC</td>
<td>Clinical Excellence Commission</td>
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<td>CGU</td>
<td>Clinical Governance Unit</td>
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<td>CHASM</td>
<td>Collaborating Hospitals Audit of Surgical Mortality Committee</td>
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<tr>
<td>CRAG</td>
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<td>DCG</td>
<td>Director of Clinical Governance</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>ID</td>
<td>Identification (number)</td>
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<td>Incident Information Management System</td>
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<td>LHD</td>
<td>Local Health District</td>
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<td>MDS</td>
<td>Minimum Data Set</td>
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<td>PD</td>
<td>Policy Directive</td>
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<td>Root Cause Analysis</td>
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<td>RIB</td>
<td>Reportable Incident Brief</td>
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<tr>
<td>SAC</td>
<td>Severity Assessment Code</td>
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<tr>
<td>SCIDUA</td>
<td>Special Committee for Investigating Deaths Under Anaesthesia</td>
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<td>SHN</td>
<td>Specialty Health Network</td>
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<td>GIPA</td>
<td>Government Information (Public Access) Act 2009</td>
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<td>Quality Systems Assessment</td>
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<td>Work Health and Safety</td>
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2. THE INCIDENT MANAGEMENT PROCESS

When an incident occurs in a Health Service a series of actions must follow. The importance of identifying these as separate steps is to ensure that all appropriate action is taken. The incident management process is represented diagrammatically below.
Diagram 1: The NSW Health Incident Management Process

1. Identification of incident

2. Immediate action(s) to mitigate harmful consequences

3. Notification of incident into the incident management system under relevant incident type(s) & allocation of an initial SAC rating
   Document the incident management system incident number in patient's medical record

4. Prioritisation – Confirm SAC rating
   Prepare and submit RIB for all SAC1 incidents and others as mandated by MOH

5. Investigation

   - Clinical SAC1
     - Privileged RCA to be completed
     - Submit report to MoH within 70 days of the date of notification into the incident management system

   - Clinical SAC2
     - LHD Investigation – submit report within 45 days
     - Privileged RCA if system issues suspected-RIB required and RCA process/report as per SAC1

   - Clinical SAC3 & 4
     - Local Investigation / review at clinical unit or division level
     - Aggregated analysis as appropriate
     - Privileged RCA if system issues suspected-RIB required and RCA process/report as per SAC1

   - Corporate SAC1
     - RCA (not privileged) or other approved investigation
     - Submit report to MoH within 70 days

   - Corporate SAC2, 3 & 4
     - Local investigation as per section 2.3.6 and Appendix A
     - Complete investigation in 45 days
     - Trend aggregated data over time

6. Classification – confirm/apply final incident type(s)

7. Analysis – identification of emerging themes/trends contributing to incidents

8. Action – implementation of recommendations +/- action plan
2.1 Step 1 – Identification

Incidents may be identified through a number of methods. These may include: direct observation, team discussion, Coroner’s reports, mortality and morbidity review meetings, death review processes, staff meeting discussions, complaints, audits and/or chart reviews.

Incidents may be identified at the time they occur or at any time after the event. Health Services need to implement processes which facilitate the identification and reporting of all incidents in a timely manner.

2.2 Step 2 – Immediate action

Following identification of an incident, it may be necessary to take immediate actions to mitigate the harmful consequences of the incident. These actions may include:

a. Providing immediate care to individuals involved in the event (patient, staff or visitors) to prevent the harm from becoming worse.

b. Making the situation/scene safe to prevent immediate recurrence of the event.

c. Removing malfunctioning equipment or supplies, isolating these items and preserving them intact.

d. Gathering basic information from staff while the details are still fresh in the minds of the involved clinicians. Further direction on how facilities might ensure this is done in a manner which maintains privilege in SAC 1 and other events requiring a privileged RCA (see 4.2.3). Information will not attract privilege unless it is prepared for the dominant purpose of assisting an appointed RCA team in the conduct of its investigation.

e. Notifying police and security.

2.3 Step 3 – Notification

Staff members are required to notify all identified incidents (both clinical and corporate), near misses and complaints in the incident management system.

2.3.1 Documentation of the clinical incident in the health record

- All actual clinical incidents must be documented in the patient’s health record.
- Care must be taken to ensure only clinically relevant information is included in the health record.
- Staff must document the incident management system ID number in the health record with the information about the incident.
- If the incident has been identified via a complaint, the complaint details should not be recorded in the health record.

2.3.2 Incident notification in the incident management system – by the Notifier

All incidents, both clinical and corporate, once identified, need to be recorded in the incident management system. The notifier undertakes an initial assessment of severity of the incident using the SAC (see Appendix B) and gives their opinion of how the incident may have been prevented. The notifier may choose to remain anonymous, or include identifying information.

This step:

a. Must occur as soon as practicable and preferably by the end of the notifier’s work day.

b. Must not include identifiable details such as staff names.
There are several mandatory fields that must be entered into the system for each incident. The minimum dataset (MDS) that guides further review, management and classification for each incident is determined by the incident category.

Health Services should have in place a mechanism for patients and/or their family members or carer to report an incident. The use of the complaints management process may be appropriate in some instances, but the patient/family member or carer should be able to notify that the incident has occurred, without the need to register a complaint. In this instance it may be appropriate for a clinician or manager to record the incident in the incident management system.

2.3.3 Incident notification – Management responsibility

The manager reviews the incident notification, completes the incident management screen and either allocates or confirms the SAC according to the details of the incident or near miss. The actual SAC must be applied and incident status changed from the original classification of 'new' within 5 days of the incident being notified in incident management system.

If it has been necessary to use a paper-based notification form, the incident form is not to be retained once entered into the incident management system.

2.3.4 Notification to Patient – Open Disclosure

As early as possible after the event, the provider should share with the patient and/or their family or carer what is known about the event and what actions have been taken to immediately mitigate or remediate the harm to the patient. An expression of apology or regret can be extended at that time. Refer to NSW Health policy and guidelines on open disclosure for further guidance (Appendix A).

2.3.5 Notification to NSW Treasury Managed Fund (TMF)

Incidents with the potential for a medico legal claim must be reported to TMF as soon as possible.

2.3.6 Notifications for Corporate Incidents

The following policies outlining notification responsibilities may be relevant depending on the nature of the corporate incident (the list is not exhaustive - further relevant policies are listed at Appendix A):
- Significant Legal Matters and Management of Legal Services PD2014_011 - notification to the General Counsel, MoH.
- Corrupt Conduct - Reporting to the Independent Commission Against Corruption (ICAC) PD2011_070 - notification to ICAC.
- Public Interest Disclosures PD2015_027 - may involve notification to ICAC or NSW Police.
- Criminal Allegations, Charges or Convictions against employees PD2014_042 notification to NSW Police.

2.4 Step 4 – Prioritisation

The purpose of prioritisation is to ensure that a standardised, objective measure of severity is allocated to each incident or near miss. The SAC must be used to prioritise all notifications. The key purpose
of the SAC is to determine the level of investigation and action required. Therefore the degree of harm suffered should be the key consideration. Experience has demonstrated that predicting the likelihood of recurrence is not helpful as it can be unreliable. In some situations it has led to inappropriate downgrading of incidents and inadequate analysis and management. Caution is therefore recommended when applying the “frequency” component.

The SAC guides the level of investigation and the need for additional notification. The Chief Executive of the organisation must be advised of all SAC 1 (clinical and corporate) incidents.

### 2.4.1 Severity Assessment Code Scoring Steps

A SAC is to be applied to all incidents. Details about the SAC process can be found at Appendix B. There are two steps required:

**Step 1:** Determine the consequence or outcome of the incident by assessing the actual outcome of the incident based on the definitions provided in the consequence table. The matrix also provides for the calculation of likelihood of recurrence. This can be difficult to assess, and adds little value in the context of deciding the level of investigation for an incident that has already occurred.

**Step 2:** Implement appropriate action

Each incident is assessed for the actual consequence and the potential consequence. The potential consequence is the worst-case scenario for the incident being assessed. There is a great deal of benefit in investigating near miss incidents especially if the potential consequence of the near miss could have been a SAC 1 or SAC 2 event.

Wherever possible, and as early as practicable, the patient and/or the family/carer and other relevant persons should be given the opportunity to provide information (verbal or written), as part of the investigation process.

The collection of evidence and basic facts about the incident should commence at the earliest possible time, preferably when the event is first recognised. For clinical SAC 1 incidents, direction is provided at 4.2.3 about the process for appointing core personnel of the RCA team, as soon as possible after the event so that statutory privilege under the *Health Administration Act 1997* attaches to the information obtained.

### 2.5 Step 5 – Investigation

All notified incidents require review at an appropriate level. The SAC applied in the prioritisation stage guides the level of investigation. If additional input is needed before an accurate SAC score can be applied, steps should be taken to address this immediately so that legislated requirements can be met without delay. It may be necessary to make a “judgement call” in relation to the SAC based on the best evidence available, where the gathering of further evidence will amount to an unacceptable delay.

All Health Services should:

a. assign appropriate levels of responsibility for investigation and action on all incidents;

b. have procedures in place for the investigation of incidents;

c. provide access to training programs for the investigation of incidents;

d. have appropriately trained staff to support staff involved in investigations;

e. assign appropriate levels of resourcing to enable effective investigations to be undertaken;

f. ensure that the Clinical Governance Unit and/or Corporate Governance Unit or equivalent) provides appropriate oversight of the quality of investigation processes and outcomes.
2.5.1 Levels of Investigation

As a general guideline, the following levels of investigation are considered appropriate.

**CLINICAL INCIDENTS**

**Clinical SAC 1 incidents**

a. All clinical SAC 1 incidents require a privileged RCA investigation. This is a legislative requirement of the *Health Administration Act 1982* and Regulations. See section 4 of this policy for detailed information about the requirements for a privileged RCA investigation of clinical SAC 1 incidents. The methodology taught and promoted by the Clinical Excellence Commission should not be deviated from without prior agreement with that organisation. This is to ensure that important considerations of investigation such as privilege and fairness are adhered to.

b. All clinical SAC 1 incidents must have the final RCA report completed and submitted to the MoH within 70 calendar days from the notification of the incident in the incident management system.

**Clinical SAC 2 Incidents**

The following are the key components of management of SAC 2 incidents.

a. Senior management is to be notified and management responsibility must be specified.

b. An investigation is to be undertaken. This may be in the form of an RCA or any other investigation methodology which enables drilling down to the causative factors of the event. Each organisation is to have policies and procedures in place for the investigation of incidents and training programs in place for staff to investigate incidents.

c. It should be noted that under the legislation a privileged RCA may be conducted for SAC 2, 3 or 4 incidents, if the Chief Executive is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of an RCA team. The commissioning of the RCA must be in accordance with this Policy, as outlined at 4.2, to attract the statutory privilege. Clinical SAC 2 Reports of investigations conducted by RCA must be submitted to the MoH within the required 70 day time frame.

d. If there is disagreement in relation to the type of investigation to be undertaken on a clinical SAC 2 incident, the Director of Clinical Governance (DCG) is to make the final determination.

e. Organisational level improvement activities are to be developed and implemented.

f. Investigation should be completed, where possible, within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date should be submitted to the appropriate senior manager.

g. Where available, State-wide or LHD tools and templates should be utilised for SAC 2 investigation reports.

**Clinical SAC 3 & 4 Incidents**

a. All SAC 3 and 4 incidents need to be reviewed. Such reviews will be undertaken at the local level, but management responsibility for the review process must be assigned.

b. It may be considered appropriate to aggregate a number of similar SAC 3 or 4 incidents and to perform a review of the aggregated incidents.

c. As well as investigation or review at the local level, monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
d. Investigation should be completed, where possible, within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date should be submitted to the appropriate senior manager.

e. As with SAC 2 incidents, a privileged RCA may be conducted for clinical SAC 3 and 4 incidents in the circumstances where the Chief Executive considers the incident may be the result of a serious systemic problem. In these circumstances the RCA report must be submitted to the MOH within the required timeframe of 70 days.

CORPORATE INCIDENTS

Corporate SAC 1 Incidents

a. Investigations of SAC1 corporate incidents will be determined by the nature of the incident. They may be in the form of an RCA or any other investigation methodology which involves ascertaining the causative factors of the event. Relevant MoH and Health Service policy documents should inform the level and nature of the investigation (Appendix A).

b. All Corporate SAC 1 incidents must have a detailed investigation completed and a report submitted to the MoH within 70 days from the notification of the incident in the incident management system.

Corporate SAC 2, 3 and 4 Incidents

a. All SAC 2, 3 and 4 incidents need to be reviewed.

b. The nature and the level of the investigations will be determined by the incident and its severity. Relevant MoH and Health Service policy documents should be referred to inform the level and nature of the investigation (Appendix A).

c. Ongoing monitoring of trended aggregated incident data may identify and prioritise issues requiring a practice improvement project.

d. Investigation should be completed within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date being submitted to the appropriate manager.

An aggregated de-identified report on all corporate SAC1,2,3 and 4 incidents is to be provided by each LHD and SHN to its Internal Audit Committee. Similarly, an aggregated report on all Workplace Health and Safety (WHS) incidents is to be provided to the Director, Workforce Development and any relevant OH&S Committee.

2.5.2 Investigations and conduct/impairment/performance issues with individual clinicians

Investigations conducted under this policy should not attempt to assess the adequacy of an individual’s performance or competence. Where a question of individual performance or competence arises, it is to be managed via the organisation’s performance management system and/or PD2006_007 Directive Complaint or Concern about a Clinician – Principles for Action and GL2006_002 Complaint or Concern about a Clinician – Management Guidelines.

Investigators are, however, expected to explore why staff involved in incidents acted as they did, and should be encouraged to pose appropriate questions to explore the human factors aspects of the event in question. Typical issues might include fatigue, training and communication. In this way, the team is not endeavouring to judge the competence or adequacy of performance of any individual.
Professional Misconduct, Unsatisfactory Professional Conduct and Impairment

Under section 20O(1) of the Health Administration Act 1982, where the RCA team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct or impairment by an individual clinician/s, the RCA team must notify the CE in writing. In relation to the meaning of “professional misconduct” and “unsatisfactory professional conduct”, see Part 8, Division 1 of the Health Practitioner Regulation National Law (NSW). In relation to the meaning of “impairment”, see S5 of the Health Practitioner Regulation National Law (NSW).

Unsatisfactory Professional Performance

Under Section 20O(2) of the Health Administration Act 1982 where the RCA team forms the opinion that an incident may involve unsatisfactory professional performance by a clinician, the RCA team may notify the CE in writing. Although the RCA team holds discretion to report in these circumstances, it should err on the side of caution and notify the concerns to the CE. “Unsatisfactory professional performance” means professional performance that is unsatisfactory within the meaning of Division 5 of Part 8 of the Health Practitioner Regulation National Law (NSW).

Content of Notification of Conduct, Performance or Impairment issues

The RCA team’s notification is to disclose the identity of the person to whom the notification relates, regardless of whether the person consents to the disclosure. The notification is also to specify whether the concern relates to professional misconduct, unsatisfactory professional conduct or unsatisfactory professional performance or whether the person is or may be suffering from impairment together with a brief description of the nature of the concern. No other information obtained during the privileged RCA should be provided.

See Appendix C for a template letter that may be used by the RCA Team Leader to inform the CE of an incident involving suspected individual conduct, performance or impairment issues.

The CE will determine appropriate action which will be in accordance with PD2006_007 Complaint or Concern about a Clinician – Principles for Action and GL2006_002 Complaint or Concern about a Clinician – Management Guidelines.

The RCA Team will take no further action on the matter that relates to the individual.

The RCA Team may continue to investigate the systems issues in the incident.

2.5.3 Decommissioning RCAs

The only reason for decommissioning an RCA is where the RCA team identifies individual clinician conduct, impairment or performance issues that may be responsible for the incident and there are no readily identifiable systems issues to consider.

The Health Service notifies the MoH following the decommissioning of the RCA and provides the reason for the decommissioning of the RCA by completing the front page of the RCA template and submitting this to the MoH – email address quality@doh.health.nsw.gov.au

This is also the email address for submission of completed RCAs.
2.5.4 The management of SAC1/Privileged clinical incident investigations across Health Service boundaries

Clinical incidents may occur in one Health Service but be notified through another e.g. when there has been a patient transfer or services provided across organisational boundaries. It is the responsibility of each DCG to oversee the management of cross-boundary incidents.

The management process is:

a. The incident is notified through the incident management system and a RIB is completed.
b. The authority for transfer of a clinical incident from one Health Service to another and acceptance of that transfer resides with the DCGs of each organisation.
c. If responsibility for managing the clinical incident is transferred to another Health Service this is to be reassigned in the incident management system. A request is to be provided to NSW Health Share helpdesk to arrange incident relocation in the incident management system.
d. The MoH is informed of action taken in regard to liaison with the other Health Service via the RIB.
e. The DCG of the Health Service with agreed primary responsibility for managing the clinical incident is responsible for overseeing management of the incident including the RCA and informing the notifying Health Service of their staff’s involvement in the RCA process.

On occasion, both organisations may need to be involved in the clinical incident management when there are issues relevant to both parties, for example by participating in an RCA and accepting responsibility for implementation of recommendations. In that case, the incident should be copied and linked in the incident management system. Both parties may also need to be involved in the open disclosure process.

RCA teams seeking to access patient health information for the purpose of an investigation across two or more Health Services are able to share the information for this purpose without patient consent under the Health Records and Information Privacy Act 2002 and Health Records and Information Privacy Regulation 2012.

2.5.5 Investigation of clinical incidents across sectors

Some incidents may occur across more than one sector, for example in primary and in secondary care settings or between the public and the private or non government organisation sectors. It is the responsibility of each DCG to ensure appropriate management of cross-boundary incidents. Depending on the severity of the incident, the DCG may need to involve personnel from the other sector(s) in the incident reporting and investigation processes.

The incident management process should be discussed and agreed with an appropriate senior representative of the other entity and the process progressed in a manner that meets the legislated/licensing requirements of each and every entity.

Where a clinical incident involves both an LHD/SHN and a private health facility licensed under the Private Health Facilities Act 2007, then both entities may be required or permitted to carry out a privileged RCA under legislation (under the Private Health Facilities Act 2007 licensed private health facilities are required to carry out an RCA in relation to clinical SAC 1 incidents, and are also permitted to carry out an RCA in respect of other clinical incidents where the incident indicates there may be a serious systemic problem).
In that event, it is possible for the LHD/SHN and licensed private health facility to elect to carry out a “joint” RCA investigation as follows:

a. Each entity would separately appoint the same RCA team members and each team is then able to carry out the statutory functions, on behalf of each entity, concurrently.
b. The RCA team members conduct meetings, interviews and other investigations acting in the capacity of both RCA teams, effectively at the same time. It is important that documentation of these processes makes it explicit that the RCA team is acting in two different statutory capacities simultaneously in carrying out these activities.
c. Team members need to ensure that they address the notification requirements of both the Health Administration Act 1982 and the Private Health Facilities Act 2007 e.g. in relation to concerns about possible misconduct or unsatisfactory professional performance.
d. A separate RCA report is required in respect of each Act, although, depending upon the team’s findings and recommendations, the content of these Reports could be the same.

Such a joint RCA process is only appropriate where there may be common factual issues or issues relating to the interaction of the two service providers, for example issues relating to communication between the services or to transfer processes.

Incidents Involving Multiple States/Territories

There are several ways in which other jurisdictions may be engaged in an investigation by an RCA team appointed by an LHD or SHN.

a. Representatives from the involved service or facility can be invited to participate actively as an RCA team member.
b. The team can request a copy of the relevant medical records and related documentation from the other jurisdiction, to inform the analysis.
c. RCA team members can include involved parties from the other jurisdiction in the interviewing and fact finding process.

Formal correspondence from the CE to his or her equivalent in the other State or Territory would assist the team in achieving its objectives. This should state clearly what the team is seeking and remind the recipient that participation on the team and provision of information to the team during interviews will be covered by privilege.

Access to relevant medical records held by another jurisdiction for the purposes of the RCA team’s investigation will generally be governed by applicable privacy legislation in that jurisdiction. Further advice may be sought from the CEC.

Management of Corporate Incidents across Health Service Boundaries

The responsibility for managing cross boundary corporate incidents rests with the most appropriate Health Service CE.

The management process is:

a. The incident is notified through the incident management system and a RIB is completed.
b. The authority for transfer of an incident from one Health Service to another and acceptance of that transfer resides with the CE of each Health Service.
c. If responsibility for managing the incident is transferred to another Health Service this is to be reassigned in the incident management system. A request is to be provided to NSW Health Share helpdesk to arrange incident relocation in the incident management system.
d. The MoH is informed of action taken in regard to liaison with the other Health Service via the RIB.
The CE of the Health Service with agreed primary responsibility for managing the clinical incident is responsible for overseeing management of the incident including the RCA and informing the notifying Health Service of their staff’s involvement in the RCA process.

On occasion, both organisations may need to be involved in the corporate incident management when there are issues relevant to both parties, for example by participating in an RCA and accepting responsibility for implementation of recommendations. In that case, the incident should be copied and linked in the incident management system. Both parties may also need to be involved in the open disclosure process.

### 2.5.6 Director General Inquiries under the Health Services Act 1997

Clinical and corporate incidents can raise issues which may require a more formal inquiry that is independent of the Health Service. This may arise where a clinical or corporate incident raises broad State-wide or general clinical practice issues, serious public interest matters or matters where there is a potential conflict of interest in the organisation overseeing its own investigation. Where the CE considers an independent external inquiry may be required, he/she should contact the MoH’s Legal and Regulatory Services Branch. In the event that the matter being investigated is clinically focused, the CEC will also have a role in determining further action.

### 2.6 Step 6 – Classification

This is the process of capturing relevant information from a range of perspectives about an incident to ensure that the complete nature of the incident, including causative and contributory factors, is documented and understood. Classification of all incidents involving patients, staff, visitors, volunteers, contractors or corporate systems can be made in the incident management system.

Classification is undertaken by nominated personnel according to the service delivery model of each Health Service and may include local managers, patient safety managers, Workplace Health & Safety managers and staff of Clinical Governance Units (CGU).

The SAC will determine the amount of information required in order to classify the incident. SAC 1 events require advanced classification. SAC 2 events require the basic classification. SAC 3 and 4 events only require completion of the minimum dataset.

### 2.7 Step 7 – Analysis

The purpose of analysis is to understand how and why the incident occurred, to identify ways of improving the systems of care and prevent recurrence. Analysis must take place at a number of levels in the system: at the level at which the incident occurred (for example the ward or the patient interface in a primary care setting), at the organisational level and at the State and National level. Different data are analysed and different action is expected at these various levels. Groups of incidents may be analysed to identify trends or emerging themes.

Health Services are responsible for analysis and action at the health organisation level; the MoH and the CEC are responsible for analysis and action at the State level.

### 2.8 Step 8 – Action

Action is the implementation of recommendations from the investigations and reviews and the development of better systems to ensure improved practice.
A suitable timeframe for the implementation of recommendations must be documented in action plans and the incident management system. Information should also include who will be accountable for the actions.

Where an RCA is involved, the CE is responsible for deciding whether recommendations are accepted and approved and for ensuring implementation of the approved recommendations. The CE must be able to justify in writing at the time of submitting the RCA Report why a particular recommendation is not supported or actioned and what alternative actions might occur. The CE may consult with other staff about the RCA team’s recommendations and provide feedback to the RCA team prior to sign-off (see 4.1.4) OK.

Ongoing monitoring is required to ensure recommendations are addressed in a timely manner and to evaluate the success of any action taken to achieve improvement.

2.9 Step 9 – Feedback following investigation

Feedback is an important component of a successful incident management program.

2.9.1 Feedback to Patients and/or Support Person - Open Disclosure

Information about SAC 1 and SAC 2 clinical incidents should be offered to the patient and/or their support person and/or family as it comes to hand. Feedback should be provided in accordance with NSW Health policy on Open Disclosure (see Appendix A).

a. Disclosures should be made to the individual patient and any family/key support person the patient would like to be present.

b. In circumstances where discussion with the patient is not possible or appropriate, his or her next of kin, designated contact person, or representative should be informed.

c. Consideration must be given to the patient’s cultural and ethnic identity and first language and the support needed.

The information provided to the patient and/or their support person and/or family can be based on a variety of sources. The final report from a RCA is one of those sources. A copy of the RCA report may be given to the patient/support person/family. Ideally, the report should be discussed with the patient/support person/family in person. This will allow for questions to be addressed and to ensure that the often impersonal and clinical nature of the report can be explained.

2.9.2 Feedback to Staff

The success of incident management is dependent on feedback to all staff on the results/outcomes of investigations in a timely manner.

Feedback must be provided to staff involved in the incident and should occur as soon as possible, including after the completion of the RCA. The information to be provided is limited to that which is included in the final RCA report. This way staff involved in the incident will be informed of the conclusions reached by the team and of the recommendations arising from any investigation.

Feedback should also be given to the broader group of clinical providers and managers within the organisation. This feedback will focus on the lessons to be learned by the organisation and system amendments that will provide a greater chance that the incident will not happen again. Such feedback and discussion could take place at; for example, ward meetings, mortality and morbidity review meetings and Grand Rounds.
12. MEDICAL CARE

Regular reports on trended aggregated data and outcomes of RCAs are to be provided to the executive team and board of management, peak quality committee (or other relevant committee) and staff. Feedback should include updates as the changes are made and improvements achieved as a result of these changes. This will also provide a level of accountability for implementation of the recommendations that come from the RCA or other investigation.

3. REPORTABLE INCIDENT BRIEFS

The Reportable Incident Brief (RIB) system is designed for the reporting of specific health care incidents to the MoH. The RIB process is used for reporting both clinical and corporate incidents.

Clinical incidents: all clinical incidents reported in RIBs are referred to the NSW Health Clinical Risk Action Group (CRAG). CRAG is responsible for examining and monitoring serious clinical incidents via a number of mechanisms, including RIBs. The clinical incident RIBs and the work of this Group are subject to special statutory privilege under Section 23 of the Health Administration Act 1982.

Corporate incidents: Corporate incidents occurring in the health care setting are those involving staff, visitor, contractors, property, security and hazards.

3.1 RIB reporting requirements

All actual SAC 1 incidents, both clinical and corporate, must be notified to the MoH via a RIB, within 24 hours of notification of the incident in the incident management system. (The RIB does not replace the requirement for early notification of an incident to the appropriate Deputy Director General and the Strategic Relations and Communications Branch of the MoH.)

The Chief Executive or his/her delegate is responsible for notifying the Minister’s Office, the Director General, the Deputy Director General and the MoH’s Media Unit when there are incidents which have the potential to become matters of public interest.

Where there is a need to notify the MoH outside of business hours, the relevant Deputy Director General is to be notified, as well as the on-call Media Unit officer, on pager 9962 9980.

Clinical RIBs are privileged in accordance with Section 23, Health Administration Act 1982, and should be maintained securely and not used for any other purpose.

An incident that has both clinical and corporate components will be covered by statutory privilege. Such incidents should be marked as “clinical” on the RIB.

A RIB is to be submitted within 24 hours of the SAC being allocated. There are instances where it is not possible to allocate a SAC to an incident (particularly a SAC 1 incident) until additional information is available. In such instances, the Health Service is required to act immediately to obtain such information or advice so that legislated requirements are met.

The following types of incidents require prompt advice to the MoH as a RIB.

3.1.1 Clinical Incidents

- Death of a patient unrelated to the natural course of illness.
- Suspected suicide of a person (including a patient or community patient) 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.
12. MEDICAL CARE

- Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months 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.
- Unexpected intra-partum stillbirth.
- Procedures involving the wrong patient/body part regardless of the outcome (SAC1-SAC4).

OR

- The Sentinel Events, those being:
  - Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
  - Suspected suicide of a patient in an inpatient unit.
  - Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
  - Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
  - Intravascular gas embolism resulting in death or neurological damage.
  - Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
  - Maternal death or serious morbidity associated with labour or delivery.
  - Infant discharged to wrong family.

“Major Clinical Consequences”

An incident with “major clinical consequences” is one which involves a patient:
- Suffering a major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management.
- Suffering significant disfigurement as a result of the incident.
- At significant risk due to being absent against medical advice/absconding.
- Subjected to threatened or actual physical or verbal assault requiring external or police intervention.

Probability of Recurrence
(i) Frequent expectation that the incident will recur immediately or within weeks or months.
(ii) Likely probability incident will recur more than once within 12 months.
(iii) Possible possibility incident may recur at some time every 1 to 2 years.
(iv) Unlikely possibility incident may recur at some time in 2 to 5 years.

When Health Services are reporting incidents involving patient on patient or patient on staff assaults resulting in injury or death of a patient or staff member and there are reasonable clinical grounds to suspect a connection between the assault/death and care provided by the organisation these are to be reported as a clinical RIB.

3.1.2 Corporate Incidents
- Unexplained death of a staff member.
- Suspected suicide or attempted suicides by a staff member where the staff member was not a client of mental health services.
- Fire, bomb or other threatening activities in the health facility.
- Critical equipment breakdown or failure.
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- Serious threats affecting the facility’s operation.
- Complete loss of service i.e. power or water failure.
- Criminal activity in or related to the workplace.
- Non-accreditation of service provider.
- Violence or threats of assaults on patients, staff or other persons in the Health Service. This includes incidents involving:
  - assaults on, and or abuse of, patients (including children) and other vulnerable patients by staff or other persons and incidents involving abuse of staff by patients or other persons;
  - staff members assaulting other staff members.
- Incidents for which reporting is mandated – (see 3.1.3 below).

3.1.3 Mandated reporting - Legal and Policy Requirements

There are matters that require mandatory notification via a RIB to the MoH regardless of the SAC. These include but are not limited to:

a. Deaths or other incidents reportable to the Mental Health and Drug & Alcohol Office.

b. When methadone or buprenorphine is associated with or potentially associated with a child’s presentation or admission to hospital.

c. Deaths in custody.

d. Significant legal action initiated by or against a Health Service. See *Significant Legal Matters and Management of Legal Services* PD2014_011, for further information concerning the notification of significant legal matters.

e. Industrial disputes, particularly where an interruption may be marked.

f. The commencement of a WorkCover prosecution.

g. All incidents that involve the incorrect patient, procedure or site.

h. Radiation incidents reportable to the Radiation Advisory Council (RAC) under the *Radiation Control Act* (2003).

i. Other matters either raising issues likely to have a major impact on the Health Service or have state-wide implications such as assault or violence against a patient/client by an employee.

j. Child related allegations, charges and convictions against staff which are notifiable to the Child Protection Helpline or Child Wellbeing Unit (where appropriate), NSW Police and/or Ombudsman and require investigation by the Health Service. These allegations may be work or non-work related.

k. Criminal charges against a staff member related to the workplace or that are outside of work but impact on the workplace in terms of risks, e.g. sexual assault criminal charges.

l. Accreditation agency notification to a health service of the detection of one or more significant risks to patient harm.

See Appendix A for policy directives and legislation outlining existing reporting requirements.

3.2 RIB reporting process

The RIB reporting process is as follows:

a. RIBs are to be completed in the incident management system or its approved equivalent.

b. A SAC is to be applied to all incidents reported via the RIB system.

c. The Chief Executive (CE) is responsible for authorising the RIB.

d. The RIB is then submitted to the MoH (RIBs@doh.health.nsw.gov.au) within 24 hours of the incident being notified in IIMS. RIBs must be forwarded under the signature of the CE or nominated delegate and dated. Where IIMS is in use, this will be by a system generated email.

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3 The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme also requires approved accrediting agencies to notify regulators if a significant patient risk is identified during an onsite visit to a health service organisation.

4 Or later if it is not possible to determine that the incident rates a SAC 1 at this time. See Section 3.1 for further explanation.
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c. If the issue requires urgent State-level response and/or involvement, the Health Service is to provide telephone advice that a RIB has been emailed. This information should be relayed to the Chief Executive at CEC and to the MoH’s Strategic Relations and Communications Branch during business hours. After hours the on call media officer for the Ministry of Health should be notified.

d. If there is a requirement for the SAC to be altered after a RIB has been submitted, the CE is responsible for authorising any change to the SAC documented in the RIB. Once the CE authorises the change to the SAC, the RIB is resubmitted to the MoH. When the RIB is resubmitted the text of the RIB must clearly indicate that this is an update of a previously submitted RIB, quote the previous MoH TRIM number and provide a reason for the update.

e. All RIBs involving suspected suicide or suspected homicide by patients of mental Health Services must be referred to the local Director of Mental Health Services for review of the SAC prior to submission of the RIB to the DCG.

f. Clinical RIBs are privileged documents. There are restrictions on their distribution. They should not be used for purposes other than providing information to CRAG in accordance with the Health Administration Act 1982.

3.3 Information required in the RIB report

a. RIBs must provide a succinct description which clearly outlines the key issues and the circumstances of the event.
b. RIBs must state the incident type (clinical or corporate), the actual SAC and the reason for reporting the incident to the MoH.
c. Patient information contained in the RIB must be de-identified.
d. The RIB is to contain facts, initial analysis and future actions to be undertaken, opinion and subjective comment are to be avoided.
e. The RIB is to indicate if initial open disclosure has occurred.
f. Do not send attachments such as health care records, pathology or autopsy reports and other patient identifying reports with the RIB.
g. As identifying details are required on the Client Death Report Form that is completed for notification of deaths of mental health patients, this form should be sent directly to the Mental Health and Drug & Alcohol office at the NSW Ministry of Health.

4. PRIVILEGED ROOT CAUSE ANALYSIS UNDER THE HEALTH ADMINISTRATION ACT 1982

All clinical SAC 1 incidents under Division 6C of the Health Administration Act 1982 require the appointment of an RCA team, and the RCA process is afforded statutory privilege (see Appendix D). The provisions under the Health Administration Act 1982 apply to all LHDs, the statutory health corporations and the affiliated health organisations, as provided under the Health Services Act 1997, as listed in Appendix E.

Further, the CE has discretion to appoint a RCA team to investigate any clinical incident of a lesser severity than SAC 1, if the CE is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of such a team. In that event, the RCA process will also enjoy statutory privilege. Health Services should implement processes to allow local quality assurance committees and mortality and morbidity committees to recommend to the CE that an RCA team be appointed to review incidents or issues that may be indicative of serious systemic problems.

The legislation does not provide privilege for the investigation of corporate SAC 1 incidents.
4.1 Statutory Privilege

4.1.1 What the Privilege covers

The privilege provided under Division 6C of the *Health Administration Act 1982*, applies to:

a. Any document prepared.

b. Any communications, whether written or verbal, between RCA team members and any other person (e.g. clinicians involved in the incident).

Where the document is prepared, or the communications are made, for the dominant purpose of the conduct of the investigation by the RCA team. Privilege will not apply to documents or communication created before a RCA team has been commissioned.

This means that:

a. RCA team members cannot be compelled to produce or give evidence of any document created by or on behalf of, at the request of, the RCA Team, where the document was for the dominant purpose of the conduct of the investigation by the RCA team.

b. Any person who is not a member of the RCA team who creates a document or makes communications (written or verbal) that is for the dominant purpose of assisting with the conduct of the investigation by the RCA team (this may include administrative assistants to the RCA team, clinicians involved in the incident investigated by the team, or experts engaged by the RCA team to assist it with the investigation) cannot be compelled to produce or give evidence of the document or communication.

c. The final RCA report prepared by the RCA team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate).

d. RCA team members acting in good faith for the purposes of the exercise of the RCA team’s function are also protected from personal liability, including actions for defamation.

The legislation also establishes tight confidentiality requirements, making it an offence for a team member to disclose any information obtained during the investigation, unless it is for a purpose that is part of the RCA process.

4.1.2 Internal Working Documents of the Privileged RCA team

During the RCA process, the team will generate documents, including preliminary notes, records of interviews with staff/clinicians, minutes of meetings and records of discussions with various people either involved in the incident or with fundamental knowledge of the incident or processes involved. During the RCA process some of these items may need to be transferred to other team members or, in limited circumstances, to the CE e.g. in relation to proposed recommendations. All this material is privileged.

a. Storage and transfer of privileged RCA material

To protect the privilege, these records are to be maintained in a separate RCA team file marked “privileged” and stored securely in a location nominated by the Director of Clinical Governance to ensure the privilege is upheld in the event of a subpoena or application for access under GIPA.

Privileged material is not to be sent in the general post but should be sent by secure internal transport processes. Health Services need to have appropriate policies and procedures in place to manage the transfer of such materials.
b. Retention of RCA documents related to clinical incidents

Records relating to RCAs are required to be retained under the same rules applying to “legal matters and incident management” under clause 1.14 of the General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17). Under this requirement, the RCA records must be retained for a minimum of 7 years after the last action. As the records are not admissible in court or other proceedings, and can only be accessed by members of the RCA team, the 7 year period applies whether or not legal proceedings have been commenced.

4.1.3 What the privilege does not cover

Statutory privilege does not cover:

a. Pre-existing documents, such as clinical incident summaries, medical records or other records created in the course of providing general care of patients or management of the Health Service, and not as part of the RCA.

b. Notifications made by the RCA team under section 200 of the Health Administration Act 1982, which relates to the responsibility of the RCA team to notify the CE where the RCA team forms the opinion that the incident raises matters that may involve professional misconduct, unsatisfactory professional conduct, impairment or unsatisfactory professional performance of an individual clinician.

c. Information entered into the incident management system.

d. The final RCA report.

e. Any communication that is not for the dominant purpose of the RCA process.

4.1.4 Disclosure of information

The privilege does not prevent information being given by a RCA team to another privileged committee (for example a RCA team is entitled to give information to The Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA), The Collaborating Hospitals Audit of Surgical Mortality Committee (CHASM); and the NSW Clinical Risk Action Group (CRAG)). Information provided in this way will retain privilege through the protections granted to those committees under Section 23 of the Health Administration Act 1982.

Further, a RCA team may disclose information about recommendation(s) proposed by the team to the CE of the Health Service that appointed the RCA team, for the purposes of informing the CE about the proposed recommendation(s) and enabling the CE to consult with other staff members of the Health Service about the proposed recommendation(s), and provide feedback to the RCA team regarding the proposed recommendation(s). All such communication between the CE and the RCA team about the proposed recommendation(s) will remain privileged, and should be done formally in writing.

4.2 The Privileged RCA Process

There are four key tasks involved in the root cause analysis process.

4.2.1 Task 1 – Appointment and membership of the RCA Team

The CE is responsible for appointing and signing off the membership of the RCA team.

At least some of the members of the team should have fundamental knowledge of the care processes in the area where the incident occurred. No member of the RCA team should have been directly involved in the incident or in the care of the patient. Where possible and practical, the RCA team
should include at least one member who is external to the LHD or Health Service. Further, RCA team members should not have any personal or non-professional connection with any clinician who has been involved in the incident. A direct line manager should not be a member of a RCA team which is investigating an incident involving his or her department or unit. All persons involved in overseeing the quality of the RCA process itself should be appointed members of the RCA Team. This will ensure they are covered by statutory privilege.

A RCA team investigating suspected suicide should in its membership include a senior mental health clinician who is independent of the facility involved in care. A RCA team investigating suspected homicides or other serious crimes should in its membership include a senior mental health clinician who is independent of the service involved in care.

Team members are to receive a letter of appointment. See Appendix F for a template.

a. **Informing team members of their roles and responsibilities**
Those appointed to a RCA team are to be informed of their role and responsibilities as members of a RCA Team. Appendix G provides a template letter outlining the role and responsibilities of team members.

b. **Record of RCA Team appointment**
The statutory privilege will only apply if it can be shown that the RCA team was properly constituted under the *Health Administration Act 1982*. As such, it is critical that comprehensive records are prepared and retained relating to the appointment of the RCA team.

Records will include:
- An original copy of the letters of appointment of the RCA team members.
- The date of appointment.
- Clear identification of the incident in relation to which the RCA is to be conducted.
- The names of the RCA team members.

c. **Process for appointment of RCA Team**
The identification of appropriate personnel for appointment to a RCA team can delay the appointment of the RCA team. Best practice in conducting RCA investigations globally recognises the advantages of the immediate collection of evidence and facts pertaining to the event, particularly in the first 48 hours following a serious clinical incident. Health Services should have in place a process that enables the immediate appointment by the CE of core personnel to a RCA team as soon as a clinical SAC 1 incident is notified to the CE. This process would involve a standing instrument of appointment for certain experienced and trained personnel, who can facilitate the early collection of such information and material for the RCA investigation e.g. the DCG and/or Patient Safety Manager. A template for the immediate appointment of a “core” RCA team member is provided at Appendix H.

Once the remaining proposed RCA team members are identified, a further instrument of appointment should be executed by the CE that refers to the earlier instrument of appointment, and appoints the balance of the members of the RCA team. A template for the later appointment of additional members after appropriately qualified and/or expert individuals have been identified, is provided at Appendix I.

This process will ensure that statutory privilege attaches to all documents and communications prepared for the purposes of the RCA team in the initial period immediately following the incident, and prior to the appointment of the full RCA team.
4.2.2 Task 2 – Notification to staff involved in the incident

The RCA team will contact staff involved to discuss the incident and gather information as part of the investigation. A template that can be used to inform staff of the RCA process and to explain the staff members’ legal rights and responsibilities is provided at Appendix J.

4.2.3 Task 3 – The RCA Investigation

There are six key steps in undertaking an RCA investigation:
1. Interviews and gathering information – interviews of people relevant to the incident are undertaken. This must include clinicians who were involved in the incident as well as the patient and/or the family or carers. It may also include people relevant to current policy and process e.g. the pharmacist, the biomedical engineer or the hospital architect.
2. Simple flow charting – a process to help determine what the team knows about the sequence of events, what they do not know and what they need to find out.
3. Detailed flow charting – to enable the identification of the most significant problems where barriers might interrupt the flow of events for future prevention of similar events. Further causal analysis will centre on these issues to determine the underlying root causes.
4. Causal factor charting – by asking what changed, what conditions were present and what was not done at each of the key potential barrier points, the team identifies the underlying causal issues and depicts them in a causal sequence. These causal factors are then analysed to determine root causes. A complex healthcare case will typically identify between 3 and 5 root causes, although this number can vary.
5. Causation statements – a written description of each of the causal sequences presented in a statement linking the root causes to the outcome.
6. Recommendations – the team nominates actions to causation that would most likely prevent or mitigate the root causes.

4.2.4 Task 4 – Reporting

All privileged RCA Teams must prepare a final report. Once this final report is signed off by the CE it is not protected by statutory privilege. The report must contain:

a. A de-identified description of the reportable incident.
b. A clear written description of the findings of the analysis of the information gathered about the reportable incident.
c. The incident ID from the incident management system and MoH RIB number.
d. Causation statement/s that indicate the reasons the RCA Team considers the incident occurred (assuming that causation has been established). These should be written in accordance with the rules of causation established by NSW Health (see Appendix K).
e. Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident if root causes have been determined and such recommendations can be made.

The final RCA report must not include the name or address of an individual patient or service provider involved in the incident, unless that person has consented, in writing, to that information being disclosed. The final report must also not disclose, as far as is practicable, any other material that identifies or may lead to the identification of such an individual. It should not contain details about the membership of the RCA team.

The final RCA report may contain recommendations about system improvement opportunities that have been identified during the investigation, but have not contributed to the adverse outcome.
See Appendix L for the final report template. Organisations should use this template to ensure the final report meets legislative and policy requirements.

4.2.4.1 Signing off the final report

a. Prior to final sign-off, the RCA team may seek a formal written opinion from the CE about any proposed recommendations, in accordance with 4.1.4.
b. At the conclusion of the RCA, the RCA team must submit a copy of its signed report (but no other documentation) to the CE.
c. The CE is to review the RCA report and endorse the report prior to submission to the MoH.
d. Any disagreement that the CE may have with any of the recommendations in the final report is to be documented separately and submitted with the final report. It should outline the reason/s for the disagreement and any proposed alternative action. The original RCA team report is to be submitted unchanged accompanied by this additional documentation.

The CE may delegate the responsibility for endorsing the final report prior to submission to the MoH, but remains ultimately accountable for its content.

4.2.5 Variation in RCA Process

There are instances when a variation to the RCA process is acceptable. These instances include:

a. Assigning more than one incident to an RCA team where incidents are of the same classification.

b. Resolution of the RCA process in a shorter timeframe due to early completion of the investigation.

Any variation to the RCA process is to be documented in the final Report for sign off by the CE or nominated delegate.

4.2.6 Timeframes for RCA Process

The maximum time allowed for an RCA to be completed and the report to be submitted to the MoH is 70 calendar days from when the incident was notified in the incident management system. This timeframe and requirement for submission applies to all privileged RCAs regardless of the incident’s SAC.

4.2.7 Incidents involving the Coroner or Police

A referral for investigation of a death to the Coroner or the Police does not affect the requirement to undertake an investigation of an incident, including, where appropriate, an RCA.

If the Coroner requests a copy of the final RCA report, the LHD should provide it so that the Coroner is aware of any system changes that are occurring since the incident. The RCA report cannot, however, be tendered in evidence. If lawyers have been engaged to represent the LHD/SHN, the panel firm should forward the RCA report to the Coroner using a standard pro-forma letter which alerts the Coroner to S20R of the Health Administration Act 1982. If lawyers are not engaged, the CE should provide a covering letter with the report noting that the RCA has been provided for information only and that pursuant to S20R of the Health Administration Act 1982, it cannot be adduced or admitted in any proceedings.

A police or coronial investigation should not delay the commencement of an RCA.

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4.3 The Corporate RCA Process

4.3.1 Detailed investigation for Corporate SAC 1 incidents

All corporate SAC 1 incidents require either a root cause analysis or a detailed investigation to be undertaken. The RCA Report or Detailed Investigation Report must be provided to the Ministry of Health within 70 calendar days after the incident is notified in the incident management system. RCAs of corporate SAC 1 incidents do not attract the statutory privilege outlined in section 4 that applies to RCAs conducted in respect of clinical SAC 1 incidents.

Nevertheless, it is important that any serious or major corporate incident that receives a SAC 1 rating be properly investigated, so that the cause of the incident can be identified, and any appropriate remedial action is implemented to mitigate against a similar incident occurring again.

4.3.2 Membership of the Corporate Investigation Team

The RCA or Detailed Investigation Team should generally consist of 3 to 5 members. The members should have fundamental knowledge about the corporate processes in the area where the incident occurred, but not have been directly involved in the incident.

4.4 Steps in the Investigation

There are six key steps in undertaking the detailed investigation.

1. Assessment of the incident to determine whether the issues, e.g. negligence, criminal, corruption and make initial reports if appropriate e.g. police, ICAC.
2. Planning the investigation – identify scope, potential sources of information and resources required.
3. Conduct interviews and collect detailed information about the incident.
4. Assessing the results – once all information has been gathered, analyse the findings.
5. Barriers and recommendations – identify the barriers that would most likely prevent or mitigate the problem – then determine appropriate recommendations.
6. Reporting to the CE and the Ministry of Health.

4.5 Timeframes for Corporate Investigation Process

Detailed Investigation Reports must be submitted to the Ministry of Health within 70 calendar days of the incident being notified in the incident management system.

4.6 The Final RCA or Detailed Investigation Report

All RCA Teams or Detailed Investigation Teams must prepare a final Report.

The Report must contain:
- A description of the reportable incident.
- The Incident ID from the incident management system.
- A causation statement/s that indicates the reasons why the Investigation Team consider the incident occurred.
- Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident.
4.7 **Signing off the final report**

- At the end of the investigation, the Investigation Team is to provide a copy of their Report to the CE.
- The CE reviews the recommendations for consideration and endorsement before the Report is submitted to the Ministry.
- The CE is able to seek clarification from the Investigation Team if the rationale for any recommendation is unclear.
- The CE is also able to add recommendations to the final report but this must be clearly documented.
- If the CE does not agree with any of the recommendations then this is documented in the final report with the reason/s why and the proposed alternative action.
- The CE is to ensure that any relevant final internal and external notification requirements as outlined in legislation and relevant policies is attended to including the NSW Health Service Check Register.

5. **EVALUATION AND REVIEW**

**Clinical Incidents**

The DCG is responsible for monitoring and evaluating notifications in the incident management system at the local level to ensure:

a. The effective management of incidents that occur within health facilities.

b. The effectiveness of risk mitigation strategies.

The DCGs are to provide a report to their peak quality committee on the management of risks identified through incident management on a regular basis. This report includes a suite of performance indicators relevant to the LHD or SHN including those listed in Section 6.1.

5.1 **Performance Indicators**

5.1.1 **Clinical Incidents**

The key performance indicator in this policy is:

- Submission of final RCA Report to the MoH within 70 calendar days of incident notification in incident management system.

The following performance indicators should be included in the quarterly reports to the peak LHD/SHN quality committee:

a. Submission of a RIB to the MoH, concerning all SAC 1 incidents, both clinical and corporate, within 24 hours of notification in the incident management system.

b. Proportion of obligatory external notifications made within required time frames.

c. Proportion of SAC 2 incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.

d. Proportion of SAC 3 and 4 investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.

e. Proportion of SAC 1 incidents notified where incident status = new in ≤ 24hrs of incident occurring.
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f. Proportion of SAC 2, 3 and 4 incidents notified where incident status = new in ≤ 5 days of incident occurring.
g. Proportion of all actual SAC 2, 3 and 4 incidents where incident status = complete in ≤ 45 days of incident occurring.
h. Proportion of RCA recommendations completed within stated timeframe.
i. Proportion of incidents notified which have recommendations for action.
j. Proportion of incidents notified where recommendations have been completed.

5.2 Corporate Incidents

The key performance indicator in this policy is:
• Submission of final RCA Report (where relevant) to the MoH within 70 calendar days of incident notification in the incident management system.

The following performance indicators should be included in the incident management framework at a Health Service level for corporate incidents:
a. Submission of a Reportable Incident Brief to the MoH, concerning all SAC 1 corporate incidents within 24 hours of notification in the incident management system.
b. Proportion of obligatory external notifications made within required timeframes.
c. Proportion of SAC 2 incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
d. Proportion of SAC 3 and 4 investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
e. Proportion of SAC 1 incidents notified where incident status = new in ≤ 24hrs of incident occurring.
f. Proportion of SAC 2, 3 and 4 incidents notified where incident status = new in ≤ 5 days of incident occurring.
g. Proportion of all actual SAC 2, 3 and 4 incidents where incident status = complete in ≤ 45 days of incident occurring.
h. Proportion of RCA recommendations completed within stated timeframe.
i. Proportion of incidents notified which have recommendations for action.
j. Proportion of incidents notified where recommendations have been completed.

6. APPENDICES

6.1 Appendix A – Relevant NSW Health legislation, Policy Directives, Guidelines, Information Bulletins and other resources

6.1.1 Relevant NSW Health legislation

1) Health Administration Act 1982
2) Health Administration Regulation 2010
3) Health Care Complaints Act 1993 (NSW)
4) Health Records and Information Privacy Act 2002
5) Health Records and Information Privacy Regulation 2012
6) Health Services Act 1997
7) Privacy and Personal Information Protection Act 1998
8) Private Health Facilities Act 2007
9) Private Health Facilities Regulation 2010

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6.1.2 Relevant NSW Health Policy Directives and Guidelines

NSW Health Policy Directive, Guidelines and Information Bulletin can be accessed at:

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</tr>
<tr>
<td>Privacy Manual for Health Information (March 2015)</td>
<td></td>
</tr>
<tr>
<td>Open Disclosure Policy</td>
<td>PD2014_028</td>
</tr>
<tr>
<td>Protecting People and Property: NSW Health Policy and Standards for Security Risk Management</td>
<td>IB2013_024</td>
</tr>
</tbody>
</table>

202(13/02/14)
12. MEDICAL CARE

<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Document Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting of Maternal Deaths to the NSW Department of Health</td>
<td>PD2005_219</td>
</tr>
<tr>
<td>Workplace Health and Safety: Policy and Better Practice Guide</td>
<td>PD2013_050</td>
</tr>
</tbody>
</table>

6.1.3 Other Resources

2) IIMS Training Coordinator Guide
4) Documentation Retention and Disposal
5) NSW Ombudsman, Child Protection in the Workplace – Responding to Allegations against Employees

Policies, Guidelines and Information Bulletin

8) NSW Health Patient Matters Manual: Chapter 9 Health Records and information
9) Investigation Resources - (Contact the Internal Audit Unit of your organisation for further information).

Resource Name

ICAC Fact Finder, A 20-step guide to conducting an inquiry in your organisation, Nov 2003
NSW Ombudsman, Investigating Complaints – A manual for Investigators
NSW Ombudsman, Natural justice/Procedural fairness, Fact Sheet 2004
NSW Ombudsman, Reasons for Decisions Fact Sheet, June 2005

202(13/02/14)
### 6.2 Appendix B – Severity Assessment Code (SAC) May 2011

**STEP 1 Consequences Table** (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

<table>
<thead>
<tr>
<th>SERIOUS</th>
<th>MAJOR</th>
<th>MODERATE</th>
<th>MINOR</th>
<th>MINIMUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with Death unrelated to the natural course of the illness and suffering from the immediate expected outcome of the patient management or:</td>
<td>Patients suffering a Major permanent loss in function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and suffering from the expected outcome of patient management or any of the following:</td>
<td>Patients with Permanent reduction in bodily functioning (sensory, motor, physiologic or psychologically) unrelated to the natural course of the illness and suffering from the expected outcome of patient management or any of the following:</td>
<td>Patients requiring Increased level of care including:</td>
<td>Patients with No injury or increased level of care or length of stay</td>
</tr>
<tr>
<td>■ Suspected suicide ⁵</td>
<td>■ Suffering significant disfigurement as a result of the incident</td>
<td>■ Increased length of stay as a result of the incident</td>
<td>■ Review and evaluation</td>
<td></td>
</tr>
<tr>
<td>■ Unexpected intra-partum stillbirth or any of the following:</td>
<td>■ Patient at significant risk due to being absent against medical advice</td>
<td>■ Surgical intervention required as a result of the incident</td>
<td>■ Additional investigations</td>
<td></td>
</tr>
<tr>
<td>The Sentinel Events</td>
<td></td>
<td></td>
<td>■ Referral to another clinician</td>
<td></td>
</tr>
<tr>
<td>■ Procedures involving the incorrect patient or body part resulting in death or major permanent loss of function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Suspected suicide in an inpatient unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Retained instruments or other material after surgery requiring re-operation or further surgical procedure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Intravascular gas embolism resulting in death or neurological damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Haemolytic transfusion reaction resulting from ABO incompatibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Maternal death or serious morbidity associated with labour and delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Infant discharged to the incorrect family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>Corps of Commission</td>
<td>Corps of Commission</td>
<td>Corps of Commission</td>
<td>Corps of Commission</td>
</tr>
<tr>
<td>Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff</td>
<td>Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention</td>
<td>Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff</td>
<td>First aid treatment only with no lost time or restricted duties</td>
<td>No injury or review required</td>
</tr>
<tr>
<td>Staff</td>
<td>Death of visitor or hospitalisation of 3 or more visitors</td>
<td>Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution</td>
<td>Medical expenses incurred or treatment of up to 2 visitors not requiring hospitalisation</td>
<td>Evaluation and treatment with no expenses</td>
</tr>
<tr>
<td>Staff</td>
<td>Complete loss of service or output</td>
<td>Major loss of agency / service to users</td>
<td>Disruption to users due to agency problems</td>
<td>Reduced efficiency or disruption to agency working</td>
</tr>
<tr>
<td>Financial</td>
<td>Loss of assets replacement value due to damage, fire etc &gt; $1M, loss of cash/investments/assets due to fraud, overpayment or theft &gt; $100K or WorkCover claims &gt; $100K</td>
<td>Loss of assets replacement value due to damage, fire etc $100K-$500K, loss of cash/investments/assets due to fraud, overpayment or theft &gt; $100K or WorkCover claims $50K-$100K</td>
<td>Loss of assets replacement value due to damage, fire etc $50K to $100K or loss of cash/investments/assets due to fraud, overpayment or theft to $10K</td>
<td>Loss of assets replacement value due to damage, fire etc to $50K</td>
</tr>
<tr>
<td>Service</td>
<td>Toxic release off-site with detrimental effect. Fire requiring evacuation</td>
<td>Off-site release with no detrimental effects or fire that grows larger than an incipient stage</td>
<td>Off-site release contained with outside assistance or fire incident stage or less</td>
<td>Off-site release contained without outside assistance</td>
</tr>
</tbody>
</table>

---

⁵ Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from a Health Service or other PHO 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.

⁶ Suspected homicide committed by a person who has received care or treatment for mental illness from a Health Service or other PHO within 6 months 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.
Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome.

**STEP 2 Likelihood Table**

<table>
<thead>
<tr>
<th>Probability Categories</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent</td>
<td>Is expected to occur again either immediately or within a short period of</td>
</tr>
<tr>
<td></td>
<td>time (likely to occur most weeks or months)</td>
</tr>
<tr>
<td>Likely</td>
<td>Will probably occur in most circumstances (several times a year)</td>
</tr>
<tr>
<td>Possible</td>
<td>Possibly will recur – might occur at some time (may happen 1 to 2 years)</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Possibly will recur – could occur at some time in 2 to 5 years</td>
</tr>
<tr>
<td>Rare</td>
<td>Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)</td>
</tr>
</tbody>
</table>

**STEP 4 Action Required Table**

<table>
<thead>
<tr>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td><strong>Extreme</strong> risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the MoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the MoH.</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td><strong>High</strong> risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td><strong>Medium</strong> risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. <strong>Exception</strong> – all financial losses must be reported to senior management.</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td><strong>Low</strong> risks – manage by routine procedures – Aggregate data then undertake a practice improvement project.</td>
</tr>
</tbody>
</table>

NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the MoH if there is the potential for media interest or requires direct notification under existing MoH legislative reporting requirements or NSW MoH Policy Directive.

**STEP 3 SAC Matrix**

<table>
<thead>
<tr>
<th>CONSEQUENCE</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>SAC 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Likely</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Possible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Unlikely</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Rare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome.**
Appendix C – Sample letter informing CE of issues that may involve individual performance

DATE

INSERT NAME
INSERT FACILITY
INSERT ADDRESS

Dear [Insert Name]

I am writing to advise you that the RCA Team appointed on [Insert date] to investigate the Clinical incident [insert the incident management system ID], has identified that the incident raises issues that may relate to individual conduct.

The RCA Team is of the opinion that the incident raises matters that may involve (Please delete whichever of the following is not relevant).

• professional misconduct or unsatisfactory professional conduct
  (mandatory reporting requirement)

or

• a person suffering from an impairment
  (mandatory reporting requirement)

or

• unsatisfactory professional performance
  (discretionary reporting)

The above concerns of the RCA Team relate to [insert name of the staff member who is of concern]. In brief the matter of concern is [Insert a brief outline of the matter of concern].

The matter is referred to you in accordance with the terms of section 20O of the Health Administration Act 1982 for appropriate action.

The RCA Team will continue to investigate the systems issues related to the incident. The RCA Team will now conclude its investigation of this incident. (Please delete whichever is not relevant).

Yours Sincerely

Signature
Name
Designation
RCA Team Leader

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6.4 Appendix D – Reportable Incident Definition under Section 20L of the Health Administration Act 1982

Under the provisions of Division 6C of Part 2 of the Health Administration Act 1982 when a “reportable incident” involving a relevant Health Services organisation is reported to the Chief Executive of the organisation, the organisation is to appoint a root cause analysis team in relation to the reportable incident.

The Ministry of Health and Health Administration Regulation 2005 has determined that “Reportable Incident” is defined as follows.

A “Reportable Incident” involves:

(1) The incident must have had “serious clinical consequences” (as defined below) and the probability of recurrence must fall into one of categories (i) to (iv) listed below; OR
(2) The incident must have had “major clinical consequences” (as defined below) and the probability of recurrence must fall into one of categories (i) to (ii) listed below.

Under section 20M of the Act, an RCA is required to be conducted once the incident has been reported to the Chief Executive.

The Chief Executive should be notified via a Reportable Incident Brief in accordance with this Policy.

“Serious Clinical Consequence”

An incident with “serious clinical consequence” is one that involves:
• The death of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management.
• Suspected suicide of a person (including an inpatient or community patient) 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.
• Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months 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.
• Unexpected intra-partum stillbirth

OR

• The Sentinel Events those being:
  o Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
  o Suspected suicide of a patient in an inpatient unit.
12. MEDICAL CARE

- Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
- Intravascular gas embolism resulting in death or neurological damage.
- Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
- Maternal death or serious morbidity associated with labour or delivery.
- Infant discharged to wrong family.

“Major Clinical Consequences”

An incident with “major clinical consequences” is one which involves a patient:

- Suffering a major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management.
- Suffering significant disfigurement as a result of the incident.
- At significant risk due to being absent against medical advice/absconding.
- Subjected to threatened or actual physical or verbal assault requiring external or police intervention.

Probability of Recurrence

(i) Frequent - expectation that the incident will recur immediately or within weeks or months.
(ii) Likely - probability incident will recur more than once within 12 months.
(iii) Possible - possibility incident may recur at some time every 1 to 2 years.
(iv) Unlikely - possibility incident may recur at some time in 2 to 5 years.
### Appendix E – Statutory health corporations and Affiliated health organisations

In addition to Local Health Districts the following facilities are defined as “relevant health Services organisations” subject to the RCA privilege provisions under the *Health Administration Act 1982*:

**Statutory health corporations**
- The Agency for Clinical Innovation
- Bureau of Health Information
- Clinical Excellence Commission
- Health Education and Training Institute
- The Justice Health and Forensic Mental Health Network
- NSW Kids and Families
- The Sydney Children’s Hospitals Network (Randwick and Westmead) (incorporating The Royal Alexandra Hospital for Children)

**Affiliated Health Organisations**

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>Recognised establishment or recognised service</th>
</tr>
</thead>
</table>
| **Benevolent Society of New South Wales** | - Central Sydney Scarba Services  
- Early Intervention Program  
- Eastern Sydney Scarba Services  
- South West Sydney Scarba Services |
| **Calvary Health Care (Newcastle) Limited** | - Calvary Mater Newcastle |
| **Calvary Health Care Sydney Limited** | - Calvary Health Care Sydney |
| **Carrington Centennial Care Ltd** | - Carrington Centennial Nursing Home |
| **Catholic Healthcare Limited** | - St Vincent’s Health Service, Bathurst  
- Lourdes Hospital and Community Health Service (other than Holy Spirit Dubbo) |
| **Hammondcare Health and Hospitals Limited** | - Braeside Hospital, Prairiewood  
- Greenwich Hospital, Greenwich  
- Neringah Hospital, Wahroonga  
- Northern Beaches Palliative Care Service |
| **Karitane** | - Child and Family Health Services at Carramar, Fairfield, Liverpool and Randwick |
| **Mercy Care Centre, Young** | - Mercy Care Centre: Young, excluding Mount St Joseph’s Nursing Home |
| **Mercy Health Service Albury Limited** | - Mercy Health: Albury |
| **NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)** | - NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) |
| **Royal Rehabilitation Centre Sydney** | **Royal Rehabilitation Centre Sydney** |
| **Royal Society for the Welfare of Mothers and Babies** | - Tresillian Family Care Centres at Belmore, Penrith, Willoughby and Wollstonecraft |
| **St Vincent’s Hospital Sydney Limited** | - Sacred Heart Health Service  
- St Joseph’s Hospital (Auburn)  
- St Vincent’s Hospital, Darlinghurst |
| **Stewart House** | - Child health screening services at Stewart House Preventorium, Curl Curl |
| **The College of Nursing** | - Nursing Education Programs conducted under agreement with the NSW Department of Health |
| **The Uniting Church in Australia** | - Lottie Stewart Hospital  
- War Memorial Hospital (Waverley) |

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1Current as the date this Policy Directive was issued
6.6 Appendix F – Appointment of RCA Team

In accordance with Part 2, Division 6C of the Health Administration Act 1982

I, (insert name of Chief Executive) in accordance with section 20M of the Health Administration Act 1982, do hereby appoint the following persons to a Root Cause Analysis Team:

Insert name, title, background, employing organisation (team leader)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)

to consider and determine the root causes and contributing factors for the Clinical incident (insert the incident management system incident ID)

[insert summary of incident (include date)]

and to prepare a report of the root cause analysis in accordance with section 20O of the Health Administration Act 1982.

A root cause analysis conducted in accordance with this appointment shall be privileged in accordance with the terms of Part 2, Division 6C of the Health Administration Act 1982.

________________________
(signed)

________________________
(name of CE)

________________________
(date)
6.7 Appendix G – Letter to RCA Team Member

DATE

INSERT NAME
INSERT FACILITY
INSERT ADDRESS

Dear (Insert Name)

I am writing to you to advise that in accordance with Division 6C of the *Health Administration Act 1982* and the *NSW Health Incident Management Policy*, you have been appointed to an RCA team to determine the root cause and contributing factors for the Clinical SAC 1 reportable incident (*insert the incident management system ID*), as set out in the attached appointment document.

You have been selected as a member of this team because your expertise and experience is essential to the review of this incident.

The work of the RCA team will be privileged in accordance with the *Health Administration Act*. This has a number of implications, of which you should be aware:

1. **Restrictions on disclosure of information**

   You are required to maintain confidentiality in relation to your work as a member of this team, and you must not make your own record or discuss the investigation with anyone who is not part of the team, except for the purposes of exercising the function or any recommendation of an RCA team or for the purposes of preparing a report on the RCA.

2. **Statutory Privilege**

   The internal workings of RCA Teams appointed under the Health Administration Act are *privileged*. This means:
   - Members of the team cannot be compelled to give evidence about information obtained by them as part of their work on the RCA Team.
   - Members of the team cannot be compelled to produce to court, papers created or communications (written or verbal) made for the dominant purpose of the RCA Team carrying out its functions.
   - The final RCA report prepared by the RCA Team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate).
   - Members of the team are protected from personal liability, including actions for defamation, provided they act in good faith as a part of the RCA Team function.

Team members should be aware there are limits to the privilege:
   - The privilege will **not** apply to pre-existing documents such as a notification in the incident management system, or medical records or other records created for general care or management reasons.
   - The privilege does not prevent release of the final report outside the organisation, to the patient or family of the patient.

202(13/02/14)
3. **Concerns or complaints about an individual clinician not to be investigated**

The RCA Team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the *Health Administration Act*, where the RCA Team considers the reportable incident may involve professional misconduct or unsatisfactory professional performance or possible impairment issues the team **must** notify the CE in writing.

The RCA Team may, at its discretion, notify the CE if an incident may involve unsatisfactory professional performance.

Following notification to the CE the team will take no further action on the individual matter.

4. **Requirements for the Final RCA Report**

The final report must contain:

- the incident management system incident number
- the MoH RIB number
- a description of the incident
- causation statements outlining root causes, where root causes have been determined
- recommendations for change and improvement where appropriate and
- monitoring processes for follow-up of recommended actions.

The final report is to be submitted to the CE on the *(insert date)*

Thank you for your participation in this important patient safety activity.

Yours sincerely

Signature
Name
Designation
6.8 Appendix H – Appointment of Core RCA Team Members

In accordance with Part 2, Division 6C of the Health Administration Act 1982

I, (insert name of Chief Executive) in accordance with section 20M of the Health Administration Act 1982, do hereby appoint the following person/s to a Root Cause Analysis Team:

Insert name, title, background, employing organisation (Team leader)
Insert name, title, background, employing organisation (Team member)

to consider and determine the root causes and contributing factors for the Clinical incident (insert the incident management system incident ID)

[insert summary of incident (include date)]

and to prepare a report of the root cause analysis in accordance with section 20O of the Health Administration Act 1982.

The Root Cause Analysis Team member/s listed above shall form the core personnel of the team, and may commence work immediately gathering material relevant to the discharge of the RCA Team’s statutory functions under the Health Administration Act. I intend to appoint additional members to the RCA Team to assist it in its work as soon as further individuals with appropriate expertise and/or experience have been identified.

A root cause analysis conducted in accordance with this appointment, including any activities carried out by the core RCA Team members appointed by this instrument in carrying out their statutory functions, shall be privileged in accordance with the terms of Part 2, Division 6C of the Health Administration Act 1982.

(signed)

(name of CE)

(date)

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6.9 Appendix I – Appointment of Additional Member to RCA Team

On [insert date] in accordance with Part 2, Division 6C of the Health Administration Act 1982, I appointed core members of an RCA Team to consider and determine the root causes and contributing factors for the Clinical incident [insert the incident management system incident ID].

A copy of the original instrument of appointment is attached and marked “A”.

Having regard to the nature of the incident and the appropriate expertise and/or experience required by the RCA Team in order to properly carry out its statutory functions, in accordance with section 20M of the Health Administration Act 1982. I have determined to appoint the following additional members to that RCA Team:

Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)

and to prepare a report of the root cause analysis in accordance with section 20O of the Health Administration Act 1982.

A root cause analysis conducted in accordance with this appointment shall be privileged in accordance with the terms of Part 2, Division 6C of the Health Administration Act 1982.

________________________
(signed)

________________________
(name of CE)

________________________
(date)

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Appendix J – Notification of staff involved in incident

DATE

INSERT NAME
INSERT FACILITY
INSERT ADDRESS

Dear [insert name]

Following the recent reporting of incident number xxx in the Incident Information Management System and in accordance with the Health Administration Act 1982 and the NSW Health Incident Management Policy, the [insert name] Local Health District Chief Executive has appointed a Root Cause Analysis (RCA) Team. The team will review systems and processes surrounding the incident to determine the root cause and factors contributing to the clinical incident [provide a brief description of the incident]. Because of your knowledge of this incident, a member of the RCA Team may contact you to arrange a suitable time to discuss the circumstances of the incident from your perspective. You are entitled to have a support person with you during the interview should you so wish.

The Health Administration Act 1982 outlines specific restrictions on and responsibilities of RCA Teams. These include

1. **Restrictions on disclosure of information**

Members of the Root Cause Analysis Team are required to maintain confidentiality in relation to this investigation. They must not make their own records or discuss the investigation with anyone who is not part of the team, except for the purposes of the RCA Team or for the purposes of preparing a report on the RCA.

2. **Statutory Privilege**

The internal workings of RCA Teams appointed under the Health Administration Act are privileged. This means:

- RCA Team members cannot be compelled to produce or give evidence of any document created by or on behalf of, at the request of, the RCA Team, where the document was for the dominant purpose of the conduct of the investigation by the RCA Team.
- Any document that you prepare, or any communication (written or verbal) that you make, that is for the dominant purpose of assisting with the conduct of the investigation by the RCA Team cannot be produced before any court, tribunal or other person.
- The final RCA report prepared by the RCA Team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate).
- RCA Team members acting in good faith for the purposes of the exercise of the RCA Team’s function are also protected from personal liability, including actions for defamation.

202(13/02/14)
There are limits to the privilege:

- The privilege will **not** apply to pre-existing documents such as incident management system notification classification, or medical records or other records created for general care or management reasons.
- The privilege does not prevent release of the final Report outside the organisation, to the patient or family of the patient.


3. **Concerns or complaints about an individual clinician not to be investigated**

The RCA Team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the *Health Administration Act*, where the RCA Team considers the reportable incident **may** involve professional misconduct or unsatisfactory professional conduct or possible impairment issues the team **must** notify the Chief Executive in writing.

The RCA Team may, at its discretion, notify the Chief Executive in writing if an incident **may** involve an unsatisfactory professional performance.

Once the CE has been notified the team will take no further action on the individual matter.

If you wish to discuss this matter, further please feel free to contact

*insert name, title and contact number*

Thank you for your participation in this important patient safety activity.

Yours sincerely

Signature
Name
Designation
6.11 Appendix K – The Five Rules of Causation

*Adapted from David Marx and the Veterans Affairs National Center for Patient Safety

The five rules of causation are designed to improve the analysis and documentation of causal issues within the RCA process.

- **Rule 1 - Causal Statements must clearly show the “cause and effect” relationship.**

When describing why an event has occurred, you should show the link between your root cause and the bad outcome. Focus on showing the link from your root cause to the undesirable patient outcome you are investigating.

**Example:**

- **Incorrect:** The established rostering practices in the surgical unit were inappropriate.
- **Correct:** The established rostering practices in the surgical unit led to the resident’s fatigue which increased the likelihood that he submitted a test request for the incorrect patient via the electronic system.

- **Rule 2 – Use specific and accurate descriptors for what occurred, avoiding negative or vague words**

To force clear cause and effect expressions (and avoid inflammatory statements), avoid the use of vague or negative words that can be replaced by a more accurate, clear description. Even words like “carelessness” and “complacency” are bad choices because they are broad, negative judgments that do little to describe the actual conditions or behaviours that led to the mishap.

**Example:**

- **Incorrect:** Poorly trained nurse.
- **Correct:** The level of the nurse’s training increased the likelihood that she misunderstood the IV pump controls which led to missing steps in the programming of the dose and rate. This resulted in the patient receiving a rapid infusion of the drug and his cardiac arrest.

- **Rule 3 – Identify the preceding cause(s), not the human error**

Most of our mishaps involve at least one human error. Unfortunately, the discovery that a human has erred does little to aid the prevention process. You must investigate to determine WHY the human error occurred. It can be a system-induced error (e.g., step not included in medical procedure) or an at-risk behaviour (doing task by memory, instead of a checklist). **For every human error in your causal chain, you must have a corresponding cause.** It is the cause of the error, not the error itself, which leads us to productive prevention strategies.

**Example:**

- **Incorrect:** The registrar did not review the discharge summary.
- **Correct:** The absence of replacement medical staff to cover registrars on sick leave led to the registrar being rushed and taking short cuts resulting in the patient being discharged with the wrong discharge summary. This resulted in the GP continuing the wrong dose of anticoagulant therapy and the patient’s gastro-intestinal bleed.
• Rule 4 - Each procedural deviation must have a preceding cause.

Procedural violations are like errors in that they are not directly manageable. Instead, it is the cause of the procedural violation that we can manage. If a clinician is violating a procedure because it is the local norm, we will have to address the incentives that created the norm.

Example:

- **Incorrect:** The pharmacy technician did not follow the correct dispensing procedure.
- **Correct:** The absence of an orientation programme led to the pharmacy technician being unaware of the practice of routine checking by two persons which resulted in the incorrect dispensing of the medication. This led to the provision of the wrong strength of solution resulting in the respiratory arrest of the child.

• Rule 5 - Failure to act is only causal when there was a pre-existing duty to act.

The duty to act may arise from standards and guidelines for practice; or other duties to provide patient care. We need to find out why this mishap occurred in our system as it is designed today. For instance, a doctor’s failure to prescribe a cardiac medication after an infarct can only be causal if he was required by established guidelines to do so.

Example:

- **Incorrect:** The Visiting Medical Officer (VMO) did not review the patient after surgery.
- **Correct:** The absence of a requirement for VMOs to review patient’s after they have undergone a surgical procedure led to the patient not being attended by a specialist for 10 days which contributed to the delay in recognition of the patient’s deterioration and her subsequent death.
6.12 Appendix L – Final RCA Report

### Final RCA Report

<table>
<thead>
<tr>
<th>Reference Numbers (where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH RIB No:</td>
</tr>
<tr>
<td>LHD TRIM No:</td>
</tr>
<tr>
<td>RCA No:</td>
</tr>
</tbody>
</table>

### Incident Details

<table>
<thead>
<tr>
<th>Date of Incident:</th>
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</thead>
<tbody>
<tr>
<td>Date of Incident Notification in IIMS:</td>
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</tbody>
</table>

### Reporting Details

<table>
<thead>
<tr>
<th>Staff member/s responsible for feedback to staff (include position)</th>
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</thead>
<tbody>
<tr>
<td>Staff member/s responsible for feedback to patient/support person (include position)</td>
</tr>
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</table>

<table>
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<tr>
<th>By when?</th>
</tr>
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<tbody>
<tr>
<td>Final RCA report signed off by RCA Team on:</td>
</tr>
<tr>
<td>Date report due to CE:</td>
</tr>
<tr>
<td>Date signed by CE:</td>
</tr>
<tr>
<td>Date due to be submitted to NSW Ministry of Health:</td>
</tr>
<tr>
<td>Date submitted to NSW Ministry of Health:</td>
</tr>
</tbody>
</table>

### Notification of decommissioning of RCA

- **RCA decommissioned:** YES / NO
  - (please select)
- **Reason for decommissioning:**
- **If the RCA has been decommissioned has an investigation been undertaken on the systems issues:** YES / NO
  - (please select)

### Comments

### Referral to other committees/agencies

<table>
<thead>
<tr>
<th>Health Care Complaints Commission</th>
<th>Coroner</th>
</tr>
</thead>
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<tr>
<td>[ ]</td>
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<tr>
<td>Other</td>
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<tr>
<th>If ‘Other’ please specify:</th>
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</table>

### Contact Details

<table>
<thead>
<tr>
<th>LHD / SHN</th>
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</thead>
<tbody>
<tr>
<td>Contact Person:</td>
</tr>
<tr>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Email Address:</td>
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</tbody>
</table>

---

202(13/02/14)
Final RCA Report

Description of incident that was investigated
(this is a concise chronological account of what happened to the patient)

Summary of RCA Team findings and recommendations

The following summary provides an analysis of the event, any contributing factors and what the team is recommending to prevent a similar occurrence in the future.

On investigation, the RCA Team found...

Following the investigation, the RCA team (Please select the appropriate box/boxes)

- was unable to identify any root causes or contributory factors
- was unable to identify any gaps in service delivery
- identified systems improvement opportunities unrelated to the root causes / contributing factors.

For Internal use only:

| | Attached in TRIM | | Date |
| | Copied to the CEC | | Date |
| | Filed | | File No. |

202(13/02/14)
12. MEDICAL CARE

Table 1 – Root Cause/Contributing Factors Table (a requirement when causes have been identified)
Documentation of causation statements is a legislative requirement. All causation statements must comply with the Rules of Causation.
Each root cause displayed must be addressed in the action plan.
Describe the root cause and categorise the cause or contributing factor according to the triage cards and flip chart definitions.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Description (of Root Cause / Contributory factor)</th>
<th>Category (described in the Checklist Flip Chart for Root cause Analysis Teams)</th>
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<tbody>
<tr>
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<td>Communication</td>
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</tbody>
</table>
### Table 2 – RCA Team Recommendations (a requirement when causes have been identified)

<table>
<thead>
<tr>
<th>Causation statement number&lt;sup&gt;8&lt;/sup&gt;</th>
<th>Recommendation/s description of action to be taken</th>
<th>Risk Classification.</th>
<th>Position of person responsible for implementation Recommendation/s</th>
<th>Outcome measure</th>
<th>Completion date e.g. 3 months = 22/02/06</th>
<th>Management Concurrence Y/N</th>
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</table>

<sup>8</sup> The number here relates to the numbered causation statement in Table 1 ROOT CAUSE/CONTRIBUTING FACTORS TABLE.

<sup>9</sup> Actions can be classified as eliminating, controlling or accepting the risk. If accepting the risk, risk minimisation strategies need to be in place. Weaker actions are those that accept the risk and include redundancy/double checks, warnings and labels, new procedures and policies, new memorandums, training in absence of knowledge deficit and additional study/analysis. Medium actions are those taken to control the risk and include checklists and cognitive aids, increased staffing, decreased workload, use of read backs, eliminating look-alikes and sound alikes and eliminating or reducing distractions. Stronger actions are those taken to eliminate the risk and include simplified processes that remove unnecessary steps, standardise equipment, processes or care plans.
Table 3 – Systems improvement opportunities unrelated to root causes or contributing factors (modification of these issues would not have helped to prevent the event)

<table>
<thead>
<tr>
<th>Item No</th>
<th>Description</th>
<th>Recommendation</th>
<th>Position of person responsible for implementation Recommendation/s</th>
<th>Outcome measure</th>
<th>Completion date e.g. 3 months = 22/02/06</th>
<th>Management Concurrence Y/N</th>
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</tbody>
</table>
RCA Report Final Sign Off
The recommendation/s from the Root Cause Analysis of the incident are endorsed/not endorsed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ CE / Service Director]</td>
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<tr>
<td>Name</td>
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<td>Name</td>
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</tbody>
</table>

I, ____________________________, from ____________________________, endorse / endorse with the following provisions/ do not endorse \(^*\) the recommendations of this RCA.

(Signature)

Chief Executive / Service Director
Date

\(^*\) If not endorsed, please provide reasons and document revised action.
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.
12. MEDICAL CARE

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**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEC</td>
<td>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.</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>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.</td>
</tr>
<tr>
<td>The Ministry</td>
<td>NSW Ministry of Health.</td>
</tr>
<tr>
<td>DCG</td>
<td>Director, Clinical Governance.</td>
</tr>
<tr>
<td>Health Services</td>
<td>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</td>
</tr>
<tr>
<td>HCCC</td>
<td>Health Care Complaints Commission.</td>
</tr>
<tr>
<td>IIMS</td>
<td>Incident Information Management System</td>
</tr>
<tr>
<td>IRR</td>
<td>Information Risk Rating</td>
</tr>
<tr>
<td>Local Health Districts, Specialty Health Networks and Services</td>
<td>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.</td>
</tr>
<tr>
<td>Private Health Facilities</td>
<td>Private health facilities licensed under the Private Health Facilities Act 2007.</td>
</tr>
<tr>
<td>Public Health Organisations (PHO)</td>
<td>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.</td>
</tr>
<tr>
<td>RIB</td>
<td>Reportable Incident Brief</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>SABS</td>
<td>Safety Alert Broadcast System</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>SABS document</th>
<th>Aim</th>
<th>Distribution strategy*</th>
<th>Health service response on receipt of SABS document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Alert</td>
<td>Alert LHDs/Specialty Health Networks to a safety matter needing <strong>immediate attention and mandatory action.</strong> &lt;br&gt;The colour coding for Safety Alerts is <strong>RED.</strong></td>
<td>The CEC distributes SABS to: &lt;br&gt;• The Chief Executive; and &lt;br&gt;• The officer responsible for designated action/s (indicated on the SABS). The LHD/Specialty Health Network distributes SABS to: &lt;br&gt;• staff identified in the Alert; and &lt;br&gt;• other relevant staff.</td>
<td>• Acknowledge receipt within a defined time frame, usually 2 working days. &lt;br&gt;• Ensure completion of required action/s within designated timeframe. &lt;br&gt;• Ensure local policies and guidelines are updated to include new information if required. &lt;br&gt;• Submit required responses to the CEC within the designated timeframe at <a href="mailto:quality@cec.health.nsw.gov.au">quality@cec.health.nsw.gov.au</a>.</td>
</tr>
<tr>
<td>Safety Notice</td>
<td>Informs LHDs/Specialty Health Networks or services about potential quality and safety issues requiring <strong>risk assessment at the local level</strong> to determine appropriate action regarding any identified problems. &lt;br&gt;The colour coding for Safety Notices is <strong>AMBER.</strong></td>
<td>The CEC distributes to: &lt;br&gt;• The Chief Executive; and The officer responsible for suggested action/s. The LHD/Specialty Health Network distributes SABS to: &lt;br&gt;• staff identified in the Notice; and &lt;br&gt;• other relevant staff.</td>
<td>• Consider relevance of information to the LHD/Specialty Health Network or service. &lt;br&gt;• Review relevant policies and procedures in place to address the issues. &lt;br&gt;• Identify required action/s and implement. &lt;br&gt;• Submit required responses to CEC within the designated timeframe at <a href="mailto:quality@cec.health.nsw.gov.au">quality@cec.health.nsw.gov.au</a>.</td>
</tr>
<tr>
<td>Safety Information</td>
<td>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. &lt;br&gt;The colour coding for Safety Information is <strong>GREEN.</strong></td>
<td>The CEC distributes to: &lt;br&gt;• The Chief Executive and the Director of Clinical Governance. The LHD/Specialty Health Network ensures: &lt;br&gt;• the availability of Safety Information to all staff.</td>
<td>• Consider relevance of the information to LHD/Specialty Health Network. &lt;br&gt;• Identify any action/s and implement (if any).</td>
</tr>
</tbody>
</table>

12. MEDICAL CARE

12.60
12. MEDICAL CARE

**SABS PROCESS**

**NOTICE**

- **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

**INFORMATION**

- **Health Service Responsibility**
  - Make available SABS notification 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**

**MEDICAL CARE**

**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
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.


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


<table>
<thead>
<tr>
<th>NSW Policies Directives</th>
<th>Document No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lookback Policy</td>
<td>PD2007_075</td>
</tr>
<tr>
<td>Open Disclosure Policy</td>
<td>PD2014_028</td>
</tr>
<tr>
<td>Patient Safety and Clinical Quality Program</td>
<td>PD2005_608</td>
</tr>
<tr>
<td>NSW Health Policy Directives and Other Policy Documents</td>
<td>PD2014_043</td>
</tr>
<tr>
<td>Complaint Management Policy</td>
<td>PD2006_073</td>
</tr>
</tbody>
</table>

5.2 References


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

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**Title**

**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

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179(30/05/13)
6.2 Safety Notice Template

Safety Notice 00#/YY

Title

(distributed by) 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
- XXXXXXXXXXX
- XXXXX
- XXXXX

Expert Reference Group
Content reviewed by:
- XXXXXXXXXXX
- XXXXXXXXXXX
- XXXXX
- XXXXX

Clinical Excellence Commission
Tel. 02 9269 5500
Fax. 02 9269 5569
Email: quality@cec.health.nsw.gov.au
Internet Website: http://www.health.nsw.gov.au/quality/stats
Intranet Website: http://intranet.health.nsw.gov.au/quality/stats/

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.

Review date
month year

179(30/05/13)
6.3 Safety Information Template

Safety Information  00#/YY

Title

Distributed to:
- Chief Executives
- Directors of Clinical Governance
  - XXXXX
  - XXXXX

Expert Reference Group
Content reviewed by:
- XXXXXXXXXXX
  - XXXXXXXX
  - XXXX
  - XXXXX

Clinical Excellence Commission
Tel: 02 9259 5500
Fax: 02 9259 5599
Email: quality@bch.health.nsw.gov.au

Review date
month year

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.
NSW HOSPITAL IN THE HOME (HITH) GUIDELINE (GL2013_006)

PURPOSE

In NSW, Hospital in the Home (HITH) is defined as the range of service delivery models providing (acute and post-acute) care that is delivered in home (including Residential Aged Care Facilities), clinic or other settings as a substitution or avoidance of hospital.

The HITH guidelines have been developed by clinicians to provide clear, standardised guidance to Local Health Districts and Specialty Health Networks regarding terminology, key elements and principles of HITH in NSW.

The need for the delivery of acute care in the home as an alternative to care in a hospital setting is being driven by advances in medicine, increased pressure on the healthcare system and evidence of improved health outcomes for patients who spend less time in hospital.

The guidelines reflect evidence based, best clinical practice, expert consensus and opinion and although they are not mandatory, they have been endorsed by clinicians and NSW Ministry of Health with an expectation that the key principles will be utilised in standardising practice across NSW.

KEY PRINCIPLES

The underlying principles will support Local Health Districts and Specialty Health Networks (LHD/SHN) to develop, evaluate and monitor HITH services to meet local needs.

Underpinning these guidelines are the following key principles:

- Keeping people healthy and out of hospital
- Local and system level strategic planning for growth of HITH to meet acute bed demand
- Mandatory reporting and data collection framework
- Consistency of evaluation
- Leveraging of funding streams including Activity Based Funding

USE OF THE GUIDELINE

Hospital in the Home (HITH) services have been developed to deliver selected types of patient-centred, multidisciplinary acute care to suitable, consenting patients at their home or clinic setting as an alternative to inpatient (hospital) care.

Where suitable, HITH services are made available to both children and adults with certain types of conditions, able to be treated outside of a hospital setting. HITH is proven to be as clinically effective as hospital care and delivers as good, if not better, health outcomes for patients in a familiar setting.

The Hospital in the Home Guideline will assist in guiding LHDs/SHNs in developing and establishing HITH services and details the requirements for the consistent implementation of data reporting for Hospital in the Home services by Local Health Districts (LHDs).

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
WAITING TIME AND ELECTIVE SURGERY POLICY (PD2012_011)


PURPOSE

The Waiting Time and Elective Surgery Policy is the reference guide for facilities to manage elective surgical waiting lists. The policy covers the procedures that facilities are required to follow and adequately manage waiting lists.

MANDATORY REQUIREMENTS

This policy has been developed to promote clinically appropriate, consistent and equitable management of elective surgery patients and waiting lists in public hospitals across NSW. Local Health Districts, Sydney Children’s Hospitals Network, St Vincent’s Health Network and hospitals must actively manage in compliance with the contents of this policy.

IMPLEMENTATION

Local Health Districts, Sydney Children’s Hospitals Network and St Vincent’s Health Network are responsible for the implementation of the Waiting Time and Elective Surgery Policy.

The Chief Executive has overall responsibility for ensuring:

• There are mechanisms in place to implement this policy
• Compliance with NSW Department of Health requirements
• Validation of the accuracy and integrity of reported data
• Regular review of individual hospital performance
• Training and education programs are in place for staff involved in managing elective patients and waiting lists
• 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 (PAS)/WLCOS.

The responsibilities of various positions under this policy are detailed in the Introduction (page 1) of the procedure.

1. INTRODUCTION

Each year approximately 200,000 patients have elective procedures/surgery in NSW public hospitals. Patients are placed on a waiting list and given a clinical priority depending on the seriousness of their condition. Clinical priority categories 1, 2, 3 referred to in this policy align with Commonwealth Categories in the National Data Dictionary.

Managing elective surgery patients and waiting lists is a key priority for the Government and NSW Health. The community insists on transparency and accountability. Patients expect timely, accessible and high quality patient centred services.

Waiting list management is a challenging, dynamic and complex process requiring input from and coordination by a multidisciplinary team.
The Waiting Time and Elective Surgery Policy has been developed to promote clinically appropriate, consistent & equitable management of elective surgery patients and waiting lists in public hospitals across NSW and has been approved by the Surgical Services Taskforce (SST). Hospitals must actively manage in compliance with the contents of this document.

This policy covers both Local Health Districts and the two networks (St Vincent’s Health Network & Sydney Children’s Hospitals Network).

The Chief Executive has overall responsibility for ensuring:
• There are mechanisms in place to implement this policy.
• Compliance with NSW Health Department requirements.
• Validation of the accuracy and integrity of reported data.
• Regular review of individual hospital performance.
• Training and education programs are in place for staff involved in managing elective patients and waiting lists.
• 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 (PAS)/WLCOS.

Consistent, equitable and efficient waiting list management through the application of this policy is expected to achieve the following outcomes:
• A transparent, patient focused process.
• Well informed patients and staff (clinical and non clinical) who understand the process, their roles and responsibilities.
• Patients are assigned to the correct clinical priority category.
• Patients are treated within clinically appropriate timeframes.
• There is timely notification and effective communication with the patient in relation to their planned admission date for surgery and practical arrangements.
• Active management of patients and their waiting list booking.
• Appropriate and timely removal of patients from the waiting list.
• Accurate data collection and documentation.
• Accurate and timely auditing and reporting.
• Regular system evaluation, monitoring and improvement.
• Efficient and effective management of demand vs available resources to promote the most effective use of available resources.
• Access to treatment is based on clinical need regardless of health insurance status.

RESPONSIBILITES

Responsibilities of the Patient
• Follow the procedures and advice outlined in the information provided by the hospital.
• Advise the hospital of any change in decision to undergo the procedure/treatment.
• Follow hospital admission procedure and advise of any changes to the proposed admission such as availability or change of address or other contact details.
• Attend any preadmission appointments as required and present, on the day of admission.

Responsibilities of the GP
• Arrange referral for patients to a hospital which has surgeons with the appropriate expertise and waiting time for the anticipated elective surgical procedure (outpatient or private rooms waiting time, travelling time and patient choice should be considered).
12. MEDICAL CARE

- Provide the hospital with appropriate health information and personal details of the patient with referral.
- Liaise with the referring surgeon if there is a change in indications for surgery or change in patient’s health with implications for surgery and treatment.

**Responsibilities of the Surgeon**

- Explain proposed procedure/treatment, options for treatment and potential complications.
- Anticipated length of stay and obtain written informed consent from the patient.
- Assign a clinical priority category for the procedure/treatment, as it applies to the individual patient as per the “Advice for Treating Doctors”.
- If patient is classified as staged, the time interval when the patient will be ready for care should be indicated.
- Ensure that RFA forms are legible and minimum data set is completed.
- Forward the completed RFA direct to the hospital within 3 working days of the patient agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer).
- Initiate prompt and appropriate communication with the referring GP regarding management of the patient.
- Referring doctors must ensure they are available to perform the procedure within the clinical priority timeframe. Alternatively, the clinician should make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe.
- Review Waiting List at least monthly and verify with the hospital.

**Responsibilities of the Surgical Booking Clerk**

- Ensure all relevant data is entered on the waiting list system within 3 working days, including changes notified by the patient, GP, surgeon, registrar, administrative or other staff.
- Check allocated Clinical Priority Categories against the Reference List (IB2012_004).
- Ensure all documentation and electronic data input is accurate, legible and complete.
- Comply with local procedures/protocols for administrative processes that support this Policy.
- Ensure procedures included in the excluded or discretionary list of procedures are not added to the waiting list without approval from the Clinical Director of Surgery.

**Responsibilities of the Clinical Director of Surgical Services**

- Ensure clinician compliance with this Policy.
- Review and manage applications to perform cosmetic and discretionary procedures or exceptions to the Policy.
- Promote efficient and effective waiting list management by clinicians within their hospital.
- Liaise with the District/Network Program Director of Surgical Services for escalation of any issues.

**Responsibilities of the District/Network Program Director of Surgical Services**

- Ensure all staff comply with this Policy.
- Ensure that mechanisms, including clear administrative and clinical procedures/protocols, are in place to implement this Policy and promote efficient and effective waiting 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.
- Facilitate prompt and appropriate communication with the referring GP regarding management of the patient.
- Liaise with the State Program Director of Surgery and the Surgical Services Taskforce.
2. REFERRING PATIENTS TO THE WAITING LIST

<table>
<thead>
<tr>
<th>POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recommendation for Admission Form (RFA) only accepted from clinicians who are currently contracted and appropriately credentialled with the Local Health District/Network or facility.</td>
</tr>
<tr>
<td>• Recommendation for Admission Form (RFA) must be complete, legible and accurate</td>
</tr>
</tbody>
</table>

The referring doctor must:
- Have fully informed the patient about the planned procedure or treatment and obtained their consent (see PD2005_406)
- Complete an approved Recommendation for Admission Form (RFA)
- Forward the completed RFA to facility within 3 working days

2.1. Clinical Priority Categories

Categorisation of Elective patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner. A Clinical priority category is assigned by the referring doctor.

Clinical Priorities are:

<table>
<thead>
<tr>
<th>Clinical Priority Category</th>
</tr>
</thead>
</table>
| *A clinical assessment of the priority with which a patient requires elective admission*

| Category 1 | Admission **within 30 days** desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency | Ready for Care |
|---------------------------|
| Category 2 | Admission **within 90 days** desirable for a condition which is not likely to deteriorate quickly or become an emergency |
| Category 3 | Admission **within 365 days** acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency |
| Category 4 | Patients who are either clinically not ready for admission (staged) and those who have deferred admission for personal reasons (deferred) | Not Ready for Care |

2.1.1. Reclassification of Clinical Priority Category

Documented evidence must be readily available to validate any changes to a patient’s clinical priority category (see Advice for Referring & Treating Doctors, Reference List for Clinical Priority Categories, [IB2012_004]). Documentation must be signed by the relevant staff member and include date and time of notification of priority change, the person notifying priority change, reason for priority change (Appendix 12).
12. **MEDICAL CARE**

If there is no supporting clinical information supplied then the referring doctor should be contacted to provide the additional clinical information that supports the selected Clinical Priority Category (CPC). In addition there should be an escalation process to a senior manager where clinical information is missing.

Only an authorised doctor may undertake reclassification of patients between categories 1, 2 and 3.

If any changes are made to a patient’s original clinical priority category, by an authorised doctor, then the referring doctor should be notified, in writing (Appendix 7), of the change.

Written advice of any clinical priority category change should always be sent to the treating doctor.

The documentation must be attached to or be part of the RFA and will become part of the patient’s medical record. The electronic waiting list must be updated with any changes.

### 2.2. Urgent Surgery - Inclusion/Exclusion Criteria

The Category 1 Clinical Priority Category is specifically reserved for those patients whose clinical condition has the potential to deteriorate to the point that an emergency admission may eventuate if the condition is not treated within 30 days.

This category is **not** to be used to advance the date for elective surgery patients whose clinical condition is not likely to become an emergency e.g. vasectomy, joint replacement surgery, routine cataract surgery, routine tonsillectomy, removal of pins and plates unless for extenuating clinical reasons which have been discussed with senior management or the Local Health District/Network Program Director of Surgery or equivalent.

Where there is concern regarding the allocation of the Category 1 status, the issue should be referred to senior management and the Local Health District/Network Program Director of Surgery.

Refer to “Advice for Referring and Treating Doctors” booklet for further information, IB2012_004.

### 2.3. Cosmetic & Discretionary Surgery - Inclusion/Exclusion Criteria

Surgery should meet an identified clinical need to improve the physical health of the patient.

- The approval of the Local health District/Network Program Director of Surgery, in consultation with senior management should be sought by the referring doctor before cosmetic and discretionary procedures are undertaken in any public hospital facility.
- The referring doctor should document on the Request for Admission 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 on the list below or where there is doubt about the nature of the proposed surgery, the request should be referred to the Local Health District/Network Program Director of Surgery for review prior to the patient being added to the waiting list.
- The patient should be advised when the Recommendation for Admission is going through the approval process.
The following list of surgical procedures should not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient’s physical health.

### Cosmetic Procedure | Exception
--- | ---
Bilateral breast reduction | Severe disability due to breast size
Bilateral breast augmentation | Nil
Replacement breast prosthesis | Replacement for post cancer patients only
Hair transplant | Disfiguring hair loss due to severe burn
Blepharoplasty/Reduction of upper or lower eyelid | Severe visual impairment
Total rhinoplasty | Major facial trauma - congenital abnormality – paediatrics
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
Varicose Veins | CEAP Grade >C3
Laser photoocoagulation | Nil

### Discretionary Procedure | Exception
--- | ---
Gender reassignment surgery | Congenital abnormalities in children
Lengthening of penis procedure | Congenital abnormalities in children
Insertion of artificial erection devices | Nil
Reversal of sterilization | Nil
Social circumcision | Nil
TMJ Arthrocentesis | Nil
Labioplasty | Nil

### New Procedures and Prostheses
Local Health District/Network New Interventions Assessment Committees or equivalent must formally approve new procedures not previously undertaken and the clinicians should be appropriately credentialed by relevant committee to undertake the procedure before patients are added to the waiting list. A doctor may only refer patients for addition to the waiting list for procedures for which the doctor has been given privileges by the relevant credentials committee.

For additional information refer to:
Monitoring and Reporting

Monitoring of the addition of these excluded procedures to the waiting list will be undertaken by each Local Health District/Network as part of normal waiting list management according to NSW Health Department policy.

Demand Management

Patients added to the elective surgery waiting list should be treated within their clinical priority timeframe.

Managers & Department Heads should actively monitor the current volume of each surgeon’s waiting list plus the additions to the waiting list to ensure that there is capacity to undertake the patient’s surgery within the recommended timeframe. If the surgeon does not have the capacity to undertake the surgery within the clinical priority timeframe then this should be managed in conjunction with the surgeon, patient and referring General Practitioner by considering:

- Additional theatre time at same or other facility.
- Transfer of patients to another surgeon with a shorter waiting list at the same facility.
- Transfer of patients to another surgeon with a shorter waiting list at another facility.
- Private sector option if the above prove unsuccessful (Local Health District/Network responsible for expenses incurred).

Dental Surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the Priority Oral Health Program and List Management Protocols Policy Directive (PD2008_056).

2.4. Completion of Recommendation for Admission Form (RFA)

- The following minimum data set on the Recommendation for Admission Form (RFA) is to be obtained by:

<table>
<thead>
<tr>
<th>Referring Doctor</th>
<th>Admission/Booking Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s full name</td>
<td>Planned admission date (if allocated)</td>
</tr>
<tr>
<td>Patient’s address</td>
<td>Anticipated election status</td>
</tr>
<tr>
<td>Patient’s contact information (home, work &amp; mobile telephone)</td>
<td>Status review date (staged patients)</td>
</tr>
<tr>
<td>Patient’s gender</td>
<td>Short notice/Standby offers</td>
</tr>
<tr>
<td>Patient’s date of birth</td>
<td>Aboriginal &amp; Torres Strait Islander Status (NSW Health Data Dictionary)</td>
</tr>
<tr>
<td>Medicare number</td>
<td></td>
</tr>
<tr>
<td>Clinical priority category</td>
<td></td>
</tr>
<tr>
<td>If classified as staged, the time interval when the patient will be ready for care should be indicated</td>
<td></td>
</tr>
<tr>
<td>Discharge intention (i.e. day only, or indication of number of nights in hospital)</td>
<td></td>
</tr>
<tr>
<td>Presenting problem</td>
<td></td>
</tr>
<tr>
<td>Planned procedure/treatment</td>
<td></td>
</tr>
<tr>
<td>Significant medical history (including allergies)</td>
<td></td>
</tr>
<tr>
<td>Treating doctor (if different)</td>
<td></td>
</tr>
<tr>
<td>Patient’s signed consent (if available)</td>
<td></td>
</tr>
<tr>
<td>General Practitioner’s name and address (if available)</td>
<td></td>
</tr>
<tr>
<td>Interpreter required</td>
<td></td>
</tr>
</tbody>
</table>
Any other relevant information should be included on the RFA e.g.
- Estimated operating time (especially if expected that the procedure will be outside benchmark timeframes)
- Specific preadmission requirements
- Special operating theatre equipment
- Requirement for an ICU/HDU bed post procedure

The referring doctor must:
- Forward the completed RFA direct to the hospital within 3 working days of the patient agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer)
- Facsimiles (fax) RFA’s should not be routinely used and only be accepted for urgent admissions where there is limited time to send a hard copy. An RFA (hardcopy) is to follow as soon as possible.
- Where patients require additional time to consider their options, the referring doctor must organise for the completed RFA to be forwarded within 3 working days of the patient’s acceptance of the surgical option
- Expedite the transmission of RFA’s for any urgent admissions e.g. patients in Category 1 (admission within 30 days)
- Where an urgent admission is requested, a facsimile can be used to communicate the information required and expedite receipt of the required information from the referring doctor’s rooms or clinic

2.5. Information for Patients

| P | Patients **must** be fully informed about the risks and benefits of the procedure and have consented to the treatment offered |
| O | Patient’s consent should ideally be obtained prior to placing the patient on the waiting list and not deferred to time of admission or pre-admission clinic |
| L | Consent **must** be confirmed in writing by having the patient sign the consent form included in the Recommendation for Admission Form (RFA) |
| I | Under the Medicare principles, public patients are allocated to a doctor by the hospital. While generally public patients will be admitted under the care of the referring surgeon this is not guaranteed. This must be explained to patient when they agree to be treated as a public patient. |

The referring doctor **must** provide information to patients as follows:
- Explain the procedure/treatment:
  - What is involved
  - The risks associated with the proposed procedure/treatment
  - Other options for management of the condition
  - The need for consent
12. MEDICAL CARE

• Explain the waiting list:
  o The reason for referral to the waiting list.
  o The waiting list process, including clinical priority categories.
  o The circumstances in which care might be provided by another doctor or health service.
  o That prioritisation is according to clinical need, regardless of whether the patient elects to be treated as a public or private patient.

• Explain difference between admission as public or private patient:
  o Provide the patient with sufficient information to enable them to choose whether to be treated as a private or public patient.
  o Where a patient elects to be treated as a private patient, the referring doctor must also ensure the patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical priority regardless of insurance status.

Consent should be obtained in line with Department of Health Policy Directive PD2005_406 Consent to Medical Treatment - Patient Information

3. ACCEPTANCE OF RECOMMENDATION FOR ADMISSION FORM (RFA)

| P | RFA forms are complete, accurate, legible and date stamped. |
| O | Patients should be placed on the electronic waiting list within 3 working days of receipt of a completed RFA. |
| L | An RFA with a requested admission date of >12 months should be discussed with the treating doctor before confirmation of acceptance. |
| I | If an RFA is not presented within 3 months of the date the RFA was signed by the referring doctor a review of the patient’s clinical condition may be required before the RFA is accepted. |
| C | At the time of lodgement of the RFA, a patient should be ready for care and be able to accept an assigned planned admission date. |
| Y | If the RFA is for a staged procedure, the time interval when the patient will become ready for care must be stated on the RFA. |

3.1. Completeness, Accuracy and Legibility

When RFA forms are received from the referring doctor, they should be examined by hospital staff to ensure completeness, accuracy and legibility of the relevant information. (Section 2.4 lists the minimum data set required for acceptance.)

• RFA forms must be date stamped upon receipt.
• It is recommended to use the RFA Checklist (Appendix 13) when in receipt of RFAs to ensure that they are complete appropriately or escalated to senior manager.
• When information is missing on the RFA, a telephone call to the referring doctor may be an appropriate option to ascertain the missing information.
• If minimum data set items are not provided or are illegible, the information should be sought as soon as possible in writing from the referring doctor (Appendix 1).
When a Recommendation for Admission Form is received by the hospital, the hospital should ensure that the patient is placed on the waiting list within 3 working days. The practice of holding Recommendation for Admission Forms and not entering them onto the Patient Administration System is not permitted.

Where there is a query about the appropriateness of the CPC, a discussion should occur immediately between the referring doctor and senior management to resolve the issue and ensure that the patient is added to the waiting list within 3 working days from receipt. If there is no clinical evidence provided on the RFA then the Reference List CPC (IB2012_004) should be used until clarification is sought from the treating doctor.

The original RFA should remain in the booking office following presentation regardless of missing information. A copy of the RFA and incomplete RFA letter proforma (Appendix 1) or telephone call to the doctor should be used to complete the mandatory information. This is to ensure that the RFA is not lost or misplaced.

If an RFA is presented with a planned operate date >12 months ahead, discussion with the referring doctor will be required. The RFA will only be accepted if the patient’s clinical condition requires surgical intervention within 12 months.

Ideally, the referring doctor should have obtained the patient’s consent prior to placing the patient’s name on the waiting list and not deferred to time of admission or pre-admission clinic.

The hospital is not obliged to add a patient to its waiting list if information is incomplete, but patient circumstances should be considered.

The original listing date stamped on the RFA should be used when adding the RFA to the PAS.

If there are problems with an RFA, the hospital must advise the referring doctor as soon as possible. Patients should not be asked to ferry the RFA between hospital and referring doctor. Communications about missing minimum data set information should be between the referring doctor and the hospital staff.

Arrangements should be in place to ensure equitable access to services for all eligible persons, regardless of their geographical location as per the Australian Health Care Agreement.

3.2. Clinical Priority Timeframes

Referring doctors must ensure they are available to perform the procedure within the clinical priority timeframe. Alternatively, the clinician should make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe.

Where the surgeon does not have the capacity to undertake the procedure in the clinical priority timeframe or has not organised an alternative option, then the case should be escalated to senior management to explore alternative options for treatment.

3.3. Variations from Standard Bookings

Procedure/treatment not provided - if a procedure/treatment is not provided at the hospital nominated on the RFA, the RFA cannot be accepted. The referring doctor should be informed and alternative arrangements negotiated with senior management before accepting a revised RFA.

New Procedures - a Local Health District/Network New Interventions Assessment Committee or equivalent must formally approve new procedures. The RFA is not to be accepted by the hospital until approval for the procedure is given. A copy of the decision is to be forwarded to the hospital’s admissions manager.
12. MEDICAL CARE

- **For additional information refer to:**

- **Bilateral Procedures** - e.g. right and left cataract extractions, right and left hip replacements
  - An RFA will only be accepted for one procedure unless the bilateral procedure is occurring in the same admission.

- **Multiple bookings** - can be accepted if the treatments/procedures are independent of each other, e.g. cataract extraction and joint replacement. Referring doctor must specify which procedures are prioritised. This may be indicated by the clinical category assigned to both bookings e.g. if one is category 2 (within 90 days) and the other is category 3 (within 365 days) then the category 2 takes precedence. However if both RFAs have the same clinical category the referring doctor should be asked to specify the priority.

  The only exception to the above is for ongoing regular treatment e.g. tissue expansion or change of supra pubic catheters.

- **Duplicate bookings** - an RFA will not be accepted for the same procedure with different referring doctors at the same hospital; or same procedure at a different hospital. The patient is to be advised of the situation and asked to make a decision as to the preferred waiting list they wish to remain on.

- **Patients treated as Privately Referred Non Inpatients (PRNIP)**
  - All Elective Surgical patient’s names should be added to the public hospital waiting list (PAS) regardless of admission type
  - A copy of the Recommendation for Admission Form is to be held at the public hospital
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy.

- **Contracts with other Local Health District/Network** - Where a contract exist with another Local Health District/Network to undertake public patient’s surgery/procedures, the following actions should be undertaken:
  - Patient should remain on the original public hospital waiting list (PAS)
  - Patient should be added to the receiving public hospital waiting list (PAS) with the new listing date
  - A copy of the Recommendation for Admission Form is to be held at the original public hospital (with the original being forwarded to the new hospital)
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy
  - The hospital where the procedure is undertaken should advise the original public hospital when the procedure is undertaken and patient is to be removed from the original hospitals waiting list.

- **Contracts with Private Hospitals** - Where a contract exist with a private hospital to undertake elective surgery/procedures for the Local Health District/Network, the following actions should be undertaken:
  - Patient should be added to the public hospital waiting list (PAS)
  - A copy of the Recommendation for Admission Form is to be held at the public hospital
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy
  - The private hospital should advise the public hospital when the procedure is undertaken and patient is to be removed from the public hospital waiting list.
4. REGISTRATION ON THE WAITING LIST

4.1. Registration Requirements

- The date stamped on the RFA form is the date used for wait list registration (this is the date when the RFA is first received by the hospital).
- RFA forms should be added to the waiting list when minimum data set available. The listing date is the original date of receipt of the RFA.
- Patients should be placed on the electronic waiting list within 3 working days of first receiving the RFA form.
- Where there is a question about the appropriateness of the CPC, then all efforts should be made to ensure that the patient is added to the waiting list within 3 working days.

4.2. Notification - Patient

Within 3 working days of the patient being added to the waiting list:
- Send notification letter to the patient advising them that they have been placed on the waiting list, including approximate waiting time, any changes to contact details (Appendix 2) or with a planned admission date.
- Attach any patient documentation to the RFA

4.3. Notification - General Practitioner

The hospital should notify the nominated general practitioner in writing of the patient’s placement on the waiting list within 3 working days of being added to the waiting list (Appendix 3)

Notification should include:
- Patient’s name and address
- Date of placement on the waiting list
- Proposed procedure
- Clinical priority category and definition
- Hospital contact information, including who to contact if the patient’s condition changes
- NSW Health’s Waiting Times Web Site

5. MANAGING PATIENTS ON THE WAITING LIST

5.1. Compilation of a Waiting List

A Waiting List is kept by the hospital and contains the names and details of all patients registered as requiring elective admission to that hospital.
5.2. Waiting Times

The **Listing Date** is the date of receipt of the RFA. Calculation of waiting time starts from this date.

Calculation of a patient’s waiting time includes only the time a patient spends as **Ready for Care**. Waiting time thus reflects a genuine waiting period.

Periods when patients are **Not Ready for Care** should be excluded in determining waiting time.

5.3. Clinical Review

- **Clinical Review** is defined as review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition.
- Examination may result in the patient being assigned a different priority rating from the initial category.
- Patients and GPs can initiate review, as some conditions will change while the patient is waiting for treatment.
- Patients remain in their current clinical priority category while undergoing clinical review (they should not be moved into NRFC).
- Following the clinical review, a new RFA is not required unless the original procedure being undertaken has changed.

The **major objectives** of clinical review are to determine:

- Change in the clinical condition of the patient.
- Any change in priority for the procedure, with the resulting need to revise the patient’s clinical priority category.
- Whether admission is still required

The clinical review is to be **organised by the hospital** and conducted by an appropriate clinician:

- Treating doctor or delegate.
- General Practitioner (GP).
- Specialist Consultant or delegate e.g. registrar.
- Registered nurse.

*Note: The clinical review must be at no cost to the patient*

Circumstances triggering a Clinical Review:

5.3.1. Category 1 Patients:

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
</table>
| • When patient is listed as Category 1 but then requests deferment as Not Ready for Care >15 cumulative days | • Consult with treating doctor, activate a management plan within 5 working days that includes documented Ready for Care date and if clinically appropriate, re-categorise  
  • Advise patient  
  • Advise GP |
| • When total RFC time is >30 days                                           | • Request clinical review by appropriate clinician within 5 working days that includes documented Ready for Care date and if clinically appropriate, re-categorise  
  • Advise patient  
  • Advise GP |
5.3.2. Category 2 Patients:

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When patient is listed as Category 2 but then requests deferment as Not Ready for Care &gt;45 cumulative days</td>
<td>Category 2 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days</td>
</tr>
<tr>
<td></td>
<td>• Depending on Clinical Review outcome:</td>
</tr>
<tr>
<td></td>
<td>o Allocated date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorisation</td>
</tr>
<tr>
<td></td>
<td>o Removal from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
<tr>
<td>• When total RFC time is &gt;90 days</td>
<td>Category 2 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days</td>
</tr>
<tr>
<td></td>
<td>• Depending on clinical review outcome:</td>
</tr>
<tr>
<td></td>
<td>o Allocated date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorisation</td>
</tr>
<tr>
<td></td>
<td>o Removal from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
</tbody>
</table>

5.3.3. Category 3 Patients:

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When patient is listed as Category 3 but then requests deferment as Not Ready for Care &gt;180 cumulative days</td>
<td>Category 3 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days</td>
</tr>
<tr>
<td></td>
<td>• Depending on Clinical Review outcome:</td>
</tr>
<tr>
<td></td>
<td>o Allocated date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorisation</td>
</tr>
<tr>
<td></td>
<td>o Removal from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
<tr>
<td>• At 270 days, if the patient has no planned admission date within the timeframe</td>
<td>Category 3 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days</td>
</tr>
<tr>
<td></td>
<td>• Depending on Clinical Review outcome:</td>
</tr>
<tr>
<td></td>
<td>o Allocated date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorisation</td>
</tr>
<tr>
<td></td>
<td>o Removal from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
</tbody>
</table>

• When a patient **declines or fails to attend** a Clinical Review, a decision regarding the patient’s status on the waiting list should be discussed with the surgeon or delegate and senior management as to whether the patient requires to remain on the waiting list.

• If a patient **fails to attend a pre-admission clinic appointment** then their risk for surgery remains undetermined. In this case their status on the waiting list should be discussed with their treating doctor.
When a patient declines treatment, fails to arrive or requests removal from the waiting list, notification of the treating doctor is required (Appendix 8b). The patient is to be removed from the waiting list after 5 days if the treating doctor has not advised that the patient is to remain on the waiting list.

**Status Review Date** is defined as the date when it is estimated or recorded on the RFA that a deferred or staged patient will become ready for admission, i.e. Ready for Care

A **Status Review Date** must be set each time a patient:
- Is added to the waiting list as a staged admission (Not Ready for Care) or defers admission whilst on the waiting list.
- Status changes from Ready for Care to Not Ready for Care.
- Status remains Not Ready for Care after assessment.
- Specifies a forward planned admission date for his or her own non-medical reasons.

A **Status Review Report**, listing details of each patient whose status review date will become due in the following month, must be generated at least monthly. Following an assessment, patients will either:
- Be assigned another status review date.
- Be returned to Ready for Care with the appropriate clinical priority category.
- Have a planned admission date scheduled.
- Be removed from the waiting list.

### 5.4. Ready for Care

A **Ready for Care** patient is defined as a patient who is available for admission to hospital for their planned procedure/treatment.

#### 5.4.1. Delayed Patients

A patient remains classified as **Ready for Care** if their admission is postponed/delayed due to reasons other than their own availability, e.g. unavailability of doctor, operating theatre or bed.

#### 5.4.2. Declined Patients

The hospital must record the reason for patients declining a planned admission date on the electronic waiting list and on the patient’s RFA.

### 5.5. Not Ready for Care

<table>
<thead>
<tr>
<th>POLICY</th>
<th>A <strong>Not Ready for Care</strong> patient can be defined as a patient who is not available to be admitted to hospital until some future date, and is either:</th>
</tr>
</thead>
<tbody>
<tr>
<td>staged</td>
<td>- not ready for clinical reasons</td>
</tr>
<tr>
<td>deferred</td>
<td>- not ready for personal reasons</td>
</tr>
</tbody>
</table>

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12. **MEDICAL CARE**

- There are timeframes for patient deferring treatment:
  - Cat 1 - 15 days (however, patient deferring their treatment in this category should be discussed with the referring doctor)
  - Cat 2 - 45 days
  - Cat 3 - 180 days

- Hospitals are required to actively manage **Not Ready for Care** patients to ensure they become Ready for Care or are removed from the waiting list.

- **Not Ready for Care** (NRFC) implies that the patient will once again become Ready for Care within the timeframes as indicated above. Should a patient require to be NRFC for a prolonged period of time (e.g. significant weight loss) prior to undergoing surgery, then the patient should **not** be placed on the waiting list or they should be removed from the waiting list (following discussions with the treating doctor) until the desired outcome is achieved.

- The hospital must record the reason for staging and deferring patients on the electronic waiting list and on the patient’s RFA.

### STAGED PROCEDURES

**Not Ready for Care - Staged Only**

- On request for admission the Not Ready for Care timeframe should be identified by the treating doctor and a RFC clinical priority category indicated.
- Once the identified NRFC staged timeframe is completed the patient then returns to the RFC category as indicated by the treating doctor.
- A PAD/TCI can be arranged whilst the patient is in the category of Not Ready for Care.

### DEFERRED PROCEDURES

5.5.1 **Not Ready for Care - Deferred Only**

- The period of time the patient request deferment should be determined and the patient returned to the original CPC at that timeframe.
- A deferred patient should not exceed the timeframes for their clinical priority category as indicated above.

5.5.2. **Staged Patients**

The hospital must record the reason for staging patients on the electronic waiting list and on the patient’s RFA. Reasons recorded may be:

<table>
<thead>
<tr>
<th>Reasons to be Recorded for Not Ready for Care Staged (Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unfit</strong></td>
</tr>
<tr>
<td>• A co-morbidity exists which, until resolved, renders them unfit for the proposed treatment</td>
</tr>
<tr>
<td><strong>Planned</strong></td>
</tr>
<tr>
<td>• A patient requiring treatment periodically (e.g. check cystoscopy)</td>
</tr>
<tr>
<td>• A patient requiring treatment as part of a staged procedure (e.g. removal of pins and plates)</td>
</tr>
</tbody>
</table>

146(02/02/12)
5.5.3. Deferred Patients

The hospital must record the reason for deferring patients on the electronic waiting list and on the patient’s RFA. Reasons recorded may be:

<table>
<thead>
<tr>
<th>Reasons to be Recorded for Not Ready for Care Deferred (Personal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient is going on holidays and will be unavailable for admission.</td>
</tr>
<tr>
<td>• Patient is unable to obtain home support.</td>
</tr>
<tr>
<td>• Patient is unable to accept a date due to work commitments.</td>
</tr>
<tr>
<td>• Patient is unable to accept a date for other significant reasons e.g. personal carer.</td>
</tr>
</tbody>
</table>

• A patient who specifically requests a forward planned admission date, for his or her own convenience or commitments should only have their status changed to Ready for Care once the hospital is advised that the patient is now Ready for Care.

• A decision to remove the patient from the waiting list may be made if a patient defers > two occasions or exceeds the maximum number of Not Ready for Care days. Refer to section 5.10 Removing Patients from the Waiting List.

5.6. Admission Process

- **Equity and Priority of Access for Admission** - the following criteria must be considered when choosing patients from the waiting list for admission:
  - Clinical priority.
  - The length of time the patient has waited in comparison with similar category patients.
  - Previous delays.
  - Pre-admission assessment issues/factors, e.g. elderly people living alone or those having to travel long distances.
  - Resource availability, e.g. theatre time, staffing, equipment and hospital capacity.

- Relevant consultation with staff from:
  - Treating Doctor
  - Theatres
  - Admissions
  - Pre-admission
  - Division of Surgery waiting list coordinator
  - Other Departments if relevant e.g. Medicine, 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 (ALO) if available, so the patient/carer is asked if they would like to request an ALO visit during their admission.
Planned Admission Date

The Planned Admission Date is the date on which it is proposed that a patient on the waiting list will be admitted for an episode of care and entered on the electronic waiting list.

- Once a planned admission date is determined the patient should be contacted by the most appropriate means (telephone or letter - Appendix 4) to determine acceptance of admission.
- Patient should be supplied with relevant information for their hospitalisation, including the proposed length of stay, discharge procedures and post operative follow up.

Pre-admission Assessment


Short Notice Patients

“Short notice” list Patients - Patients may agree to be available on the “short notice” list to have their surgery performed, e.g. if there is a cancellation.

Selection of “short notice” list patients

- Patients must agree to be on the “short notice” list.
- Patients that have undergone a pre admission assessment.
- Patients that have been clinically screened as not requiring attendance at the pre admission clinic and deemed suitable for the “short notice” list by the nurse screener.
- Patients should reside within a reasonable travelling distance to the hospital.

Calling in “short notice” list patients

- Patients should be given as much notice as possible about their proposed advancement on the list.
- Patents on the “short notice” list should be called as “in turn” as much as possible.
- Once a patient has been on called in as a “short notice” list patient and their procedure has not gone ahead, a definite PAD should be made to ensure the patient is not inconvenienced further.

5.7. Hospital Initiated Postponements

<table>
<thead>
<tr>
<th>POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient postponements should be avoided and only occur when all options are exhausted and senior management have made the decision. If a postponement is to proceed then the following steps should be taken:</td>
</tr>
<tr>
<td>- Record the reason</td>
</tr>
<tr>
<td>- Patient rescheduled on next available list according to clinical priority category</td>
</tr>
<tr>
<td>- A new PAD allocated within 5 working days of the postponement</td>
</tr>
<tr>
<td>- The patient should be advised of a new PAD within 5 working days of postponement.</td>
</tr>
</tbody>
</table>

Patients who are postponed by the hospital or doctor or for non clinical reasons remain Ready for Care “delayed” and the following actions taken.
5.7.1. Factors to Consider in Selecting Patients for Postponement

- Category 1 patients who have arrived must not be postponed without authorisation of a senior member of management and treating doctor or delegate e.g. registrar.

- Postponed patients must have priority over others not previously postponed. Postponed patients are to be placed on the next available procedure/treatment list, appropriate to the patient’s clinical priority category. Where possible, postponed patients should be prioritised on the procedure/treatment list to minimise the chance of delay (e.g. first on list where appropriate).

- If a patient has been postponed twice and cannot be treated within appropriate clinical priority timeframes, the Local Health District must actively investigate options for procedure/treatment to be undertaken at another facility (public or private). The cost is to be borne by the originating Local Health District/Network.

Decisions to postpone must involve relevant medical and operating theatre staff, bed manager, waiting list manager, senior hospital management and consider:

- Reason for the postponement.
- Clinical priority.
- Postponement history.
- Length of time on the waiting list.
- Medical input from treating doctor or delegate.

If a postponement is to proceed then the following steps should be taken:

- Record the reason.
- Patient rescheduled on next available list according to clinical priority category.
- A new PAD allocated within 5 working days of the postponement.
- The patient should be advised of a new PAD within 5 working days of postponement.

5.7.2. Informing Patients of their Postponement

- Provide the patient with the maximum possible notice. Category 1 patients and patients postponed on the day of procedure/treatment should be notified by a senior member of the surgical/medical team or senior hospital manager.

Any patient cancelled or postponed by the hospital or doctor on the day of their planned admission date after arrival to the hospital must be reported to relevant personnel - head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District/Network Chief Executive or delegate.

- Offer the following support options to the patient, where relevant:
  - Contact a family member or friend.
  - Arrange and pay for transport home, accommodation, food, etc.
  - Counselling services.
  - Access to a complaints service

- Reschedule the patient on the next available list date for their procedure/treatment and notify the patient of the new admission date within 5 working days (Appendix 5).

- Patient is to be rebooked with original listing date and history where appropriate, including previous admission dates and delays.
5.7.3. Patient Admitted and Surgery Not Performed

If a patient arrives for treatment/procedure and is admitted and then the surgery is postponed due to hospital reasons, the following actions should be taken:

• The patient should be admitted and discharged.
  o The patient should be rebooked with the original listing date and history (clinical priority categories and delays etc). Postponed patients are to be placed on the next available procedure/treatment list, appropriate to the patient’s clinical priority category.
  o A new PAD should be allocated within 5 working days of the postponement.

5.8. Patient Initiated Postponements

When a patient postpones an agreed date for procedure/treatment for personal or social reasons, a patient initiated postponement should be:

• Recorded on electronic waiting list and RFA.
• Reviewed to determine if:
  o A new date is to be scheduled.
  o The patient is to be categorised as Not Ready for Care “deferred”, or
  o Removed from the waiting list.
• Patients are only permitted to postpone maximum of 2 times for personal or social reasons.

If a patient arrives for treatment/procedure and decides to cancel after admission, the following steps should be taken:

  o The surgeon should be advised.
  o The patient should be admitted and discharged.
  o The reason for cancellation should be recorded and an appropriate clinician should discuss with the requirement for surgery with the patient’s General Practitioner.
  o If the surgery is still clinically required and the patient agrees, the patient should be re-booked on day of discharge with original listing date.
  o Or removed from the waiting list.

5.9. Avoiding Exceeding Clinical Priority Time Frames

To avoid exceeding Clinical Priority time frames, at least weekly, a review of the waiting list should be undertaken and hospitals should consider the following options:

• Clinical Review - refer to section 5.3.
• Contact the Local Health District Patient Access Coordinator - they may have viable options.
• Transfer of Patients to Doctors with a shorter waiting time (see 5.9.1) for more details).
• Transfer of Patients to another facility within the Local Health District (see 5.9.2 for more details).
• Increase theatre utilisation (e.g. extra sessions).
• Use of short notice or standby lists.
• Other options including contracting work out to the private sector.

It is not acceptable to have patients waiting past Clinical Priority time frames.

Hospitals must implement active management strategies to avoid this and are required to achieve the following Clinical Priority time frames:
### Clinical Priority Category

<table>
<thead>
<tr>
<th>Clinical Priority Category</th>
<th>Recommended allocation of PAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No patient in Category 1 should wait longer than 30 days</td>
<td>PAD on booking</td>
</tr>
<tr>
<td>No patient in Category 2 should wait longer than 90 days</td>
<td>PAD within 45 days</td>
</tr>
<tr>
<td>No patient in Category 3 should wait longer than 365 days</td>
<td>PAD within 270 days</td>
</tr>
</tbody>
</table>

#### 5.9.1. Transfer of Patients to Doctors with a shorter waiting time

The offer to the patient has to be considered “reasonable”. This needs to be determined for each individual and the following considered:

- The circumstances of the patient (e.g., age, available support, public transport, physical condition and the required procedure).
- The offer must be specific. The name of the clinician, hospital, and planned admission date or an estimate of the likely waiting period must be given.
- The offer must be a credible alternative and be available if the patient decides to accept the offer.
- Where the patient declines two genuine offers of treatment with another doctor or at another hospital, then the patient should be advised that they may be removed from the waiting list. The Local Health District Program Director of Surgery should review the patient’s status on the waiting list in consultation with the original treating doctor prior to the patient being removed from the waiting list.

The new Doctor will determine the requirement to review the patient.

The patient’s listing date and history must be that of the original booking. In this way an accurate record of waiting time is maintained. Where there is a delay in listing the patient on the shorter list, the patient must remain on the original list, pending confirmation of the patient’s acceptance by the second doctor. The patient’s current clinical priority category must be maintained, unless altered after clinical review by the new treating doctor.

#### 5.9.2. Transferring Patients to Another Facility

When a patient is booked at one hospital and subsequently has the procedure carried out at a different hospital within the same Local Health District/Network, the following steps must be followed:

- The booking at the hospital where the patient will be treated is entered with the same listing date and history as the booking at the original hospital, and with the current clinical priority category.
- The booking at the original hospital should be removed using the reason code treated elsewhere, on confirmation of the patient’s booking at the receiving hospital.
- The original RFA should be sent to the receiving hospital and a copy retained for auditing at the original hospital.

For patients being treated by another LHD/Network see section 3.3 Contracts with the other Local Health Districts/Networks.
5.10. Removing Patients from the Waiting List

<table>
<thead>
<tr>
<th>Reason</th>
<th>Category 1, 2 &amp; 3 Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient declines treatment or requests removal for other reasons</td>
<td>- Forward a copy of the RFA with a covering letter (Appendix 8b) to the treating doctor within 24 hours of notification, informing removal of patient from the waiting list unless treating doctor advises otherwise within 5 working days.</td>
</tr>
<tr>
<td>Patient defers treatment on 2 occasions (including other genuine offers of another doctor/hospital) or in deferring exceeds the maximum number of Not Ready for Care days: Cat 1 &gt; 15 days Cat 2 &gt; 45 days Cat 3 &gt; 180 days</td>
<td>- Obtain authority for Category 1 (30 day) patients prior to removal from waiting list.</td>
</tr>
<tr>
<td>Patient fails to arrive to treatment on &gt;1 occasion without giving prior notice and with no extenuating circumstances</td>
<td>Once decision is made to remove patient from waiting list:</td>
</tr>
<tr>
<td></td>
<td>- Obtain unit head or delegated unit representative’s written authorisation and documentation on RFA to remove and record of any discussion with patient.</td>
</tr>
<tr>
<td></td>
<td>- Remove patient from the waiting list.</td>
</tr>
<tr>
<td></td>
<td>- Advise GP that patient has been removed (Standard Letter Appendix 8a).</td>
</tr>
<tr>
<td></td>
<td>- Send letter to patient (Appendix 8c).</td>
</tr>
<tr>
<td></td>
<td>- Document actions on RFA and electronic record (refer to section 6.4).</td>
</tr>
<tr>
<td>Refusal of Clinical review Patient refused or failed to attend a clinical review or a pre-admission clinic when required.</td>
<td>- Obtain written authorisation of a Senior Medical Officer or delegate to remove.</td>
</tr>
<tr>
<td></td>
<td>- Remove patient from the waiting list.</td>
</tr>
<tr>
<td></td>
<td>- Advise referring doctor and GP that patient has been removed (Standard Letter Appendix 8a and 8b).</td>
</tr>
<tr>
<td></td>
<td>- Obtain authority for Category 1 (30 day) patients prior to removal from waiting list.</td>
</tr>
<tr>
<td>Patient not contactable on 2 occasions (one by phone, one by letter)</td>
<td>- Attempt to obtain patient’s correct contact details via all these methods:</td>
</tr>
<tr>
<td></td>
<td>o Referring doctor, GP, medical records, next of kin &amp; telephone directory search.</td>
</tr>
<tr>
<td></td>
<td>o Obtain written authorisation of a Senior Medical Officer or delegate to remove.</td>
</tr>
<tr>
<td></td>
<td>o Remove patient from the waiting list.</td>
</tr>
<tr>
<td></td>
<td>o Advise referring doctor and GP that patient has been removed (Standard Letter Appendix 8a and 8b).</td>
</tr>
<tr>
<td></td>
<td>o Document actions on RFA and electronic record (refer to section 6.4.).</td>
</tr>
<tr>
<td>Patient deceased</td>
<td>- Obtain verification (usually verbally from the patient’s relative, general practitioner or specialist).</td>
</tr>
<tr>
<td></td>
<td>- Remove patient from the waiting list.</td>
</tr>
<tr>
<td></td>
<td>- Document actions on RFA and electronic record (refer to section 6.4).</td>
</tr>
</tbody>
</table>

Note:
If a patient was initially removed from the waiting list due to reasons other than admission and in the following month the waiting list record needed to be re-activated for the same procedure, then the patient should be re-booked with the original listing date and history (clinical priority category and delays etc.).

146(02/02/12)
6. RECORD KEEPING

| P | • Hospitals must keep accurate records of waiting list information.  
   | O | • Document any changes on RFA and electronic waiting list.  
   | L |  
   | I |  
   | C |  
   | Y |  

Any changes made to a patient’s booking must be validated with documented evidence and reasons, and signed by relevant staff member. The documentation must be attached (Appendix 11) or be part of the RFA. The electronic waiting list must also be updated to reflect any changes.

6.1. Postponement of Planned Admission

• Accurate records are to be maintained for patients postponing and the reason for postponement (electronic waiting list and RFA).
• A patient’s postponement history should be readily available to the staff making decisions about postponing future patients.

6.2. Exceeded Planned Admission Dates

• Generate and review report to identify patients who have exceeded planned admission dates at least monthly.

6.3. Procedure being Undertaken at Another Hospital within same LD District/Network

• Listing date and clinical priority category at other hospital will be same as original hospital.
• The booking at the original hospital should be removed using the reason code (treated elsewhere) on confirmation of the patient’s booking at the receiving hospital.

6.4. Removal of Patients from the Waiting List (other than admission)

• All patients who have been removed from the waiting list (other than admission) require documentation detailing reason for removal and date of removal. This should be part of or attached to the RFA.
• Treating doctors and GP’s should be advised (Appendix 8a and 8b).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Information to be Recorded/Filed (RFA &amp; Electronic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Deceased</td>
<td>* Record the name of the person who has notified the hospital that the patient is deceased.</td>
</tr>
</tbody>
</table>
| Non contactable | * Evidence of contact:  
| | o patient letters returned (return to sender)  
| | o documentation of attempts to contact through referring doctor, GP, medical records, next of kin & telephone directory search |
| Decline treatment or clinical review/not required | * Documentation that patient has been informed of the potential risks to their health and advised to contact referring doctor (Appendix 8c).  
| | * Obtain authority for Category 1 (30 day) patients prior to removal from waiting list. |
| Fail to Arrive for Treatment | * Documentation that:  
| | o Patient has failed to arrive for treatment on the planned admission date >1 occasion without prior notice and without good reason.  
| | o Advise patient to be clinically reassessed by treating doctor. |
6.5. Reporting

- Hospitals must ensure they have a documented process for removing patients from the waiting list (other than admission). Hospital to compile a list of patients who have been removed for authorisation by a senior hospital executive. This authorisation is to occur monthly. Removals list must be retained for the normal retention period and include the following information:
  - Patient’s name
  - Reason for the patient’s removal
  - Patient’s clinical priority category
  - Patient’s diagnosis
  - Patient’s procedure

- Monthly reports must be provided to the hospital Executive Officer and Local Health District/Network CEO or delegate with the following information:
  - Patients who have 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 do not have a rescheduled planned admission date.

- Duplicate bookings are to be monitored by each Local Health District/Network monthly. The Health Services Performance Improvement Branch at NSW Health will monitor duplicate bookings across NSW and distributed reports to Local Health Districts every six months.

- Any patient cancelled or postponed by the hospital or doctor on the day of their planned admission date after arrival to hospital must be reported to the hospital Executive Officer.

7. AUDITING THE WAITING LIST

<table>
<thead>
<tr>
<th>P O L I C Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient details on the waiting list are accurate, valid and complete.</td>
</tr>
<tr>
<td>• Transport processes are in place for equitable access to elective surgery.</td>
</tr>
<tr>
<td>• Records relating to audits must be kept for three years.</td>
</tr>
</tbody>
</table>

7.1. Clerical Audit

- Each hospital is to identify a person responsible for the clerical audit of hospital waiting lists. The responsibility includes conducting audits and reporting the outcome of the audit to relevant management.

- Each Local Health District/Network is to nominate a person responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits.

- A review of the waiting list must be undertaken (at least weekly) to ensure that accurate information is provided to clinicians and administrators on request.

- Elements of the clerical audit that should be undertaken weekly include:
  - Ascertaining whether the patient has already has their procedure/treatment.
  - Checking for duplicate bookings.
  - Ensuring clinical priority category is appropriately assigned.
  - Updating Status Review Date for Category 4 patients (dependant on original clinical priority category) see 5.3.1 & 2 & 3.
12. MEDICAL CARE

- Reviewing Exceeded Planned Admission Dates.
- Identifying patients on waiting list admitted through emergency department for the same procedure.
- Ensuring delayed patient is rescheduled for next available theatre session in consultation with treating doctor.

- Documentation must provide a clear audit trail and must be readily available to validate any changes made to a patient’s booking (electronic and RFA).
- RFAs should have:
  - A dedicated section to record all changes; or
  - A designated form attached to the RFA (appendix 11).
- On completion of clerical audits, a report signed by the responsible person conducting the audit must be sent to the relevant manager and appropriate committees and be available on request.
- This report must include:
  - The type of audit conducted, methodology used, problems identified and recommendations for improvement.
  - The number of patients removed and reasons for removal from the waiting list.
- An evaluation of the audit process must be conducted regularly (at least quarterly) by the staff responsible for waiting list management at each facility.
- NSW Health departmental officers conduct regular hospital visits and also engage an independent auditor to review the waiting list management process on a regular basis.

7.2. Review of Waiting List by Treating Doctor

- The hospital must provide a comprehensive list of patients to each treating doctor monthly.
- Treating Doctors must confirm waiting list with waiting time coordinators.
- Changes required by treating doctor are to be undertaken.

7.3. Patient Audit

- Ready for Care and Not Ready for Care Patients on the waiting list should be contacted if they have been waiting for greater than six months from listing date, to ascertain if they still require admission. Two contacts should be attempted, one by letter (Appendix 9) and one by telephone.
- Audit letter must include:
  - Information on alternative options where available.
  - Advice for clinical reassessment by treating doctor or GP.
  - Hospital & District/Network contact details.
- Documentation of the patient audit must be readily available, and must include the responses received and the action taken.

8. DOCTOR’S LEAVE - TEMPORARY AND PERMANENT

<table>
<thead>
<tr>
<th>P</th>
<th>O</th>
<th>L</th>
<th>I</th>
<th>C</th>
<th>Y</th>
</tr>
</thead>
</table>
| To ensure appropriate theatre scheduling, doctors are requested to provide as much notice of intended leave as possible (minimum of 6 weeks).
| A management plan for affected patients should be developed and implemented for all leave.
| A patient’s clinical priority category and listing date does not change as a result of doctor’s leave. |
A patient’s **management plan** should ensure affected patients:
- Are assured that their queue order will not be affected.
- Know who the replacement doctor will be.
- Are advised if clinical review is required.
- Are provided with information regarding their expected waiting time.

All contact with patients must be documented and be part of or attached to the patient’s RFA.

**Affected** patients are those who during the leave period:
- Already had a planned admission date.
- Will exceed their clinical priority timeframe during the leave period (see Clinical Priority Categories Section 2.1).

<table>
<thead>
<tr>
<th>Type of Leave</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual, Study, Conference Leave</strong></td>
<td>Doctors are requested to provide as much notice of intended leave as possible (6 weeks).</td>
</tr>
<tr>
<td></td>
<td>A management plan for affected patients should be developed and implemented for all leave.</td>
</tr>
<tr>
<td></td>
<td>Consult with relevant personnel - head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District Executive or delegate.</td>
</tr>
<tr>
<td></td>
<td>During the leave period, no further patients should be added to the doctor’s waiting list unless approved by the District/Network Program Director of Surgery.</td>
</tr>
</tbody>
</table>

| **Unplanned leave** e.g. sick leave, bereavement leave | A management plan for affected patients is to be **immediately** developed and implemented.                                                                                                             |
|                                                       | Consult with relevant personnel - head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District Executive or delegate. |
|                                                       | During the leave period, no further patients should be added to the doctor’s waiting list unless approved by the District/Network Program Director of Surgery.                                             |

| **Planned Resignation** e.g. resignation from hospital, retirement | Notify affected patients and relevant GPs of intention to leave (if time permits); provide advice about patient’s management plan ASAP. No addition of patients to the doctor’s waiting list upon notification of planned resignation unless there is capacity or for an urgent case. A management plan for all patients should be developed and implemented. |
|                                                               | Consult with relevant personnel - head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District Executive or delegate. |
|                                                               | Locate replacement treating doctor in consultation with senior clinicians and management.                                                                                                              |
|                                                               | Clinical review is required for patients remaining on departing doctor’s waiting list.                                                                                                               |
|                                                               | Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the waiting list.                                              |
|                                                               | Transfer patients to nominated treating doctor’s waiting list and ensure existing and transferred patients are treated in queue order, within clinical priority categories. |
|                                                               | If unable to immediately transfer patients to a replacement doctor’s waiting list, patients are to remain on the treating doctor’s list.                                                               |
### Unplanned Resignation or Death

- No addition of patients to the doctor’s waiting list.
- A management plan for all patients should be immediately developed and implemented.
- Consult with relevant personnel - head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District Executive or delegate.
- Locate replacement treating doctor in consultation with senior clinicians and management.
- Clinical review is required for patients remaining on departing doctor’s waiting list.
- Need to consider if nominated doctor is willing to take on additional patients and has capacity to undertake the work.
- Transfer patients to nominated treating doctor’s list and ensure existing and transferred patients are treated in queue order, within clinical priority categories.
- If unable to immediately transfer patients to a replacement doctor’s waiting list, patients are to remain on the waiting list under an appropriate clinician or speciality.
- Notify relevant GPs of the resignation/death (Appendix 10).

### 9. DEFINITIONS

<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addition to the waiting list</td>
<td>As soon as a decision is made that a patient is in need of admission to the hospital and the admission is not required within 24 hours, the treating doctor should complete a Recommendation for Admission form and forward it to the hospital within 3 working days. The patient will be added to the electronic waiting list within 3 working days of receipt of a complete, accurate and legible Recommendation for Admission form. The date the RFA is received becomes the patient’s listing date. This date is used in the calculation of the waiting time</td>
</tr>
</tbody>
</table>
| Admission                        | The AIHW defines admission as 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. There are two types of Admission:  
  - Emergency Admission (Admission within 24 hours)  
  - Elective Admission (Admission >24 hours) |
| Admission Date                   | Date on which an admitted patient commences an episode of care.                                                                                     |
| Admitted patient                 | A patient who undergoes a hospital’s admission process to receive treatment and/or care.                                                           |
| Anticipated election status      | Recorded when the patient is added to the waiting list, it is the anticipated election the patient will make when admitted for the planned procedure/treatment. Classifications are:  
  - Medicare Eligible - Public patient  
  - Medicare Eligible - Private patient  
  - Medicare Eligible - Department of Veterans Affairs patient  
  - Medicare Eligible - Other (compensable, Defence forces etc)  
  - Medicare Ineligible - Overseas visitor |
| Clerical Audit                   | A clerical audit is a regular and routine clerical check that the information that the hospital has of patients waiting for admission is correct. It will facilitate the identification of patients who no longer require admission or who have duplicate bookings. |
Clinical Priority Categories
A clinical priority category is allocated to a patient based on the referring doctor’s assessment of the priority with which a patient requires elective admission. Clinical priority categories are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Admission within 30 days desirable</td>
</tr>
<tr>
<td>Category 2</td>
<td>Admission within 90 days desirable</td>
</tr>
<tr>
<td>Category 3</td>
<td>Admission within 365 days acceptable</td>
</tr>
<tr>
<td>Category 4</td>
<td>Not Ready for Care clinical reasons (staged)</td>
</tr>
<tr>
<td></td>
<td>Not Ready for Care personal reasons (deferred)</td>
</tr>
</tbody>
</table>

Clinical Review
Review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition.

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.

Day of surgery admission (DOSA)
Day of surgery admission - patients are admitted into hospital on the day of their procedure and remain in hospital for at least one post-operative night.

Day Only Surgery (DO)
Day Only Surgery involves the patient being admitted and discharged on the day of surgery. Also referred to as Day Surgery.

Declined Patient
A patient who declines a planned admission date for treatment.

Deferred
See Not Ready for Care “deferred”.

Delay
See postponement.

Discharge Intention
Recorded when the person is added to the waiting list. It identifies whether the referring doctor expects that the person will be admitted and discharged on the same day (i.e. day patient) or will stay at least overnight.

Discretionary Surgery
Surgical procedures that should not be undertaken in public hospitals in NSW unless essential for good health.

DOSA
DOSA is an acronym for day of surgery admission.

EDO
EDO units are specifically designed to accommodate patients - elective and emergency, who meet specific admission criteria including:
- absolute expectation of discharge within 24 hours, preadmission screening (elective patients), agreed clinical guidelines in place and agreement to protocol based nurse initiated discharge.

Elective Care (National Health Data Dictionary) Including planned/ booked surgery.
Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians. Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Elective admission
An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours (added to the waiting list). An elective admission usually results from a general practitioner consultation, referral to a specialist and a recommendation for admission to hospital by the specialist (or general practitioner, where appropriate). The medical consultation may take place in a hospital outpatient clinic.

Electronic waiting list
Patient administration/management system used by the hospital to manage the waiting list, e.g. CERNER, ipM & HOSPAS.

Emergency admission
An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours. These patients are not routinely added to the waiting list, however if they are added for organisational reasons, then when the patient is admitted they should be removed from the waiting list as an emergency admission. Where patients are admitted as an emergency (via emergency or as a direct admission) an emergency admission in the Patient Administration System should be generated. If the patient has an existing wait list booking, this should not be used for the emergency admission.
### 12. MEDICAL CARE

<table>
<thead>
<tr>
<th>Emergency patients</th>
<th>Emergency patients are those whose clinical conditions indicate that they require admission to hospital within 24 hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceeding Clinical Priority Timeframes or Overdue</td>
<td>Patients are considered overdue if they have waited in excess of the time recommended for the assigned ready for care clinical priority category.</td>
</tr>
<tr>
<td>High Volume Short Stay</td>
<td>High Volume Short Stay model builds on the success of the Extended Day Only model by concentrating high volume surgical procedures that require a hospital admission up to 72 hours.</td>
</tr>
<tr>
<td>Indicator procedure code</td>
<td>The procedure or treatment the patient is to undergo when admitted. There are currently around 200 possible codes.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Patients who are formally admitted to a hospital or health service facility. Formally admitted patients can be Day Only or overnight.</td>
</tr>
<tr>
<td>Listing Date</td>
<td>Listing Date is the date of receipt of the Recommendation for Admission Form. Calculation of waiting time starts from this date.</td>
</tr>
<tr>
<td>Listing Status</td>
<td>Indicates the status of the person on the waiting list that is the extent to which a patient is ready and available for admission. This may change while the patient is on the waiting list, e.g. after a clinical review. The patient may be:</td>
</tr>
<tr>
<td>Local Health District/Network Access Coordinator</td>
<td>Provides information regarding elective admissions in public hospitals and investigates options where available.</td>
</tr>
<tr>
<td>Long-wait patients</td>
<td>Surgical patients who are Ready for Care and have been waiting for planned admission longer than 12 months are termed long-wait patients.</td>
</tr>
<tr>
<td>Medicare eligibility</td>
<td>Patients must be identified as being eligible or not eligible for treatment under Medicare for each episode, and a record of the patient’s Medicare number is to be made at the time of listing - see Anticipated Election Status.</td>
</tr>
<tr>
<td>Not Ready for Care (NRFC)</td>
<td>A Not Ready for Care patient can be defined as a patient who is not available to be admitted to hospital until some future date and is either:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• staged - not ready for clinical reasons</td>
</tr>
<tr>
<td></td>
<td>• deferred - not ready for personal reasons</td>
</tr>
<tr>
<td></td>
<td>See Clinical Review Section 5.3 for timeframe for NRFC patients. A postponement of admission by the hospital does not render the patient Not Ready for Care. These patients should remain on the waiting list as they are still genuinely waiting, but are delayed.</td>
</tr>
<tr>
<td>Not Ready for Care “deferred”</td>
<td>The AIHW defines a deferred patient as a patient who for personal reasons 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. It is mandatory to indicate a reason for deferring. The reason a patient is deferred may be reported as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• a patient is going on holidays and will be unavailable for admission</td>
</tr>
<tr>
<td></td>
<td>• a patient is unable to obtain home support</td>
</tr>
<tr>
<td></td>
<td>• a patient is unable to accept a date due to work commitments</td>
</tr>
<tr>
<td></td>
<td>• a patient is unable to accept a date for other significant reasons, e.g., personal carer.</td>
</tr>
<tr>
<td></td>
<td>Patients may not be added to the waiting list as Not Ready for Care deferred.</td>
</tr>
</tbody>
</table>
### Not Ready for Care “staged”

A patient is said to be staged if for clinical reasons they will not be ready for admission until some future date. It is mandatory to indicate a reason for staging. The reason a patient is staged may be reported as follows:

**Unfit**
- a co-morbidity exists which, until resolved, renders them unfit for the proposed treatment

**Planned**
- a patient requiring treatment as part of periodic treatment
- a patient requiring treatment as part of a staged procedure (includes obstetric patients)
- a planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the ongoing disease process
- a planned re-admission for review of status following previous treatment.

### Planned admission date

The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care. A patient who has been allocated a definite date for admission by the hospital, has been scheduled (i.e. the admission or listing is scheduled). A patient who has not been given a definite date for admission by the hospital is unscheduled (i.e. the admission is unscheduled).

### Planned length of stay

The number of nights the patient is expected to stay in hospital as an inpatient. This information will be used for discharge planning and bed management.

### Planned procedure

The planned procedure is the procedure or treatment the patient is to undergo when admitted.

### Pooled lists

At some hospitals, doctors in particular specialities have agreed to include their public patients on a combined list for that speciality. This means that patients may be treated by any one of the doctors belonging to the group. Patients may therefore be added to a waiting list by one doctor but admitted by another doctor. This does not mean that if a particular doctor is part of a pooled list group that this doctor does not also list and admit patients apart from the pooled list patients. Pooled lists are generally set up for the more common routine procedures. A doctor’s private patients would not be included on a pooled list.

### Postponement

A patient’s elective admission may be postponed by the hospital due to high emergency admissions or other hospital related reasons. See Not Ready for Care “delayed”. A patient may postpone for personal reasons. See Not Ready for Care “deferred”.

### Pre-admission

Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans.

### Presenting Problem

The problem or concern that is the reason for seeking health care or assistance (NHDD).

### Private/Chargeable patients (including DVA & WC etc)

Persons admitted to a public hospital who elect to choose the treating doctor(s) will be charged for medical services and accommodation.

### Public Patient

A Medicare eligible patient admitted to a public hospital who has agreed to be treated by a nominated doctor of the hospital’s choice and to accept shared ward accommodation. This means the patient is not charged.

### Ready for Care (RFC)

A Ready for Care patient is defined as a patient who is available for admission to hospital. Ready for Care patients will be in clinical priority categories 1, 2 or 3.

### Ready for Care “Delayed”

A patient is regarded as Ready for Care but delayed where the hospital decides to postpone admission and reschedule a person’s planned admission date because of:
- non-availability of operating theatre (staff, equipment, resources etc.)
- non-availability of bed;
- non-availability of bed; pressure of emergency admissions
- non-availability of doctor

It is mandatory to indicate the reason for the patient’s admission being delayed.
### 12. MEDICAL CARE

<table>
<thead>
<tr>
<th>Removing patients from the waiting list, other than for admission</th>
<th>Patients can be removed from the waiting list for reasons other than for admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>• patient declines treatment or requests removal</td>
</tr>
<tr>
<td>12.</td>
<td>• patient defers treatment on 2 occasions</td>
</tr>
<tr>
<td>12.</td>
<td>• patient defers &amp; exceeds maximum number of Not Ready for Care days, Cat 1 &gt;15 days; Cat 2 &gt;45 days; Cat 3 &gt;180 days</td>
</tr>
<tr>
<td>12.</td>
<td>• patient fails to arrive on 1 occasion, with no notice or extenuating circumstances</td>
</tr>
<tr>
<td>12.</td>
<td>• patient not contactable</td>
</tr>
<tr>
<td>12.</td>
<td>• patient deceased</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation for Admission form (RFA)</th>
<th>Requests for admission to hospital need to be on an approved form and contain a minimum data set as specified in this policy. Forms must have a dedicated section for documentation of relevant details regarding the booking, such as contact with patient, doctors, dates and reasons for changes or delays to planned admission dates. This dedicated section may be either part of the RFA or a particular form attached to the RFA. The documentation needs to provide a clear audit trail for all transactions and must be kept as part of the patient’s medical record.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referring Doctor</th>
<th>Doctor who is referring the patient to the waiting list.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day Surgery</td>
<td>See Day Only Surgery (DO).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Specialist’s area of clinical expertise. Where a specialist undertakes surgical procedures, which can be classified into different specialities, then the specialist will have a different list for each speciality (e.g. Obstetrics/Gynaecology). The broad categories required for reporting to NSW Health Department are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>ENT</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Plastic</td>
</tr>
<tr>
<td>Vascular</td>
<td>Dental</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Obstetrics</td>
</tr>
</tbody>
</table>

| Hospitals may have many more specific clinical areas identified, but these should be categorised under the main speciality headings for central reporting. |
| --- | --- |

<table>
<thead>
<tr>
<th>Staged</th>
<th>See Not Ready for Care “staged”.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Short Notice/Standby Patient</th>
<th>Patients may agree to be available on the “short notice” list to have their surgery performed if there is a cancelled procedure. The hospital should determine what period of time prior to admission is regarded as short notice and for which procedures are appropriate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Status review date (SRD)</th>
<th>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).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treating doctor</th>
<th>The medical officer/senior clinician (a visiting practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Waiting List</th>
<th>A waiting list is kept by the hospital. This contains the names and details of patients registered as requiring elective admission to that hospital. Admission may be for same day (admission and discharge on the same day) or other acute inpatient services requiring overnight or longer stay. These patients may or may not have a planned admission date and may be proposing to be public or private patients.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Waiting Time</th>
<th>Time a patient spends as Ready for Care.</th>
</tr>
</thead>
</table>
Appendix 1 - Incomplete RFA Letter

Dear <insert Dr name>

Incomplete Recommendation for Admission (RFA) Form

An RFA for <insert patient’s name> has been received at the Admission/Booking office on <insert date> with incomplete information. The Department of Health’s Waiting Time and Elective Surgery Policy states that the hospital is unable to accept RFA forms unless all the mandatory information is completed.

Could you please provide the information requested below:

The following information/details are incomplete or missing on the RFA

(Please Tick)

- Patient’s full name
- Patient’s address
- Patient’s contact information (home, work & mobile)
- Patient’s gender
- Patient’s date of birth
- Patient’s Medicare number
- Clinical priority category
- If classified as staged, the time interval when the patient will be ready for care should be indicated
- Discharge intention (i.e. Day only, or indication of number of nights in hospital)
- Presenting problem
- Planned procedure/treatment
- Significant medical history (including allergies)
- Treating doctor (if different)
- Patient’s signed consent (if available)
- General Practitioner (name and address if available)
- Special requirements (e.g. ICU bed, theatre equipment)
- Interpreter required

Specify

Please complete the requested information on this letter and return it within 2 days by facsimile to……………. This will enable the Admission/Booking Office to complete the patient’s booking.

If you require further information please contact our <insert position name and contact number>.

Thank you for your assistance with this matter.

Yours faithfully

<Signature block>
Appendix 2 - Patient Notification Letter

Dear <patient name>

I am writing to confirm that as of <date> you have been placed on the <hospital name> elective surgery waiting under the care of <insert doctor>.

Your doctor has determined the clinical priority of your admission. The approximate waiting time is <insert waiting time> weeks/months from when your name was placed on the waiting list.

Our first priority is to ensure you receive your procedure/treatment within the clinical priority timeframe recommended by your referring doctor. Where possible, we will make every effort to:

1. allocate your referring doctor to perform your procedure
2. ensure your surgery is performed at <insert hospital name>

While every attempt will be made for you to have your procedure under the care of the referring surgeon, the hospital is committed to providing your surgery within the clinically recommended timeframe, which may involve referring you to another doctor or hospital.

Once a planned admission date has been allocated for your procedure, you will be notified of the date and provided with further information to help you prepare for your hospital stay. The name of your doctor and facility will be included in this letter.

Sometimes it is necessary to delay booked surgery to make way for life-threatening cases, which are admitted through the hospital’s emergency department. These emergency cases will always receive priority over elective surgery. However, the hospital will make every effort to avoid such postponements and to reschedule delayed patients as soon as practicable.

Should your clinical condition change you should notify your general practitioner, your specialist or the hospital <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>. Changes in your condition or general health may have implications for the timing of your procedure or lead to your clinical priority category being re-assessed.

As a patient on the waiting list, you have a responsibility to inform the hospital:
- If you decide not to proceed with the procedure for any reason. For example, if the procedure has been conducted at another hospital or you have decided to seek treatment privately or to opt for an alternative treatment
- Of any changes to your contact details
- If you are going to be unavailable for any extended period

The hospital may remove you from the waiting list in consultation with your specialist if:
- The hospital is unable to contact you because you have not informed them of a change in your contact details.
- You fail to present for the procedure without providing the hospital with prior notice.
- You postpone your surgery on two occasions for personal or social reasons.

If you have any queries about the hospital waiting list or booking procedures, please contact our <insert position name and contact number> or if you have access to the web you can access information about specialists’ waiting times at the NSW Health web site:

Yours faithfully

<Signature block>
Appendix 3 - GP Notification Letter

Dear <insert GP’s name>

I am writing to advise you that as of <date> your patient:
<Patient name><Patient address>

has been placed on the <hospital name> elective surgery waiting list to undergo <procedure> under the care of <insert treating doctor’s name>

As you may be aware, clinicians assign each elective patient with a clinical priority category according to clinical need, ensuring that priority is given to the patients who are most in need. There are four categories: These are:

- **Category 1**: Admission within **30 days** desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

- **Category 2**: Admission within **90 days** desirable for a condition that is not likely to deteriorate quickly or become an emergency.

- **Category 3**: Admission within **365 days** acceptable for a condition that is unlikely to deteriorate quickly and which has little potential to become an emergency.

- **Category 4**: Patients who are either clinically not ready for admission (staged) and those who have deferred admission for personal reasons (deferred) after placement on waiting list.

The referring doctor who examined and placed <insert patient name> on the waiting list allocated the patient a category <insert category>, and the approximate waiting time is <insert waiting time> weeks/months from when they were placed on the waiting list.

While every attempt will be made for your patient to have their procedure under the care of the referring surgeon, the hospital is committed to providing their surgery within the clinically recommended timeframe, which may involve referring them to another doctor or hospital.

When the patient is booked for the procedure, the patient will be advised of the proposed admission date and given further information to help prepare.

The patient has been advised to notify their general practitioner, the specialist or the hospital if their condition changes for a clinical review. If you are contacted and require advice on the management of the patient’s condition, you can contact <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>.

If you have any queries about the hospital waiting list or booking procedures, please contact our <insert position name and contact number> or if you have access to the web you can access information about specialists’ waiting times at the NSW Health web site: [http://www0.health.nsw.gov.au/hospitals/waitingtimes/patients.asp](http://www0.health.nsw.gov.au/hospitals/waitingtimes/patients.asp)

Yours faithfully

<Signature block>
Appendix 4 - Admission Letter

Dear <insert patient name>

We are pleased to advise that your Admission to <insert hospital name> has been arranged for <insert planned admission date>.

It is important to let us know your intention as soon as possible so we can make the right arrangements for your care.

If you do wish to have your operation on the above date, please advise the hospital on telephone number <insert number>.

Your confirmation is required within 5 working days of receipt of this letter. Failure to confirm or attend the given date may result in your admission being cancelled.

If you wish to postpone or cancel your booking, please telephone the Admissions/Booking Office on <insert number> as soon as possible so that the hospital can schedule another patient. Please note that your clinical priority category will change if you postpone, and you may wish to discuss this with your treating doctor.

Prior to the procedure you may be required to attend the Pre-Admission clinic. At the clinic you will have any tests necessary and you may be required to complete admission paperwork, which will be processed by the admissions clerk.

All pre-operative instructions and any preparations required prior to the procedure will be given to you at the clinic. You will also have the opportunity to ask questions.

Your appointment at the clinic will be on <insert date> at <insert time>. You may be required to be at the clinic for <insert timeframe e.g. 2 hours).

Please bring any medications you are taking with you to the clinic appointment. You are also required to bring your Medicare Card, Health Fund and other relevant details with you.

If the clinic appointment is not suitable please contact <insert number> as soon as possible. Failure to attend the clinic appointment will mean that your date for the procedure is postponed until another appointment and rescheduled admission date can be arranged.

Please report to <insert location>, <insert directions> for your clinic appointment. (Include map or brochure about parking and public transport options.)

If you have any queries about your admission to hospital, please contact our <insert position name and contact number>.

We look forward to providing your hospital care.

Yours faithfully

<Signature block>
Appendix 5 - Postponement/Delay Letter

Dear <insert patient name>

It is with regret that I must advise you, that due to unforeseen circumstances, it has been necessary to delay your admission to hospital. This delay has been discussed with your treating doctor.

I wish to apologise for any inconvenience this may cause, and to advise you that a new admission date has been scheduled.

Your admission is now rescheduled for <insert date/time>

If you require any additional information please do not hesitate to contact the Admission/Booking Office on <insert telephone number> between 9.00am to 4.00pm Monday to Friday.

Yours faithfully

<Signature block>
Appendix 6 - Patient Notification Letter - Change to Not Ready for Care: Personal Reasons

Dear <insert patient name>

As you are aware you were referred to <hospital> for elective surgery. The clinical priority category allocated to this procedure is <CPC> and your registration date on the waiting list for this procedure is <date>.

I am writing to confirm that as of <date> your status on the elective surgery waiting list has changed to reflect that because of personal reasons, you are not available for surgery.

When scheduling patient for surgery the hospital considers the patient clinical priority category and the length of time the patient has waited for their surgery and have been ready for care. If your circumstances change and you are once again available for surgery you should notify the hospital as soon as possible.

It is important to note that there is a maximum timeframe that a patient can elect to defer their surgery for personal reasons. The timeframes are:

- Category 1 patients (admission required within 30 days) = 15 days cumulative
- Category 2 patients (admission required within 90 days) = 45 days cumulative
- Category 3 patients (admitted required within 365 days) = 180 days cumulative

A representative from the <hospital> will contact you before you have reached these thresholds to confirm whether you are ready for your surgery. If you exceed the thresholds above for personal reasons, you may be removed from the waiting list in consultation with your treating doctor.

If you require any additional information please do not hesitate to contact the Admission/Booking Office on <insert telephone number> between 9.00am to 400 pm Monday to Friday.

Yours faithfully

<Signature block>
Appendix 7 - Change of Clinical Priority Category, Letter Advising Treating Doctor

Dear <insert Dr’s name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>
<insert patient address>

has had their clinical priority category reviewed by <insert name> and changed from <insert clinical priority category> to <insert clinical priority category>.

If you have any concerns or require further information about the change in clinical priority category for your patient, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>
Dear <insert Dr’s name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>
<insert patient address>

has been removed from the waiting list at <insert hospital name>, due to <insert reason>. The patient has been advised to contact you if they have any concerns.

The patient’s specialist <insert Dr’s name> has also been made aware of <insert patient name> removal from the waiting list.

If you have any concerns or require further information about this removal from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>
Appendix 8b - Removal from Waiting List, Letter Advising Treating Doctor

Dear <insert Dr’s name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>
<insert patient address>

(Choose the appropriate option)

has been removed from the waiting list at <insert hospital name>, due to <insert reason>. The patient has been advised to contact you if they have any concerns.

Or

will be removed from the waiting list at <insert hospital name>, due to <insert reason - declines treatment, fails to arrive or requests removal>, if you do not contact this office within 5 working days to advise that the patient is to remain on the waiting list.

If you have any concerns or require further information about the removal of your patient’s name from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>
Appendix 8c - Removal from the Waiting List, Letter Advising Patient

Dear <insert patient’s name>

I am writing to advise you as of <insert date> your name was removed from <insert Dr’s name> waiting list at <insert hospital name> due to <insert reason>.

Your specialist and general practitioner have been advised that your name has been removed from the waiting list. You may wish to discuss any concerns you have with them.

If you require further information about your removal from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<SIGNATURE BLOCK>
Appendix 9 - Audit Letter

Dear <patient’s name>

We are continually updating our waiting lists so they remain accurate, complete and ensure your timely access to our services.

To enable us to keep our waiting list accurate we would ask you to complete the section below and return it in the envelope provided within **10 days**.

We acknowledge that you may have previously received and replied to this request, and apologise for any inconvenience caused, however it is important that this information is obtained regularly, reviewed and our records updated.

Should your clinical condition change you should notify your general practitioner, your specialist or the hospital <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>. Changes in your condition or general health may have implications for the timing of your procedure or lead to your clinical priority category being re-assessed.

If you **do not** confirm that you wish to remain on the list within **10 working days** of receiving this letter, one other attempt will be made to contact you. If there is still no response your name, in consultation with your doctor may be removed from the Hospital’s waiting list.

**Would you please tick one of the boxes below**

☐ I still require my surgery and I am ready for surgery at this time

☐ I wish to be taken off the waiting list as I have had my surgery elsewhere

☐ I wish to be taken off the waiting list, as I no longer require the surgery

If you wish to know your current waiting time or discuss an alternative option for your care please contact the Local Health District Patient Access Coordinator on <insert number>.

Should you have any concerns or if we can assist you in any way please contact the Admission Office on <insert number>.

Thank you for taking the time to complete this form. Could you now sign this form and return it in the **envelope provided within 10 working days**.

Patient/Carer Signature: _______________________

Date: _______/_____/_______

Yours faithfully

<Signature block>
Appendix 10 - Notification to GP of Resignation/Death

Dear <insert gp’s name>

I am writing to inform you that <insert Dr’s name> is no longer admitting patients at this <insert hospital>.

Your patient <insert patient name> is currently on our waiting list and we will attempt to transfer your patient to another specialist’s waiting list, however in the interim your patient may contact you for advice and information, or a referral to another specialist for the management of their condition.

If you have any concerns or require further information about this situation, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>
12. MEDICAL CARE

Appendix 11 - Booking Clerk Form

**Booking Clerk Form**
(This form is Office Use Only - Administrative Staff)
Patients are not to be entered on the Waiting List until all the Minimum Data requirements are completed.

RFA received with the following incomplete minimum data requirements (please tick boxes below)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s full name</td>
<td></td>
</tr>
<tr>
<td>Patient’s address</td>
<td></td>
</tr>
<tr>
<td>Patient’s contact information</td>
<td></td>
</tr>
<tr>
<td>Patient’s gender</td>
<td></td>
</tr>
<tr>
<td>Patient’s date of birth</td>
<td></td>
</tr>
<tr>
<td>Medicare number</td>
<td></td>
</tr>
<tr>
<td>Clinical priority category</td>
<td></td>
</tr>
<tr>
<td>If classified as staged, time interval when ready for care</td>
<td></td>
</tr>
<tr>
<td>Discharge intention</td>
<td></td>
</tr>
<tr>
<td>Presenting problem</td>
<td></td>
</tr>
<tr>
<td>Planned procedure/treatment</td>
<td></td>
</tr>
</tbody>
</table>

RFA entered in Patient Administration System: Date:______ Clerk:______

Minimum Data Requirements Completed: ☐ Yes ☐ No

Completed RFA received in Admission Office: Date:______ Clerk:______

Patient Contacted/Instructions Given: Date:______ Clerk:______

This section is to be utilised to document all correspondence with the Referring or Treating Dr, Rooms, Clinics, Ward or patient after the booking has been entered into the Patient Administration System. For Example: Delays, Cancellations and patient requests can be registered on this form.

<table>
<thead>
<tr>
<th>Date</th>
<th>Clerk</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

146(02/02/12)
# Appendix 12 - Amendment to Elective Waiting Time Booking Form

**NSW HEALTH**

<table>
<thead>
<tr>
<th>Insert: Local Health District/Network</th>
<th>Affix Patient Identification Label Here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert: Hospital Name</td>
<td></td>
</tr>
</tbody>
</table>

**Amendment to Elective Waiting Time Booking**

**AMO:**

**Procedure:**

**Listing Date:**

**Original Clinical Priority:**

<table>
<thead>
<tr>
<th>Table 1: CPC Change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2: Delay (Hospital Based)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3: Deferral (Patient Based)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4: Staged (Clinically Based)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5: Removal from List (Other than Admission)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

146(02/02/12)
Appendix 13 - RFA Checklist

**RFA Receipt Checklist**

<table>
<thead>
<tr>
<th>Item for Checking</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum Data Set</strong></td>
<td></td>
</tr>
<tr>
<td>(Referring Doctor)</td>
<td></td>
</tr>
<tr>
<td>Patient’s full name</td>
<td>Send Incomplete RFA Form letter to surgeon via fax</td>
</tr>
<tr>
<td>Patient’s address</td>
<td></td>
</tr>
<tr>
<td>Patient’s contact information</td>
<td></td>
</tr>
<tr>
<td>Patient’s gender</td>
<td></td>
</tr>
<tr>
<td>Patient’s date of birth</td>
<td></td>
</tr>
<tr>
<td>Patient’s Medicare number</td>
<td></td>
</tr>
<tr>
<td>Clinical priority category</td>
<td></td>
</tr>
<tr>
<td>If classified as staged, time interval when ready for care</td>
<td></td>
</tr>
<tr>
<td>Discharge intention (no of nights in hospital)</td>
<td></td>
</tr>
<tr>
<td>Presenting problem</td>
<td></td>
</tr>
<tr>
<td>Planned procedure/treatment</td>
<td></td>
</tr>
<tr>
<td>Significant medical history</td>
<td></td>
</tr>
<tr>
<td><strong>(Admission Staff)</strong></td>
<td></td>
</tr>
<tr>
<td>Treating doctor (if different)</td>
<td></td>
</tr>
<tr>
<td>Patient Consent (if available)</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
</tr>
<tr>
<td>Aboriginal &amp; Torres Strait Islander Status</td>
<td></td>
</tr>
<tr>
<td>Interpreter Required</td>
<td>Contact Interpreter Service when required (Pre-admission &amp; admission)</td>
</tr>
<tr>
<td>Special requirements (ICU bed, equipment)</td>
<td>For ICU bed Notify (name) For special equipment notify (name)</td>
</tr>
<tr>
<td>Planned admission date (if available)</td>
<td>For data entry to PAS/Operating Theatre System</td>
</tr>
<tr>
<td>Anticipated election status</td>
<td>Election status to be discussed with patient by Admission/clerical staff</td>
</tr>
<tr>
<td>Status review date for staged patients (NRFC)</td>
<td>A status review date or planned admission date is required for all NRFC staged patients</td>
</tr>
<tr>
<td><strong>Clinical Priority Category (CPC)</strong></td>
<td>If CPC differs from reference list – RFA is to be referred to Admissions Manager for action</td>
</tr>
<tr>
<td><strong>CPC 30 day Category Patients</strong></td>
<td>Check that surgeon has allocated a planned admission date.</td>
</tr>
<tr>
<td><strong>Cosmetic &amp; Discretionary Surgery List Check</strong></td>
<td>An RFA that has no date or date is allocated outside 30 days to be referred to Admission Manager</td>
</tr>
<tr>
<td>Check that procedure is not listed under cosmetic or discretionary procedures (section 2.3 Waiting Times &amp; Elective Patient Surgery Policy)</td>
<td>An escalation process should be in place according to the management structure</td>
</tr>
</tbody>
</table>
Classification of Venous Disease

Venous disease of the legs can be classified according to the severity, cause, site and specific abnormality using the CEAP classification. Use of such a classification improves the accuracy of the diagnosis and improves communication between specialists. The elements of the CEAP classification are:

- Clinical severity
- Etiology or cause
- Anatomy
- Pathophysiology

For the initial assessment of a patient, the clinical severity is the most important and can be made by simple observation and does not need special tests. There are seven grades of increasing clinical severity:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C 0</td>
<td>No evidence of venous disease.</td>
</tr>
</tbody>
</table>
| C 1   | Superficial spider veins (reticular veins)  
http://www.simondodds.com/Venous/Spider_veins_FAQ.htm |
| C 2   | Simple varicose veins  
http://www.simondodds.com/Venous/Varicose_veins_FAQ.htm |
| C 3   | Ankle oedema of venous origin (not foot oedema) |
| C 4   | Skin pigmentation in the gaiter area (lipodermatosclerosis)  
http://www.simondodds.com/Venous/LDS.htm |
| C 5   | A healed venous ulcer  
http://www.simondodds.com/Venous/Venous_ulcer_FAQ.htm |
| C 6   | An open venous ulcer  
http://www.simondodds.com/Venous/Venous_ulcer_FAQ.htm |
## 12. ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMO</td>
<td>Attending Medical Officer</td>
</tr>
<tr>
<td>Cat</td>
<td>Category</td>
</tr>
<tr>
<td>CEAP</td>
<td>Clinical, Etiology, Anatomy, Pathophysiology</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMBS</td>
<td>Commonwealth Medicare Benefits Schedule</td>
</tr>
<tr>
<td>CPC</td>
<td>Clinical Priority Category</td>
</tr>
<tr>
<td>DO</td>
<td>Day Only</td>
</tr>
<tr>
<td>DOASA</td>
<td>Day of Surgery Admission</td>
</tr>
<tr>
<td>DR</td>
<td>Doctor</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veteran Affairs</td>
</tr>
<tr>
<td>EDO</td>
<td>Extended Day Only</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>HVSS</td>
<td>High Volume Short Stay</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>NRFCC</td>
<td>Not Ready for Care</td>
</tr>
<tr>
<td>PAD</td>
<td>Planned Admission Date</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>RFA</td>
<td>Recommendation for Admission</td>
</tr>
<tr>
<td>RFC</td>
<td>Ready for Care</td>
</tr>
<tr>
<td>SRD</td>
<td>Status Review Date</td>
</tr>
<tr>
<td>WC</td>
<td>Workers Compensation</td>
</tr>
</tbody>
</table>

146(02/02/12)
ADVICE FOR REFERRING AND TREATING DOCTORS - WAITING TIME AND ELECTIVE SURGERY POLICY (IB2012_004)

IB2012_004 rescinds IB2009_018.

PURPOSE

The aim of this Information Bulletin is to inform referring doctors as to the minor modifications to the Waiting Time and Elective Surgery Policy PD2012_011.

KEY INFORMATION

“Advice for Referring and Treating Doctors” has been developed to provide doctors with information on the changes introduced by the revised Waiting time and Elective Surgery Policy - PD2012_011.

Introduction

The aim of this Information Bulletin is to inform referring doctors as to the minor modifications to the Waiting Time and Elective Surgery Policy that has been approved by the Surgical Services Taskforce (SST). The Waiting Time and Elective Surgery Policy promotes partnerships between clinicians and hospitals to facilitate the optimal management of waiting lists. The policy also promotes improved communication between clinicians and hospitals to facilitate the treatment of patients in a clinically appropriate time frame.


For further information or clarification please contact your District/Network Program Director of Surgery or the State Program Director of Surgery at NSW Health.

Summary of the Key Elements and Issues for Clinicians

<table>
<thead>
<tr>
<th>CHANGE/ISSUE</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A recommended guide of accepted Clinical Priority categories for common procedures with certain clinical indications. (Recommended guide is located in Appendix 2)</td>
<td>A recommended guide of accepted Clinical Priority Categories has been developed with the assistance of specialist craft groups to ensure that patients with similar conditions are prioritised in a similar way. The appropriate categorisation of patients with similar conditions will provide clinicians with more certainty about being able to obtain access for their patients in a clinically appropriate timeframe. Individual patient exceptions to the recommended Clinical Priority Categorisation are facilitated by supporting documentation or following discussions with the District/Network Program Director of Surgery.</td>
</tr>
<tr>
<td>The minimum information that the referring doctor should provide on the Recommendation for Admission form (RFA). (List of the minimum information required is located in Appendix 3.)</td>
<td>To keep pace with the changing methods for booking patients for a procedure (e.g. fax, post), hospital staff need information to ensure that they are able to register the patient on to the waiting list in a timely manner.</td>
</tr>
</tbody>
</table>
### CHANGE/ISSUE

| RFA forms must be forwarded to the hospital within 3 working days of the patient agreeing to the proposed procedure/treatment (via the most relevant means, e.g. mail, hand delivery, by patient or carer). |

To ensure that patients are registered on the waiting list in a timely and equitable manner, RFA forms need to be forwarded to the hospital within 3 working days.

Hospitals are required to supply the doctor with a detailed copy of their waiting list for review, at least monthly.

| An RFA will only be accepted if the patient’s clinical condition requires surgical intervention within 12 months. |

If an RFA is presented with a planned operate date >12 months ahead, discussion with the referring doctor will be required.

| A Responsibilities section is included in the revised policy for Patients, GP, Surgeons, Booking Clerk, Clinical Director of Surgical Services and Program Director of Surgical Services. |

**Surgeon responsibilities:**

- Explain proposed procedure/treatment, options for treatment and potential complications.
- Anticipated length of stay and obtain written informed consent from the patient.
- Assign a clinical priority category for the procedure/treatment, as it applies to the individual patient as per the “Advice for Treating Doctors”.
- If patient is classified as staged, the time interval when the patient will be ready for care should be indicated.
- Ensure that RFA forms are legible and minimum data set is completed.
- Forward the completed RFA direct to the hospital within 3 working days of the patient agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer).
- Initiate prompt and appropriate communication with the referring GP regarding management of the patient.
- Referring doctors must ensure they are available to perform the procedure within the clinical priority timeframe. Alternatively, the clinician should make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe.
- Review Waiting List at least monthly and verify with the hospital.
- Provide as much notice of intended leave as possible (minimum of 6 weeks) for appropriate theatre scheduling.

| Demand Management |

Patients added to the elective surgery waiting list should be treated within their clinical priority timeframe.

If the surgeon does not have the capacity to undertake the surgery within the clinical priority timeframe then this should be managed in conjunction with the surgeon, patient and referring General Practitioner by considering:
- Additional theatre time.
- Transfer of patients to another surgeon with a shorter waiting list.

Private sector option if the above prove unsuccessful (Local Health District/Network responsible for expenses incurred).
## 12. MEDICAL CARE

<table>
<thead>
<tr>
<th>CHANGE/ISSUE</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Cosmetic and Discretionary</strong> procedures that are no longer available in NSW Public Hospitals are included in the revised Policy. (Appendix4)</td>
<td>Surgery should meet an identified clinical need to improve the physical health of the patient. When a clear clinical need to improve a patient’s physical health has been identified for Cosmetic and Discretionary procedure, approval of the Local Health District/Network Program Director of Surgery, in consultation with senior management should be sought by the referring doctor before cosmetic and discretionary procedures are undertaken in any public hospital facility.</td>
</tr>
<tr>
<td>Clinicians are now requested to provide at least 6 weeks notice for planned leave such as holiday, study and conference leave.</td>
<td>In order to facilitate better planning for operating theatres and to minimise patient delays, a minimum of 6 weeks notice for planned leave is required.</td>
</tr>
<tr>
<td><strong>Bilateral Procedures</strong></td>
<td>An RFA will only be accepted for one procedure unless the procedure is occurring in the same admission. This is to ensure that the patient has been reviewed to assess that they are clinically ready to undergo the subsequent procedure. The exception is when the surgeon undertakes the bilateral procedure in the same operation.</td>
</tr>
<tr>
<td><strong>Patient to Choice to wait</strong> has been removed from the policy.</td>
<td>Where the patient declines two genuine offers of treatment with another doctor or at another hospital, then the patient should be advised that they may be removed from the waiting list. The Local Health District Program Director of Surgery should review the patient’s status on the waiting list in consultation with the original treating doctor prior to the patient being removed from the waiting list.</td>
</tr>
</tbody>
</table>
| **Not Ready for Care - Staged & Deferred** | **Staged Only**  
  - On request for admission the Not Ready for Care timeframe should be identified by the treating doctor and a RFC clinical priority category indicated.  
  - Once the identified NRFC staged timeframe is completed the patient then returns to the RFC category as indicated by the treating doctor.  
  - A PAD/TCI can be arranged whilst the patient is in the category of Not Ready  

**Deferred Only**  
  - The period of time the patient request deferment should be determined and the patient returned to the original CPC at that timeframe.  
  - A deferred patient should not exceed the timeframes for their clinical priority category as indicated above. |
Appendix 1

Clinical Priority Categories

Categorisation of Elective patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner. The Clinical priority category is allocated by the referring doctor.

Clinical Priorities are:

<table>
<thead>
<tr>
<th>Clinical Priority Category</th>
<th>A clinical assessment of the priority with which a patient requires elective admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Admission <strong>within 30 days</strong> desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.</td>
</tr>
<tr>
<td>Category 2</td>
<td>Admission <strong>within 90 days</strong> desirable for a condition which is not likely to deteriorate quickly or become an emergency.</td>
</tr>
<tr>
<td>Category 3</td>
<td>Admission <strong>within 365 days</strong> acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency.</td>
</tr>
<tr>
<td>Category 4</td>
<td>Patients who are either clinically not ready for admission (<strong>staged</strong>) and those who have deferred admission for personal reasons (<strong>deferred</strong>).</td>
</tr>
</tbody>
</table>

Ready for Care

Not Ready for Care
### Appendix 2

**Reference List – Clinical Priority Categories**

<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>124</td>
<td>Acromioplasty</td>
<td>3 (within 365 days)</td>
<td>Acromioplasty</td>
</tr>
<tr>
<td>067</td>
<td>Adenoidectomy</td>
<td>3 (within 365 days)</td>
<td>Adenoidectomy</td>
</tr>
<tr>
<td>197</td>
<td>Amputation digit (toe/finger)</td>
<td>2 (within 90 days)</td>
<td>Amputation digit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(toe/finger)</td>
</tr>
<tr>
<td>085</td>
<td>Amputation of limb</td>
<td>1 (within 30 days)</td>
<td>Amputation of limb</td>
</tr>
<tr>
<td>175</td>
<td>Aortic bifurcation graft</td>
<td>1 (within 30 days)</td>
<td>Aortic bifurcation graft</td>
</tr>
<tr>
<td>097</td>
<td>Appendicectomy (non-emergency)</td>
<td>3 (within 365 days)</td>
<td>Appendicectomy</td>
</tr>
<tr>
<td>122</td>
<td>Arthrodesis</td>
<td>3 (within 365 days)</td>
<td>Arthrodesis</td>
</tr>
<tr>
<td>042</td>
<td>Arthroscopy</td>
<td>3 (within 365 days)</td>
<td>Arthroscopy</td>
</tr>
<tr>
<td>178</td>
<td>Biopsy - muscle</td>
<td>1 (within 30 days) or</td>
<td>Biopsy - muscle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 (within 90 days)</td>
<td></td>
</tr>
<tr>
<td>027</td>
<td>Biopsy of breast</td>
<td>1 (within 30 days) or</td>
<td>Biopsy of breast</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 (within 90 days)</td>
<td></td>
</tr>
<tr>
<td>046</td>
<td>Biopsy/conization of cervix/LLETZ</td>
<td>2 (within 90 days)</td>
<td>Biopsy/conization of cervix/LLETZ</td>
</tr>
<tr>
<td>137</td>
<td>Bladder neck incision</td>
<td>2 (within 90 days)</td>
<td>Bladder neck incision</td>
</tr>
<tr>
<td>184</td>
<td>Blepharoplasty</td>
<td>3 (within 365 days)</td>
<td>Blepharoplasty</td>
</tr>
<tr>
<td>019</td>
<td>Bronchoscopy</td>
<td>1 (within 30 days)</td>
<td>Bronchoscopy</td>
</tr>
<tr>
<td>192</td>
<td>Bursa - excision</td>
<td>3 (within 365 days)</td>
<td>Bursa - excision</td>
</tr>
<tr>
<td>016</td>
<td>Cardiac catheterisation</td>
<td>1 (within 30 days)</td>
<td>Cardiac catheterisation</td>
</tr>
<tr>
<td>001</td>
<td>Cataract extraction (+/- intra-ocular lens</td>
<td>3 (within 365 days)</td>
<td>Cataract extraction</td>
</tr>
<tr>
<td></td>
<td>insertion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>128</td>
<td>Change of muscle or tendon length</td>
<td>3 (within 365 days)</td>
<td>Change of muscle or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>tendon length</td>
</tr>
<tr>
<td>120</td>
<td>Change of plaster (GA)</td>
<td>4 (staged)</td>
<td>Change of plaster (GA)</td>
</tr>
<tr>
<td>002</td>
<td>Cholecystectomy (including laparoscopic)</td>
<td>1 (within 30 days) or</td>
<td>Cholecystectomy</td>
</tr>
<tr>
<td></td>
<td>- Acute Cholecystitis</td>
<td>2 (within 90 days)</td>
<td></td>
</tr>
<tr>
<td>054</td>
<td>Circumcision (clinical conditions only)</td>
<td>3 (within 365 days)</td>
<td>Circumcision</td>
</tr>
<tr>
<td>176</td>
<td>Closure colostomy/ileostomy</td>
<td>4 (Staged)</td>
<td>Closure colostomy/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ileostomy</td>
</tr>
<tr>
<td>075</td>
<td>Cochlear implant</td>
<td>3 (within 365 days)</td>
<td>Cochlear implant</td>
</tr>
<tr>
<td>025</td>
<td>Colectomy/ Anterior Resection/Large Bowel</td>
<td>1 (within 30 days) or</td>
<td>Colectomy/Anterior Resection/Large Bowel</td>
</tr>
<tr>
<td></td>
<td>Resection</td>
<td>2 (within 90 days)</td>
<td></td>
</tr>
</tbody>
</table>

* Generally, malignancy will be considered to require treatment within 30 days.
### Reference List - Clinical Priority Categories

<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>020</td>
<td>Colonoscopy</td>
<td>1 (within 30 days)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>High likelihood of significant organic pathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinically significant overt lower gastrointestinal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Active Inflammatory bowel disease or diarrhoea where endoscopy is indicated to progress management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinically significant iron deficiency anaemia</td>
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</tr>
<tr>
<td></td>
<td>• FOBT +ve (including the National Bowel Cancer Screening Program)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>020</td>
<td>Colonoscopy</td>
<td>2 (within 90 days)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Lower likelihood of significant organic pathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Examples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Functional bowel symptoms without alarm features</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Persistent undiagnosed diarrhoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>020</td>
<td>Colonoscopy</td>
<td>3 (within 365 days)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Surveillance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family History - (as per NHMRC Clinical Practice Guidelines – see appendix 5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete examination of colon (if not done preoperatively) within 1 year of curative surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>020</td>
<td>Colonoscopy</td>
<td>4 (Not Ready for Care - Staged or Deferred)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Waiting List Bookings for colonoscopy are not accepted for more than 12 months in advance. Category 4 used for: Staged Procedures:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patients who require the procedure after a specific time period up to 12 months in advance. For example post polypectomy follow up of high risk lesions for recurrence or incomplete resection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patients who are temporarily not fit for colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deferred Procedures:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patients who defer colonoscopy for personal reasons</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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146(02/02/12)
<table>
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<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>Colposcopy</td>
<td>2 (within 90 days)</td>
<td>Colposcopy</td>
</tr>
<tr>
<td>113</td>
<td>Corneal graft</td>
<td>3 (within 365 days)</td>
<td>Corneal graft</td>
</tr>
<tr>
<td>017</td>
<td>Coronary angioplasty/Stent/Balloon dilatation</td>
<td>1 (within 30 days)</td>
<td>Coronary angioplasty/DSA/PTA/Stent/Balloon Dilatation</td>
</tr>
<tr>
<td>003</td>
<td>Coronary artery bypass graft</td>
<td>1 (within 30 days)</td>
<td>Coronary artery bypass graft</td>
</tr>
<tr>
<td>068</td>
<td>Correction of bat ears</td>
<td>3 (within 365 days)</td>
<td>Correction of bat ears</td>
</tr>
<tr>
<td>074</td>
<td>Correction of cleft lip/palate</td>
<td>3 (within 365 days)</td>
<td>Correction of cleft lip/palate</td>
</tr>
<tr>
<td>111</td>
<td>Correction of ectropian</td>
<td>3 (within 365 days)</td>
<td>Correction of ectropian</td>
</tr>
<tr>
<td>151</td>
<td>Correction of uretero-pelvic junction</td>
<td>2 (within 90 days)</td>
<td>Correction of uretero-pelvic junction</td>
</tr>
<tr>
<td>108</td>
<td>Craniectomy</td>
<td>2 (within 90 days)</td>
<td>Craniectomy</td>
</tr>
<tr>
<td>104</td>
<td>Craniotomy</td>
<td>2 (within 90 days)</td>
<td>Craniotomy</td>
</tr>
<tr>
<td>143</td>
<td>Cystectomy</td>
<td>1 (within 30 days or 2 (within 90 days)</td>
<td>Cystectomy</td>
</tr>
<tr>
<td>004</td>
<td>Cystoscopy</td>
<td>3 (within 365 days) or 4 (staged)</td>
<td>Cystoscopy</td>
</tr>
<tr>
<td>118</td>
<td>Dacrocystorhinostomy</td>
<td>3 (within 365 days)</td>
<td>Dacrocystorhinostomy</td>
</tr>
<tr>
<td>043</td>
<td>Diagnostic laparoscopy</td>
<td>3 (within 365 days)</td>
<td>Diagnostic laparoscopy</td>
</tr>
<tr>
<td>093</td>
<td>Diathermy of warts</td>
<td>3 (within 365 days)</td>
<td>Diathermy of warts</td>
</tr>
<tr>
<td>100</td>
<td>Dilatation and curettage</td>
<td>2 (within 90 days)</td>
<td>Dilatation and curettage</td>
</tr>
<tr>
<td>026</td>
<td>Dilation of oesophagus</td>
<td>2 (within 90 days)</td>
<td>Dilation of oesophagus</td>
</tr>
<tr>
<td>055</td>
<td>Dilation of urethra</td>
<td>2 (within 90 days)</td>
<td>Dilation of urethra</td>
</tr>
<tr>
<td>039</td>
<td>Discectomy</td>
<td>3 (within 365 days)</td>
<td>Discectomy</td>
</tr>
<tr>
<td>103</td>
<td>Drainage of Bartholin’s cyst</td>
<td>3 (within 365 days)</td>
<td>Drainage of Bartholin’s cyst</td>
</tr>
<tr>
<td>105</td>
<td>Drainage of sub-dural haematoma</td>
<td>2 (within 90 days)</td>
<td>Drainage of sub-dural haematoma</td>
</tr>
<tr>
<td>057</td>
<td>Endarterectomy</td>
<td>1 (within 30 days)</td>
<td>Endarterectomy</td>
</tr>
<tr>
<td>049</td>
<td>Endometrial ablation</td>
<td>3 (within 365 days)</td>
<td>Endometrial ablation</td>
</tr>
<tr>
<td>088</td>
<td>Endoscopy - ERCP</td>
<td>1 (within 30 days) or 2 (within 90 days)</td>
<td>Endoscopy - ERCP</td>
</tr>
<tr>
<td>022</td>
<td>Endoscopy - small intestine</td>
<td>2 (within 90 days)</td>
<td>Endoscopy - small intestine</td>
</tr>
<tr>
<td>063</td>
<td>Ethmoidectomy</td>
<td>3 (within 365 days)</td>
<td>Ethmoidectomy</td>
</tr>
<tr>
<td>116</td>
<td>Examination of eye under anaesthesia</td>
<td>2 (within 90 days)</td>
<td>Examination of eye under anaesthesia</td>
</tr>
<tr>
<td>077</td>
<td>Excision lesion of pharynx</td>
<td>2 (within 90 days)</td>
<td>Excision lesion of pharynx</td>
</tr>
</tbody>
</table>

* Generally, malignancy will be considered to require treatment within 30 days.
### Reference List - Clinical Priority Categories

<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>080</td>
<td>Excision of anal fissure</td>
<td>2 (within 90 days) or 3 (within 365 days)</td>
<td>Excision of anal fissure</td>
</tr>
<tr>
<td>084</td>
<td>Excision of breast lump</td>
<td>1 (within 30 days) or 2 (within 90 days)</td>
<td>Excision of breast lump</td>
</tr>
<tr>
<td>119</td>
<td>Excision of chalazion</td>
<td>3 (within 365 days)</td>
<td>Excision of chalazion</td>
</tr>
<tr>
<td>086</td>
<td>Excision of ganglion</td>
<td>3 (within 365 days)</td>
<td>Excision of ganglion</td>
</tr>
<tr>
<td>208</td>
<td>Excision of Lipoma +/-Grafting</td>
<td>3 (within 365 days)</td>
<td>Excision of Lipoma +/-Grafting</td>
</tr>
<tr>
<td>207</td>
<td>Excision of Melanoma +/- Grafting</td>
<td>1 (within 30 days)</td>
<td>Excision of Melanoma/ SCC/BCC/+/- Grafting</td>
</tr>
<tr>
<td>207</td>
<td>Excision of SCC +/- Grafting</td>
<td>1 (within 30 days)</td>
<td>Excision of Melanoma/ SCC/BCC/+/- Grafting</td>
</tr>
<tr>
<td>207</td>
<td>Excision of BCC +/- Grafting</td>
<td>1 (within 30 days or 2 (within 90 days)</td>
<td>Excision of Melanoma/ SCC/BCC/+/- Grafting</td>
</tr>
<tr>
<td>052</td>
<td>Excision of ovarian cyst</td>
<td>3 (within 365 days)</td>
<td>Excision of ovarian cyst</td>
</tr>
<tr>
<td>112</td>
<td>Excision of pterygium</td>
<td>3 (within 365 days)</td>
<td>Excision of pterygium</td>
</tr>
<tr>
<td>045</td>
<td>Female sterilisation</td>
<td>3 (within 365 days)</td>
<td>Female sterilisation</td>
</tr>
<tr>
<td>028</td>
<td>Femoral hernorrhaphy</td>
<td>3 (within 365 days)</td>
<td>Femoral hernorrhaphy</td>
</tr>
<tr>
<td>154</td>
<td>Femoro-popliteal bypass graft</td>
<td>1 (within 30 days) or 2 (within 90 days)</td>
<td>Femoro-popliteal bypass graft</td>
</tr>
<tr>
<td>179</td>
<td>Foreign body - removal (non-emergency)</td>
<td>3 (within 365 days)</td>
<td>Foreign body - removal</td>
</tr>
<tr>
<td>031</td>
<td>Freeing abdominal adhesions</td>
<td>3 (within 365 days)</td>
<td>Freeing abdominal adhesions</td>
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<tr>
<td>185</td>
<td>Functional Endoscopic sinus surgery (FESS)</td>
<td>3 (within 365 days)</td>
<td>Functional endoscopic sinus surgery (FESS)</td>
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<tr>
<td>089</td>
<td>Fundoplication</td>
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<td>Fundoplication</td>
</tr>
<tr>
<td>210</td>
<td>Gastrectomy</td>
<td>2 (within 90 days)</td>
<td>Gastrectomy</td>
</tr>
<tr>
<td>021</td>
<td>Gastroscopy (Haemorrhage or Upper GI Cancer)</td>
<td>1 (within 30 days)</td>
<td>Gastroscopy</td>
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<tr>
<td>021</td>
<td>Gastroscopy (other)</td>
<td>3 (within 365 days) or 4 (staged)</td>
<td>Gastroscopy</td>
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<tr>
<td>005</td>
<td>Haemorrhoidectomy/Banding of Haemorrhoids</td>
<td>3 (within 365 days)</td>
<td>Haemorrhoidectomy/ Banding of Haemorrhoids</td>
</tr>
<tr>
<td>198</td>
<td>Hammertoe – correction/repair</td>
<td>3 (within 365 days)</td>
<td>Hammertoe - correction/repair</td>
</tr>
<tr>
<td>018</td>
<td>Heart valve replacement</td>
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<td>Heart valve replacement</td>
</tr>
<tr>
<td>177</td>
<td>Hernia - epigastric, repair</td>
<td>3 (within 365 days)</td>
<td>Hernia - epigastric</td>
</tr>
</tbody>
</table>

* Generally, malignancy will be considered to require treatment within 30 days.
<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>174</td>
<td>Hypospadias repair</td>
<td>3 (within 365 days)</td>
<td>Hypospadias repair</td>
</tr>
<tr>
<td>006</td>
<td>Hysterectomy</td>
<td>3 (within 365 days)</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>044</td>
<td>Hysteroscopy</td>
<td>2 (within 90 days)</td>
<td>Hysteroscopy</td>
</tr>
<tr>
<td>007</td>
<td>Inguinal herniorrhaphy</td>
<td>3 (within 365 days)</td>
<td>Inguinal herniorrhaphy</td>
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<tr>
<td>213</td>
<td>Insertion of Levovorgestrel intra uterine system</td>
<td>3 (within 365 days)</td>
<td>Insertion of Levonorgestrel intra uterine system</td>
</tr>
<tr>
<td>096</td>
<td>Insertion of hepatic artery catheter</td>
<td>1 (within 30 days)</td>
<td>Insertion of hepatic artery catheter</td>
</tr>
<tr>
<td>142</td>
<td>Insertion of ureteric stent</td>
<td>1 (within 30 days)</td>
<td>Insertion of ureteric stent</td>
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<tr>
<td>109</td>
<td>Insertion of ventricular shunt</td>
<td>2 (within 90 days)</td>
<td>Insertion of ventricular shunt</td>
</tr>
<tr>
<td>066</td>
<td>Insertion P.E. tubes (grommets)</td>
<td>3 (within 365 days)</td>
<td>Insertion P.E. tubes (grommets)</td>
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<tr>
<td>048</td>
<td>Insufflation of fallopian tube (Rubin’s test)</td>
<td>3 (within 365 days)</td>
<td>Insufflation of fallopian tube (Rubin’s test)</td>
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<tr>
<td>199</td>
<td>Joint replacement eg. shoulder (other than hip &amp; knee)</td>
<td>3 (within 365 days)</td>
<td>Joint replacement eg. shoulder (other than hip &amp; knee)</td>
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<tr>
<td>038</td>
<td>Laminectomy/Other Spinal Surgery (excluding discectomy)</td>
<td>3 (within 365 days)</td>
<td>Laminectomy/Other Spinal Surgery (excluding fusion and discectomy)</td>
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<tr>
<td>083</td>
<td>Laparotomy</td>
<td>2 (within 90 days)</td>
<td>Laparotomy</td>
</tr>
<tr>
<td>072</td>
<td>Laryngectomy</td>
<td>1 (within 30 days)</td>
<td>Laryngectomy</td>
</tr>
<tr>
<td>056</td>
<td>Lithotripsy</td>
<td>2 (within 90 days)</td>
<td>Lithotripsy</td>
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<tr>
<td>082</td>
<td>Liver biopsy</td>
<td>2 (within 90 days) or 3 (within 365 days)</td>
<td>Liver biopsy</td>
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<tr>
<td>216</td>
<td>Lobectomy any organ/lung</td>
<td>2 (within 90 days)</td>
<td>Lobectomy any organ/ Lung</td>
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<tr>
<td>181</td>
<td>Lymph node - excision</td>
<td>1 (within 30 days)</td>
<td>Lymph node - excision</td>
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<tr>
<td>135</td>
<td>Mandibulectomy/hemi-mandibulectomy</td>
<td>2 (within 90 days)</td>
<td>Mandibulectomy/hemi-mandibulectomy</td>
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<td>195</td>
<td>Manipulation under Anaesthetic</td>
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<td>Manipulation under anaesthetic</td>
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<td>030</td>
<td>Mastectomy</td>
<td>1 (within 30 days) or 2 (within 90 days)</td>
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<td>070</td>
<td>Mastoidectomy</td>
<td>2 (within 90 days)</td>
<td>Mastoidectomy</td>
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<tr>
<td>140</td>
<td>Meatooplasty (urinary)</td>
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<td>Urinary Meatooplasty</td>
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<tr>
<td>126</td>
<td>Menisectomy (knee)</td>
<td>3 (within 365 days)</td>
<td>Menisectomy (knee)</td>
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</table>

* Generally, malignancy will be considered to require treatment within 30 days.
<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
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<tbody>
<tr>
<td>064</td>
<td>Microlaryngoscopy</td>
<td>2 (within 90 days)</td>
<td>Microlaryngoscopy</td>
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<tr>
<td>050</td>
<td>Myomectomy</td>
<td>3 (within 365 days)</td>
<td>Myomectomy</td>
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<tr>
<td>008</td>
<td>Myringoplasty/Tympanoplasty</td>
<td>3 (within 365 days)</td>
<td>Myringoplasty/Tympanoplasty</td>
</tr>
<tr>
<td>009</td>
<td>Myringotomy</td>
<td>3 (within 365 days)</td>
<td>Myringotomy</td>
</tr>
<tr>
<td>217</td>
<td>Nasendoscopy</td>
<td>2 (within 90 days)</td>
<td>Nasendoscopy</td>
</tr>
<tr>
<td>069</td>
<td>Nasal cauter</td>
<td>3 (within 365 days)</td>
<td>Nasal cauter</td>
</tr>
<tr>
<td>032</td>
<td>Nasal polypectomy</td>
<td>3 (within 365 days)</td>
<td>Nasal polypectomy</td>
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<tr>
<td>141</td>
<td>Nephrectomy</td>
<td>1 (within 30 days or 2 (within 90 days)</td>
<td>Nephrectomy</td>
</tr>
<tr>
<td>191</td>
<td>Nerve decompression/release</td>
<td>3 (within 365 days)</td>
<td>Nerve decompression/release</td>
</tr>
<tr>
<td>139</td>
<td>Orchidectomy</td>
<td>2 (within 90 days) or 3 (within 365 days)</td>
<td>Orchidectomy</td>
</tr>
<tr>
<td>138</td>
<td>Orchidopexy</td>
<td>2 (within 90 days)</td>
<td>Orchidopexy</td>
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<tr>
<td>193</td>
<td>Osteotomy – ankle/foot/arm/facial</td>
<td>3 (within 365 days)</td>
<td>Osteotomy - ankle/foot/arm/facial</td>
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<tr>
<td>194</td>
<td>Osteotomy – hip/femur/tibia/shoulder</td>
<td>3 (within 365 days)</td>
<td>Osteotomy - hip/femur/tibia/shoulder</td>
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<td>180</td>
<td>Parotidectomy/Submandibular gland - excision</td>
<td>2 (within 90 days)</td>
<td>Parotidectomy/Submandibular gland - excision</td>
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<tr>
<td>187</td>
<td>Pharyngoplasty</td>
<td>3 (within 365 days)</td>
<td>Pharyngoplasty</td>
</tr>
<tr>
<td>081</td>
<td>Pilonidal sinus</td>
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<td>Pilonidal sinus</td>
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<td>058</td>
<td>Pleurodesis</td>
<td>1 (within 30 days)</td>
<td>Pleurodesis</td>
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<td>117</td>
<td>Probing of naso/lacrimal duct</td>
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<td>Probing of naso-lacrimal duct</td>
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<tr>
<td>010</td>
<td>Prostatectomy (TURP or open prostatectomy)</td>
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<td>Prostatectomy/open/TURP</td>
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<tr>
<td>147</td>
<td>Prostatic biopsy</td>
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<td>Prostatic biopsy</td>
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<tr>
<td>183</td>
<td>Ptosis - repair, correction</td>
<td>3 (within 365 days)</td>
<td>Ptosis - repair</td>
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<tr>
<td>059</td>
<td>Pulmonary artery shunt</td>
<td>1 (within 30 days)</td>
<td>Pulmonary artery shunt</td>
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<tr>
<td>145</td>
<td>Pyeloplasty</td>
<td>2 (within 90 days)</td>
<td>Pyeloplasty</td>
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<td>152</td>
<td>Pylorotomy</td>
<td>3 (within 365 days)</td>
<td>Pylorotomy</td>
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<tr>
<td>133</td>
<td>Radical neck dissection</td>
<td>1 (within 30 days)</td>
<td>Radical neck dissection</td>
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<tr>
<td>201</td>
<td>Reconstruction of shoulder</td>
<td>3 (within 365 days)</td>
<td>Reconstruction of shoulder</td>
</tr>
<tr>
<td>131</td>
<td>Reduction of fractured orbit</td>
<td>3 (within 365 days)</td>
<td>Reduction of fractured orbit</td>
</tr>
</tbody>
</table>

* Generally, malignancy will be considered to require treatment within 30 days.
**Reference List – Clinical Priority Categories**

<table>
<thead>
<tr>
<th>IPC</th>
<th>Procedure*</th>
<th>Recommended Clinical Priority Category</th>
<th>IPC List</th>
</tr>
</thead>
<tbody>
<tr>
<td>130</td>
<td>Reduction of fractured zygoma</td>
<td>3 (within 365 days)</td>
<td>Reduction of fractured zygoma</td>
</tr>
<tr>
<td>149</td>
<td>Reimplantation of ureters</td>
<td>2 (within 90 days)</td>
<td>Reimplantation of ureters</td>
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<tr>
<td>036</td>
<td>Release of carpal tunnel</td>
<td>3 (within 365 days)</td>
<td>Release of carpal tunnel</td>
</tr>
<tr>
<td>127</td>
<td>Release of clubfoot</td>
<td>2 (within 90 days) or 4 (staged)</td>
<td>Release of clubfoot</td>
</tr>
<tr>
<td>076</td>
<td>Release of tongue tie</td>
<td>3 (within 365 days)</td>
<td>Release of tongue tie</td>
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<tr>
<td>132</td>
<td>Removal of breast implants</td>
<td>3 (within 365 days)</td>
<td>Removal of breast implants</td>
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<tr>
<td>041</td>
<td>Removal of bunion (hallux valgus; hallux abducto valgus)</td>
<td>3 (within 365 days)</td>
<td>Removal of bunion Hallux valgus; Hallux abducto valgus</td>
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<tr>
<td>219</td>
<td>Removal of epididymal cyst</td>
<td>3 (within 365 days)</td>
<td>Removal of epididymal cyst</td>
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<tr>
<td>024</td>
<td>Removal of ingrown toenail</td>
<td>3 (within 365 days)</td>
<td>Removal of ingrown toenail</td>
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<tr>
<td>040</td>
<td>Removal of pins and plates</td>
<td>4 (staged)</td>
<td>Removal of pins and plates</td>
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<tr>
<td>023</td>
<td>Removal of skin lesions</td>
<td>1 (within 30 days)</td>
<td>Removal of skin lesion</td>
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<tr>
<td>148</td>
<td>Removal of stone from urinary tract</td>
<td>1 (within 30 days)</td>
<td>Removal of stone from urinary tract</td>
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<tr>
<td>061</td>
<td>Repair atrial-septal defect</td>
<td>1 (within 30 days)</td>
<td>Repair atrial-septal defect</td>
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<tr>
<td>078</td>
<td>Repair incisional hernia</td>
<td>3 (within 365 days)</td>
<td>Repair incisional hernia</td>
</tr>
<tr>
<td>047</td>
<td>Repair of cystocele, rectocele</td>
<td>3 (within 365 days)</td>
<td>Repair of cystocele</td>
</tr>
<tr>
<td>121</td>
<td>Repair of Dupuytren’s contracture/ fasciectomy/ Palmar fasciectomy</td>
<td>3 (within 365 days)</td>
<td>Repair of Dupuytren’s contracture/ Fasciectomy/ Palmar Fasciectomy</td>
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<tr>
<td>114</td>
<td>Repair of exostosis</td>
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<td>Repair of exostosis</td>
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<td>094</td>
<td>Repair of hiatus hernia</td>
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<td>Repair of hiatus hernia</td>
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<td>Repair of hydrocele</td>
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<td>Repair of hydrocele</td>
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<tr>
<td>034</td>
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<td>Repair of knee cartilage/ Repair of knee ligament/ ACL Reconstruction</td>
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<td>123</td>
<td>Repair of rotator cuff</td>
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<td>Repair of rotator cuff</td>
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<tr>
<td>115</td>
<td>Repair of squint</td>
<td>3 (within 365 days)</td>
<td>Repair of squint</td>
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<tr>
<td>029</td>
<td>Repair of umbilical hernia</td>
<td>3 (within 365 days)</td>
<td>Repair of umbilical hernia</td>
</tr>
<tr>
<td>062</td>
<td>Repair patent ductus arteriosi</td>
<td>1 (within 30 days)</td>
<td>Repair patent ductus arteriosi</td>
</tr>
</tbody>
</table>

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<th>IPC List</th>
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<tr>
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<td>Repair ventricular-septal defect</td>
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<td>110</td>
<td>Replacement/removal of ventricular shunt</td>
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<td>Replacement/removal of ventricular shunt</td>
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<tr>
<td>153</td>
<td>Resection of abdo-aortic aneurysm</td>
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<td>Resection of abdo-aortic aneurysm</td>
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<td>144</td>
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<td>1 (within 30 days or 2 (within 90 days))</td>
<td>Retrograde pyelogram</td>
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<td>136</td>
<td>Revision of scar (Non-cosmetic eg Burns)</td>
<td>4 (staged)</td>
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<tr>
<td>033</td>
<td>Rhinoplasty</td>
<td>3 (within 365 days)</td>
<td>Rhinoplasty</td>
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<tr>
<td>173</td>
<td>Salpingo-opherectomy/Oopherectomy</td>
<td>3 (within 365 days)</td>
<td>Salpingo-opherectomy/Oopherectomy</td>
</tr>
<tr>
<td>011</td>
<td>Septoplasty</td>
<td>3 (within 365 days)</td>
<td>Septoplasty</td>
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<tr>
<td>209</td>
<td>Skin Grafts, including split skin graft</td>
<td>4 (staged)</td>
<td>Skin Grafts, including Split Skin Graft</td>
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<tr>
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<td>Sphincterotomy</td>
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<tr>
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<td>Spinal fusion</td>
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<td>Spinal fusion</td>
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<td>Stapedectomy</td>
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<td>Sub-mucosal resection/Nasal</td>
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<td>Sub-mucosal resection/Nasal</td>
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<td>190</td>
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<tr>
<td>129</td>
<td>Tenotomy of hip</td>
<td>2 (within 90 days) or 4 (staged)</td>
<td>Tenotomy of hip</td>
</tr>
<tr>
<td>079</td>
<td>Thyroidectomy/hemi-thyroidectomy</td>
<td>2 (within 90 days) or 3 (within 365 days)</td>
<td>Thyroidectomy/hemi-thyroidectomy</td>
</tr>
<tr>
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<td>Tonsillectomy</td>
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<td>Total hip replacement</td>
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<tr>
<td>014</td>
<td>Total knee replacement</td>
<td>3 (within 365 days)</td>
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</tr>
<tr>
<td>182</td>
<td>Trabeculectomy</td>
<td>2 (within 90 days)</td>
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<td>073</td>
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<td>1 (within 30 days) or 2 (within 90 days)</td>
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<td>146</td>
<td>Trial of voiding</td>
<td>2 (within 90 days)</td>
<td>Trial of voiding</td>
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<tr>
<td>196</td>
<td>Trigger finger/thumb - repair, release</td>
<td>3 (within 365 days)</td>
<td>Trigger finger/thumb - repair</td>
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<tr>
<td>015</td>
<td>Varicose veins stripping and ligation (CEAP Grade &gt;C3)</td>
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<td>Varicose veins stripping and ligation</td>
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<td>053</td>
<td>Vasectomy</td>
<td>3 (within 365 days)</td>
<td>Vasectomy</td>
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<tr>
<td>220</td>
<td>Vitrectomy (including buckling/cryotherapy)</td>
<td>2 (within 90 days)</td>
<td>Vitrectomy (inc buckling/cryotherapy)</td>
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</tbody>
</table>

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Completion of Recommendation for Admission Form (RFA)

The following minimum data set on the Recommendation for Admission Form (RFA) is to be obtained by:

<table>
<thead>
<tr>
<th>Referring Doctor</th>
<th>Admission/Booking Staff</th>
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<tbody>
<tr>
<td>• Patient’s full name</td>
<td>• Planned admission date (if allocated)</td>
</tr>
<tr>
<td>• Patient’s address</td>
<td>• Anticipated election status</td>
</tr>
<tr>
<td>• Patient’s contact information (home, work &amp; mobile telephone)</td>
<td>• Status review date (staged patients)</td>
</tr>
<tr>
<td>• Patient’s gender</td>
<td>• Short notice/Standby offers</td>
</tr>
<tr>
<td>• Patient’s date of birth</td>
<td>• Aboriginal &amp; Torres Strait Islander Status (NSW Health Data Dictionary)</td>
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<td>• Medicare number</td>
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<tr>
<td>• Clinical Priority Category</td>
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<tr>
<td>• If classified as staged, the time interval when the patient will be ready for care should be indicated</td>
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<tr>
<td>• Discharge intention (i.e. day only, or indication of number of nights in hospital)</td>
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<tr>
<td>• Presenting problem</td>
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<tr>
<td>• Planned procedure/treatment</td>
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<tr>
<td>• Significant medical history (including allergies)</td>
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<tr>
<td>• Treating Doctor (if different)</td>
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</tr>
<tr>
<td>• Patient’s signed consent (if available)</td>
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</tr>
<tr>
<td>• General Practitioner’s name and address (if available)</td>
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<tr>
<td>• Interpreter required</td>
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</tbody>
</table>

Any other relevant information should be included on the RFA e.g.
- Estimated operating time (especially if expected that the procedure will be outside benchmark timeframes)
- Specific preadmission requirements
- Special operating theatre equipment
- Requirement for an ICU/HDU bed post procedure

The referring doctor must:
- Forward the completed RFA direct to the hospital within 3 working days of the patient agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer)
- Facsimiles (fax) RFA’s should not be routinely used and only be accepted for urgent admissions where there is limited time to send a hard copy. An RFA (hardcopy) is to follow as soon as possible.
- Where patients require additional time to consider their options, the referring doctor must organise for the completed RFA to be forwarded within 3 working days of the patient’s acceptance of the surgical option
- Expedite the transmission of RFA’s for any urgent admissions e.g. patients in Category 1 (admission within 30 days)
- Where an urgent admission is requested, a facsimile can be used to communicate the information required and expedite receipt of the required information from the referring doctor’s rooms or clinic
Appendix 4

Cosmetic & Discretionary Surgery - Inclusion/Exclusion Criteria

Surgery should meet an identified clinical need to improve the physical health of the patient.

• The approval of the Local Health District/Network Program Director of Surgery, in consultation with senior management should be sought by the referring doctor before cosmetic and discretionary procedures are undertaken in any public hospital facility.

• The referring doctor should document on the Request for Admission 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 on the list below or where there is doubt about the nature of the proposed surgery, the request should be referred to the Local Health District/Network Program Director of Surgery for review prior to the patient being added to the waiting list.

• The patient should be advised when the Recommendation for Admission is going through the approval process.

The following list of surgical procedures should not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient’s physical health.

<table>
<thead>
<tr>
<th>Cosmetic Procedure</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral breast reduction</td>
<td>Severe Disability due to breast size</td>
</tr>
<tr>
<td>Bilateral breast augmentation</td>
<td>Nil</td>
</tr>
<tr>
<td>Replacement breast prosthesis</td>
<td>Replacement for post cancer patients only</td>
</tr>
<tr>
<td>Hair transplant</td>
<td>Disfiguring Hair loss due to Severe Burn</td>
</tr>
<tr>
<td>Blepharoplasty/Reduction of upper or lower eyelid</td>
<td>Severe Visual Impairment</td>
</tr>
<tr>
<td>Total rhinoplasty</td>
<td>Major Facial Trauma - Congenital abnormality – paediatrics</td>
</tr>
<tr>
<td>Liposuction</td>
<td>Nil</td>
</tr>
<tr>
<td>Abdominal lipectomy (Abdominoplasty)</td>
<td>Nil</td>
</tr>
<tr>
<td>Meloplasty/Facelifts</td>
<td>Nil</td>
</tr>
<tr>
<td>Correction of bat ear (&gt;16 years old)</td>
<td>Nil</td>
</tr>
<tr>
<td>Tattoo removal procedure</td>
<td>Nil</td>
</tr>
<tr>
<td>Removal of benign moles</td>
<td>Nil</td>
</tr>
<tr>
<td>Candela Laser</td>
<td>Congenital abnormality – paediatrics &lt;17 years</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>CEAPGrade &gt; C2</td>
</tr>
<tr>
<td>Laser photoocoagulation</td>
<td>Nil</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discretionary Procedure</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender reassignment surgery</td>
<td>Congenital abnormalities in children</td>
</tr>
<tr>
<td>Lengthening of penis procedure</td>
<td>Congenital abnormalities in children</td>
</tr>
<tr>
<td>Insertion of artificial erection devices</td>
<td>Nil</td>
</tr>
<tr>
<td>Reversal of sterilization</td>
<td>Nil</td>
</tr>
<tr>
<td>Social circumcision</td>
<td>Nil</td>
</tr>
<tr>
<td>TMJ Arthrocentesis</td>
<td>Nil</td>
</tr>
<tr>
<td>Labioplasty</td>
<td>Nil</td>
</tr>
</tbody>
</table>
Appendix 5

NHMRC Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (2005)

Post Adenoma Resection Colonoscopy Surveillance

<table>
<thead>
<tr>
<th>Finding at index colonoscopy</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2 or less tubular adenomas &lt;10mms.</td>
<td>5 years</td>
</tr>
<tr>
<td>• Large adenomas ≥ 10 mms.</td>
<td>3 years</td>
</tr>
<tr>
<td>• Advanced adenoma - high grade dysplasia/villous component.</td>
<td></td>
</tr>
<tr>
<td>• 3 or more adenomas.</td>
<td></td>
</tr>
<tr>
<td>• Malignant polyps.</td>
<td>Clinician discretion for 1st surveillance (recommend within 3 months), then standard follow up as per guideline.</td>
</tr>
<tr>
<td>• Piecemeal resection of large sessile polyps (&gt;2 cms) with possible incomplete excision.</td>
<td></td>
</tr>
</tbody>
</table>

Family History

<table>
<thead>
<tr>
<th>Finding</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1st degree relative affected with colorectal cancer (CRC) Age &lt;55.</td>
<td>Every 5 years from age 50.</td>
</tr>
<tr>
<td>• Two 1st degree relatives or 2nd degree relatives on same side of family with CRC.</td>
<td>10 years younger than youngest affected relative and then 5 yearly.</td>
</tr>
<tr>
<td>• Three or more 1st degree relatives on same side of the family with CRC (suspect hereditary nonpolyposis colorectal cancer (HNPCC).</td>
<td>Yearly or 2nd yearly from age 25 or 5 years younger than earliest CRC.</td>
</tr>
<tr>
<td>• Two or more 1st or 2nd degree relatives on the same side of the family with CRC and high risk features.</td>
<td></td>
</tr>
<tr>
<td>o Multiple CRC in one person.</td>
<td></td>
</tr>
<tr>
<td>o CRC diagnosed age &lt;50</td>
<td></td>
</tr>
<tr>
<td>o At least on relative with endometrial or ovarian cancer (suspect HNPCC).</td>
<td></td>
</tr>
<tr>
<td>Post Curative Resection for Colorectal Cancer</td>
<td></td>
</tr>
<tr>
<td>• Complete examination of the colon either pre-operatively or within 1 year of curative surgery.</td>
<td></td>
</tr>
<tr>
<td>• Subsequent colonoscopy at 3 years and if normal 5 yearly.</td>
<td></td>
</tr>
</tbody>
</table>

Hereditary Non Polyposis Colorectal Cancer (HNPCC)

<table>
<thead>
<tr>
<th>Finding</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive mismatch repair (MMR) gene mutation</td>
<td>Yearly from age 25 or 5 years younger than earliest CRC</td>
</tr>
</tbody>
</table>
DEATH – VERIFICATION OF DEATH AND MEDICAL CERTIFICATE OF CAUSE OF DEATH  (PD2015_040)

PD2015_040 rescinds PD2012_036

PURPOSE

This policy directive outlines the processes for the assessment and documentation to verify death (previously referred to 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.

This policy 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.”

This policy directive does not apply to the Justice and Forensic Mental Health Network. NSW Ambulance staff may only verify death in accordance with relevant NSW Ambulance policies.

MANDATORY REQUIREMENTS

- All staff must comply with the legislative requirements in the Coroner’s Act 2009 regarding the certification of death
- Medical practitioners must comply with the death certificate requirements outlined in Births, Deaths and Marriages Registration Act 1995
- In circumstances where a registered nurse / registered midwife or qualified paramedic is required to assess and document death, they must do so using the statewide Verification of Death form attached to this policy directive.

IMPLEMENTATION

Local Health District and Specialty Network 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 respect of this policy directive
- Training is provided to relevant staff regarding assessment and documentation of death (will be available via HETI on-line in 2015)
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this policy directive.

Health Facility Managers and Staff have responsibility to:
- Understand the distinction between the procedures for Verification of Death and medical certification of death
- Understand the legislative requirements in the Births, Deaths and Marriages Registration Act 1995 and the Coroner’s Act 2009 regarding certification of death.

NSW Ambulance must ensure that:
- Ambulance policies and protocols are consistent with this policy directive
- All staff are made aware of their obligations in respect of this policy directive
- Training is provided to Ambulance Officers regarding assessment and documentation of death.

BACKGROUND

About this document
This policy directive supersedes PD2012_036.

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.

This policy directive does not apply to the Justice and Forensic Mental Health Network. NSW Ambulance staff may only verify death in accordance with NSW Ambulance Protocol A13 Verification of Death.

KEY DEFINITIONS
This policy directive makes a distinction between the procedures for assessing whether a person is deceased (Verification of Death) and issuing a Medical Certificate of Cause of Death.

Verification of Death: is a clinical assessment process undertaken to establish that a person has died. Using a standard regime of clinical assessment tools, a registered medical practitioner, registered nurse / registered midwife or qualified paramedic can establish and document that death has occurred. Verification of Death has previously been known as extinction of life in NSW Health policy.

Verification of Death is required to enable a person’s body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD).

Where a death is reportable to the Coroner, Verification of Death (pronouncement of life extinct) is documented on Report of Death of a Patient to the Coroner (Form A) (SMR010.510).

For all other patients where Verification of Death is required, it must be documented using the NSW Health statewide Verification of Death form – Attachment 2.

Medical Certificate of Cause of Death: is the form issued by the 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.

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.

For further details please see Section 2.2.

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.
Public health organisations is defined in Section 7 of the Health Services Act 1997 as:

a) A local health district and specialty health network, or
b) A statutory health corporation, or
c) An affiliated health organisation in respect of its recognised establishments and recognised services.

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

Policy framework
NSW Health policy documents relevant to this policy directive:

- PD2010_054 Coroners Cases and the Coroners Act 2009
- PD2013_001 Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements
- PD2011_052 Conduct of Anatomical Examinations and Anatomy Licensing in NSW.

NSW Health State Forms relevant to this policy directive:

- Attending Practitioners Cremation Certificate (Public Health Regulation, 2012, Clause 81)
- Medical Certificate of Cause of Death (SMR010.509)
- IB2010_058 Coronial Checklist (SMR010.513)
- Verification of Death (SMR010.530)
- Death Certification Arrangements for Expected Home Death (SMR010.531)

DOCUMENTATION REQUIREMENTS WHEN A PATIENT DIES

Please see the flow chart at Attachment 1 for a summary of the process.

Reporting a death to the Coroner
To determine if a death should be reported to the coroner refer to the Coronial Checklist (State Form SMR010.513, see IB2010_058


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) (State Form SMR010.510). No additional documentation relating to death is required.
Key elements of PD2010_054

- Medical practitioners must not issue a certificate as to cause of death under the Births, Deaths and Marriages Registration Act 1995 if the death is a reportable death (Section 6 Coroner's Act 2009). Reportable deaths include where the person died a violent or unnatural death; the person died a sudden death the cause of which is unknown; the person died under suspicious or unusual circumstances; the person died in circumstances where the person had not been attended by a medical practitioner for the six months immediately before the person's death; the person died while in or temporarily absent from a declared mental health facility while receiving care, treatment or assistance; and/or 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.

- If a health practitioner is uncertain about whether the death is reportable they should contact the Duty Pathologist, Department of Forensic Medicine during business hours in Sydney on 02 8584 7821 or Newcastle on 02 4922 3700. After hours, contact the State on call Pathologist on 02 8584 7821. The Office of the NSW State Coroner may be contacted for advice during business hours on 02 8584 7777. Information is also available on the Coroners website at http://www.coroners.justice.nsw.gov.au/Pages/for_health_professionals.aspx

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 which covers jurisdiction concerning deaths of children and disabled persons.

MEDICAL CERTIFICATION OF DEATH

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 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:

- “Give the Registrar of Births, Deaths and Marriages, notice of the death and cause of death, and
- 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 (SMR010.509) 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 should 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 should 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 the matter should be referred to the Coroner.

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 should 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 phone 1300 655 236.

Responsibilities for certification of death in NSW Health facilities
When a patient dies in a public 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 should certify the death as soon as practicable. In the case of facilities where there is not 24 hour medical coverage, the medical practitioner should certify death at the commencement of duties. Only a medical practitioner can complete the Medical Certificate of Cause of Death.

VERIFICATION OF DEATH
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.

Clinical procedure for verifying death
This is done by demonstrating all of the following:

- No palpable carotid pulse, and
- No heart sounds heard for 2 minutes, and
- No breath sounds heard for 2 minutes, and
- Fixed and dilated pupils, and
- No response to centralised stimulus, and
- No motor (withdrawal) response or facial grimace in response to painful stimulus.

No response to centralised stimulus may be assessed by trapezius muscle squeeze, supraorbital pressure or sternal rub. No motor (withdrawal) response or facial grimace in response to painful stimulus would be assessed by pinching the inner aspect of the elbow. In cases of expected deaths at home, it may be reasonable not to complete these two tests if the person has been deceased for some time and there is the potential to distress relatives who are present. In such cases, all other criteria for the verification of death assessment must be undertaken. Any decision not to assess response to painful stimulus should be briefly documented on the form.

1 Published by the Emergency Care Institute, Agency for Clinical Innovation (website accessed 2014)
Where a verification of death assessment has been undertaken and the practitioner is not certain if the person is deceased, they should 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 PD2013_001 Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_001.html.

In situations where the person has injuries incompatible with life (e.g. 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).

Documentation

Registered nurses / registered midwives who are assessing and documenting death must use the statewide Verification of Death form (SMR010.530) (Attachment 2). The original form is provided to the funeral director and the 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 registered nurse / registered midwife completes the Verification of Death form, 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. 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 should provide the funeral director with the Verification of Death form (SMR010.530) and record details of the clinical procedure to verify death in the NSW Ambulance clinical record.

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 should 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 PD 2013_001 Deceased Organ and Tissue Donation- Consent and Other Procedural Requirements http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_001.html.
• Donation of Bodies to a School of Anatomy / Medical Science
Similarly 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 make arrangements for the transfer of the body. See PD 2011_052 Conduct of Anatomical Examinations and Anatomy Licensing in NSW: Procedures and Guidelines http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_052.html.

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 should 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).

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 or registered nurse / 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.

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 should 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 (Attachment 3) 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.
LIST OF ATTACHMENTS
1. Flowchart – Roles and responsibilities for documentation when a patient dies within the NSW Health system
2. Statewide Verification of Death form (SMR010.530) (mandatory)
3. Statewide Death Certification Arrangements for Expected Home Death form (SMR010.531) (optional)

1. ROLES AND RESPONSIBILITIES FOR DOCUMENTATION WHEN A PATIENT DIES WITHIN THE NSW HEALTH SYSTEM
2. VERIFICATION OF DEATH FORM SMR010530

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GIVEN NAME</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>D.O.B.</th>
<th>M.O.</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Verification of Death is required to enable a person’s body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD).

Completion of this Verification of Death form is not required when a person’s death is reportable to the Coroner (see PD2010_054) or where a MCCD has been completed.

In the absence of a medical practitioner, a registered nurse / registered midwife or qualified paramedic may complete this Verification of Death form.

**Details of the deceased**

Family name: [Name]

Given(s): [Given Name(s)]

Sex: [Male/Female]

Age / DOB: [Date]

Address: [Address]

Place of death: [Location]

Method of verifying identity: [Method]

- Check arm band
- Patient known to health professional/service
- Information relayed by government contractor
- Other, provide details

Implantable devices remaining on / in body that require deactivation (e.g. pacemaker, implantable defibrillator)

**Clinical Assessment**

Examination Date: [Date]

Examination Time: [Time]

I have completed the following assessments and there is: (all tests must be undertaken to verify death)

- No palpable carotid pulse
- No heart sounds heard for 2 minutes
- No breath sounds heard for 2 minutes
- Fixed and dilated pupils
- No response to centralised stimulus
- No motor (withdrawal) response or facial grimace in response to painful stimulus

Details of any additional assessments undertaken (e.g. ECG strip)

**OR**

This is an obvious death (i.e. the person has injuries incompatible with life and/or has been deceased for some time)

**AND**

I declare that the person is deceased.

**Details of person verifying death**

Name: [Name]

Designation: [Medical Practitioner/Registered Nurse/Registered Midwife/Qualified Paramedic]

Pepaer/Phone: [Details]

Employing facility: [Details]

Signature: [Signature]

Date: [Date]

**Medical Certificate of Cause of Death (MCCD)**

Details of medical practitioner who is to certify death (within 48 hours of the death)

Name: [Name]

Contact Details: [Details]

Has the medical practitioner been notified of patient death? [Yes/No]

Details of arrangement with medical practitioner to complete certification: [Details]
### 3. DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH

**SMR010531**

**DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH**

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
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**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:**
  - **Date:**
  - **Signature:**
- **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:**

- **AH/IM Mobile No (if available):**
- **Surgery Ph:**
- **Print Full Name:**
- **Signature:**
- **Date:**

**ON COMPLETION, RETURN COMPLETED FORM TO:**

- **Contact person/service:**
- **FAX:**
- **or EMAIL:**

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253(24/09/15)
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WILL MAKING PUBLIC HEALTH FACILITIES (IB2014_022)


PURPOSE

This Information Bulletin provides information to NSW Health staff in public health facilities where patients wish to make a last Will and Testimony.

KEY INFORMATION

Generally, the issue of the making of a Will may be raised by a patient or relative, particularly where the patient is elderly, has been hospitalised for a long period of time, or is facing death.

Staff should not generally canvass the issue of Wills except in extreme circumstances.

Under no circumstances should a staff member be involved in the preparation of a patient’s Will or attempt to exert influence in regard to the terms of a patient’s Will.

If nominated as the executor of a Will, a staff member should decline the appointment.

Staff involvement in this process overall is to be minimal as in accordance with the following requirements:

1. Where a patient in a public health facility wishes to make a Will, determine if the patient’s affairs are managed by the NSW Trustee & Guardian.

2. If the patient’s affairs are managed by the NSW Trustee & Guardian, further inquiries and actions should be handled by the responsible estate manager/guardian via the NSW Trustee and Guardian, with the appropriate consent of the patient and/or their guardian or “authorised representative”, as defined in the Health Records and Information Privacy Act 2002 (and documented in the health record).

3. Where the patient’s affairs are not managed by the NSW Trustee & Guardian, staff should make inquiries as to whether there is a Will already in existence. This may be done by asking the patient, checking the patient health record and/or contacting family members with the patient’s consent, as appropriate.

4. If a Will exists then contact should be made with the solicitor holding the Will and the matter handed over to that person with the patient’s consent as appropriate.

5. Where a patient’s affairs are not managed by the NSW Trustee & Guardian and there is no knowledge of an existing Will, the patient should be advised or assisted to contact his/her family solicitor or a solicitor of their choice.

6. If there is no solicitor known to the patient, the staff member can assist the patient in contacting the NSW Trustee & Guardian. The NSW Trustee and Guardian provides professional and independent trustee services writing Wills, acting as Executor in deceased estates, administering trusts and Powers of Attorney and delivering financial management services; or

7. The Law Society of NSW can provide a list of local solicitors for the particular geographical area, experienced in the field of the making of Wills and for providing legal advice, from which the patient may then choose a solicitor. It is not the role of staff to recommend a specific solicitor to the patient.
8. Once a solicitor has been nominated or chosen by the patient further inquiries and procedures relating to the making of the Will are to be handled by the nominated solicitor.

9. All staff contact with the NSW Trustee and Guardian, the patient’s guardian, solicitors or family members regarding a patient’s Will, should be documented in the patient’s health record.

10. It is not the role of staff to establish testamentary capacity.

11. In circumstances where a staff member is aware that a patient has a Will being managed by the NSW Trustee and Guardian and the patient wants to make another Will without consulting the NSW Trustee and Guardian, the staff member should consider contacting the patient’s manager/guardian at the Office of the NSW Trustee and Guardian. If a decision is made to contact the Office of the NSW Trustee and Guardian, this should be done in consultation with the patient and the Nursing Unit Manager and/or treating clinician and appropriately documented in the patient’s health record.

CONTACT DETAILS

NSW Trustee & Guardian
Phone: 1300 364 103 – Trustee Services
1300 360 466 – Managed Clients

The Law Society of NSW
Phone: (02) 9926 0300 or 1800 422 713 – Outside Sydney.

FOR MORE INFORMATION GO TO:

1. NSW Trustee & Guardian - Trustee and Managed Client Services

2. The Law Society of NSW – Finding a solicitor:
OBSOLETE POLICY – (January 2017)
RECOMMENDATION OF SERVICE PROVIDERS TO PATIENTS BY STAFF OF HEALTH ORGANISATIONS (PD2005_086)
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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.
CARE COORDINATION: PLANNING FROM ADMISSION TO TRANSFER OF CARE IN NSW PUBLIC HOSPITALS (PD2011_015)


PURPOSE

The term ‘discharge’ is referred to as ‘transfer of care’ throughout this policy. This is because a patient’s health care does not end when they leave hospital. ‘Transfer of care’ demonstrates that a patient’s care continues beyond hospital as they receive care from another service/facility/or in the community. This could be by a patient’s General Practitioner (GP), community health providers, other organisation or by the patient and/or their carers.

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 transfer of care. This policy directive applies to clinical staff involved in the care of inpatients. It outlines a five stage process to guide staff and patients through their hospital stay. Implementation of this approach will enhance patient outcomes, safety and experience.

MANDATORY REQUIREMENTS

Each Health Service is required to meet the standards outlined in this policy. Admitted patients will transition through five stages of care coordination:

1. Pre Admission/Admission
2. Multidisciplinary Team Review
3. Estimated Date of Discharge (EDD)
4. Referrals & Liaison for patient transfer of care
5. Transfer of care out of the hospital

While the five stages will apply to most patients having an inpatient stay, the stages will be adapted for some patient groups. Patients having scheduled admissions for a course of treatment (eg 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 should have an assessment of their transfer of care needs and arrangements put in place prior to their admission.

IMPLEMENTATION

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 transfer of care planning.

All new clinical staff must be educated in and supplied with the staff Reference Manual: ‘Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Reference Manual’, and the principles detailed in this document will be a fundamental part of each facility’s clinical staff orientation program.

The five stages of care coordination should be implemented through:
12. MEDICAL CARE

- All departments (including emergency) must have guidelines in place for care transfer of ‘at risk’ patients especially between the hours of 10pm and 8am. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this policy.
- Structured (set time and duration) multidisciplinary team reviews in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.
- That an Estimated Date of Discharge (EDD) is allocated, documented, displayed near the bedside and on electronic patient management tools, and reviewed for each patient. The patient or carer must be informed of the EDD during their stay.
- Ensuring the Transfer of Care Checklist or equivalent is completed for all appropriate 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 or appropriate service prior to transfer of care, in plain language.

Pre-Admission/Admission

Definition

At the time of first contact with the patient, a ‘Transfer of Care Risk Assessment’ (TCRA) or equivalent should be completed by the clinician. A TCRA is used to identify those patients who may have needs that require further assessment and follow-up before they are transferred home or to ongoing care from the acute hospital service. Health Services are responsible for ensuring that a TCRA is completed for all appropriate admitted patients. The results from this TCRA tool should be used to inform the overall management of the patient. Each Health Service, Hospital, and clinical units will need to develop a process for flagging those patients who have been identified as having a transfer of care risk with the multidisciplinary team and to implement procedures for contacting the appropriate health professionals.

The TCRA tool (Appendix 3) should 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?
3. Does the patient have responsibilities to care for others?
4. Has the patient used community services before admission?
5. Does the patient usually take three or more medications and have their medications changed in the last two weeks?

A TCRA should be completed on initial presentation and whenever the patient’s clinical or social status changes.

Pre-admission

For planned admissions, transfer of care planning should begin before the patient is admitted. The TCRA should be conducted at this time. Patients with an identified risk should be referred early to the appropriate community teams so planning for transfer can begin.

Planned Day-only admission

Transfer of care planning must occur for patients having day-only procedures. Facilities may nominate their own processes to ensure the TCRA is completed. For example:
utilising a pre-admission preparation toolkit;
• nominating staff responsible for assessment of day-only patients

Ideally, this should occur prior to the day of their procedure.

Transfer of Care Risk Assessment Tool (TCRA)

The person conducting the TCRA has the responsibility to communicate any risk identified to the relevant members of the multidisciplinary team. When a transfer of care risk is identified, it must be documented and managed.

A YES response in the TCRA to question two (Does the patient live alone?) and question five (Does the patient usually take three or more medications and have their medications changed in the last two weeks?), will not always indicate that the patient is at risk. Staff should use their clinical judgement as to the requirements for follow up if these two questions are the only yes answers. The patient should be referred to the relevant health professionals for further assessment if required.

Planned Patients

All patients with a planned admission must have their TCRA completed at presentation or before admission to hospital, such as at a pre-admission clinic. 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.

Non-Planned Patients

For non-planned patients who are admitted to hospital through the ED or through direct admission, the TCRA must be completed within the first 24 hours of admission.

Multidisciplinary Team Review

Definition of the Multidisciplinary Team

There must be defined roles and responsibilities for the Multidisciplinary Team (MDT) members assisting in the care coordination process. All members of the MDT are expected to work collaboratively across disciplines to ensure improved patient outcomes. Health Services, Hospitals and Departments will need to ensure local procedures are in place to support a designated time for the MDT in inpatient wards/units to meet.

Multidisciplinary Team Review:

Based on the recommendations made in the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals; multidisciplinary rounds should take place twice weekly, while ensuring short stay patients needs are also met. MDT members should agree on the treatment plan, incorporate the transfer of care risks into the patient care plan, and set the Estimated Date of Discharge (EDD).
• It is important to conduct these meetings or a component of these meetings at the bed side so the patient and carers can be involved and be aware of the treatment plan.
• More frequent MDT reviews may be necessary for some patients to meet their needs.

In some rural settings, local medical practitioners and allied health professionals are not always available. Local processes need to be in place to ensure appropriate input into decision making regarding the transfer of care.

120(10/03/11)
Estimated Date of Discharge

Definition

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from hospital back into the community. It provides everyone involved in the patient’s care, including the patient and their family/carer/s, with a projected date to coordinate the patient’s requirements. 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. Discussions with the patient and their family/carer/s, GP, community health and service providers should occur early, for effective care planning.

Any changes to the EDD for clinical reasons or delays in transfer beyond the EDD 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 altered EDD. A regular review process will keep staff as well as the patient and their family/carer/s informed of their patient’s progress.

- **A patient’s EDD should be visible near their bed**, reminding staff of the date they are working towards and informing the patient and their family or carer.
- **The multidisciplinary team should use the EDD to synchronise referrals** to other teams and/or disciplines that are not involved in regular multidisciplinary team reviews.
- **If the patient’s condition deteriorates it is appropriate to revise the EDD.**
- **If a patient does not leave when indicated by the EDD due to system delays it is not appropriate to change the EDD. The delay reason must be recorded and a system to review those delays put in place.**

Local processes need to be in place to escalate system delays through patient flow and bed management meetings. IT tools for example, should be used to track these delays and identify the main constraints within the hospital. This data should be used to drive necessary system change to reduce delays in future.

**Planning transfer of care from specialty areas**

Specialised areas such as Intensive Care Units (ICU), High Dependency Units (HDU), Medical Assessment Units (MAU) and Critical Care Units (CCU) should use the EDD to indicate when patients are able to be transferred to inpatient wards. This will assist patient flow managers to plan the transfer into appropriate wards and prevent ICU/HDU delays in returning patients to non-critical care beds and reduce patients receiving care outside their home ward.

**REFERRALS AND LIAISON**

**Referring to Service Providers**

Service providers should 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 GP and any additional health providers the patient currently receives services from. It is desirable that the name of the patient’s GP and their contact details are displayed at the bedside with the patient’s EDD.

Once a patient’s requirements are identified, discussions with the appropriate providers should occur using the Estimated Date of Discharge as the start date. Discussions with providers should occur early to provide enough time to make the appropriate arrangements.
It is important to identify what services the patient will require during the acute episode of care. Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers. Referral details should be recorded in one place in the patient’s medical record, and on any relevant individual referrals (e.g., GP and Community Health).

It may not be possible to complete a patient assessment in hospital prior to the transfer of care. If a need for services has been identified, a referral to the appropriate community service provider or General Practitioner should 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.

**TRANSFERRING HOME**

**Transfer of Care Checklist**

Staff must use the Transfer of Care Checklist to meet the needs of patients before leaving the hospital. The Nurse Unit Manager is responsible for ensuring that these details are checked, completed and agreed to by the patient before leaving the hospital.

The Transfer of Care Checklist must cover the following information:

- Estimated Date of Transfer
- Destination of Transfer
- Notification/Transport Booked
- Personal Items Returned
- Referral Services Booked
- Care Plan
- Transfer of Care Summary provided to patient that includes medication information, community and GP referral information and follow up appointments. This should be provided in plain language and explained to the patient.

A template Transfer of Care Checklist is included in the Reference Material. Staff are strongly encouraged to use an electronic checklist if available. Each individual Health Service, Hospital and Clinical Unit should build on these fundamentals in the checklist to address specific local circumstances.

Patients with an identified medication risk as per the TCRA or advice from the MDT should 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 transfer of care and meeting the EDD.

Patient transport needs are to be considered in the transfer of care 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.

NSW Ambulance Service manages non-emergency patient transport through the Electronic Booking System. Bookings on the day of transfer are only to be made in exceptional circumstances and bookings after midday will not be taken. Early booking for the next available ambulance will prevent patients waiting long periods for PTS transport to arrive by improving resource management, and ensure appropriate transport is available for patients when required.
# Implementation Checklist

For further information and detail on the five steps of Care Coordination, please refer to the ‘Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals Reference Manual’. This document will provide additional detail in managing a patient’s care from admission. The Reference Manual also contains a Transfer of Risk Assessment template and a Transfer of Care Checklist. This document will be available through the NSW Health website.

## Implementation checklist

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<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
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<tr>
<td>1. Establishment of a Transfer of Care Risk screen that addresses the five risk areas</td>
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<td>2. Structured (set time and duration) multidisciplinary team reviews in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.</td>
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<td>3. All patients have Estimated Date of Discharge (EDD) documented and a review process in place</td>
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<td>4. Ensuring the Transfer of Care Checklist or equivalent is completed for all appropriate admitted patients before they return to the community.</td>
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<td>5. All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer or appropriate service prior to transfer of care in plain language.</td>
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12. MEDICAL CARE
GUIDEINE FOR PERIPHERAL INTRAVENOUS CANNULA (PIVC) INSERTION AND POST INSERTION CARE IN ADULT PATIENTS (GL2013_013)

PURPOSE

The purpose of this Guideline is to provide the standard for insertion, management and removal of peripheral intravenous cannulae (PIVC) in patients who are 16 years of age and older.

KEY PRINCIPLES

All clinical staff who insert a PIVC or care for a patient with a PIVC *in situ* should follow this Guideline.

Facilities should support clinicians to ensure adherence with this Guideline.

Aseptic technique should be used during each PIVC insertion and access to reduce the risk of local or systemic infection.

Every PIVC insertion should be documented at the time of insertion or as soon as possible afterwards.

USE OF THE GUIDELINE

Chief Executives and delegated officers

- Promote safe practices for insertion and post insertion care of PIVCs across their Health District/Service.
- Ensure that appropriate resources are available for implementation of this Guideline.

Clinical Staff Inserting PIVC Devices

- Are trained and assessed to insert PIVC in accordance with this guideline.
- Adhere to this guideline for every insertion of a PIVC.
- Ensure PIVC insertion is documented in the patient’s health record.

Clinical Staff Caring for, Managing and Removing PIVC Devices:

- Are trained and assessed in the care of a PIVC device in accordance with this guideline.
- Adhere to this guideline for post insertion care of a PIVC device.
- Assess daily the ongoing need for a PIVC device.

To download the Guideline please go to

NATIONAL POLICY – ACCESS TO GOVERNMENT FUNDED IMMUNOGLOBULIN PRODUCTS IN AUSTRALIA (IB2014_068)

IB2014_068 rescinds PD2012_041.

PURPOSE

The purpose of this Information Bulletin is to (1) rescind NSW Ministry of Health Policy Directive PD2012_041: Immunoglobulins, use in NSW and (2) to advise all staff who prescribe, order, dispense or treat patients with immunoglobulin products that from 5 November 2014 access to government-funded immunoglobulin is governed by a new national policy “Access to Government Funded immunoglobulin Products in Australia”.

KEY INFORMATION

Polyclonal immunoglobulins (intravenous immunoglobulin [IVIg], subcutaneous immunoglobulin [SCIG] and normal human immunoglobulin) are used to treat a variety of neurological, haematological, immunological and a smaller number of miscellaneous conditions. Access to these products under the national blood arrangements is tightly controlled through the application of the Australian Health Ministers’ Conference “Criteria for the Clinical Use of Intravenous Immunoglobulin” as well as certain policy requirements. The new national policy is one of a number of government-endorsed measures that have been developed and managed by the National Blood Authority at the request of the Jurisdictional Blood Committee to ensure good governance of these expensive products. The policy does not apply to specific immunoglobulins such as Rh D immunoglobulin and Tetanus immunoglobulin.

The new policy sets out the access requirements for each preparation of immunoglobulin and it clarifies the roles and responsibilities of all stakeholders involved in the management of immunoglobulin products.

The key changes that the policy provides for are:

1. **New Authorisation Request forms.** Forms that are currently used by prescribers will not be accepted by the “Authoriser” i.e. the Australian Red Cross Blood Service (the Blood Service) after 4 November 2014. The new Authorisation forms can be downloaded from the NBA website at: [www.blood.gov.au/immunoglobulin-ig-governance-program](http://www.blood.gov.au/immunoglobulin-ig-governance-program).

   It should be noted that the process of seeking Authorisation will no longer directly trigger an order (this must be placed separately through the health facility).

2. **The requirement for the prescriber to obtain explicit patient consent to:**
   - Treatment with immunoglobulin products, in compliance with the National Safety and Quality Health Service (NSQHS) Standard 7, and the NSW Health PD2005_406 Consent to Medical Treatment – Patient Information.
   - The collection, retention and use of their personal sensitive data, in accordance with both the Australian Privacy Principles and the NSW Privacy legislation. In NSW data is already collected to facilitate access to the products. Obtaining explicit patient consent ensures that patients are aware that their data is being collected and provided to the Blood Service.
3. **A standardised national patient treatment review process with a revised Patient Treatment Review Outcome Notification form.** Currently, patients in NSW are not supplied with immunoglobulin if they have not had specified reviews on given dates. This approach is now being standardised nationally. The Blood Service will send the form to the patient’s treating medical specialist at least eight weeks prior to the patient’s treatment review date. The outcomes of the review must be recorded on the form with any request for an increased dosage for the patient being supported by information about the patient’s weight. The completed form should be returned to the Blood Service within a month of the patient review date. Failure to comply with this requirement will, except in extenuating circumstances, result in the patient no longer being able to access government funded immunoglobulin.

4. **Coordinated ordering and management of immunoglobulin products** to (1) improve transparency of product inventory; (2) ensure that product is provided to approved patients only; and (3) to reduce product expiry-related wastage. Further information about the new national policy can be obtained from the NBA web site at: [www.blood.gov.au/immunoglobulin-ig-governance-program](http://www.blood.gov.au/immunoglobulin-ig-governance-program)

Clinicians wishing to treat a medical condition with IVIg or SCIg that is not funded under “the Criteria” can order imported product from any commercial supplier of these products or access product under the Jurisdictional Direct Order Arrangement established by the National Blood Authority. In either case, the order must be placed directly with the relevant supplier and the cost of the product will have to be paid for by either the clinician’s hospital or the patient. There is no licensed intramuscular product commercially available outside the National Blood Agreement.
MANAGEMENT OF HAEMOPHILIA AND RELATED BLEEDING DISORDERS
(PD2013_027)


This document articulates the NSW Health policy in relation to the treatment of patients with
Haemophilia and related bleeding disorders.

MANDATORY REQUIREMENTS

Compliance with NSW Ministry of Health’s policy in relation to the treatment of patients with
Haemophilia and related bleeding disorders is mandatory in public facilities.

It is recommended that licensed private facilities also comply with requirements of the Policy
Directive.

IMPLEMENTATION

Chief Executives of Local Health Districts must ensure:
• the principles and requirements of this policy are applied, achieved and sustained;
• local protocols are in place in the relevant facilities to support implementation;
• all relevant staff are made aware of their obligations regarding this Policy Directive.

BACKGROUND

This Policy Directive embodies the recommendations of the NSW/ACT Haemophilia Advisory
Council Clinical Committee, members of which provide expert clinical advice to the NSW Ministry
of Health in relation to the treatment of patients with haemophilia and related bleeding disorders. The
recommendations of this Committee reflect best practice in the field; they encompass
recommendations of the World Federation of Haemophilia and they align clinical practice in NSW
with that in the rest of Australia the USA and Europe.

INTRODUCTION

The information provided in this Policy Directive is intended for clinicians (medical practitioners,
nurses and midwives) and surgeons who treat patients with haemophilia and related bleeding
disorders.

All patients in NSW or the ACT with haemophilia or a related bleeding disorder that may or may not
require treatment must be registered with a Haemophilia Treatment Centre (HTC; see Appendix 1 for
details) and their details should be entered on the Australian Bleeding Disorders Registry.

7. TREATMENT

7.1 On demand treatment

Factor concentrates may be given on demand for bleeding episodes.

7.2 Prophylaxis

The following information is based on Guidelines developed by the Australian Health Ministers
Advisory Council11.

11 The Australian Health Minister's Advisory Council Evidence-based Clinical Practice Guidelines for the Use of Recombinant and Plasma-
derived Factor VIII and Factor IX Products (2006)
12. MEDICAL CARE

The goal of prophylaxis is to improve the quality of life for patients with severe bleeding disorders (Haemophilia A or B and Von Willebrand Disorders) by maintaining sufficient coagulation factor levels to prevent spontaneous joint bleeding and the morbidity associated with complications of joint bleeds.

Factor prophylaxis is recommended for all patients with severe Haemophilia and Von Willebrand Disorders who are at risk of, or who have experienced, joint and other serious bleeding.

For the purposes of this policy children have a severe bleeding disorder when their factor level is <5% and they have significant bleeding, for example, intracranial haemorrhage.

The age at which prophylaxis therapy is introduced will vary depending on the patient’s bleeding phenotype and whether the patient and their family are willing to comply with the prophylactic treatment regimen. Most children with severe haemophilia (A or B) start prophylaxis between the ages of 1 and 5 years.

The recommended dose range for prophylaxis in children depends on the underlying factor deficiency and is influenced by the recovery and the expected half-life of the factor. The usual dose range recommended for:

- Factor VIII deficiency is 25 – 40 International Units (IU)/Kg three times a week; and
- Factor IX is 40 – 75 IU/Kg two times a week.

These doses may need to be increased or given more frequently in some patients in order to prevent spontaneous bleeding.

Factor VIII/IX usage and selected clinical and laboratory outcome indicators should be routinely monitored and evaluated for all patients on prophylaxis.

It is mandatory that all patients receiving prophylaxis have their treatment co-ordinated and monitored by a designated NSW/ACT HTC.

It is expected that people with severe bleeding disorders will exercise reasonable precautions in managing their voluntary exposure to high risk of injury. Prophylactic treatment should be accompanied by patient/parent education about such risks.

7.3 Patients with inhibitors

Patients with inhibitors should be treated at an HTC.

1. SURGERY

Surgical intervention maybe elective or occasionally emergency in nature.

2.1 Emergency surgery

Where emergency surgery is conducted at a facility that is not an HTC the hospital should contact the Director of the HTC at the Royal Prince Alfred Hospital if the patient is an adult or the Director of the Sydney Children’s Hospital Network - Westmead Campus if the patient is a child (see Attachment 1 for contact details of the relevant HTCs). It is likely that urgent transfer of the patient would be required.
2.2 Elective surgery

General matters

Elective surgery on patients with bleeding disorders must take place in consultation with a NSW/ACT HTC.

Applications for supply of coagulation factor for surgery must be approved by the Haemophilia Advisory Council Clinical Committee. Once approval has been given, factor concentrates will be made available by the Australian Red Cross Blood Service.

Application for coagulation factors for surgery should be made on the form at Attachment 2 of this Policy Directive.

Principles relating to elective surgery

The following Guidelines govern the management of elective surgery in patients with haemophilia and other bleeding disorders:

• the Australian Health Minister’s Advisory Council Evidence-based Clinical Practice Guidelines for the Use of Recombinant and Plasma-derived Factor VIII and Factor IX Products (2006);
• the Australian Haemophilia Centre Directors’ Organisation Guideline for the Management of Patients with Haemophilia undergoing surgical procedures (2005); and

In this Policy Directive the principles outlined in the Guidelines have been adapted to balance patient safety with patient preference and equity of access.

In the interests of patient safety, patients with:
- Factor VIII < 30%
- Factor IX < 30%
- Factor XI < 30%
- Von Willebrand Factor activity < 30%; and
- other rare bleeding disorders

should have elective surgery performed in a designated NSW/ACT Haemophilia Treatment Centre since they are “high risk patients” with an increased tendency to bleed, both early and late, and they require management by clinicians experienced in managing haemophilia and related bleeding disorders.

If a patient has a factor level that is over 30% and there is a specific reason for a procedure to be conducted at a hospital that is not a designated NSW/ACT HTC, the patient/parent(s) or carer MUST be made aware of the potential risks attached to having surgery in a hospital that is not a designated or affiliated NSW/ACT HTC and the NSW/ACT Haemophilia Advisory Council Clinical Committee MUST be advised.

The NSW/ACT Haemophilia Advisory Council Clinical Committee will review such requests on a case by case basis to ensure that the following requirements are met:
12. MEDICAL CARE

(1) The hospital where it is proposed the operation is to be conducted MUST have:
   - Blood Bank/Pathology capable of providing appropriate support, even in emergency circumstances;
   - Intensive Care Unit (ICU) (where relevant) – staffed 24 hours by qualified ICU specialists to supervise treatment; and
   - Pathology – with ability to provide same day factor levels.

(2) The hospital must have access to a:
   Clinical Haematologist who is available to supervise and review treatment daily and is on-call at all times.

(3) The treating Clinical Haematologist must:
   - liaise with the Director of the relevant NSW/ACT HTC and must provide a written account of:
     - treatment plan – including dosages and target levels; and
     - monitoring plan – the protocol must be approved by an HTC Director, and it must be followed and carried out in close liaison with the Director of the relevant NSW/ACT HTC.
   - liaise daily (or as required clinically) during the treatment period with the Director of the NSW/ACT HTC; and
   - provide the Director of the relevant NSW/ACT HTC with a summary of factor usage and outcomes of the patient under their management.

(4) The HTC Director must be:
   - prepared to review and, if appropriate, approve the treatment and monitoring plan;
   - liaise with the treating Clinical Haematologist if the patient’s treatment and monitoring plan are approved; and
   - be available to the treating Clinical Haematologist during the treatment period.

2. LIST OF ATTACHMENTS

1. List of Haemophilia Treatment Centres.
2. Application Form for the Supply of Coagulation Factors for Elective Surgery
### HAEMOPHILIA TREATMENT CENTRES

The locations and contact details of the NSW/ACT Haemophilia Treatment Centres are as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSW</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Royal Prince Alfred Hospital | Telephone 02 9515 7013  
The Director  
Haemophilia Centre  
Building 77, Level 5  
Royal Prince Alfred Hospital  
Missenden Road Camperdown NSW 2050  
Emergency 02 9515 6111  
Fax 02 9515 8946 |
| Westmead Hospital | Telephone: (02) 9845 6274  
After hours & weekends: Haematology Registrar  
0409392151 |
| The Sydney Children’s Hospital Network - Westmead Campus | Telephone 02 9845 0839  
After hours & weekends: (02) 9845 0000 and ask for the Haematologist on call  
Fax 02 9845 3332 |
| Sydney Children’s Hospital Network – Randwick Campus | (02) 9382 1690  
After hours & weekends: (02) 9382 1111 and ask for the Haematologist on call  
Fax (02) 9382 1789 |
| Prince of Wales Hospital | (02) 9382 9013  
After hours & weekends: (02) 9382 2222 & ask for the Haematologist on call  
Fax: (02) 9382 9116 |
| Calvary Mater Newcastle | Telephone 02 4921 1240  
After hours & weekends: (02) 4921 1211 and ask for Haematologist on call  
Fax 02 4960 2136 |
| **ACT**  |         |
| The Canberra Hospital | Telephone (02) 6244 4048  
After hours & weekends: (02) 6244 2222 and ask for Haematologist on call  
Fax: (02) 6244 2271 |
### Application for the Supply of Coagulation Factors for Elective Surgery

**NSW/ACT Haemophilia Advisory Council Clinical Committee**

This application for the supply of the clotting factor required for elective surgery should be submitted in the first instance to the address below. Consideration will be then given to the request by the NSW/ACT Haemophilia Advisory Council Clinical Committee at its next available meeting.

If there is a shortage of the relevant coagulation factor, elective surgery may have to be deferred and be subject to the haemophilia elective surgery priority list. Please tick the relevant box where indicated.

#### Patient Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name</td>
<td></td>
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<tr>
<td>Given name</td>
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<tr>
<td>Date of birth</td>
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<tr>
<td>Sex</td>
<td>Male/Female</td>
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<tr>
<td>Weight</td>
<td>lbs</td>
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<td>Haemophilia Treatment Centre</td>
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<tr>
<td>Haemophilia Treatment Physician</td>
<td></td>
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<tr>
<td>ABDR ID Number</td>
<td></td>
</tr>
<tr>
<td>Type of Bleeding Disorder</td>
<td></td>
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<tr>
<td>Haemophilia A</td>
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<tr>
<td>Haemophilia B</td>
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</tr>
<tr>
<td>von Willebrand's disease</td>
<td></td>
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<tr>
<td>Factor VIII level</td>
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<tr>
<td>Factor IX level</td>
<td></td>
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<tr>
<td>Factor XII deficiency</td>
<td></td>
</tr>
<tr>
<td>Factor VII deficiency</td>
<td></td>
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<tr>
<td>Other Bleeding Disorder</td>
<td></td>
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<tr>
<td>Inhibitor status</td>
<td></td>
</tr>
<tr>
<td>Proposed Surgery</td>
<td></td>
</tr>
<tr>
<td>Indications for surgery</td>
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<tr>
<td>Surgery proposed</td>
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<td>Proposed Hospital/Location of surgery</td>
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<td>Proposed date of surgery</td>
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<tr>
<td>Degree of urgency</td>
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<tr>
<td>Coagulation Factor Requirements</td>
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<tr>
<td>Plasma-derived Factor VIII</td>
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<td>Recombinant Factor VIII</td>
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<td>Plasma-derived Factor IX</td>
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<td>Factor IX</td>
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<td>Factor XI</td>
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<td>Factor VII</td>
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<tr>
<td>Factor VIIa</td>
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<tr>
<td>Factor VIII</td>
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<td>Factor IX</td>
<td></td>
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<tr>
<td>FEIBA</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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<tr>
<td>Estimated requirement</td>
<td>bottles or JUs</td>
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<tr>
<td>For Continuous infusion</td>
<td></td>
</tr>
<tr>
<td>Nature of any complicating conditions</td>
<td></td>
</tr>
</tbody>
</table>

**Signed:** ____________________________  **Print Name:** ____________________________  **Designation:** ____________________________  **Date:** ____________________________

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**183(22/08/13)**
12. **MEDICAL CARE**

<table>
<thead>
<tr>
<th>Facility:</th>
<th>FAMILY NAME</th>
<th>MRN</th>
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<tr>
<td></td>
<td>GIVEN NAME</td>
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<td></td>
<td>D.O.B.</td>
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</tr>
<tr>
<td></td>
<td>ADDRESS</td>
<td></td>
</tr>
</tbody>
</table>

| APPLICATION FOR THE SUPPLY OF COAGULATION FACTORS FOR ELECTIVE SURGERY |
| LOCATION/HOSPITAL |

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Please place this application in an envelope marked Confidential and address it to:

NSW/ACT Transfusion Medicine Specialist
Medical Services
Australian Red Cross Blood Service
17, O'Connell Street
Alexandria NSW 2015

Office use only

NSW/ACT HAEMOPHILIA ADVISORY COUNCIL CLINICAL COMMITTEE
Approved for the supply of coagulation factors for elective surgery

1. Further Information to be sought:

2. Details of further information obtained:

3. Decision of the Clinical Committee:

4. Approval

☐ Approved - ARCBS to supply product

Or

☐ Deferred - to Haemophilia Elective Surgery / Coagulation Factor Waiting list

Or

☐ Not approved - for following reason(s)

Signed: ___________________________ Print Name ___________________________

Designation: __________________ Date __________________
STUDENT TRAINING AND RIGHTS OF PATIENTS (PD2005_548)

There are a number of methods used by various institutions in communicating the appropriate behaviour expected of students in the clinical setting. Some of these are student guidelines, accompanying clinical instructors, identification badges and patient brochures explaining the role of students. All New South Wales public health system services must have a Student Training and Patient Rights policy.

This Circular highlights the principles that should be encompassed in local policies to ensure that an appropriate code of conduct is maintained at all times by medical, nursing and health science students during their contact with patients. Student supervisors must also be made aware of these principles and local policies concerning expected codes of conduct.

Principles to be encompassed in local policies.

1. Patients have the right to expect a safe and adequate level of care delivered by competent staff.
2. Adequate supervision of students must be provided to ensure an adequate standard of patient care.
3. All patients using a health system facility should be made aware that public hospitals have a community role in teaching and training.
4. The provision of information/advice to a patient on a proposed treatment/procedure and the subsequent obtaining of consent to a treatment/procedure must not be undertaken by a student. Students should understand the patient and information and consent process but may only participate in the process as an observer.
5. Any patient may refuse to have a student participate in their treatment regardless of whether the activity is part of or additional to the normal requirements of care. Patients should be clearly informed where it is desired to have students participate in their treatment.
6. Patient consent is required where it is proposed a student be involved in treatment/procedure as opposed to general care. Patients are under no obligation to participate in such teaching activities. For non-invasive procedures verbal consent should be adequate subject to any local policy on consent. For invasive procedures, written evidence of consent would be required, preceded by adequate explanation of the nature of the procedure, its risks or benefits and the level of competence of the provider. This consent should include stating the identity and status of the student.
7. Patients must be treated with respect and should not be placed in situations which may cause them to feel embarrassed, harassed or offended. This means ensuring adequate privacy and appropriate supervision (or chaperoning) for interview and examinations.
8. Students and supervisors have an obligation to ensure that the student’s level of competence is such that when a student-patient interaction occurs, the patient’s safety, well-being and dignity are not compromised. This would require students to express concerns about the limits of their competence and the supervisor to provide adequate support.
9. Part of the learning experience for the student should be the opportunity for the patient to comment on the student’s interaction.

The following circulars relate to student access to health facilities and should be read in conjunction with this policy directive:

PD2016_057 “Clinical Placements in NSW Health”
PD2005_406 “Consent to Medical Treatment - Patient Information”.
LAPAROSCOPIC INSUFFLATOR – FILTERS (IB 97/28)

Please read with PD2007_036 - Infection Control Policy.

The following information should be brought to the attention of the staff involved in laparoscopy, including medical, nursing staff, technicians and bio-medical engineers.

There have been reported incidences of contamination of laparoscopic insufflators with blood, body fluids and particulate matter with potential for cross infection. Such contamination may not be obvious to the user and could create an infection risk.

Several situations, such as insufflator deactivation, elevated abdominal pressure, or an empty CO₂ gas cylinder, can cause the pressure at the insufflator’s patient connector to be lower than it is in the patient’s abdomen. This may result in the retrograde gas flow from the patient, which can force gas, blood and other body fluids back into the insufflator\(^1\).

The following precautions should be taken during the use of insufflators to minimise the risk of passage of blood and body fluids from the patient into the insufflator or from the insufflator to the patient during the procedure. Manufacturer’s instructions for the use of the insufflator should be followed. In addition:

- Always use a single use sterile hydrophobic bacterial filter 0.2 - 0.3 microns between the insufflator’s patient connector and patient. Use a single use sterile hydrophobic bacterial filter compatible with the insufflator\(^2\).
- Discard the hydrophobic bacterial filter after each procedure.
- Before each procedure, flush the insufflator and the patient connection hose with the insufflation gas. Replace the unit and filter if any evidence of contamination is present inside the insufflator\(^3\).
- Position the patient port of the insufflator and as much of the associated tubing as possible above the patient’s abdomen to avoid gravity backflow.
- All equipment downstream of the filter should either be single use or sterilised.
- Disconnect or occlude the patient tubing when the CO₂ supply is exhausted or during cylinder replacement\(^4\).
- Disconnect or occlude the patient tubing from the trocar cannula before deactivating the insufflator.

References

CARE OF CONFUSED AND WANDERING PATIENTS (IB 97/21)

A recent Health Care Complaints Commission investigation into the death of an elderly dementia patient has highlighted the need for continued vigilance by health facilities when caring for confused and wandering patients. Issues raised during the investigation into this incident included:

• protocol for searching for, and locating missing patients;
• management of confused and wandering patients; and
• obstruction of stairs

As a result of the investigation the health facility concerned developed and implemented a number of strategies to enhance the provision of care to confused and wandering patients and to assist in locating missing patients.

Protocol for searching for, and locating a missing patient

All health facilities should consider developing a written protocol for searching for missing patients. This protocol may identify:

i. activities to be undertaken by different groups of staff during the search;
ii. all relevant areas (including stairwells) of the health facility to be searched; and
iii. lines of communication between staff involved in the search.

Management of confused and wandering patients

All health facilities should consider developing a written protocol for managing confused and wandering patients. This protocol may cover issues such as the provision of a safe environment for all patients, caring for patients in the least restrictive manner and the maintenance of a duty of care to all patients.

It is important to emphasise the need for accurate diagnosis and assessment of a patient who is presenting as “confused and wandering”. Confusion may be a delirium caused by an acute infection or drug reaction that can be treated. It is therefore important to raise staff awareness of the need to investigate the reason for the confusion and to obtain an accurate diagnosis. This could include developing consultation arrangements with geriatric departments/aged care services.

Additional strategies to assist in the implementation of a protocol may be to:

• raise staff awareness about the need for continued vigilance particularly with patients who are confused and may wander;
• identify those patient care areas with greater potential for admitting and caring for confused and wandering patients;
• equip potentially confused and wandering patients with security tracking bracelets;
• educate staff in the management of confused patients; and
• increase security rounds throughout the health facility.

The NSW Action Plan on Dementia identifies a number of strategies related to the care of people with dementia in hospitals. The Department of Health also has a role in supporting Areas in the development of dementia training programs. Personnel with a particular interest in developing a protocol and looking at dementia training issues should contact Ms Anne Cumming, Dementia Project Officer, on (02) 9391 9168.
Obstruction of stairs

Storage of equipment in fire stairs does not comply with fire safety standard 26 of the Australian Council on Healthcare Standards Guide (13 edition) which states that:

Doorways, corridors, ramps and stairways which are a means of egress in case of fire are kept free of obstruction at all times and are wide enough for the evacuation of non-ambulatory patients.

It is also a contravention of “Part D - Access and Egress” of the Building Code.

All health facilities should be advised of the importance of maintaining fire stairs free of obstructions.

Your assistance and co-operation in considering these matters is appreciated.

VICTIMS RIGHTS 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.
12. MEDICAL CARE

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.
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.
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.
12. MEDICAL CARE

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 the 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.
## Appendix 5

<table>
<thead>
<tr>
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<th>Complaints Contact Officer</th>
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<tr>
<th>Service</th>
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<th>Role and Contact Information</th>
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<tr>
<td>Macquarie Health Service</td>
<td>Ms Rhonda Gleeson</td>
<td>Sexual Assault Coordinator, Dubbo Community Health Centre</td>
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<td>2 Palmer Street</td>
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MIGRAINE AND LOW BACK PAIN - EVIDENCE BASED PRESCRIBING AND RATIONAL USE OF OPIOIDS (IB99/15)

The Pharmaceutical Services Branch of the New South Wales Health Department receives a number of applications from doctors seeking authority to prescribe short-acting injectable opioids such as pethidine for the treatment of recurrent migraine and back pain. The use of such drugs for these conditions is of concern, as the risk of patients becoming dependent is high and adequate pain control is difficult to achieve.

As a result, the NSW Therapeutic Assessment Group Inc (NSW TAG) was commissioned to develop evidence based guidelines for general practitioners to assist them in the early management of patients with migraine and low back pain, with the aim of improving long term health outcomes.

Although the guidelines were developed for use by general practitioners, the principles of evidence based prescribing and the rational use of opioids in the management of migraine and low back pain are equally relevant to prescribing in the hospital setting, and they will therefore provide a valuable education resource for medical staff.

Copies of the guidelines are available from the Department’s Better Health Centre by telephoning (02) 9816 0353 and quoting the following State Health Publication numbers:

Guidelines for General Practitioners - Migraine (PSB) 990134
Guidelines for General Practitioners - Low Back Pain (PSB) 990135

Alternatively, the guidelines can be accessed through the Department’s Clinical Information Access Project (CIAP) or via the Internet at http://healthcpd.com.au/

HAEMOCHROMATOSIS (IB2000/9)

Information for Health Care Providers on Diagnosis and Management

Introduction

Hereditary or genetic haemochromatosis (HH) is the commonest genetic disorder in Australia, affecting one in 200-300 people. It is characterised by accumulation of iron in various organs which leads to conditions such as cirrhosis, cardiomyopathy and diabetes. Early diagnosis and treatment is important to prevent organ damage and allow normal life expectancy. However, it is under-diagnosed because of its late onset (average age of onset of symptoms is late 40s) and multiple non-specific clinical presentations. Treatment consists of regular blood collection from the patient to reduce excess body iron stores. 12, 13 The collected blood can potentially be used for blood transfusion services.

This document has been prepared to improve awareness about this common and easily treatable condition, and to provide a unifying approach to the early diagnosis, testing and management of individuals and their families.

Incidence and inheritance

One in 200-300 people of Northern European or Anglo Saxon descent have a genetic predisposition to haemochromatosis, and are likely to develop the condition.  

One in eight to ten people is likely to be a carrier of the gene mutation. Carriers usually show no symptoms of the disease but may develop it if they have diabetes, are alcohol dependent or have some other triggering factor. A couple who are both carriers of the mutated gene have a 1 in 4 chance in every pregnancy of having a child who will develop haemochromatosis as an adult.

Three gene mutations have been identified and their expression is summarised below. Further studies are needed to clarify whether S65C is a mild mutation or polymorphism.

<table>
<thead>
<tr>
<th>Gene Mutation</th>
<th>Gene Carriers (people with 1 copy of the mutation, rarely develop clinical haemochromatosis)</th>
<th>Genetic Predisposition (likely to develop haemochromatosis)</th>
</tr>
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<tbody>
<tr>
<td>All mutations</td>
<td>• 1 in 200 to 1 in 300</td>
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</tbody>
</table>
| C282Y         | 1 in 8 to 1 in 10 people of Northern European and Anglo Saxon descent  

15 16 | • 90% of people with a clinical diagnosis of haemochromatosis are homozygous (C282Y/C282Y)  

• 90% of homozygous males and 50-70% of homozygous females will develop haemochromatosis  

• approximately 1 in 1000 carriers will develop haemochromatosis |
| H63D          | 1 in 5  

17 |

homozygosity (H63D/H63D) rarely causes haemochromatosis (<1%) |
| C282Y/H63D    | 1 in 50  

2 |

2% of people with a clinical diagnosis of haemochromatosis  

<1% will develop haemochromatosis |
| S65C          | 1 in 33 |
| Unknown       | 10% with clinical HH |

Clinical features

Haemochromatosis is characterised by excess accumulation of iron in various organs. Symptoms usually develop between the ages of 30 and 60 years and may include:

• weakness  

• lethargy  

• chronic fatigue  

• depression  

• abdominal pain  

• arthritis  

• decrease in libido

12. MEDICAL CARE

- impotence
- arrhythmias

Modifying features which can affect disease expression include:
- the ancestral haplotype - associated with more severe disease
- blood loss in menstruation and pregnancy
- blood donation
- physiological and pathological blood loss
- diet - supplementary vitamin C and iron tablets; intake of iron containing foods
- gender - higher penetrance in males
- coexisting liver disease e.g. viral hepatitis
- excessive alcohol consumption.

Haemochromatosis can lead to:
- cirrhosis
- cardiomyopathy
- pituitary dysfunction
- diabetes
- skin pigmentation
- arthropathy
- premature death resulting from chronic liver disease, hepatocellular carcinoma and heart failure.

Diagnosis

Excess body iron is commonly due to haemochromatosis.

1. Iron studies

For the patient exhibiting one or more of the signs or symptoms listed above, fasting iron studies (transferrin saturation and serum ferritin) is the most appropriate initial test. Transferrin saturation levels of >55% is likely to indicate haemochromatosis. Serum ferritin levels of >300 $\mu$g/L in men and >200 $\mu$g/L in women is suggestive, but by no means diagnostic of haemochromatosis.

2. Gene studies

Where individuals have elevated ferritin and transferrin saturation or a relative known to have haemochromatosis, simultaneous mutation studies are recommended. PCR tests on DNA from venous blood, mouthwash or buccal smear can identify both C282Y and H63D mutations.

3. Cascade testing

For each person homozygous for C282Y, there is a 1 in 4 chance for each of their siblings to be homozygous and a 1 in 2 chance of carrying one copy of the mutation. Their parents are obligatory carriers and aunts and uncles have at least a 1 in 2 chance of being a genetic carrier. The chance of their children developing haemochromatosis depends on the genetic status of their spouse. If the spouse is homozygous normal then there is no indication to test the children. If the children are adults, risk to their children should be ascertained through their spouse.

4. Liver biopsy

A liver biopsy is sometimes required for confirmation of the diagnosis of haemochromatosis. It also allows the clinician to quantitate the degree of iron overload or determine the presence of cirrhosis.
12. **MEDICAL CARE**

Patient Management

Removal of excess iron stores in the pre cirrhotic patient results in normal life expectancy.\(^1\) If commenced early, fatigue, abdominal pain, liver function and diabetic control should improve. Gonadal failure and arthropathy do not usually improve and cirrhosis is irreversible.

Given the frequency of the disorder, the general practitioner should be the primary care giver. Specialists may be involved, e.g. for diagnosis and treatment of difficult cases or for management of complications such as cirrhosis and arthritis. A guide for managing haemochromatosis and a diagnostic pathway chart are attached.

Venesection is begun in the presence of iron overload, rather than on the results of genetic testing. When serum ferritin and/or transferrin saturation is greater than normal, venesection is performed twice weekly to twice monthly (depending on the health of the individual and their Hb) until transferrin saturation returns to normal. This may take months to years (average is 18 months), depending on the degree of iron overload. A serum ferritin level of 50-100 μg/L is generally maintained by about 4 venesections/year.

In NSW, blood collected can potentially be used for blood transfusion services, providing LFT’s are normal. Some GPs will arrange venesections in their rooms and some local pathology services will arrange venesection. However, the Blood Transfusion Services do not automatically accept blood thus collected, unless it has been collected at facilities approved by the Blood Transfusion Service.

For those individuals with a genetic predisposition to iron overload,

- if they have normal iron studies, venesection is not required. Iron studies are recommended every two years.
- if they have normal ferritin and raised transferrin saturation, venesection needs to be considered. If venesection is not implemented, iron studies should be repeated yearly.

Venesection in the form of regular blood donation (3-4 monthly) is recommended by some clinicians, as theoretically, this may help prevent clinical disease.

Glossary

**Carrier of a mutated gene:**

Every cell contains two copies of each gene. One gene copy may be mutated and the other may be ‘correct’. If the mutated gene is not expressed in the cells (resulting in a particular characteristic or a disorder), the mutated gene is said to be recessive to the other ‘correct’ copy of the gene. An individual who has one correct gene copy and one faulty (recessive) gene copy is said to be a ‘carrier’ for the mutation leading to a specific condition. The carriers of a recessive mutation in a gene are usually not affected but they are at risk for passing on the mutant gene to their offspring.

**Homozygote:**

Refers to an individual in whom the two alleles or gene copies contain identical information. An individual can be homozygous for the correct copies of the gene or can be homozygous for the mutated copies of the gene.

**Heterozygote**

Refers to an individual with two different alleles at a single locus

**Compound heterozygote**

Refers to an individual with two different mutant alleles at a single locus
Genetic Haemochromatosis confirmed
- Homozygous (C282Y/C282Y) with iron overload
- Compound heterozygote (C282Y/H63D) with iron overload
- Heterozygote (C282Y/normal) with iron overload

Review Iron Studies
- FBC (1)
- LFT (2)

Plan venesection
- Blood bank
- Hospital
- Own rooms (require adequate equipment)

Venesection weekly
- Check Hb for the first 2-3 weeks to ensure patient does not become anaemic
- If no adverse effects, continue weekly venesections and check iron studies every 6 weeks.

If patient is symptomatic after venesection
- check Hb and iron
- reduce frequency to minimise symptoms

Until iron studies are in normal range

3-4 monthly venesection
- (or as frequently as required)
- check iron studies twice yearly
- maintain iron studies in the normal range

Explanatory Notes:
(1) The higher the transferrin saturation and serum ferritin the more likely the patient has very significant iron loading and will require venesection for months.
(2) If Hb is low, venesection will need to be monitored very closely.
(3) ALT/AST elevation (regardless of the cause) may be associated with raised ferritin & transferrin saturation levels, complicating the interpretation of iron studies.

References
Genetic Haemochromatosis Diagnostic Pathway

General population

Iron studies

Normal iron studies

Transferrin saturation > 55% or Serum ferritin > 300 μg/L M, > 200 μg/L F + normal LFT

Gene testing for C282Y

Iron studies

No mutation

C282Y/--
Carrier
Cascade testing

C282Y/H63D or C282Y/C282Y
Genetics review for cascade testing

Serum ferritin > 300 μg/L M, > 200 μg/L F +/- transferrin saturation > 55%

Normal iron studies

Normal iron studies

Consider Gastroenterology or Physician review, liver biopsy.

2nd yearly iron studies +/- regular blood donation

Frequent venesection and iron studies

Normal iron studies

Family history of haemochromatosis
The HFE Gene

The HFE gene, cloned in 1996, encodes a novel MHC class 1-like protein. It is a cell membrane molecule, which regulates iron absorption. HFE is physically associated with the transferrin receptor (TfR), which is located on the cellular plasma membrane. The HFE protein binds to TfR and decreases the affinity of TfR for diferric transferrin. The HFE protein is highly expressed in the deep crypt cells of the duodenum. Three gene changes in the HFE gene have been identified: C282Y and H63D are clearly mutations, whilst the recently described gene change, S65C may be either a mild mutation or a polymorphism.

The C282Y mutant protein is not expressed on the cell surface (the mutation disrupts a disulphide bridge required for non-covalent interaction with β2 microglobulin and for correct cell surface presentation), does not bind to TfR and therefore has no effect on the affinity of TfR for diferric transferrin. The H63D mutant protein is expressed on the cell surface, but decreases the affinity of TfR for diferric transferrin to a lesser extent than the wild type HFE protein. The S65C mutation may also partially decrease the affinity of TfR for diferric transferrin, but its function and effect have not yet been determined.

Homozygosity for the C282Y mutation has been found in over 90% of people with a clinical diagnosis of haemochromatosis, who are of northern European descent. Carrier frequency of the C282Y mutation is between 1 in 8 and 1 in 10 people of northern European descent, but is rarely seen in Indigenous Australians and those of African or Asian descent. A smaller percentage of individuals with HH have been found to be compound heterozygotes (C282Y/H63D). Carrier frequency for the H63D mutation may be as frequent as 1 in 5 individuals and compound heterozygosity (C282Y/H63D) occurs in as many as 1 in 50 people. The carrier frequency of S65C is approximately 1 in 33 people. As many as 10% of individuals with haemochromatosis have no identifiable mutation.

Genotype/Phenotype Correlations

The data available on the expressivity of clinical disease is scant. Based on family studies, approximately 90% of males and 50-70% of females who are homozygous for C282Y will develop clinical haemochromatosis. Homozygosity for the H63D mutation seems to cause clinical HH rarely; < 1% will develop haemochromatosis. Approximately 10% of C282Y and H63D carriers and 26% of compound heterozygotes have been shown to have mild increases in serum iron, transferrin saturation +/- serum ferritin, compared to 3% of controls. However, clinical haemochromatosis occurs rarely in...
carriers (perhaps in 0.1%) and then possibly only in the presence of other associated conditions, such as hepatitis and alcoholism.\textsuperscript{8,9} Martinez reported that 30\% of compound heterozygotes had either iron overload or clinical haemochromatosis, but this study had a non random sample base.\textsuperscript{10} It is more likely, based on the frequency of compound heterozygotes and the small numbers actually seen with HH, that clinical expression is 1\%.\textsuperscript{11,12} Modifying factors are very important in determining disease expression. They include the ancestral haplotype (associated with more severe disease), diet (supplementary vitamin C and iron tablets, intake of iron containing foods), blood loss (menstruation and pregnancy in women, blood donation, physiological and pathological blood loss), gender (higher penetrance in males), coexisting liver disease (e.g. viral hepatitis), alcohol consumption and age.

GUIDELINES FOR DIAGNOSIS AND MANAGEMENT OF HAEMOGLOBINOPATHIES (IB99/14)

Genetic disorders of globin including: $\alpha$ and $\beta$ thalassaemias and variants such as HbS and HbE

Background

Genetic disorders result usually from a change in the hereditary (genetic) material contributed by the parents at the time of conception. Certain conditions occur more frequently in some families than others. Also, certain nationalities or ethnic groups may experience a higher incidence of certain inherited disorders. For example, cystic fibrosis and haemochromatosis are more prevalent in populations who have originated from Northern Europe. Haemoglobinopathies occur more frequently in populations who have originated from Southern Europe, the Middle East, Africa, Asian countries and the Indian sub-continent.

Haemoglobinopathies are recessively inherited blood disorders for which there is no cure. $\alpha$ thalassaemia major is fatal at birth. Those affected by $\beta$ thalassaemia major have a severe anaemia. Affected children usually present in infancy with pallor, irritability and enlarged liver and spleen. They usually require regular (four weekly) blood transfusions throughout life. Although blood transfusion prolongs life, it also causes iron accumulation in the body that may result in diabetes, liver damage and cardiac problems. This may cause death in adolescence or early adulthood unless iron chelating therapy is used. The latter involves subcutaneous infusion of desferrioxamine for 10-12 hours most days of the week, usually overnight.

$\alpha$ and $\beta$ thalassaemia minor may cause a mild anaemia. However, people usually have good health and their bodies function normally. People with the minor forms of thalassaemia are “genetic carriers” of a mutation in their $\alpha$ or $\beta$ haemoglobin gene. They have one normal copy of the haemoglobin gene and one copy that is mutated.

During reproduction, if a couple are both carriers of the same thalassaemia mutation, there is a one in four chance in each pregnancy that a child will receive both copies of the mutant gene, ie one from each parent. Such a child will be affected with thalassaemia. In each pregnancy there is a 50\% chance that the child will be a carrier of the mutant gene like the parents, and thus will have thalassaemia minor.

If only one parent is a genetic carrier of thalassaemia the couple will not have a child with thalassaemia major. However, there is a 50\% chance in every pregnancy that their child will be a genetic carrier of thalassaemia and have thalassaemia minor.

\textsuperscript{9}Martinez P, Biron, C, Blanc F et al. Compound heterozygotes for hemochromatosis gene mutations: may they help to understand the pathophysiology of the disease? Blood Cells, Molecules and Diseases. 1997; 23: 269-276
\textsuperscript{10}Martinez P, Biron, C, Blanc F et al. Compound heterozygotes for hemochromatosis gene mutations: may they help to understand the pathophysiology of the disease? Blood Cells, Molecules and Diseases. 1997; 23: 269-276
A conservative estimate of the genetic carrier frequency for haemoglobinopathies in NSW/ACT is about 60,000 genetic carriers.

Key Information

Detection of genetic carriers of thalassaemia

a) **Low MCV or MCH**

It is important to consider that an individual could be a genetic carrier for thalassaemia or HbE whenever a blood count shows a low MCV or MCH, particularly if an individual or their ancestors have originated from one of the at-risk groups identified below. The blood picture described is frequently mistaken for iron deficiency. It is also important to note that both iron deficiency due to other causes and thalassaemia can co-exist in the same individual. Therefore a low MCV or low MCH which appears to be refractory to iron treatment should be considered to represent thalassaemia minor until proven otherwise.

b) **Family history or at-risk group**

People who have a family history of haemoglobinopathies or whose ancestry is from Southern Europe, India, Africa, Middle East and Asia are considered to be in a higher risk group for genetic carrier status for thalassaemia. As Australia is a multicultural society, with a large degree of intermarriage, it is not always easy to identify at-risk groups. Therefore it is vitally important to consider all of the following in identifying risk for thalassaemia.

Target Groups

- Anyone with a blood count showing low MCV or MCH.
- People whose origins are from Southern Europe, Africa, the Middle East, Asian countries and the Indian Subcontinent where the incidence of haemoglobinopathies is significantly higher.
- All pregnant women when they are having routine antenatal blood examinations, and especially those with ancestry from the above groups who are at higher risk.

Reproduction issues for haemoglobinopathy carriers

Options are available for those who are either at-risk for being a genetic carrier or whose carrier status has been confirmed. These include laboratory detection, genetic counselling and prenatal diagnosis.

Further Information

1. Clinical and laboratory features

1.1 **β Thalassaemia**

Homozygous β thalassaemia, sometimes called thalassaemia major, is usually a cause of severe anaemia. Thalassaemia is the most common type of thalassaemia in Australia, and occurs predominantly in people of South European, African, Middle-Eastern, Asian and Indian descent.

Genetic carriers of β thalassaemia are said to have thalassaemia minor (or β thalassaemia trait). The β thalassaemia trait is asymptomatic. The red cells are smaller (low MCV) and paler (low MCH) than normal, and the haemoglobin level is normal or slightly reduced. Unlike other recessive disorders the carrier state in most cases is suspected on a routine blood count and can be confirmed by special studies (see also Diagnosis and Management of Haemoglobinopathies, 4.1).
If two genetic carriers have children, there is a 1:4 chance (25%) in each pregnancy that the child will have homozygous β thalassaemia.

The child who has homozygous β thalassaemia usually presents after the age of 6 months with pallor, irritability and an enlarged liver and spleen. Affected children usually require regular blood transfusion. Although blood transfusion prolongs life, it also causes iron accumulation in the body which may result in diabetes, liver damage and cardiac problems. This may cause death in adolescence or early adulthood, unless other steps have been taken to prevent iron accumulation i.e. iron chelation therapy. The latter involves subcutaneous infusions of desferrioxamine most days of the week. For those who cannot take desferrioxamine, there are trials underway to assess the efficacy of other medical treatments including oral chelating agents. However, these are investigative and should not be considered as alternatives for the well-proven subcutaneous treatment. In selected cases, bone marrow transplantation has been curative. Infection with hepatitis C is another complication of regular blood transfusion and those so affected need careful monitoring in case antiviral treatment is indicated (see also Diagnosis and Management of Haemoglobinopathies, 4.3).

1.2 α Thalassaemia

The genetic carrier for α thalassaemia, another form of thalassaemia, is also asymptomatic, and as with β thalassaemia, the red blood cells may be small and pale. Because there are 4 α globin genes compared to 2 β globin genes, there is greater variability in the types of α thalassaemias. The important one, from the point of view of children who might be affected with severe α thalassaemia, is the genetic carrier who has 2 α globin genes missing from one chromosome (this is called α0 thalassaemia or α thalassaemia-1 and is written as αα/−−). This type of genetic carrier often originates from Asia, Southern Europe, Africa, India or the Middle East.

Like β thalassaemia, 2 parents with α0 thalassaemia have a 1 in 4 chance (25%) that their children will be homozygous for a severe form of α thalassaemia (Hb Bart’s hydrops fetalis, which is written as −−/−−). This is a fatal disorder with the fetus being stillborn or dying soon after birth. The mother in such a pregnancy is at greater risk for some pregnancy-related complications. HbH disease (written as -α/−−) is another form of α thalassaemia. In this case, the clinical and laboratory phenotypes are difficult to predict i.e. mild or asymptomatic to a severe disorder requiring regular blood transfusions. Determining the type of α thalassaemia present in an individual is more difficult than is the case with β thalassaemia. DNA studies are usually required (see also Diagnosis and Management of Haemoglobinopathies, 4.1).

1.3 Variant Hb (HbS and HbE)

There are over 200 variant haemoglobins (Hb). However, in Australia the common variant haemoglobins are HbS (sickle haemoglobin) and HbE. Like thalassaemia, genetic carriers of these traits originate from countries in which malaria is or was endemic. The reason for this is that thalassaemia and some of the variants (e.g. HbS and HbE) provide some protection from malaria. In Australia, HbS genetic carriers are predominantly individuals of Southern European, African, or Middle Eastern origin. HbE genetic carriers usually have a South Asian or South East Asian ethnic background. Like α and β thalassaemias, genetic carriers for both these variants are asymptomatic. The heterozygote (carrier) for the HbS trait has normal haematological parameters. Clinical complications arise in the case of: (1) a homozygote for HbS or (2) a double-heterozygote for β thalassaemia and HbS or (3) a double-heterozygote for β thalassaemia and HbE. In the first two cases, sickle cell disease develops. The individual with sickle cell disease can have a variable presentation but usually that person has an episodic disorder characterised by “crises” that may require hospital admissions for blood transfusion and/or pain relief. A female with sickle cell disease
is particularly at risk for serious complications during pregnancy. The severity of sickle cell disease (just like homozygous $\beta$ thalassaemia or HbH disease) cannot always be predicted and so counselling in the haemoglobinopathies can be difficult. A double-heterozygote for $\beta$ thalassaemia and HbE can have a similar clinical picture to homozygous $\beta$ thalassaemia.

3. **Prevalence of the haemoglobinopathies in NSW**

2.1 $\beta$ thalassaemia genetic carriers

It is difficult to assess the number of people in Australia or NSW who are at risk of having one of the forms of thalassaemia or one of the above variant haemoglobins i.e. the carrier frequency for these disorders. A figure of at least 1.0% is estimated for NSW, based on the 1991 Census figures which calculated that 41% of the NSW/ACT population had one or more parents born overseas from a non-English speaking background. Thus, a conservative estimate is that there are **about 60,000 genetic carriers of a haemoglobinopathy in NSW/ACT**.

It is important to consider that an individual could be a genetic carrier for thalassaemia or HbE whenever a blood count shows a **low MCV or MCH**, particularly if an individual or their ancestors have originated from an at-risk group. The blood picture described is frequently mistaken for iron deficiency. It is also important to note that both iron deficiency due to other causes and thalassaemia can co-exist in the same individual. Therefore a low MCV or low MCH which appears to be refractory to iron treatment should be considered to represent thalassaemia minor until proven otherwise.

2.2 $\beta$ thalassaemia homozygotes

In 1998, there were about 123 patients with a transfusion-dependent thalassaemia living in NSW or the ACT. Of these, 106 (86%) had homozygous $\beta$ thalassaemia and 17 (14%) had related blood disorders. During the period 1989-1998 there were 23 new cases of homozygous $\beta$ thalassaemia treated in NSW (figures provided by NSW Thalassaemia Centre). While it is difficult to be sure of the emerging trends it appears as though the numbers of cases of homozygous $\beta$ thalassaemia detected are increasing, and the at risk groups are now predominantly those with a Middle Eastern or Asian background.

**New thalassaemia major patients treated in NSW 1989 - 1998**

<table>
<thead>
<tr>
<th>Country of origin or ancestry</th>
<th>No of Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle East</td>
<td>8</td>
<td>34.5%</td>
</tr>
<tr>
<td>South East Asia</td>
<td>6</td>
<td>26.2%</td>
</tr>
<tr>
<td>Southern Europe/Africa</td>
<td>6</td>
<td>26.2%</td>
</tr>
<tr>
<td>Indian Sub Continent (including Maldives)</td>
<td>3</td>
<td>13.1%</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100%</td>
</tr>
</tbody>
</table>

4. **Target groups:**

- Anyone with a blood count showing low MCV or MCH.
- People whose origins are from Southern Europe, Africa, the Middle East, Asian countries and the Indian Subcontinent where the incidence of haemoglobinopathies is significantly higher.
- All pregnant women when they are having routine antenatal blood examinations, and especially those with ancestry from these geographic regions.
4. Diagnosis and Management of Haemoglobinopathies

4.1 Homozygous haemoglobinopathies

- **Initial screening**: This should include determinations of haemoglobin, red cell indices and examination of a blood film. HbEPG is essential if there is the possibility of HbS being present.

- **Follow up tests**: Blood samples showing a low MCV or MCH should have iron deficiency excluded. Iron deficiency should be treated and the individual followed to ensure that the MCV and MCH are corrected. Failure to do so usually means there is an underlying haemoglobinopathy. In some cases, the blood film might be suggestive of a haemoglobinopathy and so appropriate investigations should be started immediately. Haematological tests to confirm thalassaemia and the variant haemoglobins include: HbA2, HbF, HbH inclusions and Hb EPG. **These should be performed by experienced laboratories.**

Laboratory detection of thalassaemia (or HbE, HbS) genetic carriers is readily available in NSW public hospital or private pathology laboratories. Specialised referral laboratories for the haemoglobinopathies are found at the Royal Prince Alfred and Westmead hospitals.

Further investigations, including DNA analysis, may also be necessary, particularly in the case of the α thalassaemias. Since the MCV or MCH is likely to be normal in the HbS carrier, the appropriate tests (HbEPG followed by the confirmatory HbS sickle test) will need to be requested in an individual whose ancestry includes an at risk group or whose pregnancy is at risk.

- **Follow up**: Where a person is a genetic carrier of thalassaemia (thalassaemia minor) it is imperative that the partner is tested if reproduction is an issue. Testing should also be offered to blood relatives.

4.2 Genetic carriers of haemoglobinopathies

It is important that females of child bearing age in the target groups are tested before pregnancy, or as soon as possible, if already pregnant. If the woman is a genetic carrier for thalassaemia, HbS, HbE or another less common but relevant haemoglobinopathy, the partner should be tested. If both are genetic carriers, genetic counselling and information regarding prenatal diagnosis can be provided.

- **Counselling:**

When couples are identified as genetic carriers of thalassaemia or other haemoglobinopathies, it is important that in-depth and experienced counselling is provided to minimise anxiety, to clarify risk, to avoid stigmatisation and dispel misconceptions about thalassaemia.

Because of the heterogeneity of abnormalities and the complex interactions that occur in the haemoglobinopathies, it is recommended that counselling is undertaken in conjunction with advice from a haematologist. Counselling services are available through the NSW Thalassaemia Centre at the Royal Prince Alfred Hospital, Clinical Genetics Units throughout NSW. Information about counselling services is available from the NSW Genetics Education Program (Details in Appendix 1). It is Department of Health policy that a professional interpreter be used in such situations where the client is not fluent in English (see Appendix 1).
Prenatal diagnosis

Prenatal diagnosis is an option that couples may wish to consider where pregnancies are at risk of producing a child who is severely affected with a haemoglobinopathy. Counselling sensitive to the issues concerning prenatal diagnosis should be offered by experienced counsellors.

In most cases prenatal testing for haemoglobinopathies is undertaken during the first trimester of pregnancy by a combination of chorionic villus sampling (CVS) and analysis of fetal DNA. However, to ensure that this type of prenatal testing is possible, it is essential to confirm the thalassaemia or variant haemoglobinopathy in both partners early in the pregnancy or preferably before the woman becomes pregnant.

Second trimester prenatal testing can be undertaken by testing fetal blood rather than DNA obtained at CVS or amniocentesis. However, the analysis of fetal blood has a higher rate of miscarriage related to the test and is now less frequently performed.

CVS, amniocentesis and, in some cases, fetal blood sampling can be obtained at the Royal Hospital for Women, King George V, Royal North Shore, Westmead, Liverpool, Nepean, John Hunter Hospitals as well as a number of country centres (see Appendix 1 for information).

4.3 The birth of an affected child

Children born with homozygous β thalassaemia should be referred to the thalassaemia units at the Sydney Children’s Hospital or the Royal Alexandra Hospital for Children as soon as possible. Special centres to treat adults who have homozygous β thalassaemia are found in the Royal Prince Alfred Hospital and the Prince of Wales Hospital. It is important to ensure referral to appropriate support systems. It is also relevant to note that there may be stigmatisation of the affected family (“bad blood”), involving lack of support from blood relatives and avoidance by the community, and/or voluntary isolation by the family (see Appendix 1 - Thalassaemia Society of NSW and the NSW Thalassaemia Centre).

Treatment of the severe forms of the haemoglobinopathies is complex and involves the management of anaemia as well as potential complications of blood transfusion. Hence, treatment should be undertaken in a limited number of centres so that experienced health professionals are involved. With optimal treatment regimens in the severe forms of β thalassaemia, sickle cell or HbH disease, the life expectancy for a number of affected individuals is now considerably improved with some approaching normal. As indicated earlier, bone marrow transplantation in selected cases of severe β thalassaemia appears to be curative.

Treatment clinics for those with the severe haemoglobinopathies are held at the Sydney Children’s and the Royal Alexandra Hospital for Children, as well as some of the major teaching hospitals in which adults are treated (Details B Appendix 1).

5. Interpreter Service:

It is Department of Health policy that a professional interpreter be used where the client is not fluent in English. This is mandatory when seeking consent for treatment or when informing individuals of the results of tests. Non-use of a professional interpreter may leave a practitioner open to legal liability. Appendix 1 gives contact details.

Interpreters can also provide valuable information on socio-cultural factors affecting patients’ attitudes to health and medical conditions, and expectations for treatment.
6. Educational Resources

The NSW Thalassaemia Centre and the NSW Genetics Education Program have produced several educational resources. Some of these are available in a number of community languages. Titles are listed in Appendix 1.
APPENDIX 1

THALASSAEMIA RESOURCES

Health Information/Education Resources

**NSW Thalassaemia Centre**
Queen Mary Building
Royal Prince Alfred Hospital
Missenden Road
Camperdown NSW 2050
Phone: 02 9550 4844

**NSW Genetics Education Program**
PO Box 317
St Leonards NSW 1590
Phone: 02 9926 7324

Printed Information Material in Community languages:

- **So you have the minor form of Thalassaemia** - available in English, Arabic, Greek and Italian
  - A pamphlet in question and answer format to be used as an adjunct for counselling individuals with β thalassaemia trait. This leaflet is available through the Thalassaemia Centre of NSW.

- **Thalassaemia - an information guide for people with the minor form of thalassaemia** - available in Arabic, Greek, Italian, Maltese, Vietnamese, Lao, Chinese, Kampuchean, Spanish, Indonesian and Turkish. Translations may also be available in other languages. This leaflet is available through the Thalassaemia Centre of NSW.

- **Thalassaemia - an inherited blood condition** - general introductory pamphlet - produced by the NSW Thalassaemia Group, the NSW Thalassaemia Centre, the NSW Thalassaemia Society and the NSW Genetic Education Program. At present the pamphlet is only available in English but it is planned to have it translated into appropriate languages.

- **Pregnancy Care** The 1998 booklet has a small section on thalassaemia and can be obtained through the Better Health Centre on 02 9816 0452.

- **Information on the Internet.** A useful site to obtain information about the haemoglobinopathies is: [http://www.chime.ucl.ac.uk/APoGI/](http://www.chime.ucl.ac.uk/APoGI/). Like all Internet-based documents the information provided should be viewed with some care although it originates from a reputable source.

The following translated documents were prepared by the Department of Health as Health Columns for the ethnic press, and are available in a range of languages from the Multicultural Health Communication Service (9382 8111) or from their website [http://www.mhcs.health.nsw.gov.au](http://www.mhcs.health.nsw.gov.au)

- **Why you should know about thalassemia.** Guide to understanding the inherited blood disorder thalassemia, how it’s inherited and what it’s like to live with the disorder.

- **How can genetic counselling help?** Description of the role and benefits of genetic counselling to people at risk of genetic disorders, including thalassemia.
Translated documents are also available from this website in relation to general procedures such as blood tests.

**New South Wales Thalassaemia Group**

This group comprises health professionals, both clinical and laboratory, who have a special interest in the haemoglobinopathies. The NSW thalassaemia Group can be contacted through:

- The Thalassaemia Centre of NSW 02 9550 4844 (see above)

**The Thalassaemia Society of New South Wales**

The Thalassaemia Society of NSW is an organisation for people with thalassaemia, their families and others who are interested. The Society’s contact address and phone number is the same as for the Thalassaemia Centre of NSW B 02 9550 4844. The mailing address is:

- The Thalassaemia Society of NSW
  - PO Box 80
  - Marrickville NSW 2204

**Interpreter service**

The NSW Health Care Interpreter Service is available at all NSW public health facilities, free of any charge to patients/clients, 7 days a week 24 hours a day. Health Care interpreters cater for the communication needs of most communities. This includes Auslan and Signed English.

<table>
<thead>
<tr>
<th>Area Health Service</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Coast</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Central Sydney</td>
<td>9515 3222</td>
</tr>
<tr>
<td>Far West</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Greater Murray</td>
<td>1800 247 272</td>
</tr>
<tr>
<td>Hunter</td>
<td>4924 6285</td>
</tr>
<tr>
<td>Illawarra</td>
<td>4274 4211</td>
</tr>
<tr>
<td>Macquarie</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Mid North Coast</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Mid Western</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>New England</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Northern Rivers</td>
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<tr>
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<td>9828 6088</td>
</tr>
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<td>Southern</td>
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<tr>
<td>The New Children’s Hospital</td>
<td>9840 3456</td>
</tr>
<tr>
<td>Wentworth</td>
<td>9840 3456</td>
</tr>
<tr>
<td>Western Sydney</td>
<td>9840 3456</td>
</tr>
</tbody>
</table>

When Health Care Interpreters are not available, the following should be contacted:

- Translating and Interpreting Service 131 450
Multicultural Health Services

A range of services are available to assist health professionals to provide services to people from diverse cultural backgrounds. These services include bilingual counsellors, multicultural health workers, ethnic obstetric liaison workers and specialist services such as the Transcultural Mental Health Service. For information on your local services, contact the Multicultural Health service in your Area Health Service:

<table>
<thead>
<tr>
<th>Area Health Service</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Sydney</td>
<td>9515 3273</td>
</tr>
<tr>
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<td>4924 6285</td>
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<td>Northern Sydney</td>
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<tr>
<td>South Eastern Sydney</td>
<td>9382 8366</td>
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<td>South Western Sydney</td>
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<tr>
<td>Wentworth</td>
<td>4736 0539</td>
</tr>
<tr>
<td>Western Sydney</td>
<td>9840 3940</td>
</tr>
</tbody>
</table>

SAFDA (Support After Fetal Diagnosis of Abnormality) network

SAFDA was developed to help individuals, their partners and families at a time of crisis. SAFDA may be contacted through the NSW Genetic Education Program or the Head Social Worker at the Royal Hospital for Women Randwick (02 9382 6670).
APPENDIX 2

INFORMATION SHEETS SUITABLE FOR USE BY HAEMATOLOGY LABORATORIES IN COMMUNICATING WITH REFERRING DOCTORS

General details which should be provided to the referring doctor:

1. This patient’s blood examination shows that α or β thalassaemia trait (or HbS or HbE trait) is present.
   A. Other blood relatives should be offered the opportunity of being tested for the condition.
   B. the patient is likely to have children, the spouse should be tested. If both partners have a haemoglobinopathy (thalassaemia, HbS or HbE traits), they should be counselled on likely implications.
   C. If the patient is pregnant, it is essential that her spouse be tested as soon as possible because of the possibility of the child having a severe form of α or β thalassaemia (or HbS or HbE) if both partners have the trait. If both partners do show the trait, they should receive expert counselling as soon as possible so that they can consider the options available to them.

2. Thalassaemia carrier status is not associated with significant ill-health.

3. Information and pamphlets on thalassaemia trait (suitable for patients) and on thalassaemia and pregnancy (suitable for medical practitioners) are available from:

   The NSW Thalassaemia Centre
   Level 5, Queen Mary Building
   Royal Prince Alfred Hospital
   Missenden Road
   Camperdown NSW 2050
   Phone: 02-9550 4844

   The NSW Genetics Education Program
   PO Box 317
   St Leonards NSW 1590
   Phone: 02-9926 7324.

A reference to the laboratory testing of haemoglobinopathies:

Re: MEDICAL CARE


PURPOSE

The purpose of this policy directive is to ensure that all human and animal research conducted within or supported by NSW Health complies with National Health and Medical Research Council (NHMRC) guidelines relating to medical and health research.

MANDATORY REQUIREMENTS

Human and animal research falling under one or more of the following categories must comply with relevant NHMRC guidelines:

- Research conducted at sites under the control of NSW Health;
- Research involving human participants, their tissue or data, and animals accessed through NSW Health;
- Research conducted by NSW Health staff;
- Research conducted by those acting as agents of NSW Health; and
- Research conducted by organisations in receipt of funding from NSW Health.

NSW Health refers to the public health system and Department of Health. Under the Health Services Act 1997, the NSW public health system comprises Area Health Services, statutory health corporations, affiliated health organisations (with respect to their recognised services), and the Director-General with respect to health support and ambulance services.

Compliance with relevant NHMRC guidelines is a condition of NHMRC funding to its recipients under the National Health and Medical Research Council Act 1992 (Cth).

Furthermore, compliance with NHMRC’s Australian code of practice for the care and use of animals for scientific purposes (2004) is a requirement under the Animal Research Regulations 2005 (NSW).

Failure to comply with relevant NHMRC guidelines may result in disciplinary action and withdrawal of NHMRC funding. For an organisation in receipt of NHMRC funding non-compliance may, regardless of the source of funding for a particular project, place at jeopardy all funding it receives from the NHMRC.

Relevant NHMRC guidelines include, but are not limited to, the following (or their replacement) and any new guidelines that are relevant to the conduct of human and animal research:

- National Statement on Ethical Conduct in Human Research (2007);
- Australian Code for the Responsible Conduct for Research (2007); and
- Australian code of practice for the care and use of animals for scientific purposes (2004).

Other guidelines issued by the NHMRC, which may be relevant to particular types of research conducted within or supported by NSW Health are listed below.

103(09/09/10)
IMPLEMENTATION

Chief Executives, Deputy Directors-General and senior executives of the public health system and Department of Health are required to ensure that the requirement under this policy directive is communicated to all individuals involved in human and animal research conducted within or supported by NSW Health.

All staff are required to comply with relevant NHMRC guidelines when conducting human and animal research.

NHMRC guidelines relating to the conduct of medical and health research

- A guide to the use of Australian native mammals in biomedical research - Section 4: Care of individual species (1995) - under review
- Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2007)
- Guidelines for the generation, breeding, care and use of genetically modified and cloned animals for scientific purposes (2007)
- Guidelines to promote the wellbeing of animals used for scientific purposes: The assessment and alleviation of pain and distress in research animals (2008)
- Guidelines under section 95A of the Privacy Act 1988 (Cth) (2001)
- National Statement on Ethical Conduct in Human Research (2007)
- NHMRC Guidelines on the Care of Cats Used for Scientific Purposes (2009)
- NHMRC Guidelines on the Care of Dogs Used for Scientific Purposes (2009)
- NHMRC Guidelines on the Use of Animals for Training Interventional Medical Practitioners and Demonstrating Medical Equipment and Techniques (2009)
- Policy on the care and use of non-human primates for scientific purposes (2003) - under review
- Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research (2003)

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.

PRESSURE INJURY PREVENTION AND MANAGEMENT (PD2014_007)


PURPOSE

The purpose of this policy is to:
1. Minimise the incidence of pressure related injuries to NSW Health patients through adequate risk assessment, risk management and appropriate treatment.
2. Establish a consistent, systematic best-practice approach to pressure injury prevention and management across NSW Health.
3. Support Health Services to comply with the relevant National Safety and Quality Health Service Standards (NSQHSS) in relation to pressure injury prevention and management.
4. Increase the awareness of staff, patients and the public to the importance of pressure injury prevention and management strategies.

MANDATORY REQUIREMENTS

It is the responsibility of each health service to:
1. Adopt best practice guidelines to prevent and manage pressure injuries.
2. Take reasonable steps to ensure appropriate patient care for patients at risk of and with pressure injuries.
3. Ensure they comply with the National Safety and Quality Health Service Standards (NSQHSS).

IMPLEMENTATION

An implementation guide to support this policy will be available early 2014.

Clinical Excellence Commission is responsible for:
• Developing and supporting the implementation of the best practice guidelines and provide advice to health services.
• Reviewing reported patient pressure injury incidents and investigation reports derived from incident management systems (e.g. Incident Information Management System - IIMS), conducting analysis, and disseminating information gained.

Chief Executive of Local Health District/Network (LHD/N) is responsible for:
• Implementing best practice guidelines for the prevention and management of pressure injuries.
• Allocating resources to enable effective prevention and management of pressure injuries, including:
  a. Delegating the day-to-day responsibility of establishing and monitoring the implementation of this policy to the relevant senior managers and/or governance group/committee.
  b. Making appropriate education and training available to all clinical and support staff (e.g. wardspersons and hotel services).

Senior Health Management is responsible for:
• Establishing local clinical practice which follows best practice guidelines, to support safe and effective prevention and management of pressure injuries.
• Making appropriate education and training in pressure injury prevention and management available to staff.
• Encouraging a culture of harm prevention and patient participation in their own care.
12. MEDICAL CARE

- The availability and accessibility of necessary products and equipment to ensure safe and effective patient care for pressure injury prevention and management.
- Developing, implementing and monitoring the product and equipment strategies for the prevention and management of pressure injuries.

LHD/N Clinical Governance Unit is responsible for:
- Supporting and monitoring this policy in line with best practice guidelines for the prevention and management of pressure injury.
- Collecting, collating, analysing and evaluating relevant data to improve patient safety and supporting quality improvement activities.
- Providing feedback to the relevant clinical unit/s validated information on outcomes in relation to this policy.

All NSW Health staff are responsible for:
- Complying with this policy and best practice guidelines to deliver safe clinical practice to prevent and manage pressure injuries.
- Documenting and communicating the pressure injury risk assessment and prevention strategies to all relevant members of the multidisciplinary team.
- Notifying pressure injury incidents in the incident reporting system (e.g. IIMS) in accordance with the NSW Health Incident Management Policy.
- Providing best practice wound management to optimise healing of pressure injuries.
- Providing information and education to patients and/or carers on the risk, prevention and management of pressure injuries.

1 INTRODUCTION

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has recognised pressure injuries as the fifth most costly commonly occurring preventable condition. Many pressure injuries are preventable, and it is recognised that their lengthy healing time has consequences for quality of life including susceptibility to infection, pain, sleep and mood disturbance. They also impact on rehabilitation, mobility and long term quality of life. The prevention of pressure injuries is the responsibility of all staff who work in health regardless of location and position. Everyone from staff, patients and/or carers have a role to play in the prevention of pressure injuries.

This Policy Directive describes best practice in accordance with the ACSQHC, National Safety and Quality Health Service Standards (NSQHSS), Standard 8 - Preventing and Managing Pressure Injuries, 2012.

Evidence indicates the most effective approaches to pressure injury prevention and management include:

a) Timely risk assessment to identify risk factors.

b) Use of a validated risk assessment tool to guide clinical decision making to identify pressure injury risk.

c) The engagement of patients and/or their carers with clinicians.

d) Implementation of a plan of care that is:
   - Tailored to the individual and addresses their risk factors.
   - Supported by systems of care that focus on prevention and optimise healing.
   - Multifactorial and interdisciplinary.
   - Delivered by staff with appropriate skills and knowledge who use appropriate prevention techniques and materials.
   - Inclusive of access to appropriate products and equipment.
e) Systems to monitor and analyse pressure injury data, and to implement relevant quality improvement activities.

Despite all prevention strategies being implemented to reduce the risk, pressure injuries may still occur in some patients, e.g. patients with skin failure in end stages of life as part of the dying process.

Appendix 10.1 provides a clinical practice flowchart for the prevention and management of pressure injuries for inpatients.

Appendix 10.2 provides a clinical practice flowchart for the prevention and management of pressure injuries for Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities.

Appendix 10.3 provides a clinical practice flowchart for the prevention and management of pressure injuries for non-inpatients (community nursing services, ambulatory facilities or clinics).

1.1 NSQHSS, Standard 8 – Preventing and Managing Pressure Injuries

The National Safety and Quality Health Service Standards (NSQHSS) were introduced nationally from 1 January 2013. Standard 8 describes the systems and strategies to prevent patients developing pressure injuries, and management when pressure injuries occur.


Standard 8 requires that:
1) Health service organisations have governance structures and systems in place for the prevention and management of pressure injuries.
2) Patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated.
3) Patients who have pressure injuries are managed according to best practice guidelines.
4) Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.²

1.2 Key definitions

**Active support surface**
A powered support surface that produces alternating pressure through mechanical means, thereby providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternation 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 bony projection.³
Carers
Carers are people who provide unpaid 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. Carers include parents and guardians caring for
children.

Classification of pressure injury
The classification of pressure injury is based on the National Pressure Ulcer Advisory Panel (NPUAP),
European Pressure Ulcer Advisory Panel (EPUAP) cited in the Australian Wound Management
Association Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure
Injury, 2012. See 10.2 for the description of the pressure injury classification system.

Must
Indicates a mandatory action.

NSW public health facility
For the purpose of this Policy, a NSW public health facility is any clinical unit or service that delivers
healthcare services. Health facilities include hospitals, multi-purpose services, emergency services,
ambulatory care services, Aboriginal Medical Services and community health services.

Pain
In the context of this policy, pain refers to an unpleasant sensory and emotional experience associated
with a pressure injury. Patients may use different words to describe pain including discomfort, distress
and agony.

Patient
Refers to inpatient, resident, client or any person that the health service provider owes a duty of care to
in respect in the provision of health services. Patient includes adults, paediatrics, infants and
neonates.

Pressure Injury
A localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of
pressure, shear and/or friction, or a combination of these factors.

Pressure Injury Risk Assessment scale/tool
Formal scale or score used to help determine the degree of pressure injury risk. The tool must be
appropriate for the patient population in accordance with best practice guidelines e.g. Waterlow,
Braden, Norton for adult population and Braden Q or Adapted Glamorgan for neonatal/infant and
paediatric population.

Pressure Injury Risk Screening
For the purpose of this Policy, screening is a process to identify those individuals who may benefit by
further assessment to reduce pressure injury risk. Those individuals include patients who are not
necessarily perceived as at risk of, or already affected by pressure injury.

Should
Indicates a recommended action that should be followed unless there are sound reasons for taking a
different course of action.
Skin assessment
General examination of the skin. Skin assessment includes examination of the entire skin surface to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised heat, oedema, induration and skin breakdown. Check the skin beneath devices, prosthesis and dressings when practical.

Staff
For the purpose of this Policy staff refers to any person working within the NSW Health system including contractors, students and volunteers.

Standard mattress
The definition of a “standard mattress” is variable, and may change between facilities and over time. High standard specification foam mattress that meets Australian Standards - classified as Type N according to Australian Standards (AS2281-1993).

Two part pressure injury assessment
The pressure injury risk assessment consists of two parts.

   a) Use a validated pressure injury risk assessment tool/process appropriate for the patient population in accordance with best practice guidelines, and

   b) Skin assessment that is based on visual inspection.

2 GOVERNANCE
A senior manager and/or a governance group/committee is responsible for monitoring compliance with the health service pressure injury policies, procedures and protocols, and ensuring there are systems in place to monitor and analyse pressure injury data, and conducting relevant quality improvement activities.

3 CLINICAL PRACTICE – PREVENTING AND MANAGING PRESSURE INJURY
3.1 Pressure Injury Risk
All LHD/Networks must take reasonable steps to have pressure injury risk screening and assessment processes in place appropriate for their patient populations.

   As a minimum, risk screening of all patients must consider the three primary predictors of pressure injury development:

   1) Mobility/activity which can be restricted by physical, excessive weight, sensory, cognitive, substance-related, affect and motivational problems.

   2) Factors influencing perfusion e.g. diabetes, peripheral vascular disease, poor venous return.

   3) Skin/pressure injury status:

      a) General skin status relating to factors which may make the skin more vulnerable to pressure injury development.

      b) Pressure injury status including stage/grade 1 equivalent pressure injury, existing pressure injuries, and previous pressure injuries.

If a patient has a history of pressure injury or pressure injury is present they will be deemed at high risk.

A higher/lower level of risk may be determined for some patients based on the two-part risk assessment with consideration of co-morbidities and environmental factors informing clinical decision making.

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### 3.2 Risk Assessment

As a minimum, all patients must undergo initial risk screening to inform the clinical risk assessment decision making process.

Risk assessment of patients using a validated tool is recommended and does not require a separate screening process.

The pressure injury risk assessment consists of two parts:

a) Use a validated pressure injury risk assessment tool/process appropriate for the patient population in accordance with best practice guidelines, and

b) Skin assessment that is based on visual inspection.

The following table outlines risk assessment requirements based on patient care setting.

<table>
<thead>
<tr>
<th>Inpatients</th>
<th>Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities</th>
<th>Non-inpatients (community nursing services, ambulatory facilities or clinics)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First pressure injury screen or assessment</strong> to guide clinical decision making</td>
<td>Assessed within 8 hours of presentation to the health facility by health staff skilled in using the risk assessment tools or process appropriate for the patient population.</td>
<td>Assessed at the first presentation by health staff skilled in using the risk assessment tools or process appropriate for the patient population.</td>
</tr>
</tbody>
</table>

**Patient at risk of developing a pressure injury** the two part assessment to be repeated

- Daily as a minimum and:
  - If there is a change to health status or mobility
  - Pre-operatively, and as soon as feasible after surgery
  - If a pressure injury develops

- Weekly as a minimum and:
  - If there is a change to health status or mobility
  - On transfer of care
  - If a pressure injury develops

**Patient not at risk or low risk** the two part screen or assessment to be repeated

- Weekly as a minimum and:
  - If there is a change to health status or mobility
  - On transfer of care
  - If a pressure injury develops

- Monthly as a minimum and:
  - If there is a change to health status or mobility
  - On transfer of care
  - If a pressure injury develops

**Pressure injuries present** - skin inspection and pain assessment

- Additionally should occur at each patient care intervention and/or positioning change.

- Additionaly should occur at each patient care intervention and/or positioning change.

- Additionally should occur at each patient care intervention and/or positioning change.

*NB: Community nursing services that are not the primary care provider for patients who are identified at risk must provide education to the patient and/or carer or other care provider so that they understand the level of risk and their responsibility for ongoing skin assessment monitoring.

NB: Non-inpatient spinal cord injury patients are at high risk however may have little change in health status and have prevention strategies in place. Patients may have reassessments completed every three months or if there is a change in health status or mobility.
3.3 Prevention Strategies

1) All patients identified as being at risk (with or without existing pressure injury) should have:
   a) Best practice prevention strategies implemented as a priority within two hours of the assessment.\(^3\)
   b) For inpatients pressure injury prevention strategies reviewed for their effectiveness:
      • At least four-hourly
      • At every patient care intervention
      • At handover
      • On transfer of care episode.
   c) Best practice strategies reviewed as a minimum at each community nursing visit.

2) Prevention strategies that includes:
   a) Repositioning and/or mobilising routine, including appropriate manual task techniques.
   b) Education of all patients/personal carers on regular repositioning and pressure relieving strategies.
   c) Management and monitoring of pain.
   d) Provision of appropriate products and equipment; support surfaces for beds, trolleys/ wheelchairs, chairs, aids, equipment/devices, according to the patient’s risk assessment.
   e) Reduction of pressure, friction, and/or shear through:
      • Use of active support surfaces/positioning aids during care, including theatre, intensive care and emergency departments.
      • Use of dressing products (note dressing products do not reduce pressure).
      • Appropriate hazardous manual task techniques.
      • Correct fitting, removal and checking of pressure from devices/orthoses/anti-embolic stockings, casts and other clinical equipment.
   f) Skin protection and moisture reduction.
   g) Continence management.
   h) Adequate nutrition and hydration, including high protein supplements where indicated (with dietitian supervision if available).\(^8\)
   i) Referral to health disciplines as clinically indicated for assessment and treatment.

3) Contra-indications for active support surface.

**NB:** In the case of the patient with an unstable spinal or unstable pelvic fracture, the active support surface is contra-indicated. This is regardless of the patient being identified as at risk for the development of pressure injury or if they have an existing pressure injury. The patient with an unstable spinal or unstable pelvic fracture should stay on the appropriate non-powered mattress and receive regular pressure relief for their condition. Adequate pain relief should be provided.

3.4 Care Planning and Documentation

1) The care plan must be documented and discussed with all patients and/or carers who are assessed as at risk, irrespective of degree of risk. This plan must be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and as soon as possible (within 24 hours) of initial home visit for community services. Care plans are to include strategies aimed at:
   a) Preventing the development of pressure injury/injuries.
   b) Optimising healing and preventing complications of existing pressure injury/injuries.
2) The care plan must include:
   a) How the patient and/or carer are involved in the pressure injury prevention care planning process.
   b) Input from the multidisciplinary team about additional assessment, recommendations and treatment.
   c) Strategies for:
      • Pressure injury risk and skin assessment, monitoring and reassessment.
      • Mobilising to maintain function.
      • Position changes to relieve pressure, avoiding shear and friction.
      • Skin hygiene.
      • Pain assessment and management.
      • Optimising hydration and nutrition, including supplementation and feeding assistance, if required.
      • Promotion of continence and management of incontinence
      • Wound management.
      • Oedema management
   d) Strategies for protection of skin from moisture, high temperature, skin irritants and medical devices eg. gastrostomy and enteral feeding leakage, friction and skin trauma.
   e) Equipment, devices; manual task techniques to minimise wound pain, eliminate or reduce pressure, friction, shear and to protect existing pressure injury.
   f) Arrangements and planning for transfer of care.

3.5 Managing Pressure Injuries

1) **Prevention** - All patients with a pressure injury are at a high risk of the injury worsening, or developing other pressure injuries, and therefore:
   a) Where possible, prevention strategies must be implemented immediately, and documented. Any exceptions and the rationale must be documented.
   b) The two part pressure injury assessment and pain assessment must be conducted and care planned.

2) **Assessment** of pressure injuries should occur when a pressure injury is identified, or on transfer of care at next dressing change.

   Appendix 10.4 provides the description of the pressure injury classification system.³

3) **Wound Management** is provided by or supervised by staff with skills, knowledge and equipment to provide treatments in accordance with best practice.

4) **Document** the pressure injury in the patient health care record e.g. on a wound chart or care plan or in the Electronic Medical Record. Notify the pressure injury in the incident reporting and management system e.g. NSW Health Incident Information Management System (IIMS).

5) **Wound reassessment** should occur at least weekly. Wound management should be reviewed if not healing at an optimal rate, i.e. 25% reduction in four weeks.³

6) **Consultations** should occur in a timely fashion with medical or other health disciplines for their assessment and contribution, planning, and management.

7) **Pain** should be assessed in accordance with best practice guidelines at least every shift/home visit using a validated tool.

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8) **Nutritional management** provided in accordance with NSW Health Nutrition Care Policy.

### 3.6 Transfer of Care

Transfer of care for patients with an existing pressure injury, or at risk of developing a pressure injury, requires timely communication with doctors, next health care providers, patients and/or carers, other community or residential services, equipment suppliers, and appropriate allied health clinicians. Communication should include:

1) The goal of treatment
2) Classification and progress of pressure injury
3) Wound management
4) Prevention strategies
5) Follow-up care required.

### 4 RESOURCES FOR PREVENTING AND MANAGING PRESSURE INJURY

All LHDs/Networks must take reasonable steps to have:

1) Systems in place so that both adequate expertise and resources, products and equipment, are readily available and accessible to provide best practice in pressure injury prevention and wound management.

2) All pressure injury prevention equipment must be:
   a) Used and maintained in accordance with manufacturers’ instructions.
   b) Used and maintained in accordance with NSW Health Infection Control Policies.
   c) Used and maintained in accordance with NSW Health Workplace Health & Safety.
   d) Purchased in accordance with NSW Health Procurement Guidelines.

### 5 COMMUNICATION WITH PATIENTS AND/OR CARERS

All LHDs/Networks must take reasonable steps to have:

1) Systems in place to educate patients and/or carers of the risks, prevention strategies and management of pressure injuries.

2) Information, including written information and other resources, appropriate to the patient population.

3) Education to patients and/or carers by staff following the components of and/or using the CEC Pressure Injury Prevention Patient Information flyer which will be available on the CEC Pressure Injury Prevention Project webpage.

### 6 EDUCATION AND TRAINING

All LHDs/Networks must take reasonable steps to have:

1) Orientation and ongoing training programs related to pressure injury prevention and management available to support staff in the delivery of quality patient care.

2) All clinical staff involved in direct patient care undertake training in pressure injury prevention and management.

   As a minimum, this training should use the comprehensive pressure injury prevention and management education and training program provided by NSW Health.

3) Training for:
   a) Clinical coders on pressure injury classification
   b) Auditors and surveyors who conduct pressure injury audits and point prevalence surveys.

4) Systems in place to monitor education resources and records of attendance at training by staff on preventing and managing pressure injuries.

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7 REPORTING

7.1 Pressure Injury Incidents

All LHDs/Networks must take reasonable steps to ensure:

1) All pressure injuries are notified in the local incident reporting and management system e.g. NSW Health Incident Information Management System (IIMS) and reported to the appropriate medical team.

    This includes those pressure injuries present on admission, new pressure injuries, and those that have significantly deteriorated (progressed to the next stage of pressure injury) since admission.

2) A Severity Assessment Code (SAC) 2 rating is applied to health service acquired (i.e. local site) pressure injury of Stage 3, Stage 4, suspected deep tissue or unstageable as the length of stay may increase, there is a likelihood of disfigurement and additional treatment is required.

3) All incidents are investigated, recommendations reported and monitored in accordance with the NSW Health Policy on incident management.

4) The care plan is reviewed by the multidisciplinary care team, within twenty four hours if possible, if a pressure injury develops, or an existing pressure injury significantly deteriorates (progresses to the next stage of pressure injury).

5) When a pressure injury occurs during care, the patient and/or carer are informed in accordance with NSW Health Open Disclosure Policy.

7.2 Auditing and reporting

All LHDs/Networks must take reasonable steps to have systems in place to:

1) Identify pressure injuries that develop during episodes of care for which they are responsible. Reports should be reviewed regularly, preferably quarterly and have engagement from district clinical governance unit.

2) Ensure pressure injury data are communicated to executive sponsors and those responsible for governance of this aspect of clinical care.

3) Analyse pressure injury data to inform care, quality improvement and monitor progress. These requirements are ideally met by:
   a) An annual point prevalence survey (combining audit of documentation with patient assessment using validated tools and supported by a training program for surveyors).
   b) Biannual incidence reports derived from routinely collected data (patient activity data and incidence data), supported by a training program for coders.

4) Measure process data (risk assessment/risk assessment outcomes/preventive care prescribed/delivered) and outcomes data (pressure injury incidence per bed days and annual point prevalence).
REFERENCES

6) NSW Department of Health, Patient Matters, Part 1, Section 9.

RELATED LITERATURES, DOCUMENTS AND RESOURCES

1) Australian Charter of Healthcare Rights.
2) Getting Started Kit: Prevent Pressure Ulcers, How-to Guide 2008. 5 Million Lives Campaign. Institute for Healthcare Improvement; Cambridge, MA
3) NSW Procurement Guidelines
4) The related NSW Health policies and guideline (i.e. incident management, nutrient care, open disclosure, infection control and workplace health and safety) can be found at: http://www.health.nsw.gov.au/policies/pages/default.aspx
5) Other (NSQHS) Standards underpinned this policy are Standard 1 (Governance for Safety and Quality in Health Service Organisations) and Standard 2 (Partnering with Consumers) which can be found at: http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/
6) Pressure Area Care: Management 2012. The Joanna Briggs Institute
8) Pressure Ulcers: Prevention and Management 2011. The Joanna Briggs Institute
12. MEDICAL CARE

10 APPENDIX

10.1 Clinical practice flowchart for the prevention and management of pressure injuries for inpatients.

Inpatient Pressure Injury (PI) Prevention and Management Flowchart

Within 8 hours of presentation, two part PI assessment/screening process to be completed to guide clinical decision making.

a) Use a validated PI risk assessment tool/process appropriate for the patient population
b) Skin assessment based on visual inspection

Does the patient have existing PI?

Reassess:
- If there is a change to health status or mobility
- On transfer of care
- If a PI develops
- At least weekly

BOX A - Reassess:
Daily PI risk assessment using the two part pressure injury assessment and:
- If there is a change to health status or mobility
- Pre-operatively, and repeated as soon as possible after surgery
- On transfer of care
- If a pressure injury develops

Develop the care plan in consultation with the patient and/or carer
- Implement prevention strategies appropriate to the level of risk e.g. equipment needs, repositioning
- Make referrals as appropriate
- Detailed documentation in patient health care record
- Communicate PI risk and management at handover and transfer of care
Clinical practice flowchart for the prevention and management of pressure injuries for Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities

**Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities Pressure Injury (PI) Prevention and Management Flowchart**

**Patient presents to facility**

Within 8 hours of presentation, two part PI assessment/screening process to be completed to guide clinical decision making.

a) Use a validated PI risk assessment tool/process appropriate for the patient population

b) Skin assessment based on visual inspection

Does the patient have existing PI?

- Yes
  - Reassess as per **BOX A**
  - Complete an IIMS Notification for each PI using the NPUAP/EPUAP classification system
  - For patients with PI, skin inspection and pain assessment should occur at each patient care intervention and/or each positioning change

- No

Is the Patient ‘At Risk’?

- No
  - Reassess:
    - If there is a change to health status or mobility
    - On transfer of care
    - If a PI develops
  - At least monthly

- Yes

**BOX A - Reassess:**
Weekly PI risk assessment using the two part pressure injury assessment and:

- If there is a change to health status or mobility
- On transfer of care
- If a PI develops

- Develop the care plan in consultation with the patient and/or carer
- Implement prevention strategies appropriate to the level of risk e.g. equipment needs, repositioning
- Make referrals as appropriate
- Detailed documentation in patient health care record
- Communicate PI risk and management at handover and transfer of care
10.3 Clinical practice flowchart for the prevention and management of pressure injuries for non-inpatient (community) nursing services, ambulatory facilities or clinics

Non-inpatient (community) nursing services, ambulatory facilities or clinics
Pressure Injury (PI) Prevention and Management Flowchart

Patients first presentation

Assessed at the first presentation, two part PI assessment/screening process to be completed to guide clinical decision making.

a) Use a validated PI risk assessment tool/process appropriate for the patient population
b) Skin assessment based on visual inspection

Does the patient have existing PI?

Yes

Reassess as per BOX A
- Complete an IIMS Notification for each PI using the NPUAP/EPUAP classification system
- For patients with PI, skin inspection and pain assessment should occur at each patient care intervention and/or each positioning change

No

Is the Patient ‘At Risk’?

Yes

Reassess:
- If there is a change to health status or mobility
- On transfer of care
- If a PI develops

No

Box A - Reassess:
Monthly PI risk assessment using the two part pressure injury assessment and:
- If there is a change to health status or mobility
- On transfer of care
- If a pressure injury develops

- Develop the care plan in consultation with the patient and/or carer
- Implement prevention strategies appropriate to the level of risk e.g. equipment needs, repositioning
- Make referrals as appropriate
- Detailed documentation in patient health care record
- Communicate PI risk and management at handover and transfer of care

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10.4 Pressure injury classification system

<table>
<thead>
<tr>
<th>Stage I pressure injury: non-blanchable erythema</th>
<th>Stage II pressure injury: partial thickness skin loss</th>
<th>Stage III pressure injury: full thickness skin loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Damp or wet skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warm or cooler compared to adjacent tissue. May be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk).</td>
<td>- Partial thickness loss of dermis presenting as a shallow, open wound with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). Stage III PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.</td>
<td>- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.</td>
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Stage IV pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.

Unstageable pressure injury: depth unknown

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable, dry, adherent, intact without erythema or fluctuance eschar on the heels serves as the body’s natural biological cover and should not be removed.

Suspected deep tissue injury: depth unknown

- Purple or maroon localized area or discoulored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blisters over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

All 3D graphics designed by Jared Gittos, Geo Interactive, http://www.geointeractive.com.au
Photos stage 1, 4, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy X. Cordier, Silver Chain, Used with permission.

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:
12. MEDICAL CARE

- 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 coordinators, 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.
12. MEDICAL CARE

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.
12. MEDICAL CARE

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.
12. MEDICAL CARE

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.
12. MEDICAL CARE

- 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.
12. MEDICAL CARE

- 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

- 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
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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/11 – 10/01/11</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>10/01/11 – 13/01/11</td>
<td>Acute</td>
</tr>
<tr>
<td>13/01/11 – 30/01/11</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
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<tbody>
<tr>
<td>01/01/11 – 30/01/11</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/02/12 – 03/03/12</td>
<td>Palliative Care</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/04/12 – 10/05/12</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>10/05/12 – 11/05/12</td>
<td>Acute Care</td>
</tr>
<tr>
<td>11/05/12 – 03/06/12</td>
<td>Palliative Care</td>
</tr>
</tbody>
</table>

### 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 or treatment goal of the episode did not change.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/11 – 07/01/11</td>
<td>Acute</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/11 – 10/01/11</td>
<td>Acute</td>
</tr>
<tr>
<td>10/01/11 – 30/01/11</td>
<td>Geriatric Evaluation and Management (GEM)</td>
</tr>
</tbody>
</table>
12. MEDICAL CARE

(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 whilst 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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>26/02/11 – 14/03/11</td>
<td>Acute</td>
</tr>
<tr>
<td>14/03/11 – 21/03/11</td>
<td>Maintenance</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/09/12 – 18/09/12</td>
<td>Acute</td>
</tr>
<tr>
<td>18/09/12 – 05/10/12</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/07/16 – 31/08/16</td>
<td>Mental Health</td>
</tr>
</tbody>
</table>

(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.
12. MEDICAL CARE

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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/07/16 – 30/07/16</td>
<td>Acute</td>
</tr>
<tr>
<td>30/07/16 – 16/08/16</td>
<td>Mental Health</td>
</tr>
<tr>
<td>16/08/16 – 27/09/16</td>
<td>Acute</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/08/16 – 29/09/16</td>
<td>Mental Health</td>
</tr>
<tr>
<td>29/09/16 – 30/09/16</td>
<td>Acute</td>
</tr>
<tr>
<td>30/09/16 – 22/03/17</td>
<td>Mental Health</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/16 – 17/11/16</td>
<td>Mental Health</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/08/16 – 15/08/16</td>
<td>Acute</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/10/16 – 01/11/16</td>
<td>Acute</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/02/16 – 16/03/16</td>
<td>Acute</td>
</tr>
<tr>
<td>16/03/16 – 15/06/16</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>15/06/16 – 19/07/16</td>
<td>Acute</td>
</tr>
<tr>
<td>19/07/16 – 12/12/16</td>
<td>Mental Health</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/11 – 13/03/11</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/11 – 31/03/11</td>
<td>Palliative Care</td>
</tr>
</tbody>
</table>
(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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/12 – 10/08/12</td>
<td>Acute Care</td>
</tr>
<tr>
<td>10/08/12 – 17/10/12</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care type</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/12 – 14/09/12</td>
<td>Acute Care</td>
</tr>
<tr>
<td>14/09/12 – 07/10/12</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Episode Date Range</th>
<th>Care type</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/12 – 06/08/12</td>
<td>Acute Care</td>
</tr>
<tr>
<td>06/08/12 – 14/09/12</td>
<td>Maintenance</td>
</tr>
<tr>
<td>14/09/12 – 17/10/12</td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>
Appendix 2: Definitions of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Certificate</td>
<td>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.</td>
</tr>
<tr>
<td>AMO</td>
<td>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.</td>
</tr>
<tr>
<td>Other Authorised Clinician</td>
<td>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.</td>
</tr>
<tr>
<td>APDC</td>
<td>Admitted Patient Data Collection: the framework for mandatory data reporting for all admitted patients within New South Wales.</td>
</tr>
<tr>
<td>Clinical Coding</td>
<td>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.</td>
</tr>
<tr>
<td>Clinician</td>
<td>Medical, nursing and allied health staff involved in patient care.</td>
</tr>
<tr>
<td>AR-DRGs</td>
<td>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.</td>
</tr>
<tr>
<td>Episode of Care</td>
<td>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)</td>
</tr>
</tbody>
</table>
### 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 Change

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](http://meteor.aihw.gov.au/content/index.phtml/itemId/491557)

### 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.
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](http://meteor.aihw.gov.au/content/index.phtml/itemId/327254)
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.

Contents

1. Introduction
2. Key components
3. Guiding principles
4. Patient expectations
5. Roles and responsibilities
6. Policy and standards
7. Clinical Governance Units
8. Incident management
9. Clinical Excellence Commission
10. Quality System Assessments (QSA)
11. Key policy directives and related documents supporting the program
12. Definition of terms

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.
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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
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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

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 health 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
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- 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**

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.

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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.
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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.
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.

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.
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Incident\textsuperscript{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.

\textsuperscript{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 months¹.

CKD is responsible for a substantial burden of illness and premature death with:
• 1 in 3 Australians at risk of developing the disease²;
• 1 in 7 Australians over the age of 25 years having at least one clinical indicator of existing CKD³;
• the disease being the 7th leading cause of death⁴;

87(15/04/10)
• 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%; and
• proteinuric, which is a clinical marker for CKD, also indicative of an increased risk of cardiovascular disease.

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.

<table>
<thead>
<tr>
<th>Test for protein</th>
<th>Abnormal &gt; 30mg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient without diabetes</td>
<td></td>
</tr>
<tr>
<td>Patient with diabetes</td>
<td>Test for albumin</td>
</tr>
<tr>
<td></td>
<td>Abnormal &gt; 3mg/dL</td>
</tr>
<tr>
<td></td>
<td>(albumin specific dipstick)</td>
</tr>
</tbody>
</table>

• **Blood pressure assessment**

Hypertension can contribute to the development of CKD.

<table>
<thead>
<tr>
<th>Abnormal result</th>
<th>&gt;140/&gt;90 mmHg</th>
</tr>
</thead>
</table>

• **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).

<table>
<thead>
<tr>
<th>Abnormal result</th>
<th>&lt; 60 mL/min/1.73m²</th>
</tr>
</thead>
</table>

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

   http://www.heartfoundation.org.au/Professional_Information/Clinical_Practice/Hypertension/Pages/default.aspx
APPENDIX 1: Algorithm for CKD screen

Algorithm for CKD screen

<table>
<thead>
<tr>
<th>STEP 1. Identification of high risk patient</th>
<th>Not at risk</th>
<th>NO Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient at risk of CKD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2. Kidney Health Check</th>
<th>No abnormality</th>
<th>NO Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABNORMAL result requires Action</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STEP 3:
A) Inform patient of risk of Chronic Kidney Disease. Recommend follow-up with usual General Practitioner or Nurse Practitioner (Form Letter suggested)
B) Send information regarding identified abnormalities to patient’s General Practitioner or Nurse Practitioner (Form Letter suggested)

<table>
<thead>
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<th>STEP 2: Kidney Health Check comprises:</th>
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<td>1. Cardiovascular Disease</td>
<td>I. Dipstick analysis for protein.</td>
</tr>
<tr>
<td>2. Diabetes</td>
<td>II. &gt; 30 mg/dL is abnormal</td>
</tr>
<tr>
<td>3. Aboriginal and Torres Strait Islander peoples</td>
<td>III. Check Blood pressure.</td>
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<tr>
<td>4. Tobacco Smokers</td>
<td>IV. &gt;140/&gt;90 mmHg is abnormal</td>
</tr>
<tr>
<td>5. Obesity</td>
<td>V. Check eGFR (estimated from serum creatinine).</td>
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<tr>
<td>6. Hypertension</td>
<td>&lt; 60 mL/min/1.73m² is abnormal</td>
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<tr>
<td>7. Age over 50 years</td>
<td></td>
</tr>
<tr>
<td>8. Family history of Kidney Disease</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2: Sample Letter Patients

APPENDIX 2: SAMPLE LETTER PATIENTS (Copy to GP or Nurse Practitioner)

[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

[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:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Abnormal Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP 1 Dipstick analysis for protein</td>
<td>Greater than 30 mg/dL</td>
</tr>
<tr>
<td>STEP 2 Check blood pressure</td>
<td>Greater than 140/90</td>
</tr>
<tr>
<td>STEP 3 Check eGFR (estimated from serum creatinine)</td>
<td>Less than 60mL/min</td>
</tr>
</tbody>
</table>

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]
INTRODUCTION

Advance care planning refers to the process of preparing for likely scenarios near the end of life and usually includes assessment of, and dialogue about, a person’s understanding of their medical history and condition, values, preferences, and personal and family resources. An advance care directive (ACD), sometimes called a ‘living will’, is a document that describes one’s future preferences for medical treatment in anticipation of a time when one is unable to express those preferences because of illness or injury. Completion of an ACD ideally should be one component of the broader advance care planning process. This document was guided by a literature search conducted in March 2003 (see Search strategy).
Why is advance care planning important?

Improving advance care planning for end of life care is likely to become an increasingly important quality of care issue. There is a growing societal expectation that one’s wishes for medical treatment will be respected at the end of life if progressive disease has taken away decision-making capacity. At the same time there is a need for improved mechanisms whereby an incompetent person’s prior wishes about end of life care can be known and considered at the time that critical treatment decisions need to be made. This is likely to become even more urgent in the next decade as a large predicted increase in the number of people with dementia and cognitive disability results in greater numbers with loss of capacity to determine their own medical treatment.

In addition, there appears to be significant variation in the ways that health care professionals currently approach situations where the use of life-sustaining treatment is being considered. There are concerns that such treatments are being used in terminally ill patients resulting in over-zealous treatment or, less frequently, inappropriate under-treatment. Advance care planning may allow for use of life-sustaining treatments in ways that are more consistent with the individual’s choice and priorities at the end of life.

Although family or others close to the person who becomes incompetent usually become involved in making treatment decisions, they are often not able to easily judge the person’s wishes without prior discussions taking place with that person. Families and others often shoulder significant burdens in such situations. Reflective discussion in a non-crisis situation can prepare all involved and may diminish any guilt or concerns over later decisions to limit treatment.

AIMS OF ADVANCE CARE PLANNING

Effective and thorough advance care planning aims to achieve the following:

1. Encouraging conversation about what are the most important things for someone as they approach death, and specifically the place of life-sustaining treatment in relation to that.

2. Achieving a sense of control for the person as their death approaches, and a means of mapping a personal approach to their care during the terminal phase by explicitly considering the person’s values and goals. It is nonetheless important not to focus solely on medical treatment preferences as this may result in avoiding thinking about the person’s goals, values, priorities and expectations during the final phase of their life.

3. Engaging others in decision-making according to the person’s wishes. An ACD can be a private, individual process, and does not have to involve family members or close friends. However, evidence suggests that many people would like selected members of their family or friends to be involved, in which case the ACD is not only an instruction to health care workers but also a document guiding family and friends who may be called upon to help make decisions. The process of advance care planning may provide opportunity for talking about dying wishes, settling interpersonal differences, may prevent later conflict over substitute decisions about treatment, and improve communication amongst family members. The autonomy of the patient is enhanced whether the locus of control is with the individual alone, or the individual plus their family.

4. Providing flexibility in how treatment decisions are made. Advance care planning is a continuum of treatment choices that may be reviewed as the person’s condition, and possibly preferences, change. The person may defer at any time to family or others close to them to decide on their behalf. In some cultural groups, such as some Aboriginal or Torres Strait Islander communities, the latter is the preferred way of making decisions about care during the dying phase.
Advance care planning and the use of advance care directives are always optional and some individuals will prefer not to make decisions for the future, but rather make decisions about their medical treatment at the time the need arises.

BARRIERS TO ADVANCE CARE PLANNING

A number of barriers or impediments to effective advance care planning may exist in the health care sector and wider community. These include:

1. Time constraints - advance care planning is perceived as onerous with necessarily lengthy discussions with patients and their families.
2. Discomfort in talking about death on the part of the patient, family, or health professionals.
3. Patient perceptions about who should or does control medical decision-making. Where people prefer their doctors to lead decision-making, they may be less inclined or willing to engage in this process.
4. Fears about being unable to change one’s mind once treatment preferences are documented.
5. Patients and families may not know about the availability of advance care directives, or the medical implications of their documented preferences.
6. Health professionals may not appreciate the legal standing of advance directives, or the legal implications of acting on treatment limitation decisions generally.

HOW AN ADVANCED CARE DIRECTIVE (ACD) FUNCTIONS AS ONE COMPONENT WITHIN THE PROCESS

Advance care planning may or may not involve the completion of an ACD. Where an ACD is used the following comments are applicable:

1. Different contexts An ACD may be made in a wide variety of circumstances. These may include the person who is healthy but wants to plan their future medical care, the chronically ill person who anticipates deterioration in their condition, or someone who is terminally ill and faces more immediate treatment choices.
2. Authority - An advance care directive that complies with the requirements set out in this document is legally binding in NSW, and functions as an extension of the common law right to determine one’s own medical treatment. A failure to comply with such an advance care directive refusing a particular treatment may result in the health professional incurring criminal or civil liability for providing that treatment. See 5.3 and 5.4 for discussion of documentation standards for ACDs.
3. A tool for discussion - Although the ACD has legal authority, its use in practice should be thought of as an assisting device: an education tool, a ‘worksheet’, a framework for discussion, or a way of documenting preferences when substitute decision-makers may later be unsure or disagree. Its completion is not the only goal, and effective advance care planning does not necessarily require the completion of a directive. The person may instead choose to verbally communicate specific wishes to treatment decisions on their behalf in the event of their incompetence.
4. Scope - An ACD can usefully document:
   • Medical treatment preferences, including those influenced by religious or other values and beliefs.
Particular conditions or states that the person would find unacceptable should these be the likely result of applying life-sustaining treatment, for example severe brain injury with no capacity to communicate or self-care.

How far treatment should go when the patient’s condition is ‘terminal’, ‘incurable’ or ‘irreversible’ (depending on terminology used in specific forms).

The wishes of someone without relatives to act as their ‘person responsible’ in the event they became incompetent, or where there is no-one that person would want to make such decisions on their behalf.

A nominated substitute decision-maker that the treating clinician may seek out to discuss treatment decisions.

Other non-medical aspects of care that are important to the person during their dying phase.

Although the content of an ACD usually stipulates treatment limitation preferences, this should never be assumed as some individuals may indicate they want full measures to prolong their life.

Enduring guardianship and ACDs - Two main elements to advance care planning are recognised: the written directive and the appointment of a substitute decision-maker. In NSW, the Guardianship Act provides for a person to make their wishes known about medical treatment through appointment of an ‘enduring guardian’ who acts as their substitute decision-maker. A person may choose to prepare written instructions as to their future care in the enduring guardianship appointment document. Where a person has made both a separate ACD and appointed an enduring guardian, an examination of both documents is required. See 6.6 and 6.7 for further discussion.

BEST PRACTICE RECOMMENDATIONS

Starting the discussion process

A key factor in effective advance care planning is starting up and continuing discussions about what the person finds important at the end of life. These wishes usually focus on medical treatment preferences but may also include other matters, such as spiritual or interpersonal issues. The patient, their family and health professionals should expect ongoing consultation in order to allow the person to make their choices known over time as death approaches.

Suggest that the person involve family members, such as the ‘person responsible’ or others close to them, so as to minimise the decision-making burden and thoroughly understand their wishes. The question is ‘How can you guide those closest to you to make the best decisions for you if you are no longer able to do so yourself?’ The family’s role may initially involve only listening, taking notes or asking questions for clarification. The person should at least inform them of their wishes and the existence of an advance directive (where one exists). It is likely that the family will be involved in some way in the decision-making process if the person becomes incompetent, whether they have an ACD or not.

Some people will not have an eligible substitute decision-maker or ‘person responsible’ (see Glossary), or may prefer that no-one makes particular medical decisions on their behalf. Encouraging the person to consider making a more detailed directive in these circumstances may be appropriate.

Where a health professional conducts discussions about end of life care, it is best if they are someone who is identified as significantly involved in active care of the person and can discuss prognostic information in clear terms. It is recognised that pastoral care workers or clergy also frequently conduct these discussions but, in order for it to be useful, such information needs to be communicated to the treatment team; therefore a multidisciplinary approach to advance care planning is recommended.
Many individuals welcome the opportunity to discuss end of life care in advance, when raised by doctors or other health professionals. Some people will raise these issues themselves, but many will usually expect health professionals to initiate these discussions. Not all, however, will choose to complete an ACD.

Opportunities for opening these discussions may include when the person or their family enquires about whether palliative care is appropriate, when a person has recently been hospitalised for severe progressive illness or with repeat recent admissions, when a person says they want to forego recommended life-sustaining treatment, or when they express a wish to die.

Advance care planning is most easily accomplished during stable health or after adjustment to a new illness has occurred. A non-threatening environment like an outpatient or GP’s clinic may be preferable.

Begin by enquiring how familiar the person is with advance care planning and explain the goals: that is, to plan for the potential loss of their capacity to make decisions, either temporarily or permanently, and to ensure they are protected from either unwanted or under-treatment.

An understanding of the person’s goals and values may be elicited through asking about past experiences with illness, either their own or others, describing possible scenarios, or potentially by asking them if they would like to write down in a letter how such scenarios should be handled. Such a letter may be a tool for developing a formal ACD, if the person subsequently chooses to prepare one.

The person usually needs information to understand the meaning of the types of clinical scenarios that may arise in their situation, and the benefits and burdens of various treatment options. Key medical terms should be explained in words they can understand. Time for reflection and discussion is usually needed after this information has been given.

5.2 Multicultural perspective

Different cultural groups in NSW may have different perceptions of how end of life decisions are to be made, and by whom. Different views of autonomy and how this is to be respected exist, and any advance care planning process should be sensitive to this.

5.3 Documentation standards

The following should be satisfied before an ACD is considered to have sufficient authority to act on:

- **Specificity** - It must be clear that an advance directive applies to the clinical circumstances arising. This can include treatment preferences in relation to both conditions existing at the time the ACD is made, as well as future anticipated conditions (including catastrophic injury). The advance care directive should be clear and specific enough to guide clinical care. The specificity of the ACD may be improved if the person discusses it with their doctor.

- **Currency** - An advance care directive prepared a long time before it is referred to may not reflect the current intentions of the patient. Nonetheless, if the person was competent at the time the ACD was made then it should still be treated as legally binding. People should be encouraged to review their directives periodically, for example once a year, after an illness, or with a change in health as treatment preferences may change accordingly.

- **Competence** - The person must have been competent to make their own health care decisions when the advance directive was drafted. A person should be considered competent to make a health care decision if they appear able to comprehend, retain, and weigh up the relevant information and then make a choice. Some situations may pose particular difficulties in assessing competence to make an ACD, such as early dementia or intermittent mental health problems. A second opinion from a suitably qualified health professional is advisable.
Witnessing - It is not essential to have an ACD witnessed. However, there are a number of reasons to encourage a person to do this. It may allow for later follow-up if doubts are raised about the person’s competence at the time of drafting. It offers some protection against forgery. It may also allay concerns about undue influence in the expressed treatment choices. If an ACD is completed in conjunction with the appointment of an enduring guardian, then the witness may only be a solicitor, barrister or registrar of the Local Court. If a ‘stand alone’ ACD is prepared, the person may select whom they wish to witness the document.

See also 6: Questions about interpreting and acting on advance care directive instructions for further information on legality of advance care directives in NSW.

5.4 Ways of documenting an ACD

Someone wanting to prepare an ACD may or may not choose to initially discuss this with a health or legal professional, although such discussion is encouraged (see 5.1 and 5.6).

A person may simply write their wishes down, as if writing a letter and with no ‘form’ used.

Alternatively, and more commonly, a specifically designed form is used. Several forms are available in NSW from a number of organisations but forms obtained from other states or overseas may also be used. As there is no legislation in NSW pertaining to ACDs, there is no mandated form. The NSW Department of Health does not endorse the use of one particular form over another but does endorse forms that satisfy the recommendations in Parts 5.1 and 5.3 of this document.

There is no requirement to lodge the form with any agency or office in NSW. There is also currently no register of people who have appointed an enduring guardian.

Advance care directives are designed in different ways. One size does not fit all and different forms are more or less appropriate in different contexts. For example they may contain:

- **Statement of general values** (a ‘values history’ - this will often ask the person to rank certain states as ‘worse than death’). The values expressed can be referred to, and inform later treatment decisions made by substitute decision-makers. This approach may be good for situations that were not anticipated - perhaps if the person was healthy when they prepared the ACD.

- **Statement of goals** - may provide a bridge between general values and specific wishes (eg comfort measures only).

- **Statement of specific treatment preferences** relevant to an existing illness (eg use of invasive or non-invasive ventilation techniques in a patient with chronic respiratory failure).

Often these approaches are combined within one form.

5.5 Role of health professionals

A person is not required to involve a health professional in preparing an ACD. There are however a number of advantages in having a doctor or other health professional involved with the person in preparing an ACD. These include:

- Raising the issue of end of life care options at the outset.
- Providing information about prognosis or treatments that may specifically relate to the person’s condition.
12. MEDICAL CARE

- Clarifying terminology.
- Encouraging the person to involve other appropriate substitute decision-maker/s in discussions about treatment preferences.
- Witnessing the ACD as a means of vouching for the person’s competence at the time of discussion/writing.

5.6 More information

More information about ACDs and/or forms can be obtained from the following organisations:

1. Advance Care Directive Association
   - Write to the Advance Care Directive Association Inc. at 18/113 Johnston Street, Annandale NSW 2038, asking for a form
   - Leave a message with your name and address on 0423 157 003.

2. Department of Disability, Health and Aged Care ‘Planning Ahead Kit’
   - Tel. (02) 8270 2000

3. Law Consumers Association
   - Tel. 1300 668 001

4. Guardianship Tribunal

5. Voluntary Euthanasia Society

QUESTIONS ABOUT INTERPRETING AND ACTING ON ADVANCE CARE DIRECTIVE INSTRUCTIONS

1. Can a person use an ACD to instruct a doctor or other health professional to help them die?

   No. An ACD may not contain instructions for illegal activities, such as euthanasia or assisted suicide.

2. What are the legal implications of acting contrary to an advance directive?

   A failure to comply with an advance care directive that meets the standards discussed in this document and refuses treatment may be considered an assault and battery under common law. Civil liability may also ensue.

3. Who else should be consulted if there are concerns about the details or the legality of an ACD?

   Where concerns about legality or applicability arise in an emergency, then the medical practitioner can treat the person in accordance with the person’s perceived best interests, regardless of what is said in an advance care directive. Legal advice should be sought as a matter of urgency so that timely treatment decisions can subsequently be made.
Where there is more time to resolve concerns and the person is not competent, the family or those close to the person should be consulted to see if those concerns could be resolved. For example, if an ACD was made some years ago and there are concerns about its currency, those close to the person may be able to confirm that the person’s wishes remained the same. When there are concerns about the person’s competence at the time of making the ACD, those close to the person may be able to provide information on this issue.

4. **What should be done if undue influence on the person preparing the ACD is suspected?**

A directive must be free from the ‘undue’ influence of others. The person must not have been forced or pressured by others to such an extent that they could not exercise free choice when the ACD was made. Factors to consider are the person’s level of maturity, the effect of their condition, the influence of treatment and the relationship between the persuader(s) and the person. If it is suspected that a person was unduly influenced into making an ACD and they are now incompetent, the health professional should seek legal advice and, in the interim, make treatment choices consistent with what is perceived to be in the patient’s best interests.

5. **What should be done when the prior documented wishes of the patient conflict with those of substitute decision-makers?**

If the person’s prior expressed wishes regarding treatment or its limitation are known, and the documentary evidence is authoritative, then these wishes take priority over those of the family. Disagreement by the family or other legitimate substitute decision-maker with the person’s prior wishes is usually resolved by further discussion and the provision of ancillary support through social workers, pastoral care workers or others aimed at the family’s acceptance of the person’s wishes.

While some cultural groups believe that the locus of control appropriately lies with collective or family decisions when a person is dying, there may be wide variation in beliefs within a population and the dying person may not adhere to the dominant cultural norm. The overriding legal and ethical responsibility of the health care professional is to the patient and thus to his or her desire for direct communication and information. Family involvement in treatment discussions is only permissible on the fact or presumption that the person would permit their involvement.

6. **What if the person has appointed an enduring guardian and made an ACD?**

A person may choose to prepare written instructions as to their future care in the enduring guardianship appointment document. If an ACD has been drafted independent of the enduring guardianship appointment, and this ACD is authoritative, then an enduring guardian is bound by these directions. If such a directive is not sufficiently authoritative to act on (for example it does not apply to the clinical circumstances at hand), then the enduring guardian consents or refuses consent to treatment according to the perceived best interests of the patient. Where a person has not appointed an enduring guardian and an ACD is not sufficiently authoritative to act on, the ‘person responsible’ (see Glossary) takes on this role.

7. **What if an appointed enduring guardian disagrees with the ACD?**

They are bound like everyone else. An ACD is the author’s decision. The enduring guardian has no power to disagree.
8. What is the status of an oral directive, for example if a person tells the family or a nurse what they do or do not want regarding life sustaining treatments?

Advance care directives are usually written and signed by the person himself or herself. However, anyone can make an oral directive by making their wishes known through discussion with their family or health care team. This may arise where physical disability, illness or illiteracy means that writing is not possible but may also be the person’s preferred approach. These wishes should be clearly documented in the person’s medical history, even if a specific advance care directive ‘form’ is not used, and made known through liaison between treating health professionals.

9. Is a NSW ACD valid interstate and is an interstate ACD valid in NSW?

Yes, in both circumstances. Most states preserve the right to make an ACD at common law in addition to prescribed forms where they exist, such as in Queensland or South Australia. In some states, like Queensland, there is express recognition of interstate ACDs.

10. What should a person do with an ACD after they have completed it?

In order for an advance care directive to be acted upon, it must be available and its contents known at the time decisions need to be made, including time-pressured situations such as resuscitation decisions. A simple approach is for the likely ‘person responsible’ to be given a copy of the directive and any revisions it receives, along with the GP, any other doctors involved, and other key family members. An ACD should be brought to the attention of new treating clinicians as soon as possible. The ACD should be included in a prominent position in the medical history.

GLOSSARY

Advance care directive - An ‘advance care directive’ contains instructions that consent to, or refuse, specified medical treatments in the future. They become effective in situations where the person is no longer able to make decisions. For this reason advance care directives are also, though less frequently, referred to as ‘living wills’.

Advance care planning - The process of preparing for likely scenarios near the end of life that usually includes assessment of, and dialogue about, a person’s understanding of their medical history and condition, values, preferences, and personal and family resources.

Enduring guardian - A formally appointed substitute decision-maker of an individual’s choice to make lifestyle and/or health care decisions should the individual lose the capacity to make their own decisions at some time in the future. The terms of all guardianship appointments must be carefully checked to ensure they cover the situation at hand, as some appointments are limited to handling only property and financial affairs and do not apply to health care decisions.

Person responsible - The role of the ‘person responsible’ is to make substitute decisions that consent to, or refuse consent to medical treatment. This person is required to have regard to the views of the patient but they are not bound to follow them. The ‘person responsible’ replaces the old term ‘next of kin’ as the person from whom consent for active treatment in the incompetent patient must be sought. The ‘person responsible’ is determined according to the hierarchy within the Guardianship Act 1987 (NSW) and in the following order:
- An appointed guardian (enduring guardian) with the function of consenting to medical and dental treatment. If there is no-one in this category:
- A spouse or de facto spouse who has a close and continuing relationship with the person. If there is no-one in this category:
12. MEDICAL CARE

- The carer or person who arranges care on a regular basis and is unpaid (the carer pension does not count as payment). If there is no-one in this category:
- The carer of the person before they went into residential care. If there is no-one in this category:
- A close friend or relative.

SEARCH STRATEGY


Websites of the e-journals MJA, BMJ, CMAJ, NZJM and Internal Medicine Journal were also searched with these strategies, and Google was used to search for material not available in these databases.

The bibliographies of key articles were hand-searched for further articles relevant to the Australian experience of advance care planning. Preference was given to papers including empirical data as well as expert opinion, those from Australian jurisdictions and those in peer-reviewed journals.

Three hundred articles were selected on the basis that they provided insight into the following themes: ‘efficacy’, ‘reliability and validity’, ‘accessibility’, ‘durability’, ‘consumer view’, ‘portability’, ‘principles, processes and forms’. Forms from various jurisdictions were collated to provide examples of legally mandated forms, disease- or treatment-specific forms and goals, values or outcome-based forms.

Some of these citations are included in the reference section.

REFERENCES

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GUIDELINES FOR END-OF-LIFE CARE AND DECISION-MAKING (GL2005_057)

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NSW Health consulted extensively in developing these guidelines. Comment was sought from health professionals, service providers, ethical organisations, government departments, as well as religious, community, and multicultural groups, and members of the public. NSW Health is appreciative of this input as it has been invaluable in developing these guidelines.

NSW Health wishes to thank in particular:
- Members of the expert advisory group:
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  John Le Breton - former Public Guardian, Office of the Public Guardian
  Geoff Bloom - Legal & Legislative Services Branch, NSW Health
  Professor Malcolm Fisher - Area Director, Intensive Care Services, Northern Sydney Area Health Service
  Deborah Frew - Manager, Health Ethics Branch
  Julie Letts - Health Ethics Branch (project manager)
  Nick O’Neill - former President, Guardianship Tribunal
  Dr Ray Raper – Head, Intensive Care Unit, Royal North Shore Hospital
  Dr Peter Saul - Senior Intensive Care Specialist, John Hunter Hospital & Director, Clinical Unit in Ethics and Health Law, University of Newcastle
  Associate Professor Cameron Stewart - Senior Lecturer in Law, Macquarie University
  Managers and staff of Quality & Clinical Policy Branch who undertook early phase consultation
  Dr Bernadette Tobin - Director, Plunkett Centre for Ethics in Health Care

PURPOSE

NSW Health places a high priority on health professionals working collaboratively with each other, and with patients and their families throughout all phases of end-of-life care. Such care is dependent on open and early communication in an environment of trust. These guidelines set out a process for reaching end-of-life decisions. This process promotes such communication, compassionate and appropriate treatment decisions, fairness, and seeks to safeguard both patients and health professionals.
Ideally, patients are able to determine their own decisions for end-of-life care. Some aspects of the guidelines apply to these patients. Often, however, patients lose decision-making capacity before their wishes for the use of life sustaining treatment have been determined. In those situations, the treating team and family together need to plan care that considers the patient’s best interests: reflecting the patient’s wishes and values as much as possible and avoiding both inappropriate over- and under-treatment. These guidelines are particularly relevant to such situations where a consensus building approach is recommended.

Dying patients are cared for in many settings including intensive care units, hospital wards, hospice facilities, aged care facilities and the home. These guidelines provide useful advice for health professionals about a process for negotiating end of life decisions wherever that care is delivered.

These guidelines replace the Dying with Dignity: interim guidelines on management (1993).

**PRINCIPLES**

A large part of this document focuses on building consensus, in particular where patients do not have the capacity to decide on life-sustaining treatment for themselves. Consensus building is the most inclusive process for determining what is the best treatment for that individual, at that time, and in that place. A consensus view about best treatment is ethically based when it is in accordance with the following guiding principles.

**Respect for life and care in dying**

A primary goal of medical care is preservation of life, however when life cannot be preserved, the task is to provide comfort and dignity to the dying person, and to support others in doing so.

**The right to know and to choose**

All persons receiving healthcare have a right to be informed about their condition and their treatment options. They have a right to receive or refuse life-prolonging treatment. Caregivers have an ethical and legal obligation to acknowledge and honour these stated choices and preferences in accordance with these guidelines.

**Appropriate withholding and withdrawal of life-sustaining treatment**

Appropriate end-of-life care should intend to provide the best possible treatment for an individual at that time. It recognises that if the goals of care shift to primarily accommodate comfort and dignity, then withholding or withdrawal of life-sustaining medical interventions may be permissible in the best interests of the dying patient.

**A collaborative approach to care**

Families and healthcare professionals have an obligation to work together to make compassionate decisions for patients who lack decision-making capacity, taking account of previously expressed patient wishes where known. Many health professionals in the treating team play a role in end-of-life care and a collaborative approach should be fostered.

**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 and its outcomes should be clear to the participants and accurately recorded.
Non-discriminatory care

Treatment decisions at the end of life should be non-discriminatory and should be dependent only on factors that are relevant to the patient’s medical condition, values and wishes.

Rights and obligations of healthcare professionals

Health professionals are under no obligation to provide treatments that, in the circumstances, are unreasonable, in particular, those that offer negligible prospect of benefit to the patient. Patients have a right to receive care, and health professionals have a responsibility to practice, in accordance with community and professional norms and legal standards.

Continuous improvement

Health professionals have an obligation to strive for ongoing improvement in standards of end-of-life care. This situation requires education and support for those health professionals managing dying patients and their families.

PLANNING IN ADVANCE

Decision-making capacity is often lost as serious illness or death approaches. Therefore timely and appropriate decision-making about end-of-life care is more likely where those close to the patient understand the patient’s wishes in advance. With discussion and planning, the patient’s preferences and values can inform decision-making as priorities change during the time leading to the patient’s death. Currently in NSW, people can plan in advance for end-of-life care by:

• developing an advance care plan in conjunction with their healthcare professionals while being treated in a care setting
• discussing their preferences for life-sustaining treatment with their family before they are acutely ill
• formally appointing and informing an enduring guardian
• writing an advance care directive.

The critical element for effective advance care planning by any of the above approaches is discussion between the patient and those close to him or her while the patient still has decision-making capacity.

NSW Health has developed best practice guidelines for health professionals on advance care planning for end-of-life care titled Using Advance Care Directives (NSW). Those guidelines should be read in conjunction with this document in order to assist advance care planning where possible and at the earliest appropriate stage. The guidelines are available at http://www.health.nsw.gov.au (see also paragraph 7.6 of these guidelines).

FOUNDATIONS OF SOUND DECISION-MAKING

The following section discusses a number of factors that support a sound process for end-of-life decision-making. The process itself is discussed in more detail in section 5. These factors include:

• the changing context of treatment limitation decisions at the end of life
• the relationship between the treating team and the patient with decision-making capacity
• the collaborative nature of the treating team
• the consensus building model where the patient has no decision-making capacity
• accountability
• the importance of palliative care.
4.1 The changing context of treatment limitation decisions at the end of life

Because planning for end-of-life care usually takes place in the context of ever-changing circumstances, it is useful to follow the cyclic feedback process for end-of-life decision-making set out in section 5 (see 5.1). One reason for this constant change is the difficulty in predicting, with certainty, an individual’s response to particular treatment. Often life-sustaining treatment will be commenced while further investigations are carried out or information sought in order to make a more accurate prognosis. When all available information has been collected, the appropriateness of continuing the treatment is reviewed with the treating team, patient and/or their family. Furthermore, patients’ wishes may change as they develop an appreciation of their clinical condition. This process of review, decision-making and treatment trial may be repeated a number of times as the patient’s condition improves or deteriorates. These decisions are often based on probabilities, rather than certainties.

4.2 The relationship between the treating team and the patient with decision-making capacity

People are said to have decision-making capacity if they are able to comprehend, retain and weigh up relevant information and then make a choice. A person’s decision-making capacity may be adversely affected by a number of chronic or acute illnesses. As a result, decision-making capacity may vary over time and therefore necessitate re-assessment periodically.

An adult patient with decision-making capacity may accept or refuse life-sustaining treatment, even where that decision may lead to serious deterioration in health or death. It is crucial that the patient is properly informed of the consequences of refusing such treatment. A patient may make choices about treatment consistent with his or her own values, even where these values differ from those of the treating team.

A patient with decision-making capacity does not share decision-making authority with treating health professionals. Rather the treating team acts in an advisory capacity to the patient enabling him or her to make choices regarding reasonable treatment options. Such patients may choose to make decisions without reference to family or others close to them. It is essential that health professionals continue to keep patients informed about their medical condition as they improve or deteriorate, and as the patient’s decision-making capacity fluctuates. Patients should be given the opportunity to participate in treatment decisions consistent with their level of decision-making capacity.

The general principles regarding consent for medical treatment apply in relation to the treatment of dying patients as they do for other patients. Healthcare professionals must be familiar with the Department’s policy on consent PD2005_406.

4.3 The collaborative nature of the treating team

The treating team involved in end-of-life care, either through direct decision-making or in supportive roles, may variously include medical specialists, surgeons, general practitioners, nurses and allied health workers such as social workers, patient advocates, chaplains or pastoral care workers. Individual members of the treating team may have closer or prolonged involvement with the patient and may be aware of the patient’s values and wishes. Other team members may be more involved in how the patient is psychologically or spiritually coping with illness. Each member may bring valuable perspectives and information to the process of planning care and their collaborative involvement should be actively pursued. Junior nurses and doctors should not be excluded where end-of-life decisions are considered, although they should be supervised in any discussions about end-of-life decisions with patients or their families. Reaching agreement within the treating team about appropriate care is an important initial step in a collaborative approach, particularly where the patient no longer has decision-making capacity. It can help reduce subjectivity or bias, particularly in cases of uncertainty.
Nurses and doctors have independent ethical duties towards patients, and the particular burdens that treatment limitation decisions place on nurses should be recognised. Nurses play a significant role in providing clinical and social information about or to the patient and family; in the potential initiation of treatment limitation discussions; and as managers of the dying process. Nurses must be part of the collaborative process whereby the treating team develops a management plan with patients and/or their families.

4.4 A consensus-building model when the patient lacks decision-making capacity

A consensus building approach to end-of-life decision-making that considers the patient’s best interests as paramount is recommended where the patient lacks the capacity to determine his or her own care. This collaborative process aims to draw on the family and treating team’s knowledge and understanding of the patient’s personal values and medical condition. A consensus is sought within the treating team, and between the treating team and family about a plan of care that is as consistent with the patient’s wishes and values as possible, and which also supports the family in the degree of involvement it wishes to have.

The approach of shared decision-making is recommended as sole decision-making by any one party, either the senior treating clinician or the family, may fail to achieve the best possible treatment decision. A consensus approach with appropriate involvement from both treating team and family:

- avoids placing a senior treating clinician in a position of guessing at a patient’s wishes concerning end-of-life treatment without the participation of others, or precipitously withholding or withdrawing treatment
- is consistent with a desire by many patients for their family to be involved in end-of-life decisions when they are not able
- avoids imposing possibly additional stress on a family who may perceive that they carry the burden of decision-making and which may later contribute to feelings of guilt
- minimises inappropriate input to decisions where concerns arise about conflict of interest within a family or a family’s inability to understand medical aspects of care.

The treating team, and senior treating clinician in particular, should therefore not merely outline treatment options then delegate decision-making responsibility to families, but rather they should make recommendations for management based on their understanding of the patient’s medical condition and prognosis, allow time for discussion and reflection, while continuing to work with, and support, a family and reach a consensus decision.

Families should be provided with a contact point for appropriate members of the treating team, hospital or community-based staff after the patient’s death to discuss unanswered questions, as this may be beneficial in allaying guilt or uncertainties.

Elements that are critical to the success of this approach and options for resolving disagreements are discussed in section 5.

4.5 Accountability

The senior treating clinician is accountable, as leader of the treating team, to the patient, the family, the employing health authority, and ultimately the courts for the process whereby a consensus about end-of-life decisions is sought, and the reasonableness of the planned course of action. Following the process set out in these guidelines and adequate documentation of that process will ensure that the senior treating clinician and the treating team meet the obligations required for accountability in end-of-life treatment decisions.
4.6 Importance of palliative care

The provision of palliative care for patients should continue throughout all phases of terminal illness, and especially during the dying phase. This care should encompass controlling pain, relieving other systems of disease and providing emotional and psychological support in preparation for death. Other issues such as relief of psychological suffering, spiritual care and addressing any unresolved issues for the patient may be raised during discussions about end-of-life care. The specific details of palliative care should be documented. See 7.3.

DEVELOPING A MANAGEMENT PLAN

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. This process can take place over a short period, such as hours, where the patient suddenly or unexpectedly deteriorates, but it can also extend over weeks or months. The key points in each step of this process (section 5.1) are discussed in the following sections.

5.1 Process of end-of-life decision-making

5.2 Assessment

A sudden or unexpected deterioration, or uncertainty about prognosis, usually requires efforts to stabilise the patient so that a complete assessment can be undertaken and potential reversibility of the condition be established. The treating team should undertake this assessment at the earliest appropriate time. Life-sustaining treatment already commenced may be subsequently withdrawn if deemed appropriate upon assessment of the patient’s wishes or clinical condition.

Where there is reasonable doubt about the medical assessment in the treating team, advice should be sought from other senior clinicians with experience in the condition if possible. Second opinions should be documented.
Assessment should also include evidence of the patient’s preferences and values where available from the patient, or his or her family if the patient has no capacity to express those wishes. Patients’ preferences for life sustaining treatment are not static over time and should be regularly reviewed by the treating team.

A patient’s desire regarding direct communication and information must be respected. The patient also has a choice to nominate someone to receive information on his or her behalf, or to exclude family members from discussions and decision-making processes.

The desire for autonomous-style decision-making or the preference for a collective or delegated approach to end-of-life decisions may vary among patients from different cultural or religious backgrounds. This aspect should be explored on an individual basis to avoid inappropriate clinical decisions and poor interaction with patients and families. The informal use of untrained interpreters such as other family members should be avoided where possible to prevent role confusion and misinterpretation of clinical information.

Failure to demonstrate any improvement in clinical condition over an extended period appropriately generates questions about further initiation or continuation of treatment. The patient, the treating team or the family may initiate such discussions.

5.3 Disclosure

Honest information in non-technical language should be provided to patients and their families for them to participate meaningfully in decisions about end-of-life care. Uncertainty about prognosis or likely response to treatment should be communicated to patients and their families. Prognostic information is ideally given by a health professional who is respected as an expert.

Patients and families may be caught off guard when conversations about the goals of care and possible treatment cessation occur suddenly, very late, without preparation, or when they have not received a balanced picture of the patient’s prognosis. Patients and their families should be engaged in open communication about possible outcomes early in treatment, especially where the patient is seriously or critically ill, in order to prevent unrealistic expectations about what can be achieved with treatment. Early, honest and regular communication can also help create the trust needed for shared decision-making and to defuse tension.

5.4 Discussion

Discussions with patients and their families about treatment limitation should ideally occur in stages over a period of time, preferably while the patient can determine the appropriateness of treatment or its cessation. The presence of nursing staff, or other key members of the treating team, at these discussions is recommended to support and facilitate communication between the treating team and the family.

Strategic opportunities for the treating team to initiate or revisit discussion about end-of-life care may include recent hospitalisation with severe, progressive illness or repeated recent admissions, inquiries from the patient or family about palliative or hospice care or an expression by the patient of a wish to die.

Having the same person/s communicate with the patient or family on behalf of the treating team throughout this process can be useful, as minor differences in explanation of the patient’s condition or progress can seem to patients and families like major disagreements or discord in the team. Ideally, this health professional should be experienced in conducting such discussions, have earned trust before treatment limitation is discussed, and be able to discuss prognostic information.
The phrases ‘do everything’ or ‘do nothing’ are unproductive and should be avoided: neither term is ever strictly enacted and such terminology is a barrier to informed discussion regarding the benefits and burdens of certain courses of action. The ongoing care with the goal of providing comfort to the dying patient should be emphasised with the patient and his or her family where limitation of life-sustaining treatment is planned.

5.5 Documenting a consensus decision

The agreed management plan for end-of-life care, and decisions about the use of life-sustaining treatment within that plan, should be documented and conveyed to all members of the treating team. Such communication may be difficult where many staff care for the patient but adequate documentation may assist in this regard. The senior treating clinician is responsible for summarising discussions held with the patient, family and treating team in the patient notes. These notes must clearly state:
• medical facts leading to the decision, including prognosis
• persons involved in the discussion
• statement of the patient’s wishes, where known
• goals of treatment
• details about medical treatments to be provided, timeframe before review, or details about treatments to be withdrawn/withheld.

Management plans may cover a shorter or longer period of time, depending on the clinical situation of the patient. Decisions that involve withholding treatment such as CPR should be regularly reviewed in accordance with fluctuations in the patient’s condition. A change in the appropriateness of withholding treatment such as CPR needs to be re-documented. (See also 7.5).

Other appropriate treating team members should continue to document other aspects of care that will be maintained or enhanced, such as comfort measures.

Thorough documentation of decision-making processes and subsequent care enables greater transparency and accountability in the care provided and ensures that all health professionals fulfil their professional and legal obligations.

RESOLVING DISAGREEMENTS

In most situations where a patient is dying, the patient, family and treating team readily come to an agreement on appropriate medical management. However, disagreements can arise regarding treatment limitation decisions, or about other aspects of end-of-life care. Most disagreements between the treating team, the patient or the family can be prevented by early, sensitive and proactive communication that clarifies goals of treatment, possible outcomes and the patient’s values and wishes.

6.1 Disagreement in the healthcare team

In circumstances where one team member is in disagreement with the others, the team as a whole should consider the basis for disagreement and seek the opinions of professionals from the same discipline as the disagreeing member. In the event that support for this position cannot be found, it may be appropriate for the dissenting member not to continue being involved in the treating team. As in other areas of clinical practice, a health professional may exercise conscientious objection and not participate in a particular practice which is contrary to his or her moral beliefs.
Counselling or other psychological support may be appropriate where disagreement occurs about the appropriateness of treatment limitation, particularly for nurses who, in some settings and by their more intimate involvement in the care of dying patients, may be more acutely aware of the patient’s distress.

6.2 When a patient’s family disagrees with a patient’s decision

The wishes of the adult patient with decision-making capacity are paramount. If the patient’s expressed wishes regarding active treatment or refusal of treatment prior to loss of decision-making capacity are known, then these wishes prevail over the wishes of the family. Disagreements between the patient and his or her family may arise if the family is not properly informed by the treating team about the directions given by the patient, and every effort should be made to communicate this information to the family.

6.3 Inappropriate requests for continuing treatment

At times a family or a patient requests a test or intervention that appears unreasonable or inappropriate to the treating team. Such a request may appear inappropriate in the following scenarios:
- where the patient’s condition continues to deteriorate even with optimal therapeutic interventions
- where the treatment would not be successful in producing the clinical effect for which it is ordinarily used
- where the treatment might successfully produce a clinical effect, but still fail to serve important patient goals such as independence from life-support devices, survival in order to leave hospital, or improvement from permanent unconsciousness.

A focus should be kept on the patient. All requests for continuing treatment should be given due consideration before decisions about the appropriateness of treatments are made. Any request should lead to a review of the diagnosis and prognosis and the margins of certainty in each aspect. Health professionals should initially endeavour to explain to the patient or family why they think the desired test or treatment is inappropriate.

Families of patients without decision-making capacity who demand continued treatment in such situations might have unrealistic expectations about what can be achieved. More often though, a family will ask for ‘everything to be done’ if they are not ready to accept the patient’s inevitable death. This situation may be exacerbated when the family are not engaged early in treatment planning prior to the onset of the dying process (see 5.2) or where guilt may be associated with fractured or distant relationships within the family.

The efforts of nursing and medical staff, pastoral care workers, social workers or other counsellors should be directed to supporting family members and assisting them to resolve their difficulties in accepting the reality of the patient’s impending death. In such circumstances, it is preferable to continue treatment until conflict with relatives is resolved; however time critical situations pose extremely difficult choices and challenges (see 6.5).

6.4 Potentially inappropriate requests for cessation of treatment by the patient

Unrelieved pain, suffering or depression may influence a patient’s request for treatment cessation. Under such circumstances, it is appropriate to explore the patient’s feelings, possibly with the assistance of a qualified professional, and to address any issues that may be resolvable.
It may be appropriate to negotiate with the patient an agreed plan of continuing treatment and further discussion in the near future, while acknowledging that sustained wishes for treatment refusal in the competent patient are ultimately paramount.

6.5 Options for resolving disagreement

The following approaches are possible avenues for resolving disagreements in the end-of-life care setting. Not all options will be available in all clinical contexts. However, the simple approaches should be taken first.

Time and repeat discussion

Unless decisions about life-sustaining treatment need to be made urgently, giving families time to come to terms with the impending death of the patient, and to seek further discussion with family or others providing support may be sufficient to resolve outstanding issues.

Second medical opinion

A request for a second medical opinion may be raised with, or directed to, any member of the treating team. Offering a second opinion may also be appropriate if the family are displaying anxieties or uncertainties regarding diagnosis or prognosis. It is the responsibility of the senior treating clinician to facilitate any second medical opinion. This opinion should be from a health professional with relevant expertise in the patient’s condition and who is demonstrably independent from the treating team.

Time limited treatment trial

Such a course of action may be undertaken to clarify prognostic uncertainty or resolve disagreement about prognosis, provided the trial is in the best interests of the patient. It may be advisable to clarify with the treating team and family what treatments are being commenced or continued, the criteria for assessment and the timeframe for review before possible continuation or withdrawal.

Facilitation

Involvement of a third party may assist in clarifying and addressing the concerns of the patient and/or family members, or in finding agreement where an impasse has occurred between the family and the treating team. The third party may be a senior member of the hospital administration, a senior health professional, or another person agreed upon by those involved. The person should have sufficient seniority, be respected by all parties, and be demonstrably independent of the treating team.

Patient transfer

When the above steps have not resolved the situation, the practicality of transferring the care of the patient to another institution or another suitable treating clinician within the same institution should be investigated with those involved.

Guardianship Tribunal

The Guardianship Tribunal may provide advice in relation to end-of-life care for patients lacking decision-making capacity. Advice may include whether it is appropriate for the Tribunal to deal with an application for consent to a proposed treatment on behalf of such a patient.
12. MEDICAL CARE

As palliative care is medical treatment under Part 5 of the Guardianship Act, consent may be sought for it to be provided to replace more active treatment. The application must set out the proposed treatment, and any alternative treatments, and the nature and degree of any significant risks associated with either the proposed treatment or the alternatives to it.

Legal intervention

The NSW Supreme Court, or the Family Court of Australia in respect of children and young people under 18 years old, has jurisdiction to hear matters relating to treatment limitation decisions. Senior treating clinicians or their delegates may consider initiating a Court action when they are unsure of whether the proposed treatment or treatment limitation is in accordance with their duties as medical practitioners, and when all of the above steps have failed to resolve their concerns.

Before initiating a Court action, the senior treating clinician should usually have:

• obtained a second specialist medical opinion in writing
• received senior institutional advice
• discussed this course of action with the family
• sought advice from the Guardianship Tribunal if the patient does not have decision-making capacity
• informed the hospital executive of the proposed approach.

Where this option is taken, continued consultation should take place with family members to assist in clarifying the issues and to determine whether a legally acceptable solution that is in the best interests of the patient can be reached. Family members or ‘persons responsible’ may decide to independently initiate a Court action if they have concerns regarding end-of-life decisions where the patient lacks decision-making capacity. Family members or person responsible should be specifically informed that they have this option, where appropriate.

SPECIFIC ISSUES

7.1 Distinction between euthanasia, assisted suicide and lawful treatment limitation decisions

Euthanasia and assisted suicide both involve deliberate acts or omissions that are undertaken with the intention of ending a person’s life and are inconsistent with the duties of a medical practitioner.

Euthanasia and assisted suicide are different from withholding or withdrawing life-sustaining treatment in accordance with good medical practice by a medical practitioner. When treatment is withheld or withdrawn in these circumstances, and a patient subsequently dies, the law classifies the cause of death as the patient’s underlying condition and not the actions of others (see 7.3). Care of terminally ill patients that is lawful never involves an intention to end a patient’s life.

Both euthanasia and assisted suicide are crimes under the Crimes Act 1900 (NSW) and are not endorsed in this document, or by the NSW Department of Health.

7.2 Children and young people

End-of-life decisions in children pose particular difficulties. This difficulty is in part because, unlike adults, children are often unable to understand or fully understand choices concerning life-sustaining treatments or functional states, and the implications for decision-making. Children are also less likely to have expressed values that would, in adults, be known by the family and inform treatment decisions. Parents and the treating team may nevertheless consider that continued treatment is not appropriate where the child’s condition is intolerable to the child or where the child is dying.
Older or mature minors (that is, between 14 and 18 years) may not make treatment limitation decisions solely by themselves, even where their capacity to make other medical decisions is not in doubt. However, older minors should be involved in discussions with their parents and the treating team regarding their prognosis and treatment, as appropriate to their level of understanding, emotional maturity and in accordance with their best interests. Multidisciplinary support, as described below, may be necessary where a child’s expressed wishes about end-of-life treatment are contrary to those of his or her parents.

Where the treating clinician and parents differ in their assessment of what is in the best interests of the child, or where the parents disagree with each other, the following strategies (additional to those discussed in 6.5) may be useful:

- The understandable anxieties of parents in relation to treatment limitation decisions may be complicated by potential feelings of guilt and responsibility for the child’s subsequent death. Appropriate multidisciplinary support for parents should be provided at this time. This assistance may ultimately involve working with parents to refocus their hopes and goals.
- Assessment of the family dynamics and possible genesis of disagreement within that family by an appropriately qualified mental health or social work professional and family counsellor.
- Appointment of an appropriately qualified professional, such as a counsellor, in the treating team to advocate independently for the interests of the child.

The consensus-building approach to treatment limitation decisions outlined elsewhere in these guidelines is also applicable in this setting. Where the process fails to bring a consensus about the appropriateness of treatment limitation, resolution will require application to the Court.

In situations where the child is subject to a care order conferring parental responsibility on the Minister for Community Services generally or specifically for medical decisions, the law treats the Minister as the child’s parent. The treating clinician should consult with the Minister about the appropriateness of life-sustaining medical treatment by contacting the Department of Community Services. Treatment should continue to be provided, time permitting, while consultation takes place. Disagreements between the treatment team and the Minister or Minister’s delegate about the appropriate course of action should be resolved by the same processes as apply to other parents as outlined in these Guidelines.

7.3 Appropriate use of analgesia and sedation

Analgesia and sedation should be provided by whatever route is necessary for relief, in proportion with clinical need, and with the primary goal of relieving pain or other unwanted symptoms. Such administration will not be unlawful provided the intention of the medical practitioner is the relief of symptoms, even if the medical practitioner is aware that the administration of the drug might also hasten death.

7.4 Artificial hydration and nutrition

Use of artificial hydration and nutrition is an intervention with its own possible burdens and discomforts, for example, those related to having tubes in situ or regularly replaced. Withdrawal of artificial hydration and nutrition, like the withdrawal of other medical interventions, can be seen as a treatment limitation decision that may be made in accordance with these guidelines. It is recognised that the provision of artificial hydration and nutrition may be a particularly sensitive matter for some in the community who believe that it must be continued, unless specifically refused by the patient.
The offering of food and fluids by ordinary, non-medical means should be part of the care of dying patients as appropriate to their clinical condition or wishes.

7.5 No CPR orders

The term No Cardiopulmonary Resuscitation (No CPR) order is preferred as less ambiguous than Do Not Resuscitate (DNR) or Not For Resuscitation (NFR) orders and the interventions to which they apply.

The principles for withholding CPR are consistent with those for withdrawing life-sustaining treatment as outlined in these guidelines. Decisions relating to withholding CPR should be made on an individual basis, not involving blanket decisions or policies, for example, related to age or disability. (See also section 3 Planning end-of-life care in advance).

A No CPR order may be compatible with providing the patient with maximum therapeutic care, short of CPR. The treating clinician and treating team should reassure the patient, or his or her family, that all comfort and other appropriate care will be provided.

No CPR orders should be clearly written in the patient’s medical notes as with other treatment decisions. Use of covert symbols on charts, medical notes or wristbands is not appropriate. Where the decision to apply a No CPR order has not been discussed with the patient because he or she lacks decision-making capacity, that fact should be documented.

Where no explicit decision has been made about the appropriateness, or otherwise, of attempting resuscitation of the hospitalised patient, then resuscitation should be commenced until a senior doctor is available who should determine, based on likely prognosis, whether CPR should continue and then direct the team accordingly.

Where paramedics have been called to a patient whose condition has deteriorated and cardiac arrest occurs, there is a presumption that emergency medical care is appropriate.

7.6 Advance care directives

A number of conditions, outlined below, should be met before the treatment decisions in an advance care directive (see Glossary) are followed:

- the directive is intended to apply to the clinical circumstances that have arisen
- the directive must be sufficiently clear and specific to guide clinical care
- there must not be any evidence to suggest that the directive does not reflect the current intentions of the patient, or was made as a result of undue influence
- the directive should be made by the patient him or herself and should reflect his or her wishes, rather than the wishes of another person.

In addition, it is best practice, but not legally necessary, that:

- the patient should periodically review the directive, for example, once a year, after an illness, or with a change in health status
- the directive should be available at the time decisions need to be made, for example, by ensuring the likely person responsible and primary healthcare provider have a copy of the directive and any of its revisions
- the directive should be signed and witnessed
- a medical practitioner should be involved in discussions with the patient to assist with the development of the directive.
See also section 3 of these guidelines. For more detailed information about advance care directives and advance care planning, see Using Advance Care Directives (NSW), NSW Health, 2004.

7.7 Persistent vegetative state (post-coma unresponsiveness)

Treatment limitation for a severely brain-injured patient is a decision that should be made in accordance with these guidelines. Diagnosis of persistent vegetative state is difficult and usually protracted, often taking months to confirm. The National Health and Medical Research Council has released advice on this matter titled Post-coma unresponsiveness (vegetative state): a clinical framework for diagnosis. It is available on http://www.nhmrc.gov.au.

7.8 Emergency treatment

In some circumstances, for example where a patient’s condition suddenly deteriorates and his or her wishes or likelihood of recovery are unknown, a treating clinician or health professional may provide medical treatment without consent (from either the patient or the person responsible) if the treatment is necessary as a matter of urgency. Such situations might be to:

• save the patient’s life
• prevent serious damage to the patient’s health; or, except in cases of special medical treatment,
• alleviate significant pain or distress.

This treatment should be no more than is reasonably required in the best interests of the patient. This does not apply, however, if the patient, when competent, has unequivocally refused the provision of such treatment in the applicable circumstances and the clinician is satisfied on the available evidence that such a direction has been made.

DEVELOPING LOCAL POLICY

These guidelines should form the basis of local policy on end-of-life decision-making, considering local conditions and resources. Local policy development is recommended for the following situations:

• No CPR orders
• minimum standards for documentation of decisions about withholding, or withdrawal of, treatment
• dispute resolution for patients, families and staff.

Local policy may expand on these guidelines by, for example, identifying relevant persons or contacts within the hospital/Area Health Service who may serve certain roles.

Quality improvement activities for end-of-life care that incorporate self-audit, with other sources of performance feedback, such as complaints and commendations, should be developed to guide future practice.

Area Health Services or individual hospitals should identify an appropriate implementation group to undertake local policy development using these guidelines.

GLOSSARY

Advance care directives

An advance care directive contains instructions that consent to, or refuse, the future use of specified medical treatments. It becomes effective in situations where the patient no longer has the capacity to make treatment decisions.
Family
For the purposes of this document and recognising the collaborative nature of end-of-life care, the term ‘family’ is used to refer to a person or persons who have a close, ongoing, personal relationship with the patient, whom the patient may have expressed a desire to be involved in treatment decisions, and who have themselves indicated a preparedness to be involved in such decisions. This person or persons may or may not include the immediate biological family. However, it may include other relatives, partner (including same sex and de facto partners), friend, or ‘person responsible’ according to any expressed wishes of the patient.

Life-sustaining treatment
Life-sustaining treatment is any medical intervention, technology, procedure or medication that is administered to forestall the moment of death, whether or not the treatment is intended to affect life-threatening diseases or biological processes. These treatments may include, but are not limited to, mechanical ventilation, artificial hydration and nutrition, cardiopulmonary resuscitation or certain medications (including antibiotics).

Palliative care
Palliative care is competent and compassionate care which provides coordinated medical, nursing and allied health services for people who are terminally ill, delivered where possible in the environment of the patient’s choice. It provides relief from pain and other distressing symptoms, integrates psychological and spiritual aspects of care, focuses on supporting patients to live as actively as possible until death, and includes grief and bereavement support for the patient, family and other carers during the life of the patient, and continues after the death of the patient.

Patient
For the purposes of this document, the patient describes the person receiving end-of-life care in an institution such as an intensive care unit, hospital ward, hospice facility, aged-care facility and the home.

Person responsible
The Guardianship Act 1987 (NSW) establishes who can give valid consent for medical treatment to an incompetent patient aged 16 years and over. Consent of the person responsible is required in relation to provision of minor and major medical treatment. The Act establishes a hierarchy for determining 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.

See the Department’s consent policy PD2005_406 for further information on substitute consent and persons responsible.

Treatment limitation decisions
Decisions that involve the reduction, withdrawal or withholding of life-sustaining treatment.

Treating team
The multidisciplinary team of health professionals involved in the patient’s management and care, including medical, nursing, allied health, social workers and counsellors, carers and spiritual advisors.
12. MEDICAL CARE

RESOURCES AND CONTACTS

NSW Department of Health

1. Information on requirements for organ donation and autopsy:
   PD2005_341 - Use and retention of human tissue including organ donation, post-mortem examination and coronial matters

2. Information on informed consent requirements:
   PD2012_014 - Human Tissue - Consent for Donation of Regenerative Tissue by Young Children and Consent Form

These Policy Directives, further copies of these Guidelines and Using Advance Care Directives (NSW) can be downloaded through NSW Health websites:

- Health website (internet)
- Healthnet (intranet)

Hard copies of these guidelines can also be obtained through:
Better Health Centre,
Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452   Fax. (02) 9816 0492

Other websites

3. Information on palliative care standards and guidelines:
   http://palliativecare.org.au/

4. Information on substitute consent and the role of the Office of the Public Guardian

5. Information on enduring guardianship and the role of the Guardianship Tribunal Guardianship Tribunal

6. Information on organ donation and brain death

Other resources

Video - Substitute consent: when the patient can’t give a valid consent,
Guardianship Tribunal, Locked Bag 9, Balmain NSW
Tel. (02) 9555 8500 or Fax. (02) 9555 9049

Guide - Enduring Guardianship: Your Way to Plan Ahead,
Office of the Public Guardian,
PO Box A231 Sydney South NSW
Tel. (02) 9265 3184 or Fax. (02) 9265 2645

NSW Health General Bereavement Support Training Program (information booklet and CD ROM)
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.

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.” 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.

1 NSW Disability Inclusion Act 2014 No 41
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.

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
- 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.

3 Complex communication needs. Department of Communities (Disability Services), QLD. 2011
The Policy Directive, PD2006_053 - Interpreters - 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
- 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 19924 (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 disability5 discrimination. A failure to make reasonable adjustments6 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

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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.
12. MEDICAL CARE

- 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.

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


8 This Direction has effect until 28/10/2017
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:

**Resource: Privacy Information Leaflet for Patients**

### 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.
12. MEDICAL CARE

Carers

A carer provides ongoing, unpaid 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.

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, 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.

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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.
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:
2. Care Coordination Policy Directive Staff Booklet
3. Planning your hospital stay patient brochure
12. MEDICAL CARE

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.

**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.*

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.

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 NDIS or 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

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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

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 not an NDIS participant, 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.
12. MEDICAL CARE

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. 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, 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.

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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 (Com Packs)
- Hospital outpatient department services
- Community nursing
- General Practitioners.

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
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- 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
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- 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 hospital for people who live in supported accommodation settings.

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.
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.  
- Courses and programs are offered by Health Education and Training Institute and Intellectual Disability Mental Health e-learning
- 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
- 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
- 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 - Interpreters – Standard Procedures for Working with Health Care Interpreters is mandatory.

19 Information on:
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Translation Services can be found on the Health Care Interpreting and Translating Services website.  
- 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:  
- NSW Carers 3 2014-2019; factsheet 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
age, gender, type of disability, place of residence and cultural background. 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.

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:

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.


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.
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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


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](http://example.com)
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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.\(^\text{27}\)

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.*

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.

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.

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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 AHSs30 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).
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• 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, 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.
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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.
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- 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.**

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\(^{32}\) 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:
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- 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.
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.

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:
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- 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.

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.

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• 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.
• 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).
Appendix 1 - Membership of the advisory group

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Chief Executive Officer  
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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 (e.g., 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 (e.g., 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 (e.g., cannot 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).
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- 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:
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- 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 that your own health or that of another practitioner does not put patients at risk.
- 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.
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- 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.


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.


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:

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.
12. MEDICAL CARE

• 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:
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 _____ / _____ / _____

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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

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>What was learnt?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of Supervisor</th>
<th>What was the contract for the session?</th>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Name of Supervisee</th>
<th>What will I do differently in the future?</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>What was the contract for the session?</th>
<th>What will I do differently in the future?</th>
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<table>
<thead>
<tr>
<th>Key issues identified during the session?</th>
<th>Further agreements:</th>
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<tr>
<th>Key issues identified during the session?</th>
<th>Further agreements:</th>
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<tr>
<th>Action taken:</th>
<th>Comments:</th>
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<tr>
<th>Action taken:</th>
<th>Comments:</th>
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</table>

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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?

What will be done differently and by whom?

Checklist:

☐ issues identified
☐ Ethical practice/compliance with codes of conduct
☐ Increased learning
☐ Objectives met

Key issues identified during the session:

Notes and evaluation:

Action taken:

Plans for next supervision session:

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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.

<table>
<thead>
<tr>
<th>How helpful has been clinical supervision been?</th>
<th>How has clinical supervision influenced your work with drug and alcohol clients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>Not helpful at all</td>
<td></td>
</tr>
<tr>
<td>Very helpful</td>
<td></td>
</tr>
</tbody>
</table>

What have been the most helpful aspects of clinical supervision?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

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 B: 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:

Supervisors signature __________________________
Date _____/_____/____

Supervisees signature __________________________
Date _____/_____/____
cc Manager

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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

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12. MEDICAL CARE

DRUG & ALCOHOL TREATMENT GUIDELINES FOR RESIDENTIAL SETTINGS (GL2007_014)

The aim of the Guidelines is to provide recommendations for residential treatment of people with drug or alcohol dependence. The intent of the Guidelines is to increase the effectiveness of treatment and to improve treatment outcomes. They are based as far as possible on the evidence reported in peer reviewed literature. The Guidelines differentiate between services which provide residential care and those which provide residential treatment and make a further distinction between residential treatment services and therapeutic communities.


PALLIATIVE CARE ROLE DELINEATION FRAMEWORK (GL2007_022)

NSW Department of Health commissioned the Palliative Care Association of NSW to conduct a review of palliative care services in the State. The review revealed a high degree of variability in the structure and resourcing of palliative care services in the NSW health system, reflecting similar variability in other states. The review found it was difficult to benchmark or to plan services collaboratively because of differences in structure, organisation and service. The findings of the review were subsequently considered at statewide palliative care workshops in NSW. The workshops supported the need for a framework to classify palliative care services according to role and resource capability. Role delineation frameworks provide consistent and common language to describe and differentiate health care services. They are used to facilitate strategic planning at area, regional and state levels. They can also be used to support program and service level evaluation, quality and research activity.


DEMENTIA SERVICES FRAMEWORK 2010-2015 (GL2011_004)


PURPOSE

The NSW Dementia Services Framework 2010-2015 is a joint publication of the NSW Department of Health and NSW Department Ageing, Disability and Home Care that sets the direction for improving quality of life for people with dementia, their carers and families in NSW. It is underpinned by the following principles that emphasise quality dementia care is contingent on being responsive to the needs and experiences of people with dementia, their carers and families.

KEY PRINCIPLES

1) All people with dementia have access to competent and timely, multidisciplinary assessment, diagnosis, care management and support services.
2) People with dementia are valued and respected. Their right to dignity and quality of life is supported.
3) Carers and families are valued and supported. Carers are able to exercise choice in their role as a carer.
4) People with dementia, carers and families are central to making choices about care.
5) Services recognise that individuals vary in their symptoms, rates of progression and needs. Service responses should consider the person, the family and the context as well as the immediate concern irrespective of the service being provided.
6) All people with dementia, carers and families receive care and support that is sensitive to social, cultural or economic background, location and need.
7) A well-trained and supported workforce delivers quality dementia care.
8) Communities play an important role in quality of life for people with dementia, their carers and families.

USE OF THE GUIDELINE

The Framework is for services in health, community and residential care settings to assist with planning and development of dementia services and programs. It reviews service needs and makes recommendations along a dementia care service pathway from awareness through diagnosis, assessment, community, hospital and residential care.

Recommendations are practical and aim to improve access, diagnosis and continuing care.

It can be used as a checklist for reviewing the way services are currently provided and can encourage reflection on how services could be delivered differently to improve outcomes for people with dementia, carers and families.

A NSW implementation plan will be developed to provide further direction for action that aligns with NSW Health responsibilities.

12. **MEDICAL CARE**

**DRUG AND ALCOHOL WITHDRAWAL CLINICAL PRACTICE GUIDELINES - NSW (GL2008_011)**

To provide the most up-to-date knowledge and current level of best practice for the treatment of withdrawal from alcohol and other drugs such as heroin, and other opioids, benzodiazepines, cannabis and psychostimulants.


**NOTIFICATION OF OBSOLETE GUIDELINE: GL2008_012 & PUBLICATION OF UPDATED NSW BURN TRANSFER GUIDELINES (IB2014_071)**

Refer to IB2014_071 for details.

**PREVENTION OF VENOUS THROMBOEMBOLISM (PD2014_032)**

*PD2014_032 rescinds PD2010_077.*

**PURPOSE**

The purpose of this policy is to ensure routine venous thromboembolism (VTE) risk assessment is undertaken on adult patients, and that patients identified at risk of developing a VTE receive appropriate pharmacological and/or mechanical prophylaxis.

**MANDATORY REQUIREMENTS**

- All adult patients admitted to NSW public hospitals must be assessed for the risk of VTE within 24 hours and regularly as indicated/appropriate.
- 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, must be assessed for risk of VTE.
- Patients identified at risk of VTE are to receive the pharmacological and/or mechanical prophylaxis most appropriate to that risk and their clinical condition.
- All health services must comply with the Prevention of VTE Policy.
- All Public Health Organisations must have processes in place in compliance with the actions summarised in the VTE Prevention Framework (Appendix 4.1 of the attachment). A VTE risk assessment must be completed for all admitted adult patients and other patients identified at risk, and decision support tools made available to guide prescription of prophylaxis appropriate for the patients risk level.

**IMPLEMENTATION**

**Clinical Excellence Commission**

- Provide the tools and resources to support implementation of this policy.

**Chief Executives**

- Assign responsibility and resources to ensure adult inpatients are assessed for VTE risk with those found to be at risk provided with appropriate prophylaxis.

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12. MEDICAL CARE

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Director of Clinical Governance

- Ensure local processes are in place to monitor compliance with VTE risk assessment and prophylaxis and to report the results to the relevant local and State committees.

Director of Clinical Operations, Hospital, Facility and Clinical Network Managers

- Ensure all staff receive education regarding VTE prophylaxis.
- Distribute VTE risk assessment and prophylaxis decision support tools to all clinical units.
- Include compliance review in routine clinical audit programs.
- Ensure formulary management includes availability of medications recommended for VTE prophylaxis.
- Data on indicators for VTE should be collected at clinical audit and provided, as required to:
  - The NSW Ministry of Health for state wide performance and compliance monitoring
  - Clinical Department Heads to 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)

- Ensure VTE risk assessment is performed on all adult admitted patients within 24 hours, and those discharged from an Emergency Department with significantly reduced mobility relative to normal state.
- Review the patient’s related bleeding risk and based on that assessment, ensure prescription and administration of appropriate prophylaxis as required.
- Discuss the reason for treatment, risks and consequences of VTE prophylaxis with the patient on admission and on transfer to community or home care where required.
- Document VTE risk assessment and prophylaxis treatment on the VTE National Inpatient Medication Chart (NIMC), where in use. This, and other significant information, including any relevant dosage adjustment can be documented 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.
- Ensure regular review of VTE risk is performed during the patient care episode, particularly as clinical condition changes, and that prophylaxis is monitored and adjusted accordingly.
- Ensure clinical speciality protocols include VTE prophylaxis where appropriate.

1 BACKGROUND

1.1 About this document

Venous thromboembolism (VTE) involves the formation of a blood clot within the deep veins, most commonly of the legs or pelvis (deep venous thrombosis or DVT). These blood clots may become dislodged and then obstruct the pulmonary artery or one of its branches (pulmonary embolism or PE). 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. Serious adverse outcomes resulting from VTE may occur, including an increased risk of recurrent thrombosis, morbidity from post-thrombotic syndrome or death.
12. MEDICAL CARE

The risk of developing VTE depends on the patient’s intrinsic risk factors such as existing medical conditions, age, or family history, and extrinsic risk factors such as surgical intervention, medical treatment, or immobility. Effective prevention of VTE is achieved through assessment of risk factors and the provision of appropriate prophylaxis.

This Procedure describes the strategies for standard workflow and clinical practice to reduce a patient’s risk of developing VTE. These strategies 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 in implementing the strategies described and current clinical practice.

The Prevention of Venous Thromboembolism Framework (Appendix 4.1) provides a summary of the required actions for NSW public hospitals and health services.

This procedure applies to Attending Medical Officers, nurses/midwives and pharmacists. It requires 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 and pharmacists are 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 has developed a supporting tool for VTE risk assessment (this risk assessment tool can be found on the CEC website http://www.cec.health.nsw.gov.au/programs/vte-prevention). The use of this tool is NOT mandatory. Where this tool is not used, a similar tool meeting the requirements set out in this Procedure must be implemented.

The Clinical Excellence Commission will be working with LHDs to facilitate VTE prevention strategies across NSW public hospitals.

1.2 Key definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulant</td>
<td>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.</td>
</tr>
<tr>
<td>Attending Medical Officer (AMO)</td>
<td>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.</td>
</tr>
<tr>
<td>Clinically Significant Bleeding</td>
<td>Major haemorrhage that is life threatening and is likely to result in the need for a massive transfusion; haemorrhage of a smaller volume in a critical area or organ resulting in patient morbidity or mortality; or chronic blood loss resulting in patient morbidity or mortality over time.</td>
</tr>
<tr>
<td>Creatinine Clearance (CrCl)</td>
<td>The volume of serum or plasma that would be cleared of creatinine by excretion of urine over one minute. A measured or calculated renal function test.</td>
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</tbody>
</table>
## 12. MEDICAL CARE

### Prophylaxis

<table>
<thead>
<tr>
<th>Prophylaxis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep Vein Thrombosis (DVT)</td>
<td>A blood clot that occurs in the “deep veins” in the legs, thighs or pelvis.</td>
</tr>
<tr>
<td></td>
<td>- <em>Asymptomatic deep vein thrombosis</em> is defined as painless DVT detected only by screening with fibrinogen scanning, ultrasound, or ascending venography and is often confined to the distal veins.</td>
</tr>
<tr>
<td></td>
<td>- <em>Symptomatic deep vein thrombosis</em> 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.</td>
</tr>
<tr>
<td>Extrinsic Risk Factor</td>
<td>Risk factor external to patient eg surgery, hospitalisation.</td>
</tr>
<tr>
<td>Foot Impulse Device (FID)</td>
<td>The foot impulse device is designed to stimulate the leg veins (venous pump) artificially by compressing the venous plexus and mimicking normal walking and reducing stasis in immobilised patients. Other names for this method of mechanical VTE prophylaxis include foot impulse technology (FIT) or venous foot pump (VFP).</td>
</tr>
<tr>
<td>Graduated Compression Stockings (GCS)</td>
<td>Stockings constructed to provide graduated compression by putting pressure on the leg muscles to squeeze the vein valves, improving the flow of blood back to the heart. Compression is firmest at the ankle and gradually reduces as the distance from the ankle increases. GCS are indicated to treat and prevent various types of vein disease including blood clots (DVTs) in ambulatory patients. The stockings are used to help prevent varicose veins, vein deterioration, oedema and ulcers and can be worn as travel socks. Caution is required to avoid falls when wearing GCS due to slipping. Non-slip oversocks or footwear should be worn to avoid falls. (Another type of compression stocking are anti-embolism stockings indicated to help prevent blood clots in bedbound or non-ambulatory patients.)</td>
</tr>
<tr>
<td>Heparin-induced thrombocytopenia (HIT)</td>
<td>Thrombocytopenia occurring due to treatment with heparin.</td>
</tr>
<tr>
<td>Intermittent pneumatic compression (IPC)</td>
<td>A mechanical method of VTE prophylaxis that comprises the use of inflatable garments wrapped around the legs inflated by a pneumatic pump. The pump provides intermittent cycles of compressed air which alternatively inflate and deflate the chamber garments, enhancing venous return.</td>
</tr>
<tr>
<td>Intrinsic Risk Factor</td>
<td>Risk factor internal to patient or individual risk factors eg age, family history.</td>
</tr>
<tr>
<td>Low Molecular Weight Heparins (LMWH)</td>
<td>Group of anticoagulant drugs termed the Low Molecular Weight Heparins (LMWH) which are obtained by fractionation of heparin with mass &lt; 8000 e.g. enoxaparin sodium, dalteparin sodium.</td>
</tr>
<tr>
<td>Mechanical Prophylaxis</td>
<td>VTE prophylaxis in the form of a GCS, anti-embolic stocking, IPC or FID.</td>
</tr>
<tr>
<td>Must</td>
<td>Indicates a mandatory action requiring compliance.</td>
</tr>
<tr>
<td>Post-partum Period</td>
<td>Period beginning immediately after the birth of a child and extending for about six weeks.</td>
</tr>
<tr>
<td>Prescriber</td>
<td>A health professional legally entitled to prescribe medicines according to prevailing <em>NSW Poisons and Therapeutic Goods Act 1966</em> and Regulations.</td>
</tr>
<tr>
<td>Pulmonary embolism (PE)</td>
<td>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. <em>Plural = pulmonary emboli</em></td>
</tr>
</tbody>
</table>

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224(25/09/14)
12. MEDICAL CARE

<table>
<thead>
<tr>
<th>Should</th>
<th>Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Significantly Reduced Mobility Relative to Normal State</strong></td>
<td>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 ridged immobilisation, or non-weight bearing status. The change in mobility should be assessed in relation to the patient’s normal state of functioning.</td>
</tr>
<tr>
<td><strong>Anti-embolic stockings</strong></td>
<td>A type of compression stocking indicated to help prevent blood clots in bedbound or non-ambulatory patients.</td>
</tr>
<tr>
<td><strong>Thromboprophylaxis</strong></td>
<td>Measures taken to assist in reduction of the risk of thrombosis.</td>
</tr>
<tr>
<td><strong>Venous thromboembolism (VTE)</strong></td>
<td>The blocking of a blood vessel by a blood clot. Includes both deep vein thrombosis and pulmonary embolism.</td>
</tr>
<tr>
<td><strong>Venous thrombosis</strong></td>
<td>A condition in which a blood clot (thrombus) forms in a vein.</td>
</tr>
</tbody>
</table>
| **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

2.1.1 Patients in the Emergency Department

Adult patients 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 must 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.

Adult patients being admitted to an inpatient ward or unit from an Emergency Department:

- Who will not be seen by the admitting team until the next day, must undergo a VTE risk assessment and be prescribed appropriate prophylaxis by an Emergency Department clinician as part of their interim orders prior to leaving the Emergency Department
- Must undergo a VTE risk assessment and be prescribed appropriate prophylaxis by the admitting team if transferred within the same day.
2.1.2 Admitted Patients
All adult patients admitted to a NSW public hospital or health service must undergo a VTE risk assessment within 24 hours of admission and, if appropriate, be prescribed pharmacological and/or mechanical prophylaxis.

2.1.3 Pregnant and Post-Partum Women
All pregnant and post-partum women must undergo VTE risk assessment:
• During the first antenatal review and/or during booking
• During admission into a non-obstetric setting for a non-pregnancy related complaint
• During admission into an obstetric setting for a pregnancy or non-pregnancy related complaint
• Immediately after birth (postnatal period).

2.1.4 Planned Admission
Patients undergoing planned surgical and invasive interventions and/or imaging guided invasive interventions:
• Prior to planned surgery and invasive procedures, and/or imaging guided invasive procedures, medical officers must assess 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 anaesthesia and for patients demonstrating one or more other risk factors. Examples are provided on page 21 of National Health and Medical Research Council (NHMRC) guidelines.2

2.2 Risk Assessment

2.2.1 Assessing VTE Risk

The risk assessment tool must ensure the following steps are undertaken during the assessment.

Step 1 Assess baseline risk (intrinsic risk).
Step 2 Assess additional risks posed by hospitalisation or illness (extrinsic risk), particularly level of mobility relative to normal state.
Step 3 Assess contraindications.
   a. Assess risk of bleeding or contraindication to pharmacological prophylaxis.
   b. Assess any contraindication to mechanical prophylaxis.
Step 4 Formulate overall risk assessment outcome (consider risk of prophylaxis against benefit).

| Decide if VTE prophylaxis is required |
| Inform patient/carer of the VTE prophylaxis measures to be undertaken |

Step 5 Select the form of prophylaxis to be used based on the risk assessment.
Step 6 Reassess prophylaxis regularly (at least every 7 days), if condition changes, and at transfer of care.

2.2.2 Assessing VTE Risk in Pregnant and Post-Partum Women
• A standard risk assessment tool can be used for a pregnant woman admitted into a non-obstetric setting for a non-pregnancy related complaint.
Any other tools used to assess VTE risk in a non-obstetric setting must identify all pregnant and postpartum women to be at risk of VTE. The decision to commence pharmacological and/or mechanical prophylaxis must be referred to an obstetrics consultant/team.

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 patient group.

2.2.3 Documenting VTE Risk

Attending Medical Officers (or delegate) must document:
- That a risk assessment has been completed
- The outcome of the risk assessment.

The National Inpatient Medication Chart (NIMC) includes a dedicated VTE section (not included on the long-stay version). When in use, medical officers must use this section to document when a risk assessment has been completed.

Additional areas for documentation may include:
- The patients’ health care record
- Approved risk assessment tools
- Other locally approved forms, such as patient care plans
- Electronic medical record.

2.2.4 Additional Prevention Strategies

Irrespective of a patient’s VTE risk outcome, the following measures should be observed during the episode of care:
- Patients must remain adequately hydrated (unless contraindicated due to their clinical condition e.g. fluid restriction due to congestive cardiac failure) and must be encouraged to mobilise as soon as possible and to continue being mobile post discharge.3
- A plan for early mobilisation should be developed by a multidisciplinary team with the patient and their family/carer.

2.3 Prescribing Appropriate Prophylaxis

To assist in reducing risk of VTE, prophylaxis should be commenced as early as possible during the patient’s admission or commenced as scheduled after immediate care and risk assessment is carried out.

The standardised risk assessment tool made available should provide clinical decision support for Attending Medical Officers when prescribing prophylaxis.

Further information to assist in selecting the type of prophylaxis is available in Prevention of Venous thromboembolism in patients admitted to Australian hospitals, NHMRC Guideline Summary (Appendix 4.2) and NHMRC Summary of Availability of Evidence for Use of Thromboprophylactic Agents by Clinical Category, (Appendix 4.3).

There are two types of prophylaxis, pharmacological and mechanical.

2.4 Pharmacological Prophylaxis

VTE prophylaxis agents may consist of:
- Heparin
  - Unfractionated heparin
  - Low molecular weight heparins (e.g. enoxaparin, dalteparin)
- Factor Xa inhibitors (e.g. rivaroxaban, fondaparinux, apixaban)
12. **MEDICAL CARE**

- Direct thrombin inhibitors, (e.g. dabigatran)
- Heparinoids
  - Danaparoid
- Based on evidence, for patients with heparin sensitivity or diagnosed as having heparin-induced thrombocytopenia (HIT), the heparin and heparin-like agents should generally be avoided. A heparinoid (e.g. danaparoid) can be used as a substitute. (See Contraindications 2.4.3). A Haematologist should be consulted for further advice when managing a patient with heparin sensitivity or HITs.
- These drugs are recommended to be continued until the patient regains normal mobility or is transferred to home or other care setting. Pharmacological prophylaxis may need to be continued beyond the hospital stay, particularly in the case of joint replacement surgery (hip and knee).
- The choice of drug to use must be informed by evidence, (eg NHMRC guidelines); a clinical specialty protocol, as well as reference to drugs available on the hospital formulary.
- The risk of bleeding related to surgery is the main complication of pharmacological prophylaxis.
- 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).

2.4.1 **Individualising the Dose of Pharmacological Prophylaxis**

Note: Some agents are contraindicated or require a reduction of dose in elderly patients or those with renal impairment

Prescribers should refer to current product information to select a safe dose for individual patients, taking care to select the dose recommended for prophylaxis and not the dose recommended for therapeutic anticoagulation.

Obese patients (body mass index > 30kg/m²) may have an increased risk of VTE and may require higher pharmacological prophylaxis doses. Evidence is limited regarding the recommended dosing regimen, therefore clinician discretion is warranted, taking into account both the risk of clotting and the risk of bleeding.

Patients with renal impairment often require a reduced dose of pharmacological prophylaxis; or depending on level of impairment, one agent may be preferred over the other. Renal impairment should be calculated using creatinine clearance as the unit of measure before decisions regarding pharmacological prophylaxis are made.

\[
\text{Creatinine clearance in mL/min} = \frac{(140 - \text{age (years)}) \times \text{ideal body weight (kg)}}{0.815 \times \text{serum creatinine concentration (micromol/L)}}
\]

(Multiple by 0.85 for females)

2.4.2 **Drug Interactions**

Drugs like anticoagulants (e.g. warfarin, dabigatran), anti-platelet agents, selective and non-selective non-steroidal anti-inflammatory drugs, and antithrombotic agents may interact with prophylactic agents to increase the risk of bleeding. Other drugs may interact with prophylactic agents to increase bleeding risk or reduce their efficacy. Check carefully and refer to product information and/or appropriate clinical references.
Decisions about appropriate concomitant use of these medications for VTE prophylaxis should be made on an individual patient basis in consultation with the Attending Medical Officer.

2.4.3 Contraindications to Pharmacological Prophylaxis

Contraindications to pharmacological prophylaxis must be considered before a patient is prescribed therapy.

Contraindications can be either absolute or relative. Where an absolute contraindication exists, 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.

Absolute contraindications may include (but not limited to):
• Known hypersensitivity to agents used in pharmacological prophylaxis
• History of, or current, heparin-induced thrombocytopenia (alternative agents available)
• Active bleeding or risk of clinically significant bleeding.

Relative contraindications may include (but not limited to):
• Any risk of bleeding
• Creatinine clearance < 30mL/minute (reduced dosages or specific agents may be used in some cases)
• Use of low dose aspirin for prevention or treatment of cardiovascular disease or other antiplatelet therapy.

Where pharmacological prophylaxis is contraindicated, mechanical prophylaxis remains an option and should be considered, as indicated, until the patient is mobile.

2.4.4 Anaesthesia and VTE

The type of anaesthesia a patient receives has been identified as impacting on risk of VTE. Patients receiving regional anaesthesia (also referred to as central neural blockade), have significantly lower rates of DVT compared with those receiving general anaesthesia. As for all surgery and imaging guided invasive procedures (but particularly if central neural blockade is used), timing of pharmacological prophylaxis should be carefully planned with the anaesthetist to minimise the risk of developing an epidural haematoma.²

The NHMRC² recommends:
• No pharmacological prophylaxis with LMWH should be administered prior to establishment of neural blockade, or the block should be performed ≥ 12 hours after the last does of LMHW if preoperative prophylaxis has been administered with this drug. Dosing after surgery should start ≥ 6 hours postoperatively.
• If an epidural catheter has been placed it should be removed:
  o ≥ 2 hours before a postoperative dose of pharmacological prophylaxis with LMWH; and
  o ≥ 10 hours after a previously administered LMWH dose
• Because of the longer half-life of fondaparinux and dabigatran etexilate, special arrangements should be made between the surgical and anaesthetic teams if these drugs are to be used.
2.5 Mechanical Prophylaxis

The following may be used as indicated:

- Graduated Compression Stockings (GCS) for ambulant patients or anti-embolic stockings for immobile patients.
- Intermittent pneumatic compression (IPC) or foot impulse devices (FID).
- Intravascular filtration.

Local protocols are to be developed to guide the use of foot impulse devices (FIDs).

2.5.1 Graduated Compression Stockings and Compression Devices

- For higher risk surgical patients, mechanical prophylaxis with appropriate pharmacological prophylaxis are usually provided until the patient is fully mobile or as indicated. If pharmacological prophylaxis is contraindicated, the most appropriate mechanical device available e.g. intermittent pneumatic compression (IPC) or foot impulse devices (FID) should be used until the patient is mobile or as indicated.
- All stockings must be fitted and worn correctly according to the manufacturer’s recommendations.
- It should be noted that graduated compression stockings may increase the risk of falls in mobilising patients. Approved non-slip oversocks or appropriate footwear should be worn to avoid falls.
- Stockings must be removed daily to assess skin condition and perfusion and to provide skin care. Outcome should be documented in the patient’s medical notes.
- Pressure areas (such as the heel, toes and behind the knee) should be checked twice daily, most preferably at every shift. Outcome should be documented in the patient’s medical notes.

2.5.2 Contraindications to Graduated Compression Stockings, Anti-embolic stockings/Devices

Compression stockings may be contraindicated in patients with:

- Morbid obesity where correct fitting cannot be achieved
- Inflammatory conditions of the lower leg
- Severe peripheral arterial disease
- Diabetic neuropathy (there is a risk of injury due to decreased sensation and discomfort if there is a problem with the fitting).
- Severe oedema of the legs
- Unusual leg deformity
- Allergy to stocking material
- Cardiac failure.

IPC or FID can exacerbate lower limb ischemic disease and are contraindicated in patients with peripheral arterial disease or arterial ulcers. IPC is contraindicated in acute lower limb DVT. The NHMRC notes that a recent study provides no evidence to support the routine use of graduated compression stockings anti-embolic stockings in immobile, hospitalised patients following acute stroke.

2.5.3 Complications of Mechanical Prophylaxis

Bunching of the stockings from incorrect fitting could result in leg ulceration, pressure injuries, slipping and falling on mobilisation.
2.5.4 Intravascular Filtration
In exceptional circumstances, an Inferior Vena Cava (IVC) filter may be implanted into the inferior vena cava or other major blood vessel to prevent fatal pulmonary emboli in the event that anticoagulation prophylaxis is contraindicated.

2.6 Documentation of Prophylaxis

Once the decision is made to prescribe pharmacological and/or mechanical prophylaxis, an order must be written.

The regular NIMC contains a dedicated VTE section. Where this chart is used, the Attending Medical Officer (or delegate) 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, where mechanical prophylaxis has been prescribed.

Where electronic prescribing systems are in use, Attending Medical Officers should prescribe pharmacological and/or mechanical prophylaxis as per local protocol.

2.7 Other Patient Groups

2.7.1 Peri-operative and Peri-procedural Management of Patients Receiving Regular Anticoagulation
For surgery and invasive procedures an important consideration is the timing of stopping and restarting regular anticoagulants (e.g. warfarin), and the timing of prescription of pharmacological prophylaxis to bridge anticoagulation therapy for peri-operative patients. As an example after warfarin therapy is discontinued, it takes several days for the antithrombotic effect to recede. When warfarin is re-commenced, several days are required to reach therapeutic anticoagulation levels.

There is no current consensus on the appropriate peri-operative management of anticoagulation. Attending Medical Officers (or delegate) should review current evidence prior to planning treatment.

Attending Medical Officers should review current evidence regarding continuation of regular anticoagulants or antiplatelet therapy where only minor procedures (including dental) are planned.

2.7.2 Patients on Medication containing Oestrogen
Medical officers should review current evidence (including risks of unplanned pregnancy vs benefit of VTE prevention) to determine whether patients, prior to, or during admission, should discontinue oestrogen-containing oral contraceptives or hormone replacement therapy if clinically appropriate. In the case of oestrogen-containing oral contraceptives, these risks should be communicated to the patient and if it is thought appropriate to stop oral contraceptives, adequate alternative contraception should be arranged until oral contraceptives are restarted.6
2.7.3 Patients on Medication Increasing the Risk of VTE
There are a number of other medications that may increase the risk of developing a VTE, particularly during periods of immobilisation or after surgery. These may include (but not limited to) agents such as tamoxifen, epoetin alfa, strontium ranelate, and raloxifene. Medical officers should consider temporary cessation of such agents or VTE prophylaxis where appropriate.

2.8 Engaging the Patient

Patients, carers and their families must 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 blood clot in hospital should be available, and patient leaflets summarising key points should be provided. Resources are available at:

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/.

2.8.1 Documentation of Patient Information
When a treatment decision has been made, clinicians must document that the patient has received an explanation of risks and benefits of prophylaxis. This should be recorded within the patients’ health care record and/or other approved form/tool.

Clinicians must also document when they provide patients/carers additional information regarding VTE prevention.

2.9 Reassessing VTE Risk
After the initial risk assessment, the patient’s risk of bleeding and of VTE should be reassessed:
- 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.

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.

2.9.1 Reassessing Risk at Discharge and Continuity of Care
Patients who have been identified as being at risk of VTE during their admission should be reassessed at the point of discharge. Consideration should be made regarding the need for extended prophylaxis.
Attending Medical Officers must 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 care provider and explained to the patient/carer/family. This is particularly important when patients are transferred into community or residential aged care.

The recommended duration of pharmacological prophylaxis will vary depending on the patient’s medical status. When determining the duration of prophylaxis, consideration should be given to the patient’s mobility status and the clinical evidence related to their specific condition – see Appendix 4.2 for recommended duration.

Clinicians must comply with key principles for clinical handover (PD2009_060) with special regard to VTE prophylaxis treatment at all transition points including transfer home or to another care services.

On transfer to home or another care services, a patient’s supplies 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 understand 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).

2.10 Monitoring Performance and Practice

2.10.1 Reporting

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 (IIMS) with the appropriate level of investigation initiated.

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 IIMS.

2.10.2 Clinical Audit

Health services should ensure monitoring processes are in place to assess compliance with risk assessment completion and the prescription of appropriate prophylaxis.

A number of audit measures are available to assist with review of clinical processes. These include:


It is recommended that clinical audit be conducted at least annually, more frequently where compliance is poor.
2.10.3 Feedback to Clinical Staff

VTE incidents are to be reviewed with other clinical indicators and any incidents are to be included as part of the existing hospital morbidity and mortality review process.

The outcome of clinical audits should also be communicated to clinicians in a timely manner in order to review practice and procedure.

2.10.4 Staff Education

Clinical staff should be provided with education on VTE prevention strategies.

Training resources can be found at:


3 REFERENCES

### 4.1 VTE Prevention Framework

#### Prevention of Venous Thromboembolism Framework

This Framework has been developed to guide LHDs and facilities in the implementation of the Prevention of Venous Thromboembolism Policy Directive

<table>
<thead>
<tr>
<th>To Prevent VTE</th>
<th>What this means for Patients</th>
<th>Actions Required by NSW Hospitals and Health Services</th>
</tr>
</thead>
</table>
| 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 be referred to an Obstetrics consultant/team to undergo appropriate VTE risk assessment |
| 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) National Inpatient Medication Chart (NIMC)  
(ii) Patient health care record  
(iii) Approved risk assessment tool  
(iv) 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 Clinicians are prompted at discharge to assess the need for 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 is 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 |
### 4.2 Prevention of Venous thromboembolism in patients admitted to Australian hospitals – NHMRC Guideline summary

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Recommendations (and grade of recommendations)</th>
<th>Thromboprophylaxis for admitted medical patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total hip replacement</strong></td>
<td>• Use LMWH (A) or fondaparinux (B) or dabigatran etexilate (B) for up to 35 days</td>
<td>• Consider LMWH, based on degree of immobility and risk of bleeding (B)</td>
</tr>
<tr>
<td></td>
<td>• Use GCS or IPC or foot pump (B) whether or not pharmacological prophylaxis is used</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• If pharmacological prophylaxis is contraindicated, use GCS and foot pump (B)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use until fully mobile</td>
<td></td>
</tr>
<tr>
<td><strong>Hip fracture surgery</strong></td>
<td>• Fondaparinux (A) or LMWH (B)</td>
<td>• Do not use any pharmacological prophylaxis due to the risk of intracranial bleeding (GPP)</td>
</tr>
<tr>
<td></td>
<td>For up to 35 days</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td><strong>Total knee replacement</strong></td>
<td>• Use LMWH (B) or fondaparinux (B) or dabigatran etexilate (B) for up to 4 days</td>
<td>• UPH (C), only when full anticoagulation is not in use</td>
</tr>
<tr>
<td></td>
<td>• Use foot pump or IPC (C) whether or not pharmacological prophylaxis is used</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Use until fully mobile</td>
<td></td>
</tr>
<tr>
<td><strong>Knee arthroscopy</strong></td>
<td>• Thromboprophylaxis is not recommended unless the patient has additional VTE risk factors (see Step 2, page 1) (C)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Use LMWH (A) for the entire period of immobilization</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td><strong>Lower leg fractures/immobilization in a brace or plaster cast</strong></td>
<td>• Use LMWH (B) for 5–9 days</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Use GCS, whether or not pharmacological prophylaxis is used (B)</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>General surgery</strong></td>
<td>• Use LMWH (B) or UPH (B)</td>
<td>• Consider using GCS or other mechanical options, especially if pharmacological prophylaxis is contraindicated (GPP)</td>
</tr>
<tr>
<td></td>
<td>For up to one week or until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Urological surgery</strong></td>
<td>• Consider thromboprophylaxis based on assessment of the patient’s risk of VTE and of bleeding (GPP)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Use LMWH (B) or UPH (B)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>For up to one week or until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Gynaecological surgery</strong></td>
<td>• Use LMWH (B) or UPH (B)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>For up to one week or until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Abdominal surgery</strong></td>
<td>• Use LMWH (B) or UPH (B)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>For up to one week or until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Cardiac, thoracic and vascular surgery</strong></td>
<td>• Use LMWH (B) or UPH (B)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>For up to one week or until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Neurosurgery</strong></td>
<td>• Due to high risk of bleeding use thromboprophylaxis with extreme caution (GPP)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Use LMWH or UPH (B)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td><strong>Trauma and spinal surgery</strong></td>
<td>• Use LMWH, starting 5 days after admission (C)</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Do not start thromboprophylaxis until primary haemostasis has been established (GPP)</td>
<td>• Use LMWH or UPH (B)</td>
</tr>
<tr>
<td></td>
<td>• Use until fully mobile</td>
<td>• Use until fully mobile</td>
</tr>
<tr>
<td><strong>Cancer patients having general, abdominal, pelvic or neurosurgery (see also next category)</strong></td>
<td>• For at least 2–10 days post surgery</td>
<td>• Instructive evidence; unable to make a recommendation</td>
</tr>
<tr>
<td></td>
<td>• Consider extending the duration of LMWH to 28 days for patients having major abdominal or pelvic surgery for cancer, especially if obese, slow to mobilise or with past history of VTE (GPP)</td>
<td>• Use LMWH or UPH (B)</td>
</tr>
<tr>
<td><strong>Head and neck cancer patients having head and neck surgery</strong></td>
<td>• Unless other significant VTE risk factors are present (see Step 2, page 1), thromboprophylaxis is not recommended (GPP)</td>
<td>• Consider using ICP during and for 24 hours after surgery (GPP)</td>
</tr>
<tr>
<td><strong>Caisseion section</strong></td>
<td>• Mobile promptly post caesarean (GPP)</td>
<td>• Consider using ICP during and for 24 hours after caesarean (GPP)</td>
</tr>
<tr>
<td></td>
<td>• Use LMWH or warfarin delivery for 3–7 days post caesarean or until fully mobile (GPP)</td>
<td>• Consider using ICP during and for 24 hours after caesarean (GPP)</td>
</tr>
<tr>
<td></td>
<td>For women with additional risk factors (see Step 2, page 1), extend LMWH or adjusted therapeutic dose warfarin to 3 weeks (GPP)</td>
<td>• Consider using ICP during and for 24 hours after caesarean (GPP)</td>
</tr>
</tbody>
</table>

**NHMRC grading of recommendations**

- **A**: Body of evidence can be trusted to guide practice
- **B**: Body of evidence can be trusted to guide practice in most situations
- **C**: Body of evidence provides some support for recommendation(s) but care should be taken in its application
- **D**: Body of evidence is weak and recommendation must be applied with caution
- **GPP**: Good practice point – consensus-based recommendations

**Key**

- **LMWH**: Low molecular weight heparin
- **UFH**: Unfractionated heparin
- **GCS**: Graduated compression stockings
- **IPC**: Intermittent pneumatic compression

This summary is based on the National Health and Medical Research Council’s Clinical Practice Guideline for the Prevention of Venous Thromboembolism in Patients Admitted to Australian Hospitals. This summary and the guideline on which it is based are available for download from [www.nhmrc.gov.au](http://www.nhmrc.gov.au).

July 2010

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### 4.3 Summary of availability of evidence for use of thromboprophylactic agents by clinical category – excerpt from NHMRC\textsuperscript{2}

<table>
<thead>
<tr>
<th>Condition</th>
<th>UFH</th>
<th>LMWH</th>
<th>HEPARINOID</th>
<th>RIVAROXABAN</th>
<th>DABIGATRAN</th>
<th>FONDAPARINUX</th>
<th>WARFARIN</th>
<th>ASPIRIN</th>
<th>IPC</th>
<th>FOOT PUMP</th>
<th>REGIONAL ANAESTHESIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total hip replacement</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>✓±</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hip fracture surgery</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓±</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total knee replacement</td>
<td>—</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>—</td>
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<tr>
<td>Knee arthroscopy</td>
<td>—</td>
<td>X</td>
<td>—</td>
<td>—</td>
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<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lower leg fractures and injuries with immobilisation</td>
<td>—</td>
<td>✓</td>
<td>—</td>
<td>—</td>
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<td>—</td>
<td>—</td>
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<td></td>
<td></td>
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<tr>
<td>General surgery</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✓±</td>
<td>—</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urological surgery</td>
<td>X</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Gynaecological surgery</td>
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<td>—</td>
<td>—</td>
<td>X</td>
<td>✓±</td>
<td>✓±</td>
<td>✓±</td>
<td></td>
<td></td>
<td>—</td>
</tr>
<tr>
<td>Abdominal surgery</td>
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<td>—</td>
<td>X</td>
<td>✓</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Cardiac, thoracic and vascular surgery</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✓</td>
<td>✓±</td>
<td>—</td>
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<tr>
<td>Neurosurgery</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓±</td>
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<td>—</td>
</tr>
<tr>
<td>Trauma surgery and spinal surgery</td>
<td>—</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✓±</td>
<td>✓±</td>
<td>—</td>
<td></td>
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<td>—</td>
</tr>
<tr>
<td>Stroke</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td>—</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>General medical*</td>
<td>✓</td>
<td>—</td>
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<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Cancer</td>
<td>—</td>
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<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Pregnancy and childbirth</td>
<td>—</td>
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<td>—</td>
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</tr>
</tbody>
</table>

**Note:** Only recommendations that are based on evidence have been included in this table (including graded recommendations and Good Practice point recommendations).

*Refer to the relevant section of the NHMRC guidelines\textsuperscript{1} for a detailed description of patients considered in the general medical category as well as considerations for treatment in cancer and pregnancy/childbirth.

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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.


USING RESUSCITATION PLANS IN END OF LIFE DECISIONS (PD2014_030)


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).

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). These 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).
12. MEDICAL CARE

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.

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:*
  
12. MEDICAL CARE

- 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.

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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.
12. MEDICAL CARE

• 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)

RESUSCITATION PLAN - ADULT
For patients aged 16 years and over
Refer to PD2014_030

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:

Asides from an intense focus on comfort, in the event of deterioration the following may be appropriate:

- Respiratory Support:
  - Drongofial suction: Yes □ No □
  - Supplemental oxygen: Yes □ No □
  - Non-invasive ventilation: 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
YELLOW ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Rapid Response Call are to be activated
RED ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Nurse/ 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 authorize 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, use a diagonal line through both sides. Print & sign your name & date on the line.

NO WRITING Page 1 of 2

223(11/09/14)
12. MEDICAL CARE

12.370

RESUSCITATION PLAN - ADULT
For patients aged 18 years and over
Refer to PD2014_030

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: __________________________

*The NSW Guardianship Act establishes the Person Responsible who can give valid consent for medical treatment to an incompetent patient aged 18 years and over according to this hierarchy:
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 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 progress 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

223(11/09/14)
12. MEDICAL CARE

Attachment 2: Resuscitation Plan – Paediatric (SMR020.055)

For patients aged between 20 days and 18 years
Refer to PD2014_030

Patient Name: 

This Plan was discussed with and authorized by the Attending Medical Officer

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.

The Goals of Care negotiated through conversations with the doctor/patient/family/guardian

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 □
  - Non-invasive ventilation: Yes □ No □

- Referral to ICU: Yes □ No □
- Are other non-urgent interventions appropriate? Yes □ No □
  (e.g. vascular access, blood products, antibiotic, NO, feed/feeds, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required:

Clinical Review Calls are to be activated

Yellow Zone on Standard Paediatric Observation Chart

Yes □ No □

Rapid Response Call are to be activated

Red Zone on Standard Paediatric Observation Chart

Yes □ No □

Nurses/medical staff may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life-prolonging treatment is not indicated.

In the event of cardiopulmonary arrest:

CPR □ No CPR □
(see rationale overleaf)

Delegated signatory Medical Officer (the AMO must authorize 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 and 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.

NSW HEALTH RESUSCITATION PLAN PEDIATRIC 10/2012

No Writing
12. MEDICAL CARE

RESUSCITATION PLAN - PAEDIATRIC
For patients aged between 29 days and 18 years
Refer to PD2014_030

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 FACCS 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-hospital Ambulance transfers) ☐
- For up to 3 months for frequent and routine admissions (e.g. regular immunoglobulin infusions) ☐
- Until review date at ………/………./……… or at 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.
Attachment 3: Figure 1: Resuscitation Plans in the context of Advance Care Planning and End of Life

- **Goals of care conversations**
- **Advance Care Plans**
  - Patient’s Values Profile
  - Correctly identified and engaged Persons Responsible
- **Resuscitation Plans**
  - Recognition of Uncertain Recovery - eg. AMBER Care Bundle
  - TRIGGERS
  - Surprise question
  - Recovery uncertain
  - Recurrent admissions with severe chronic disease
  - Progressive advanced illness
  - Rapid response system activated or anticipated
- **+/− Last days of life care plans enacted**
- **DEATH & Bereavement**

**Outcomes of Advance Care Planning**
- **Appointments of Enduring Guardianship**
- **+/− Advance Care Directives**
Attachment 4: Implementation checklist

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USE OF FINE BORE NASOGASTRIC FEEDING TUBES FOR ADULTS (PD2009_019)

Purpose

To provide appropriate and safe strategies to reduce risks associated with the use of fine bore nasogastric tubes for adult patients.

The strategies and process outlined in this policy are to be incorporated into health facility procedures in relation to fine bore nasogastric tubes.

Roles and responsibilities

Every person has responsibility for the health and welfare of our patients. To ensure our standard and commitment are delivered, the following responsibilities are assigned:

Chief Executives
• Assign responsibility and resources to promote the policy standard for the use of fine bore nasogastric feeding tubes.

Directors of Clinical Governance
• Promote safe fine bore nasogastric tube insertion and post insertion care.
• Promote the policy for the use of fine bore nasogastric feeding tubes within health services.
• Ensure successful implementation of the standard within their organisation.

Director of Clinical Operations, Hospital, facility and clinical stream managers:
• Distribute fine bore nasogastric tube insertion and placement decision support tools to all clinicians.
• Provide education and training on the correct and safe insertion and removal of fine bore nasogastric tubes.
• Ensure equipment such as pH indicator strips are available to ensure clinicians can assess fine bore nasogastric feeding tube placement.
• Ensure that any incorrect insertion and/or placement of fine bore nasogastric tubes are discussed at appropriate patient safety and clinical review meetings.

Clinicians:
• Complete education and training to ensure knowledge and practical skill for fine bore nasogastric tube insertion and care.
• Assess every patient for their increased risk of nasogastric tube complications.
• Correctly insert fine bore nasogastric tubes according to the patient’s risk.
• Reassess fine bore nasogastric tube placement as outlined in the standard.
• Document the correct insertion and placement of the fine bore nasogastric tube in the patient’s health care record.

About this standard

This document outlines strategies to reduce risks associated with the use of a fine-bore nasogastric tube in the adult patient. Descriptions of how to insert a nasogastric tube, when and how to test for placement of the tube are provided, with a flowchart outlining the steps to take when testing placement of newly inserted and in situ tubes.
The strategies and processes outlined in this document are to be incorporated into health facility procedures in relation to fine bore nasogastric tubes.

**Definition of fine bore nasogastric tubes**

A fine bore nasogastric tube is a narrow bore tube passed into the stomach via the nose as a means of meeting a patient’s nutritional needs when they are unable to maintain adequate oral intake. Fine bore nasogastric tubes are long term devices that can remain in situ up to six (6) weeks and can come with or without a guidewire.

**Scope**

Who must use this standard?

All clinical staff involved in the medical or surgical management of adults must be aware of these standards for use of nasogastric feeding tubes in adults.

**All clinical staff must:**

Complete education and training to ensure knowledge and practical skill for fine bore nasogastric tube insertion and care before undertaking an insertion of fine bore nasogastric tubes.

**Patient Population:**

This policy standard relates to the insertion and care of nasogastric tubes in adults only.

**Related Documents**

Fine Bore Nasogastric Feeding Tubes for Paediatric Patients Policy (*in development*).

**Risks - Incorrect insertion and placement of nasogastric feeding tubes**

Poor technique or using the incorrect procedure to insert or check tube placement can result in adverse patient outcomes including:

- Trauma to surrounding tissues;
- Pneumothorax;
- Aspiration associated with tube dislodgement;
- Pneumonitis from nasogastric feeds being deposited into the lungs;
- Misplacement of the tube into the lungs or rarely, in patients with cribriform plate disruption, intracranial insertion.

**BE AWARE THAT….**

- Critically ill patients may be at increased risk of nasogastric tube complications e.g. patients with neurological deficits.
- Insertion a fine bore nasogastric tube into a patient with no or diminished reflexes may cause accidental insertion into other anatomical structures.
- Caution is required when inserting fine bore nasogastric tubes in patients on anticoagulants or who have impaired blood clotting.
- Caution is required when inserting fine bore nasogastric tubes in patients with a tracheostomy because of the risk in inadvertent tracheal intubation (particularly patient’s with un-cuffed tracheostomy tubes).
- A fine bore nasogastric tube may cause gastric contents to leak from the stomach causing oesophageal erosions in patient with gastro-oesophageal reflux.
12. MEDICAL CARE

DO NOT....
- Reinsert the guidewire after tube insertion or to advance tube at anytime.
- Refrigerate fine bore nasogastric tubes prior to insertion.

Do not insert nasogastric tubes for patients who:
- Have oesophageal varices or signs of long standing alcohol abuse including hepatomegaly, Wernicke-Korsakoff’s syndrome, telangiectasia - patients are at higher risk of damage to the oesophageal wall causing veins to bleed uncontrollably.
- Have had upper gastrointestinal stricture/obstruction - perforation of the gastrointestinal tract may occur by the tube being pushed through the walls.
- Are post gastrectomy/oesophagectomy - may cause trauma to the anastomosis.
- Are post oesophageal/head and neck surgery - may damage or create orifices/fistula around surgery site. Inadverted insertion of tube into other anatomical structures may occur.
- Have severe maxillary trauma/nasal injuries/possible base of skull fractures - tube may be incorrectly inserted into other anatomical structures e.g. intracranial or tracheopulmonary. Use an orogastric tube instead.
- Have had plastics reconstruction to mouth, nose or orophagus due to changes in the anatomy.
- Have a suspected spinal injury - tube normally requires hyperflexion of the neck which may lead to permanent damage.

* In extenuating circumstances, there may be a need to perform insertion of fine bore nasogastric tube in the above conditions. In this instance only a Medical Officer experienced in the insertion of fine bore nasogastric tube may perform the procedure.

Strategies to reduce risk

DO....
- Ensure that insertion of a tube is ordered by a medical officer, with the order and the rationale for insertion of the tube documented in the patient’s health care record.
- The patient must be assessed that they do not have a contraindication or potential complications for insertion of a fine bore nasogastric tube.
- Check the patient’s allergies, including allergies to Lidnocaine and to tape.
- Use feeding tubes that are opaque with markings to enable accurate measurement, identification and documentation of tube position.
- Undertake patient observations pre and post insertion of the nasogastric tube. Observations must include temperature, pulse, blood pressure, respiratory rate and oxygen saturation; and be documented in patient’s health care record.
- Confirm the position of the nasogastric tube radiologically after insertion if pH is inadequate to ascertain gastric placement i.e. pH < or equal to 5.4
- Consider referring the patient to radiology for insertion of the nasogastric tube under imaging if the patient is known to have oesophageal varices, strictures or severe coagulopathy.
TIPS

- This procedure can be uncomfortable. Consider prescribing and administering a small amount of Lidnocaine gel in the nostril, and/or a spray of Lidnocaine to the back of the throat.2
- For patients with a dry mouth but impaired gag reflex moisten the mouth with a moist cotton bud prior to requesting them to swallow or ask them to sniff to lift the soft palate.2

Procedure for insertion of nasogastric tube2

1. Perform baseline observations - temperature, pulse, blood pressure, respiratory rate and oxygen saturation.
2. Read the manufacturer’s instructions and gather equipment required.
3. Explain procedure and equipment to the patient.
5. Preferably, sit patient upright with neck flexed for optimal neck/stomach alignment and to assist insertion.

Note: Spinal and some neurological patients must be positioned according to the treating medical team instructions throughout the procedure.

6. Examine nostrils for deformity/obstructions to determine best side for insertion. Ask the patient if they have any problems with one side of the nose more than others, e.g. sinusitis can increase irritation from the nasogastric tube.
7. Measure tubing from the tip of the nose to earlobe, then xiphisternum (point halfway between the end of the sternum and the navel). Note the cm marking on the tube at this measurement point.
8. If present, lubricate the end of the nasogastric tube as per manufacturer’s guidelines (usually with water flush) and ensure guidewire placement is locked within the tubing.
9. Lubricate the distal 5-10 cm of tube (with lubricant such as KY gel® if not self lubricating).
10. Pass tube via a nostril posteriorly and inferiorly. Ask the patient to sniff to ease passage from nose to oropharynx. Pause at this time and ensure the patient is not coughing.
11. Instruct patient to swallow and advance the tube as the patient swallows. Coincide advancement with the swallow, evidenced by elevation of the laryngeal cartilage; advance the tube into the oesophagus. For patients with intact gag reflex swallowing small sips of water or ice may enhance passage of tube into oesophagus.

If resistance is met withdraw the tube 1 - 2cm and rotate it slowly with downward advancement toward closest ear. Do not force the nasogastric tube.

12. Withdraw tube immediately if the patient exhibits signs of distress, changes occur in patient’s respiratory status, if tube coils in mouth, if the patient begins to cough or changes colour.
13. Advance tube until mark is reached. Tape in place at this point before the tube moves and do not remove guidewire until the X-ray has been attended and reviewed or the tube placement has been confirmed.
14. Attach syringe or oral/enteral dispenser to the free end of the tube, aspirate sample of gastric contents (as described in flowchart below).

15. Test pH of the aspirate using indicator strips.

16. The pH must be < or equal to 5.\(^1\) If pH is not < or equal to 5, obtain an X-ray to verify placement before instilling any feedings/medications, or if you have concerns about the placement of the tube.

**Note:** This test is not useful in the presence of acid suppression therapy and an X-ray must be used confirm placement.

17. Perform observations - temperature, pulse, blood pressure, respiratory rate and oxygen saturation and compare with pre-procedure observations. Notify the medical team or medical officer on call if there is significant deviation from baseline observations or if change in condition.

18. Document in patient’s medical record reason for the tube insertion, nostril used, type and size of tube, the insertion distance and note the external length of the tube, the nature and amount of aspirate, and the effectiveness of the intervention. Document all observations.

### Procedure for testing position of a nasogastric tube

It is recognised that the best method of determining nasogastric tube location is provided by reliably obtained and interpreted X-ray that visualises the entire course of the tube.\(^1,3\)

However, many factors, including exposure to radiation, delay in obtaining and interpreting radiographs, risk of tube misplacement while moving the patient, and the cost to the patient, contribute to the need for other reliable methods for confirming tube placement. Therefore:

**DO:**
- Follow the steps set out in the attached flowchart 1.
- Use radiography to check placement of tube if pH is not < or equal to 5.\(^1\)
- Test pH of aspirate using pH indicator strips. Indicator strips with 0.5 gradations or paper with a range of 0 to 6 or 1 to 11 is recommended.
- Check exit-point mark at nose for signs of any tube migration.

**NOTE:** While pH testing is helpful in evaluating tube placement on initial placement or before intermittent feeding, it’s of little use with regard to continuous feeding because most tube-feeding formulas have a pH value close to 6.6 and therefore tend to neutralise gastronintestinal pH.\(^1\)
DO NOT:

☒ Use auscultation of air insufflated through the feeding tube (‘whoosh’ test). There are many reports on the ineffectiveness of this method.\textsuperscript{3,4,5,6}

☒ Use absence of respiratory distress as an indicator of correct positioning. Observing for signs of respiratory distress is often ineffective in detecting a misplaced tube.\textsuperscript{7,8} Tubes can enter the respiratory tract without resulting in observable symptoms\textsuperscript{8}, particularly if the patient is unconscious.\textsuperscript{9}

☒ Commence feed if aspirate pH > or equal to 6 (may occur with respiratory or oesophageal placement\textsuperscript{15}) or if in doubt about the position of the nasogastric tube.

☒ Use blue litmus paper to test the acidity/alkalinity of aspirate. It is not sufficiently sensitive to distinguish bronchial from gastric secretions.\textsuperscript{11}

☒ Rely on observations of bubbling at the proximal end of the tube. This method is unreliable because the stomach contains air and could falsely indicate respiratory placement.\textsuperscript{12}

☒ Rely on the appearance of the feeding tube aspirate to rule out misplacement. This method is unreliable because gastric contents can look similar to respiratory secretions.\textsuperscript{13,14}

When to re-check the nasogastric tube position?

☒ Following initial insertion

☒ Before administering each feed and/or giving medication.

☒ At least once per shift during continuous feeds.

☒ Following episodes of respiratory distress vomiting, retching or coughing. Note: the absence of coughing does not rule out misplacement or migration.

☒ If suspicion of tube displacement, e.g. poor tolerance to feed, reflux of feed into the throat, discomfort in the throat, change in tube length is suspected.

☒ If the patient has been transferred from one clinical area to another.
Flowchart 1 - Procedure for testing placement of the nasogastric tube

**NEW Nasogastric Tube Placement**
1. Measure tube length
2. Insert tube (see Insertion of nasogastric tube instructions)
3. Check if patient on acid inhibiting medication
4. Aspirate using gentle suction

**Nasogastric Tube in situ**
1. Check position for tube displacement
2. Reposition or repass tube if required
3. Check if patient on acid inhibiting medication
4. Aspirate using gentle suction

- **YES** 0.5 – 1 ml aspirate obtained?
  - **YES**
    - Test aspirate pH on strip
    - *NB: test may not be accurate in the presence of acid suppression therapy or if patient has been on enteral feeds previously*
    - **YES** Is pH < or equal to 5?
      - **YES**
        - Proceed to feed
      - **NO**
        - Check position by X-ray
    - **NO**
      - **YES** 0.5 – 1 ml aspirate obtained?
        - **YES**
          - **DO NOT FEED**
            1. If possible turn adult onto side
            2. Inject 10 – 20 ml of air into tube using syringe
            3. Attempt aspiration again
        - **NO**
          - **DO NOT FEED**
            1. Advance tube 10 – 20 cm
            2. Attempt aspiration again
      - **NO**
        - **YES** 0.5 – 1 ml aspirate obtained?
          - **YES**
            - **DO NOT FEED**
              1. Call for advice
              2. Consider repassing tube & repeating steps
          - **NO**
            - Replace nasogastric tube as per protocol

- **NO** Is tube in position?
  - **YES** Proceed to feed
  - **NO** Replace nasogastric tube as per protocol
Standards for Administration of Enteral Feeds/Medications via Fine Bore Nasogastric Tubes

- Fine bore nasogastric tube placement is confirmed prior to commencing and administering enteral feed or medications.
- Use equipment specified for the purpose of enteral feeding/administration of medications and complies with the manufacturer’s instructions for use unless otherwise clinically contraindicated.
- Decanted feeds must not be hung for more than 10 hours.
- Patients are regularly observed for correct position of tube and tolerance of enteral feed/medications e.g. vomiting, nausea, coughing.
- If the patient has a tracheostomy or endotracheal tube insitu, check if the cuff requires inflating prior to administering enteral feed/medications.
- Feeds are ceased immediately if aspiration is suspected and medical staff are notified.
- Medication and enteral feed compatibility, drug solubility and stability are confirmed by pharmacists.
- Infection control standards are maintained during preparation and administration of enteral feeds/medication.

Removal of nasogastric tubes

1. Confirm need for removal of the nasogastric tube.
2. Explain procedure and equipment to the patient.
3. Don personal protection equipment. Including non-sterile gloves, eye protection and apron/gown.
4. Positions patient upright with the patient’s head supported on pillows where possible.

**Note:** Spinal and some neurological patients must be positioned according to the treating medical team instructions throughout the procedure.

5. Turn off the feeding apparatus to decrease the risk of aspiration.
6. Spigot or cap the nasogastric tube using either the cap provided or a spigot to prevent backflow and aspiration.
7. Remove the securing tape. An adhesive remover may be required to promote patient comfort.
8. Remove the tube in a slow continuous movement to promote patient comfort and prevent trauma.
9. Dispose of equipment adhering to occupational health and safety requirements.
10. Document in the patient’s medical record the reason for tube removal.
11. Observe that patient for complications or any changes in the patient’s condition.
References


12. MHRA Notice MHRS/MS/2004/026


### ACTION PLANNER FOR:

*Chief Executives, Health Service Executives, Managers, Directors of Clinical Governance*

| Responsibility and personnel to implement The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy not assigned | Comments/Actions: |
| Support to line managers to mandate The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy in their areas not provided | Comments/Actions: |
| Compliance with The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy not reported to NSW Department of Health | Comments/Actions: |

### IMPLEMENTATION STANDARD

<table>
<thead>
<tr>
<th>Current compliance status (✓)</th>
<th>Actions Required</th>
<th>Assigned to</th>
<th>Target Completion Date</th>
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<tbody>
<tr>
<td>Not Started</td>
<td>Partially Completed</td>
<td>Completed</td>
<td></td>
</tr>
</tbody>
</table>

- Assign responsibility and personnel to implement The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy
- Support provided to line managers to mandate The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy standard in their areas
- Ensure equipment is available to support the implementation of The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy within clinical areas

### COMPLIANCE STANDARD

- The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy promoted across the Health Service
- The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy is successfully implemented within organisations
- Facility wide auditing of staff hand hygiene practices as per NSW Department of Health compliance program
- The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy compliance reported to the NSW Department of Health
- Staff not complying with The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy are managed in accordance with NSW Health policy directives for staff performance management

### LEADERSHIP STANDARD

- Sets The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy as an institutional standard
- Provides routine feedback to staff on compliance with The Use of Fine Bore Nasogastric Feeding Tube for Adults Policy

*NB: This action planner is NOT mandatory – it is a tool to monitor the implementation of this policy*
YOUR HEALTH RIGHTS AND RESPONSIBILITIES (PD2011_022)

PD2011_022 rescinds PD2009_053.

PURPOSE

*Your Health Rights and Responsibilities* policy directive outlines the rights and responsibilities of NSW Health services and staff, and patients and carers. Basic rights are detailed in the policy, including: Access, Safety, Respect, Communication, Participation, Privacy, and the right to Comment. The Policy Directive has been produced to set out NSW Health’s Public Patients’ Hospital Charter and Commitment to Service. The publication incorporates the principles of the Australian Charter of Healthcare Rights and is consistent with the National Healthcare Agreement (NHCA) 2009.

MANDATORY REQUIREMENTS

All health professionals delivering healthcare services within NSW Health must be made aware of the detailed rights and responsibilities outlined in this publication.

IMPLEMENTATION

Chief Executives must ensure:
- that information about patients’ rights and responsibilities is provided to health professionals and stakeholder agencies concerned with treatment and healthcare provision;
- associated documents are displayed and available to healthcare professionals, consumers, carers, and visitors.

IMPLEMENTING STANDARDISED KEY PRINCIPLES IN ALL FORMS OF CLINICAL HANDOVER (PD2009_060)

PURPOSE

The policy mandates the implementation of standard key principles for clinical handover, by all clinicians in the NSW Health system, regardless of a patient’s clinical diagnosis, location or the time of day. Compliance with the standard key principles for clinical handover will improve the transfer of information, accountability and responsibility for patient care. Compliance with this policy will improve patient outcomes and experience.

MANDATORY REQUIREMENTS

Health service implementation

Area Health Services, Justice Health, the Ambulance Service of NSW and the Children’s Hospital at Westmead must develop and implement a plan for the implementation of standard key principles for clinical handover consistent with the principles as summarised in attachment 1.

Health services should include General Practice, private health care providers and residential aged care facilities in implementation plans of the standard key principles for clinical handover.

Health service evaluation

Health services must monitor and evaluate local clinical handover on a regular basis with feed back of evaluation results provided to staff in accordance with the evaluation framework at attachment 2.

Training and Orientation

Health services must incorporate the standard key principles for clinical handover into the orientation programs of all new clinical staff.

Health services must implement an education program regarding the standard key principles for clinical handover for all current clinical staff.

IMPLEMENTATION

Roles and responsibilities of the NSW Department of Health:
• Provides advice and assistance for the implementation of this policy including maintaining the website and eLearning support.
• Monitors and evaluates the health system implementation of standard key principles for clinical handover.

Roles and responsibilities of Chief Executives:
• Assign responsibility, personnel and resources to implement the standard key principles for clinical handover.
• Report on the implementation and evaluation of standard key principles for clinical handover 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 standard key principles for clinical handover across their services.
• Monitor and evaluate the implementation of standard key principles for clinical handover across their services and feedback evaluation results to staff.
• Ensure the standard key principles for clinical handover are incorporated into orientation programs for new clinical staff.
• Educate clinical staff in the use of the standard key principles for clinical handover.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:
• Locally implement the standard key principles for clinical handover.
• Evaluate compliance with the standard key principles for clinical handover.
• Annually monitor and evaluate local clinical handover processes in line with the standard key principles for clinical handover.

Roles and responsibilities of all clinicians:
• Ensure their work practices are consistent with the standard key principles for clinical handover.

The following materials are provided on the clinical handover website:
• Standard Key Principles for Clinical Handover: Implementation Toolkit. www.archi.net.au/e-library/clinical/nsw-handover
• Standard Key Principles for Clinical Handover: Implementing Change - Templates. www.archi.net.au/e-library/clinical/nsw-handover
Attachment 1: Standard Key Principles for Clinical Handover: 2 page summary document.

SAFE CLINICAL HANDOVER
KEY PRINCIPLES FOR SAFE AND EFFECTIVE HANDOVER

Clinical handover is the effective...
transfer of professional responsibility and accountability from 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.

* The OSSIE Guide to Clinical Handover Improvement – Australian Commission on Safety and Quality in Health Care (2009)

Does your process for clinical handover meet these standard key principles?

1. Leadership
☐ Nominate a leader at each clinical handover.

2. Valuing Handover
☐ Set the expectation that clinical handover is valued and an essential part of daily work.
Ensure staff are available to attend for the handover of all patients relevant to them.

3. Handover Participants
☐ Identify and orient handover participants.
Involve them in regular review of clinical handover processes.
Whatever possible, patients and carers should be recognised and included as handover participants.

4. Handover Time
☐ Set an agreed time, duration and frequency for clinical handover to occur.
It is highly recommended that, where possible, strategies are in place to reinforce punctuality.

5. Handover Place
☐ Set a specific location for clinical handover to occur.
Preferably, clinical handover occurs:
☐ Face to face
☐ In the patient’s presence, where appropriate (bedside handover)

6. Handover Process
☐ Standardised Protocol: Generate flow charts, scripts and cues for how clinical handover occurs each and every time. Your standard protocol should:
☐ Clearly identify the patient, you and your role
☐ State the immediate clinical situation of the patient
☐ List the most important and recent observations
☐ Provide relevant background/history to the patient’s clinical situation
☐ Identify assessments and actions that need to occur
☐ Identify timeframes and requirements for transition of care
☐ Promote the use of the patient record to cross-check information
☐ Ensure documentation of all important findings or changes of condition
☐ Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover.

Clinical handover should be documented. Some examples of effective handover tools that aid clinical handover communication and documentation are explained in the implementation toolkit (e.g. ISBAR, SISAR, SBAR).

☐ Where the condition of a patient is deteriorating:
   Escalate the management of these patients as soon as a deterioration in condition is detected.

☐ Other Critical Information:
   Prioritise alerts for any other important information (e.g. outstanding actions, planned patient moves, Occupational Health and Safety risks impacting staff or patient safety).
SAFE CLINICAL HANOVER
BACKGROUND TO HELP YOU MEET KEY PRINCIPLES

Clinical handover must be valued, supported and embedded

Objective
To contribute to optimal patient care by:
• Embedding the importance and value of effective clinical handover
• Standardising a set of high level key principles for all clinical handover

Origins of this document
The Acute Care Taskforce developed this document and the supporting implementation toolkit, following extensive consultation with Area Health Services, the Clinical Excellence Commission, the Australian Medical Association (NSW), the Greater Metropolitan Clinical Taskforce, other health priority taskforces and their sub-committees.

Cross-referencing of key principles has occurred with current guidelines published by the Australian Commission on Safety and Quality in Health Care and the Australian Medical Association.

Case for change
The Clinical Excellence Commission (Apr ‘09) reviewed Root Cause Analysis (RCA) and IMS data (Jan ‘08—Apr ‘09), in relation to adverse events resulting from deficiencies in clinical handover.

All scenarios of clinical handover will benefit from standardisation of key principles, but the following were identified by RCA data as points of clinical handover that require the earliest priority for review:
• Community and General Practice to hospital
• Hospital to the community and General Practice
• Emergency Department to ward
• Multidisciplinary team handover
• Escalation of deteriorating patients
• High acuity to low acuity transfer (e.g. Intensive Care Unit to ward or recovery unit to ward)

Who should use this document?
This document should be used by all executive and clinical teams (medical, nursing and allied health) to improve clinical handover processes within and between teams. This document is supported by the Clinical Handover Implementation Toolkit.

A standardised process
Standardisation of handover will ensure effective, concise and complete communication in all clinical situations and facilitate care delivery.

Clinical handover does not just happen at the change of a shift
Clinical handover happens within and between teams. When reviewing clinical handover you need to consider situations where transfer of clinical information, responsibility and accountability impacts patient safety e.g.:
• Escalation of deteriorating patient
• Patient transfers to another ward
• Shift to shift change over
• Patient transfers for a test or appointment
• Patient transfers to another hospital
• Multidisciplinary team handover
• Patient transfers to, from and within the community

Although face to face handover is the preferred modality, it is recognised that many handovers appropriately require telephone communication.

Did you check all of the boxes on page 1?
Even if you did, this is not a paper exercise. The Clinical Handover Toolkit will help you to:
1. Map your current clinical handover process.
2. Identify areas for process improvement.
3. Develop a plan to implement and continually re-evaluate your new process for clinical handover.

Project Contacts:
Ian Richards
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IRCH@doh.health.nsw.gov.au

James Dunne
Area Performance Manager – HSIR
JDUNN@doh.health.nsw.gov.au
# 2. Standard Key Principles for Clinical Handover: Evaluation framework

<table>
<thead>
<tr>
<th>Evaluation method</th>
<th>Responsibility</th>
<th>Why needs to be collected</th>
<th>Target</th>
<th>How reported</th>
<th>Data sent to</th>
<th>Frequency of reporting</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Health System RCA and IIMS data review, where clinical handover was identified as a contributing factor.</td>
<td>NSW Department of Health - Report generated by Clinical Excellence Commission</td>
<td>Case for change highlights high number of RCA incidents where patient care was drastically impacted by ineffective clinical handover</td>
<td>First 12 months baseline data, then reduce</td>
<td>Table of incident occurrence. Key recurring themes highlighted. Specific RCA events explored further with Public Health Organisations, as required.</td>
<td>Data reviewed by Acute Care Taskforce. Data sent back to AHS</td>
<td>Quarterly</td>
<td>Self-reporting nature of data limitations. May experience an initial rise in incidents due to awareness.</td>
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<tr>
<td>Submission of Area Health Service implementation and evaluation plan for the standard key principles of clinical handover by Area Health Services, Justice Health, NSW Ambulance and the Children’s Hospital at Westmead.</td>
<td>Chief Executives, or delegate, of: - Area Health Services - Public Health Organisations - Justice Health - NSW Ambulance - The Children’s Hospital at Westmead</td>
<td>To evaluate and monitor health agency implementation of standard key principles in clinical handover.</td>
<td>30th November 2009</td>
<td>Implementation and evaluation plan</td>
<td>Health Services Performance Improvement Branch <a href="mailto:HSPB@doh.health.nsw.gov.au">HSPB@doh.health.nsw.gov.au</a></td>
<td>Once – by 30th November 2009</td>
<td>Listed health agencies must maintain implementation and evaluation plans. Current implementation and evaluation plans can be requested by NSW Health in relation to future review of RCA events.</td>
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<tr>
<td>Area Health Service annual analysis of RCA and IIMS data, where clinical handover was identified as a contributing factor</td>
<td>Chief Executives, or delegate, of: - Area Health Services - Public Health Organisations - Justice Health - NSW Ambulance - The Children’s Hospital at Westmead</td>
<td>Analysis or occurrence and causative factors related to incidents forms an important part of process review for improved patient safety.</td>
<td>First 12 months baseline data</td>
<td>Analysed and stored locally by Health Agency</td>
<td>Data not required to be sent</td>
<td>Annually</td>
<td>Listed health agencies must maintain RCA and IIMS analysis reports. Analysis reports can be requested by NSW Health in relation to future review of RCA events.</td>
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The following table represents methods that are recommended for the evaluation and review of local clinical handover processes.

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<td>Length, timeliness and location of handover – Template 6 - <a href="http://www.archi.net.au/e-library/clinical/nsw-handover">http://www.archi.net.au/e-library/clinical/nsw-handover</a></td>
<td>Recommended for local evaluation and process review</td>
<td>Relates to standard key principles for clinical handover</td>
<td>Local baselines for improvement</td>
<td>Locally informing annual review of clinical handover processes</td>
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<td>These items are described in the “Annual Check up” at Appendix C of the Implementation Toolkit</td>
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<td>Whether key principles are incorporated into handover – Template 3 - <a href="http://www.archi.net.au/e-library/clinical/nsw-handover">http://www.archi.net.au/e-library/clinical/nsw-handover</a></td>
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<td>Whether local standard protocol items were included in handover – Template 6 - <a href="http://www.archi.net.au/e-library/clinical/nsw-handover">http://www.archi.net.au/e-library/clinical/nsw-handover</a></td>
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<td>Staff experience surveys – Template 4 - <a href="http://www.archi.net.au/e-library/clinical/nsw-handover">http://www.archi.net.au/e-library/clinical/nsw-handover</a></td>
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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 Plans*. 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.

SAME GENDER ACCOMMODATION (PD2015_018)

PD2015_018 rescinds PD2010_005.

PURPOSE

This policy statement and the associated procedures are intended to ensure that:
(a) The privacy and dignity of NSW Health patients is respected at all times during their healthcare experience.
(b) Patients who are staying overnight in a NSW Public Health Organisation do not have to sleep in the same room or ward bay, use mixed bathroom facilities or pass through opposite gender areas to reach their own facilities (except when considered clinically appropriate)\(^34\).

MANDATORY REQUIREMENTS

There are no exemptions from the need to ensure that the privacy and dignity of all NSW Health patients is respected at all times during their health care experience. This applies to all areas.

There are some exceptional circumstances\(^35\) (i.e. when patients need very specialised or urgent care), where providing fast safe effective care may take priority over ensuring same gender specific accommodation. When this does occur it must be in the interest of all the patients affected.

For the purpose of this policy Public Health Organisations and Public Health System are used in accordance with section 7 of the Health Services Act (1997). Under this Act, Local Health Districts, statutory health corporations, such as the Children’s Hospital Westmead and affiliated health organisations in respect of its recognised establishments and recognised services (such as Tresillian and other third schedule establishments) are called “Public Health Organisations” (PHOs).

For the purpose of this policy Health worker refers to any person working within a PHO.

This policy is to be read in conjunction with PD2011_022 Your Health Rights and Responsibilities.

IMPLEMENTATION

PHO executives are to ensure:
• 100% of all patients that are staying overnight in a NSW PHO will be in a gender specific bed within 24 hours.
• In the longer term, designing out mixed gender accommodation will be the focus.
• The Patient Flow Systems Program\(^36\) is made available to all NSW Public Hospitals.
• The Respecting Patient Privacy and Dignity in NSW Health Survey\(^37\) is used as an audit tool on a regular basis in every NSW PHO excluding those wards/units that are operating under the clinically inappropriate or exceptional circumstances (section 1.2 and section 3 of procedures).

\(^{34}\) Clinically appropriate and exceptional circumstances for providing Gender Specific Accommodation is provided in the attached procedures at section 1.2 and section 3

\(^{36}\) The Patient Flow Systems Program information is provided in the attached procedures at section 1.2

\(^{37}\) The Respecting Patient Privacy and Dignity in NSW Health: 8 ways to make a difference staff handbook information is provided in the attached procedures at section 1.2
12. MEDICAL CARE

1. BACKGROUND

1.1 About this document

Throughout NSW in 2013/14 there were around 948,500 acute patients that spent a night or more in a NSW Public Hospital.

For the majority of inpatients their hospital stay is a positive one. The results of the NSW Health Annual Patient Experience Survey and patient interview process demonstrate this; we also know from these results that the staff of NSW Health are providing excellent care to our patients despite increasing demand.

Patients who are treated by NSW Health expect and generally receive excellent clinical care, although there are always ways in which we can improve their experience.

The January to June 2013 Adult Admitted Patient Survey noted that 85% of surveyed patients report that they were “always treated with respect and dignity” and 86% of patient identified that they were “given enough privacy when being treated”.

In November 2008 the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals that was conducted by Commissioner Garling recommended “the policy which authorises, and the practice which gives effect to, using inpatient wards (except Intensive Care Units, High Dependency Units and Emergency Departments) to house both men and women in the same room, or separate ward space ought to cease forthwith”.

From 2011 NSW Health has set the target of 100% of all patients that are staying overnight in a NSW Public Health Organisation (PHO) will be in a same gender room or ward bay within 24 hours. In the longer term, designing out mixed gender accommodation will also be the focus.

Respecting patient privacy and dignity is “everyone’s responsibility”. Each of us play our part in this and must work together to meet these important expectations of patients and carers.

1.2 Key definitions

Clinically appropriate or exceptional circumstances are when providing rapid safe and effective care may take priority over ensuring gender specific accommodation. This is only applicable in critical care environments or short stay environments, where patients need very specialised or urgent care.

Children and Adolescents are any person under the age of 16 years, for the purpose of this policy. It should be recognised that the borderline between childhood and adulthood is not distinct and clinical need and stage of development will take precedence in determining accommodation needs.

Critical Care Environments refers to Intensive Care Units (ICUs), Coronary Care Units (CCUs), High Dependency Units (HDUs), Neuro High Dependency Units (NHDUs), Emergency Departments (EDs) and Recovery Units.

Same Gender Accommodation is when both men and women who are staying overnight in a NSW PHO DO NOT share the same room or ward bay, use mixed bathroom facilities or pass through opposite gender areas to reach their own facilities.

Health worker refers to any person working within a Public Health Organisation (PHO).

Patient Flow Systems Program is a whole of hospital approach to managing patient flow. This approach will enable PHO to identify and resolve delays within their current system to create capacity. 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 patientflow@doh.health.nsw.gov.au

Public Health Organisations and Public Health System are used in accordance with section 7 of the Health Services Act 1997. Under this Act, Local Health Districts, statutory health corporations, such as the Children’s Hospital Westmead and affiliated health organisations in respect of their recognised establishments and recognised services (such as Tresillian and other third schedule establishments) are called “Public Health Organisations” (PHOs).

‘Respecting Patient Privacy and Dignity in NSW Health: 8 ways to make a difference’ is a staff booklet that is to be provided to all frontline NSW Health workers, and readily available to all other NSW Health workers.

Short Stay Units refers to both Emergency Department short stay units and in-patient short stay units. Examples of Emergency Department Short Stay Units are Emergency Department Short Stay Units (EDSSUs) and Emergency Pregnancy Units (EPUs). Examples of in-patient short stay units are Psychiatric Emergency Care Centres (PECC), Extended Day Only (EDO) Units (also known as 23hr units) and Medical Assessment Units (MAUs), Acute Assessment Units (AAUs), Stroke Units, Close Observation Units and Falls Risk rooms.

2. RESPECTING PATIENT PRIVACY AND DIGNITY IN NSW HEALTH

2.1 The eight areas of focus

In order to deliver better patient experiences we are focusing on eight areas that need the most attention to ensure that the privacy and dignity of our patients are respected at all times during their health care experience. These eight areas include:

1. Make patients and carers welcome
2. Communicate more often with patients and carers
3. Protect privacy during consultations and treatment
4. Respect the special needs of dying patients and their carers
5. Respect culture and beliefs
6. Manage noise for patient comfort
7. Avoid mixed gender rooms and ward bays
8. Provide same gender bathrooms

3. SAME GENDER ACCOMMODATION

There are no exemptions from the need to ensure that patient’s privacy and dignity is respected at all times during their health care experience. This applies to all areas.

Respecting patient privacy and dignity at all times during their health care experience requires men and women do not have to sleep in the same room or ward bay, use mixed bathroom facilities or pass through opposite gender areas to reach their own facilities.
3.1 When Same Gender Rooms and Ward Bays cannot be provided in the short term

Patient admissions cannot be deferred simply because same gender rooms or ward bays cannot be immediately provided. In such cases, every reasonable effort must be made to rectify the situation as soon as possible and staff must take extra care to ensure the patients’ privacy and dignity is maintained, particularly in sleeping areas and bathroom facilities. **Patients and carers must be informed if this does occur**, they must also be told what is being done to address the situation and must be informed when a same gender room or ward bay will be provided.

Staff must make it clear to patients and carers that NSW Health considers mixed gender rooms and ward bays to be the exception, never the normal practice. When mixed gender rooms and ward bays are unavoidable, transfer to a same gender room or ward bay should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.

Transgender Patients

All PHOs should consider the needs of transgender patients and their specific requirements, including allowing transgender people to dress and use the amenities in their preferred gender including sleeping in same gender rooms and using same gender bathroom facilities.

3.2 When providing Mixed Gender Rooms or Ward Bays is considered Clinically Appropriate

There are some exceptional circumstances (i.e. when patients need very specialised or urgent care), where providing rapid safe effective care may take priority over ensuring same gender rooms or ward bays. When this does occur it must be in the interest of all the patients affected.

In the cases where mixed gender rooms or ward bays is clinically appropriate, these decisions must be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. Furthermore, the mixing must be justifiable for **ALL** patients in the room.

This is only applicable in critical care environments and short stay units (for definitions see section 1.2), where patients need very specialised, rapid or urgent care.

3.3 Delivering Same Gender Rooms or Ward bays in Critical Care and Short Stay Environments

In critical care environments, we recognise that mixed gender rooms or ward bays may be considered clinically appropriate. These decisions must be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. Furthermore, the mixing must be justifiable for **ALL** patients in the room.

In short stay units, we recognise that same gender rooms or ward bays may be sometimes unachievable due to the specialised and rapid care received in these units. Every effort must be made to provide patients with same gender rooms or ward bays. If same gender rooms cannot be provided in the short term, **patients and carers must be informed**, patient preference must be sought, recorded and respected. These decisions must be based on the needs of each individual patient, not the constraints of the environment, or the convenience of staff. Furthermore, the mixing must be justifiable for **ALL** patients in the room.
3.3.1 Guiding Principles for delivering gender specific accommodation in critical care areas and short stay units

- Decisions are to be made on the needs of each individual patient whilst in critical care and short stay environments, and their clinical needs must take priority.
- Decisions are to be reviewed as the patient’s condition improves and should not be based on the constraints of the environment, or the convenience of staff.
- The risk of clinical deterioration associated with moving patients within critical care environments to facilitate segregation must be assessed.
- Where mixed gender accommodation does occur, greater protection needs to be provided where patients are unable to preserve their own modesty. Each patient must have their modesty constantly maintained by nursing staff. This may mean a constant nurse presence within the room or bay.
- Where possible patient preference should be sought, recorded and where possible respected. Ideally, this should be done in conjunction with carers and relatives.

3.3.2 Implications for delivering same gender rooms and ward bays in critical care areas and short stay units

- When a patient’s survival, recovery, instilling falls risk mitigation, and/or the management of acute delirium depend on the presence of highly specialised equipment and care, the requirement for same gender rooms or ward bays clearly takes a lower priority. This does not mean that no attempt at providing same gender rooms and ward bays is necessary. At the very least staff should consider whether it is possible to improve segregation. In new units, the design should support same gender rooms and ward bays.
- In theatre Recovery Units separate male and female units are not required, although some degree of segregation remains the ideal. High levels of observation and nursing attendance should mean that all patients can have their privacy and dignity preserved whilst unconscious or in a semi conscious state.

3.4 Same Gender Bathrooms

Every effort must be made to provide patients with access to a same gender bathroom and every effort must be made to ensure that patients do not have to walk through an opposite gender area to reach their own bathroom.

Patients and carers must be informed if same gender bathrooms cannot be provided, they must also be told what is being done to address the situation and must be informed of the bathroom options that are available.

Staff must make it clear to patients and carers that NSW Health considers mixed bathroom facilities to be the exception never the normal practice. When mixed bathroom facilities are unavoidable, each patient must have their privacy and dignity constantly maintained.

In new units, the design should support same gender bathroom facilities.

3.5 Nightingale Units or Wards

Nightingale wards or units are not excluded from providing same gender accommodation. Every effort must be made to provide some form of segregation on these wards. The ideal would be for complete separation of males and females on separate wards, although it is recognised that this is not always possible.
Segregation through the use of partitions or bedside curtains is the minimum requirement on these wards. This is intended to maintain patient privacy and dignity, as well as protect patients from unwanted exposure, including casual overlooking or overhearing.

### 3.6 Children and Adolescent Units

- There are no exceptions from the need to ensure that the privacy and dignity of our patients is respected at all times during their health care experience. This applies to all areas, including children and adolescent units.
- A child or adolescent, for the purpose of this policy is defined as any person under the age of 16 (refer to definitions: section 1.2).
- 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. Further, adult patients should not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents should not 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.
- For many children and adolescents, clinical need, age and stage of development will usually take precedence. Many children and adolescents take comfort from sharing with others of their own age and this may outweigh any concerns about providing same gender rooms or ward bays.
- Mixed gender rooms and ward bays are not recommended for adolescent patients. Where possible adolescent patient preference should 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).
Attachment 1: References and Useful Resources


Privacy Manual for Health Information (March 2015)


Children and Adolescents – Guidelines for Care in Acute Care Settings (PD2010_034)

Children and Adolescents – Safety and Security in NSW Acute Health Facilities (PD2010_033)

NSW Paediatric Inpatient Advisory Working Group (2009) Children and Adolescent definition for inpatient units, NSW Ministry of Health, North Sydney

NSW Surgical Services Taskforce Paediatric Surgery Sub Group (2008) Paediatric Surgery Model for Designated Area Paediatric Surgical Sites, NSW Ministry of Health, North Sydney


Useful Resources

National Health Service (NHS): Institute for Innovation and Improvement, Privacy and Dignity website: http://www.institute.nhs.uk/quality_and_value/introduction/privacy_and_dignity.html


UK Department of Health, Same Sex Accommodation website: https://www.gov.uk/search?q=same+sex+accommodation&tab=government-results
### Attachment 2: Respecting Patient Privacy and Dignity in NSW Health Survey

**Local Health District:**

**Hospital:**

**Ward/Unit Name:**

**Date:**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you reached the target for achieving Same Gender Accommodation?</td>
<td><strong>Excellent</strong></td>
</tr>
<tr>
<td>Target 100%</td>
<td>□</td>
</tr>
<tr>
<td>A. At this point in time, how many ward/unit bays and single rooms do you have in use on your ward/unit?</td>
<td>A =</td>
</tr>
<tr>
<td>B. At this point in time, how many of the above mentioned ward/unit bays contain single gender only (include in use single rooms, in this calculation)?</td>
<td>B =</td>
</tr>
<tr>
<td>C. Calculate your % of providing Gender Specific Accommodation.</td>
<td>C = B/A x 100% =</td>
</tr>
<tr>
<td>2. Is patient privacy able to be maintained at all times on your ward/unit?</td>
<td>□</td>
</tr>
<tr>
<td>Target 100%</td>
<td>□</td>
</tr>
<tr>
<td>A. At this point in time, how many curtained/partitioned beds and single rooms do you have on your ward/unit?</td>
<td>A =</td>
</tr>
<tr>
<td>B. At this point in time, how many of the abovementioned curtained/partitioned beds are able to be closed without gaps and single rooms have functioning doors that close?</td>
<td>B =</td>
</tr>
<tr>
<td>C. Calculate your % of providing adequate privacy to all patients?</td>
<td>C = B/A x 100% =</td>
</tr>
<tr>
<td>Additional items to assist in ensuring that the patient’s privacy and dignity is maintained</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>* Please ensure that you always introduce yourself to your patients and carers and talk to them in everyday language about their treatment (avoid medical jargon and abbreviations).</td>
<td></td>
</tr>
<tr>
<td>* Please ensure that patient accommodation is not rearranged, where possible between 9.30pm and 8am, as nobody likes to be woken up and relocated. If empty beds are in patients’ room/bay please let them know that other patients may be admitted overnight.</td>
<td></td>
</tr>
<tr>
<td>* For conscious patients, please ensure that you ask permission from the patient before entering closed curtains or knock before opening doors. Having signage or similar notifications available on your ward/unit can assist to prevent intrusions.</td>
<td></td>
</tr>
<tr>
<td>* Please ensure that patient gowns provide adequate coverage for patients when mobilising. Encouraging patients to wear their own pyjamas or clothes, where appropriate, may assist in ensuring their privacy and dignity is maintained.</td>
<td></td>
</tr>
</tbody>
</table>
12. MEDICAL CARE

RECOGNITION AND MANAGEMENT OF PATIENTS WHO ARE CLINICALLY DETERIORATING (PD2013_049)

PD2013_049 rescinds PD2011_077.

PURPOSE

This document describes the standards and principles of the NSW Between the Flags (BTF) System to improve the recognition, response to and management of patients who are clinically deteriorating. These standards and principles are to be implemented by NSW Public Health Organisations (as defined in this Policy Directive).

MANDATORY REQUIREMENTS

All Public Health Organisations must:

• Have a governance structure to support all elements of Between the Flags (BTF).
• Introduce and implement the NSW Health Standard Observation Charts (paper or electronic) and ensure that all patients have their vital sign observations recorded on one of these charts.
  NOTE: Intensive care units, high dependency units, coronary care units and operating theatres where patients are appropriately monitored, and care is escalated as required by BTF calling criteria, may be exempted from this requirement. The determination of whether an exemption should apply to any such unit is to be made by the Director of Clinical Governance on the basis of whether appropriate monitoring and escalation systems are in place.
• Implement and formalise a local Clinical Emergency Response System (CERS), including Clinical Review and Rapid Response, for prompt review and treatment of patients who are clinically deteriorating with referral to higher levels of care where necessary.
  This formalised system must:
  - Clearly define who is responsible for obtaining and providing assistance;
  - Operate 24 hours per day, 7 days per week;
  - Ensure the provision of core emergency equipment;
  - Be available for all inpatients;
  - Be known and understood by all clinical staff.
  NOTE: Initial urgent resuscitation may include The Ambulance Service of NSW ‘CERS Assist’ and the consequent referral systems may also include formal liaison and assistance from the Aeromedical and Medical Retrieval Services (AMRS), Royal Flying Doctor Service (RFDS), Newborn and Paediatric Emergency Transport Service (NETS) or the Perinatal Advice Line (PAL) as required.
• Ensure that all staff are aware of Between the Flags and know how to activate their local Clinical Emergency Response System.
• Ensure that all clinicians providing direct patient care must complete both Tier 1 and Tier 2 of the BTF education curriculum.
• Ensure that registers are kept of staff who have completed the mandatory training requirements including those authorised to participate in Rapid Response calls.
• Collect and provide performance data including the BTF key performance indicators for reporting to clinical units and the NSW Ministry of Health.

IMPLEMENTATION

NSW Ministry of Health:

• Ensure compliance with the mandatory requirements of this policy.
• Monitor implementation of policy by Public Health Organisations through the Local Health District Service Agreements.
Clinical Excellence Commission:
- Continue to advise the Ministry and Public Health Organisations on the strategies, standards and tools required for the continued development of BTF.
- Support clinical staff and the Directors of Clinical Governance (DCGs) to implement BTF across NSW.
- Evaluate BTF and make changes are required to improve the system.

Local Health District & Specialty Network Chief Executives:
- Assign responsibility, personnel and resources to implement this policy.
- Ensure all elements of BTF required by this policy are effectively implemented including effective governance, Standard Observation Charts, CERS, education and evaluation.

Ambulance Service of NSW:
- Incorporate the core principles of BTF and Clinical Handover into Ambulance clinical practice, where appropriate.
- Support Public Health Organisations with the implementation of BTF.
- Work with Public Health Organisations in the development of local Clinical Emergency Response Systems including the provision of CERS Assist, where required.

1. BACKGROUND

Failure to recognise and appropriately manage deteriorating patients is a contributing factor in many adverse events in hospitals and health care organisations around the world.\(^1\)\(^-\)\(^4\) Evidence derived from the NSW Patient Safety and Clinical Quality Program has demonstrated the same problem exists in NSW hospitals.

*Between the Flags* (BTF) was implemented in response to a recommendation from a major health review, the Garling Commission of Inquiry,\(^5\) which identified the Clinical Excellence Commission’s program as an opportunity to improve recognition and response to deteriorating patients.

In January 2010, NSW Health introduced *Between the Flags* statewide, with the aim to: improve early recognition and response to clinical deterioration and thereby reduce potentially preventable deaths and serious adverse events in patients who receive their care in NSW public hospitals.

The system uses the analogy of Surf Life Saving Australia’s lifeguards and lifesavers who keep swimmers safe by observing them and ensure they don’t venture into unsafe areas; and if they get into trouble, that rescue occurs rapidly.

*Between the Flags* has been designed by the Clinical Excellence Commission (CEC) with advice from clinical experts and is based on research initiated in NSW and published in the international literature.\(^6\)\(^-\)\(^7\)

The five elements of the System are:

1. **Governance:** structures and processes to support implementation at State, Local Health District/Specialty Network, facility and clinical unit level.
2. **Standard Calling Criteria:** observation charts with standard criteria for Clinical Review and Rapid Response.
3. **Clinical Emergency Response System (CERS):** established procedures for escalation of clinical concern to a Clinical Review or Rapid Response, in every facility.
4. **Education:** tiered education for clinical staff to reinforce their skill in recognising and responding to patients who are clinical deteriorating.
5. **Evaluation:** key performance indicators for measuring the performance of the Between the Flags Program.
12. MEDICAL CARE

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.®

1.1 Key Definitions

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>AMRS</td>
<td>The NSW Aeromedical and Medical Retrieval Service.</td>
</tr>
<tr>
<td>Attending Medical Officer and Team</td>
<td>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.</td>
</tr>
<tr>
<td>Attending Medical Team</td>
<td>The AMO may lead an ‘attending medical team’ (AMT) and this team plays a critical role in the Clinical Review of the patient.</td>
</tr>
<tr>
<td>Blue Zone</td>
<td>Used on paediatric and newborn Standard Observation Charts. Observation range requiring an increase in the frequency of observations. Staff should consider calling for an early Clinical Review.</td>
</tr>
<tr>
<td>Calling Criteria</td>
<td>An observation range that triggers an escalation of care to a Clinical Review or Rapid Response or increasing the frequency of observations.</td>
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<tr>
<td>Child</td>
<td>Any person under 16 years.</td>
</tr>
<tr>
<td>Clinical Emergency Response System (CERS)</td>
<td>A formalised system for obtaining urgent assistance when a patient is clinically deteriorating. The CERS includes the facility based response (Clinical Review and Rapid Response) as well as the formalised referral and escalation steps to obtain expert assistance and/or request for transfer to other levels of care within the facility or to another facility.</td>
</tr>
<tr>
<td>CERS Assist</td>
<td>The Ambulance Service of NSW 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.</td>
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<tr>
<td>Clinical Review</td>
<td>A patient review undertaken within 30 minutes by the attending medical team, or designated responder, as defined in the local CERS protocol.</td>
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<tr>
<td>Clinical Staff</td>
<td>Clinicians who provide direct patient care.</td>
</tr>
<tr>
<td>Facility</td>
<td>Hospital or Multi-purpose service (MPS)</td>
</tr>
<tr>
<td>FONT</td>
<td>The Fetal welfare assessment, Obstetric emergencies and Neonatal resuscitation Training (FONT) Program.</td>
</tr>
<tr>
<td>ISBAR</td>
<td>Acronym for the following structured communication tool: Introduction, Situation, Background, Assessment, Recommendation.</td>
</tr>
<tr>
<td>Must</td>
<td>Indicates a mandatory action requiring compliance</td>
</tr>
<tr>
<td>NETS</td>
<td>The Newborn and paediatric Emergency Transport Service.</td>
</tr>
<tr>
<td>PAL</td>
<td>The Perinatal Advice Line supports clinicians seeking advice about management of high risk obstetric patients; including potential transfer to a higher level hospital.</td>
</tr>
<tr>
<td>Rapid Response Team Leader (RRTL)</td>
<td>Is the nominated leader of the Rapid Response Team who:</td>
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<tr>
<td></td>
<td>• Directs appropriate clinical care for the patient, within their scope of practice, and communicates clearly with all team members.</td>
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<td></td>
<td>• Oversees and coordinates the Rapid Response process including escalating patient care as required.</td>
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<td></td>
<td>• Activates the local transfer or retrieval, as required.</td>
</tr>
<tr>
<td>Red Zone</td>
<td>Observation range and Additional Criteria representing late warning signs of deterioration for which a Rapid Response Call is required.</td>
</tr>
</tbody>
</table>
1.2 Implementation in LHDs/Specialty Networks

**Directors of Clinical Governance are to:**
- Lead the successful implementation and continual improvement of BTF within their LHD/Specialty Network.
- Ensure BTF key performance indicators are monitored and made available to relevant staff within facilities and clinical units so that they can use this to inform improvement to systems.
- Inform the Clinical Excellence Commission of opportunities to improve BTF based on experience with implementation.

**Hospital/Facility Managers are to:**
- Ensure the successful implementation of BTF within their facility.
- Implement approved NSW Health Standard Observation Charts.
- Ensure that all staff complete Tier 1 ‘awareness’ training of the BTF education curriculum and that a record is kept of those who have completed training.  
- Ensure that all clinical staff complete Tier 2 training of the BTF education curriculum and that a record is kept of those who have completed training.
- Ensure that all staff who are members of Rapid Response Teams (RRTs) have the skills in advanced life support as defined in local CERS protocols with a record kept of any relevant training undertaken.
- Ensure that the local CERS protocol defines how to access specialty paediatric/neonatal/obstetric expertise and the escalation process to obtain the expert assistance where the facility has paediatric/neonatal and obstetric inpatients.
- Ensure that core emergency equipment as outlined in this policy is available.
- Ensure data collection and auditing procedures are undertaken as required and resourced to evaluate their programs to management improvement and sustainability.

**Attending Medical Officers (AMO) are to:**
- Complete Tier 1 and Tier 2 of the BTF education.
- Lead their medical team to ensure they provide the Clinical Review required in response to a patient’s observations falling within the Yellow Zone on the Standard Observation Chart, as per local CERS protocol.
- Ensure a member of their Attending Medical Team attends patients within 30 minutes when required to undertake a Clinical Review.
- Ensure the required frequency of observations is formally authorised, and reviewed for appropriateness, on the NSW Health Standard Observation Charts.
- Ensure any alterations to calling criteria are formally authorised, and reviewed for appropriateness, on the NSW Health Standard Observation Charts.
- Ensure medical management plans for acute care patients are reviewed and documented after Clinical Review and Rapid Response calls so that patients are never left without a documented management plan.
• Ensure treatment/resuscitation plans are formally agreed to and documented in the patient’s health care record, where appropriate.
• Ensure that the Attending Medical Team (AMT) understand their obligation to escalate to a Rapid Response call if they are concerned, and/or if they are unable to reverse clinical deterioration in a patient, or if a patient’s observations deteriorate.

**Attending Medical Team (AMT) is to:**
• Complete Tier 1 and Tier 2 of the BTF education program.
• Ensure the required frequency of observations is prescribed on the NSW Health Standard Observation Charts in consultation with the AMO.
• Ensure any alterations to calling criteria are discussed with the AMO before being formally authorised on the NSW Health Standard Observation Charts and the rationale is documented in the patient’s health care record.
• Ensure patients are attended within 30 minutes when required to undertake a Clinical Review.
• Ensure Clinical Review calls attended are documented in the patient’s health care record so that patients are never left without a documented management plan and outcomes are communicated to the AMO and clinical staff as appropriate.
• Complete appropriate data collection of any Clinical Review call attended.
• Communicate outcomes of Clinical Review calls to the patient and their family as appropriate.
• Escalate to a Rapid Response call if they are concerned, and/or if they are unable to reverse clinical deterioration in a patient, or if a patient’s observations deteriorate.

**Nursing/Midwifery Unit Manager (or delegate/Team Leader) is to:**
• Complete Tier 1 and Tier 2 of the BTF education program.
• Assess patients whose observations are in the Yellow Zone to determine if a Clinical Review is required.
• Ensure that care is escalated to a Rapid Response in the event that a Clinical Review is not attended within 30 minutes.
• Ensure that there is a plan to release staff to attend BTF education.
• Provide feedback to the facility BTF/CERS/quality committee regarding implementation of the 5 elements of the BTF Program.

**Nursing/Midwifery/Allied Health staff, within their scope of practice, are to:**
• Complete Tier 1 and Tier 2 of the BTF education program.
• Conduct a patient assessment including a full set of observations at least every 8 hours.
• Increase the frequency of observations and initiate appropriate clinical care when a patient’s observations are in the Blue Zone on the Standard Observation Charts.
• Consult promptly with the Nurse/Midwife in-charge to determine if a Clinical Review is required when a patient’s observations are in the Yellow Zone on the Standard Observation Charts.
• Call for a Rapid Response and inform the Nurse/Midwife in-charge when a patient’s observations are in the Red Zone on the Standard Observation Charts.
• Know how to activate their local Clinical Emergency Response System (CERS).
• Document actions taken in the patient’s health care record.
• Inform the Nurse/Midwife in-charge and the AMT of the outcome of the Clinical Review call if they are not involved in the process.

**Rapid Response Teams are to:**
• Ensure patients are attended urgently when required as part of the local CERS.
• Ensure Rapid Response calls attended are documented in the patient’s health care record and outcomes are handed over to the AMO/AMT and ward staff to ensure continuity of patient care.
12. MEDICAL CARE

- Complete appropriate data collection of any Rapid Response call attended.
- Communicate outcomes of Rapid Response calls to the patient and their family as appropriate.
- Never leave the patient without a documented management plan following a Rapid Response call.

All other staff, visiting clinicians and students:
- Compliance with this policy is mandatory.

Public Health Organisations may wish to use the *Between the Flags: Guidelines and implementation toolkit* to assist in the implementation of this policy.

2. GOVERNANCE

All Public Health Organisations (PHO) must have a clearly defined governance structure to oversee the implementation and sustainability of the BTF Program.

Each PHO must identify governance structures at the following levels:

**Local Health District/Specialty Network Level**
- Executive Sponsor.
- Program Coordinator.
- Clinical Champions.
- Quality Committee overseeing implementation and sustainability of the BTF Program.

**Facility Level**
- Executive Sponsor.
- Clinical Champion.
- Quality Committee to oversee the operation and management of the facility CERS.

3. NSW HEALTH STANDARD OBSERVATION CHARTS

The Standard Observation Charts are designed using human factors principles, incorporate colour-coded calling criteria and a ‘track and trigger’ format to highlight those patients who are clinically deteriorating by graphically ‘tracking’ their observations over time and ‘triggering’ an appropriate response based on the coloured calling criteria.

All Public Health Organisations must introduce and implement the NSW Health Standard Observation Charts approved for use in NSW by the Director General.

The Standard Observation Charts currently approved for use in NSW are the:
- Standard Adult General Observation (SAGO) Chart
- Standard Paediatric Observations Charts (SPOC)
- Standard Newborn Observation Chart (SNOC)
- Standard Maternity Observation Chart (SMOC)
- Adult Emergency Department Observation Chart
- Paediatric Emergency Department Observation Charts

*NOTE: For those Emergency Departments who choose to use the paper SAGO chart or SPOC to document patient’s observations instead of using the Adult or Paediatric Emergency Department Observation Charts they must have an established process to collect all the information required (including the screening tools, and authorisation for departure/discharge checklists) on pages 4, 5 & 6 of these charts.*
12. MEDICAL CARE

- Standard Observation Charts developed in the electronic Medical Record (eMR) across the FirstNet, PowerChart and SurgiNet platforms.

NOTE: Where the facility has implemented the Standard Observation Charts in the eMR the paper based charts will be used as eMR downtime forms. In facilities where a hybrid medical record (eMR and paper) is used, local business rules apply as to how observations are transcribed between the two systems.

The Standard Observation Charts may not be appropriate when a patient is in the last days of their life where other end of life care plans may be more appropriate.

Local Health Districts and Specialty Networks will be advised of any new charts that are approved, and will be required to comply with their implementation.


3.1 Calling Criteria

The colour coded zones on the Standard Observation Charts indicate when a patient is showing early and late warning signs of clinical deterioration and outline the appropriate escalation of care to a Clinical Review or Rapid Response.

For example in the charts:
- The Blue Zones (where applicable) represent criteria for which increasing the frequency of observations is required.
- The Yellow Zones represent early warning signs of deterioration and the criteria for which a Clinical Review (or other CERS) call may be required.
- The Red Zones represent late warning signs of deterioration and the criteria for which a Rapid Response Call is required.

3.2 Observations

Unless stated otherwise in section 3.2.3, the core physiological observations are to include respiratory rate, oxygen saturations, blood pressure, heart rate, level of consciousness, temperature and pain score as a minimum and are to be recorded (graphed) at the time the observations are taken on the appropriate Standard Observation Chart.

A full set of observations must be conducted just prior to and on transfer of care from:
- One ward/unit or procedural area to another.
- Emergency Department/High Dependency/ICU to general clinical units.
- One facility to another facility.

A full set of observations must be conducted prior to a patients discharge from a facility.

Observations that fall into the coloured zones are to trigger an escalation of care consistent with the CERS protocols in each facility, UNLESS there are documented alterations to the calling criteria (see section 3.3) or documented “Not for Rapid Response or Clinical Review calls”.

3.2.1 Frequency of Observations

In the absence of a documented monitoring plan the patient must have a complete set of vital sign observations conducted at least three (3) times per day, at eight hourly intervals.
The frequency of observations should be increased as indicated by the patient’s condition and clinical judgement of the clinical staff.

The frequency of observations must be increased for patients who have observations in the Blue, Yellow or Red Zones on a Standard Observation Chart, unless they have documented altered calling criteria (see section 3.3) for these observations.

The required frequency of observations should be discussed and determined during the multidisciplinary ward round and prescribed on the relevant Standard Observation Chart.

### 3.2.2 Variations to the Frequency of Observations

Decreasing the frequency of observations to below the minimum requirement may only be authorised by a medical officer following consultation with the Attending Medical Officer and must be prescribed on the relevant Standard Observation Chart and the rationale documented in the patient’s health care record.

Where an approved Clinical Pathway sets out a schedule for varying the frequency of observations, a medical officer (following consultation with the AMO) may document this as “consistent with clinical pathway for [insert title of pathway]” in the relevant section of the Standard Observation Charts. Varying observation frequency in this manner may only occur provided that this does not reduce the frequency to less than the minimum of three (3) times per day, at eight hourly intervals.

### 3.2.3 Standard variations to observations for patients in specialist services

<table>
<thead>
<tr>
<th>Service</th>
<th>Minimum required frequency of observations</th>
<th>Minimum set of vital signs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics and Special Care Nursery Service</td>
<td>Six (6) times per day at four hourly intervals</td>
<td>Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, pain score</td>
<td>BP is required at least once during the admission, (PD2010_032)</td>
</tr>
<tr>
<td>Acute Mental Health Facility</td>
<td>Three (3) times per day at eight hourly intervals for first 48 hours then daily thereafter</td>
<td>Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score</td>
<td>If patients develop an acute medical problem the required frequency of observations reverts to a minimum of three (3) times per day at eight hourly intervals.</td>
</tr>
<tr>
<td>Sub-acute/long stay/rehabilitation/palliative care</td>
<td>Twice a day</td>
<td>Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score</td>
<td>If patients develop an acute medical problem the required frequency of observations reverts to a minimum of three (3) times per day at eight hourly intervals.</td>
</tr>
<tr>
<td>Maternity</td>
<td>Three (3) times per day at eight hourly intervals for women who have risk factors identified on the SMOC</td>
<td>Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness</td>
<td>The SMOC chart does not replace the use of the partogram for women during the intrapartum period.</td>
</tr>
<tr>
<td>Newborn</td>
<td>All newborns must have one (1) full set of observations documented before discharge from the “birthing” environment</td>
<td>Respiratory rate, heart rate and temperature</td>
<td>If perinatal risk factors are identified based on local guidelines and/or an observation is abnormal, further observations should be recorded on a Standard Newborn Observation Chart (SNOC). The frequency of such further observations should be determined by local guidelines or as directed by the most senior medical officer responsible.</td>
</tr>
</tbody>
</table>
3.3 Alterations to Calling Criteria

Standard calling criteria can be altered for Yellow or Red Zone observations and must be clearly documented by a medical officer, in consultation with the AMO, on the appropriate Standard Observation Chart. If the AMO is unable to countersign the order at the time of the consultation, this should be noted in the patient’s healthcare record by the medical officer and attended to as soon as practical.

The rationale for altering the calling criteria must be documented in the patient’s health care record. Altered calling criteria should be formally reviewed as per the time frames on the Standard Observation Charts by the Attending Medical Team.

The thresholds for the calling criteria may be altered up or down based on a patient’s health care requirements. For example, the threshold for the calling criterion for systolic blood pressure may be altered downwards to alert to re-bleeding of a cerebral aneurysm or may be altered upwards to better reflect the patient’s usual observation patterns.

Special treatment plans which may alter calling criteria such as a ‘Resuscitation Plan’ must also be documented in the patient’s health care record and noted on the front page of the Standard Observation Chart, where appropriate.

3.4 Interventions/Comments/Actions

This section should be used to briefly note what actions and interventions have taken place in response to an observation being charted in the Yellow or Red Zones or meeting Additional Calling Criteria. All actions and interventions must be documented in the patient’s health care record.

4. CLINICAL EMERGENCY RESPONSE SYSTEM

A Clinical Emergency Response System (CERS) is a formalised system for obtaining urgent assistance when a patient is clinically deteriorating, and ensures that the required skills, knowledge and equipment are available to the deteriorating patient as needed. All facilities must have a Clinical Emergency Response System protocol that includes a clearly defined escalation process for a patient who is clinically deteriorating.

The local CERS protocol must include:

- A defined escalation process, which is accessible and known by all clinicians, for a patient who requires a Clinical Review. This must include clear instructions on who will respond to a Clinical Review and how they will be contacted 24 hours a day.
- A defined escalation process, accessible and known by all clinicians, for a patient who requires a Rapid Response. This must include clear instructions on who will respond to a Rapid Response and how they will be contacted 24 hours a day.
- For facilities which use the Ambulance Service of NSW ‘CERS Assist’ program, the point at which a CERS Assist call is to be made.
- How to access specialty paediatric/neonatal and obstetric expertise and the stepped escalation process to obtain expert assistance, e.g. NETS, AMRS, PAL (see section 4.3 and Appendices 8.1, 8.2).
- The process for transfer to other levels of care within the facility or to another facility.
- How to access the equipment to support advanced resuscitation including specialist equipment for paediatric/neonatal and obstetric patients cared for at the facility.

Based on the local CERS protocol, facilities should develop a local CERS and Beyond Facility Escalation Algorithm, as a one page flowchart, that clearly identifies the local escalation processes and these flowcharts should be displayed in all clinical units.
In addition, each LHD should have a designated regional specialist paediatric service, which is a point of advice, referral and paediatric expertise, with a 24hour/7 days a week on call specialist paediatric (medical) consultation available (see Section 4.3.1).

NOTE: A Guide to Paediatric CERS and Beyond Facility Escalation Documentation (Appendix 8.1) and NSW Health BTF Paediatric CERS and Escalation Matrix (Appendix 8.2) are included as Appendices.

Each level of escalation within the local CERS requires a ‘fresh set of eyes’ to review the patient who is clinically deteriorating.

As facilities introduce Patient and Family Escalation of Care Response programs (e.g. CEC’s REACH program) as part of the National Safety and Quality Health Service Standard 9, these should be incorporated into local CERS protocols.

4.1 Clinical Review

This is a patient review undertaken within 30 minutes by the attending medical team, or designated responder, as defined in the local CERS protocol.

NOTE: 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 with post graduate qualifications in emergency/critical care nursing.

Prompt and effective Clinical Review is an essential element in managing patients who are clinically deteriorating and should be undertaken or supervised by experienced staff.

4.1.1 Clinical Review Process

If a patient has any Yellow Zone observations or Additional Criteria on a Standard Observation Chart you must:

• Initiate appropriate clinical care
• Repeat and increase the frequency of observations, as indicated by your patient’s condition
• Consult promptly with the Nurse in Charge to decide whether a Clinical Review (or other CERS) call should be made.

Together with the Nurse in Charge consider the following:

• What is usual for your 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 your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned.
• Document an A-G assessment, reason for escalation, treatment and outcome in your patient’s health care record.
• Inform the Attending Medical Officer that a call was made as soon as it is practicable.

Where required, outcomes of the Clinical Review call should also be entered into any relevant NSW Health, LHD/Specialty Network or local database for capturing key performance indicators.

When providing clinical handover to the designated responder(s) a structured communication tool (ISBAR) must be used.
At an appropriate time, the patient and their family or carer are to be informed that a Clinical Review was activated and the outcomes of this review.

4.2 Rapid Response

This is an urgent review for patients who have Red Zone observations or Additional Criteria on a Standard Observation Chart undertaken by a Rapid Response Team, or designated responder(s), as defined in the local CERS protocol.

The Rapid Response Team (RRT) members or designated responder(s) must have an advanced level of competence in the management of the clinically deteriorating patient.

The Rapid Response Team (RRT) must have a designated team leader who has an advanced level of competence in resuscitation and stabilisation of patients, and has completed all three tiers of the Between the Flags Education Curriculum.

NOTE: In small or rural public health facilities, the designated responder may be a Registered Nurse/Midwife with First Line Emergency Care Course (FLECC) training or a paramedic who attends as a result of a CERS Assist call.

Where the case mix of the facility includes obstetric, paediatric and neonatal patients the RRT (or designated responder) must have a member of the team who is competent in obstetric, paediatric and neonatal resuscitation.

A facility may implement a graded Rapid Response (e.g. two tiers) to a patient with Red Zone observations or Additional Criteria on a Standard Observation Chart that is activated based on the severity of the patient’s condition. This graded response must be risk assessed by the local peak safety and quality committee and clearly defined in the local CERS protocol. For example, patients with an immediately life threatening condition (cardio-respiratory arrest, airway obstruction or stridor, patient unresponsive – see Standard Observation Chart) are prioritised to a Rapid Response Team, and patients with Red Zone observations or Additional Criteria that are not immediately life threatening must be attended by a senior registrar or equivalent.

4.2.1 Rapid Response Process

If a patient has any Red Zone observations or Additional Criteria on a Standard Observation Chart you must call for a Rapid Response (as per local CERS) and:

- Initiate appropriate clinical care.
- Inform the nurse in charge that you have called for a Rapid Response.
- Repeat and increase the frequency observations, as indicated by your patient’s condition.
- Document an A-G assessment, reason for escalation, treatment and outcome in your patient’s health care record.
- Inform the Attending Medical Officer that a call was made as soon as it is practicable.

Designated providers of the Rapid Response must attend urgently (as defined by local CERS protocol) to assess the patient; treat the underlying cause of clinical 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.

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45 If it can be demonstrated that a clinician has already undertaken advanced clinical and resuscitation skills training equivalent to content and learning outcomes of the relevant module of BTF Education then the clinician may be exempt from the requirement to undertake this level of BTF training.
12. MEDICAL CARE

Where required, outcomes of the Rapid Response call should also be entered into any relevant NSW Health, LHD/Specialty Network or local database for capturing key performance indicators.

When providing clinical handover to the designated responder(s) a structured communication tool (ISBAR) must be used.

At an appropriate time, the patient and their family or carer are to be informed when a Rapid Response has been activated and the outcomes of this review.

4.3 Escalation beyond facility and transfer processes

Patients must not be transferred between clinical units, to another facility or to their usual place of residence when their observations indicate the need for a Clinical Review or Rapid Response. The transfer may occur as part of the escalation of care process, or where the transferring AMO approves the transfer (and/or the alterations to calling criteria) and has advised the receiving AMO/AMT and nursing staff.

If following a Clinical Review or Rapid Response call a patient requires transfer to another facility the local CERS protocol and algorithm must:
- Outline the escalation steps to obtain expert advice and request for transfer.
- The roles and responsibilities of the transferring and accepting facility.
- How they will be contacted 24 hours a day.
- The process for transfer to another facility.

PD2011_031 - Inter-facility Transfer Process for Adults Requiring Specialist Care provides a process for the inter-facility transfer of adult patients requiring time critical access to specialised care. It states that 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.

The policy mandates that each Local Health District (LHD) must have a process outlining policy and operational guidelines on inter-LHD transfer for patients requiring access to specialist care.

PD2010_021 - Critical Care Tertiary Referral Networks & Transfer of Care (Adults) states that it is a mandatory requirement that access to emergency care and/or surgical intervention for time-urgent critically ill/injured patients is not to be delayed due to “no-available” ICU bed. Aeromedical and Medical Retrieval Service (AMRS) is to be contacted immediately should this situation arise (1800 650 004).

PD2009_060 - Clinical Handover - Standard Key Principles should be used in handover of patients to other levels of care.

4.3.1 Paediatric escalation beyond facility and transfer processes

There must be a paediatric specific CERS and escalation response relevant to all units and departments within any facility where children are cared for or may present.

The NSW Health Paediatric CERS and Escalation Matrix (Appendix 8.2) describes the response and escalation process for all facilities (medical role delineation 1-6). Local CERS and Escalation algorithms must be developed based on this matrix and be clearly displayed in all clinical units.

NOTE: A Guide to Paediatric CERS and Beyond Facility Escalation Documentation can be found in Appendix 8.1.
In the first instance, local/regional escalation plans should promote a stepped approach to services within the LHD; accordingly, step 1 is the most senior available expertise within the local facility of presentation. Step 2 is the designated regional specialist paediatric service, as described in Section 4. Step 3 in escalation of consultation and/or request for transfer is consistently the NETS service (1300 36 2500) across NSW.

Escalation of care or request for advice should not be delayed by failure to reach the nominated clinician on the CERS algorithm. Where the case is time critical, the clinician at the presenting facility should continue to escalate through the algorithm until an appropriate level of advice and/or support is achieved within the required timeframe.

The most senior Attending Medical Officer must review and seek specialist paediatric consultation (local or regional) for:

- All paediatric patients whose observations fall within the Yellow Zone on the Standard Paediatric Observation Chart and are identified for transfer and/or retrieval.
- All paediatric patients whose observations fall within the Red Zone on the Standard Paediatric Observation Chart.
- Major trauma patients.
- Whenever other clinical factors or level of concern indicate it is appropriate (including history or severity of pain).

PD2010_032 Children and Adolescents - Admission to Services Designated Level 1-3 Paediatric Medicine & Surgery (p5)\(^1\) indicates when a consultation with a specialist paediatrician/or appropriate other specialist is required.

PD2010_030 - Critical Care Tertiary Referral Networks (Paediatrics) (p6)\(^2\) and PD2010_031 - Children and Adolescents Inter-facility Transfer (p12)\(^3\) provide summaries of the conditions requiring consultation regarding management and/or transfer by NETS. PD2010_031 emphasises that NETS need to be consulted for all children with a triage category 1 or 2 and all children with a triage category 3 who are not improving.

In recognition of the 3 steps of escalation described, NETS will seek to establish simultaneous telephone (and/or video) contact between local, regional and statewide expertise and, when appropriate, the relevant Children’s Hospital.

In addition, any significant change in the condition of a patient should result in further consultation with NETS, even after retrieval has been arranged to discuss any required modification in management strategy.

Where LHDs have alternative (to NETS) consultation/retrieval and/or cross border arrangements these should be clearly stated in the local CERS and Escalation protocols and algorithms, and be developed in consultation with NETS.

All transfers between facilities, including non-urgent transfers to access inpatient beds, should be notified to the designated regional specialist paediatric service, unless there is a paediatrician available at the transferring and/or receiving facilities.

### 4.4 Equipment and Support

All facilities must have equipment to support advanced resuscitation.

Each facility must have an agreed, age appropriate, minimum set of emergency equipment and drug listing developed with reference to current best practice that is approved and reviewed by the facility’s resuscitation or other Quality Committee.
Hospitals must also have access to the following equipment in patient care areas and non-patient care areas frequented by the public:

- Barrier devices for expired air resuscitation (sizes depending on the age profiles of the hospital’s patients).
- A controllable supply of oxygen.
- A high pressure suction source.
- Disposable gloves.

5. EDUCATION

All facilities must have an education program in place, based on the Between the Flags Education Strategy and Curriculum18–19, which supports their staff to recognise and appropriately manage patients who are clinically deteriorating.

*Between the Flags* provides a tiered approach to education which includes an introduction to the NSW BTF system and the Standard Observation Charts, a structured approach to clinical assessment of the patient, the local CERS escalation protocol and appropriate care to provide while waiting for assistance.

All staff must have an awareness of the NSW BTF system and know how to activate their local Clinical Emergency Response System.

All clinicians providing direct patient care must complete both Tier 1 and Tier 2 of the BTF education curriculum.

The BTF Education Strategy contains a “Guidance for Prioritisation of Clinical Staff to attend Tier 2 face-to-face workshops” to assist LHDs/Specialty Networks to identify staff that should be prioritised to attend Tier 2 training.

Some clinical staff may have completed courses/specialty training whose core curriculum exceeds the requirements of the Tier 2 face-to-face workshop. The BTF Education Strategy document contains information to assist LHDs/Specialty Networks to identify those staff to which ‘Recognition of Prior Learning’ can be granted for the Tier 2 face-to-face workshop.

All Public Health facilities must establish systems to ensure regular educational up-dates for existing staff and the training of new staff.

The three tiers of the BTF education are:

**Tier 1 - Awareness Training**

All clinical staff and students must be aware of the BTF Program. They should also be able to recognise a patient who is clinically deteriorating, identify the key features of the Standard Observation Charts and explain how to apply the principles of the Clinical Emergency Response System.

The Tier 1 ‘awareness’ training is available online at [http://nswhealth.moodle.com.au](http://nswhealth.moodle.com.au)

**Tier 2 – DETECT/DETECT Junior**

These programs are aimed at enhancing clinical assessment and management skills for the early intervention for patients who are clinically deteriorating. All clinicians providing direct patient care should develop the theoretical and practical knowledge to recognise and provide appropriate care for patients who are clinically deteriorating and incorporate appropriate communication, escalation and
As a prerequisite for Tier 2 training and to align with action 9.6.1 of the National Safety and Quality Health Service Standards the clinical workforce must be trained and proficient in basic life support. The Tier 2 education resources include:

- Online e-learning modules
- DETECT and DETECT Junior manuals
- A face-to-face practical session.

The Fetal welfare assessment, Obstetric emergencies and Neonatal resuscitation Training (FONT) Program has been developed by the NSW Pregnancy and newborn Services Network (PSN) and is mandatory for all NSW Health maternity clinicians including Obstetricians, General Practitioner Obstetricians, Trainees in Obstetric Medicine, Registered Midwives and Midwifery Students. The principles of BTF have been incorporated into FONT education.

**NOTE:** Clinicians working solely in maternity services, who complete all aspects of the FONT program, will not be required to attend the BTF Tier 2 education program (DETECT). Those clinicians who work across both general and maternity will be required to attend both FONT and the DETECT education program.

**Tier 3 - Advanced clinical and resuscitation skills**

Members of the RRT are required to have advanced clinical and resuscitation skills, for example Advanced Life Support. The Clinical Excellence Commission is developing learning objectives for BTF Tier 3 education.

**6. EVALUATION**

All Public Health Organisations must collect and monitor data to assess performance and evaluate the implementation of the Between the Flags system.

The results of data analysis should be fed back in a timely manner to clinical units, facility/LHD/Specialty Network quality and safety committees and through the Public Health Organisation to the NSW Ministry of Health.

Standard Observation Chart audits to monitor compliance and the regular review of Clinical Review and Rapid Response calls should form the basis of the facilities evaluation, along with the collection and analysis of the key performance indicators.

**6.1 Key Performance Indicators**

Since July 2010, public health facilities have been required to collect data for two key performance indicators to evaluate Between the Flags:

- Rapid Response call rate per 1000 acute separations.
- Cardio-respiratory arrest rate per 1000 acute separations.

Separate advice on key performance indicators, including definitions and methods for collection will be provided to Public Health Organisations by the NSW Ministry of Health as part of the LHD/Specialty Network service agreements.

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41 If it can be demonstrated that a clinician has already undertaken advanced clinical and resuscitation skills training equivalent to content and learning outcomes of the relevant module of DETECT then the clinician may be exempt from the requirement to undertake this level of DETECT training.
12. MEDICAL CARE

7. REFERENCE DOCUMENTS

5. Peter Garling SC, Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, November 2008, State of NSW.

Related documents
8. APPENDICES
8.1 Guide to Paediatric CERS and Beyond Facility Escalation Documentation

The local Paediatric CERS and Beyond Facility Escalation Algorithm should:

- Be applicable and readily available to all departments within all facilities, where a child might be seen.
- Be based on the NSW Health ‘Between the Flags’ Paediatric CERS & Escalation Matrix (provided as Appendix 8.2) and consistent with all other aspects of PD – Recognition and Management of Patients who are Clinically Deteriorating.
- Developed as a one page flow-chart (although LHDs may choose to have accompanying documentation such as a policy directive, guidance, procedures).
- Include a list of actions consistent with the three coloured zones.
- Be consistent with response timeframes outlined in PD – Recognition and Management of Patients who are Clinically Deteriorating for Clinical Review and Rapid Response.
- Include the hierarchy of internal responses (step 1: local mechanisms to gain help) and beyond facility escalation (step 2: regional and step 3: tertiary/state).
- Outline the role of, and how to contact, the regional specialist paediatric service (step 2), which is a point of referral and paediatric expertise, with a 24hour/7 days a week on call specialist paediatric (medical) consultation available.
- Outline the role of Ambulance Service of NSW in the LHD CERS Assist response and external escalation (including transport).
- Outline the role of, and how to contact, NETS (step 3) as the consistent NSW wide expert resource.
- Clearly state that urgency supersedes the hierarchy.
- Be paediatric specific: where it is identified that a more generic algorithm is required, the algorithm must include a set of paediatric specific instructions that are clearly identified.
### 8.2 NSW Health Between the Flags Paediatric CERS and Escalation Matrix

<table>
<thead>
<tr>
<th>Paediatric Medical Role Delineation</th>
<th>Paediatric Blue Zone ‘Increased Vigilance’</th>
<th>Paediatric Yellow Zone ‘Clinical Review’</th>
<th>Paediatric Red Zone ‘Rapid Response’</th>
</tr>
</thead>
</table>
| **Level 1** (FLEC RN only)        | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Seek Senior nursing advice either locally or at local referral hospital  
▪ Complete a full set of observations and increase the frequency of observations  
▪ If clinician or parental concern escalate to ‘Clinical Review’ | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Consultation within 30 minutes with local medical referral network or RFDS where applicable  
▪ Complete a full set of observations and increase the frequency of observations  
▪ Consider consultation with Paediatrician at local referral facility  
▪ If Clinical Review mechanisms fail or time frames not met escalate to a Rapid Response | ▪ Immediate treatment / Resuscitation as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Initialise local mechanism to gain additional help i.e. CERS Assist/ on-call staff  
▪ Depending on need for immediate resuscitation contact NETS on 1300 36 2500 or immediate consultation with local medical referral network  
▪ Continuous Monitoring |
| **Level 1 -3** (RN / GP VMO /CMO) | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Seek Senior Nursing advice either locally or at local referral hospital  
▪ Complete a full set of observations and increase the frequency of observations  
▪ If clinician or parental concern escalate to ‘Clinical Review’ | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Consultation within 30 minutes with On-call GP VMO or allocated proxy where applicable  
▪ Complete a full set of observations and increase the frequency of observations  
▪ Consider consultation with Paediatrician at local referral facility  
▪ If Clinical Review mechanisms fail or time frames not met escalate to a Rapid Response | ▪ Immediate treatment / Resuscitation as per NSW Rural Emergency Clinical Guidelines for Children  
▪ Initialise local mechanism to gain additional help i.e. CERS Assist/ on-call staff  
▪ Immediate consultation with GP VMO or allocated proxy and/or initialise RRT where available and/or  
▪ Consultation ASAP with NETS on 1300 36 2500 or Interstate retrieval service where applicable  
▪ Continuous Monitoring |
| **Level 3** (RN / VMO Paed/ CMO Non-training hospital) | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children or local paediatric protocols  
▪ Seek Senior Nursing advice  
▪ Complete a full set of observations and increase the frequency of observations  
▪ If clinician or parental concern escalate to ‘Clinical Review’ | ▪ Immediate treatment as per NSW Rural Emergency Clinical Guidelines for Children or local paediatric protocols  
▪ Consultation within 30 minutes with On-call CMO or Paediatrician where applicable  
▪ Contact on-call paediatrician or specialty consultant if delays or specific concerns  
▪ Complete a full set of observations and increase the frequency of observations  
▪ If Clinical Review mechanisms fail or time frames not met escalate to a Rapid Response | ▪ Immediate treatment / Resuscitation as per RECG, ARC or NSW Health paediatric guidelines or local paediatric protocols  
▪ Initialise local mechanism to gain additional help  
▪ Initialise RRT including on call paediatrician OR consultation within 5 minutes with On-call Paediatrician  
▪ Always initialise RRT if any delays  
▪ Continuous Monitoring  
▪ Consultation ASAP with NETS on 1300 36 2500 (or Interstate retrieval service where applicable) |
<table>
<thead>
<tr>
<th>Level 4 (RN / Res / Reg / Paed / Staff Paed / CMO / FACEM)</th>
<th>Level 5-6 (Tertiary/Quaternary Service)</th>
<th>Level 5-6 (Tertiary/Quaternary Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate treatment as per local/NSW Health paediatric protocols or guidelines</td>
<td>Immediate treatment as per local/NSW Health paediatric protocols or guidelines</td>
<td>Immediate treatment / Resuscitation as per RECG, ARC or NSW Health paediatric guidelines or local paediatric protocols</td>
</tr>
<tr>
<td>Seek Senior Nursing advice</td>
<td>Consultation within 30 minutes with paediatric, emergency or specialty resident/registrar where applicable</td>
<td>Initialise local mechanism to gain additional help</td>
</tr>
<tr>
<td>Complete a full set of observations and increase the frequency of observations</td>
<td>Contact on-call paediatrician or specialty consultant if delays or specific concerns</td>
<td>If immediate resuscitation required initialise RRT including on call paediatrician OR</td>
</tr>
<tr>
<td>If clinician or parental concern escalate to ‘Clinical Review’</td>
<td>Complete a full set of observations and increase the frequency of observations</td>
<td>Consultation within 5 minutes with On-call paediatrician/FACEM</td>
</tr>
<tr>
<td></td>
<td>If Clinical Review mechanisms fail or time frames not met escalate to a Rapid Response</td>
<td>Always initialise RRT if ANY delays or concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuous Monitoring</td>
</tr>
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</tbody>
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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.
<table>
<thead>
<tr>
<th>Clinical Condition</th>
<th>Urgency of Transfer</th>
<th>Refer To</th>
<th>First Phone Call To</th>
<th>Responsibility for Bed Finding and Clinical Advice</th>
<th>Responsibility for Initiating Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD2010_021</td>
<td>Patient has a time-urgent clinical condition needing transfer in the shortest time possible. Patient's condition is not time-urgent</td>
<td>Linked Tertiary Hospital</td>
<td>AMRS 1800 650 004</td>
<td>Patient is automatically transported to the linked Tertiary Referral Hospital.</td>
<td>AMRS 1800 650 004</td>
</tr>
<tr>
<td>Inter-facility Transfer Process for Adult Patients Requiring Specialist Care PD2011_031</td>
<td>Patient requires transfer for urgent specialist care (within 24hrs) Inpatient requiring specialist care (within 24-72hrs)</td>
<td>Linked LHD or Tertiary Hospital</td>
<td>Receiving specialty clinician via documented LHD referral pathways</td>
<td>Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.</td>
<td>Patient Flow Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linked LHD or Tertiary Hospital</td>
<td>Receiving specialty clinician via documented LHD referral pathways</td>
<td>Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.</td>
<td>Patient Flow Unit</td>
</tr>
</tbody>
</table>

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.
12. MEDICAL CARE

- **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.
12.  MEDICAL CARE

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 timeframe, 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.
### ATTNACHMENTS

Appendix 1 EXAMPLE of an Inter-hospital Transfer Checklist

#### For Medical Record Use Only

**South Eastern Sydney Illawarra Area Health Service**

**INTERHOSPITAL TRANSFER SUMMARY**

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:** SHSEH Transport  
- **Bed availability confirmed by receiving facility:** yes  
- **Date:** / /  
- **Time:** hrs

**Management/Intervention/Assessments**

<table>
<thead>
<tr>
<th>Oxygen therapy: yes □ no □</th>
<th>IV therapy: yes □ no □</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specify:</strong></td>
<td><strong>Type:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Site:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dietary requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NBM:</strong> yes □ no □</td>
</tr>
<tr>
<td><strong>NT/Peg:</strong> yes □ no □</td>
</tr>
<tr>
<td><strong>TPN:</strong> yes □ no □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility issues: yes □ no □</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Falls risk score:</strong></td>
</tr>
<tr>
<td><strong>Walking aid:</strong> yes □ no □</td>
</tr>
<tr>
<td><strong>Type:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incontinent: yes □ no □</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specify:</strong></td>
</tr>
<tr>
<td><strong>Urinary Catheter:</strong> yes □ no □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk of cross infection:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>no □ yes □ precautions:</strong></td>
</tr>
<tr>
<td><strong>Contact:</strong> A, Droplet B, Airborne C</td>
</tr>
<tr>
<td><strong>Infection (Type):</strong></td>
</tr>
</tbody>
</table>

**Assessment prior to transfer**

<table>
<thead>
<tr>
<th>Yes □ No □</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient ID bands in place:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Alert Bands in place:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pain management on route:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score:</th>
<th>/10, last dose given at:</th>
<th>Pain medication due:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obs on discharge:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Glasgow coma scale if required:**  |
| **Score:**  |

| **Bleed sugar level if required:**  |
| **Current BSL:** |
| **Next due:** |

| **Wound care chart:**  |
| **Pressure Ulcer Assessment:**  |
| **Waterfall score:** |

<table>
<thead>
<tr>
<th>Dentures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostheses</td>
</tr>
<tr>
<td>Communication defect</td>
</tr>
<tr>
<td>Personal / Valuables / Spectacles</td>
</tr>
<tr>
<td><strong>X-rays/ scans (pts own):</strong></td>
</tr>
</tbody>
</table>

| **Appropriate Sustenance provided:**  |
| **Sandwiches and drinks required for road travel outside metro Sydney:** |

**Handover of Patient’s condition**

**Nursing Management:**

---

**EXAMPLE ONLY**
Appendix 2 HD and Nominated Tertiary Referral Centres for Urgent and Non Urgent Specialist Care

Metropolitan NSW LHDs

<table>
<thead>
<tr>
<th>LHD</th>
<th>Central Coast</th>
<th>Illawarra Shoalhaven</th>
<th>Nepean Blue Mountains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominated Tertiary Referral Centre</td>
<td>Royal North Shore</td>
<td>St George</td>
<td>Nepean</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gosford</td>
<td></td>
<td>Bulli</td>
<td>Blue Mountains</td>
</tr>
<tr>
<td>Long Jetty</td>
<td></td>
<td>Coledale</td>
<td>Hawkesbury</td>
</tr>
<tr>
<td>Woy Woy</td>
<td></td>
<td>David Berry</td>
<td>Lithgow</td>
</tr>
<tr>
<td>Wyong</td>
<td></td>
<td>Kiama</td>
<td>Portland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milton Ulladulla</td>
<td>Springwood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Port Kembla</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shellharbour</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shoalhaven</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wollongong</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LHD</th>
<th>Northern Sydney</th>
<th>South Eastern Sydney</th>
<th>South Western Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominated Tertiary Referral Centre</td>
<td>Royal North Shore</td>
<td>Prince of Wales</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td>St George</td>
<td></td>
</tr>
<tr>
<td>Greenwich</td>
<td></td>
<td>Royal Hospital for Women</td>
<td></td>
</tr>
<tr>
<td>Hornsby</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macquarie</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manly</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mona Vale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neringah</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ryde</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calvary Healthcare</td>
<td>Bankstown Lidcombe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gower Wilson (Lord Howe Island)</td>
<td>Braeside</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sutherland</td>
<td>Bowral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sydney &amp; Eye Hospital</td>
<td>Camden</td>
</tr>
<tr>
<td></td>
<td></td>
<td>War Memorial</td>
<td>Campbelltown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fairfield</td>
</tr>
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<table>
<thead>
<tr>
<th>LHD</th>
<th>Sydney</th>
<th>Western Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominated Tertiary Referral Centre</td>
<td>RPAH/Concord</td>
<td>Westmead</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balmain</td>
<td>Auburn</td>
<td></td>
</tr>
<tr>
<td>Canterbury</td>
<td>Blacktown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mount Druitt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>St Josephs</td>
<td></td>
</tr>
</tbody>
</table>
### Rural LHDs

<table>
<thead>
<tr>
<th>LHD</th>
<th>Hunter New England</th>
<th>Mid North Coast</th>
<th>Murrumbidgee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominated Tertiary Referral Centre</td>
<td>John Hunter</td>
<td>John Hunter</td>
<td>Prince of Wales St George St Vincent’s</td>
</tr>
<tr>
<td>Hospital</td>
<td>Armidale</td>
<td>Bellingen</td>
<td>Albury**</td>
</tr>
<tr>
<td></td>
<td>Barraba</td>
<td>Coffs Harbour</td>
<td>Balranald</td>
</tr>
<tr>
<td></td>
<td>Belmont</td>
<td>Dorridge</td>
<td>Barham Koondrook</td>
</tr>
<tr>
<td></td>
<td>Bingara</td>
<td>Kempsey</td>
<td>Batlow</td>
</tr>
<tr>
<td></td>
<td>Boggabri</td>
<td>Macksville</td>
<td>Berrigan</td>
</tr>
<tr>
<td></td>
<td>Bulahdelah</td>
<td>Port Macquarie</td>
<td>Boorowa</td>
</tr>
<tr>
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*Albury is networked with clinical services in Victoria however referral to a NSW facility may be required due to clinical need.*
### 12. MEDICAL CARE

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#### Sydney Children’s Hospital Network

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(State-wide referral role)

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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, Queenbeyan, Tumut, Yass and Young.

45 Broken Hill maintains clinical referral networks with South Australia
### Post Implementation Checklist

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
<th>Notes</th>
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<tr>
<td>4. Evidence of documented clinical referral pathways established across and between the Local Health Network</td>
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<td>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</td>
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<td>6. Single LHD arbitrator designated for the resolution of escalated patient inter-facility transfer issues</td>
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<td>7. Number of patients requiring arbitration at tier 2 level to successfully occasion an inter-facility transfer to a higher level care facility</td>
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<td>8. Number of patients breaching &gt;24hr for a return transfer time at 3 and 6 months</td>
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CHEST PAIN EVALUATION (NSW CHEST PAIN PATHWAY) (PD2011_037)

PURPOSE

The policy mandates the implementation of minimum standards for chest pain evaluation, by all hospitals in the NSW Health system for patients presenting to Emergency Departments with chest pain. Compliance with these minimum standards for chest pain evaluation will improve the management of patients by guiding clinicians through risk stratification and outlining the best practice management. Facilities may continue to use existing local Pathways provided that they meet all of the minimum standards and are in active use in emergency departments.

Facilities who do not use an existing Chest Pain Pathway that meets the minimum standards must implement the standard NSW Chest Pain Pathway. The NSW Chest Pain Pathway aligns with the National Heart Foundation/Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes.

MANDATORY REQUIREMENTS

1. All facilities with Emergency Departments must have and use a pathway that meets the following minimum standards for chest pain patients:
   - Assigns triage category 2
   - Includes risk stratification
   - ECGs are taken and reviewed
   - Troponin levels are taken and reviewed
   - Vital signs are taken and documented
   - Critical times are documented (symptom onset, presentation)
   - Aspirin is given, unless contraindicated
   - A Senior Medical Officer is assigned to provide advice and support on chest pain assessment and initial management, 24/7
   - A nominated Cardiologist is assigned to provide advice on further management 24/7
   - The pathway gives instruction regarding atypical chest pain presentations
   - High risk alternate diagnosis listed for consideration e.g. Aortic Dissection, Pulmonary Embolism & Pericarditis.
   - Sites that do not have 24/7 PCI capability must have Thrombolysis as the default STEMI management strategy unless there is an existing documented system for transfer.

2. All facilities who do not use an existing Chest Pain Pathway that meets the minimum standards must implement the standard NSW Chest Pain Pathway that matches their facility (i.e. only sites that can provide 24/7 Primary PCI are able to use the Primary PCI site Pathway) as the minimum standard.

IMPLEMENTATION

ROLES AND RESPONSIBILITIES

NSW Department of Health:
- Review the minimum standards of a Chest Pain Pathway in line with relevant national guidelines and best practice evidence.
- Develop and make accessible implementation support tools.
- Evaluate Chest Pain Pathway implementation and performance against the minimum standards across the NSW Health system.
LHN Chief Executives:
• Ensure effective implementation of the minimum standards for chest pain evaluation in all LHN Emergency Departments
• Report minimum standards for chest pain evaluation implementation to the LHN Governing Council
• Report Chest Pain Pathway implementation and performance against the minimum standards to NSW Department of Health as requested

LHN Directors of Clinical Governance:
• Direct a LHN gap analysis against the chest pain evaluation minimum standards
• Develop and lead implementation strategy
• Coordinate appropriate educational resources for clinicians
• Evaluate LHN Chest Pain Pathway implementation and performance against the minimum standards
• Investigate RCA incidents relating to the minimum standards for chest pain evaluation

Facility General Managers and Heads of Cardiology and Emergency Departments:
• Direct a local gap analysis against the chest pain evaluation minimum standards
• Implement the chest pain evaluation minimum standards locally
• Evaluate and monitor local implementation and performance against the chest pain evaluation minimum standards
• Coordinate local education requirements for clinicians
• Coordinate local rostering to ensure that a senior clinician is available to assist 24/7 as per the chest pain evaluation minimum standards or utilise documented referral network

Clinicians:
• Comply with the minimum standards of chest pain evaluation
• Escalate management of deteriorating patients as per Recognition and Management of Patients Who Are Clinically Deteriorating (PD2013_049)
• In Emergency Departments that do not have a medical officer accessible 24/7, it will be necessary to implement processes where the nurse in charge of the ED signs the Chest Pain Pathway form in place of the medical officer.

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 effectiveness 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).

NUTRITION CARE (PD2011_078)

PURPOSE

Local Health Districts and other NSW public health organisations have a responsibility to provide nutrition care and support for all their inpatients and residents. This policy directive sets out the NSW Health framework for a strategic and coordinated approach to nutrition care and support from admission to transfer of care.

MANDATORY REQUIREMENTS

All NSW Local Health Districts and other NSW Health organisations which provide food and nutrition care services to patients must have in place nutrition care processes based on this policy directive.

The implementation of the Nutrition Care Policy in NSW Local Health Districts and other NSW public health organisations is to occur over a 24 month period as follows:
1. Implementation Standard: to be met within twelve months of release of the Policy
2. Compliance Standard: to be met within twenty four months of the release of the Policy

The requirements for meeting these standards are detailed in Attachment 1.

IMPLEMENTATION

Chief Executives are responsible for:
• Implementing the Nutrition Care Policy within their respective facilities
• Ensuring governance structures are in place at 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 is in place
• Ensuring systems for nutrition risk screening and nutrition assessment using validated tools are in place
• Ensuring clinician work practices are consistent with the requirements of the Policy
• Ensuring a system to evaluate nutrition care is in place
• Reporting on the implementation and evaluation of the requirements of the Policy.

Nursing/Midwifery Unit Managers (or Nurse/Midwifery Manager where appropriate)
• Enabling and monitoring systems to ensure patients receive appropriate nutrition.

The Agency for Clinical Innovation is responsible for:
• Providing support to NSW Local Health Districts and other NSW public health organisations for the implementation of the Nutrition Care Policy.
• Monitoring and evaluating implementation of the Nutrition Care Policy within NSW Local Health Districts and other NSW public health organisations in collaboration with the NSW Ministry of Health and Health Support Services.
• 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.
Health Support Services is responsible for:

- Ensuring the standards set out in this policy and other related policies are incorporated into all Health Support Services’ activities including menu planning and design, food service and delivery in NSW Local Health Districts and other NSW public health organisations.
- Ensuring appropriate consultation and communication with NSW Local Health Districts and other NSW public health organisations.

1. BACKGROUND

1.1 Food and nutrition in health

Good nutrition is important for everyone, but particularly for those who are ill or suffering from injury. The provision of adequate nutrition is an integral aspect of nutrition care and is associated with better patient outcomes. Hospital patients, who are already maintaining good nutritional status and those who are malnourished and gaining nutritional repletion, rely on the hospital to provide foods which are nourishing and acceptable to the patient in terms of their cultural and psychosocial needs. To achieve the best outcomes for the patient other issues such as patient access to foods and assistance with eating also need to be addressed.

Food is not only essential for physical health but also essential to an individual’s sense of self. Food has strong psychological connotations associated with nurturing. Frequently when a person is admitted to hospital, the only familiar thing and one of the few things the patient feels qualified to evaluate is the food. Familiar foods are important in stressful situations as they can represent comfort and security. Although hospital food services may be constrained by limitations, such as the system of food preparation and the statutory requirements of providing safe food to patients, they have a duty of care to meet the nutrition requirements and the cultural and psychosocial needs of each patient. All staff can contribute to making the hospital mealtime environment pleasant and can assist patients in accessing and enjoying their meals.

1.2 Hospital malnutrition - recognition and consequences

Hospital malnutrition is a world-wide phenomenon the causes of which are multifactorial. While many patients are malnourished on admission, the nutrition status of patients may worsen during the course of admission. This may result from impaired intake, impaired digestion and/or absorption, altered metabolic nutrient requirements and/or excessive nutrient losses.

Unless systematic efforts are made to identify and manage patients at risk, malnutrition may go undetected during the patient’s admission. If untreated, malnutrition can cause a wide range of adverse outcomes for the patient and the health system. These include:

For the individual:

- Delayed wound healing
- Increased risk of pressure areas
- 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.
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.

1.3 Key definitions

The following terms apply in this document

**Malnutrition**
‘A state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome’

**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. This encompasses all aspects of the nutrition continuum of care from nutrition assessment and intervention, including access to safe, acceptable and appropriate food services, nutrition supplements and/or enteral and parenteral nutrition.

**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.’

**Nutrition Assessment**
A comprehensive approach to gathering pertinent data in order to define nutritional status and identify nutrition-related problems. The assessment often includes consumer/patient history, medical diagnosis and treatment plan, nutrition and medication histories, nutrition-related physical examination including anthropometry, nutritional biochemistry, psychological, social, and environmental aspects.

**Nutrition Support**
The provision of nutrients to make up the shortfall between the patient’s nutrient requirements and their nutrient consumption. Supplementary nutrition can be given in the form of additional snacks, enteral feeds or total parenteral nutrition (TPN).

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

1.4 Related NSW health policies and guidelines

- IB2013 039 Foodborne Listeriosis - Control in Health Care Institutions
- PD2010 049 Multipurpose Services - Policy and Operational Guidelines
- PD2011 015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
- PD2012 069 Health Care Records - Documentation and Management
- PD2014 004 Incident Management Policy
- GL2005 057 End-of-Life Care and Decision-Making - Guidelines

**Agency for Clinical Innovation Nutrition Standards**
- Nutrition standards for adult inpatients in NSW Hospitals

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48 Watterson C; Fraser A; Banks M; Iserning E.; Miller M; Hoeveunars R; Bauer J; Vivanti A; Ferguson M, 2009, Evidence based guidelines for nutritional management of malnutrition in adult patients across the continuum of care. Nutrition and Dietetics, vol 66, S1-S34.
12. MEDICAL CARE

- Nutrition standards for paediatric inpatients in NSW Hospitals

**Agency for Clinical Innovation Therapeutic Diet Specifications**
- Therapeutic diet specifications for adult inpatients
- Therapeutic diet specification for paediatric inpatients

1.5 Other related documents
- NSW Food Authority, Guidelines for food service to vulnerable persons

2. POLICY AND GOVERNANCE

2.1 Governance

Governance structures should include consumer, clinical and corporate representation. Each Local Health District and Network should have a Food and Nutrition Committee that includes representatives from the following groups:

- Senior management
- Medical staff
- Nursing/midwifery staff
- Consumers and their carers
- Clinical 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 committees should include the following activities:

- Implementation of the nutrition care strategic plan
- Operational policy/procedure development, endorsement and review
- Effective communication of policies and procedures to staff
- Monitoring implementation of agreed standards
- Monitoring performance against agreed standards
- Evaluation of nutrition care which includes the consideration of feedback received from consumers and staff

A governance group at each health facility should be considered.

2.2 Policy Implementation in NSW Local Health Districts and other NSW public health organisations

A strategic and coordinated approach is required by Local Health Districts and other NSW public health organisations to ensure a high standard of nutrition care is provided to patients. The implementation of this policy should be multidisciplinary in scope and address the following key elements:

- Implementation of the policy across the organisation
- Governance of nutrition care should include consumer, clinical and corporate representation
- Policy, procedures, service review and development should be informed by patients and staff views on nutrition care.
3. NUTRITION SCREENING

Nutrition screening is a key to early identification of patients with nutritional problems which may go unrecognised and therefore remain untreated during the patient’s hospital stay. Factors that may prevent a patient from eating and/or drinking adequately and safely while in hospital include, but are not limited to, physical difficulties, changes to sense of taste as a result of treatment 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.

NSW Local Health Districts 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. Nutrition screening should occur:

- on admission and then weekly during the patient’s episode of care
- at least monthly in slower stream facilities
- if the patient’s clinical condition changes.

All patients should have their weight and height documented on admission and weight should continue to be recorded at least weekly.

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 risk of malnutrition should be referred to a dietitian for a full nutrition assessment and nutrition support as appropriate.

4. NUTRITION ASSESSMENT

Nutrition assessment indicates the degree of an individual’s malnutrition and helps determine appropriate mitigation actions. Early detection of malnutrition and implementation of appropriate nutrition support reduces the risk of patients’ nutrition status deteriorating while in hospital.

Local Health Districts and Networks must have in place a system for nutrition assessment using a validated tool such as the Subjective Global Assessment (SGA) Tool, Mini Nutritional Assessment (MNA) and Patient Generated Subjective Global Assessment (PG-SGA). The nutrition assessment must be undertaken by a dietitian.

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 should be in place and communicated to staff.

Nutrition assessment should be discussed with the treating doctor and multidisciplinary team and documented in the patient’s medical record.

5. NUTRITION CARE PLANNING

Individuals identified as malnourished or at risk of becoming malnourished should have an appropriate nutrition care plan developed by a dietitian and documented. This nutrition care plan should contain clearly identified goals of treatment and may include social measures to ensure provision of meals, help with feeding, food and fluid intake records, modified menus, dietetic advice and oral nutrition supplements and/or artificial nutrition support. Patients and relatives should have input into the care plan.
Nutrition care plans should be:
- reviewed regularly and documented to reflect changes
- monitored to ensure goals are met with further action 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.

5.1 Transfer of care

Patients who require ongoing nutrition support on transfer of care should 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. On transfer, the care plan for malnourished patients should include information about:
- nutrition status
- special dietary requirements
- provision/purchase and preparation of specialised nutrition support products and relevant equipment where required
- arrangements for follow-up.

Arrangements should be in place for continuing care, this could include but is not limited to, community care, private practitioners or an outpatient service such as a Home Enteral Nutrition (HEN) 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 (eg enteral formula or equipment, thickened fluids, thickener).

6. 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 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.

6.1 Menus

The menu should provide the nutrition requirements of patients in accordance with the following:
- Nutrition standards for adult inpatients in NSW Hospitals
- Nutrition standards for paediatric inpatients in NSW Hospitals
- Therapeutic diet specifications for adult inpatients
- Therapeutic diet specifications for paediatric inpatients

Patients should be:
- provided on admission with information about meal services and the importance of nutrition in an easy-to-read format
- given the opportunity of selecting food and fluids from the menu
- assisted with menu selection, if required, by a qualified member of staff
- able to make their menu selections no more than one day ahead of the day of service. This has been shown to enhance meal consumption
12. MEDICAL CARE

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.

6.2 Provision of food and fluids

Patients should be able to access a minimum of 1.5 litres of fluid per day unless contraindicated. Drinking water should be accessible to patients at all times as appropriate. Patients requiring thickened fluids whose fluid intake is insufficient to prevent risk of dehydration should be considered for additional hydration support.

All food provided by the hospital should comply with relevant legislative standards, including those pertaining to food safety. Systems should be in place to cater for high risk patient groups including those with dysphagia, allergies and those who are severely immunocompromised.

Where possible, patients’ nutrition requirements should be provided by food. Oral supplements should not substitute for, or be relied upon, to enhance the provision of food and fluid unless there are clear clinical indicators.

Patients who cannot consume adequate nutrition orally, including those patients on textured diets, should be considered for artificial nutrition support.

Patients who are designated as ‘Nil-By-Mouth’ for more than three days should be considered for artificial nutrition support.

The diet ordering and the meal delivery systems should be efficient, timely and safe.

The number of meal occasions (mealtimes) should 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.

Specific nutrition concerns related to end-of-life issues should be considered according to GL2005_057 End-of-Life Care and Decision-Making - Guidelines.

7. 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.

Clinical 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 to the patient’s meal time
• preparing patients for eating prior to the meal delivery. (e.g. positioning, toileting, hand washing 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.

8. PROVISION OF ASSISTANCE TO EAT AND DRINK

Many patients require some form of assistance with eating and drinking while in hospital. This ranges from assistance with opening packages 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.

Wards 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 should include consultation with appropriate stakeholders (e.g. consumers).

9. STAFF EDUCATION AND TRAINING

Training and education programs enhance an understanding of the link between good nutrition care, 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
• be aware of the role of food and nutrition in preventing malnutrition, maximising patients’ clinical outcomes and quality of life
• be appropriately qualified and have knowledge of key aspects of nutrition care
• be aware that nutrition status may be compromised in patients who are overweight or obese.

Education programs on nutrition care and malnutrition should be provided annually and additionally as required.

10. EVALUATION

NSW Local Health Districts and other NSW public health organisations must have a system to evaluate nutrition care. The system must include monitoring and reporting of the following:
• audit of weight and height documentation
• audit of nutrition screening and nutrition assessment
• patient food satisfaction surveys.

11. BIBLIOGRAPHY


12. MEDICAL CARE


Northern Sydney Central Coast Area Health Service, 2008, Nutritional Care Policy, Document No. PD2011_078

Sydney South West Area Health Service, 2009, Food and Nutrition, Document No. PD2009_030

Sydney West Area Health Service, 2006, Food and Nutrition Policy, Document No. Poly10414

Watterson C; Fraser A; Banks M; Iserning E.; Miller M; Hoevenaars R; Bauer J; Vivanti A; Ferguson M, 2009, Evidence based guidelines for nutritional management of malnutrition in adult patients across the continuum of care. Nutrition and .Dietetics, vol 66, S1-S34.

12. ACKNOWLEDGEMENTS

The Agency for Clinical Innovation (ACI) Nutrition in Hospitals Group
Northern Sydney Central Coast Area Health Service
Sydney South West Area Health Service
Sydney West Area Health Service
**12. MEDICAL CARE**

**Attachment 1: Staged Implementation Checklist**

It is expected that NSW Local Health Districts (LHDs) and other NSW public health organisations will meet:

- the implementation standard within 12 months of the release of the policy
- the compliance standard within 24 months of the release of the policy

<table>
<thead>
<tr>
<th>Staged Implementation Checklist:</th>
<th>IMPLEMENTATION STANDARD</th>
<th>Date Achieved:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current compliance status</td>
<td>Actions required</td>
</tr>
<tr>
<td></td>
<td>Not started</td>
<td>Partial</td>
</tr>
</tbody>
</table>

LHDs and other NSW public health organisations have a Nutrition Care Policy implementation plan.

LHDs and other NSW public health organisations have a nutrition care governance structure that has clinical, consumer and corporate representation in place that is appropriate for each facility.

LHDs and other NSW public health organisations are responsible for assigning responsibility and personnel to implement the Nutrition Care Policy.

Equipment (such as scales, height measures and specialised feeding equipment) is available to support the implementation of the Nutrition Care Policy in clinical areas.

Patients have their weight and height measured and documented on admission and then weight measured weekly.

**COMPLIANCE STANDARD**

There is a system in place to ensure patients undergo nutrition screening on admission and weekly using a validated nutrition screening tool.

There is a system in place to ensure patients undergo a nutrition assessment using a validated nutrition assessment tool. This should occur within two working days of referral to a dietitian.

There is a staff training and education program in place.

There is a system in place to evaluate nutrition care which includes:
- audit of weight and height documentation
- nutrition screening and nutrition assessment compliance audits
- patient food satisfaction surveys.

**LEADERSHIP STANDARD**

100% compliance with this policy is achieved by all facilities within the health service

A system is in place to provide routine feedback to staff on compliance with the Nutrition Care Policy

142(22/12/11
SAFE ADMINISTRATION OF LIQUID MEDICINES BY ROUTES OTHER THAN INJECTION (PD2012_006)

PURPOSE

There have been a number of incidents resulting in serious injury where doses of oral liquid medicines have been administered parenterally.

These incidents have occurred through the use of parenteral syringes to prepare liquid medicine doses resulting in inadvertent administration of the dose via the incorrect route. The outcomes of this type of incident may be catastrophic and can be fatal.

This policy has been developed to minimise the risk of serious injury or death from the parenteral administration of liquid doses of medicines intended for other routes (principally oral or enteral).

MANDATORY REQUIREMENTS

- Oral/enteral dispensers (also called oral/enteral syringes) or graduated medicine cups are to be used to prepare, measure and administer all liquid doses intended for:
  - Oral and enteral use
  - Inhalational, intranasal, topical, or rectal use where measurement of volume is required
  - Injectable medicines intentionally prescribed for non-parenteral use
- Devices used for withdrawing liquid medicine doses intended for non-parenteral use from their container must have connections compatible with the oral/enteral dispensers
- Enteral feeding catheters, both nasogastric and percutaneous must have connections compatible with the oral/enteral dispensers in use.
- No device intended for access to the gastrointestinal tract should feature a female Luer® connector (Luer-Lok® or Luer-Slip®).

IMPLEMENTATION

Local Health District Chief Executives
- Assign responsibility for implementation of the standard and maintenance of the use of oral/enteral dispensers in line with mandatory requirements within the Local Health District.

Directors of Clinical Governance
- Ensure systems are in place to:
  - Implement the mandatory requirements and standards.
  - Monitor compliance with the policy and standards.

Hospital, facility, clinical stream and unit managers, Heads of Departments, Nurse/Midwife In Charge
- Ensure systems and practices prescribed in this policy are implemented and sustained successfully.
- Clearly identify and store oral/enteral dispensers separately from parenteral syringes.
- Ensure that oral/enteral dispensers and compatible connectors are available at the point-of-care.
- Monitor compliance and practices described in this policy.
- Ensure compliance of staff with use of the devices as described.
Directors of Pharmacy

- Liaise with relevant staff to ensure supply of oral/enteral dispensers and compatible connectors are maintained in all clinical areas.
- Ensure all clinical pharmacists and technicians are aware of this policy and ensure it is followed in all clinical areas.
- Ensure all dose measuring devices issued to outpatients and those transferring to the community comply with this policy.

1. BACKGROUND

The policy statement and standards together provide direction to minimise the risk of patient injury or death from inadvertent parenteral administration of liquid drug doses intended for other routes.

This policy mandates use of oral/enteral dispensers to measure and administer liquid medication doses by routes other than injection. Oral/enteral dispensers allow accurate volume measurement and prevent connection with injectable access devices. Use of dedicated devices provides a check against a medicine dose being administered by the incorrect route.

This policy is relevant to all clinical staff involved in administration of medicines and applies to adults, children and neonates.

2. KEY DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration line</td>
<td>This includes all giving sets, administration lines and invasive monitoring lines through which medicines and fluids could be administered.</td>
</tr>
<tr>
<td>Barrel (of syringe)</td>
<td>The hollow cylinder of a syringe in which fluids are measured</td>
</tr>
<tr>
<td>Catheter</td>
<td>A flexible tubular device for removing fluids from, or delivering fluids to, a body cavity.</td>
</tr>
<tr>
<td>Calibration</td>
<td>(the scale of a measuring instrument) an instrument divided into marked intervals for optimal measuring so that it can be read in the desired units.</td>
</tr>
<tr>
<td>Dead space</td>
<td>The volume of fluid remaining in the tip of a syringe after the plunger of the syringe has been fully depressed into the barrel.</td>
</tr>
<tr>
<td>Enteral</td>
<td>Fluids (nutrition or medicine) given into the gastrointestinal tract.</td>
</tr>
<tr>
<td>Female (Luer) Connector</td>
<td>Describes the shape and size of the port which connects with a male Luer connector. The standard shape of devices designed to access the vascular system.</td>
</tr>
<tr>
<td>Hub/syringe adaptor</td>
<td>The proximal end of a needle which attaches to the syringe barrel by means of a press-fit mechanism (Luer) or a twist-on mechanism (Luer-Lok).</td>
</tr>
<tr>
<td>Injection</td>
<td>For the purposes of this policy includes intravenous, intramuscular, intra-arterial, epidural, subcutaneous routes of administration</td>
</tr>
<tr>
<td>Intravenous</td>
<td>Paravenous drug and fluid administration into or within a vein or veins.</td>
</tr>
<tr>
<td>Luer taper</td>
<td>A Luer taper is a standardised system of small-scale fluid fittings used for making leak-free connections between a male taper fitting and its mating female part on medical and laboratory instruments, including hypodermic syringe tips and needles. It originated as a 6% taper fitting for glass bottle stoppers. Key features of Luer taper connectors are defined in the ISO 594/1:1986 standard. (BS EN 20594-1:1994).</td>
</tr>
</tbody>
</table>
### 12. MEDICAL CARE

<table>
<thead>
<tr>
<th>Luer-Lok</th>
<th>Luer-Slip</th>
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<tbody>
<tr>
<td>There are two varieties of Luer taper connections: Luer-Lok and Luer-Slip. Luer-Lok fittings are securely joined by means of a tabbed hub on the female fitting which screws into threads in a sleeve on the male fitting. Luer-Slip fittings simply conform to Luer taper dimensions and are pressed together and held by friction (they have no threads). Luer components are manufactured either from metal or plastic and are available from many companies worldwide.</td>
<td></td>
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<tr>
<td>“Luer-Lok” and “Luer-Slip” are registered trademarks of Becton Dickinson. In the literature a “Luer-Lok” style connector is often generically referred to as a “Luer lock connector” and it has since become an industry standard.</td>
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</tbody>
</table>

| Male (Luer) Connector | Describes the shape and size of the nozzle (tip) of a syringe that connects to a female Luer port. The standard shape of the tip of an intravenous syringe. |
| Must | Indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument. |
| Nasogastric tube | A flexible plastic tube passing into the stomach through the nostril and nasopharynx. |
| Oral/enteral dispenser | A device manufactured with a non-Luer taper male tip so that it cannot be fitted to a female Luer port. This device is used to measure and/or administer liquid doses of medicines for non-parenteral administration. Some products may be labelled as oral/enteral syringes. |
| Parenteral (Medicine) | Taken into the body or administered in a manner other than through the digestive tract. For the purposes of this policy, refers to administration by injection. |
| Public health organisation (PHO) |  |
| • A local health district. |  |
| • A statutory health corporation that provides inpatient services, or |  |
| • An affiliated health organisation in respect of its recognised establishments that provide inpatient services. |  |
| Plunger | The movable part of the syringe which is pushed down the barrel to expel its contents or pulled up within the barrel to fill the syringe. |
| Route of administration | The path by which a substance is taken into the body (i.e., by mouth, injection, inhalation, rectum, or by application). |
| Should | Indicates an action that should be followed unless there are sound reasons for taking a different course of action. |
| Straw | A length of plastic tubing that connects to an oral/enteral dispenser used to draw up liquids from a container. |
| Syringe | A device for injecting or withdrawing fluids. For the purposes of this policy a syringe is used to administer medication or fluid parenterally. Devices used to measure and/or administer liquid doses of medicines for non-parenteral administration are referred to as oral/enteral dispensers. |
| Tip (of syringe) | The point of the syringe which is connected to a needle or device and from which fluids are delivered. |

#### 3. ORAL/ENTERAL DISPENSERS - REQUIREMENTS

- Oral/enteral dispensers are manufactured with non-Luer connector geometry and in several coloured presentations. Requirements include:
  - must be designed with a tip which is unable to be connected to a Luer fitting on injectable systems. This lack of connectivity may be achieved by variation of the angle of the Luer taper e.g. reverse Luer taper, straight taper, non-Luer taper.
12. MEDICAL CARE

- must be readily distinguishable from parenteral syringes by labelling (oral/enteral use only) and/or colour (of plunger or barrel).
- must be available in a size range from one millilitre (1mL) to at least fifty millilitres (50mL) to accommodate the possible range of oral dose volumes.
- must be provided clean, not necessarily sterile, but over-wrapped, individually or in small quantities to facilitate clean handling.
- must be single patient use devices.
- must have minimal dead space to ensure accurate measurement.
- must be calibrated in metric quantities and in millilitre increments.
- must be compatible with administration sets used for enteral feeding purposes. These should be clearly differentiated from giving sets for parenteral use. There must be a mechanism or use of clear labelling to alert clinical staff that the device is in use for enteral feeds ONLY.
- Oral/enteral dispenser caps must be used for pre-packed doses e.g. from pharmacy, but must be kept out of reach of children due to potential choking hazard.
- Devices to assist withdrawal of doses from liquid containers (stoppers or straws) must be compatible with the oral/enteral dispensers.

4. ENTERAL FEEDING SYSTEMS

- All nasogastric and enteral feeding tubes chosen for use must have connections compatible with the oral/enteral dispensers in use and should not feature any in-line female Luer administration ports nor be able to be connected to the patient using a male Luer terminal connector.
- Only devices with non-Luer or catheter-tip connectors to fit catheter-tip ports on enteral feeding systems must be used.
- Three-way taps and syringe-tip adaptors should not be used in enteral feeding systems.
- A portal for administration of oral medicines via enteral feeding catheters must be available. Note: the oral medicines portal must not contain ports that can be connected to parenteral syringes or have (distal or proximal) end connectors which can be connected to parenteral lines.
- Enteral feeding tubes should be labelled to indicate route of administration.
- Oral/enteral dispensers must be used for expressed breast milk or formula, if administered via enteral catheter or by mouth to an infant except when cups or bottles are in use.

5. LIQUIDS FOR INHALATION, INTRANASAL, TOPICAL OR RECTAL ADMINISTRATION

- Liquids for inhalation, intranasal, topical or rectal administration
  - are to be purchased in ready to use units wherever possible.
  - parenteral syringes should not be used for measurement or administration of doses.
- If injectable solutions are prescribed for inhalation, intranasal, topical or rectal administration and there is no alternate product,
  - oral/enteral dispenser and compatible straw should be used where possible.
  - withdrawal of doses from vials may require the use of needles and luer-compatible syringes.
  - to reduce risk of inadvertent injection dose should be both drawn up and administered at the bedside. Where this is not possible the container must be labelled with the intended route of administration eg FOR INHALATION ONLY.
  - labelling of any dispensed product must include the intended route of administration.
12. MEDICAL CARE

- If a bulk pack of solution for inhalation must be used, a non-Luer dispenser must be used to withdraw doses and expel them into inhalation reservoirs.
- Where a sterile solution is prepared in a pharmacy, it must be dispensed in a container clearly labelled with the intended route of administration. Containers should be chosen that are not amenable to withdrawal of solution for injection\(^7\).

6. PROCEDURES

6.1 Obtain and stock oral/enteral dispensers which are:
- clearly differentiated from parenteral syringes through barrel or plunger colouring or through clearly distinguished packaging.
- readily available in clinical areas where liquid medicine doses for routes other than injection are prepared.
- clearly recognised through use of pre-printed labelling eg FOR ORAL/ENTERAL USE ONLY.
- stored separately from parenteral syringes and storage areas clearly identified.

6.2 Prepare and administer doses as follows:
- Oral/enteral dispensers should be used to prepare and administer liquid medication doses which are:
  o not readily measured by available calibrations using an oral medicine measure or cup
  o administered by the oral or the enteral route (whether by nasal or percutaneous entry)
  o given by inhalation, intranasal, topical or rectal administration where measurement of volume is required
  o injectable medicines intentionally prescribed for non-parenteral use.
- Shake containers of oral medicine in suspension form prior to withdrawal of doses, to ensure accurate dose delivery.
- Devices to assist measurement and withdrawal of medicine doses from liquid containers (stoppers or straws) must be compatible with oral/enteral dispensers.
- Oral/enteral dispensers are single patient use devices and must be discarded after use. If several liquid medicine doses are to be given to one patient at the same time of day, they should each be separately prepared and administered.
- For accurate dose measurement, align the widest part of the plunger with the calibrated markings on the barrel.
- Determine compatibility of the medicine with oral feeds and flush feed tubing between administration of doses.

6.3 Labelling of non-parenteral liquid doses
- Preparation of doses for immediate administration is preferred.
- If doses must be prepared in advance, these must be labelled at a minimum with the drug, dose, volume and intended route of administration eg FOR ORAL/ENTERAL USE ONLY. The label is to be affixed so that it does not obscure calibrations.
- If a single dose is prepared for immediate administration labelling is not required.
- All administration lines used for administration of non parenteral medication should be labelled and include route of administration with the label near the insertion point on the patient side. For paediatric patients where the label should be placed near the container to minimise dislodgement.
- If a dose of medicine is prepared for enteral administration via an infusion device, the dispenser must be labelled with drug, dose, volume, route and time of preparation, name of person preparing as well as patient identification.
6.4 **Dispensing**

- Where unusual drug doses are to be administered, professional judgement should be used to determine if pre-loaded doses in capped oral/enteral dispensers are to be be provided by the pharmacy service.
- Bulk pre-packing of oral doses in oral/enteral dispensers must not be routinely undertaken unless in exceptional cases and by an accredited pharmacy service using principles of Good Manufacturing Practice and adherence to Australian pharmacy manufacturing standards.
- Oral/enteral dispensers must be provided to outpatients or patients transferred to community care for all non-parenteral medicine doses of liquid medicines not readily measured in a calibrated oral medicine cup.
- Oral/enteral dispensers supplied as part of a commercial drug product pack must be used unless the dose to be given is unable to be accurately measured using the device or if a Luer fitting syringe has been provided.

7. **PATIENT EDUCATION**

When patients or carers are required to administer liquid medicines by routes other than injection, only oral/enteral dispensers are to be supplied.

Particular care is required to educate such patients or carers of patients where a long-term intravenous catheter is in situ as some medicines may need to be given by injection and others by the oral/enteral route. Interpreters are to be used for patients or carers of culturally and linguistically diverse backgrounds. Visual aids such as brochures may be provided.

8. **REFERENCES**

5. European Standard EN 1615:2000 Enteral feeding catheters and enteral giving sets for single use and their connectors. Design and testing. This European Standard specifies requirements for the design and testing of single-use enteral feeding catheters, single-use enteral giving sets and their connection systems.
11. AS 1094-1993 Medical equipment – Single-use syringes (sterile) for general medical use.
12. Standards aligned with PIC/S: Pharmaceutical Inspection Convention (PIC) and the Pharmaceutical Inspection Co-operation Scheme (PIC Scheme), developed with the Therapeutic Goods Administration – Pharmacy Manufacturing Technical working group.
15. National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines. Australian Commission on Safety and Quality in Health Care, August 2010
17. NSW Health Policy Directive PD2007_036 Infection Control Policy
12. **MEDICAL CARE**

**APPENDIX 1 – IMPLEMENTATION & COMPLIANCE CHECKLIST**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Responsibility is assigned to personnel for implementation of Safe Administration of Liquid Medicines by Routes Other Than Injection</td>
<td></td>
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<tr>
<td>2. Oral/enteral dispensers are present in all clinical areas where non-parenteral doses are prepared and administered.</td>
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<td></td>
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<tr>
<td>3. Oral/enteral dispensers are stored away from parenteral syringes and are accessible at the location used for preparation of doses.</td>
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<tr>
<td>4. Only oral/enteral dispensers or a graduated medicine cup are used to prepare and administer non-parenteral liquid doses, including oral, enteral, topical intranasal, rectal and inhaled doses</td>
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<tr>
<td>5. A pharmacy service, where available, pre-loads unusual medication doses into oral/enteral dispensers for accurate, ready-to-use administration.</td>
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<tr>
<td>6. On transfer, patients are always provided with oral/enteral dispensers for all non-parenteral medicine liquid for medicines not readily measured in a calibrated oral medicine cup</td>
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</table>

Assessed by: [Assessment Details] 

Date of Assessment: [Assessment Date]
USER-APPLIED LABELLING OF INJECTABLE MEDICINES, FLUIDS AND LINES
(PD2016_058)

PD2016_058 rescinds PD2012_007

PURPOSE
This Policy Directive sets out the requirements for user-applied labelling of injectable medicines, fluids and lines in NSW Public Health Organisations and NSW Ambulance.

MANDATORY REQUIREMENTS
All NSW Health Public Health Organisations and NSW Ambulance are to apply the requirements set out in the Australian Commission on Safety and Quality in Health Care's National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines (Labelling Standard).

IMPLEMENTATION

NSW Ministry of Health is responsible for:
• Providing access to user-applied labels through state contracted suppliers (cost of labels being dependent on demand).

NSW Clinical Excellence Commission is responsible for:
• Monitoring the implementation of this policy by reviewing the completed implementation checklists
• Providing resources to support implementation and ongoing compliance with this policy
• Informing the State Forms Management Committee and HealthShare NSW Procurement Services of any changes to the Labelling Standard.

Chief Executive is responsible for:
• Assigning responsibility, personnel and resources to implement and comply with this policy.

Director of Clinical Governance is responsible for:
• Reporting the status of the policy implementation to the NSW Clinical Excellence Commission by returning a completed Implementation checklist (Attachment 5.1) within twelve months of publication of the policy.

Drug and Therapeutics Committees are responsible for:
• Providing local oversight of safe implementation of this policy.

Health Service Managers are responsible for:
• Ensuring relevant labels are available for use in clinical areas
• Ensuring clinicians receive education on user-applied labelling
• Monitoring implementation and compliance with the policy.
1. BACKGROUND

Failure to recognise the correct container (for example; bags, bottles, syringes) for injectable medicines and fluids, or the correct conduit (for example; administration lines, invasive monitoring lines, catheters or burettes) can result in an administration error.

Use of multiple label design; colour; size and content, and lack of use of labels in certain circumstances, has also contributed to medication safety incidents.

Where multiple parenteral and enteral lines are in use, incorrect line selection has contributed to adverse patient outcomes from administration of fluids and medicines by an incorrect route.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed the National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines (Labelling Standard) to ensure accurate communication of injectable medicines and fluids information through standardised user-applied labelling. The Labelling Standard replaces the 2012 National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines(1).

Consistent with the Labelling Standard, NSW Health provides access to user-applied labels through state contracted suppliers for use in all NSW Public Health Organisations.

1.1 Related documents

NSW Health Policies:
Medication Handling in Public Health Facilities

Australian Commission on Safety and Quality in Health Care:
National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines

2 PROCEDURES

All NSW Public Health Organisations and NSW Ambulance are to:

- Implement this policy
- Apply requirements as set out in the Labelling Standard
- Ensure there is no customisation or alteration of Labelling Standard labels.

3 RESOURCES

A range of resources to support implementation of the Labelling Standard are available on the ACSQHC webpage.
Resources are also available on the Clinical Excellence Commission User-applied Labelling webpage.

4 REFERENCES

5 LIST OF ATTACHMENTS

5.1 Implementation checklist

<table>
<thead>
<tr>
<th>LHD/Facility:</th>
<th>Date of Assessment:</th>
</tr>
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<table>
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<tr>
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<th>Partial compliance</th>
<th>Full compliance</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An assessment has been conducted to determine the user-applied labelling requirements (consistent with the Labelling Standard) in all clinical areas.</td>
<td></td>
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<tr>
<td>Notes:</td>
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<tr>
<td>2. The required user-applied labels are available in clinical areas.</td>
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<td>Notes:</td>
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<tr>
<td>3. User-applied labels are applied to injectable medicines and containers in accordance with the Labelling Standard.</td>
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<td>4. A process is in place to ensure relevant clinical staff receive education on user-applied labelling.</td>
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<td>5. A process is in place for the ongoing monitoring of compliance with the Labelling Standard.</td>
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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.

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.


**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 person’s health and disability support needs makes a positive difference to a person’s health outcomes.

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12. MEDICAL CARE

- **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.

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 on 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.