Patient Matters Manual for Public Health Organisations

Chapter 12 – Medical Care

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Note

Where a number appears at the bottom of an amended page [such as 252 (17/09/15) – amendment number, date] an alteration has been made or new section included. Amendment numbers are sequential, the date represents the date the source document was published on the Policy Distribution System (PDS).

Below is a summary of each policy document. To navigate to the complete policy document, click the hyperlink in the Table of Content or under each policy document title.

Incident Management

Document number PD2020_047 rescinds PD2020_020.

POLICY STATEMENT

NSW Health Services must have incident management processes in place that are consistent with the requirements of this Policy and the Health Administration Act 1982, to effectively respond to clinical and corporate incidents and act on lessons learned.

SUMMARY OF POLICY REQUIREMENTS

All staff are responsible for identifying incidents and for taking immediate action to ensure the safety of patients, visitors and other staff.

Notify incidents and escalate

Clinical and corporate incidents, near misses and complaints are to be recorded in the incident management system, ims+.

For all clinical incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues; the Chief Executive must immediately contact the Ministry of Health and the Clinical Excellence Commission Chief Executive.

For all corporate incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues, the Chief Executive must immediately contact the Ministry of Health.

Serious incidents must be notified and escalated within the Health Service and to the Ministry of Health via a reportable incident brief (RIB). The RIB is to be submitted in ims+ within 24 hours of notification for RIB Part A, and within 72 hours (or earlier, as directed by the Chief Executive or Ministry of Health) for RIB Part B.

Open disclosure

Open disclosure must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance, or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure, as per the NSW Health *Open Disclosure Policy* (PD2014_028).

Clinical incident review

Health Services must undertake a preliminary risk assessment within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for reportable incidents (clinical Harm Score 1 incidents). The Chief Executive may also direct that a preliminary risk assessment be completed for other clinical incidents (Harm Score 2 – 4) that may be due to a serious systemic problem.

Any person appointed to undertake a preliminary risk assessment must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff.

A serious adverse event review must be undertaken using an approved review method, following a clinical Harm Score 1 incident. The review is to identify any factors that caused or contributed to the incident, and any practices, processes or systems that could be reviewed for the purposes of a recommendations report. The Chief Executive may also direct a serious adverse event review be undertaken for other clinical incidents (Harm Score 2 – 4) which may be due to serious systemic problems.

Preliminary risk assessment assessors and serious adverse event review team members are bound by strict confidentiality requirements and must not disclose information obtained during the preliminary risk assessment or serious adverse event review, unless it is for the purpose of the preliminary risk assessment or serious adverse event review.

The serious adverse event review findings report, and recommendations report (if there is one), must be submitted to the Ministry of Health within 60 calendar days of the incident notification in ims+.

At the completion of a serious adverse event review, the family is to be invited to meet to discuss the findings and recommendations and to be given copies of the findings report and recommendations report.

Corporate incident review

Health Services must undertake a safety check within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for corporate Harm Score 1 incidents.

Any person appointed to undertake a safety check must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff, or continuing critical risk due to loss of service.

A corporate Harm Score 1 review must be undertaken following a corporate Harm Score 1 incident, using a review method determined by the type of corporate incident. The review is to identify any underlying factors as to why the incident occurred and make recommendations to prevent and minimise risk of recurrence.

A corporate Harm Score 1 review report is due to the Ministry of Health within 60 calendar days of incident notification in ims+.

Implementation and feedback

Health Services are to monitor the implementation of recommendations arising from incident reviews and have escalation processes in place for recommendations that cannot be progressed.

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and recommendations. Health Services are also to share feedback on the lessons learned and proposed changes more broadly with clinicians, managers and staff.

333 (14/12/20)

Open Disclosure

Document number PD2023_034 rescinds PD2014_028.

POLICY STATEMENT

NSW Health is committed to ensuring open and timely discussions occur between NSW Health Services and patients and support persons following an incident by implementing open disclosure processes.

SUMMARY OF POLICY REQUIREMENTS

Open disclosure must occur whenever a patient has been harmed. Open disclosure is an open discussion with the patient and/ or their support person(s) about a patient safety incident which could have resulted in or did result in harm to that patient while they were receiving health care.

Clinician disclosure is the first stage of open disclosure and must be undertaken within 24 hours of incident identification. Formal open disclosure is the second stage of open disclosure and is undertaken as required, however may be needed for any incident of any level of harm.

NSW Health Services must have appropriate governance and implementation frameworks to ensure that open disclosure roles, responsibilities and functions are met.

The practice of open disclosure involves:

- **Acknowledgement** of an incident to the patient and/ or support person within 24 hours of incident identification. This includes recognising the significance of the incident to the patient.
- **Truthful, clear and timely communications** on an ongoing basis as required.
- **An apology** to the patient and/ or support person, including the words “I am sorry” or “we are sorry”.
- **Ongoing care and support to patients** and/ or support persons that is responsive to their needs and expectations, for as long as is required.
- **Support to staff** which is responsive to their needs and expectations.
- An **integrated approach to improving patient safety** in which open disclosure is linked with clinical and corporate governance, incident reporting, risk management, consumer feedback/ complaints management and quality improvement policies and processes. This includes evaluation of the process by patients, carers and families, and staff, accountability for learning from incidents and evidence of systems improvement.
- **Multidisciplinary involvement** in the open disclosure process.
- Compliance with the legal requirements of **privacy and confidentiality** for the patient and/ or support person, and staff delivering health care.

Safety Alert Broadcast System Policy Directive

Document number PD2013_009 rescinds PD2006_102.

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 PD2009_029, Policy, Guideline and Information Bulletin Distribution System for the NSW Ministry of Health.

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.

179 (30/05/13)

Adult and Paediatric Hospital in the Home Guideline

Document number GL2018_020 resinds GL2013_006.

PURPOSE

The purpose of this Guideline is to support the implementation and expansion of the Hospital in the Home (HITH) program within NSW Health by providing standardised guidance for local health districts and networks. It will assist districts and networks develop, monitor and evaluate HITH services while meeting local needs and state-wide standards.

KEY PRINCIPLES

HITH is a hospital substitution program which means that the patient admitted to HITH would otherwise be accommodated in a hospital. Access is needs based and available regardless of age, diagnosis, disability, geography, culture or gender. The objective being to provide patient centred care as close to home as possible.

Admission to a HITH service is voluntary and should not result in the patient incurring costs additional to what they might have had they been admitted to hospital.

HITH services provide integrated clinical care that meets National Safety and Quality Health Service Standards.

USE OF THE GUIDELINE

Districts and networks should use this Guideline to:

- develop district/network level governance for HITH
- integrate HITH as part of an overall acute demand strategy
- establish appropriate systems for clinical engagement

Animal Visits and Interventions in Public and Private Health Services in NSW

Document number 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

Elective Surgery Access

Document number PD2022_001 rescinds PD2012_011.

POLICY STATEMENT

NSW Health organisations that manage elective surgery services must ensure clinically appropriate, consistent and equitable management of access for patients across the state.

Arrangements must be in place to provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

SUMMARY OF POLICY REQUIREMENTS

All local health districts and speciality health networks with surgical services must have local procedures in place that are consistent with the principles and requirements identified in this Policy.

Referring patients to the elective surgery list occurs with receipt of the Recommendation for Admission (RFA) form in a timely manner by the treating doctor.

Clinical urgency categories (CUCs) are to be assigned in accordance to this policy, and any variance or reclassification validated by the surgeon with documented evidence. The procedures part of this policy also provides the management process for colonoscopy, cosmetic and discretionary procedures and new procedures and interventions.

The acceptance of a Recommendation for Admission (RFA) form and variations to normal bookings, including bilateral procedures and duplicate bookings are also included together with the importance of ensuring that the minimum data is set and legible. When the information on the RFA is not legible there is instruction on how to proceed and an example letter that is to be sent to the surgeon requesting clarity.

Once the RFA has been reviewed for completion and appropriate category allocation, timely registration on the elective surgery list is required. Patients and their General Practitioners should also be aware of the patient's addition to the elective surgery list, clinical urgency category and estimated timeframe for their surgery. It is also important that both patients and their general practitioners are aware and how to contact the hospital in the event of a change in the patients' clinical condition or circumstances.

In the event that a patient's clinical condition changes and a clinical review is required, the procedures part of this policy explains the process to instigate a clinical review. It also explains how the patient's booking is to be managed, when changes are made to the original listing procedure and when there are hospital-initiated delays. This includes if a patient is to be removed from the elective surgery list for reasons other than surgery including who is required to be informed and consulted when this occurs.

All patients on the elective surgery list are to be managed according to their clinical urgency category and treated in turn. Surgical services must keep accurate records of hospital delays and patient deferrals. The clinical staging of procedures and the importance of accurate recording of these events when a patient is 'not ready for care' should also be recorded and monitored.

Finally, it is essential that the elective surgery list is regularly audited to ensure accurate information is available for patients, clinicians and administrators. Succession planning of key auditing processes should be in place to ensure this practice continues in the event of annual leave or a staff member resigns.

Verification of death and medical certificate of cause of death

Document number PD2023_014 rescinds PD2021_029.

POLICY STATEMENT

NSW Health provides a uniform procedure for completing clinical assessments and documentation to verify death and when issuing a *Medical Certificate of Cause of Death*.

This Policy Directive describes the roles of medical practitioners, registered nurses/ registered midwives and qualified paramedics in relation to assessment and documentation when patients die within the NSW Health system.

SUMMARY OF POLICY REQUIREMENTS

Verification of death

Determination of death in patients is preceded by a minimum observation period of five minutes to establish that irreversible cessation of cardiorespiratory function has occurred. The observation period is to be done by the clinician determining death. After five minutes of continued cessation of cardiorespiratory function, the:

- absence of pupillary responses to light
- absence of response to central painful stimulus
- absence of a central pulse on palpation
- absence of heart sounds on auscultation
- absence of respiratory effort

indicate irreversible cessation of cardiorespiratory function and the time of death is then recorded.

A medical practitioner must conduct the verification of death assessment. In cases where there is no medical practitioner available to verify death, registered nurses, registered midwives and qualified paramedics can do so. The *Verification of Death* form must be completed. Qualified paramedics must only verify death as outlined in NSW Ambulance Protocol A13 *Verification of Death*.

Where a body is transported to a NSW Health facility for verification of death assessment, a medical practitioner, registered nurse or registered midwife can assess death and complete the *Verification of Death* form. The Coroner will issue a death certificate in such cases.

In situations where the person has injuries incompatible with life or has been deceased for some time, the death is considered obvious and no clinical assessment is required.

Medical Certificate of Cause of Death

The medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death must, within 48-hours of the death, notify the Registrar of the Registry of Births, Death & Marriages using the *Medical Certificate of Cause of Death* form. The contact details of the medical practitioner who will complete the *Medical Certificate of Cause of Death* form must be included in the *Verification of Death* form.

In situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the *Medical Certificate of Cause of Death* form and the name of the medical practitioner who will complete the *Medical*

Certificate of Cause of Death form is not known, the registered nurse/ registered midwife may write “transfer to <name of NSW Health facility>” in the *Medical Certificate of Cause of Death* section on the *Verification of Death* form.

A medical practitioner is to only certify the cause of death if a diagnosis of cause of death can be made. If the medical practitioner is unable to ascertain the cause of death, the matter must be referred to the Coroner.

Training must be provided to relevant staff regarding assessment and documentation of death (available via My Health Learning).

347 (06/07/23)

Will Making in Public Health Facilities

Document number GL2023_006 rescinds IB2018_002.

GUIDELINE SUMMARY

NSW Health staff must not be involved in the preparation of a patient's will or attempt to exert influence over the terms of a patient's will.

Where a patient asks for assistance in making a will, the matter must be referred to the hospital's social work team to enable referral to external, independent advice. Staff involvement must be minimal and generally only for the purpose of facilitating the patient's access to their solicitor or the NSW Trustee & Guardian.

KEY PRINCIPLES

NSW Health staff working in public health facilities (including those in community settings) must not be involved in the preparation of a patient's will or attempt to exert influence regarding the terms of a patient's will under any circumstances.

In the event that a patient asks or nominates a staff member to be the executor of their will, or appoints a staff member to be the executor of their will, the staff member must decline the offer or renounce the appointment.

Staff members must not act as a witness to the patient's signature in the preparation of a patient's will. Where a patient in a public health facility (or a patient's family or carer on behalf of a patient), requests assistance with making a will, or with changing an existing will, staff are to refer the request to the hospital's social work team.

The role of the hospital's social work team is limited to assisting the patient, patient's family or patient's carer in contacting appropriate external resources or advisory services, such as legal services or the NSW Trustee & Guardian, where appropriate.

The assistance provided by the hospital's social work team may include (as relevant), where the patient's affairs are managed by the NSW Trustee & Guardian, referring the patient to the NSW Trustee & Guardian.

In circumstances where a patient or their carer would like to discuss the patient's will with a solicitor and the patient's affairs are not managed by the NSW Trustee & Guardian, the hospital's social work team may make inquiries with the patient as to whether there is a will already in existence and/or held by a solicitor. This can be done by asking the patient or their carer, checking the patient health records and/or contacting family members with the patient's consent.

If a will exists and is being held by the patient's solicitor, then the solicitor holding the will may be contacted by a staff member on behalf of the patient and notified that the patient requires their assistance. The matter is to be handed over by the staff member to that solicitor with the patient's consent as appropriate.

Where a patient's affairs are not managed by the NSW Trustee & Guardian and the patient has no knowledge of an existing will, the hospital's social work team may assist the patient in contacting a solicitor of the patient's choice. Staff must not recommend any particular solicitor to the patient.

Where the patient does not know of a solicitor, the hospital's social work team may assist the patient in contacting either:

- The NSW Trustee & Guardian – for professional and independent trustee services, writing of wills, acting as Executor in deceased estates, administering trusts and Powers of Attorney and delivering financial management services;

- The Law Society of NSW – for access to a list of local solicitors for the geographical area that are experienced in the field of the making of wills and for providing legal advice, from which the patient may then choose a solicitor.

Once a solicitor has been selected by the patient, the hospital's social work team may contact the nominated office or solicitor on the patient's behalf with the patient's consent, or assist the patient in contacting the nominated office or solicitor.

A solicitor preparing a will on behalf of a patient in a public hospital may need to establish the patient's testamentary capacity. It is not the role of staff to establish testamentary capacity of the patient. However, on written request by the patient and/or the patient's solicitor, and with the patient's consent, staff may provide the relevant health information to the patient's nominated solicitor. The provision of information for this purpose is to be coordinated by the hospital's social work team.

All staff contact with the NSW Trustee & Guardian, the patient's authorised representative, solicitors, or family members regarding a patient's will, must be documented in the patient's health record.

Contact Details

NSW Trustee & Guardian	
Trustee Services	1300 364 103
Managed Clients	1300 360 466
The Law Society of NSW	
Sydney	(02) 9926 0300
Outside Sydney	1800 422 713

345 (03/04/23)

Advertising Legal Services

Document number 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.

283 (17/12/15)

Admission to Discharge Care Coordination

Document number PD2022_012 rescnds PD2011_015.

POLICY STATEMENT

NSW Health organisations have a duty of care to ensure that care coordination provides the care needed to identify and manage safe and appropriate care to all patients within NSW Health. It must ensure all clinical staff are aware of their obligations to coordinate patient care and follow the principals of admission to discharge care coordination.

SUMMARY OF POLICY REQUIREMENTS

NSW Health must comply with admitted patients transitioning through the five stages of care coordination outlined in this Policy Directive.

1. Pre-Admission / Admission
2. Multidisciplinary Team Review
3. Estimated Date of Discharge
4. Referral and Liaison for patient transfer of care
5. Transfer of care out of Hospital

Pre-Admission/Admission must develop and use an admitted patient 'Discharge Risk Assessment' Tool'.

All departments (including the emergency department) must have procedures in place for the care of discharged patients at risk, especially between the hours of 2200hrs and 0800hrs. Where procedures and checklists already exist (including in paediatrics) it must be confirmed that they comply with the requirements of this Policy Directive.

Multidisciplinary team review structured allocates set time, duration and frequency of all multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.

An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and are reviewed for each patient. The patient and carer must be kept informed of the estimated date of discharge during their stay.

Referrals and liaison for patient transfer of care must ensure that the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.

All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language.

While the five stages will apply to most patients having an inpatient stay, the stages may require adjustment for some patient groups. Patients having scheduled admissions for a course of treatment (e.g. chemotherapy, dialysis or a multi-staged procedure) may not require a review for each admission in the absence of a change in personal/social circumstances or clinical condition. Planned day only or extended day only patients are to have an assessment of their discharge needs and arrangements put in place prior to their admission.

All Local Health Districts and Speciality Health Networks (Districts/Networks) have duty of care to ensure that patients have a safe and appropriate discharge plan.

For those being discharged from Mental Health Inpatient Units this Policy Directive serves as an addition to the overarching principles outlined in NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045).

341 (11/04/22)

Intravascular Access Devices (IVAD) - Infection Prevention & Control

Document number PD2019_040 rescinds PD2011_060, GL2023_013.

PURPOSE

The purpose of the NSW Health Intravascular Access Device (IVAD) Infection Prevention and Control Policy is to provide guidance to NSW Health Organisations (HO's) including Affiliated Health Organisations on the minimum standards for insertion, management and removal of IVADs, in order to minimise the adverse health impacts on patients and reduce burden of healthcare associated Infections (HAIs). This Policy is to be read in conjunction with NSW Health Infection Prevention and Control Policy.

MANDATORY REQUIREMENTS

All clinical staff who insert IVADs or care for a patient with an IVAD must comply with this Policy Directive. For each insertion a record of insertion must be completed.

Every IVAD insertion, management and removal must be documented at the time of care or as soon as possible afterwards.

HO's must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices for clinicians.

HO's must support clinicians to ensure adherence with this Policy Directive.

Aseptic technique must be adhered to during each IVAD insertion, management and removal to reduce the risk of local or systemic infection.

IMPLEMENTATION

NSW Health Organisations (HOs) and the governance structure for the implementation of this Policy Directive to reduce the risk of healthcare associated infections (HAIs).

Clinical Excellence Commission

- Provides tools to support the implementation, monitoring and evaluation of this Policy.

Health Education and Training Institute (HETI)

- Compliance with the existing mandatory education components (Aseptic technique, Hand Hygiene and Infection prevention and Control Practices from HETI online) applies.

Chief Executive of Local Health District and Specialty Health Network

- Assigns leadership responsibility, personnel and resources to implement and comply with this Policy.

Directors of Clinical Governance

- Ensure that this Policy is communicated to all managers and health workers.
- Ensure local infection prevention and control programs and systems are in place to implement and monitor this Policy.
- Monitor and provide regular reports on the progress and outcomes of infections related to IVADs.
- Monitor, evaluate and address issues with compliance with this Policy.

Clinical leaders and senior managers

- Provide resources and equipment necessary for compliance with this Policy.
- Implement and evaluate local infection prevention and control systems.

Infection prevention and control professionals

- Provide leadership in infection prevention and control surveillance and reporting.
- Provide advice on compliance with the insertion, management and removal of IVADs policy within their health organisation.
- Provide leadership in the management of HAIs or other transmission risks and in the communication of these risks to health workers, patients, volunteers, carers and visitors.

Clinical Staff Inserting, Caring for, Managing and Removing IVAD Devices

- Comply with IVAD Infection Prevention and Control, Insertion and Post Insertion Care policy this Policy.
- Are trained, competent and assessed in the insertion, management and removal of an IVAD device in accordance with this Policy Directive.
- Ensure IVAD insertion and care is documented in the patient's health record.
- Assess and document daily the ongoing need for an IVAD device.

315 (16/08/19)

Patients with inherited bleeding disorders in hospitals without a Haemophilia Treatment Centre

Document number PD2023_005 rescinds PD2022_013.

POLICY STATEMENT

Any clinician treating a patient with an inherited bleeding disorder who may require replacement therapy in a hospital that does not have a designated Haemophilia Treatment Centre must seek the advice of a specialist clinician from a designated Haemophilia Treatment Centre.

Advice must be sought immediately when the patient requires emergency surgery or emergency factor therapy replacement. Advice must be sought during the planning of elective surgery for a patient if the procedure is to be carried out in a hospital that does not have a designated Haemophilia Treatment Centre.

SUMMARY OF POLICY REQUIREMENTS

Patients with inherited bleeding disorders requiring emergency surgery or emergency clotting factor replacement therapy at a non-Haemophilia Treatment Centre hospital must be treated promptly.

The patient's senior treating medical officer must consult with a haematologist (local or haematologist at a Haemophilia Treatment Centre) and a designated Haemophilia Treatment Centre must be urgently contacted to determine whether the patient is to be transferred to a facility (usually a designated Haemophilia Treatment Centre) where definitive care can commence and clotting factor is available.

If the patient does not need to be transferred, the product needed to treat them must be ascertained. A treatment plan for the patient must be discussed between the patient's senior treating medical officer at the non-Haemophilia Treatment Centre hospital and the director (or their assigned delegate) of the Haemophilia Treatment Centre and the plan must be documented in the patient's medical record.

Patients with bleeding disorders, particularly high-risk patients, are to have elective surgery performed in a designated Haemophilia Treatment Centre whenever possible.

A patient who has a specific reason for having a procedure carried out in a non-Haemophilia Treatment Centre hospital may be able to do so provided that:

a) the patient or person responsible for the patient has been made aware of the potential risks attached to having surgery in a hospital with no designated Haemophilia Treatment Centre, and

b) the director (or assigned delegate) of a designated Haemophilia Treatment Centre approves the alternative arrangement.

The patient's senior treating medical or dental officer must contact the director (or assigned delegate) of a designated Haemophilia Treatment Centre ideally before the patient is placed on an elective surgery waiting list, but not less than two weeks before the date of the planned surgery, to discuss the proposed surgery. Failure to do so may delay the surgery, if approved.

A written patient treatment and monitoring plan, which has been approved by the director of the Haemophilia Treatment Centre, must be put in place.

Once the director (or assigned delegate) of the designated Haemophilia Treatment Centre has approved the patient's treatment and monitoring plan, the patient's senior treating medical or dental officer or the haematologist at the non-Haemophilia Treatment Centre hospital must:

1. complete the Bleeding Disorder Elective Surgery Information for Clinical Review state form and send it to the Office of the Chief Health Officer using the eHealth NSW Secure File Transfer Service (Kiteworks).

and

2. notify the hospital blood transfusion staff that they can order the clotting factor from Lifeblood using BloodNet. Staff must include the wording:

"Endorsed by [Name] Haemophilia Treatment Centre Director [Name] or delegate [Name] on [Date]"

in the free text "comments" section of the BloodNet order form. Failure to include the completed statement will lead to a delay in receiving product.

The patient's senior treating medical or dental officer must liaise daily (or more frequently as required) with the director (or assigned delegate) of the designated Haemophilia Treatment Centre during the period the patient is being treated in the non-Haemophilia Treatment Centre hospital.

The patient outcome and a summary of factor usage must be provided to the director (or assigned delegate) of the designated Haemophilia Treatment Centre.

345 (14/02/23)

Victims Rights Act 1996

Document number 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.

Research Governance in NSW Public Health Organisations

Document number 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

Document number PD2021_023 rescinds PD2014_007.

POLICY STATEMENT

All staff involved in patient care in NSW Health facilities/services are responsible for minimising the risk of pressure injuries through timely identification and management of modifiable risk factors and when pressure injuries are present appropriate treatment is provided.

SUMMARY OF POLICY REQUIREMENTS

On presentation/admission to a health service, all patients are to be screened to identify pressure injury risk factors, using an agreed risk screening process to guide clinical decision making.

If risk factors are identified, in partnership with the patient/family/carer, a plan of care with agreed strategies/interventions is to be developed considering the patients preferences and goal of care.

All care and treatment delivered to people who are at risk of pressure injury development or with an existing pressure injury is to be person centred and culturally sensitive.

A multidisciplinary approach to care provision to ensure appropriate intervention/strategies are implemented based on risk factor/s. The care plan is to be reviewed regularly for effectiveness, with referral to specialist providers as required.

Individuals with identified risk factors are to have regular skin assessments to monitor the effectiveness of prevention strategies.

Systems are in place to ensure adequate expertise, resources, products and equipment are readily available and accessible to provide best practice in pressure injury prevention and management.

All pressure injuries are to be documented in the medical record, specifying the classification and dimensions, anatomical location and if the pressure injury was acquired during the current episode of care or was pre-existing.

Clinical staff, who care for patients at risk of developing pressure injuries or with existing pressure injuries, are to undertake training in pressure injury prevention and management.

Systems and processes are to be in place to report/notify hospital/health service acquired pressure injury incidents, monitor and analyse pressure injury data, and implement relevant quality improvement activities to improve patient care as required.

A patient's pressure injury prevention and management health care needs are to be integrated into their transition of care planning process.

Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care

Document number 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 (ARDRGs)
- 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.

Kidney Health Check: Promoting the Early Detection & Management of Chronic Kidney Disease

Document number 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.

87 (15/04/10)

End of Life Care and Decision-Making

Document number GL2021_004 rescinds GL2005_057.

GUIDELINE SUMMARY

Dying patients can be any age and are cared for in many settings including emergency departments, intensive care units, hospital wards, palliative care units, paediatric wards, residential aged care facilities, supported disability accommodation and the home. This Guideline provides useful advice for NSW Health staff about the process for navigating complex end of life decisions wherever that care is delivered.

NSW Health places a high priority on health practitioners working collaboratively with patients, their families and carers, as well as each other, throughout all phases of end of life care. This guideline sets out a process for reaching end of life decisions, in a way that safeguards both patients and health practitioners, through open and compassionate communication, appropriate treatment decisions and fairness.

KEY PRINCIPLES

Building consensus

A large part of this document focuses on building consensus, particularly where patients do not have the capacity to engage in the decision-making process about the role of lifesustaining treatment for themselves.

Respect for life and care in dying

A primary goal of medical care is preservation of life, however when life cannot be preserved, the goal is to provide comfort and dignity to the dying person and to support the person's family and/or carers in doing so.

The right to know and to choose

People relate to death and dying differently, often based on personal experience, culture and history.

Appropriate withholding and withdrawal of life-sustaining treatment

The goals of care shift to ensuring comfort and dignity, whereby withholding or withdrawal of life-sustaining medical interventions are often appropriate in the best interests of the patient or in accordance with a patient's Advance Care Directive (ACD).

A collaborative approach to care

The person responsible, families, carers and health practitioners have an obligation to work together to make compassionate decisions for patients who lack decision-making capacity.

Transparency and accountability

In order to preserve the trust of those receiving health care and to ensure that decisions are fairly made, the decision-making process, the decisions made and likely outcomes should be clear to the participants and accurately documented.

Non-discriminatory care

Everyone in NSW should be able to access quality end of life care when it is needed, regardless of their geographic location, age, condition, disability, socio-economic needs, cultural and religious background, gender identity, sexual orientation or languages spoken.

Rights and obligations of health practitioners

Adults have a right to accept or decline care and health practitioners have a responsibility to practice in accordance with community and professional norms and legal standards.

Continuous improvement

Health practitioners must strive for ongoing improvement in standards of end of life care.

USE OF THE GUIDELINE

This Guideline is designed for use by NSW Health staff who are part of the treating team involved in end of life care.

This Guideline should form the basis of local policy on end of life decision-making, considering local conditions and resources Local policy development is recommended for:

- minimum standards for documentation of decisions about withholding, or withdrawal of, treatment
- providing culturally safe and responsive end of life services
- dispute resolution for patients, person responsible, families, carers and staff.

Local policy may expand on this Guideline by, for example, identifying relevant persons or contacts within the hospital/local health district/specialty health network who may serve certain roles.

336 (08/04/21)

Responding to Needs of People with Disability during Hospitalisation

Document number 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.

285 (12/1/17)

Drug and Alcohol Clinical Supervision Guidelines

Document number GL2006_009.

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.

58 (12/06)

Managing withdrawal from alcohol and other drugs

Document number IB2022_041.

PURPOSE

This information bulletin advises clinicians about new clinical guidance for managing withdrawal from alcohol and other drugs (AOD). Implementation of the clinical guidance is mandatory in NSW Health facilities. The document also seeks to guide clinicians in other settings including private facilities, aged care facilities, the primary health sector and community settings.

KEY INFORMATION

Clinical guidance for managing withdrawal from alcohol and other drugs

NSW Health has published updated clinical guidance on managing withdrawal from alcohol and other drugs. It is available here.

The document summarises the appropriate management of patients who are experiencing, or who are at risk of, withdrawal from alcohol or other drugs. It provides guidance on screening, assessment, care planning, medications and transfer to post-withdrawal care. It will form the basis for development and implementation of evidenced-based local procedures for screening, assessing and managing patients experiencing or at risk of withdrawal from alcohol and other drugs.

This clinical guidance applies to NSW Health staff in specialist withdrawal units of hospitals, general inpatient units, emergency departments and community health settings. Clinicians in other settings such as non-government facilities and primary care settings such as general practice, Aboriginal Community Controlled Health Organisations and community and welfare services are also encouraged to use this clinical guidance.

The Chief Executives of NSW Local Health Districts and Specialty Health Networks are responsible for the implementation of this guidance within their services/facilities to ensure that local protocols, models of care or operating procedures are in place that are aligned and consistent with the guidance.

All clinicians working in NSW Health facilities who are involved in the care of patients who are, or who are at risk of, withdrawing from alcohol or other drugs are to be aware of the clinical guidance and actively participate in its implementation.

Local Health Districts and Specialty Health Networks are to use this clinical guidance to develop, implement and monitor strategies and tools aligned to the key actions specified in the document, including in electronic clinical information systems.

Prevention of Venous Thromboembolism

PD2019_057 rescinds PD2014_032.

PURPOSE

This Policy Directive outlines the mandatory requirements for an effective Venous Thromboembolism (VTE) Prevention Program and aims to ensure that systems are in place that support clinicians to undertake these requirements.

MANDATORY REQUIREMENTS

- All NSW Public Health Organisations (PHOs) have a strategy to embed systems to comply with the actions summarised in the Prevention of Venous Thromboembolism Framework (Appendix 4.1 of this policy).
- The systems would enable risk assessments for VTE to be undertaken for:
    - All adult patients admitted to NSW public hospitals within 24 hours, and reassessed regularly as clinically appropriate (as a minimum every 7 days), if clinical condition changes and at transfers of care
    - All adult patients discharged home from the Emergency Department who, as a result of acute illness or injury, have significantly reduced mobility relative to normal state
    - All pregnant and postpartum women during the first comprehensive antenatal assessment; within 24 hours of any antenatal admission; when clinical situation alters; and during postpartum care, within 2 hours of birth (vaginal or caesarean section)
- The systems would also enable patients identified at risk of VTE to receive prophylaxis most appropriate to that risk and their clinical condition.
- All PHOs should make available decision support tools to guide prescription of prophylaxis appropriate for the patient's risk level.
- All PHOs are to have a strategy in place that includes regular monitoring of VTE prevention indicators to facilitate continuous improvement, and a system of communicating findings from review of VTE indicators.
- Clinicians are made aware of their role in undertaking routine VTE risk assessment, providing appropriate prophylaxis where patients are identified at risk of VTE, and to participate in their local public health organisation's VTE prevention program.

IMPLEMENTATION

Clinical Excellence Commission

- Provide the tools to support PHOs in the implementation of this Policy.

Chief Executives of Local Health Districts and Specialty Health Networks

- Assign leadership responsibility and resources to support implementation and compliance with this Policy.

Director of Clinical Governance

- Ensure that a local monitoring and evaluation program is in place that includes regular review of VTE prevention indicators, assess the effectiveness of VTE prevention strategies and assist with identifying areas that require focused attention.

- Regularly report on VTE prevention indicators to local quality committees, the Clinical Excellence Commission and other relevant State committees.

Director of Clinical Operations, Hospital, Facility and Clinical Network Managers

- Ensure all relevant staff receive education regarding VTE prophylaxis.
- Distribute VTE risk assessment and prophylaxis decision support tools to all clinical units.
- Ensure formulary management includes availability of medications recommended for VTE prophylaxis.
- Ensure clinical speciality protocols include VTE prophylaxis where appropriate.
- Participate and contribute to the PHO's monitoring and evaluation program for VTE prevention and include compliance review in routine clinical audit programs.
- Ensure data on indicators for VTE prevention processes are collected at clinical audit and provided, as required to, the Clinical Excellence Commission to enable and support quality improvement initiatives at a state level, the NSW Ministry of Health for state wide performance and compliance monitoring, and Clinical Department Heads to communicate findings from review of VTE indicators to clinical staff and support local improvement strategies.
- Ensure case review of patients developing a VTE that occurs during, or as a result of, a hospital admission.
- Ensure each clinical unit regularly reviews their VTE data and develops strategies towards improving prophylaxis where required.

Attending Medical Officer (or Delegate)

- Actively participate in their local public health organisation's VTE prevention program.
- Are aware of undertaking VTE risk assessment on all eligible patients (as noted above).
- Review the patient's related bleeding risk and based on that assessment, ensure prescription and administration of appropriate prophylaxis as required.
- Partner with patients and their carers to have an active role in preventing VTE by discussing the reason for treatment, risks and consequences of VTE prophylaxis on admission and on transfer to community or home care where required.
- Document outcome of VTE risk assessment, prophylaxis treatment; and other significant information, including any relevant dosage adjustment in the patient's health care record, approved risk assessment tools, or other locally approved forms.
- Confirm appropriate peri-operative prescription of both pharmacological and mechanical prophylaxis where indicated.
- Regularly review VTE risk during the patient care episode, particularly as clinical condition changes, and that prophylaxis is monitored and adjusted accordingly.

315 (03/12/19)

Term Changeover - Ensuring an effective handover of patient care

Document number GL2008_015.

Summary

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.

223 (11/09/14)

Using Resuscitation Plans in End of Life Decisions

Document number PD2014_030 rescinds GL2008_018.

PURPOSE

This policy directive supersedes GL2008_018 *Decisions relating to No CardioPulmonary Resuscitation (CPR) Orders*.

Planning care for patients who are approaching end of life will generally involve a shift in the focus of care away from aggressive medical intervention and towards a palliative approach, opting out of Rapid Response Systems and/or initiating palliative care.

Making a Resuscitation Plan is one important step in this process of planning quality end of life care. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

MANDATORY REQUIREMENTS

Development of standardised Resuscitation Plans and implementation policy is required by the NSW Health *Advance Planning for Quality Care at End of Life: Action Plan 2013- 2014* (Action 2.1, 2.2). Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

This policy directive will commence two weeks after release when the state Resuscitation Plans (adult and paediatric) are available.

All Public Health Organisations must:

- Adopt the state Resuscitation Plans (adult and paediatric). 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.

223 (11/09/14)

Insertion and Management of Nasogastric and Orogastric Tubes in Adults

GL2023_001 rescinds PD2009_019.

GUIDELINE SUMMARY

This Guideline provides direction to clinicians who are responsible for the insertion and/or management of intragastric tubes, such as nasogastric or orogastric tubes, in conscious adult patients. Clinicians performing the insertion / management are expected to be appropriately trained, or under appropriate supervision, to perform the procedures.

The Guideline covers strategies for each stage of tube insertion and management including pre-insertion of the tube, insertion of the tube, confirmation of placement of the tube (both radiologically and non-radiologically) tube care and maintenance, and removal of the tube.

It also guides on the health record documentation requirements, and incident reporting.

The insertion and management of post pyloric tubes, and the insertion and management of nasogastric and orogastric tubes in children are out of scope of this document.

KEY PRINCIPLES

NSW Health organisations are responsible for the implementation of this Guideline within their services / facilities to ensure local protocols or operating procedures are in place and aligned and consistent with this Guideline. This includes where education and training may be required to improve skill and competency, and a process for monitoring practice.

Decisions to insert an intragastric tube are the responsibility of a medical officer. This decision making must consider the indications for use of an intragastric tube, and the complexity of the presenting clinical condition. Some complex clinical presentations require senior medical officer / medical consultant assessment.

Nasogastric tube insertion is commonly performed at the ward level by a nurse or medical officer. The clinician responsible for tube insertion must have relevant training, and recency of practice in tube insertion. Where experience is limited, the insertion should be supported by a more experienced clinician.

Orogastric tube insertion however is a specialised procedure not routinely performed in a ward, but more likely a critical care unit. The insertion must be completed by, or under the supervision of, a clinician experienced in orogastric tube insertion. As this procedure may require use of a laryngoscope, insertion may be completed at the time of intubation, and usually in a critical care setting.

There are risks associated with incorrect intragastric tube insertion. This risk could include death. Use of an incorrectly positioned naso- or oro-gastric tube resulting in serious harm or death is classified as an Australian Sentinel Event. The patient should be monitored for early warning signs of deterioration and if recognised the local clinical emergency response system must be initiated.

Before an inserted tube can be used for any enteric intake (feeding formula, medication or fluids), confirmation of correct tube placement must be actioned and documented. Confirmation of tube placement can be done radiologically (via chest x-ray), or via pH testing of aspirates. Radiological confirmation also requires that the chest x-ray is reported by a radiologist, or reviewed by an experienced medical officer, who can exclude insertion complications and can confirm the anatomical position of the tip of the tube below the diaphragm and in the stomach.

Radiological confirmation must be ordered by a medical officer to confirm safe placement of a tube if:

- there was difficulty experienced when inserting the tube

- the patient had a clinical presentation which may have increased the risk of tube misplacement during the insertion
- there is any concern about potential tube misplacement
- an aspirate cannot be obtained
- the pH testing of the aspirate is greater than five.

pH testing can be performed in other instances. It requires attainment of an aspirate via the tube, and testing of the pH level on pH indicator strips with clear gradation markings, with a result of five or less (Litmus paper must not to be used).

Tube care and maintenance is important to maintain effectiveness of the tube and prevent the need for removal and replacement. It involves monitoring for tube migration, monitoring tube condition and patient skin integrity, maintenance of tube patency and safe and appropriate management of tube blockages.

Although an orogastric tube may not be inserted on a ward, management of an orogastric tube may be occasionally required on a ward, e.g., if a patient is transferred from critical care. The ongoing care and maintenance of orogastric tubes is similar to a nasogastric tube with differences in management in tube measurement guidance and securement, and dislodgement and reinsertion protocols.

345 (12/01/23)

Healthcare Rights

Document number IB2023_032 rescinds PD2011_022.

PURPOSE

This Information Bulletin advises NSW Health has adopted the *Australian Charter of Healthcare Rights* (second edition) and the *Charter on the Rights of Children and Young People in Healthcare Services in Australia* (collectively referred to as the Charters) The Charters reflect NSW Health focus on elevating the human experience and the responsibility of health service staff to ensure that consumers or someone they care for are aware of their healthcare rights.

KEY INFORMATION

The Partnering with Consumers Standard of the National Safety and Quality Health Service (NSQHS) Standards requires that all health organisations have a charter of rights that is consistent with the *Australian Charter of Healthcare Rights* and easily accessible for patients, carers, families and consumers at different points throughout the healthcare journey.

The Charters are essential to ensure that safe and high-quality care is provided to all people, in all health settings. NSW Health facilities/ services should select the Charter that is relevant to their facility/ service. For some facilities/ services the use of both Charters may be appropriate.

The Australian Commission of Safety and Quality in Health Care (ACSQHC) has developed a range of resources to support people to understand and use the *Australian Charter of Healthcare Rights*. These include both text based and multimedia resources. The Charter is available in languages other than English as well as accessible formats including Auslan, Braille and Easy English.

NSW Health has also developed a range of resources to support people to understand and use the *Charter on the Rights of Children and Young People in Healthcare Services in Australia*.

The Charters in various formats and languages, along with supportive resources for staff and consumers are available for order through stream solutions.

The Charters are to be accessible via local health district/ speciality health network websites and other appropriate digital applications.

All health professionals delivering healthcare services within NSW Health must be aware of the detailed rights outlined in the Charters and their responsibility to ensure all consumers understand their rights and have their rights protected and respected.

Staff are to provide consumers with the relevant Charter in their preferred language and format.

A process of education must exist for all staff to ensure there is up-to-date knowledge of the Charters and how they relate to NSW Health services.

The use and impact of the Charters is to be measured by local health districts and specialty health networks. This can be achieved through strategies such as audits of printing and distribution, interviews or surveys of patients, families and carers, and interviews or surveys of the workforce.

Consumers and the broader community can have confidence in our ability to uphold healthcare rights through our feedback and complaints management systems and public reporting mechanisms.

A frequently asked questions document is available.

Additional information about rights of consumers detained under the *Mental Health Act 2007* (NSW) is available here.

Clinical Handover

Document number PD2019_020 rescinds PD2009_060.

PURPOSE

The purpose of this policy is to enhance patient safety by ensuring systems andprocesses are in place to provide a consistent approach to clinical handover. The policy outlines key principles designed to guide and direct NSW Health staff to implement a minimum standard for conducting patient care handovers. Health services must demonstrate the engagement of patients and family/carer as key participants. This policy applies to all staff involved in the delivery of health care to patients in the NSW Public Health System.

MANDATORY REQUIREMENTS

NSW Health Local Health Districts/ Specialty Health Networks must have a governance structure in place to support all elements of clinical handover and demonstrate systems are in place to:

- Ensure a documented, consistent approach to clinical handover
- Apply the seven (7) key principles outlined in this policy for all types of clinical handover
- Partner with patients and family/carer during clinical handover
- Monitor the effectiveness of clinical handover and documentation processes
- Develop an action plan for continuous quality improvement, based on the outcomes of monitoring.

IMPLEMENTATION

Clinical Excellence Commission

- Work with clinical staff and Executive Sponsors to support implementation of this policy across NSW Health.
- Provide tools to support implementation, monitoring and evaluation.

eHealth and local Information and Communication Technology

- Collaborate with local teams to ensure tools based on the key principles are available in a responsive manner.
- Collaborate with clinical staff to identify digital solution needs in relation to this policy.

Chief Executive of Local Health Districts/ Specialty Health Networks

- Assign leadership responsibility, personnel and resources to implement and monitor this policy.

Directors of Clinical Governance

- Ensure that the policy is communicated to all managers and health workers.
- Ensure local monitoring and reporting processes are in place.
- Address system issues relating to compliance with this policy.
- Take responsibility for the oversight of continuous quality improvement and the development of action plans.

Hospital, facility, clinical stream and unit managers

- Set the expectation that clinical handover is valued and an essential part of patient care and safety.
- Develop a documented process for clinical handover based on this policy maximising consistency across all settings.
- Ensure sufficient resources and staff training opportunities are available to support clinical handover.
- Demonstrate continuous quality improvement activity, through action plan development based on lessons learned during monitoring processes.
- Address performance issues relating to compliance with this policy.

Clinical staff

- Ensure their work practices are consistent with the key principles for clinical handover.

315 (07/07/19)

Palliative Care Strategic Framework 2010-2013

Document number 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

Document number PD2022_042 rescinds PD2015_018.

POLICY STATEMENT

In NSW Health all patients, families, and carers will feel welcome, safe, and respected. Staff need to recognise and be responsive to each person's rights and needs, as well as able to provide empathy and sensitivity in their care for all patients.

NSW Health organisations must ensure the privacy and dignity of patients during all stages of their healthcare experience. Every effort must be made to be sensitive in the delivery of their care to all patients, and responsive to each person's rights and needs.

SUMMARY OF POLICY REQUIREMENTS

There are some exceptional clinical circumstances, such as highly specialised or urgent care, which may take priority over gender specific accommodation. When this does occur, it must be in the interest of all the patients affected.

Admission to hospital must not be delayed when same gender accommodation is not available. Staff must make it clear to patients and carers that mixed gender accommodation is not normal practice.

Mixed gender accommodation in critical care and short stay units may take priority over gender specific accommodation.

For many children and adolescents, clinical need, age and stage of development will usually take precedence over single gender ward allocation. Many children and adolescents take comfort from sharing with others of their own age and this may outweigh any concerns about mixed gender accommodation.

Staff must never make assumptions about a patients' sexual characteristics, gender, sexuality or body. If not informed, staff are to ask patients for their name, pronouns or how they would like to be addressed. All patients must be assured that asking questions is to ensure that every patient is able to receive the health care they need.

342 (05/09/22)

Recognition and management of patients who are deteriorating

Document number PD2020_018 rescinds PD2020_015.

POLICY STATEMENT

All NSW public health organisations are to have local systems, structures and process in place to support the recognition, response to and appropriate management of the physiological and mental state deterioration of patients.

In this policy, public health organisations include local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.

SUMMARY OF POLICY REQUIREMENTS

All NSW public health organisations are to:

- Have a clearly defined governance system to oversee the management and continuous improvement of the local Deteriorating Patient Safety Net System.
- Use standard clinical tools and approved local clinical management guidelines/pathways as part of the local Deteriorating Patient Safety Net System to assess and monitor patient deterioration, including the NSW Health standard observation charts (paper or electronic) (unless an exemption from use of the charts has been granted).
- Formalise and implement a local Clinical Emergency Response System (CERS) that meets the requirements outlined in section 5 of this Policy Directive.
- Engage all patients, carers and families in a culturally appropriate manner to inform them about processes to escalate their concerns about patient deterioration, including who to contact and how to contact them.
- Have a local education program to support the local Deteriorating Patient Safety Net System that aligns with the Deteriorating Patient Education Strategy.
- Ensure that all staff are made aware of the local Deteriorating Patient Safety Net System (including how to activate their local CERS), and their roles and responsibilities under the system during orientation and/or ward induction.
- Ensure that all clinicians who provide direct patient care have completed the mandatory BTF Tier one and Tier two education and training prior to or during their induction to the health service, as outlined in the Deteriorating Patient Education Strategy.
- Implement a local measurement strategy that monitors the performance and effectiveness of the Deteriorating Patient Safety Net System, including the collection and reporting of mandatory quality improvement measures.
- Communicate data and information about the performance of the local Deteriorating Patient Safety Net System to key stakeholders, including patients, carers, families and clinicians/staff.

Inter-facility Transfer Process for Adults Requiring Specialist Care

Document number PD2011_031 rescinds GL2005_038.

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.

127 (02/06/11)

Pathway for Acute Coronary Syndrome Assessment (PACSA)

Document number IB2023_009 rescinds GL2019_014.

PURPOSE

This Information Bulletin advises NSW Health organisations of the publication of the updated *Pathway for Acute Coronary Syndrome Assessment (PACSA)*.

KEY INFORMATION

The *Pathway for Acute Coronary Syndrome Assessment (PACSA)* is a set of documents that outline how to assess and manage patients with suspected acute coronary syndrome (ACS).

The PACSA has been designed to standardise practice throughout the variety of health services operating in NSW and supports practice in rural, remote and tertiary clinical environments. It is not designed to be a comprehensive review of the assessment and management of ischaemic heart disease and should be used in conjunction with other clinical resources.

The PACSA consists of four documents:

- *PACSA Flowchart (NH700422)*
- *PACSA Checklist (NH700420)*
- *PACSA STEMI Reperfusion Flowchart (NH700423)*
- *PACSA STEMI Reperfusion Checklist (NH700421).*

The *PACSA Flowchart and PACSA STEMI Reperfusion Flowchart* outline each step of management with corresponding colour-coded details on the right-hand side. Each Flowchart has a corresponding Checklist.

The *PACSA Flowchart*, the *PACSA STEMI Reperfusion Flowchart* and corresponding Checklists are available from the NSW Health state forms catalogue. The product numbers are listed above for each flowchart/checklist. NSW Health staff can order and print forms via Stream Solutions (a division of Toll).

More information for NSW Health staff is available on the HealthShare NSW intranet.

People outside of NSW Health are able to purchase the resources by contacting Stream Solutions directly on 1300 786 075.

345 (03/04/23)

Aboriginal Ear Health Program Guidelines

Document number GL2011_013.

PURPOSE

The purpose of this document is to provide Local Health Districts with a range of suggested strategies developed by the NSW Otitis Media Expert Advisory Committee to:

Reduce the number of young Aboriginal children being adversely affected by otitis media by reducing lifestyle risk factors amongst parents, carers and their extended families.

Improve the level of awareness about otitis media amongst the Aboriginal community, health and education professionals, thereby supporting a preventive approach and improved early identification.

Improve the effectives of services which lessen the impacts of otitis media on health and learning outcomes.

KEY PRINCIPLES

The primary aim of the attached guidelines are to encourage Local Health Districts to move away from, screening-only approaches, which have been found to be ineffective at reducing prevalence rates and to instead focus on prevention using a broad public health approach.

Effective primary prevention strategies outlined in the attached NSW Aboriginal Ear Health Program Guidelines include improving nutrition and the home environment, increasing breastfeeding and reducing passive smoking.

USE OF THE GUIDELINE

Local Health Districts developing local and regional responses addressing otitis media are asked to consider the directions and suggested strategies contained herein which place priority on prevention through a broad public health approach incorporating existing child health surveillance and health care programs (rather than universal-style screening).

138 (10/11/11)

Nutrition Care

Document number PD2017_041 rescinds PD2011_078.

PURPOSE AND SCOPE

Local Health Districts, Specialty Health Networks and other NSW public health organisations have a responsibility to provide nutrition care for all their admitted patients1. This Policy directive sets out the NSW Health framework for a strategic and coordinated approach to nutrition care for admitted patients, including weight and height/length assessment, from admission to transfer of care.

MANDATORY REQUIREMENTS

This Policy applies to all NSW Local Health Districts, Specialty Health Networks and other NSW Health organisations which provide services to admitted patients including, but not limited to hospitals and emergency departments, Day stay centres (e.g. renal dialysis, chemotherapy etc.), Multipurpose services, Mental Health facilities and Hospital in the home.

Where these facilities provide food and nutrition care services to admitted patients, consumers and residents, the nutrition care processes described in this policy directive including weight and height/length assessment **must** be in place.

IMPLEMENTATION

Chief Executives are responsible for:

- Implementing the Nutrition Care Policy, within their respective facilities.
- Ensuring governance structures are in place for all sites within the Local Health District or Network.
- Assigning responsibility, personnel and resources to meet the requirements of the Policy.
- Ensuring a staff/volunteer education and training program for nutrition care is in place.
- Ensuring systems for nutrition risk screening, nutrition assessment, and weight and height assessment using appropriate equipment and validated tools are in place.
- Ensuring clinician work practices are consistent with the requirements of the Policy.
- Ensuring systems to evaluate the nutrition care and weight and height assessment processes are in place.
- Reporting on the implementation and evaluation of the requirements of the Policy.
- Ensuring providers of food services comply with the requirements of this Policy.

Nursing/Midwifery Unit Managers (or Nurse/Midwifery Managers where appropriate) are responsible for:

- Enabling and monitoring systems to ensure patients, consumers and residents receive appropriate nutrition care.

The Agency for Clinical Innovation is responsible for:

- Providing support to NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations for the implementation of the Nutrition Care Policy.

1 When the term 'patient' is used throughout this Policy it refers to all patients, consumers, and residents admitted to a NSW Health facility for care.

- Monitoring and evaluating implementation of the Policy within NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations in collaboration with the NSW Ministry of Health and key stakeholders.
- Reporting on the implementation and evaluation of the Policy to the NSW Ministry of Health Nutrition and Food Committee. This includes recommendations for amendments to the Policy and other relevant documents such as nutrition standards and diet specifications.

Food Service Providers (including HealthShare NSW and contracted providers) are responsible for:

- Ensuring the standards set out in this Policy and other related policies are incorporated into all food service provision activities for admitted patients, including menu planning and design, and food service system design and delivery in NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations.
- Ensuring appropriate consultation and communication with NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations.

Health Education and Training Institute

- Provides educational resources to support the implementation of this Policy.

315 (17/11/17)

NSW Aboriginal Health Plan 2013-2023

Document number PD2012_066.

PURPOSE

The NSW Aboriginal Health Plan 2013-2023 (the Plan) is the result of the NSW Government's commitment in 2011, toward closing the gap in health outcomes for Aboriginal people.

Over the next ten years the Plan provides unique opportunities for NSW Health to reexamine 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 (LHDs), Specialist Health Networks, Pillars and other NSW health related statutory authorities.

Six strategic directions have been identified to drive the changes needed in the health system to improve Aboriginal health. They are:

1. Building trust through local partnerships
2. Building the evidence and implementing what works
3. Ensuring integrated planning and service delivery
4. Strengthening the Aboriginal workforce
5. Ensuring culturally safe work environments and health services
6. Strengthening performance monitoring, management and accountability

To support achievement of these strategic directions, several strategic actions that support each of the strategic directions require implementation. Please refer to these actions on pages 10-16 in the Plan.

IMPLEMENTATION

The Plan adopts a systems reform approach to improve health equity for Aboriginal people, and will support the NSW health system to achieve the *NSW 2021: A plan to make NSW number one* targets to:

- Reduce smoking rates by 4% for Aboriginal people
- Reduce the rate of smoking by 2% per year for pregnant Aboriginal women
- Halve the gap between Aboriginal and non-Aboriginal infant mortality rates by 2018
- Reduce the age-standardised rate of potentially preventable hospitalisations by 2.5% for Aboriginal people by 2014–15.

LHDs, 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.

171 (20/12/12)

NSW Health & Ageing and Disability and Home Care (ADHC) Joint Guideline

Document number GL2013_001.

Supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital

PURPOSE

The aims of the Guideline are:

1. To ensure that staff working in hospitals and disability accommodation support services are aware of their respective roles and responsibilities to people with disability before, during and after transfer of care from hospital.
2. To provide a framework for best practice for health care staff and disability support staff/nurses so together they can:
   - Identify areas of risk that could compromise a person with disability's capacity to achieve the best health outcomes and their safety and/or dignity during a hospital stay;
   - Agree on what additional supports are required to reduce identified risks; and
   - Negotiate responsibility and resources for the provision of agreed additional support.
3. To link and reference each agency's policies rather than replicating them (staff should refer to relevant policies where indicated in this Guideline).

This Joint Guideline (the Guideline) has been endorsed by ADHC and NSW Health and was developed in consultation with key stakeholders across health and disability sectors.

KEY PRINCIPLES

The following general principles underpin the Guideline:

- Person Centred Approach

  An approach that places the person at the centre of decision making and treats natural networks of support and service providers as partners. A philosophical background based on the value of human rights, independence, choice and inclusion.

- Patient Centred Approach

  An approach that is geared towards using resources to develop a culture where the patient is both the heart of the system and the driver behind every decision.

- Communication

  Good communication between the person, their family/guardian, hospital staff and the disability support staff and sharing information about the persons health and disability support needs makes a positive difference to a person's health outcomes

- Sharing Information

  Key information that hospital staff need to know about the person and their support needs should be provided in a universally consistent format and travel with the person around the hospital for ease of access.

- Sharing Expertise

  Sharing expertise to ensure that people with disability achieve the best health care outcome is central to this Guideline.

- Capacity to consent.

It is the responsibility of the treating practitioner to determine if the person is able to give consent for medical or dental treatment. Disability Support Staff cannot provide consent for medical treatment under any circumstances.

The document covers issues relating to workforce, care coordination and transfer of care, the key stages of planned and unplanned admission to hospital, resolution of issues arising during the hospital stay, local liaison mechanisms and implementation.

USE OF THE GUIDELINE

Local Health Districts should use this Guideline in conjunction with NSW Health Policy Directives- PD2011_015: *Care Coordination: Planning for Admission to Transfer Care in Public Hospitals* and PD2008_010: *People with Disability: Responding to Needs During Hospitalisation*.

Some Local Health Districts (LHDs) and ADHC Regions have developed local protocols which provide the framework for effective support of ADHC clients during a hospital stay. This Guideline aims to facilitate a higher level of compliance with existing NSW Health and AHDC policies.

As a minimum requirement, all local protocols need to comply with the general principles set out in this Guideline. Providing these principles are included in local protocols, all other protocol features can be negotiated, expanded and adapted to meet existing local needs.

The implementation of the Guideline should be reported through the Local Health District's Disability Action Plans.

Use of the Jointly Agreed Hospital Support Plan Part 1 & 2 (Appendix 1)

The Hospital Support Plan may be inserted into the plastic sleeve of *My Health Record*. Part 1 of the Hospital Support Plan contains all relevant personal, consent, health/medical and disability support information necessary to help hospital staff provide safe and effective health care and will be completed by the disability support staff. It will be presented to hospital staff at every pre admission/admission and a copy be kept with the person at all times including all transfers of care.

Part 2 of the Hospital Support Plan is designed to facilitate the sharing of clinical and disability support expertise. It provides the framework to negotiate the range and level of support the person will require during hospitalisation to ensure they achieve the best health outcomes and maintain their safety and dignity.

Part 2 of the Hospital Support Plan is completed in partnership with disability support staff/nurses, the nurse in charge of the unit/ward, the person and, if the person agrees, the family/guardian, at a pre admission meeting or as soon as the person is settled following an unplanned admission to hospital.

Snakebite and Spiderbite Clinical Management Guidelines 2013 - Third Edition

Document number GL2014_005 rescinds GL2007_006.

PURPOSE

Clinical resource document to advise on the management of patients with actual or suspected snakebite or spiderbite, and the appropriate levels, type and location of stored antivenom in NSW health facilities. These are clinical guidelines for best clinical practice which are not mandatory but do provide essential clinical support.

KEY PRINCIPLES

Determination of antivenom stock requirements is best done at a regional level, either for a whole Local Health District (LHD) or important regions within a Local Health District in collaboration with local Critical Care Clinicians based a review of risks, facilities, past usage and other practical considerations using the following principles:

- Geographic location and degree of isolation
- Local snake and spider distribution
- History of envenoming cases
- Referral role of regional, rural and metropolitan hospitals.

Whilst, the definitive management of snake envenoming can only occur in a hospital with a laboratory that can do an INR/aPTT and there is sufficient nursing care; antivenom treatment can (and should) be given to obviously envenomed patients in smaller hospitals without laboratory services prior to retrieval.

Specifically, the guidelines recommended that at a minimum ALL hospitals in NSW should have:

- One (1) vial of brown snake antivenom
- One (1) vial of tiger snake antivenom
- One (1) vial of polyvalent antivenom should be kept in larger regional and referral hospitals, retrieval services across NSW, and in larger hospitals west of the Great Dividing Range for mulga snake
- Two (2) vials of funnel-web spider antivenom should be kept in all hospitals where the spider occurs.

USE OF THE GUIDELINE

The guidelines should be used as a clinical resource document to assist in the assessment, decision making and clinical management of patients with confirmed or suspected snakebite or spiderbite, and the appropriate levels, type and location of stored antivenom in NSW health facilities.

205 (20/03/14)

Insertion and Management of Urethral Catheters for Adult Patients

Document number GL2021_015 rescinds GL2015_016.

GUIDELINE SUMMARY

This Guideline provides best practice principles for inserting and managing urethral catheters for adult patients in NSW Health Organisations (HOs) with the aim of reducing unnecessary catheterisation and minimising the risk of catheter-associated urinary tract infection (CAUTI).

This document will support trained and credentialed health workers (HW) who are competent in urinary catheter practice for acute care settings.

KEY PRINCIPLES

To minimise the risk of a patient acquiring a CAUTI, clinicians are to ensure that indwelling urethral catheters are always:

- Inserted only if clinically indicated
- Inserted and maintained using aseptic technique
- Removed as soon as the clinical need has been resolved.

Catheter insertion, routine care and catheter removal are to be documented in the patient's healthcare record.

USE OF THE GUIDELINE

The Chief Executives of NSW HOs are responsible for the implementation of this Guideline within their services/facilities to ensure that local protocols or operating procedures are in place, aligned and consistent with the Guideline.

All clinicians working in adult acute care settings and who are involved in the care of patients with catheters should be aware of the Guideline and actively participate in its implementation.

The Clinical Excellence Commission will have responsibility for producing resources for NSW HOs to support the implementation of this Guideline.

315 (26/09/16)

Cardiac monitoring of adult cardiac patients in NSW public hospitals

Document number IB2022_027.

PURPOSE

This Information Bulletin is to notify NSW Health that the *Cardiac monitoring of adult cardiac patients in NSW public hospitals* document has been revised and is now available on the Agency for Clinical Innovation website as a clinical practice guide.

KEY INFORMATION

The Agency for Clinical Innovation Cardiac Network has revised the *Cardiac monitoring of adult cardiac patients in NSW public hospitals* document in line with contemporary evidence and it has been published as a clinical practice guide.

The revised document provides further clarification on:

- The role for, limitations of, and institutional resources to support ST segment and QT interval monitoring.
- Lead selection according to indication.
- Advice on avoidance of inappropriate monitoring in low-risk patients.
- Advice on avoidance of inappropriate monitoring in low-risk patients.
- Safe adjustment of alarm parameters to reduce alarm fatigue and the expectations for reviewing and documenting cardiac monitoring alarms.
- The skills within the advanced escort skill set that are patient-dependent.
- The capacity for senior nurses with advanced cardiac skills to act as delegate decision makers about cardiac monitoring.
- The revised monitoring requirements for clinically stable patients awaiting pacemakers or internal cardioverter defibrillator implantation and for patients receiving inotropes as supportive care at the end of life.

342 (18/08/2)

NSW Clinical Service Framework for Chronic Heart Failure 2016

Document number GL2017_006.

PURPOSE

The NSW Clinical Service Framework for Chronic Heart Failure (CHF) provides nine evidence-based standards to support clinicians in community and hospital environments to provide best-practice care in the prevention, diagnosis and management of people with CHF across the continuum of care.

Compliance with the Framework will improve patient outcomes and experience and reduce length of stay and re-hospitalisation.

KEY PRINCIPLES

- Management of people with CHF should align with the nine evidence-based standards described in the Framework.
- The document may be used by general practitioners, nurses, doctors, allied health staff and Aboriginal health service providers.
- The Framework provides guidance for a range of clinical settings including Primary Health Networks (PHNs) and general practices, Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Medical Services (AMS), community health services, hospitals and Local Health Districts (LHDs).
- Health services for people with chronic and complex conditions need to be reconfigured to be more integrated, coordinated and patient focused throughout the continuum of care.
- People with CHF often have multiple comorbidities and physiological and psychosocial needs that change over time. Access to different levels of care at various stages of the disease trajectory is needed to reduce presentations to hospital.
- The General Practitioner (GP) or other primary care provider plays a central coordinating role in the person-centred medical home model where care is delivered in partnership with a multidisciplinary team. The GP may be able to reduce unplanned admissions by early identification of patients with increasing care needs and planned admission for rapid assessment and treatment rather than an emergency hospital presentation.
- Supported self-management underpins the aims of services, therefore, clinical team members should be trained in health behaviour change to deliver the service in partnership with the patient, their family and carers who are central to decision making and setting patient-centred achievable goals.

USE OF THE GUIDELINE

Chief Executives

- Should provide the document to staff working in areas where patients may present for example, emergency departments, cardiac and medical wards

Directors of Clinical Governance and Patient Flow Managers

- Should monitor the implementation of the Framework and its impact on patient experience, outcome and patient flow within their facilities

Nurse Unit Managers

- Should support their staff to implement the Framework

Nursing Staff

- Should provide evidence-based care as recommended in the protocol

Medical Staff (including GPs working in mainstream and Aboriginal Health Services)

- Should assess, risk stratify and manage patients using the 12 evidence-based minimum standards described in the protocol.

315 (24/04/17)

Growth Assessment in Children and Weight Status Assessment in Adults

Document number GL2017_021.

PURPOSE

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

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

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

Youth Health and Wellbeing Assessment

Document number GL2018_003.

PURPOSE

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

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

This guideline supports NSW Health's commitment to implement appropriate psychosocial assessment tools, such as HEEADSSS, to assess and respond to the holistic health and wellbeing needs of young people outlined in the *NSW Youth Health Framework 2017-2024* (PD2017_019).

KEY PRINCIPLES

Youth health and wellbeing assessments are important to assist clinicians to identify and respond early to areas of concern in a young person's life that might affect their health and wellbeing.

The youth health and wellbeing assessment is not a diagnostic tool. It is a holistic, flexible approach designed to build rapport and engage with a young person in a clinical setting. The information gathered can then be used to directly address any concerns and/or refer a young person for a specialist response.

The most widely used youth health and wellbeing assessment tool in Australia and internationally is known as a HEEADSSS assessment.

Each letter of HEEADSSS reflects a major domain of a young person's life. Capturing information in each domain helps reveal risks, behaviours and protective factors. It helps to identify areas of intervention where the clinician can work with the young person to achieve better health outcomes.

- H Home
- E Education and Employment
- E Eating and Exercise
- A Activities, Hobbies and Peer Relationships
- D Drug Use (cigarettes, alcohol)
- S Sexual Activity and Sexuality
- S Suicide, Self-Harm, Depression, Mood, Sleeping Patterns
- S Safety and Spirituality

In general, a youth health and wellbeing assessment (12-24 years old) should be conducted with every young person who attends a health service or hospital. Where appropriate young people in an adult or paediatric inpatient area within a hospital should have a youth health and wellbeing Assessment completed in conjunction with other screening assessment/admission processes.

Clinical judgement should be used to determine the appropriateness of the assessment for 12-24 year olds. This includes considering the young person's health condition, maturity, the environment and health service context (for example, sufficient time or privacy may not be available in an Emergency Department context).

In general an assessment is done through conversation with a young person. On some occasions, where it is more appropriate a young person can be asked to complete the Youth Health and Wellbeing Assessment Chart (Appendix 1).

It is essential that clinicians/healthcare workers read and understand this guideline in particular Sections 6 to 11 of the Guideline.

- Section 6 Issues covered by a youth health and wellbeing assessment
- Section 7 When to conduct a youth health and wellbeing assessment
- Section 8 Youth health and wellbeing assessment flow diagram
- Section 9 Self-completed assessment using Youth Health and Wellbeing Assessment Chart
- Section 10 Setting up and concluding the assessment
- Section 11 Contraindications and cautions

USE OF THE GUIDELINE

This guideline should be considered when conducting Youth Health and Wellbeing Assessment with young people (12-24 years old) who attend a health service or hospital.

This document outlines the –

- approach that should be taken by NSW Health staff when conducting a youth health and wellbeing assessment (Sections 7 - 10)
- issues to consider when implementing the youth health and wellbeing assessment within different health settings and with different age groups (Sections 11 - 12)

A range of resources for workers are available to support Youth Health and Wellbeing Assessment when needed (Appendices 1 – 4).

The document should not be seen as a prescriptive set of rules to be applied without the clinical input and discretion of the managing health professionals. Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

Establishing a Subcutaneous Immunoglobulin Hospital Program

Document number GL2020_024.

GUIDELINE SUMMARY

NSW Health's commitment to providing world class clinical services, enhancing the quality of life of its patients and empowering patients to be partners in their care underpin the matter covered in this Guideline.

This Guideline outlines the principles for establishing a SCIg hospital program to train and support suitable, SCIg-eligible patients to treat themselves at home in familiar surroundings and at a time that suits them. Trained patients will not have to travel to hospital for regular intravenous infusions of immunoglobulin and will be able to pick up their treatment product as close to their home as possible.

KEY PRINCIPLES

This Guideline applies to all NSW Health staff involved in the establishment and running of a SCIg hospital program.

Local Health Districts (Districts) involved in the planning of a SCIg hospital program are encouraged to promote the collaboration of clinical specialty areas to ensure equity of patient access to the program. In addition, consideration should be given to patients being able to access training and product as close to their homes as possible.

The hospital General Manager must approve the provision and resourcing of SCIg clinical services by facilities in their hospital.

SCIg may be managed (ordered, receipted, stored and released for dispensing) by a facility's pathology/transfusion medicine laboratory or by the facility's pharmacy department. The unit/facility that manages SCIg must be registered as an Approved Health Provider (AHP). If the unit/facility that manages SCIg is different from the unit/ facility that normally manages blood and blood products, a second AHP registration will be required.

The NSW Ministry of Health's Office of the Chief Health Officer must be advised of the following by the hospital General Manager:

1. approval has been given to commence providing subcutaneous immunoglobulin therapy at the health facility;
2. health facility has all the necessary processes and resources in place to support service provision; and
3. in the event that a second AHP has been arranged, provide confirmation that the Local Health District Blood Management Committee and Drug and Therapeutics Committee (or their equivalents) will be responsible for oversighting the governance of SCIg in the facility.

BloodSTAR must be used by treating clinicians to obtain authorisation for patients to receive government-funded subcutaneous immunoglobulin. Before entering patient details into BloodSTAR the treating clinician must obtain the patient's consent to do so. In addition, patient consent is required before the patient is treated with SCIg.

BloodNet must be used to order SCIg, to replenish SCIg imprest, to receipt the product and to record SCIg dispensing episodes.

There is no prescriptive dispensing arrangement for SCIg but the product must be dispensed by a pharmacist and recorded by them in iPharmacy. The dispensing arrangement that a facility proposes to adopt must be endorsed by the District Drug and Therapeutics Committee and the

Blood Management Committee (or their equivalents) and approved by the District Director of Pharmacy (or equivalent).

It is NSW Health policy that hospital pharmacies can charge a dispensing fee for SCIg in line with the Pharmaceutical Benefits Scheme (PBS) fee. Chief Executives may waive the fee either by a local directive or on a case-by-case basis. If patients are charged a dispensing fee for SCIg they must be charged a single fee, regardless of the duration of supply and the number of different vial sizes and doses prescribed.

Public hospitals can dispense SCIg to a community patient who has a prescription from a private authorised prescriber.

333 (27/11/20)

National Health and Medical Research Council's New National Guidelines for Drinking Alcohol

Document number IB2021_001.

PURPOSE

The National Health and Medical Research Council (NHMRC) released '2020 Australian Guidelines to Reduce Health Risks from Drinking Alcohol'.

These Guidelines replace the NHMRC's 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol.

This Information Bulletin informs all NSW Health entities to update resources, programs, policies, guidelines and public health messages that reference the Australian guidelines, calling attention to the changes since 2009.

KEY INFORMATION

The Guidelines have been developed from a rigorous review of evidence over a four-year period. They are backed up by extensive analysis of systematic reviews of the health effects of drinking alcohol and data on Australian drinking patterns which is available at https://www.nhmrc.gov.au/health-advice/alcohol

The NHMRC was guided by a group of independent health experts including doctors, medical and public health professionals, researchers and consumer representatives on an Alcohol Working Committee. The Guidelines were reviewed and endorsed by NHMRC Council which included Chief Medical Officers of the Commonwealth, each State and Territory, together with leaders in health, research and ethics. All Australians could comment whilst the Guidelines were being drafted, including the alcohol industry.

Main changes to the revised guidelines are:

Guideline 1: Adults

To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.

The less you drink, the lower your risk of harm from alcohol.

Guideline 2: Children and people under 18 years of age

To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.

Guideline 3: Women who are pregnant or breastfeeding

A. To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.
B. For women who are breastfeeding, not drinking alcohol is safest for their baby.

Clinical Principles for End of Life and Palliative Care

Document number GL2021_016.

GUIDELINE SUMMARY

This Guideline outlines the clinical principles and key actions that will support good quality, evidence-informed practice and improvement in the provision of end of life and palliative care (EoLPC) in NSW. This Guideline aligns with the *NSW Health End of Life and Palliative Care Framework 2019-2024* (the Framework).

The key actions described in this Guideline have been identified as meaningful, measurable and achievable priority actions that can be implemented locally to drive state-wide, coordinated efforts to address the priority areas of the Framework.

KEY PRINCIPLES

The objectives of this Guideline are to identify overarching key principles which guide provision of EoLPC, identify key actions which will contribute to achieving the state-wide priorities of the Framework and communicate expectations regarding alignment with published 'standards' for the delivery of EoLPC to all people across NSW.

All NSW Health services providing EoLPC are to ensure they have evidence-informed, locally developed model/s of care that meet the needs of their community and, at a minimum:

- address the five priority areas of the Framework
- incorporate the nine key actions from this Guideline
    - Screening and identification o Triage
    - Comprehensive assessment
    - Care planning
    - Open and respectful communication
    - Symptom management
    - 24/7 access to support o Place of death
    - Grief and bereavement support.
- ensures reference with applicable nationally agreed standards for the provision of EoLPC
- ensures use of appropriate, evidence-based tools and resources
- articulates pathways to ensure access is available to multidisciplinary services
- integrates the use of clinically appropriate virtual care modalities to support the provision of integrated care
- improves equitable access for priority and underserved populations.

USE OF THE GUIDELINE

NSW Local Health Districts (Districts) and Specialty Health Networks (Networks) are responsible for ensuring their services and facilities meet the requirements of this Guideline. It is recommended that local governance mechanisms are in place to oversee the implementation of the Guideline.

All staff and services who provide end of life care and/or palliative care (includes, but is not restricted to, specialist palliative care services) are to be aware of this Guideline and actively participate in its implementation.

This Guideline is applicable across all care settings including community settings, nonadmitted settings, admitted settings, or other settings in which NSW Health services are providing care. It is relevant to all people (neonates, infants, children, adolescents, young adults, adults and older adults) who have a life-limiting illness or are identified as approaching the end of life.

Districts and Networks are to use this Guideline to:

- develop, implement and monitor strategies aligned to the key actions specified in this Guideline
- understand the expectations of NSW Health regarding alignment with relevant nationally agreed standards for EoLPC
- ensure locally developed model/s of care reflect appropriate, evidence-informed tools and resources
- assist in meeting accreditation requirements.

339 (06/09/21)

Domestic Violence Routine Screening

Document number PD2023_009.

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning. All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying

responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

347 (03/04/23)

Voluntary Assisted Dying

Document number PD2023_037.

POLICY STATEMENT

The Voluntary Assisted Dying Act 2022 (the Act) will allow eligible people the choice to access voluntary assisted dying in NSW from 28 November 2023. Local health districts (LHDs) must have appropriate clinical and administrative arrangements in place to support voluntary assisted dying as an end of life care option from this date.

SUMMARY OF POLICY REQUIREMENTS

Legislative framework

The Act sets out the framework for voluntary assisted dying in NSW, including the eligibility criteria, the process that must be followed and the roles and responsibilities of practitioners that are involved in the process.

Policy requirements

The requirements of this Policy Directive are in addition to the legal requirements of the Act.

This Policy Directive outlines mandatory requirements for LHDs to manage and respond to requests for information about and access to voluntary assisted dying, and to support patients through the voluntary assisted dying process. This includes:

- having processes and systems in place to safely and effectively:
    - respond to general requests for information about voluntary assisted dying
    - raise awareness of eligibility criteria and internal referral processes for voluntary assisted dying, including how the request for voluntary assisted is to be managed within different settings
    - respond to first requests made to any medical practitioner by a patient
    - provide patients with information about the full suite of palliative care and end of life options available to them, including, if aligned with their goals of care, voluntary assisted dying
    - support patients through the request and assessment process
    - comply with documentation requirements throughout the process
    - provide access to facilities for external authorised practitioners or persons required as part of the voluntary assisted dying process, who are not employed by or do not normally provide contracted services to a facility
    - manage requests in a timely manner for assessments of decision-making capacity
    - support substance administration for patients in a variety of settings and circumstances
    - respond to any questions or concerns from staff members about voluntary assisted dying and available pathways to escalate concerns to local executive or the NSW Ministry of Health
    - manage and respect conscientious objections amongst staff whilst also ensuring care pathways for voluntary assisted dying are in place, and usual processes for accessing care or continuation of care are maintained
    - link patients, families and staff to existing support services

- governance arrangements to support the ongoing service delivery of, and quality improvement processes for, voluntary assisted dying, and processes for documenting relevant information in the local patient medical record
- establishing voluntary assisted dying pathways, where appropriate, with:
    - local private health and residential facilities
    - primary care networks and general practitioners who may receive requests or who are participating practitioners
    - Schedule 3 affiliated health organisations
- endeavouring to have a sufficient number of authorised coordinating, consulting and administering practitioners within their services to support timely access to each step of the voluntary assisted dying process for patients
- compliance with requirements for the access, storage, administration and disposal or return of the voluntary assisted dying substance

349 (08/11/23)