

Patient Matters Manual for Public Health Organisations

Chapter 2 – Paediatrics

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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.

Newborn Bloodspot Screening

Document number [PD2016_015](#) rescinds PD2006_099.

PURPOSE

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

MANDATORY REQUIREMENTS

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

All parents / guardians must be told about:

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

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

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

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

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

IMPLEMENTATION

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

265 (19/5/16)

Breastfeeding in NSW: Promotion, Protection and Support

Document number [PD2018_034](#) rescinds PD2011_042.

PURPOSE

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

MANDATORY REQUIREMENTS

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

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

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

IMPLEMENTATION

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

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

321 (21/09/18)

Breastmilk: Safe Management

Document number [GL2023_021](#) rescinds PD2010_019.

GUIDELINE SUMMARY

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

KEY PRINCIPLES

NSW Health facilities are required to reduce the risk of the misadministration of breastmilk.

This includes ensuring that all babies have secure identification in place and babies are not separated from their mothers without a compelling reason.

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

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

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

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

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

347 (18/08/23)

Apnoea Monitors

Document number [GL2012_002](#) rescinds GL2005_069.

PURPOSE

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

KEY PRINCIPLES

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

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

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

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

(24/01/12)

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.

296 (17/11/17)

Circumcision of Normal Male Infants

Document number [PD2020_035](#) rescinds PD2012_009.

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

Parents who request circumcision for their infant son must be provided with accurate, unbiased and up to date information about the risks and benefits of the procedure. Two resources that are recommended for staff:

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

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

THIS POLICY DIRECTIVE MUST BE READ IN CONJUNCTION WITH:

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

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

332 (07/10/20)

Maternity and Neonatal Service Capability

Document number [GL2022_002](#) rescinds GL2016_018.

GUIDELINE SUMMARY

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

KEY PRINCIPLES

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

District/networks are responsible for annual reporting of maternity and neonatal service capability levels.

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

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

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

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

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

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

341 (20/05/22)

Management of Sudden Unexpected Death in Infancy (SUDI)

Document number [PD2019_035](#) rescinds PD2008_070.

PURPOSE

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

MANDATORY REQUIREMENTS

SUDI is a reportable death under the Coroners Act 2009¹. Most SUDI deaths occur in the community and are brought to their local emergency department, however SUDI can also occur in hospital. NSW Health's role in management of SUDI includes that local health districts and specialty health networks must:

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

IMPLEMENTATION

Local health district chief executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy.

¹ NSW Health Policy Directive Coroners Cases and the Coroners Act (PD2010_054 section 5).

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

321 (30/07/19)

Recommended Safe Sleeping Practices for Babies

Document number [GL2021_013](#) rescinds PD2019_038.

GUIDELINE SUMMARY

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

KEY PRINCIPLES

Health professionals use a partnership approach to engage and work with families in a culturally sensitive manner to build relationships and find ways to support families to keep their babies safe. Carers receive consistent, clear information about the recommended safe sleeping practices routinely and opportunistically in antenatal, postnatal, newborn care and community settings until the baby is 12 months of age. Risk assessments are conducted at specified points in care for factors that may indicate a higher risk of SUDI. All care and care planning, including risk assessments, must be documented in the health record.

USE OF THIS GUIDELINE

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

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

339 (27/02/21)

Feeding Difficulties in Children - A Guide for Allied Health Professionals

Document number [GL2016_007](#).

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDE

Chief Executives must ensure:

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

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

296 (18/2/16)

Suspected Child Abuse and Neglect (SCAN) Medical Protocol

Document number [GL2014_012](#).

PURPOSE

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

KEY PRINCIPLES

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

USE OF THE GUIDELINE

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

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

218 (10/07/14)

Neonatal Abstinence Syndrome Guidelines

Document number [GL2013_008](#) rescinds PD2005_494.

PURPOSE

These Guidelines specifically address the management of newborns to mothers with a history of opioid use or opioid dependence, including women currently receiving opioid substitution treatment (methadone or buprenorphine) or using prescription pharmaceutical opioids (such as oxycodone, morphine, pethidine or tramadol). While Neonatal Abstinence Syndrome (NAS) is more common in infants born to opioid dependent women than in infants born to women dependent on other drugs, the effect of polydrug use on NAS is not clearly established and is most likely dependent upon the specific combination and quantities of drugs used by the mother. Provided that neonatal abstinence syndrome is appropriately managed, it is not currently known to be associated with long-term health problems.

KEY PRINCIPLES

The Guidelines concentrate on two main aspects of care:

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

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

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

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

USE OF THE GUIDELINE

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

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

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

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

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

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

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

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

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

185 (05/09/13)

Rural Paediatric Emergency Clinical Guidelines - Third Edition

Document number [GL2021_011](#) rescinds GL2020_016.

GUIDELINE SUMMARY

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

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

KEY PRINCIPLES

The Guideline is designed to:

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

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

USE OF THE GUIDELINE

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

Chief Executives must ensure that:

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

FLECC-trained nurses must ensure that:

- a designated medical officer is notified as soon as practicable

FLECC-trained nurses and medical officers must ensure that:

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

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

Standards for Paediatric Intravenous Fluids

Document number [IB2014_066](#).

PURPOSE

To advise clinicians and managers about the products recommended in the Standards for Paediatric IV fluids (GL2014_009) published in June 2014. The Standards address the appropriate choice of IV fluids and measures related to their procurement, storage and safe administration.

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

KEY INFORMATION

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

Compounded IV Products

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

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

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

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

IV Bag Sizes

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

Potassium Chloride products

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

Pre-Packaged Bags

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

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

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

Paediatric Infusion Sets

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

Neonatal Fluids

For Neonates 0.225% sodium chloride + 10% glucose +/- 20mmol/L potassium chloride is recommended as an option for maintenance fluids. Please note when ordering:

- The version **without** potassium chloride (product code AHB2026) is labelled as 0.22% sodium chloride + 10% glucose
- The version **with** potassium chloride (product code AHK6021) is labelled as 0.225% sodium chloride + 10% glucose + 10mmol potassium chloride.

Ordering enquiries

For AHK and AHB Baxter IV fluid codes

Baxter Customer Service – Telephone - 1300 789646

For the compounded IVS.1000-5000 products

Baxter Pharmacy Services:

Telephone: 1800 227 487 or (02) 9848 1395

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

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

ATTACHMENTS

Baxter – 2014 – Paediatric IV Fluids Order Form NSW.

250 (03/09/15)

Statewide Infant Screening – Hearing (SWISH) Program

Document number [GL2010_002](#).

PURPOSE

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

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

KEY PRINCIPLES

The Guidelines outline the responsibilities each stage has in the hearing screening pathway.

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

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

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

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

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

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

USE OF THE GUIDELINE

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

- Screening Staff (Chapters 2 and 3)

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

80 (18/02/10)

The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities

Document number [PD2022_053](#) rescinds PD2010_032, PD2010_034 and PD2010_033.

POLICY STATEMENT

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

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

POLICY REQUIREMENTS

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

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

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

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

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

344 (08/11/22)

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Adoption of a Child - Guidelines for Hospitals & Maternity Staff in Response to Parents Considering

Document number [PD2005_545](#).

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

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

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

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

Maternity services – nursing, medical and allied health staff;

Paediatricians and Paediatric Registrars;

Hospital Social Workers;

Medical Records Staff to note section 3.7 of the Guidelines.

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

(07/03/05)

Maternity - Maternal Group B Streptococcus (GBS) and the Minimisation of Neonatal Early - Onset GBS Sepsis

Document number [GL2017_002](#) rescinds GL2016_021.

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

The Chief Executives of NSW LHDs are responsible to:

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

271 (19/1/17)

NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements

Document number [PD2023_019](#) rescinds PD2005_157, PD2010_030 and PD2010_031.

POLICY STATEMENT

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

Local health districts and the Sydney Children's Hospitals Network will optimise access to appropriate care close to home through services operating at their designated service capability level and actively managing patient flow.

Infants, children, adolescents and their families/carers are to be provided with timely, culturally appropriate and accessible information about clinical care, decisions and the transfer process.

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

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

347 (07/08/23)

Neonatal Consultation, Referral and Transfer Arrangements in Collaboration with NETS

Document number [IB2020_015](#).

PURPOSE

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

KEY INFORMATION

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

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

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

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

Where there is a difference of opinion regarding a neonatal transfer, the final decision to transfer will be made by the NETS medical retrieval consultant, in line with the NSW Health Policy [PD2010_030 Critical Care Tertiary Referral Networks \(Paediatrics\)](#).

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

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

Contact NETS on 1300 362 500

Early notification will enable early assistance.

In a time-critical emergency, NETS notification can occur prior to full patient assessment and investigation.

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

327 (30/04/20)

Paediatric Clinical Guidelines

Document number [IB2020_041](#) rescinds PD2012_056, PD2011_038, PD2010_063, PD2010_053, GL2014_013, PD2011_024 and PD2013_053.

PURPOSE

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

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

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

KEY INFORMATION

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

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

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

Interstate clinical practice guidelines are now available at:

<https://www.rch.org.au/clinicalguide/>

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

333 (19/11/20)

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).

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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.

296 (1/2/18)

Infants and Children: Initial Management of Fever/Suspected Sepsis in Oncology /Transplant Patients

Document number [GL2015_013](#).

PURPOSE

The *Infants and Children: Initial Management of Fever or Suspected Infection in Oncology and Stem Cell Transplantation Patients, first edition* Clinical Practice Guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of NSW Kids and Families.

KEY PRINCIPLES

This guideline applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts and specialty health networks to determine where local adaptations are required or whether it can be adopted in its current Clinical Practice Guideline format in all hospitals and facilities required to manage infants and children undergoing therapy for cancer or stem cell transplantation presenting with fever or suspected infection.

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- Hospitals and facilities either adopt this protocol or adapt local protocols to comply with the *Infants and Children: Initial Management of Fever or Suspected Infection in Oncology and Stem Cell Transplantation Patients, first edition* Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric oncology and stem cell transplantation patients with fever or suspected infection
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

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

273 (8/10/15)

Neonatal - Jaundice Identification and Management in Neonates ≥ 32 Weeks Gestation

Document number [GL2016_027](#).

PURPOSE

This Guideline provides a framework for the early identification and management of jaundice in neonates ≥ 32 weeks gestation. Approximately 60% of neonates born at term and 85% of preterm neonates will develop jaundice. Many of these neonates will develop 'physiological jaundice', which is usually benign. However, when unconjugated serum bilirubin levels are too high, bilirubin can cross the blood brain barrier. Bilirubin is neurotoxic, particularly to the auditory nerve and basal ganglia, which can result in brain injury and lifelong disability. It is important therefore, to identify those neonates at risk of acute bilirubin encephalopathy and kernicterus.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations providing care for neonates ≥ 32 weeks gestation which should include:

- The identification at birth of neonates with risk factors for neonatal jaundice
- Regular visual assessment from birth of all neonates
- Management of neonatal jaundice identified in the first 24 hours of age
- Management of neonatal jaundice identified ≥ 24 hours of age
- Follow-up care for neonates discharged at less than 3 days of age with risk factors for jaundice or jaundice at discharge
- Assessment and escalation of care for neonates with prolonged jaundice > 14 days of age in a term neonate, and beyond 21 days in a preterm neonate.

USE OF THE GUIDELINE

The Chief Executives of all NSW Local Health Districts are responsible for the implementation of this guideline within their services / facilities to ensure:

- Local processes and operating procedures are developed in line with this document to manage neonates ≥ 32 weeks gestation to ensure:
 - Prompt appropriate identification, management and escalation of neonatal jaundice
 - Equipment is used, maintained and its effectiveness is monitored
 - Discharge is planned and follow up processes are in place
 - Assessment and appropriate escalation of care for neonatal jaundice > 14 days of age in a term neonate and beyond 21 days in a preterm neonate.
- The Directors of Clinical Governance inform relevant staff in maternity, neonatal services and biomedical departments of this new Guideline
- Morbidity and mortality associated with neonatal jaundice is monitored and reviewed.

270 (24/11/16)

Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management

Document number [IB2023_028](#) rescinds PD2010_006.

PURPOSE

This Information Bulletin notifies the NSW Health system of the publication of the Clinical Practice Guide [Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management](#).

KEY INFORMATION

The *Hypoxic ischaemic encephalopathy in newborns - recognition, monitoring and early management* provides guidance on the management of newborns with hypoxic ischaemic encephalopathy who may benefit from therapeutic hypothermia.

The Clinical Practice Guide is accompanied by a parent information sheet *Therapeutic hypothermia (cooling) to protect babies with hypoxic ischaemic encephalopathy (HIE)* and the evidence check document *Therapeutic hypothermia in neonatal hypoxic ischemic encephalopathy*.

The management of newborns with HIE includes:

- identification and management of newborns with encephalopathy through the use of the Newborn Encephalopathy Pathway
- assessment of the severity of encephalopathy in newborns using the Encephalopathy Severity Tool every hour in the first six hours of birth
- criteria for initiating therapeutic hypothermia for newborns and initial management in neonatal units.

General principles

Resuscitation and stabilisation of the newborn should be prioritised before commencing therapeutic hypothermia.

Therapeutic hypothermia must not be commenced without discussion with the Newborn and Paediatric Emergency Transport Service (NETS) and a tertiary centre neonatologist.

All newborns for whom therapeutic hypothermia has been commenced should be transferred to a neonatal intensive care unit (NICU) for ongoing management.

Reporting

Reporting processes via the incident management system (ims+) should be in place to monitor the incidence of newborns with moderate or severe encephalopathy. Serious incidents, including term newborns diagnosed with severe HIE or who receive therapeutic hypothermia, should be notified to the NSW Ministry of Health via a Reportable Incident Brief in accordance with the NSW Health Policy Directive Incident Management ([PD2020_047](#)).

347 (27/07/23)

Child Wellbeing and Child Protection Policies and Procedures for NSW Health

Document number [PD2013_007](#) rescinds PD2011_057, IB2010_005, PD2007_023, PD2005_299 and PD2006_104.

PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents / carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

[Children and Young Persons \(Care and Protection\) Act 1998](#)

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit; ♣ Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

[Commission for Children and Young People Act 1998](#) / [Child Protection \(Working with Children\) Act 2012](#)

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

[Ombudsman Act 1974](#)

Maintain systems to prevent 'reportable conduct' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;

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- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the [Mandatory Reporter Guide](#) and seek assistance from the [NSW Health Child Wellbeing Unit](#) to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the [NSW Health Child Wellbeing Unit](#) and the [Family Referral Services](#) to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the [Child Wellbeing and Child Protection - NSW Interagency Guidelines](#) and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and / or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

177 (18/04/13)

Statewide Eyesight Preschooler Screening (StEPS) Program

Document number [PD2018_015](#) rescinds PD2012_001.

PURPOSE

The purpose of this policy directive is to guide StEPS coordinators in the consistent implementation and management of the Statewide Eyesight Preschooler Screening (StEPS) program at the Local Health District (LHD) level.

This policy directive describes the roles and responsibilities of StEPS personnel and training requirements, identifying four year old children for vision screening, vision screening protocols, referral processes and reporting requirements so that childhood vision problems can be detected early and treatment outcomes maximised.

MANDATORY REQUIREMENTS

LHDs must ensure compliance with the requirements set out in this policy directive as the basis for administering the StEPS program in LHDs. Mandatory requirements for the StEPS program are:

- Vision screening protocols relating to consent, vision screening, assessment, referrals, referral follow up, and reporting and data management (Section 2).
- All four year old children in LHDs, including disadvantaged groups and children with special needs, should be offered the StEPS program, to meet StEPS performance benchmarks (Section 3).
- StEPS vision screening staff must be suitably trained and provided with the necessary equipment and resources to conduct vision screening (Sections 4 and 5).
- All standardised templates attached to this policy are used by LHDs when administering the StEPS program (Section 7).
- LHDs must develop operating processes consistent with this policy directive, to maximise screening and meet local needs in each LHD.

IMPLEMENTATION

The Ministry of Health provides funding to assist LHDs in the implementation of the StEPS program in NSW. This policy directive applies to all staff and relevant managers involved in delivering the StEPS program in LHDs across NSW.

Roles and Responsibilities

Ministry:

- Provide mandatory requirements and guidelines for the implementation and management of the StEPS program.
- Evaluate the overall efficiency and performance management of the StEPS program in LHDs across NSW.
- Meet regularly with all LHDs through the StEPS Coordinators Meetings to review overall progress and implementation of the StEPS program in LHDs.
- Ensure the content of this StEPS policy directive is effectively communicated to all staff involved in coordinating the StEPS program in NSW.

LHDs:

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- Actively identify all four year old children in their LHDs to offer them a free StEPS vision screen.
- Assign responsibility and personnel to implement the StEPS program in line with this policy directive.
- Ensure appropriate vision screening staff are employed, that vision screening staff are trained to undertake the StEPS vision screen, and staff are provided with appropriate equipment and resources to carry out the functions of the StEPS program.
- Ensure compliance and full implementation of this policy directive in their LHD.
- Ensure that the budget provided for the StEPS program is expended on implementing the StEPS program.
- Provide all required reports to the Ministry of Health relating to screening activity, referrals, assessments, follow ups, monitoring and reporting.
- ensure that StEPS performance benchmarks are achieved and maintained (Section 3.3)
- Ensure the content of this StEPS policy directive is effectively communicated to all staff involved in implementing the StEPS program in the LHD.

321 (28/05/18)

New Street Service Policy and Procedures

Document number [PD2018_035](#).

PURPOSE

This Policy specifies the procedures and minimum standards for delivering New Street Services, and sets out the NSW Health framework for effective clinical practice in responding to children and young people with harmful sexual behaviours and their carers.

MANDATORY REQUIREMENTS

This Policy requires that New Street Services:

- prioritise the safety and wellbeing of young people who have been sexually harmed and those who are potentially at risk
- facilitate access to treatment for eligible families and caregivers of children and young people aged between 10 and 17 years who have engaged in harmful sexual behaviour, with priority given to those aged between 10 and 14 years, Aboriginal children and children with complex needs
- deliver services in ways which minimise harm
- integrate with NSW Health Violence Abuse and Neglect services, particularly Sexual Assault Services
- collaborate with interagency partners at local and district levels
- operate under a Service Agreement between the Local Health District in which the New Street service is located and the Sydney Children's Hospital Network, to receive clinical direction, advice and support
- comply with New Street staffing profiles as set out in the New Street Service Policy and Procedures
- deliver services in a culturally safe way
- participate in the New Street Advisory Committee
- apply the clinical processes and practices set out in the New Street Service Policy and Procedures
- comply with NSW Health Violence Abuse and Neglect Service Standards.

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- establishing mechanisms to ensure the directives and requirements of the New Street Service Policy and Procedures are applied, achieved and sustained
- ensuring that NSW Health staff understand and are aware of their obligations in relation to the New Street Service Policy and Procedures and related policies and procedures ensuring resources are available to deliver and meet the directives and requirements of the New Street Service Policy and Procedures
- ensuring that NSW Health staff are trained to operationalise and implement the New Street Service Policy and Procedures

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- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the New Street Service Policy and Procedures
- ensuring NSW Health staff are advised that compliance with the New Street Service Policy and Procedures is part of their patient / client care responsibilities.

New Street managers are responsible for:

- ensuring the requirements of the New Street Service Policy and Procedures are disseminated and implemented in their service
- monitoring implementation and compliance with the New Street Service Policy and Procedures.

NSW Health workers are responsible for:

- implementing and complying with the directives and requirements of the New Street Service Policy and Procedures.

321 (21/09/18)

Pasteurised Donor Human Milk For Vulnerable Infants

Document number [PD2018_043](#).

PURPOSE

NSW Health is committed to the safe, equitable and ethical provision of pasteurised donor human milk (PDHM) to vulnerable infants in Neonatal Intensive Care Units (NICU).

Vulnerable infants refer to those infants at an increased risk of necrotising enterocolitis. This includes preterm infants, very low birth weight infants and other infants assessed as clinically high risk.

A partnership between NSW Health and the Australian Red Cross Blood Service (ARCBS) has been established in order to provide PDHM to these infants through the 'NSW Health Agreement for Pasteurised Donor Human Milk'. PDHM is supplied to NICUs on a cost-recovery basis.

This Policy supports mothers of vulnerable infants to optimise lactation; to supplement breast milk feeding of vulnerable infants with PDHM when mothers own milk is insufficient and ensure access to PDHM is equitable across NSW and in accordance with clinical need.

Only facilities with NICUs are eligible to receive PDHM. This Policy outlines the responsibilities of local health districts (districts) and Sydney Children's Hospital Network (SCHN) NICUs who choose to participate in the provision of PDHM to vulnerable infants under the NSW Health Agreement.

MANDATORY REQUIREMENTS

To receive PDHM districts and SCHN must:

- Implement the attached, Pasteurised Donor Human Milk for Vulnerable Infants Protocol (the Protocol)
- Ensure they have sufficient resources to meet the requirements of this service.
- Ensure each ARCBS Milk Bank Coordinator complies with:
 - NSW Health Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases policy.
 - NSW Health Code of Conduct.
 - National Criminal Record completed by ARCBS and sighted by facility.
 - Local orientation procedures.
- Support donor recruitment within their facilities.
- Provide appropriately trained staff to ensure that adequate ongoing lactation support is offered, and that NICU breastfeeding rates on discharge are optimal.
- Provide facility-specific data for the purpose of quarterly performance monitoring in accordance with Section 1.6 in the Protocol.
- Coordinate the management of reactive serology screening results for hospitalbased donors as per Appendix 1 in the Protocol.

IMPLEMENTATION

The districts/SCHN Chief Executives or delegated officers must ensure the NICUs undertake the following actions:

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- All NICU staff are made aware of the Policy and Protocol.
- Appoint an authorised person to act as the 'Agency Contract Manager', as outlined in Section 14 in the Protocol, who will also be the point of contact for supply management in case of PDHM shortage.
- Key personnel are made aware of their responsibilities in the Protocol.
- Designated lead to develop local guidelines to support the implementation of the Policy and Protocol.

Supply of PDHM to NICUs during a shortage is determined by the principles of statewide equity, with state-wide eligibility being determined as per the attached Protocol and not by the individual NICU.

The monitoring reports will be compiled quarterly by the Health and Social Policy Branch, Strategy and Resources Division, Ministry of Health. These reports will be provided to the PDHM Governance Committee and Clinical Advisory Group for review.

Documentation of ARCBS Milk Bank Coordinator compliance with NSW Health policy and Code of Conduct can be performed at one site and these documents shared with other relevant sites to streamline credentialing processes in NSW.

Other relevant NSW Health Policies are:

- [Breastfeeding in NSW: Promotion, Protection and Support](#)
- [Breast Milk: Safe Management](#)

321 (27/11/18)

The First 2000 Days Framework

Document number [PD2019_008](#).

PURPOSE

The First 2000 Days Framework (the Framework) is a strategic policy document which outlines the importance of the first 2000 days in a child's life (from conception to age 5) and what action people within the NSW health system need to take to ensure that all children have the best possible start in life.

MANDATORY REQUIREMENTS

Local Health Districts and Speciality Health Networks will ensure that strategies to implement the First 2000 Days Framework appear within their local plans, commencing by 1 July 2019. Local Health Districts and Specialty Health Networks will provide an annual report, on request, to the NSW Ministry of Health on progress against their implementation plan.

IMPLEMENTATION

Local Health Districts and Specialty Health Networks have lead responsibility for implementing the Framework within their district or network. They are to use the information provided in the Framework about the first 2000 days and opportunities for action to inform local priority setting and planning against the Framework's strategic objectives. The three objectives of the Framework are:

1. All staff in the NSW health system understand and promote the importance of the first 2000 days and the best opportunities for action
2. The NSW health system provides care to all and works in partnership to promote health, wellbeing, capacity and resilience during the first 2000 days
3. The NSW health system provides additional services for those who need specialised help, when they need it.

NSW Ministry of Health, will support implementation of the Framework. The Branch will monitor implementation through annual reports that will be requested from Local Health Districts and Speciality Health Networks about progress towards priorities in their local plans.

321 (08/02/19)

First 2000 Days Implementation Strategy

Document number [IB2021_011](#).

PURPOSE

The NSW Health First 2000 Days Framework Implementation Strategy is a strategic document which will guide NSW Health's implementation of NSW Health Policy Directive *The First 2000 Days Framework* ([PD2019_008](#)).

KEY INFORMATION

NSW Health Policy Directive *The First 2000 Days Framework* (PD2019_008) is a strategy document which outlines the importance of the first 2000 days in a child's life and what actions people within NSW Health need to take to ensure that all children have the best possible start in life.

The [NSW Health First 2000 Days Implementation Strategy](#) was developed to assist Local Health Districts and Specialty Health Networks in implementing the First 2000 Days Framework, including providing information to assist them in developing their local plans.

NSW Ministry of Health is supporting the implementation of the Framework. The Health and Social Policy Branch will monitor implementation through annual reports that will be requested from Local Health Districts and Specialty Health Networks about progress towards priorities from their local plans.

336 (23/03/21)

Maternity - Management of Monochorionic Twin Pregnancy

Document number [GL2020_011](#).

PURPOSE

This Guideline provides best practice guidance to clinicians caring for women with monochorionic (MC) twin pregnancies. It promotes consistent recognition, monitoring, reporting, management and appropriate referral within the tiered NSW Maternity and Neonatal (Perinatal) Networks to optimise fetal and maternal wellbeing.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services. The Guideline:

- endorses the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) recommendations for MC twin pregnancies (see Section 2)
- recommends that women with MC twin pregnancies require as a minimum, antenatal care from a Level 4 maternity service in consultation with a Level 5 or 6 maternity service, and planned birth at a Level 5 or 6 maternity service in line with *NSW Maternity and Neonatal Service Capability Framework* [GL2016_018](#) (see Section 1.6)
- defines minimum standards for the frequency of ultrasound scanning and ultrasound reporting for women with a MC twin pregnancy (see Section 2.2 and Appendix 1)
- recommends all Tiered Perinatal Networks have an agreed pathway to communicate ultrasound scan results between ultrasound departments and maternity care providers in line with *Tiered Networking Arrangements for Perinatal Care in NSW* [PD2020_014](#) (see Section 1.6).

USE OF THE GUIDELINE

Chief Executives of Local Health Districts are responsible for:

- ensuring appropriate referral, escalation and transfer of care for women with MC twin pregnancies in line with this Guideline and *NSW Maternity and Neonatal Service Capability Framework* [GL2016_018](#) (see Section 1.6)
- developing local referral to and reporting pathways for appropriate obstetric ultrasound providers with capability to assess a twin pregnancy (see Section 1.5)
- monitoring and review of outcomes for women diagnosed with MC twin pregnancy (see Section 6).

329 (11/05/20)

Management of Positional Plagiocephaly by Allied Health Professionals

Document number [GL2020_013](#).

GUIDELINE SUMMARY

The Guideline was developed to provide best practice guidance for management of infants with positional plagiocephaly.

The objectives of the Guideline are to:

- assist clinicians working in primary and secondary health service areas with early detection and assessment and of infants with positional plagiocephaly
- provide clinicians with best practice guidance for management of infants diagnosed with positional plagiocephaly
- provide clinicians with best practice guidance for referral of infants with positional plagiocephaly to tertiary services (e.g. Craniofacial–Helmet clinic).

KEY PRINCIPLES

The Guideline should be used in conjunction with the *Physiotherapy management of plagiocephaly* eLearning module available through the NSW Health Education and Training Institute (HETI) online learning portal, My Health Learning.

Key principles for the Guideline are outlined further in Section 1.3. The Guideline is one component of clinical decision making and provides a guide for best practice for clinicians working with infants with suspected or diagnosed positional plagiocephaly.

USE OF THE GUIDELINE

Chief Executives must:

- ensure that the Guideline is adopted and that local policies based on the Guideline are in place in all hospitals and facilities likely to be required to care for children with positional plagiocephaly.

Directors of Clinical Governance are required to:

- inform relevant clinical staff treating paediatric patients of this guideline
- ensure that all staff treating infants are educated and supported in the use of the locally developed protocols for referral and management of positional plagiocephaly.

329 (12/06/20)

Clinical Determination for Boarder Baby Registration

Document number [GL2020_020](#).

GUIDELINE SUMMARY

This Guideline clarifies when a neonate (a baby up to 28 days of age) is required to be registered in the **Patient Administration System** (PAS) as a boarder. It sets out the responsibilities for the assessment and care of neonates who are accommodated in a NSW Public Health Organisation (PHO) to ensure patient safety and quality care.

KEY PRINCIPLES

- A neonate less than 10 days of age who is in hospital cannot be registered as a 'boarder'. Neonates under 10 days of age who remain in hospital or return to hospital because the caregiver (usually the mother) is unwell must be an admitted patient.
- A neonate 10 or more days of age not requiring clinical care, may be a boarder when accompanying the caregiver who is an admitted patient. In this case the neonate is not an admitted patient and should be registered as a boarder.
- A neonate in a PHO must have a clinical assessment by an appropriate medical officer prior to admission or registration as a boarder.
- Regardless of the admission status all neonates should have two identification bands in place preferably on each ankle.
- Care planning for the neonate should be individualised and take into consideration the caregiver's clinical condition, physical and mental health, the impact of treatment on the caregiver's capacity to care for the neonate, and any additional supports required for the family,
- Any neonate, irrespective of age, whose caregiver (or sibling of the same multiple birth) is admitted for treatment of sepsis, must be physically assessed, investigated where appropriate and monitored for sepsis. A neonate in these circumstances would usually be admitted and should not be registered as a boarder.
- Wherever possible caregivers and neonates should not be separated. Support, protection and promotion of breastfeeding is essential.

LOCAL HEALTH DISTRICT RESPONSIBILITIES

Local health districts are responsible for developing local Guidelines, pathways and resources to ensure:

- neonates receive appropriate care in an appropriate place
- assessment, care and care planning is documented
- correct registration of all neonates in the PAS

331 (25/08/20)

Syphilis in Pregnancy and Newborns

Document number [PD2023_029](#).

POLICY STATEMENT

NSW Health is committed to addressing concerning increases in the number of women diagnosed with syphilis in pregnancy (maternal syphilis) and mother-to-child transmission of syphilis (congenital syphilis) resulting in adverse outcomes including preterm birth, low birth weight, congenital anomalies, fetal loss or stillbirth, and neonatal death. Congenital syphilis is an entirely preventable disease and its occurrence reflects a failure of delivery systems for antenatal care and syphilis control programs.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive introduces new antenatal syphilis screening intervals for all pregnant women, and outlines Local Health Districts (Districts), Specialty Health Networks (Networks) and service level responsibilities to ensure appropriate referrals, assessment and management of syphilis in pregnancy and neonates.

This Policy Directive must be read as a supplement to existing gold-standard clinical guidance outlined in the current edition of the Australasian Society for Infectious Diseases (ASID) guidelines [Management of Perinatal Infections](#).

Assessment, diagnosis, and treatment of maternal and congenital syphilis is multifaceted and requires a multidisciplinary response. Leadership at Districts and Networks must ensure that local processes are in place to enable effective implementation of this Policy Directive including identified referral pathways and responsibilities for follow-up of women at risk of syphilis in pregnancy, and pregnant women diagnosed with syphilis in pregnancy.

All pregnant women in NSW must be offered syphilis screening as part of their first antenatal visit blood screen and again at 26-28 weeks gestation. Pregnant women who have received minimal or no antenatal care, or are at risk of missing an appointment, should be opportunistically screened for syphilis and blood-borne viruses Hepatitis B and HIV at the service they present at, regardless of gestation. Documentation of all antenatal syphilis screening must be entered into the relevant District maternity database and medical records.

All positive syphilis results in pregnancy should be discussed with a clinician who has expertise in managing and treating syphilis. Local pathways must be developed to ensure pregnant women are referred to maternity services, and all relevant services are informed including sexual health services, the local public health unit and primary care services to facilitate appropriate contact tracing and treatment where relevant.

Timely assessment and initiation of treatment is essential for all cases of maternal syphilis per the Australasian Society for Infectious Diseases (ASID) guidelines [Management of Perinatal Infections](#). All pregnant women diagnosed and treated for syphilis in pregnancy need the details of their investigations and management, and recommendations for future testing requirements clearly documented in their medical records. Local pathways must be developed to ensure maternal and neonatal assessment is clearly documented in the patient's medical record in a manner that ensures this is flagged at the time the pregnant women presents for birth.

Responsibility for neonatal follow-up must be clearly defined on discharge identifying the most appropriate service as relevant to the local context and woman's needs (such as paediatric outpatient clinic or outreach service). Auditing processes must be developed to monitor and review follow-up care and clinical outcomes.

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All cases of congenital syphilis are to be investigated as a clinical incident and entered into the Incident Management System (ims+) with a harm score relevant to the case. NSW Health employees must be aware of the importance of reporting incidents and near misses to ensure timely investigation and ensure lessons are learnt to facilitate the elimination of congenital syphilis in NSW.

347 (06/10/23)