**CHAPTER 2 - PAEDIATRICS**

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**ALWAYS refer to the electronic copy for the latest version.**
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NEWBORN BLOODSPOT SCREENING POLICY (PD2016_015)

PD2016_015 rescinds PD2006_099.

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

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

All parents / guardians must be told about:
- What information is collected
- Storage of the blood sample
- The potential uses of the information collected
- The potential future uses of the blood sample
- The privacy and protection processes.

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

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

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

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

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

1 BACKGROUND

1.1 Introduction
Newborn bloodspot screening (NBS) detects babies at risk of serious disorders including phenylketonuria, primary congenital hypothyroidism, cystic fibrosis, galactosaemia and rare metabolic disorders of amino acids, organic acids and fatty acid oxidation defects. Early diagnosis and treatment by medication or diet can prevent death or serious complications and can lead to significantly improved outcomes. Among the 100,000 babies born each year in NSW and ACT, over 100 babies are diagnosed with one of these conditions.
A checklist (Appendix 1) has been developed for health professionals to ensure that parents have been provided the information at the most appropriate time about the:

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

1.2 Key definitions

**Must** - Indicates a mandatory action requiring compliance.

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

1.3 Abbreviations

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<td>CF</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>DNA</td>
<td>Deoxyribonucleic acid</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MCAD</td>
<td>Medium chain acyl coenzyme A dehydrogenase</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NBS</td>
<td>Newborn Bloodspot Screening</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Organisation</td>
</tr>
<tr>
<td>PKU</td>
<td>Phenylketonuria</td>
</tr>
<tr>
<td>PPM</td>
<td>Privately practising midwife</td>
</tr>
</tbody>
</table>
FLOWCHART: NEWBORN BLOODSPOT SCREENING PROCESS

ANTENATAL PERIOD
In the last 4-6 weeks of pregnancy

- Provide consumer brochure to parents *Tests To Protect Your Baby*
- Provide an opportunity for questions and discussion
- Offer to show DVD *Tests To Protect Your Baby*

**POSTNATAL PERIOD**
Prior to the screening test

Parents received information?

**Consent gained?**

**YES**

**Written Consent**
Ensure parent completes consent section on NBS card and signs the card prior to sample collection.

Sample collection
- Explain process
- Feeding or holding baby is encouraged
- Ensure the baby is warm and comfortable before blood collection
  - Clean heel with a alcohol wipe or sterile water
- Dry the heel
- Puncture the clean dry heel at the edge of the plantar surface using an automated lancet.
- Wipe away the first drop of blood to remove any contamination
- Completely fill each circle from one side and until the blood has soaked through the paper
- Fill all three circles
- Air dry card for 4 hours
- Send NBS card to laboratory as per local procedure.

**Consent gained?**

**YES**

- Provide consumer brochure to parents *Tests To Protect Your Baby*
- Provide an opportunity for questions and discussion

- Ensure parents/guardians are aware of the risks and benefits of having their baby screened
- Offer discussion with paediatrician or contact with the Director of the Newborn Screening Programme.

**NO**

Documentation
Document in the baby’s clinical notes:
- That information was provided and discussion occurred about NBS
- Consent or Refusal
- That the test occurred if consented
- Date of test

*If NBS refused, document the reason why and steps taken to allay parent/s concerns.*
Document in the baby’s Personal Health Record whether or not the test occurred.

**Consent gained?**

**YES**

- Complete the NBS card with all information required
- Write refusal on the NBS card
- ‘Refusal’ form signed
- Send NBS card and refusal form to laboratory, place copy of refusal form in clinical notes.

**NO**
2 INFORMATION FOR PARENTS / GUARDIANS

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

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

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

3 BLOODSPOT SCREENING

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

Therefore:

- Newborn bloodspot screening must be offered to all babies.
- Parents / guardians should be informed about newborn bloodspot screening during the last four to six weeks of their pregnancy to allow sufficient time for consideration, clarification and informed decision-making
- Prior to the blood sample being collected, the person taking the sample must:
  - Check that parents / guardians have received a copy of the consumer brochure *Newborn Bloodspot Screening*
  - That they have had opportunity for discussion and clarification
  - That they consent to the screening test
  - Cross check patient identification.
The Newborn Bloodspot Screening program screens for approximately 25 medical conditions. Only a small number of babies will be diagnosed with one of the medical conditions of which the following are the more common conditions detected.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidence</th>
<th>Caused by</th>
<th>If left untreated</th>
<th>Treatment</th>
</tr>
</thead>
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<td>Primary congenital hypothyroidism:</td>
<td>1 in 2,600 live births (about 40 babies per year).</td>
<td>Absence or abnormal formation or function of the thyroid gland.</td>
<td>Causes growth and intellectual disability if not treated.</td>
<td>Medication with thyroid hormone started early results in normal growth and development.</td>
</tr>
<tr>
<td>Cystic Fibrosis (CF):</td>
<td>1 in 3,700 live births (about 30 babies per year).</td>
<td>A dysfunctional gene results in thick mucus in different organs throughout the body in particular the lungs and gastrointestinal tract.</td>
<td>Without treatment severe chest infections occur and often very serious failure to thrive leading to early death.</td>
<td>Early commencement of treatment greatly improves the health of individuals with CF.</td>
</tr>
<tr>
<td>Phenyketonuria (PKU):</td>
<td>1 in 10,000 live births (about 10 babies per year).</td>
<td>Inability of the body to break down the essential amino acid phenylalanine.</td>
<td>High blood levels of phenylalanine cause severe intellectual disability if left untreated.</td>
<td>A carefully managed diet low in phenylalanine, started in the first two to three weeks prevents this damage.</td>
</tr>
<tr>
<td>Medium chain acyl coenzyme A dehydrogenase (MCAD) deficiency:</td>
<td>1 in 15,000 births (about 6-8 babies a year).</td>
<td>Inability of the body to completely break down fat.</td>
<td>May be life-threatening or cause severe disability during times of common childhood illnesses.</td>
<td>Extra precautions are taken to ensure adequate energy intake during illnesses.</td>
</tr>
<tr>
<td>Galactosaemia:</td>
<td>1 in 40,000 births (about 1-3 babies per year).</td>
<td>Inability of the body to process galactose, a component of lactose found in milk and other foods.</td>
<td>Life-threatening liver failure and infections can occur.</td>
<td>A galactose-free diet commenced before 2 weeks of age is lifesaving.</td>
</tr>
<tr>
<td>Other rare metabolic disorders:</td>
<td>Rarer disorders that in total affect approximately 20 babies a year.</td>
<td>Some disorders of the metabolism of amino acids, urea cycle, organic acids and fatty acid oxidation can be detected.</td>
<td>Without appropriate management they can have severe disability or death.</td>
<td>Early detection is important as diet and medications can treat most of these disorders.</td>
</tr>
</tbody>
</table>

NOTE: Newborn bloodspot screening detects about 95% of babies with CF. Screening will also detect some babies who may only be healthy carriers. For these babies a sweat test at about six weeks of age determines whether the baby has CF or is a healthy carrier.

5.1 Consent

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

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

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

5.2 Processes for obtaining consent to newborn bloodspot screening

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

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

| Baby’s name: ___________________________ | Signature (Health Professional) | Date: ________________ |
| Provision of the NBS pamphlet: ___________________________ | Date: ________________ |
| Discussion of NBS information: ___________________________ | Date: ________________ |
| Verbal/written consent: ___________________________ | Date: ________________ |
| Completion of sample collection: ___________________________ | Date: ________________ |
5.3 Refusals

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

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

Clinicians should undertake the following:

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


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

6 COLLECTING THE BLOODSPOT SAMPLE

- The process for collecting the bloodspot must be explained to parents
- A blood sample is obtained by heel prick ideally when the baby is 48 to 72 hours old
- The blood sample is placed on a special pre-printed filter paper card
  - Do not use the card if damaged
  - Do not touch the sample area.
- The heel is the preferred site to obtain the sample. In the event that a sample cannot be obtained at the heel and a venepuncture is being undertaken for other tests, this blood can be used for Newborn Bloodspot Screening. In this case clinicians should ensure that the blood obtained is not mixed with other solutions or taken from a tube containing preservative prior to placing the sample on the card. Any blood sample obtained should be placed directly onto the card before being used for other testing purposes
- Mothers / parents / guardians are encouraged to be present and hold the baby during the procedure
- To relieve discomfort for the baby, breast-feeding is encouraged or alternatively comfort measures should be provided
- Should an adverse reaction or injury occur when obtaining the blood sample, a notification should be made through the NSW Health Incident Information Management System (IIMS).
Table 4: Sample collection

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

6.1 Discharge prior to 48 hours of age

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

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

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

7 RESULTS

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

7.1 Repeat blood test

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

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

7.2 Abnormal results

The paediatrician / doctor / privately practising midwife (PPM) identified on the newborn bloodspot screening card is notified of test results which are abnormal, the disorder being considered and any appropriate further samples required. It is the responsibility of this person to ensure that the baby is promptly referred for further investigation and treatment. The name of the person responsible must be filled in on the test card. Where there is uncertainty regarding whose name is to be written, it is recommended that the name be that of the paediatrician of the day.
Newborn bloodspot screening cards are provided by the NSW Newborn Screening Programme, and used in accordance with the NSW Newborn Screening Programme Sampling Information and Guidelines. Contact details are provided in Section 9.

8.1 Information collection and process

The newborn bloodspot screening card collects written information and three bloodspots. ALL INFORMATION must be completed on the card as each field has been included for a specific purpose.

Once the heel prick process has occurred the newborn bloodspot screening card is sent to the laboratory at the NSW Newborn Screening Programme at The Children’s Hospital at Westmead. The laboratory:

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

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

8.2 Privacy, storage, security and retention periods

8.2.1 Privacy, storage and security

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

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

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

8.2.3 Deoxyribonucleic acid (DNA) testing and data

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

8.3 Potential uses of bloodspots

Stored bloodspots have a number of potential uses (Table 5). Any further use must be in compliance with privacy law, NSW Human Tissue Act 1983 and the NSW Human Tissue Legislation Amendment Act 2012. Potential benefits from stored bloodspots include obtaining clinical information for the child and/or the family. Whilst requests for use for this purpose are rare, the information potentially available to families is extremely valuable. Bloodspots may also be used for research to improve newborn screening techniques or develop new tests. Individual consent will be sought before research on any identified sample. However, de-identified samples may be used for ethics committee approved research with the approval of the NSW Newborn Screening Advisory Committee.

8.3.1 Table 5: Potential uses of bloodspot samples

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

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5 NSW Human Tissue Act, 1983
6 NSW Human Tissue Amendment Act, 2012
2. PAEDIATRICS

<table>
<thead>
<tr>
<th>Consent given on the card covers the following:</th>
<th>SEPARATE consent other than on the card is required for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory quality control</strong></td>
<td><strong>Third party access</strong></td>
</tr>
<tr>
<td>• Access to stored samples or information by employers, insurers, police, legal representatives, other relatives or medical practitioners requires written consent of the parent/guardian (or child if of age of consent) or by court order.</td>
<td></td>
</tr>
</tbody>
</table>

| Patient access                                  | **Coronial purposes**                                               |
| • Parents/guardians on behalf of the child or the patient at adulthood have the right to access personal information held about them | • A memorandum of understanding (MOU) between NSW Health and NSW police 2002 sets out parameters and processes for requests for access to newborn bloodspot screening cards. |

| **Access for law enforcement purposes and access and disclosure authorised by law** |                                                |
| • It is possible that access to samples and disclosure of information may be required by court order. |

8.4 Transfer of cards to parents / guardians

The laboratory must retain the bloodspot cards for a minimum of 2 years for quality assurance and audit purposes in accordance with National Pathology Accreditation Advisory Council requirements. Any requests from parents/guardians for the destruction or transfer of the screening cards must be made in writing and must be supported with identification.

**NOTE:** Destruction or transfer of a screening card can only occur after the 2 year retention period is complete.


9 SAMPLING INFORMATION AND GUIDELINES

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

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

These are updated as required to incorporate new information and procedures and are supplied to hospitals / maternity units and privately practising midwives.

**The Guideline is available either online at**
Locked Bag 2012, WENTWORTHVILLE NSW 2145
Telephone: (02) 9845 3255 / 3659, Facsimile: (02) 9845 3800, Email: newborns@chw.edu.au
10 QUALITY ASSURANCE AND MONITORING

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

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

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

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

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

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

11 CONSUMER INFORMATION

Newborn Bloodspot Screening Consumer Brochure

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


NSW & ACT Newborn Screening Tests Education Video for Parents
2. PAEDIATRICS

12 APPENDIX 1: CHECKLIST FOR HEALTH PROFESSIONALS

<table>
<thead>
<tr>
<th>Table 3 Checklist for health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During pregnancy</strong></td>
</tr>
<tr>
<td>Provide the consumer brochure <em>Newborn Bloodspot Screening</em> to parents preferably in the last four to six weeks of pregnancy.</td>
</tr>
<tr>
<td>Provide an opportunity for discussion and questions and offer to show the DVD <em>NSW &amp; ACT Newborn Screening Tests Education Video for Parents</em>.</td>
</tr>
</tbody>
</table>

| **After birth**                             |
| Make sure that parents / guardians have been provided the consumer brochure *Tests to protect your baby*. |
| Make sure that parents/guardians have been provided with an opportunity for discussion and questions. |

| **Inform parents/guardians about:**        |
| 1. Conditions tested – phenylketonuria, galactosaemia, hypothyroidism, cystic fibrosis and rare metabolic disorders. |
| 2. Benefits of testing - diagnosis and treatment can prevent death or serious disability. |
| 3. Collection of blood sample – encourage mothers to be present and breastfeed or offer alternative comfort measures. |
| 4. Information collected – name, date of birth, hospital, etc. |
| 5. Bloodspot storage - minimum of 2 years and in general are stored for up to 18 years – written consent on the back of the card. |
| 6. Bloodspots and record security – governed by privacy and human tissue legislation and Health Department policy. |
| 7. Potential uses of, access to, and storage of bloodspot cards: |
| • Identified cards may be used for family benefit or research and only with separate consent obtained before testing |
| • Non-identifiable cards, i.e. with identifiers permanently removed may be used for research approved by a health research ethics committee and with the approval of the NSW Newborn Screening Advisory Committee – consent on the back of the card |
| • Parents have a right to access their child’s information. Other access requires parental consent except where there is a court order. |
| 8. Inform the parents about how results are conveyed |
| • Normal results |
| • Retesting |
| • Abnormal results. |

| **After all the above information has been provided and discussed:** |
| 1. Record in the mother’s / baby’s medical record that information has been provided and discussed. |
| 2. Obtain and document parent / guardian consent in the baby’s clinical record. |
| 3. Hospital staff are required to complete the relevant section of the baby’s Personal Health Record (Blue Book). |
| 4. If parents refuse testing, see Section 5.3 of this Policy for further guidance |
| 5. Conduct the test following sampling guidelines provided by the NSW Newborn Screening Programme. |
## APPENDIX 2: RELEVANT DOCUMENTS

<table>
<thead>
<tr>
<th>Type</th>
<th>Published by</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Directive</td>
<td>NSW Health</td>
<td><strong>PD2005_406 Consent to Medical Treatment – Patient Information</strong></td>
</tr>
<tr>
<td>Policy Directive</td>
<td>NSW Health</td>
<td>NSW Health Privacy Manual for Health Information as at March 2015:</td>
</tr>
<tr>
<td>Information Bulletin</td>
<td>NSW Health</td>
<td>General Retention and Disposal Authority – Public Health Services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient/Client Records (GDA 17), NSW Department of Health Information Bulletin No 2004/20,</td>
</tr>
<tr>
<td>Policy Directive</td>
<td>NSW Health</td>
<td>Health Care Records - Documentation and Management</td>
</tr>
<tr>
<td>Legislation</td>
<td>NSW Act</td>
<td><strong>Human Tissue ACT 1983</strong></td>
</tr>
<tr>
<td>Legislation</td>
<td>NSW Act</td>
<td><strong>Health Records and Information Privacy Act, 2002</strong></td>
</tr>
<tr>
<td>Legislation</td>
<td>NSW Act</td>
<td><strong>NSW State Records Act, 1998</strong></td>
</tr>
<tr>
<td>Legislation</td>
<td>NSW Act</td>
<td><strong>Privacy and Personal Information Protection Act, 1998</strong></td>
</tr>
<tr>
<td>Legislation</td>
<td>NSW Act</td>
<td><strong>NSW Children and Young Persons (Care and Protection) Act, 1998</strong></td>
</tr>
<tr>
<td>Other Guidelines</td>
<td>Australian Government, Department of Health</td>
<td>National Pathology Accreditation Advisory Council, Retention of laboratory records and diagnostic material.</td>
</tr>
</tbody>
</table>

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2. PAEDIATRICS

14 IMPLEMENTATION CHECKLIST

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

15 ATTACHMENT 1: CONSUMER BROCHURE

PURPOSE
This Policy Directive:
• Provides a framework for action to increase the promotion, protection and support of breastfeeding within the NSW Health system; and
• Clarifies roles and responsibilities to assist in a coordinated effort and a consistent approach across the NSW Health system.
It is expected that the Policy will act to support breastfeeding in the NSW Health system and to enhance and contribute to improved breastfeeding practices within the NSW population.

MANDATORY REQUIREMENTS
Mandatory requirements are outlined in Section 3 of the procedures manual. Mandatory requirements include the provision of support, promotion and protection of breastfeeding across the following Priority Areas:
1. Monitoring and surveillance
2. Health professionals’ education and training
3. Breastfeeding friendly environments (workplaces and childcare settings)
4. Support for breastfeeding in health care settings
5. Breastfeeding support for priority groups
6. Continuity of care, referral pathways and support networks

IMPLEMENTATION
Timeframes
The deadline for implementation of this Policy Directive is June 2016. By June 2016 it is expected that all areas outlined in Section 3 of the Action Plan will have been implemented.

A mid-term review of progress will be conducted in 2013. To inform this report, Directors of Population Health Services, Chief Executives of Local Health Districts and relevant Departmental branch managers will be asked to provide a progress report on policy implementation as of the end of September 2013.

An implementation plan that outlines roles, responsibilities and timeframes for strategies and actions will be developed to accompany the Policy. It is intended that the implementation plan be released by the end of 2011.

Roles and Responsibilities
In accordance with this Policy Directive and Procedures, staff members of the NSW Department of Health and Population Health Services/Local Health Districts are to ensure that the following actions are undertaken:
• Key personnel are made aware of the revised Policy Directive and their responsibilities under it;
• Mandatory Policy Directive requirements (Section 3) are implemented and key personnel (Section 2) engaged; and
• Staff and visitors are informed about local implementation of the policy.

This Policy Directive should be read in conjunction with the NSW Health Fundraising Policy Directive PD2009_067 and NSW Health Sponsorships Policy Directive PD2005_415.
MATUREITY - BREAST MILK: SAFE MANAGEMENT (PD2010_019)

PD2010_019 rescinds PD2006_088.

PURPOSE

This policy outlines the requirements to safely manage expressed breast milk and manage adverse incidents of neonatal exposure to breast milk from a non-birth mother.

MANDATORY REQUIREMENTS

NSW Health facilities are required to safely manage and store expressed breast milk (EBM), and ensure babies are only fed breast milk from their birth mother (section 2.1).

All NSW Health facilities must develop local operational arrangements to manage adverse incidents relating to a baby receiving breast milk from a non-birth mother (Section 5.2) and identify designated officers who can conduct risk assessments in such an event. (Sections 5.4 and 5.5)

IMPLEMENTATION

Chief Executives must ensure:

• all clinical areas that manage EBM implement the strategies outlined in Section 3 to reduce risk of babies receiving incorrect breast milk;
• all staff working in maternity services receive biannual education/updates on safe management of breast milk (Section 4);
• local policy addresses education and communication criteria as outlined in this Policy Directive (Section 4);
• if the exposure of a baby or neonate to breast milk from a non-birth mother occurs maternity services staff implement appropriate management of these events (Section 5).

1. BACKGROUND

1.1 About this document

Area Health Services are required to safely manage and store expressed breast milk (EBM), as babies must only be fed breast milk from their birth mother.

The importance of babies receiving breast milk is well documented, and supported by the NHMRC Infant Feeding Guidelines for Health Workers (2003). Mothers may need to express their breast milk for a variety of reasons, if their infant is sick or premature, if mother and baby are temporarily separated, or in order to increase the existing milk supply.

Breast milk has the potential for the possible transmission of infectious pathogens if contaminated and/or given to the wrong infant. The risk of transmission of disease by this route is low but is possible.

It is important to note that there is the potential for babies to receive incorrect breast milk in any clinical area where mothers and babies are separated and/or expressed breast milk (EBM) is dispensed. Factors that may lead to babies receiving the incorrect breast milk include the separation of mothers and babies, inadequate identification processes, and the absence of systems to manage safe storage and dispensing of EBM (Section 2).
2. PAEDIATRICS

Maternity Services must ensure that strategies to reduce risk of babies receiving incorrect breast milk are implemented (Section 2).

All staff working in maternity services must receive biannual/education updates on safe management of breast milk and local policy should address the content of this Policy Directive (Section 3).

When the exposure of a baby or neonate to breast milk from a non birth mother occurs. Maternity services staff must implement appropriate management of these events when they occur (Section 4).

1.2 Related Documents

This Policy Directive should be read in conjunction with the following policy directives:

- **PD2011_042 Breastfeeding in NSW: Promotion, Protection and Support.**
- **NSW DoH Safety Advocate (July 2004).**
- **PD2014_004 Incident Management Policy** - Advice to staff on the effective response to all corporate and clinical incidents that occur in the health system. Contains important information on the legal aspects of health care incident management, the requirements for a privileged Root Cause Analysis (RCA) and information on privilege and Reportable Incident Briefs (RIB).
- **PD2005_311 HIV, Hepatitis B and Hepatitis C - Management of Healthcare Workers Potentially Exposed** provides direction on the management of potential exposure to infectious pathogens.
- **PD2005_222 Hepatitis B Vaccination Policy** - Specifies how and when specific groups of persons are to be offered Hepatitis B vaccine. Also covers reporting requirements.
- **Open Disclosure Policy PD2014_028.** All Health Services are required to have appropriate local procedures in place to ensure consistency and compliance with the policy.

2. RATIONALE

2.1 Area Health Services are required to:

- Safely manage and store expressed breast milk (EBM)
- Ensure babies are breastfed by their birth mother, except for current milk banks which have been approved by the Chief Executive.

Area Health Services (AHSs) should make local arrangements for special circumstances such as adoption, same sex couples, foster carers and surrogacy.

2.2 The importance of babies receiving breast milk is well documented, and supported by the NHMRC Infant Feeding Guidelines for Health Workers (2003). Mothers may need to express their breast milk for a variety of reasons, if their infant is sick or premature, if mother and baby are temporarily separated, or in order to increase the existing milk supply.

2.3 Breast milk has the potential for the possible transmission of infectious pathogens if contaminated and/or given to the wrong infant. The risk of transmission of disease by this route is low but is possible.
2.16

2.4 It is important to note that there is the potential for babies to receive incorrect breast milk in any clinical area where mothers and babies are separated and/or expressed breast milk (EBM) is dispensed. Factors that may lead to babies receiving the incorrect breast milk include the separation of mothers and babies, inadequate identification processes, and the absence of systems to manage safe storage and dispensing of EBM.

3. STRATEGIES TO REDUCE THE RISK OF BABIES RECEIVING INCORRECT BREAST MILK

Unless clinically indicated, babies should not be separated from their mothers for any length of time. Ideally, babies should “room in” with their mothers in order to promote successful breastfeeding.

All clinical areas that manage EBM or where breast-fed babies are potentially separated from their mothers should implement the following strategies (incorporate into local policies):

3.1 Separation of Mothers and Babies

Babies must not be separated from their mothers without a compelling reason.

Where Babies must be separated from their Mothers

- On return to their mother, two members of staff, or one member of staff and the mother if appropriate, should check identification of both mother and baby prior to breastfeeding or feeding of EBM.
- When babies and mothers are separated, for example, when babies are admitted to the Neonatal Intensive Care Unit (NICU), a procedure should be implemented to ensure the correct identification of these babies at all times (See 3.2).

3.2 Identification of Babies

- Ensure that all babies have secure identification in place on two sites (ideally two ankles) at all times according to the facility/hospital local policy.
- Communicate to parents the importance of ensuring that their baby has correct identification tags at all times.
- Replace identification tags immediately if removed and encourage parents to report loss of tags when it occurs.
- Be aware of babies with similar or the same names and have a system for managing this occurrence. For example, babies with the same name should not be accommodated in the same room, unless clinically indicated.

3.3 Storage Fridge/Freezer Environment

- Appropriately sized fridges/freezers should be available for the storage of expressed breast milk (EBM) to avoid overcrowding.
- EBM should be refrigerated at 4°C and only up to 48 hours. Thawed EBM should be used within 24 hours.
- If EBM is to be transported (for example, from the mother’s home), frozen EBM must be maintained in a completely frozen state and refrigerated EBM kept at 4°C by using appropriate equipment (such as an esky and freezer brick). It should be placed in the refrigerator (or in the freezer if it is still frozen) immediately upon arrival.
2. PAEDIATRICS

- EBM brought in from home should be checked in to the milk fridge/freezer by two staff, or one staff and one parent if appropriate.

- Each baby should have an allocated area and a labelled storage basket/container for the EBM in the fridge/freezer. All EBM containers should be consistently, correctly and clearly labelled using moisture-resistant ink, with the following information:
  - the baby’s and mother’s names
  - baby’s medical record number
  - contents (eg. EBM)
  - any additives
  - date and time expressed, and
  - date and time thawed.

- Policy regarding labeling must apply equally to EBM expressed in the hospital and to EBM brought from home to the hospital facility.

- A specific label is recommended if existing EBM container labels are unable to accommodate this information.

- A member of staff should be allocated to check the fridge on each shift for all of the above, using a locally agreed process.

3.4 Dispensing of EBM

- EBM that is dispensed into a second or third container/syringe should be checked with the original EBM container at that time. It should be correctly labelled and signed by two members of staff, or one member of staff and the mother if appropriate. EBM must have two (preferably three) of the following identifiers: the name of the mother, name of the baby and the baby’s medical record number (MRN). Other identifiers include date of birth of the baby, and the mother’s MRN.

- Ensure that labeling is complete for each EBM container before dispensing further EBM.

- Never refreeze or reheat EBM.

- Do not use a microwave to thaw EBM. Thaw EBM by standing the container in either cool or warm water. Check to ensure identification labels do not become loose while being warmed using this method. EBM can also be thawed in the fridge. Thaw frozen breast milk by moving it from the freezer to the fridge for slow thawing over 24 hours.

- If a feed is delayed, EBM should never be left at the bedside.

3.5 Checking of EBM prior to Feeding a Baby

Two members of staff, or one member of staff and the mother if appropriate, should always undertake identification of the EBM and checking the baby’s identification bands. The checking of EBM should be treated the same as checking medications prior to administration.

Ensure the following:

- Correct EBM: by cross checking the details identified on the EBM identification label are a match with the baby’s identification tags.

- Correct feeding time and amount: by checking the EBM identification label with the baby’s feed chart.
2. PAEDIATRICS

- Correct baby: by checking the baby’s identification tags and signing off on the baby’s feeding chart that this check is correct prior to the baby receiving EBM.

4. EDUCATION/COMMUNICATION

4.1 All staff managing breast milk/EBM must comply with this directive, and receive biannual education/updates on this issue.

4.2 A local policy should address the content of this policy direction to ensure that:

- All policy changes relating to breastfeeding/EBM are communicated with staff through appropriate formal in-service education processes e.g. seminars, ward meetings.
- All casual and pool/relieving staff who are working in these areas are aware of current policy and practice in relation to the safe management and storage of EBM.
- All parents are provided with appropriate information regarding the collection, labeling, and storage of EBM and that they are coherent with the unit policies for checking, storage and management of EBM.
- Parents are made aware that the best place for their baby in postnatal wards is next to their own bed.
- Staff and parents are aware of the potential risks should a baby mistakenly receive incorrect breast milk. In the event of this occurring, the correct “exposure” procedures should be followed.

5. MANAGEMENT OF NEONATAL EXPOSURE TO BREASTMILK FROM A NON-BIRTH MOTHER

5.1 Background

There is a small but possible risk of transmission of infectious agents from the ingestion of breast milk. Twenty-one infectious agents have been identified in breast milk but only a small number of these agents have been shown to be transmitted via breast milk (see Appendix 1).

The exposure of a baby or neonate to breast milk from a non-birth mother may arise in the following circumstances:

- EBM from one mother is given to another mother’s baby in error; or
- A mother inadvertently breastfeeds a baby other than her own.

5.2 Local Operational Arrangements

All NSW Health facilities must develop local operational arrangements to manage adverse incidents relating to a baby receiving breast milk from a non-birth mother (an example flowchart and checklist is provided in Appendix 2).

These arrangements must include:

- An immediate response plan to manage the incident (see 4.3).
- Reporting of all incidents to the appropriate medical, nursing/midwifery and infection control personnel immediately. Guidelines for reporting to the Department of Health by IIMS (Incident Information Management System) and RIBs (Reportable Incident Brief) are set out in PD2014_004 Incident Management Policy.

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2. **PAEDIATRICS**

- Counselling of both the source mother/parents and exposed baby’s mother/parents in the event of an incorrect breast milk feed occurring.
- An individual assessment of clinical risk factors to identify the appropriate screening and follow up pathology tests that should be obtained. This will include obtaining informed consent from both the source mother and the birthmother.
- Ensure that mothers who allow another mother to breastfeed their baby (outside a NSW Health Care Facility) are informed of the associated risks.
- Adequate processes to check and audit incidents for causation. If required, local procedures for the management of breast milk must be appropriately amended in accordance with this Policy Directive and staff must be informed of the amendments.
- Provision of information regarding the risks associated with a single breast milk feed from a non-birth mother (noting that information from the literature on the risk of transmission from one episode is not available, but has to be extrapolated from long term exposure of babies to maternal breast milk).

5.3 **Immediate Response - Treatment of Baby**

If the baby is being fed EBM via a nasogastric or *orogastric* tube and the incident is identified at the time of feeding, aspirate the stomach contents immediately. The feed can be aspirated up to 30 minutes after feeding but only if the nasogastric or *orogastric* tube is still in situ.

If the baby is not being fed EBM via a nasogastric or orogastric tube, proceed to a risk assessment of the source (non-birth) mother (see 4.4). Nasogastric or orogastric tubes must not be inserted for the purpose of aspirating EBM.

5.4 **Risk Assessment of the Source (non-birth) Mother**

Each facility must identify designated officers who can conduct risk assessments that include:

- An assessment of the clinical status of the source mother at the time of breast milk collection/expression or feeding with regard to:
  - the presence of fever
  - the presence of rash (including vesicles on the breast), and
  - the presence of mastitis, breast abscess or bleeding nipple.
- Checking the source mother’s antenatal serology for previous results, e.g. syphilis, hepatitis C (HCV) antibodies, hepatitis B (HBV), and Human Immunodeficiency virus (HIV) antibodies.
- Checking for a history of HBV vaccination.
- Checking medications prescribed to the source mother.
- Where recent serological results are lacking, discussing risk factors for blood borne viruses (HIV, HBV and HCV) and syphilis in the source mother. These include:

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- Injecting drug use
- Birthplace or previous residence or travel in a country with high prevalence of HIV (see Appendix 3) or other blood borne viruses (as identified by an appropriate specialist; see 4.7)
- Tattoo or piercing
- History of syphilis (including date and treatment)
- Blood transfusion history or possible iatrogenic exposure to a blood borne virus, and
- Unprotected sex with a partner who has or is at risk of having a blood borne virus.

It is important this information is obtained by an experienced clinical staff member, and that these questions are asked in an appropriate manner. The clinician must be cognisant of the source mother’s emotional state during questioning, and adequate counselling must be provided during the questioning about these sensitive areas (see 4.8).

- Provision of pre and post-test counselling and support, obtaining consent to collect appropriate serology and breast milk (as per 4.6 below).
- Arranging an appointment to discuss results and arrangements for follow-up blood testing if required.

5.5 Risk Assessment of the Exposed Baby’s Birth Mother/Parents

Each facility must identify designated officers who can conduct risk assessments maintaining the following principles:

- The confidentiality of the source mother is maintained.
- The legal right of the source mother to refuse testing is recognised.
- The reason for testing of the mother and not the baby is clearly explained.
- There is open disclosure to the birthmother/parents regarding the incident.
- The birthmother is advised of any potential risks associated with the exposure (see Appendix 1) and appropriate measures to be taken.
- Pre and post-test counselling is provided and informed consent is obtained to collect appropriate serology and breast milk (as per 4.6 below).
- An appointment is arranged to discuss test results and arrangements for follow-up blood testing, and
- The parents of the affected baby are informed of the appropriate follow up and/or treatments required for their baby, and are offered counselling and support.

All information should be documented in both the source mother’s clinical records and the exposed baby’s medical records. The source mother SHOULD NOT be identified during any counselling sessions.
2. PAEDIATRICS

5.6 Serological and Breast Milk Screening

Testing should be expedited, in order to inform appropriate treatment to the baby, should it be required. Pre and post-test counselling must be conducted and informed consent obtained for testing.

It is recommended that at the time of the exposure the following should be collected from the source mother and the mother of the exposed baby:

<table>
<thead>
<tr>
<th>Blood</th>
<th>HIV RNA NAT, HIV proviral DNA (if available) and HIV antibody/antigen test. However this information will be unlikely to be available in time to guide initiation of prophylactic therapy of the baby.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCV antibody test, HCV RNA test.</td>
</tr>
<tr>
<td></td>
<td>HBV surface antigen, HBV core antibody.</td>
</tr>
<tr>
<td>Breast milk</td>
<td>Cytomegalovirus (CMV) NAT (if baby is less than one month of age, or has underlying immune deficiency illness).</td>
</tr>
</tbody>
</table>

Where the risk assessment of the source mother identifies risk factors that may indicate a potential window period for HIV infection HIV serology should be repeated on both mothers 3 months after the exposure of the newborn.

If a result from either mother is positive or equivocal, further investigations and management will be required for the exposed newborn, and should be discussed with an ID physician or other appropriate consultant.

Additional testing should also be discussed with a clinical microbiologist or ID physician if the source mother is clinically unwell (e.g. fever, breast abscess).

If post-exposure HBV immunoglobulin, HBV vaccination, HIV post-exposure prophylaxis (PEP) and/or CMV antiviral therapy are clinically appropriate or being considered, instigation and management must be undertaken with advice from clinicians with relevant expertise.

5.7 Non-consent to Testing

If either of the mothers decline consent for testing, then the baby’s blood or urine should be taken for CMV testing, with parental consent.

The relative risk of the source mother being infected with HIV or HBV must be assessed from epidemiological and historical information and the baby treated appropriate to the level of risk. This must be done in consultation with an ID physician, experienced HIV physician, or virologist.

5.8 Counselling

Hospitals should identify individuals with appropriate clinical expertise and provide them with appropriate training if needed to counsel mothers in relation to breast milk feeding from a non-birth mother. For cases with cultural sensitivities regarding the exchange (deliberate or accidental) of breast milk, NSW Health staff can consult with the NSW Multicultural Health Communication Service for advice on effective communication.

---

5.9 Management and Treatment for the Source and Birth Mothers

If the source mother or birthmother is found to have positive results for HIV, HBV or HCV during the screening process they must be referred immediately to a clinician with relevant expertise for appropriate management.

5.10 Management and Treatment for the Baby

Treatment for the baby who has inadvertently been fed breast milk from a non-birth mother is as follows:

If the results of testing in the source mother are all negative, no further action is required.

If the source mother is HIV positive:
- Sydney Children’s Hospital, Randwick offers statewide expertise in the management of paediatric HIV disease; an expert clinician should be consulted regarding the event and, if required, advice on antiretroviral HIV prophylaxis doses for infants or neonates.

If the source mother is HBsAg or hepatitis B DNA positive:
- hepatitis B immunoglobulin (ideally within 24 hours of exposure); and
- commence hepatitis B vaccination (in a different limb) if birth dose of HBV vaccine has not already been administered (refer to PD2005_222 Hepatitis B Vaccination Policy).

If testing of the source is not possible with rapid availability of results and the source is assessed to be at high risk of being HBsAg or DNA positive (that is, is a person from an endemic country or known to have engaged in risk behaviours which may have exposed them to hepatitis B), advice should be sought from an expert clinician regarding the need for administration of hepatitis B immunoglobulin to the exposed baby.

If the source mother is HCV positive:
- the baby should be referred to a clinician with expertise in the management of HCV.

If either mother is CMV positive:
- the baby should be referred to a clinician with expertise in the management of CMV, for example a paediatrician.

Advice regarding these or any other infection risk (other than HIV) should be sought from the relevant tertiary children’s hospital supporting the NSW Child Health Network domain in which the event occurred (see contact details Appendix 4).

6. DOCUMENTATION

All screening, management plans, results and counselling are to be contemporaneously documented in the relevant medical record.

7. MONITORING

Audit to assess compliance with this Policy Directive should be undertaken on a yearly basis.
8. REFERENCES

## APPENDIX 1 Infectious agents transmitted via breast milk

<table>
<thead>
<tr>
<th>Agents</th>
<th>Transmission Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bacteria</strong></td>
<td>Bacteria, particularly normal skin flora, may be present in expressed breast milk. Bacteria in breast milk are extremely unlikely to cause infections in healthy neonates or infants. The absence of clinical features in the source (mother) such as fever, mastitis, and breast abscess further reduces the risk for transmission of bacteria. Neonates and infants are monitored for signs and symptoms of sepsis as part of general routine care. A number of viruses have been found to be present in breast milk and some have been implicated in transmission. This transmission has occurred with regular breastfeeding rather than a one-off feed.</td>
</tr>
<tr>
<td><strong>Human Immunodeficiency Virus (HIV)</strong></td>
<td>HIV RNA has been identified in infected mothers’ breast milk and HIV can be transmitted by breast milk. The risk of HIV transmission from expressed breast milk consumed by a neonate or baby is considered to be very low because: 1. women who are HIV positive and aware of that fact are advised not to breastfeed their babies; 2. chemicals present in breast milk act, together with time and cold temperatures, to destroy the HIV present in expressed breast milk; and 3. transmission of HIV from a single breast milk exposure has never been documented.</td>
</tr>
<tr>
<td><strong>Cytomegalovirus (CMV)</strong></td>
<td>Transmission of CMV has been well recognised after primary or recurrent maternal CMV infection. Babies at particular risk from CMV infection include premature infants; those with very low birth weight (less than 2000 grams); and babies with T cell immune deficiency.</td>
</tr>
<tr>
<td><strong>Hepatitis B (HBV)</strong></td>
<td>HBV particles have been detected in human milk, but have been identified as extremely low risk in causing transmission of the virus and disease in neonates or infants.</td>
</tr>
<tr>
<td><strong>Hepatitis C (HCV)</strong></td>
<td>Hepatitis C RNA and antibodies have been detected in breast milk. The role of infected breast milk in the transmission of HCV remains unclear, but is considered to be extremely low risk.</td>
</tr>
<tr>
<td><strong>Human T cell leukaemia virus type I (HTLV1)</strong></td>
<td>HTLV1 can be transmitted by breastfeeding. The virus occurs in general populations in Japan, the West Indies, parts of Africa and South America, and in many Aboriginal populations in central and northern Australia.</td>
</tr>
<tr>
<td><strong>Human T cell leukaemia virus type II (HTLVII)</strong></td>
<td>HTLVII DNA has been detected in breast milk however the epidemiology of transmission to the baby and risk of subsequent disease are unclear. HTLVII has been identified in some indigenous populations and the risk of transmission is considered to be extremely low.</td>
</tr>
<tr>
<td><strong>Herpes simplex virus types 1 &amp; 2 (HSV 1&amp;2)</strong></td>
<td>HSV 1 &amp; 2 can be found in breast milk. Active lesions and viral shedding have been implicated in transmission of the disease.</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>Wild-type and vaccine rubella virus have been isolated from breast milk but other routes of infection are more likely. There are high rates of immunity to Rubella and the mother’s status should be known from antenatal screening.</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>There is no evidence that syphilis can be transmitted by breast milk alone. The presence of clinical features of syphilis infection in the source mother (particularly syphilitic lesions on the breast) has been associated with the transmission of syphilis.</td>
</tr>
<tr>
<td><strong>Varicella Zoster Virus (VZV)</strong></td>
<td>Breastfeeding is not considered to be a significant route of transmission for VZV.</td>
</tr>
</tbody>
</table>

---

### APPENDIX 2 Checklist – Exposure of baby to breast milk from a non-birth mother

<table>
<thead>
<tr>
<th>Exposure checklist</th>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
</table>
| 1. Breast milk feeding from a non-birth mother verified | Yes No | Date of exposure:  
Time of exposure:  
Time identified: |
| 2. Breast milk feed aspirated from infant stomach (only if nasogastric or orogastric tube is in situ at time of incident or still in situ and <30 minutes after event) | Yes No | Date of aspiration:  
Time aspiration: |
| 3. The birthmother/parents have been informed of the exposure and relevant information and fact sheets provided | Yes No | Date informed:  
Counselling provided by:  
Time informed: |
| 4. A clinical assessment has been performed on the source (non-birth) mother at time of breast milk collection/expression or feeding | Yes No | Date of assessment:  
Presence of fever:  
Presence of rash (including vesicles on the breast):  
Presence of mastitis or breast abscess or bleeding nipples: |
| 5. A check of the antenatal serology for previous results has been done for:  
a) Non-birth mother  
b) Birthmother | Yes Yes No No | Non-birth mother  
Birthmother  
Rubella:  
Syphilis:  
HCV antibodies:  
HBV:  
HIV antibodies:  
CMV: |
| 6. Risk factors for blood borne viruses and/or syphilis have been identified | Yes No | If Yes, indicate which:  
o Injecting Drug Use:  
o Birthplace or previous residence or travel in a country with high prevalence of HIV: |
### Exposure checklist

<table>
<thead>
<tr>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
</table>
|           | o Birthplace or previous residence or travel in a country with high prevalence of HBV or HCV:  
o Tattoo or piercing  
o History of syphilis (including date and treatment):  
  o Blood transfusion history or possible iatrogenic exposure to a blood borne virus  
  o Unprotected sex with a partner who has or is at risk of having a blood borne virus  
  o Other risk factors: |
| Yes       | List relevant medications: |
| No        |                               |
|           |                               |

7. A check of medications prescribed to source mother has been conducted

<table>
<thead>
<tr>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>List relevant medications:</td>
</tr>
</tbody>
</table>

8. Pre and post test counselling provided and consent given for relevant serological testing for:
   (a) Non-birth mother  
   (b) Birthmother

<table>
<thead>
<tr>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
<tr>
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<td></td>
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<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name of counsellor:</td>
</tr>
<tr>
<td></td>
<td>Name of counsellor:</td>
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9. Infectious Diseases Physician consulted

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</tr>
<tr>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td></td>
<td>Time:</td>
</tr>
<tr>
<td></td>
<td>Name:</td>
</tr>
<tr>
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<td>Facility/Hub:</td>
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10. Appropriate testing for exposure performed on non-birth mother

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<tr>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date collected:</td>
</tr>
<tr>
<td></td>
<td>Time collected:</td>
</tr>
</tbody>
</table>
|           | Blood - HIV RNA NAT:  
  HIV proviral DNA (if available):  
  HIV antigen:  
  HCV antibody:  
  HCV RNA: |
## 2. Exposures

<table>
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<tr>
<td></td>
<td></td>
<td>HBV surface antigen:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HBV core antibody:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breast milk - CMV NAT (if baby less than one month of age):</td>
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### 11. Appropriate testing for exposure performed on birthmother

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date collected</th>
<th>Time collected</th>
</tr>
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<tr>
<td>Blood - HIV RNA NAT:</td>
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</tr>
<tr>
<td>HIV proviral DNA (if available):</td>
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<tr>
<td>HCV RNA:</td>
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</tr>
<tr>
<td>HBV surface antigen:</td>
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<td></td>
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</tr>
<tr>
<td>HBV core antibody:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast milk - CMV NAT (if baby less than one month of age-corrected):</td>
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<td></td>
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</table>

### 12. Arrangement for appointment to discuss results and arrangement for follow-up blood testing:

#### a) Non-birth mother

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Recommended follow up: Yes</th>
<th>No</th>
<th>Appointment date:</th>
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</table>

#### b) Birthmother/parent

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Recommended follow up: Yes</th>
<th>No</th>
<th>Appointment date:</th>
</tr>
</thead>
</table>

### 13. Results of testing for exposure reviewed:

#### a) Non-birth mother

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date:</th>
<th>Time:</th>
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</thead>
</table>

#### b) Birthmother

<table>
<thead>
<tr>
<th></th>
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<th>No</th>
<th>Date:</th>
<th>Time:</th>
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</table>
### Exposure checklist

<table>
<thead>
<tr>
<th>Exposure checklist</th>
<th>Completed</th>
<th>Results/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Exposed baby requires treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B immunoglobulin and/or vaccine given</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV prophylaxis given (access via Paediatric specialist hospital)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infant hepatitis B immunoglobulin: Date: Time:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commence hepatitis B vaccination (in a different limb) if birth dose of HBV vaccine has not already been administered. Date: Time:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV prophylaxis commenced: Date: Time:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single/double/triple therapy:</td>
</tr>
<tr>
<td>15. Incident has been documented and reported appropriately:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(a) Baby’s medical record:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(b) Source mother’s medical record:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(c) IIMS:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
INCIDENT OCCURS
Expressed breast milk from one mother is given to another mother’s baby in error; or a mother inadvertently breastfeeds a baby other than her own

Source Mother
- Advise source mother of event and action to be taken
- Advise of confidentiality

Risk assessment
- Assess clinical status
- Check antenatal serology
- Check medications
- Discuss risk factors

Pathology testing
- Obtain written consent
- Provide pre and post-test counselling
- Collect appropriate serology and breast milk

Follow up results
- Arrange for appointment to discuss results
- Arrangement for follow-up blood testing if required

Positive Results
- Refer to a clinician with appropriate expertise for immediate treatment and management

Exposed baby
Aspirate the stomach contents <30mins (if NGT or OGT in situ)

Risk assessment
- Check antenatal serology

Pathology testing
- Collect baby’s blood or urine for CMV with parental consent

Positive Results
- Refer to a clinician with appropriate expertise for immediate treatment and management

Follow up baby in 3 months
- If source tested at 3 months, provide results
- If source declined testing and is high risk, arrange for baby to have HIV, HBV and HCV serology with parental consent
- Provide pre and post-test counselling
- Arrange follow up for results

Non-consent
- Collect baby’s blood or urine for CMV with parental consent

Positive Results
- Refer to a clinician with appropriate expertise for immediate treatment and management

Biological Mother/ Parents
- Advise biological mother/parents of event and action to be taken
- Advise of risks and provide information and fact sheets

Risk assessment
- Assess clinical status
- Check antenatal serology
- Check medications
- Discuss risk factors

Pathology testing
- Obtain written consent
- Provide pre and post-test counselling
- Collect appropriate serology and breast milk

Follow up results
- Arrange for appointment to discuss results
- Arrangement for follow-up blood testing if required

Positive Results
- Refer to a clinician with appropriate expertise for immediate treatment and management
## APPENDIX 3 - Estimated Adult (15-49) prevalence of HIV, 2007


**Notice:** Estimates only.

<table>
<thead>
<tr>
<th>Region/Country</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa – Regional Estimate</td>
<td>5</td>
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<tr>
<td>Angola</td>
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<tr>
<td>Benin</td>
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<tr>
<td>Botswana</td>
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<tr>
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<tr>
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<td>Chad</td>
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<tr>
<td>Comoros</td>
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<tr>
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<tr>
<td>Côte d’Ivoire</td>
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</tr>
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<tr>
<td>Zimbabwe</td>
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</table>

### East Asia - Regional Estimate

<table>
<thead>
<tr>
<th>Region/Country</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>0.1</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
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</tr>
<tr>
<td>Japan</td>
<td>...</td>
</tr>
<tr>
<td>Mongolia</td>
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</tr>
<tr>
<td>Republic of Korea</td>
<td>&lt;0.1</td>
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<td>New Zealand</td>
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84(25/03/10)
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APPENDIX 4 Contact points for specialised advice

As per Section 4.10, advice regarding infection risk, investigations and management should be sought from the relevant tertiary children’s hospital supporting the NSW Child Health Network domain in which the event occurred.

Appropriate contacts are as follows:

For HIV (State-wide):

*Sydney Children’s Hospital*
Larissa Mackey, CNC HIV Immunology 9382 1654
Alternatively, contact the consultant on-call for Infectious Diseases via switch 9382 1111

All other queries:

- In Northern Child Health Network (Hunter New England and North Coast):

  *John Hunter Children’s Hospital*
  Contact the Infectious Diseases team member on-call via switch 49213000

- In Western Child Health Network (Greater Western, Northern Sydney Central Coast, Sydney South West and Sydney West):

  *The Children’s Hospital at Westmead*
  A/Prof Cheryl Jones, Paediatric ID Consultant 9845 3448
  Alternatively, the consultant on-call for Infectious Diseases via switch 9845 0000

- In Greater Eastern and Southern Child Health Network (Greater Southern, South Eastern Sydney Illawarra, Sydney South West, Northern Sydney Central Coast and ACT Health):

  *Sydney Children’s Hospital*
  Consultant on-call for Infectious Diseases via switch 9382 1111

APNOEA MONITORS (GL2012_002)

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

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

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

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

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

GROWTH ASSESSMENT IN CHILDREN AND WEIGHT STATUS ASSESSMENT IN ADULTS
(GL2017_021 issued 17/11/2017)

PURPOSE

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

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

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

To download the guideline go to [Growth Assessment in Children and Weight Status Assessment in Adults](http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A) 296(17/11/17)

ROUTINE CIRCUMCISION OF NORMAL MALE INFANTS - POLICY (PD2012_009)


PURPOSE

To ensure a consistent, evidence-based, state-wide policy approach to the routine circumcision of normal male infants in the NSW Public Health System. It does not relate to cases where there is a clear clinical need for intervention, nor directly to adult male circumcision.

MANDATORY REQUIREMENTS

Consistent with the advice of the NSW Maternity and Perinatal Committee and the Maternity and Perinatal Health Priority Taskforce, NSW Health endorses the 2010 statement of the Paediatrics & Child Health Division of the Royal Australasian College of Physicians (RACP) on Circumcision of Infant Males. Information from the RACP for doctors and parents is available at [http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A](http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A)

*This Policy Directive is to be read in conjunction with [PD2012_011 Waiting Time and Elective Surgery Policy](http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A) and [IB2012_004 Advice for Referring and Treating Doctors - Waiting Time & Elective Surgery Policy](http://www.racp.edu.au/index.cfm?objectid=7424E1CD-0C3B-2516-C2EC3ACB1099A79A), which place ‘social circumcision’ (ie not clinically indicated) on a list of surgical procedures 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.”

IMPLEMENTATION

**Local Health Districts are responsible for ensuring that:**

- Routine circumcision of infant males is not performed in public hospitals in NSW.
- Where parents request circumcision for their infant son, they will be provided with accurate, unbiased and up-to-date information on the risks and benefits of the procedure. The RACP Parent Resource is appropriate for this purpose and is available at the RACP website. Parents who request further information should also be referred to the RACP Statement.

146(02/02/12)
2. **PAEDIATRICS**

**CRITICAL CARE TERTIARY REFERRAL NETWORKS (PERINATAL) (PD2010_069)**


**PURPOSE**

This Policy Directive relates to critically ill neonates and women with high risk pregnancies that require inter-hospital transfer, and should be read in conjunction with the Policy Directive PD2010_021; Critical Care Tertiary Referral Networks & Transfer of Care (Adults).

Pursuing ‘best practice’ perinatal care across NSW requires services to embrace an integrated model of maternity care that recognises the need for effectively linked and networked services across primary (role delineation 1 to 3), secondary (role delineation 3 to 5) and tertiary (role delineation 5 and 6) levels of care. This Policy Directive does not replace the requirement for Area Health Services to ensure the establishment and maintenance of tiered networks for the provision of timely access to higher levels of obstetric and neonatal support for women and babies as the need arises.

The NSW Critical Care Tertiary Referral Networks (Perinatal) Policy Directive defines the links between referring hospitals and tertiary referral hospitals, taking into account unit: capacity; AHS birth rates; and, ensuring functional clinical referral relationships.

**MANDATORY REQUIREMENTS**

Each AHS is required to make certain that escalation plans are in place to ensure the appropriate accommodation of a neonate or a pregnant woman. In the first instance, local escalation plans should promote the tiered network of services within the Area Health Service and the Perinatal Services Network. In circumstances where it is identified that there are beds/cots required beyond the local Network, the local escalation plans should also articulate procedures for clinicians to seek advice and/or support beyond their designated Network. This will be the responsibility of a designated senior Area Health Service position.

Local escalation plans should include direction for clinicians regarding review of all inpatients to determine whether internal transfer of patients within a facility, or across facilities, would improve access to required beds. Where, after thorough exploration of local resources, it is determined that there are no locally available, appropriate resources for patient management, clinicians will escalate these requirements through the NSW neonatal and paediatric Emergency Transport Service (NETS) and the Perinatal Advice Line (PAL) where advice, or transfer, is required.
A tertiary referral hospital designated by the NSW Perinatal Default Matrix must take responsibility for providing critical care, irrespective of bed status, to a specified group of referral hospitals when the Default Perinatal Policy is invoked.

IMPLEMENTATION

Area Health Service Chief Executives are responsible for:

- Meeting the perinatal intensive care needs of that Area and linked rural Area Health Services where specified, including the provision of clinical advice and ensuring access to appropriate treatment.
- Ensuring that all options for placement of critically ill neonates and at risk mothers within the referral network have been explored and that all appropriate transfers from NIC and maternity Units within and outside the Area to inpatient wards have been made.
- Ensuring formalised intra-Area and inter-Area referral arrangements are in place for critically ill neonates and pregnant women needing a higher level of definitive care and for non-critically ill patients requiring referral for specialist care.
- Ensuring formalised cross-jurisdictional border arrangements exist for the referral of critically ill neonates and women with high-risk pregnancies where required.
- Ensuring that clinical referral and support processes are transparent and effectively communicated to all staff to ensure patients can access timely definitive care. This responsibility lies ultimately with the Area Director of Clinical Operations.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

Directors of Clinical Governance are required to inform relevant clinical staff of this Policy Directive.

BACKGROUND

Introduction

Owing to the high level of complexity and specialist service requirements, neonatal intensive care and high risk obstetric services are not located in all Area Health Services. However, these services are available to all residents as they are provided through a formalised state network. This statewide network has been in operation since the development of the NSW Pregnancy and newborn Services Network (PSN) in 1990; this network includes the ACT as a partner. In order to provide stronger linkages between referral and other facilities, maternal and newborn service networks will be established in collaboration with clinicians, to support an integrated statewide approach.

This Policy Directive relates to critically ill neonates and women with high risk pregnancies that require inter-hospital transfer, and should be read in conjunction with the Policy Directive PD2010_021; Critical Care Tertiary Referral Networks & Transfer of Care (Adults).

This Policy Directive supersedes PD2005_107 Newborn Stabilisation Prior to Transport (Guidelines for Facilities for the) and PD2005_156 Emergency Obstetric and Neonatal Referrals - Policy.

Pursuing ‘best practice’ perinatal care across NSW requires services to embrace an integrated model of maternity care that recognises the need for effectively linked and networked services across primary (role delineation 1 to 2), secondary (role delineation 3 to 4) and tertiary (role delineation 5 and 6) levels of care.
This Policy Directive does not replace the requirement for Area Health Services to ensure the establishment and maintenance of tiered networks for the provision of timely access to higher levels of obstetric and neonatal support for women and babies as the need arises. The effective operation of the Statewide Perinatal Network relies on the intra- and inter-Area tiered Networks.

The NSW Critical Care Tertiary Referral Networks (Perinatal) Policy Directive defines the links between referring hospitals and tertiary referral hospitals, taking into account unit capacity; AHS birth rates; and, ensuring functional clinical referral relationships.

Operating in conjunction with this Policy Directive, are clinical super-specialty referral networks which are also defined within this policy directive and include:

1. NSW Severe Burn Injury Service (Adult)
2. NSW Acute Spinal Cord Injury Referrals (Adult)
3. NSW Major Trauma Referrals (Adult)
4. NSW Critical Care Tertiary Referral Networks (Adults)
5. NSW Critical Care Tertiary Referral Networks (Paediatrics)

Each AHS is required to ensure that escalation plans are in place to ensure the appropriate accommodation of a neonate or a pregnant woman. In the first instance, local escalation plans should promote the tiered network of services within the Area Health Service and the Perinatal Services Network. In circumstances where it is identified that there are clinical services required beyond the local Network, the local escalation plans should also articulate procedures for clinicians to seek advice and/or support beyond their designated Network. This will be the responsibility of a designated senior Area Health Service position.

Local escalation plans should include direction for clinicians regarding review of all inpatients to determine whether internal transfer of patients within a facility, or across facilities, would improve access to required beds. Where, after thorough exploration of local Network resources, it is determined that there are no available, appropriate resources for patient management, clinicians will escalate these requirements through the Neonatal and paediatric Emergency Transport Service (NETS) and the Perinatal Advice Line (PAL) where advice, or transfer, is required.

NETS provides statewide coordination of neonatal and paediatric retrieval, and complements the Perinatal Advice Line (PAL) in coordinating difficult or complex high-risk maternal referral consultation and transfer. Women with high obstetric risks who live near NSW borders may be appropriately referred, via mechanisms developed for obstetric transfer, with the adjoining state. Patient transport is arranged by the referring facility in consultation with the NSW Ambulance Service or through NETS.

To Contact NETS
Call: 1300 36 2500
All maternity hospitals and other health care facilities have the potential to deal with obstetric patients and as such should have procedures in place for the co-ordination of emergency inter-hospital transfer of obstetric and/or newborn patients. Where there are complications of pregnancy or labour (including preterm onset of labour), it is essential that the clinician responsible is aware of appropriate processes for escalation. If the clinical issue is beyond the normal scope of practice for the facility, the advice of obstetric and neonatal clinicians in a higher delineated unit should be sought. Where a clinician has determined that a patient needs to be transferred to receive the most appropriate care, the parent(s) should be aware of current information including the infant’s likely chance of survival; options for care around labour and birth; care of the infant immediately after birth; and, types of ongoing care that the baby may require. The Outcomes for Premature Babies Book, produced by PSN may be a useful resource for clinicians: [http://www.psn.org.au/documents/doc_download/2-outcomes-booklet](http://www.psn.org.au/documents/doc_download/2-outcomes-booklet)

The NSW Critical Care Tertiary Referral Networks (Perinatal) are supported by a number of organisations; policies and procedures; and, education supports. These include: the NSW Pregnancy and Newborn Services Network (PSN); the Neonatal and paediatric Emergency Transport Service (NETS); the Perinatal and Paediatric Resources System (PPRS); the Pregnancy Advice Line (PAL); as well as evidence based practice; policy; and, guideline development; and statewide education resources.

It is expected that AHSs will ensure the provision of clinical support, cooperation and appropriate education between units through current clinical and education staff. This process will be facilitated through the tiered maternity networks which are currently under development. It is acknowledged that the introduction of the proposed Local Hospital Networks may have an impact on the composition of the perinatal networks in NSW. As that work is progressed, and the perinatal networks finalised, it is acknowledged that there will be a requirement to revise this Policy Directive.

When women have been identified as requiring referral to a higher role delineated maternity unit, clinicians should contact the tertiary referral centre in their Network to discuss the care and transfer arrangements. Consultants at the tertiary referral centres should be readily available to discuss clinical issues; The Pregnancy Advice Line is a roster of senior obstetric specialists with high-risk pregnancy expertise from tertiary units who are available for clinical advice as a back-up to the network tertiary referral centre. If neonatal transport needs consideration, the NETS consultant should be included in the discussion, through teleconference facilitated by NETS.

Appendix One details the requirements for facilities for the stabilisation of patients prior to medical retrieval.

**Key definitions**

**Neonatal and paediatric Emergency Transport Service** - NETS is a statewide service of NSW Health that provides expert clinical advice, clinical co-ordination, stabilisation, and emergency treatment and inter hospital retrieval for very sick babies and children up to the age of 16 years; 24 hours a day, 7 days a week.

**Perinatal and Paediatric Resource Service (PPRS)** - The Perinatal and Paediatric Resources System (PPRS) is a statewide database showing available high-risk obstetric, neonatal and paediatric clinical resources in NSW and ACT. The site is updated regularly (two to three times daily) by all tertiary perinatal and paediatric hospitals in NSW and ACT and is pivotal to the day to day clinical functioning of the NSW Pregnancy and Newborn Services Network, the NSW Paediatric Intensive Care Network, and their medical retrieval arm, the NSW neonatal and paediatric Emergency Transport Service (NETS).
Pregnancy and newborn Services Network (PSN) - The PSN is multidisciplinary organisation of clinicians striving to provide the best care for high risk pregnant women and newborn infants. The aim of the NSW Pregnancy and Newborn Services Network is to improve the process and outcome of maternal and neonatal care in NSW, especially to those women and/or babies at risk of an adverse outcome, through clinical co-ordination, education and research.

Pregnancy Advice Line (PAL) - is a telephone hotline available to provide clinicians and ambulance staff with advice on the management and emergency transfer of women who require intensive care during pregnancy.

Pregnancy Advice Line (PAL) Consultant - fetomaternal specialists and obstetricians with an interest in high risk obstetrics from Level 6 obstetric hospitals in New South Wales and Australian Capital Territory who provide the telephone advice.

Role Delineation - Role delineation identifies the level of clinical complexity that can be safely managed with a clinical service based on the clinical support services available at the facility.

Tiered Maternity Networks – The organisation of maternity services from low risk to high risk in appropriately resources facilities. Role delineations of maternity services range from 1 to 6. The tiered maternity networks reflect complex and the inter-dependent relationships across clinical maternity services. The tiered maternity networks provide guidance for escalation when risk factors are identified beyond the designated role delineation of the local maternity service.

High Risk Obstetric Referral Networks and Neonatal Intensive Care

High risk obstetric and neonatal care may be provided in a level 5 or 6 facility, as described by the NSW Guide to the Role Delineation of Health Services. Clinicians will make the decision as to the most appropriate facility for care, based on patient needs in conjunction with available beds and resources.

Whilst recognising the Statewide remit of the NSW Neonatal Network, and that access for all high-risk babies and mothers is the priority, each referral hospital has a primary responsibility for provision of advice and accepting referrals from the associated group of hospitals. This list should be made readily available to all clinical staff likely to receive calls.

The tables below identify hospitals and the tertiary referral hospitals which are the primary source of advice and referral networks.
### 2. PAEDIATRICS

#### Referral Hospital: Royal North Shore Hospital
- Gosford
- Hornsby
- Manly/Mona Vale
- Ryde
- Wyong

Private
- Mater
- North Shore
- North Gosford
- Sydney Adventist Hospital

- Cobar
- Collarenebri
- Coonabarabran
- Coonamble
- Goodooga
- Lightning Ridge
- Narromine
- Walgett

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#### Referral Hospitals: Westmead & Nepean Hospitals

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112(25/11/10)
### Referral Hospital: John Hunter Hospital

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<td>Gloucester</td>
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<td>Coffs Harbour</td>
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<td>Maitland</td>
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<tr>
<td>Newcastle Private</td>
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**Private:**

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<tr>
<th>Hospital Name</th>
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<tr>
<td>St Vincent’s Lismore</td>
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### Referral Hospitals: Royal Prince Alfred & Liverpool Hospitals

**Liverpool**

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<tr>
<th>Hospital Name</th>
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<tbody>
<tr>
<td>Bowral</td>
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<td>Camden</td>
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<td>Campbelltown</td>
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<tr>
<td>Fairfield</td>
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<td>Bankstown/Lidcombe</td>
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**Royal Prince Alfred (RPA)**

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<th>Hospital Name</th>
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<td>Balmain - emergency only</td>
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<tr>
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<tr>
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<th>Hospital Name</th>
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<td>Sydney South West Private</td>
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**South West Private**

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North of Grafton will usually refer to Brisbane, owing to proximity.

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112(25/11/10)
2. PAEDIATRICS

Referral Hospital: Royal Hospital for Women

- Milton Ulladulla
- Shoalhaven and District
- St George
- St Vincent’s - emergency only
- Sutherland
- Wollongong

Private:
- Calvary Hurstville
- Kareena
- Prince of Wales
- St George Private
- Figtree Private (Illawarra)

usually refer to Melbourne
- Albury
- Cowra
- Deniliquin

Referral Hospital: The Canberra Hospital (TCH)

TCH provide support for
- Calvary

Private:
- Calvary Private
- John James Private within ACT

and in NSW as follows:
- Batemans Bay
- Bega
- Bombala
- Cooma
- Cootamundra
- Goulburn
- Moruya
- Pambula
- Queanbeyan
- Temora
- Tumut
- Wagga Wagga
- Young

Private:
- Mercy Care Centre, Young
- Calvary – Wagga Wagga

Whilst predominantly providing neonatal surgical services, the neonatal intensive care beds at Sydney Children’s Hospital and The Children’s Hospital at Westmead should also be considered when maternity beds are identified at The Royal Hospital for Women and Westmead Hospital, due to campus co-location.
The Greater Southern Area Health Service, Greater Western Area Health Service and North Coast Area Health Service have tertiary obstetric and neonatal links with facilities in the Sydney metropolitan area. It is acknowledged that these Area Health Services and northern sections of the Hunter New England Area Health Service also have appropriate cross border relationships, owing to proximity, to tertiary critical care services in Queensland, South Australia, Victoria and the ACT. These linkages are appropriate and supported by NSW Health.

In specific cases, the referring consultant, medical retrieval consultant and the receiving consultant may decide to refer the woman or neonate to another hospital which is considered more clinically appropriate for the woman or neonate’s definitive care. Wherever possible, the woman or parent(s) should be included in these discussions.

**NSW Statewide Default Paediatric and Neonatal Intensive Care and High Risk Obstetric Bed Policy**

Each Area Health Service with tertiary neonatal and obstetric services is required to ensure that all options for placement of critically ill neonates and at risk mothers within the referral network have been explored and that all appropriate transfers from NIC and maternity Units within and outside the Area to inpatient wards have been made.

In situations where it needs to be declared that a combination of no neonatal intensive care and/or high risk obstetric beds are available and a tertiary transfer is necessary, then the Default Perinatal Policy may be invoked. This step is taken only after thorough assessment of statewide Neonatal Intensive Care and High Risk Maternity services capacity and intra-Area default mechanisms within the appropriate Critical Care Tertiary Referral Networks for Perinatal Care.

However, fundamental to this procedure being activated is the principle that:

> Where the condition of a patient or fetus is critical and requires immediate emergency treatment, then the process of initiating transfer of the patient must start without delay; regardless of bed issues. If in any doubt, transfer should be to the facility designated by the NSW Statewide Default ICU Matrix – Perinatal that is able to provide appropriate emergency treatment irrespective of bed status. This can be addressed following the initiation of emergency care.

In the event of the default system being activated, a referral hospital will be designated as the hospital responsible to provide critical care, irrespective of bed status, as specified in the NSW Statewide Default ICU Matrix – Perinatal. This matrix has been developed following consultation with Area Health Services, the Neonatal and paediatric Emergency Transport Service, the Paediatric Intensive Care Advisory Group, the Pregnancy and newborn Service Network, the High Risk Obstetric Group, Maternal & Perinatal Health Priority Taskforce, Neonatal Intensive Care Unit Managers Group and other key stakeholders.

The referring hospital will call the Obstetric or Neonatal Unit at the default matrix tertiary hospital to discuss the patient and arrange appropriate transfer.
2. PAEDIATRICS

Should the first tertiary hospital called be unable to accept the transfer, **that tertiary hospital will make alternative arrangements with another tertiary hospital within the network**; ensuring at all times that the patient’s clinical need is met, and communication maintained with the referring centre. No patient should be refused admission without discussion involving the senior specialist at the referral hospital. NETS can provide clinical conference facilities to assist this process but clinical leadership of the process rests with the default matrix tertiary hospital involved.

Where necessary, a rostered consultant is available for the state to discuss clinical (statewide obstetric advisor), system (PSN consultant) or logistic (NETS consultant) issues. In many cases, a solution will be found after a discussion between senior obstetric and neonatal clinicians. If transfer is required and other options are not possible, the patient will be transferred to default referral hospital listed in the matrix.

**Operational Principles for NETS and PAL**

The key principles of the operation of NETS and PAL are:

1. Statewide coordination of neonatal and paediatric retrieval services, in collaboration with the Specialist Neonatal Retrieval Services located at:
   - Newcastle
   - Canberra
   - Victoria (Melbourne)
   - Queensland (Brisbane)
   - South Australia (Adelaide) and
   - Regional adult retrieval services in Orange, Tamworth, Lismore, Sydney and Wollongong.

2. Single point of access for referring hospitals (public and private) anywhere in the state. All critical care transfer requests or consultation (related to high-risk obstetrics, neonates or paediatrics) where a critical care transfer is contemplated must be made through NETS.

3. Use of conference call facilities to:
   - bring the referring clinician in direct contact with the medical retrieval consultant; preferred referral consultant; PAL; and, other clinicians, as appropriate. The patient’s **immediate** treatment requirements are the highest priority.
   - consult with various teams, coordination centres, ambulance services and vehicle operators.

4. NETS will **facilitate** the bed-finding process for critically ill or high risk babies and children for more complex or definitive care. NETS does not find beds for patients being electively transferred between hospitals. It is also not the role of NETS to find beds for maternity patients when there is no risk to the baby.

5. Where there is a variance in view regarding the clinical appropriateness of the transfer, then the final decision concerning the transfer will be made by the NETS medical retrieval consultant (babies) or PAL Consultant (mothers) following a conference call between the referring clinician, receiving medical consultant. This may need to include discussion with the relevant Area Health Service Executive.

6. If a medical retrieval is planned for a baby or child, NETS will determine the most appropriate transport vehicle to effect the retrieval.
Newborn and paediatric Emergency Transport Service (NETS-NSW)

NETS is the 24-hour coordination service and major provider of neonatal and paediatric retrievals. These services include:

- Clinical advice from a critical care medical retrieval consultant;
- A “one phone call” referral which uses conference call facilities;
- Mobilisation of an appropriate retrieval team or ambulance escort;
- Support to hospitals having difficulties referring high risk obstetric patients;
- Support for Ambulance Service dealing with pre-hospital emergencies;
- Liaison with interstate high risk obstetric, neonatal and paediatric emergency transport services;
- Assistance with Intensive Care support when usual neonatal and paediatric hospital ICU beds are unavailable;
- Assistance with any emergency where routine patterns of referral are unavailable or delayed.
- Liaison and consultation; including PAL.

Which Newborns May Need Medical Retrieval?

It is impossible to provide an exhaustive list detailing every consideration that may require referral to a tertiary facility. Table One provides a list that offers cues to facilitate clinical decision-making.
### Table One - Seek consultation regarding management and/or transfer of babies that have/are:

<table>
<thead>
<tr>
<th>Airway</th>
<th>• Intubated</th>
<th>• Actual or threatened airway obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>• Respiratory distress of early onset</td>
<td>• Respiratory distress persistent beyond 4 hours</td>
</tr>
<tr>
<td></td>
<td>• Apnoea</td>
<td>• Oxygen requirement &gt; $\text{FiO}_2$ 0.6 (blood gases available)</td>
</tr>
<tr>
<td></td>
<td>• Oxygen requirement &gt; $\text{FiO}_2$ 0.4 (blood gases not available)</td>
<td>• Respiratory distress with meconium aspiration proven radiologically</td>
</tr>
<tr>
<td>Circulation</td>
<td>• Shocked (if not sure of threshold, refer)</td>
<td>• Significant bleeding</td>
</tr>
<tr>
<td>Disability</td>
<td>• Born before 35 weeks (outside role delineation)</td>
<td>• Born before 33 weeks</td>
</tr>
<tr>
<td></td>
<td>• Weigh &lt; 2,000g and are outside role delineation facility</td>
<td>• Asphyxia with symptoms not rapidly correcting</td>
</tr>
<tr>
<td></td>
<td>• “Apgar” score persistently less than 7.</td>
<td>• Cyanosis despite oxygen therapy</td>
</tr>
<tr>
<td></td>
<td>• Heart failure or arrhythmia</td>
<td>• Seizures</td>
</tr>
<tr>
<td></td>
<td>• Surgical conditions requiring acute therapy</td>
<td>• “Unwellness”, especially if initially well.</td>
</tr>
</tbody>
</table>

### Which Pregnant Women May Need Medical Retrieval?

Critically injured pregnant women should be treated as to any adult in this position, and transferred to the nearest designated appropriate facility (eg. Major Trauma Centre), irrespective of ICU bed status, so that emergency treatment can commence with minimal delay. Where possible it is prudent to transfer a critically injured pregnant woman to a facility that also has an obstetric and neonatal intensive care service.

A number of statewide clinical super-speciality networks operate in tandem with the NSW Tertiary Referral Networks (Perinatal).

These networks are largely determined by the location of the clinical super-specialty services, and in some cases, the imperative to achieve early clinical intervention such as for those patients with major trauma.

The following clinical super-specialty referral networks that may be required for pregnant women:

1. NSW Severe Burn Injury Service Referral Network (Adult)
2. NSW Acute Spinal Cord Injury Referral Network (Adult)
3. NSW Major Trauma Services (Adult)
4. NSW Critical Care Tertiary Referral Networks (Adult)

It is impossible to provide an exhaustive list detailing every consideration that may require referral to a tertiary facility. Table Two provides a list that offers cues that may facilitate clinical decision-making.
TABLE 2 - Conditions requiring consultation regarding management and/or transfer

<table>
<thead>
<tr>
<th>Condition</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Hypertension</td>
<td>• BP Diastolic &gt; 110mmHg</td>
</tr>
<tr>
<td></td>
<td>• BP Systolic &gt; 170mmHg</td>
</tr>
<tr>
<td></td>
<td>• +/- proteinuria ≥ 2 +</td>
</tr>
<tr>
<td></td>
<td>• +/- hyperreflexia</td>
</tr>
<tr>
<td>Threatened Premature Labour</td>
<td>• &lt; 34 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>• Premature rupture of the membranes</td>
</tr>
<tr>
<td></td>
<td>• Premature cervical dilation identified with ultrasound scanning</td>
</tr>
<tr>
<td>Ruptured Membranes</td>
<td>• &lt; 34 weeks gestation</td>
</tr>
<tr>
<td>Antepartum Haemorrhage</td>
<td>• Bleeding &lt; 34 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>• Bleeding in excess of 200 mls</td>
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<td></td>
<td>• Placenta praevia encroaching or covering the internal os</td>
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<tr>
<td>Insulin Dependant Diabetes Mellitus (IDDM) or Gestational Diabetes Mellitus (GDM) on insulin</td>
<td>• In the presence of ketoacidosis</td>
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<tr>
<td></td>
<td>• Unstable Blood Glucose Levels</td>
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<tr>
<td>Intra Uterine Growth Retardation (IUGR)</td>
<td>• Identified on ultrasound assessment</td>
</tr>
<tr>
<td>DVT/Pulmonary Embolus/Coagulopathies</td>
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<tr>
<td>Cholestasis</td>
<td>• &lt; 34 weeks gestation</td>
</tr>
</tbody>
</table>

NSW Statewide Default ICU Matrix – Perinatal

Each Area Health Service with tertiary neonatal and obstetric services is required to ensure that all options for placement of at risk mothers and critically ill neonates within the referral network have been explored and that all appropriate transfers from NIC and maternity units, within the Area, to inpatient wards have been made.

Access to emergency care for time-critical patients is not to be delayed due to no availability of a Level 5 or 6 maternity or Neonatal Intensive Care bed. The appropriate retrieval service should be contacted immediately regarding such patients.

In situations where it needs to be declared that a combination of no neonatal intensive care beds and/or high risk obstetric beds are available and a tertiary transfer is necessary, then the NSW Statewide Default Perinatal Bed Policy may be invoked. This step is taken only after thorough assessment of statewide Neonatal Intensive Care and High Risk Maternity services capacity and intra-Area default mechanisms, and, where they exist, within the appropriate Critical Care Tertiary Referral Networks for Perinatal Care.

Fundamental to this procedure being activated is the principle that:
Where the condition of a patient or fetus is critical and requires immediate emergency treatment, then that patient must be transferred immediately to the facility designated by the NSW Statewide Default ICU Matrix - Perinatal that is able to provide appropriate emergency treatment irrespective of bed status; this can be addressed following the initiation of emergency care.

In the event of the default system being activated, a referral hospital will be designated as the hospital responsible to provide critical care, irrespective of bed status, as specified in the NSW Statewide Default ICU Matrix – Perinatal. This matrix has been developed following consultation with Area Health Services, the Neonatal and paediatric Emergency Transport Service, Paediatric Intensive Care Advisory Group, Pregnancy and newborn Service Network, High Risk Obstetric Advisory Group, Neonatal Intensive Care Unit Managers Group, Maternal & Perinatal Health Priority Taskforce, and other key stakeholders.

The referring hospital will call the Obstetric or Neonatal Unit at the default matrix tertiary hospital to discuss the patient and arrange appropriate transfer.

Should the first tertiary hospital called be unable to accept the transfer, that tertiary hospital will make alternative arrangements with another tertiary hospital within the network; ensuring at all times that the patient’s clinical need is met, and communication maintained with the referring centre. No patient should be refused admission without discussion involving the senior specialist at the referral hospital.

NETS can provide clinical conference facilities to assist this process but clinical leadership of the process rests with the default matrix tertiary hospital involved.

Where necessary, a rostered Statewide Perinatal Advisor is available for the state to discuss clinical system or logistic issues and is contactable through NETS. In many cases, a solution will be found after a discussion between senior obstetric, neonatal and retrieval clinicians. If transfer is required and other options are not possible, the patient will be transferred to default referral hospital listed in the matrix.

**Invoking the Default Perinatal Bed Policy**

The referring hospital contacts their Network maternity or neonatal Level 6 service to verify that there is no capacity to accept the patient within their Network.

- All units are to review exit blocked beds, liaise with the hospital executive to have them cleared and update PPRS.
- The referring hospital verifies that there are no appropriate available beds as shown on PPRS.
- The referring hospital contacts NETS who will explore any alternative destination for a neonatal intensive care bed, or the PAL Consultant for a maternal bed.
- Where no appropriate available bed can be identified across the system the on-duty NETS Consultant, in consultation with the PAL Consultant will invoke the Default Perinatal Bed Policy and contact the receiving NICU and/or Obstetric Consultant.
- The designated tertiary unit will accept the patient, irrespective of bed status, as per the Default Matrix.

112(25/11/10)
2. **PAEDIATRICS**

- Where there is continued difficulty accessing a maternity bed, the PAL Consultant may need to discuss the issue with the relevant AHS Executive. On-going difficulties should be discussed with the Director, Statewide Services Development Branch.
- If NETS becomes aware of any exit block issues affecting access to tertiary neonatal beds, they will notify the Director, Statewide Services Development Branch who will liaise with the relevant AHS Executive to address these issues.

Fundamental to this procedure being activated is the principle that:

| Where a patient requires time-critical care, not available at the referring hospital, then the patient must be transferred immediately to the facility designated by the Default Hospital Matrix that is able to provide appropriate emergency treatment irrespective of bed status. |

112(25/11/10)
Emergency Obstetric Referral Process

All higher level centres can offer clinical advice whether they have a "bed" or not. If there is no "bed" for the fetus they may still accept the transfer. Otherwise they will arrange an alternate destination. Each level 6 unit has information about the status of resources in other centres via PFSS.

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**Legend**

PFSS: Perinatal and Paediatric Resource System
NHS: Newborn and paediatric Emergency Transport Service
PAN: Pregnancy and newborn Service Network
Level 6: Canberra, John Hunter, Liverpool, Ngaera, Royal Women's, Royal North Shore, Royal Prince Alfred, Westmead

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NETS can assist with a telephone conference call between multiple parties involved in a particularly difficult case. The call is chaired by a Consultant in Retrieval Medicine (neonatal retrieval) or in Materno-fetal Medicine (high-risk obstetric transfer request) or in perinatal care (resource issue such as beds). Apparently insoluble problems are generally solved by appropriate involvement of senior staff, with appropriate clinical and administrative escalation.
2. PAEDIATRICS

Neonatal and Paediatric Referral Process

- Rural Hospital (L1-3 service)
  - Needs retrieval or ICU?
    - Yes: Call NETS
    - No: Consider...

- NETS Clinical conference call
  - Medical retrieval
  - Ambulance Transfer
  - Advice, no transfer

- Children’s Hospital

- Tertiary Perinatal Centre (L6)

- Regional base or urban hospital
  - Calls received via regional retrieval service and/or ED may need local solution ± NETS collaboration

- NETS can assist with the process where required:
  1. Medical Retrieval
  2. Clinical conference call (> 2 participants)
  3. System problems/failures
  4. Escalation of discussion (clinical/operational)
  5. Multi-unit discussion

AD = Admitting Officer. TPC = Tertiary Perinatal Centre. NETS = Newborn & paediatric Emergency Transport Service.
2. PAEDIATRICS

Appendix

Requirements for Facilities for the Stabilisation of Patients Prior to Medical Retrieval

These guidelines are provided to assist hospitals using a medical retrieval team to transfer a patient requiring intensive care. It sets out the resources that are required for the safe and efficient stabilisation of patients of all ages. These resources are required at those hospitals at or above role delineation Level 2 for Maternity Services (newborn infants) and at or above Level 1 for all other age-groups.

These guidelines are designed to assist referring hospitals offer optimal care using the combined resources of the referring hospital and the retrieval team to manage, stabilise and prepare patients for transport.

The guidelines were developed by NETS in collaboration with the Ambulance Service Medical Retrieval Unit; regional advisory/retrieval services; and, referring hospitals.

Background

Guidelines were issued in 1997 for newborn patients to promote an effective mechanism for the stabilisation of newborns, from referring hospitals. It was recognised that the scope of these guidelines needed to be expanded to offer advice encompassing all age groups and include new aspects of clinical networking such as telemedicine. Accordingly, this document covers all age groups.

Compliance

It is acknowledged that not all hospitals will be able to immediately provide the physical space specified in this guideline. Hospitals are advised that if there is currently no suitable space within the ED, ICU, children’s ward or neonatal nursery, alternative resuscitation areas can be provided in an appropriate area. However, when a hospital is being refurbished or rebuilt, the requirements listed in this circular should be followed and reference made to the functional space requirements contained in the current “Health Facility Guideline”.

Where specific essential equipment items listed below are not available at present, provision should be made to include these items in forward planning cycles as soon as possible.

Ventilatory Support

Facilities that have medical officers formally trained in managing ventilated patients may have ventilators capable of supporting Adults, Children, Infants and Neonates - depending on caseload of patients requiring ventilatory support. Where such ventilators are available, they must be complemented by the capacity to measure airway pressure, expiratory tidal or minute ventilation, and end tidal CO₂ (or skin CO₂ monitoring).

Imaging Facilities

If imaging facilities are available in the referring facility, an X-Ray viewing box or Picture Archiving and Communication System (PACS) system must be in a location that allows use without losing visual contact with the patient. In addition, diagnostic images of the patient must be available to accompany the patient to their destination hospital.

Pathology facilities

If Pathology facilities are available in the referring facility, a pathology results viewing system must be in a location that allows use without losing visual contact with the patient.

Access by the mother of a newborn

After resuscitation of a newborn and prior to transport, it should be possible for the NETS Infant Transport Module to be wheeled to the mother’s bedside (or vice versa). Sufficient room is needed for the mother to be able to see and touch her baby in the NETS transport system from her bed.
### Essential Facilities

- An area or room that can be dedicated to the patient for retrieval and the workings of the team (minimum size $21\text{m}^2$ child/adult; $15\text{m}^2$ for a newborn). This area may be created from existing areas for those times a medical retrieval team is present. For instance, by combining two patient care areas into one.
- Easy, uncluttered access for a stretcher or hospital trolleys used by the retrieval team (size $900\text{mm} \times 2000\text{mm}$) from hospital entry to patient care area without obstruction to other functions.
- Procedure light (angle-poise type)
- Resuscitation trolley with appropriate drugs and equipment for those age-groups being treated
- Infant resuscitation trolley (open care system for body weight < 5kg):
  - Integrated overhead lighting
  - Variable radiant heat source
  - Swing-away hinge for overhead modules for mobile x-ray access
  - Space available for retrieval team module to be positioned adjacent and at right angles
- Panel fixtures:
  - Oxygen x 2 (reticulated preferred, cylinder supply will suffice in some locations)
  - Medical Air x 2 (reticulated preferred, cylinder supply will suffice in some locations)
  - Suction x 2 (one regulated for low/controlled suction, one high flow (reticulated supply and second high flow preferred)
  - Body-protected GPOs x 10 (2 for retrieval team use, 8 for referring hospital equipment)
- Height adjustable trolley to facilitate the loading and unloading of the patient/transport stretcher/medical equipment
- Counter, bench top or table (min. $550 \times 1200\text{mm}$) for additional treatment equipment
- Wash sink, soap dispenser, paper towel and alcohol/chlorhexidine hand rub dispenser
- Waste receptacle of large capacity with large aperture orifice; positioned close to resuscitation area
- Sharps disposal container, preferably mobile
- Procedure trolley ($900\text{mm} \times 450\text{mm}$ minimum)
- Telephone:
  - Capable of direct call to relevant retrieval services (without using an operator)
  - Handset usable at the bedside of the patient (may use cordless technology)
  - Programmed for 1-key dialling to Regional Advisory/Retrieval Service, NETS, MRU
  - Capable of direct in-dial with that number displayed on handset prominent
- Facsimile machine:
  - In a location that allows use without losing visual contact with the patient
  - Programmed for 1-key dialling to Regional Advisory/Retrieval Service, NETS, MRU
  - Capable of direct in-dial with that number displayed on device prominently
- Photocopier with contrast and brightness adjustment
- In-service training in using the medical retrieval system

### Desirable Facilities

- Lighting to meet standards of operating theatre, with adjustable intensity
- Infant resuscitation trolley (open care system for body weight < 5kg):
  - In built frame for X-Ray plate positioning without disturbing the patient for contact-less imaging
- Digital camera for clinical photography (including simple connection to computer for file transfer)
- Computer:
  - In a location that allows use without losing visual contact with the patient
  - That allows access to clinical email services
  - That allows access to approved clinical web-based services (eg. CIAP, NETS, etc.)
  - That allows electronic transmission of digital images
  - That allows rapid access to relevant policies and procedures for care and retrieval
- Capacity to export clinical data from local information systems to retrieval coordination centres and/or receiving hospitals
- Capability of continuously monitoring a patient’s ECG, pulse oximetry and automated non-invasive blood pressure measurements
- Interview room immediately accessible to resuscitation area for family conferences
2. PAEDIATRICS

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

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

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

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

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

This Framework does not cover Level 6 services.

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

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

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

To download the guideline go to
NSW Paediatric Service Capability Framework

296(01/06/17)
NSW MATERNITY AND NEONATAL SERVICE CAPABILITY FRAMEWORK (GL2016_018)

GL2016_018 issued 22/7/16 replaced PD2010_062 Antenatal Maternal Referral / Transfer: Known Congenital Structural Malformations - Early Surgery as notified in IB2016_057

PURPOSE

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

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

KEY PRINCIPLES

Maternity service levels range from no planned service, Level 1 to Level 6. Level 6 maternity care is provided in tertiary perinatal centres.

Neonatal service levels range from no planned service, Level 1 to Level 6. Level 6 neonatal care is provided in specialist children’s hospitals where neonatal surgery and complex genetic and metabolic services are located.

Generally, linked maternity and neonatal service levels will be different with the maternity service level a step higher than the neonatal level (e.g. a Level 4 maternity service has a Level 3 neonatal service).

USE OF THE GUIDELINE

Local Health Districts are responsible for determining the maternity and neonatal service capability level of their facilities, taking into account the clinical support services available (e.g. pathology, diagnostic imaging). The Framework recognises that mothers and babies are inextricably linked and planning needs to be undertaken jointly for maternity and neonatal services.

The Framework also includes the Maternity and Neonatal Service Capability Assessment Tool for assessing the planned service capability of a facility and a methodology to assist in maternity and neonatal service planning and risk management.

To download the guideline go to: NSW Maternity and Neonatal Service Capability Framework

267 (28/7/16)
ANTENATAL CARD (IB2016_042)

PURPOSE
The purpose of this Information Bulletin is to notify the NSW health system that the Guideline
GL2005_025 Antenatal Card has been made obsolete and an updated Antenatal Card: Antenatal Record
SMR060.455 is available for order as a NSW state form.

KEY INFORMATION
The Guideline GL2005_025 Antenatal Card has been made obsolete and an updated Antenatal Card: Antenatal Record SMR060.455 is available to order online from the NSW Health catalogue for clinical forms.

The Antenatal Card:
1. Is an essential communication tool between clinicians internal and external to NSW Health
2. Contains emergency contact information, the woman’s relevant history, a record of her antenatal care and care plans to facilitate comprehensive care provision when the woman presents at another facility
3. Provides information to the woman about her pregnancy
4. Should be carried by the woman as she moves between service providers.

The Antenatal Card has been updated to align with antenatal screening and care recommendations within the National Clinical Practice Guidelines - Antenatal Care: Modules I and II (Australian Health Ministers’ Advisory Council 2013 and 2014) and the work undertaken on the National Woman Held Maternity Record, a project under the auspice of the (former) Maternity Services Interjurisdictional Committee.
HUMIDIFIED HIGH FLOW NASAL CANNULA OXYGEN GUIDELINE FOR METROPOLITAN PAEDIATRIC WARDS AND EDs – 1ST EDITION (GL2016_004)

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

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

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

USE OF THE GUIDELINE
Chief Executives of Metropolitan LHD’s must ensure:

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

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

ATTACHMENTS
1. Humidified High Flow Nasal Cannula Oxygen Guideline for Metropolitan Paediatric Wards and EDs, 1st Edition: Guideline
INFANTS AND CHILDREN INSERTION AND CONFIRMATION OF PLACEMENT OF NASOGASTRIC AND OROGASTRIC TUBES (GL2016_006)

GL2016_006 rescinds GL2016_003

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

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

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

ATTACHMENT

2. Infants and Children Insertion and Confirmation of Placement of Nasogastric and Orogastric Tubes 1st Edition: Guideline.
DEATH – MANAGEMENT OF SUDDEN UNEXPECTED DEATH IN INFANCY (PD2008_070)

Introduction

This document represents policy for the management of sudden unexpected infant death. It has been developed in response to recommendations in the Child Death Review Team (CDRT) Sudden Unexpected Death in Infancy Report (2005). There are two aspects of management: the diagnosis of the cause of death, and the support of the surviving family members. The aim of the process is to take a comprehensive medical history to assist the forensic pathologist in the post-mortem assessment to establish as far as is possible the cause of death.

Each Area Health Service is responsible for ensuring that local protocols based on this policy are developed. Each Area Health Service must develop mechanisms to coordinate and provide this response, and designate the facilities where this service will be available. Area Health Services are also responsible for ensuring that all staff treating paediatric patients are educated in the use of the locally developed paediatric guidelines and protocols.

Throughout this document the senior paediatrician is referred to as being the person who supplies the paediatric medical expertise required for the health response. While this is the ideal, local protocols may be developed in which a General Practitioner Visiting Medical Officer with paediatric expertise undertakes this role.

It is critical that contemporaneous, accurate and complete documentation is maintained during the course of patient management.

Overview

Definition of sudden unexpected death in infancy (SUDI)

The death of an infant:
- Less than 12 months of age;
- That was sudden in nature;
- That was unexpected.

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

When this protocol should be used

- When there is an unexpected infant death during an admission to hospital.
- Following an unexpected death of an infant outside hospital, where the infant is brought into an Emergency Department.
The multi-agency response to SUDI

The health response is one aspect of the multi-agency response to SUDI. The involvement of health professionals should complement the work of police, ambulance, forensic pathologists and the Coroner. All sudden, unexpected deaths in infancy must be reported to the Coroner. Failure to work within the context of the multi-agency response may increase confusion and distress for the family, and undermine the work of other agencies. A summary of the multi-agency response, including the health response, is included in Appendix A for the information of Health workers.

The role of health in the SUDI response

The role of health workers in SUDI is to provide health care and assessment for the family, remembering that the infant’s death will be investigated by other services. In some cases the cause(s) of death may have relevance to the health of other family members, including subsequent children. A thorough health assessment is in the best interests of the family, as well as acting to complement the other components of the multi agency response to SUDI.

Care of the family

The unexpected death of an infant is a tragedy for the parents. The immediate care provided for parents by police and ambulance officers in the home or by staff in hospitals may make a great difference to the resolution of the family’s grief. Staff involved should have appropriate knowledge, skills and sensitivity.

The parents may be in shock. Their behaviour may be atypical. There is no “correct” or “appropriate” response to such an overwhelming shock. If they so desire the family should be given the opportunity to say goodbye to their infant, and to hold the infant for a time in the presence of a health professional. It is important that they are given support during this time. This process cannot be hurried but it should be acknowledged that an urgent post mortem is required.

Sudden Infant Death Syndrome (SIDS)

Successful diagnosis of the cause of unexpected infant death is dependent on the post mortem being carried out as soon as possible after the death of the infant. A comprehensive medical history of the infant and other family members is an important contribution to the post mortem process, and provides the basis for a well informed post mortem examination by the Forensic Pathologist.

As SIDS is a post mortem diagnosis by exclusion, the term SUDI, ‘sudden unexpected death in infancy’ should be used until the cause of death is classified as SIDS following post mortem examination.

Even though SIDS has not been confirmed as a cause of death all parents are still able to access support from SIDS and KIDS NSW and contact details should be provided to the parents.

Facilities Providing the Health Response

Each Area Health Service will have clear policies designating which facilities can provide the SUDI response. Area Health Service policies will be in place to ensure that appropriate physical space is available for the SUDI response, and that arrangements are in place to ensure key staff involved in providing the SUDI response are able to provide uninterrupted care to the family. For most facilities, a SUDI presentation will be a rare event.
An appropriate multidisciplinary response to SUDI includes paediatric expertise, social work and nursing care as a minimum. Treating health professionals need to be excused from other duties while providing care to the family. Hospitals with the capacity to ensure paediatric, nursing and social work care should be nominated by the Area Health Service to undertake the SUDI response.

Area Health Services will develop clear protocols describing how the response to SUDI will be undertaken in their designated facilities. Area Health Service protocols should provide pathways for the transfer of SUDI cases from non-designated response hospitals to those sites able to provide a SUDI response.

Area Health Services must also ensure that other services involved in the multi-agency response to SUDI such as NSW Police Force, Ambulance and Government Contractors are aware of those hospitals designated to provide the SUDI response, and can transport the infant and family members directly to those sites in the event of a SUDI.

Because the cause of death can be difficult to establish, it is very important that the post mortem examination be done by a pathologist with extensive experience in infant post mortems at a centre with appropriate facilities for special tests. The NSW State Coroner has therefore directed that all post mortems following unexpected deaths of infants be done in Sydney, either at the Department of Forensic Medicine at Glebe or in Newcastle at the Department of Forensic Medicine, Royal Newcastle Hospital. The agreed protocol for post-mortem Standard guidelines: Sudden Unexpected Death in Infancy (SUDI) has been included at Appendix D for information only.

Based on the post mortem results, the NSW Health Department monitors the occurrence of SUDI, looking for trends which might provide information that will help in the prevention of these types of deaths.
Flowchart of the Emergency Department Response to SUDI

1. Infant dies suddenly and unexpectedly
   - Infant transported to hospital emergency department
     (If death occurs in hospital, the response may occur on the ward)
   - Family transported to hospital emergency department

2. Director or Supervisor of the Emergency Department notifies the on-call social worker and senior paediatrician, who attend urgently

3. Director or Supervisor of the Emergency Department allocates a key person to care for the family

4. Key person takes hand over from police

5. Formal identification of the infant with police assistance

6. Paediatrician ensures that extinction of life has been certified.

7. Paediatrician discusses the case with the key person, confirming that no objections to postmortem have been made.

8. Paediatrician meets family and informs them of processes to take place including post mortem
   - Family given the opportunity to spend some time with infant under supervision
   - Paediatrician takes full history from family (social worker to be present)

9. History faxed to forensic pathologist prior to post mortem
   - Letter requesting full post mortem report is enclosed

10. Paediatrician offers regular medical follow up to family (or refers back to the usual paediatrician as appropriate).

11. General practitioner is notified of the death and future care plans (with appropriate consent from family members).

12. Key person arranges for infant to be transported to morgue for urgent postmortem at Glebe or Newcastle only

13. Paediatrician offers regular medical follow up to family members at a later time if appropriate

14. Ongoing care of family coordinated by paediatrician, social worker, and key person, including:
   - Grief counselling: Initial service provided and social work handover to Forensic counsellor completed.
   - Services, and
   - Medical care of family (for example, lactation advice).
Initial Management

Following an unexpected death of an infant:

All babies dying unexpectedly and brought to the hospital should be taken into the Emergency Department. The Emergency Department is a “safe place” where parents and other relatives are able to talk with health professionals.

The senior on call paediatrician must be notified and attend as soon as possible, in order to confirm that life is extinct, and to take a history from the family.

The Director or Supervisor of the Emergency Department in the SUDI response hospital nominates a key person to coordinate the immediate care of the parents. This will usually be the social worker, but could be the senior nurse on duty, the duty social worker or the senior paediatrician on call. A senior nurse should act as the key person until the social worker or paediatrician arrives.

The infant should be registered as a patient and hospital labels printed.

The paediatrician ensures that extinction of life has been certified. The Duty Forensic Pathologist should be contacted as soon as death is established.

Initial care of the family

If the infant is deemed dead on arrival, the parents should be informed as soon as possible by the Emergency Department doctor or nominated key person.

It is important to keep the parents/family informed at every step of the process that is taking place with their child. The parents may be in shock and need information to be repeated.

Handling of the infant’s body should be minimised. However, the parents may want to hold the infant after death has been established and should be given the opportunity to do so in the presence of a health professional. As any SUDI death is a matter for the Coroner, the health professional is required to witness that no evidence relating to potential cause of death has been altered after arrival at the hospital. The health professional should be as supportive as possible while providing the necessary supervision.

Ink prints of the infant’s feet or hands must not be made until after the post mortem examination. At the parents’ request, ink prints can be taken at the forensic facility where the post mortem takes place by a forensic counsellor at Glebe or the SIDS and Kids representative at Newcastle.

Handover from Police

The key person takes a hand over from the police officers in attendance, including:

- Any objections that have been raised by the family to a post mortem
- Confirmation that the death has been reported to the Coroner, or the arrangements made for this to occur.

If the infant and family have arrived at the hospital without contact with the Police, the key person must arrange for the Police to be notified immediately.
Once the infant is declared deceased the police officer, as the representative of the Coroner, is responsible for the care of the body, the investigation of the death, and timely removal of the infant for examination by a forensic pathologist.

**Formal identification of the infant**

Formal identification by the police is necessary in all coronial cases. In view of the circumstances surrounding an unexpected infant death, positive identification may be obtained in a number of ways. The parents may be asked to do this. The police or anyone who knew the infant’s identification in life, or to whom the infant’s body has already been identified, can assist in this formality. **Formal identification is best done before leaving the Hospital Ward or Emergency Department.**

**When a sudden infant death occurs during a hospital admission:**

The Admitting or Senior Medical Officer who had cared for the infant should nominate a **key person** to coordinate the care of the parents. This could be the nurse unit manager, the ward social worker or other appropriate person depending on the circumstances and/or who has been involved with the family during the admission. The parents should be informed of the death of the infant as soon as possible. The senior on call or treating paediatrician must be notified and attend urgently.

The nominated **key person** should ensure that the police have been promptly informed of the death of the infant so that an early post mortem can be conducted, and ensure that the appropriate report is made to the Coroner.

If the infant has been a hospital in-patient, some pathology samples such as blood and urine may have been taken prior to death. In this case, it may not be necessary to obtain repeat samples post-mortem. The availability of such samples for metabolic analyses should be confirmed with the pathology service.

*The Guidelines for Nursing Staff and Medical Officers on Coroners’ Cases Dying in Hospital* as detailed in **PD2010_054 Coroner’s Cases and the Coroner’s Act 2009** should be followed by nursing staff and medical officers following a sudden infant death that occurs during a hospital admission.

**Medical Intervention with a Family after a SUDI**

1. **Take a history from the family**

On arrival at the Emergency Department, the senior paediatrician should introduce him or herself to the family.

The family may not fully understand that a post-mortem examination is necessary in the case of unexpected infant death. The senior paediatrician should explain to the family that the postmortem will be undertaken at a designated facility, that this is important to help establish the cause of death, and that the diagnosis of the cause of death may benefit other family members, especially future siblings. The Forensic Pathology Service to which the infant is sent will undertake this testing. The senior paediatrician should explain that a comprehensive medical history of the infant and close family members is important to ensure that the post mortem examination is as comprehensive as possible. A full history should be taken according to the protocol attached at Appendix B.
2. Objections to post mortem examination

The police who transport the family to hospital will normally have discussed the post mortem with the family and provided them with *The Coroner’s Court* brochure. This brochure provides information on the coronial system, why the Coroner has become involved and the processes that may be necessary to determine the cause of death.

The outcome of the discussion regarding post mortem between police and the family should be communicated by police to the nurse manager or key person on arrival at the hospital.

Parents should be informed that unexpected infant deaths have to be reported to the Coroner, who will order a post mortem examination. Some parents may have reservations about a post mortem examination because of cultural, religious or other reasons. It should be explained that a post mortem is required to ensure that the cause of death was thoroughly investigated and no illness was missed.

If the family has raised an objection to post mortem in writing, the senior on call paediatrician should ensure that the Coroner has been informed.

If parents have continuing concern regarding the post mortem process they can discuss this with the Coronial Information and Support Program during business hours and the Department of Forensic Medicine Counsellors after hours. Contact details for these services are:

- The Coronial Information and Support Program (CISP) at Glebe on (02) 8584 7777.
- Department of Forensic Medicine at Glebe, telephone (02) 8584 7800 (After hours ph. 02 8584 7821).

**Electrocardiograph (ECG)**

The senior paediatrician is responsible for recommending screening at a later time of first-degree relatives for long QT interval and inherited cardiac disorders. This may be valuable both for the family’s sake and to inform the post mortem process. Results should be made available to the forensic pathologist undertaking the infant’s post mortem.

**Transporting the Infant for Post-mortem**

The infant should be transported to Glebe or Newcastle for the post-mortem as soon as possible. This will normally be done by the government contractor who delivered the infant to hospital. The key person will need to contact the Police to ensure the arrangements are in place for this. If the infant was brought to hospital by ambulance, the key person should contact police to arrange transport to the morgue by the government contractor.

There is no charge to the parents for transporting the infant to Glebe or Newcastle or returning the infant to the home locality. Every effort will be made to ensure that post mortems are done as quickly as possible.

Prior to leaving the hospital the parents should be given the contact details of the Forensic Counsellor at the institution to which the infant is being transferred for post mortem examination. The parent should be advised they can contact a counsellor at Glebe 24 hours a day 7 days a week to seek information and support regarding the post mortem process. Newcastle provides this service Monday to Friday during business hours.
The Forensic Counsellor will contact the parents/senior next of kin when the post mortem examination is to take place. The counsellor will telephone the parents/senior next of kin and convey the Interim Cause of Death and confirm when the infant is ready to be released into the care of the funeral director. The Forensic Counsellor can facilitate viewings of the infant after post mortem examination.

Ink prints of the infant’s feet or hands will not be made until after the post mortem examination. At the parents’ request ink prints can be taken, by the forensic counsellors or by the SIDS and Kids representative, at each of the forensic facilities.

The post mortem report

Post mortem reports are available to parents from the Coroner’s offices in Sydney, or the clerk of the local court in country areas. The initial report can be obtained by telephone, usually within 48 hours. Requests for the final report must be made in writing. There is no charge to parents for the report. Because the tests are complex it may take several months to produce the final report.

Taking the Medical History

<table>
<thead>
<tr>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>The senior paediatrician takes the history in the presence of a social worker</td>
</tr>
<tr>
<td>Use the protocol as a guide and encourage parents to use their own words</td>
</tr>
<tr>
<td>Be sensitive to the needs of the parents</td>
</tr>
<tr>
<td>Take a full comprehensive history from the family to inform pathology testing</td>
</tr>
<tr>
<td>Consider child protection issues for surviving siblings</td>
</tr>
<tr>
<td>Fax the medical record to the forensic pathologist prior to post mortem</td>
</tr>
</tbody>
</table>

Using the protocol

The importance of the history being taken by an experienced paediatrician, with knowledge and understanding of the care of infants and sensitivity to the needs of the family, cannot be over-emphasised. The social worker is to be present during this consultation.

This list is meant as a guide. It cannot be comprehensive, as additional specific questions may arise as a consequence of information given by the parents. Encouraging the parents to talk spontaneously, with prompts about specific information, is likely to be better than trying to collect a structured history in the more usual way. In recording parents’ accounts of events, it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

Sensitive interviewing

Much of the information is sensitive. Parents may feel vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgment or criticism.

At the end of the interview, it is essential that the paediatrician spends some time with the family ensuring they know what will happen next, when they will next be contacted by the paediatrician, when and where the post mortem will take place, and how they will be informed of the preliminary results.

Time will also be needed for the paediatrician and the social worker to help the parents deal with the very powerful emotions that are commonly brought out by this discussion.
Child protection issues

A small percentage of SUDIs are the result of non-accidental injury. Thus child protection issues should be borne in mind by health professionals assessing SUDIs. If there are any concerns that child protection issues may be present, a report to DoCS should be considered to ensure the safety of surviving siblings. Health workers do not need to be certain that abuse or neglect has occurred. A report relates to a reasonable suspicion of risk of harm. Risk of harm refers to the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or emotional abuse, exposure to domestic violence) or not done (neglect) by another person.

When this information has been collected, the full medical record should be faxed (see sample fax coversheet at Attachment C) to the morgue where the post mortem will take place:

<table>
<thead>
<tr>
<th>Department of Forensic Medicine</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glebe</td>
<td>02 8584 7800</td>
<td>02 9552 1613</td>
</tr>
<tr>
<td>Newcastle</td>
<td>02 4922 3703</td>
<td>02 4922 3730</td>
</tr>
</tbody>
</table>

Care of the Family

Practical help for the family
Practical help should be offered to the parents, including:

- Arranging transport home
- Making sure they are calm enough to drive if they brought their infant in the family car
- Care of the other children
- Discussing funeral arrangements
- Contacting any relatives (with permission)
- Helping the mother if she has been breastfeeding.

If there is a surviving twin, initial management and advice should be given by the senior on-call paediatrician. Further appointments with a paediatrician should be made as appropriate.

Ongoing care of the family

The social worker and the senior paediatrician should co-ordinate plans for future care of the family prior to them leaving hospital. The Forensic Counsellor should be contacted and a handover given.

The names of all health professionals (for example, the general practitioner, child and family health nurse, paediatrician, obstetrician or postnatal clinic nurse) involved in the infant’s care should be sought so that they can be informed (with permission) and become involved in the parents’ care. The infant’s Personal Health Record (blue book), if available, may give details of health professionals involved in the infant’s care. The parents should be offered the support services of SIDS and Kids (contact details below).

The senior paediatrician should include a letter applying for a copy of the forensic pathology report with the faxed full medical record. The paediatrician should arrange a follow up appointment with the family to discuss the findings of the post mortem. If possible, the family’s general practitioner should also attend this meeting. This should ideally occur within six months of the death.
2. PAEDIATRICS

Professional and organisational support available to the family

1. Family general practitioner
2. Paediatrician
3. Community Health and/or the Community Mental Health Team
4. Department of Forensic Medicine Forensic Counselling Unit
5. SIDS and Kids NSW and SIDS and Kids Hunter

The Role of the Forensic Counsellor

Forensic Counsellors are employed at the Department of Forensic Medicine Glebe and Newcastle to assist relatives and friends when they experience a sudden unexpected death that is reported to the Coroner.

The Counsellors role is to provide information, support and counselling to family and friends of the infant. The Counsellors are available to facilitate viewings of the infant after the post mortem examination and to make hand and foot prints at the parent’s request.

The counsellors at the Department of Forensic Medicine at Glebe (02) 8584 7800 or the Department of Forensic Medicine, Newcastle (02) 4922 3703 are also available to help parents, relatives and professional staff to obtain information where possible. A pamphlet on post mortems is available.

SIDS and Kids NSW and SIDS and Kids Hunter are self-help organisations that support all who experience the sudden and unexpected death of a young child, as well as undertaking community education, research and fundraising activities.

Professional counsellors and trained volunteers are available to provide phone support and information to parents and families following the death of a child. Home visits can be arranged when the family is ready. SIDS and Kids NSW and SIDS and Kids Hunter provide information booklets to both parents and health professionals.

SIDS and Kids NSW can be contacted on 1800 651 186 (for country and after hours support). SIDS and Kids Hunter is available for families in the Hunter region and can be contacted on (02) 4969 3171 (24 hours).

Paediatric Hospitals

Contacts for further information on SIDS at NSW Paediatric Hospitals are listed below.

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>TELEPHONE</th>
<th>CONTACT PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Children's Hospital at Westmead</td>
<td>(02) 9845 0000 (24 Hours)</td>
<td>• Sleep Unit Social Worker on call</td>
</tr>
<tr>
<td>Sydney Children’s Hospital Randwick</td>
<td>(02) 9382 1111 (24 Hours)</td>
<td>• Emergency Department Director on Duty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Paediatric Social Worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sleep Medicine Department</td>
</tr>
<tr>
<td>John Hunter Children’s Hospital Newcastle</td>
<td>(02) 4921 3676 or (02) 4921 3000 (24 hours)</td>
<td>• Department of Respiratory Medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Paediatric Social Worker</td>
</tr>
</tbody>
</table>
### Appendix A: Summary of Agency roles in responding to Sudden Unexpected Death in Infancy (SUDI)

<table>
<thead>
<tr>
<th><strong>Parent or caregiver</strong> – Infant found unresponsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ambulance usually called.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ambulance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend immediately</td>
</tr>
<tr>
<td>Resuscitation if appropriate</td>
</tr>
<tr>
<td>Takes care of the family while present</td>
</tr>
<tr>
<td>Record details on Ambulance Patient Health Care Record</td>
</tr>
<tr>
<td>Reports to Department of Community Services (DoCS) if appropriate</td>
</tr>
<tr>
<td>Informs police of receiving Emergency Department of the nominated SUDI response facility</td>
</tr>
<tr>
<td>Notifies local Emergency Department of impending transfer</td>
</tr>
<tr>
<td>Hand over to Police before leaving scene when no longer required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>NSW Police Force</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Immediate response</td>
</tr>
<tr>
<td>• Interview of family</td>
</tr>
<tr>
<td>• Completion of P79a and P534 (NCIS) form</td>
</tr>
<tr>
<td>• Examination of death scene</td>
</tr>
<tr>
<td>• Explain to family that death is a coronial matter</td>
</tr>
<tr>
<td>• Give brochure on post mortems to family</td>
</tr>
<tr>
<td>• Explain the right to object to post mortem</td>
</tr>
<tr>
<td>• Notify NSW Police Force Forensic Services</td>
</tr>
<tr>
<td>• Report to DoCS if appropriate</td>
</tr>
<tr>
<td>• Take care of family after ambulance officers have departed</td>
</tr>
<tr>
<td>• Advise of other immediate support for family as required (relatives, SIDS and Kids NSW or SIDS and Kids Hunter, etc)</td>
</tr>
<tr>
<td>• Transport family to hospital at the same time as infant is transported by government contractor</td>
</tr>
<tr>
<td>• Hand over to hospital staff prior to leaving hospital</td>
</tr>
<tr>
<td>• Assist with formal identification of the infant in the Emergency Department</td>
</tr>
<tr>
<td>• Arrange transport of infant by government contractor from home to hospital and from hospital to morgue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Forensic services, NSW Police Force</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Notified and attend as a matter of urgency</td>
</tr>
<tr>
<td>• Undertake thorough death scene investigation including taking of photographs and exhibits</td>
</tr>
<tr>
<td>• Scene remains preserved until released by the Crime Scene Investigator or the Officer in Charge</td>
</tr>
<tr>
<td>• On completion, call government contractor for transport of infant to hospital</td>
</tr>
</tbody>
</table>

70(2/09)
### 2. PAEDIATRICS

<table>
<thead>
<tr>
<th>Government contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transports infant to hospital</td>
</tr>
<tr>
<td>• Transports infant from hospital to morgue for post mortem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse manager of emergency department</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Retrieves policy directive/procedure and makes available to staff involved in case</td>
</tr>
<tr>
<td>• Calls senior on call paediatrician</td>
</tr>
<tr>
<td>• Notifies social worker on call, if available</td>
</tr>
<tr>
<td>• Receives hand over from police regarding post-mortem objection and government contractor arrangements</td>
</tr>
<tr>
<td>• Initiates care of family</td>
</tr>
<tr>
<td>• Co-ordinates transport of infant to morgue by government contractor</td>
</tr>
<tr>
<td>• Faxes medical records to morgue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provides care of family according to Policy Directive.</td>
</tr>
<tr>
<td>• Assists at interview of family by paediatrician</td>
</tr>
<tr>
<td>• Co-ordinates ongoing care of family with other health practitioners</td>
</tr>
<tr>
<td>• Pages Forensic Counsellor and gives handover.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Senior on call paediatrician</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Follows policy directive</td>
</tr>
<tr>
<td>• Ensures extinction of life has been certified</td>
</tr>
<tr>
<td>• Informed regarding objections to post mortem</td>
</tr>
<tr>
<td>• If objections have been raised, discusses further with family</td>
</tr>
<tr>
<td>• Takes comprehensive history from family</td>
</tr>
<tr>
<td>• Ensures that this history is received by the forensic pathologist prior to post mortem</td>
</tr>
<tr>
<td>• Co-ordinates care of family according to clinical practice guideline</td>
</tr>
<tr>
<td>• Ensures ongoing care of family according to clinical practice guideline, including (as appropriate):</td>
</tr>
<tr>
<td>• Investigation for long QT interval in surviving family members</td>
</tr>
<tr>
<td>• Grief counselling</td>
</tr>
<tr>
<td>• Services</td>
</tr>
<tr>
<td>• Medical care of family (for example, lactation advice)</td>
</tr>
<tr>
<td>• Ensures GP is notified of death and future care plans</td>
</tr>
<tr>
<td>• Offers regular medical follow up to family, including discussion of post mortem and coronial findings when available and appropriate (or refers back to usual paediatrician) as appropriate</td>
</tr>
<tr>
<td>Forensic Counsellor</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td>• Calls parents to confirm infant is at mortuary. Inform when post mortem examination will take place.</td>
</tr>
<tr>
<td>• Calls parents after post mortem to convey Interim Cause of Death and confirm date of release into the care of funeral director.</td>
</tr>
<tr>
<td>• Discuss opportunity to view and take hand and foot prints.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forensic pathologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensures that the comprehensive history taken by the paediatrician has been received and read prior to post mortem</td>
</tr>
<tr>
<td>• Completes the post mortem according to the NSW revised version of the International Standardised Autopsy Protocol</td>
</tr>
<tr>
<td>• Provides a post-mortem report to the Coroner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coroner</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Forwards post mortem and coronial findings to managing paediatrician if requested.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department of Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Department will visit a family where there are siblings or other children are residing in, or are expected to return to, a household where a child death has occurred that is or may be due to abuse, neglect or suspicious circumstances.</td>
</tr>
</tbody>
</table>
Appendix B: History protocol

NSW DEPARTMENT OF HEALTH

SUDDEN UNEXPECTED DEATH IN INFANCY

MEDICAL HISTORY PROTOCOL
2. PAEDIATRICS

PROTOCOL – CONFIDENTIAL

DEFINITION OF SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)
The death of an infant:

- Less than 12 months of age;
- That was sudden in nature;
- That was unexpected.

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

NOTES ON USING THIS PROTOCOL
The history should be taken by an experienced paediatrician. While this is the ideal, local protocols may be developed in which a General Practitioner Visiting Medical Officer with paediatric expertise undertakes this role. A social worker should also be present.

This form is meant as a guide. Encourage the parents to talk spontaneously, with prompts about specific information. In recording parents' accounts of events, it is important to use their own words as far as possible.

Ask the questions in a non-threatening way, with no implication of value judgment or criticism.

It is critical that contemporaneous, accurate and complete documentation is maintained during the course of patient management.

When this information has been collected, the full medical record should be faxed to the morgue where the post-mortem will take place:

<table>
<thead>
<tr>
<th>Department of Forensic Medicine</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glebe</td>
<td>02 8584 7800</td>
<td>02 9652 1613</td>
</tr>
<tr>
<td>Newcastle</td>
<td>02 4922 3703</td>
<td>02 4922 3730</td>
</tr>
</tbody>
</table>

CHILD PROTECTION ISSUES
A small percentage of SUDI deaths are the result of non-accidental injury. If there are any concerns that child protection issues may be present, a report to DoCS should be considered to ensure the safety of surviving siblings. See PD2006_104 Child Protection Roles and Responsibilities – Interagency.
ATTACH A COPY OF THE COMPLETED SECTIONS OF THE PERSONAL HEALTH RECORD (BLUE BOOK) IF POSSIBLE

Date:
Name of examining paediatrician:
Name of social worker present:
Nominated key person:
Name and designation of other health workers present:

PERSONAL AND CONTACT INFORMATION

INFANT
Date of birth: Male  Female
Given name:
Family name:
Other names by which known:
Aboriginal  Torres Strait Islander  Both Aboriginal and Torres Strait Islander
Place of birth:
Residential address:

Copy of infant's Personal Health Record ('Blue Book') taken (Y/N):
General Practitioner (name, address, phone number):

Paediatrician (name, address, phone number):

Early Childhood Health Centre attended (address, phone number and contact person):
## PERSON 1
Relationship to deceased infant: [Relationship]

- Given names: [Name]
- Family name: [Name]
- Date of birth: [Date]
- Residential address: [Address]
- Telephone Number: [Number]

## PERSON 2
Relationship to deceased infant: [Relationship]

- Given names: [Name]
- Family name: [Name]
- Date of birth: [Date]
- Residential address: [Address]
- Telephone Number: [Number]

## PERSON 3
Relationship to deceased infant: [Relationship]

- Given names: [Name]
- Family name: [Name]
- Date of birth: [Date]
- Residential address: [Address]
- Telephone Number: [Number]

## PERSON 4
Relationship to deceased infant: [Relationship]

- Given names: [Name]
- Family name: [Name]
- Date of birth: [Date]
- Residential address: [Address]
- Telephone Number: [Number]
### MEDICAL HISTORY OF INFANT

**Gestation at birth:**

- Singleton birth
- Multiple birth

**Birth weight:**

**Birth length:**

*(Plot weights on a percentile chart)*

**Type of feeding:**

If type of feeding has changed, date and reason for change:

**Medication, including prescription, over-the-counter, and complementary (record regular medications and recent medications):**

**Immunisation status:**

At any time in the infant’s life did he or she have a history of (record yes or no – if yes, describe):

**Perinatal or neonatal problems (including any birth defects):**

**Evidence of failure to thrive:**

**Abnormal growth or weight gain/loss:**

**Developmental delay or mental retardation:**

**Metabolic disorders:**

**Recent contact with infection:**
## SUDI MEDICAL HISTORY

**Allergies:**

---

**Apnoea (stopped breathing):**

---

**Cyanosis (turned blue/grey):**

---

**Seizures or convulsions:**

---

**Cardiac abnormalities:**

---

Document any growth, development and other past assessments (e.g., health home visit, GP, well-child health checks):

---

Has the child been investigated for neurological disorders, e.g., seizures or any other disorder?

If yes, give full details:

---

Details of any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household:

---

Other medical history – record full details:

---

### SLEEPING ARRANGEMENTS OF INFANT

Location of infant when found (cot, cradle, adult bed, sofa, etc.):

---
2. PAEDIATRICS

NSW HEALTH

FAMILY NAME

DATE OF BIRTH: ______/_____/______

SEX: [ ] MALE [ ] FEMALE

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SUDI MEDICAL HISTORY

Bedding found with the infant (sheet, pillows, blankets, quilts, cot bumpers, etc):

Other objects found with the infant (soft toys, etc):

Were any items covering the infant’s head or face?

Position of infant when put down (record exact position – on side, on back, on stomach, head to left or right side, or unknown):

Position of infant when found (record exact position – on side, on back, on stomach, head to left or right side, or unknown):

Recent changes in sleeping arrangements or sleeping patterns:

MEDICAL HISTORY FOR THE 48 HOURS PRIOR TO THE INFANT’S DEATH
(Record yes or no – if yes, describe)

Changed level of alertness:

Fussiness/excessive crying:

Diarrhoea:

Fever:

Decrease in appetite:
<table>
<thead>
<tr>
<th>Changes in stool:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Changes in passages of stool or urine:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Lethargy or more sleep than usual:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Difficulty waking infant:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Excessive sweating:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Vomiting:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Choking:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Respiratory problems (including difficulty breathing, wheezing, stridor, in-drawing of ribs, snoring):</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Any fall or injury:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Visit to a health professional (record presenting problem and advice given):</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
2. PAEDIATRICS

SUDI MEDICAL HISTORY

OTHER ACTIVITY IN PAST 48 HOURS

Changes in routine care:

Changes in routine activity levels:

Disruptions to normal patterns:

DETAILED NARRATIVE ACCOUNT OF INFANT’S FEEDING, SLEEPING, ACTIVITY AND
HEALTH OVER THE TWO WEEK PERIOD PRIOR TO DEATH

Include:

- Changes in feeding or sleeping patterns
- Changes in place of sleep or sleeping arrangements
- Changes in individuals responsible for caring for infant
- Any social, family, or health-related changes in routine
- Any illness, accident or other major event affecting other family members
- Any visits to a health professional, including reason for visit and outcome
### MEDICAL HISTORY OF MOTHER

Details of past medical and social history of the mother, including any significant past illnesses or injuries:

- 
- 
- 
- 

Detailed information on the pregnancy leading to the birth of the infant who has died:

- 
- 
- 
- 

Detailed past obstetric history for previous pregnancies:

- 
- 
- 
-
A DETAILED ACCOUNT OF PAST MEDICAL HISTORY OF ALL MEMBERS OF IMMEDIATE FAMILY AND HOUSEHOLD

Include:
- Cardiac disease, epilepsy or history of sudden death in family, including parents, their siblings, and their parents
- Family history of developmental delay and mental retardation, including parents and their siblings
- Any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household (include as much information as possible concerning date of birth, age at death, place of death, cause of death and any other known information)

<table>
<thead>
<tr>
<th>CHILD 1</th>
<th>CHILD 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Place of birth:</td>
<td>Place of birth:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD 3</th>
<th>CHILD 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Place of birth:</td>
<td>Place of birth:</td>
</tr>
</tbody>
</table>
HISTORY OF THE FAMILY AND OF THE HOUSEHOLD

Include:

- Detailed information on tobacco use, including exposure of the infant to passive smoking (including smoking in the house and car, and any close contact of the infant with smokers)
- Detailed information on alcohol and other drug use
- Information on any prescription or non-prescription medications that may have been present or in use in the household
- Information on recent changes in composition of the household (e.g., who has come and who has gone, and for what reason)

Activity and location of all significant members of the household in past 48 hours:

Alcohol intake and recreational drug use by members of the household in past 48 hours:
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<th>The examining forensic pathologist</th>
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Please find following the medical history of (insert child’s name) taken on (date) from (insert names of parent(s)/caregivers interviewed) by (insert name of examining doctor) in the presence of (insert name of social worker).

Continuing health care for this issue will be provided to the family by (insert name of examining doctor). An autopsy report is requested in order to facilitate the continuing care of surviving family members of (insert child’s name). Please send a copy of the autopsy report to:

For further information regarding this history, please contact: (insert name of the key person for further contact)
Appendix D: Standard Guidelines: Sudden Unexpected Death In Infancy (SUDI)

This protocol is based on “The autopsy protocol for sudden unexpected deaths in infancy”, outlined in Appendix III of “The report of a working group” convened jointly by the Royal College of Pathologists and The Royal College of Paediatrics and Child Health. It was published in September 2004 and can be viewed in full at http://www.rcpath.org and http://www.rcpch.ac.uk.

In all cases of sudden unexpected death in infancy total body radiographs (a skeletal survey) must be considered and appropriate photography carried out prior to post-mortem examination.

1. Introduction

In all cases of potential SIDS it is important before determining that the death is from natural causes to exclude accidental death such as trauma, drowning or poisoning, to consider the possibility of airway obstruction (as in overlaying due to co-sleeping) and to exclude non-accidental injury. There are certain other protocols of varying complexity available; the pathologist should conform to the local requirements.

Prior to autopsy, a full police report of death to the coroner and the police child death scene investigation protocol should be available. If not, there should be a documented verbal discussion with the police officer in charge of the scene, circumstances of death and available history.

All cases of sudden unexpected death in infancy must be reported to one of the three specialist forensic pathology departments for specialist examination.

2. External examination
   - Measure weight, crown-heel length, crown-rump length, chest and head circumference.
   - Assess nutritional status and extent of hydration.
   - Note evidence of injuries and assess age.

3. Internal examination
   - All organs are to be systematically examined and weighed, including the thymus.
   - Note the distribution of, or absence of, petechial haemorrhages.
   - Brain to be examined. Discuss with the neuropathologist the value of examining the spinal cord.

4. Organ retention
   - This can only be done with the specific consent of the Coroner and after discussion with the family.

5. Histology
   - All major organs including:
     - Five lobes of lung stained with H&E.
     - Epiglottis and larynx.
     - Trachea including thyroid.
     - Heart including right and left ventricles. Depending on the size, a complete transverse section of the heart can be embedded as a single block, or possibly two blocks.
     - All internal organs including duodenum with head of pancreas.
     - Bone marrow including costochondral junction.
     - Skeletal muscle.
     - Brain - If the brain is cut unfixed a minimum of the following sections should be taken: hippocampus, cerebellum, frontal cortex, basal ganglia, medulla, pons, and midbrain.
     - Frozen sections of liver and kidney for fat stains depending on case.
6. **Other samples**

- Toxicology. (Toxicology should always be performed in cases of SUDI. If there has been a significant period of survival in hospital, ante mortem specimens should be obtained for analysis.)
- Biochemistry: Vitreous humour/CSF (sodium, potassium, chloride, urea, creatinine, ketones, glucose).
- Virology and microbiology as required.
- DNA for genetic testing, e.g. for prolonged QT interval 5 ml blood in EDTA.

In all cases, blood (or other specimen suitable for extraction of DNA) should be retained for prolonged QT genetic testing in case it is required later. If there is a history of similar death in other family members and siblings, which is suggestive of long QT syndrome, then the pathologist should discuss the case with a cardiologist and strongly consider genetic testing for inherited causes of cardiac arrhythmias particularly prolonged QT.

Where indicated by autopsy and/or clinical findings, testing for genetic and/or inherited metabolic disorders should be undertaken.

**Samples required for metabolic testing**

1. **Blood**

This procedure is the same as normal clinical practice for a live infant. Blood collection may be difficult, especially as the time since death increases. The first attempt to take blood should be from the femoral vessels. Peripheral blood is better than heart blood, particularly for toxicological analysis.

If insufficient blood is obtained peripherally, blood should be taken from the heart. Use a large (e.g. 14-gauge) needle and aspirate blood from the right ventricle of the heart first for blood culture to minimise the chances of contamination. Then incise the right ventricle anteriorly and aspirate any remaining blood using a syringe. This technique provides the largest amount of blood, which can then be used for other purposes.

The order of priority for blood collection and analysis is:

- Sample of blood from syringe for Guthrie card. Send the newborn screening card for metabolic analysis to the Biochemical Genetics, The Children’s hospital at Westmead.
- Blood for toxicological analysis.
- Blood for blood culture.

2. **Bile**

Bile should be collected from the gall bladder and frozen at –70°C and sent on dry ice to Biochemical Genetics, The Children’s Hospital at Westmead for storage and possible later analysis for diagnosis of metabolic analyses.

3. **Urine**

It may not be possible to collect urine from the infant, however even a very small amount can be analysed (2mls of urine is sufficient).

Priorities for urine are:

1. toxicological analysis
2. metabolic analysis
2. PAEDIATRICS

Open the trunk and directly visualise the bladder, followed by either opening the bladder or using a syringe and needle to obtain urine.

Freeze sample at -20°C. Urine should be sent on dry ice to the Children’s Hospital at Westmead for analysis. This sample can also be used for toxicology.

4. Cerebrospinal Fluid (CSF)

Place the CSF into two sterile CSF tubes, one for microscopy and culture, and the other to be stored frozen for later PCR for viruses and/or metabolic testing as appropriate. CSF for metabolic analysis should be sent to the Biochemical Genetics, The Children’s Hospital at Westmead. Note the colour and type of CSF and site of collection of CSF.

Depending on the sample size, CSF can also be used for biochemistry - urea, creatinine and electrolytes.

Samples for metabolic screening should be forwarded to Biochemical Genetics Department in the Children’s Hospital at Westmead and should arrive between the hours 8.30am - 5pm Monday to Friday. Telephone number: (02)9845 3654.

For enquiries out of office hours, page the Senior Scientist through the Children’s Hospital switchboard: (02)9845 0000.

Sampling muscle, liver and skin

These samples can all be taken via the same abdominal incision. In exceptional circumstances where metabolic disease is likely, consideration should be given to a paediatrician taking the liver samples immediately after the infant’s death. This should be done in consultation with the forensic pathologist, the coroner and the pathology laboratory.

5. Skin

Take a thin ellipse of skin from the edge of the incision under sterile conditions. Place in cytogenetics fluid (Hanks). If this is not available, then sterile normal saline or Stuart’s viral transport medium can be used. Place in normal fridge. Do NOT freeze.

6. Muscle

Note the state of the muscle and take a rectangular biopsy approximately 10x20mm if possible. Stay anterior to the peritoneum.

Wrap half the muscle sample in foil. Place in a suitable sealed container and snap freeze in liquid nitrogen then maintain at -70°C or place on dry ice. Do NOT allow to thaw. If available, place half of remainder in formalin and freeze other half on a chuck with fibers orientated transversely. The most important step is freezing the muscle at -70°C.

7. Liver

Cut through the peritoneum and expose the liver. Note any free fluid in the abdomen - amount, colour, blood etc. Note the appearance of the liver - colour, presence of contusions, haemorrhage and texture.
Take a wedge of liver 10x10mm. Wrap majority in foil, place in a suitable container and snap freeze in liquid nitrogen then maintain at -70°C or on dry ice. **Do NOT allow to thaw.** Place the remainder of the liver sample in formalin.
SUDDEN INFANT DEATH SYNDROME (SIDS) AND SAFE SLEEPING FOR INFANTS
(GL2005_063)

This Guideline updates Information Bulletin Number 2003/17. This Guideline provides a more explicit explanation of the risk of SIDS associated with positioning babies on their stomach and includes information on safe sleeping practices, commonly asked questions and more detail on SIDS and Kids resources and contacts.

The recommendations in this Guideline should be implemented as NSW Health policy in all NSW Health facilities.

Health professionals in maternity units should ensure that positioning infants to sleep follow these guidelines, and that parents are strongly encouraged to maintain these practices when they return home with their infants.

This Guideline may be used by both health professionals and parents, and incorporates the parent information developed by SIDS and Kids (formerly known as SIDSAustralia). The language used by SIDS and Kids has been retained so that health professionals may distribute the information directly to parents.

Sudden Infant Death Syndrome (SIDS) and Safe Sleeping for Infants

Some sleeping arrangements are not safe. They can increase the risk of SIDS or cause serious sleeping accidents. Research has found some important ways to reduce the risks of SIDS and to create a safe sleeping environment for babies and young children. The following provides information on how to create a safe sleeping environment for a baby.

There are three main ways to reduce the risk of SIDS:
1. Put baby on the back to sleep, from birth;
2. Make sure baby’s head remains uncovered during sleep.
3. Keep your baby smoke free, before birth and after;

Put baby on the back to sleep, from birth

Sleeping on the back reduces the risk of SIDS. The chance of babies dying from SIDS is greater if they sleep on their tummies or sides. Put your baby on the back to sleep, from birth, unless your doctor or nurse tells you otherwise. Healthy babies placed to sleep on the back are less likely to choke on vomit than tummy sleeping infants.

The best position for babies to sleep is on their backs. If you choose to sleep your baby on the side, make sure that his or her lower arm is well forward to stop rolling onto the tummy. The side position is not recommended for babies as they may roll onto their tummies during sleep. However, if your baby has certain rare medical conditions, side or tummy sleeping may have been recommended by your doctor.

When the baby is awake it is important to vary the baby’s position from lying on its back. Tummy play is safe and good for babies when they are awake and an adult is present, but don’t put baby on the tummy to sleep.

Older babies can turn over and move around the cot. Put them on the back but let them find their own sleeping position. The risk of SIDS in babies over six months is extremely low.
Make sure baby’s head remains uncovered during sleep

Be careful your baby’s face and head stay uncovered during sleep as this decreases the risk of SIDS. Loose bedding can cover your baby’s head. Tuck your baby in securely so that he or she can’t slip under the bedclothes. Make up the bed so that the baby’s feet are at the foot of the bed. Quilts, doonas, duvets, pillows, soft toys and cot bumpers should not be placed where your baby sleeps during the first year.

Taking a baby into an adult bed may be unsafe if baby:
- Gets caught under adult bedding or pillows;
- Is trapped between the wall and the bed;
- Falls out of bed;
- Is rolled on by someone who sleeps very deeply or who is affected by drugs or alcohol.

Keep your baby smoke free, before birth and after

Cigarette smoke harms babies before birth and after. Parents who smoke during the pregnancy and after the baby is born increase the risk of SIDS for their baby. In fact, if mother smokes, the risk of SIDS doubles, and if father smokes too, the risk doubles again.

There is an increased risk of SIDS if parents are smokers, even if they smoke outside, away from the baby. If mothers who are smokers bed share with their babies the risk of SIDS is increased. The reasons for this are not clear. However, we do know that being a non-smoker or smoking less will reduce the risk for your baby.

Try not to let anyone smoke near your baby - not in the house, the car or anywhere else your baby spends time. If you want to quit smoking and you’re not finding it easy, ask for help. Call the Quitline on 131 848 or ask your doctor, midwife or child health nurse for information and advice about quitting.

Other important information

The following outlines other important information for parents.

Is immunisation linked with SIDS?

No. There is very strong evidence to show that immunisation is not associated with SIDS. The peak age of SIDS is the same age babies are most often immunised (two to four months), so by chance they can occur at the same time. Have your baby fully immunised on time.

How can I stop my baby getting a flat ‘pressure spot’ on the skull?

Some babies are born with a different shaped head. A flat pressure spot can develop on baby’s head if the baby lies in the one position for long periods of time. These flat spots improve with age and most, but not all, will disappear completely. They are not dangerous and improve naturally as baby’s head grows and when baby starts to sit up and look about.

Babies often develop a preference to look in one direction. Sleep baby on the back and encourage him/her to look in a different direction. You can change baby’s head position for each sleep, from face turned to one side, then to the other, then to looking straight up. If the baby always seems to turn his/her head to face out into the room, alternate putting the baby at different ends of the cot, so they will turn their head to a different position. If baby has a favourite object to look at, change the position of this object so that the position of baby’s head changes.
If the baby continues to turn only to one side, parents need to speak to the early childhood health nurse or doctor about referral to physiotherapy. Parents can then be given exercises to encourage full head movement and therefore reduction or prevention of flat pressure spots. If the baby’s head seems to be oddly shaped or crooked, parents should have it checked out by the doctor.

**Will bed sharing during sleep increase the risk of sudden infant death syndrome?**

Bed sharing does not appear to increase the risk of SIDS for any of the following groups:
- When you bed share to feed and cuddle the baby and put the baby back in the cot;
- When the baby is older than 4 months;
- If you and your partner are non-smokers.

If you or your partner smoke, sleeping with your baby in the first 4 months may increase the risk of SIDS. Particular circumstances that may increase the risk for all parents include when you or your partner have consumed alcohol or have taken drugs which make you sleep more heavily.

If you sleep with your baby, make sure that the baby’s head cannot become covered by bedding. Keep the baby away from the pillows; use firm bedding and lightweight blankets rather than doonas or duvets and place your baby in a position where there is not the risk of him/her falling out of the bed. The safest place for the baby to sleep is in a basinet beside your bed.

**Does sleeping with baby on a couch increase the risk of sudden infant death syndrome?**

Yes. Some research into sudden infant death has shown that an adult sleeping on a couch with a baby can be dangerous. This is because baby may become wedged into cushions or the back of the sofa and the sleeping person would not notice. Put baby back into his or her own sleeping place before you doze off on a couch.

**Further information**

More information on how to reduce the risk of SIDS and sleeping your baby safely can be obtained from the SIDS and Kids website [http://www.sidsandkids.org](http://www.sidsandkids.org) or by contacting SIDS and Kids on telephone 1300 308 307.

The following SIDS and Kids information products are available:
- SIDS & Kids safe sleeping Brochure;
- SIDS & Kids safe sleeping Easy Read Brochure;
- SIDS & Kids safe sleeping Frequently Asked Questions;
- SIDS & Kids safe sleeping Door Hanger;
- SIDS & Kids safe sleeping Parent Video;
- Reducing the Risk of Sudden Infant Death Syndrome - Scientific literature to support the recommendations of the Forum to review the risk factors for SIDS.

Copies of the above resources are available from SIDS and Kids on telephone 1300 308 307. SIDS and Kids also provides education and training on reducing the risk of SIDS and safe sleeping for health professionals on request. Safe sleeping resources for midwives are available that outline recent research and other up to date evidence for back sleeping.
2. PAEDIATRICS

MATERNITY - SAFE SLEEPING PRACTICES FOR BABIES IN NSW PUBLIC HEALTH ORGANISATIONS (PD2012_062)


PURPOSE

The purpose of this Policy Directive is to provide direction to all staff in NSW Public Health Organisations (PHOs) on how to reduce the risk of Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infancy (SUDI) in situations where mothers and babies are accommodated together by:

- Providing consistent, evidenced based information to assist staff in educating, promoting and modelling a safer sleeping environment and practices to all expectant mothers, parents, extended family members and caregivers of babies under their care.
- Identifying and addressing risk factors following birth and in the postnatal period.
- Ensuring all staff implement, model and promote the safest possible sleeping environments and practices for babies and infants in NSW Public Health Organisations.
- Ensuring all expectant mothers, new mothers, parents and caregivers receive consistent, current and accurate information on safer sleeping environment and practices.

MANDATORY REQUIREMENTS

All NSW PHOs that provide maternity services and/or accommodate mothers and babies together must have procedures and/or protocols for the safer sleeping of babies that are consistent with this Policy Directive.

This Policy Directive applies to all NSW PHOs:

- Who provide care to expectant parents and/or parents and caregivers of well term babies and young infants where mothers and babies are accommodated together.
- Where babies and/or infants are admitted, boarded, or where they or their mother/parent/caregivers remain for some hours while receiving services including: birthing units, postnatal wards, well babies in Special Care Nurseries (SCNs) and community health care settings (including day stay facilities).

This Policy Directive does not apply to unwell babies or preterm babies under the care of a medical team in a Special Care Nursery or Neonatal Intensive Care setting.

IMPLEMENTATION

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

RESPONSIBILITIES

The Chief Executives of NSW PHOs are responsible for:

- Ensuring that all NSW Health staff who provide care to babies, infants, expectant or new parents and/or families with young infants comply with this Policy Directive.
- Establishing and implementing work practices which enable appropriate education and support for mothers/parents and their babies in hospital on safer sleeping practices.
- Ensuring that all sleeping equipment for babies and infants complies with the Australian Standard AS/NZS2130:1998 (Section 5); and
2. PAEDIATRICS

- Ensuring that quality assurance processes are in place which includes an annual local audit of safer sleeping practices to ensure compliance with this Policy Directive.

Directors Nursing/Midwifery/Medical/Allied Health are responsible for:
- Providing all health professionals who provide care to babies, infants, expectant or new parents and/or families with young infants with opportunities to maintain their clinical skills and knowledge of evidence-based parenting advice on safer infant sleeping practices.

Managers of individual NSW PHOs who provide care to babies, infants, expectant or new parents and/or families with young infants are responsible for:
- Ensuring that safer sleeping practices in accordance with this Policy Directive are implemented and modelled by their staff at all times which is monitored through the annual audit of safer sleeping practices; and
- Providing expectant mothers, parents, extended family members and caregivers with babies and young infants with consistent information in accordance with this Policy Directive including antenatal and postnatal education to promote safer sleeping practices for all babies from birth.

All health professionals/providers of NSW PHOs who provide care to babies, infants, expectant or new parents and/or families with young infants are responsible for:
- Maintaining their clinical skills and knowledge of evidence-based parenting advice on safer infant sleeping best practice.

1. DEFINITIONS

Sudden Infant Death Syndrome (SIDS):
“Is the sudden and unexpected death of an infant under one year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, and review of the circumstances of death and the clinical history”ii.

Note: The above Kraus et al (2004) definition of SIDS remains current and is broadly accepted and is referenced in the NSW Child Death Review Team Annual Report 2011 (October 2012).

Sudden Unexpected Deaths in Infancy (SUDI):
“Where an infant less than one year of age dies suddenly and unexpectedly. Included in SUDI are:
- Deaths that were unexpected and unexplained at autopsy (that is those meeting the criteria for Sudden Infant Death Syndrome (SIDS);
- Deaths occurring in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life threatening;
- Deaths arising from a pre-existing condition that had not been previously recognised by health professionals;
- Death resulting from accident, trauma or poisoning where the cause of death was not known at the time of death” iii.

Note: The NSW Child Death Review Team has specifically excluded from this definition infants who died unexpectedly in misadventures due to external injury where the cause of death was known at the time of death (such as transport incidents and accidental drowning) and deaths that occurred in the course of a known sudden acute illness in a previously healthy infant.

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2. **BACKGROUND**

Epidemiological evidence has repeatedly shown that most of the risk factors associated with SIDS are modifiable and that the implementation of simple safer sleeping practices can dramatically reduce the incidence of SIDS, as seen world-wide during the last 20 years\(^iv, v\).

Despite this knowledge, modifiable risk factors have still been present in the majority of SIDS deaths and in up to 90% of neonatal fatalities\(^vi\). Fatal sleeping accidents due to unsafe sleeping practices and/or environments continue to be a significant risk factor for preventable SUDI, particularly during the neonatal period\(^vii\). SIDS continues to be the most common cause of infant deaths in the post neonatal period (between 28 and 365 days after birth).\(^viii, ix, xi\)

Regardless of the strong evidence that placing babies to sleep on their back reduces the risk of SIDS, there have been a number of sudden unexpected infant deaths in recent years where babies have been found prone or side sleeping.

Studies have found that the provision of information and modelling by health professionals directly influences the behaviour of expectant mothers, parents, caregivers and extended family members.\(^xii, xiii, xiv\) As such, all health professionals who have contact with babies, infants, expectant parents or families with babies or young infants have a significant role in the reduction of the incidence of SIDS. This can be achieved by providing and promoting consistent information and modelling safer sleeping practices in hospitals and community settings using resources from the SIDS and Kids Safe Sleeping program. The SIDS and Kids program is based on scientific evidence and was developed by Australian researchers, paediatricians, pathologists, and child health experts with input from overseas experts in the field.

3. **SCOPE**

This Policy Directive is relevant to all NSW Health staff who are required as part of their clinical care to provide safer sleeping information, education and modelling to expectant parents, parents, caregivers and extended family members commencing in the antenatal period and continuing through the postnatal period and up until the mother and baby/babies are discharged from NSW PHOs.

4. **PROMOTING SAFER SLEEP PRACTICES - ANTENATAL PERIOD**

Health professionals have an important role in educating, promoting and influencing safer sleeping practices to parents and the broader community.

NSW Health staff who care for expectant mothers, parents and caregivers of babies must provide consistent evidence based information and education about safer sleeping practices. It is particularly important to target multiparous mothers and their partners and other caregivers to ensure they are made aware of current safer sleeping practices. Consistent information and modelling should influence and encourage the use of safer sleeping practices in the home.

This policy is aligned to SIDS and Kids Safe Sleeping program. It is strongly recommended that ‘Sleep Safe, My Baby’ educational resources available on SIDS and Kids website (http://www.sidsandkids.org) be made available and displayed prominently in antenatal clinics, parenting classes, birthing units and postnatal wards to complement the information provided in this policy. These resources should be promoted by NSW Health staff to advise women and their families on safer sleeping practices.
2. PAEDIATRICS 2.96

The following messages for safer sleeping are to be promoted and modelled to mothers, parents, caregivers and extended family members in all NSW PHOs to reduce the risk of SIDS and SUDI:

- **Sleep baby on back from birth**
  - Do not lay baby in the prone (tummy) or side sleeping position.
  - Make sure baby’s feet are positioned at the bottom of the cot.

- **Keep baby’s head and face uncovered**
  - Do not apply bonnets, beanies, hats or hoods whilst sleeping indoors.
  - An alternative to bedding is a safe baby sleeping bag which has a fitted neck and arm holes and no hood.

- **Keep baby smoke free before and after birth**
  - Prevent exposure to smoke from cigarettes; tobacco and marijuana.
  - Ensure the car, the home and anywhere else the baby spends time, is a smoke free zone.
  - Consider contacting Quitline on 137 848 or talking with an appropriate health care professional about nicotine replacement therapy or counselling.

The key message to provide to expectant mothers, parents, caregivers and extended family members is that it is strongly recommended that adults do not sleep together with their babies on the same sleep surface and that their babies are always returned to their own safe cot/sleeping surface prior to the adult falling asleep.

- **Provide a safer sleeping environment night and day**
  - Place babies to sleep in their own cot that meets the current Australian Standard (AS/NZ S2172:2003: Cots for household use - Safety Requirements).xvi
  - A clean mattress that is firm, flat and the right size for the cot.
  - Do not have soft toys, or soft bedding such as sagging mattress, doonas, lamb’s wool or cot bumpers in the cot or adult bed.
  - Waterbeds, sofas, bean bags, couches, pillows and cushions are not safe for babies.

- **Sleep baby in their own safe sleeping environment next to the parents’ bed for the first six to twelve months of life**
  - Room sharing next to the parents’ bed has been shown to be protective and reduce the risk of SUDI.xvii

- **Encourage breastfeeding, wherever possible**
  - There is strong evidence that breastfeeding baby reduces the risk of SUDI.

5. SAFER SLEEPING PRACTICES IN NSW PHOs - FOLLOWING BIRTH AND IN THE POSTNATAL PERIOD

To promote a safer sleeping environment, staff need to advise all mothers that sleeping with their babies is strongly discouraged and is not recommended under any circumstances in NSW PHOs. Babies must be returned to their own safe cot prior to the mother/adult falling asleep.

All staff must place well babies under their care, on their back to sleep from birth. This includes babies in birthing units, postnatal wards, well babies in SCNs and community health care settings (including day stay facilities).
2. PAEDIATRICS

The safest place for a baby to sleep in the first six to twelve months of life is in the same room as their mother, parents or caregiver in a safe cot next to the adults’ bed. This includes birthing units and postnatal wards, unless medically contraindicated.

To ensure a safer sleeping environment for babies in NSW PHOs the following should be provided:

- **A safer place** - babies must remain with their mothers/parents/caregiver at all times, unless otherwise medically indicated.

- **A safer position** - babies must only be placed on their back to sleep from birth with their feet positioned at the bottom of the cot, unless otherwise medically indicated.

- **A safer cot** - fitted with a clean mattress that is flat and the right size for the cot eliminating any gaps that a baby may get trapped in.
  - Must meet the current Australian Standard (AS 2130:1998 *Cots for day surgery, nursery, hospitals and institutional use - Safety Requirements*).

- **Safer bedding** - the baby’s face must be uncovered at all times.
  - No bonnets, beanies, hats or hoods whilst sleeping indoors.
  - Bedding tucked in firmly.
  - A safe baby sleeping bag which has a fitted neck and arm holes and no hood may be used.

**Note**: Remind mothers, parents and caregivers that soft toys are not to be placed in the cot and that soft or loose bedding such as doonas, pillows, cot bumpers, lambswool are not to be used. It is particularly important to target multiparous mothers, their partners and grandparents to ensure they are aware of current safer sleeping practices.

5.1 FEEDING AND SETTLING

For many mothers/parents, it is common practice for their babies to share their adult bed particularly for breastfeeding and settling during the first year of life. Mothers often wish to start their preferred feeding and settling practices while still in hospital. There appears to be no increased risk of SIDS whilst sharing a sleep surface with a baby during feeding, cuddling, and settling, providing the baby is returned to their own safe cot/sleeping surface prior to the adult falling asleep.

NSW Health promotes the early establishment of breastfeeding, and strategies which assist the development of healthy maternal/infant attachment and recognises that for some mothers this will include breastfeeding and settling their baby in their adult bed. Many mothers will be exhausted and tired following the birth of their baby and are more prone to fall asleep and therefore it is important that staff are vigilant in the early postnatal period.

**All staff must follow the safer sleeping practices outlined in this policy and remind all new mothers, parents and caregivers of the key message that following feeding and settling, their baby must be returned to their own safe cot prior to the mother/adult falling asleep.**

In addition, staff should be aware that the following group of mothers are at greater risk of unintentionally falling asleep when feeding or settling their baby in their adult bed which increases the risk of SUDI to their babies. Mothers who are:

- Under the effects of general anaesthetic (first 24 hours).
2. PAEDIATRICS

- Immobile due to spinal or epidural anaesthetic (until fully mobile).
- Under the influence of drugs/medications that may cause drowsiness e.g. alcohol, illicit drugs, medications including sedatives, analgesia especially narcotics and other opioids, methadone etc.
- Maternal illness that may affect consciousness or ability to respond normally to the baby e.g. fever, excessive blood loss, severe hypertension etc.
- Maternal fatigue or tiredness to the point that would affect their ability to respond to the baby e.g. laboured through the night and awake >24 hours.

5.2 CLINICAL RISK ASSESSMENT

It is the responsibility of all maternity facilities/services in NSW PHOs to establish protocols and controls incorporating clinical risk assessment to facilitate a safer environment for the above group of mothers/parents (who are at greater risk of unintentionally falling asleep) should they choose to take their babies to bed with them when feeding and/or settling.

A clinical risk assessment must be made by a suitably qualified health professional in conjunction with the mother, and/or partner to determine potential risks and identify appropriate interventions including the level of monitoring and support required during feeding and settling a baby in the maternal/adult bed.

The clinical risk assessment should consider the following factors:
- Mother’s clinical condition
- Baby’s clinical condition
- Safety of the physical environment

All mothers in birthing and postnatal units who are given medication of a sedative nature should be reminded verbally that once the medication is taken, their baby should not be taken into their bed, even for feeding or settling for the period of time determined by the local protocol and clinical risk assessment. Babies must be returned to their own safe cot prior to the mother/adult falling asleep.
- In the event that a baby requires breastfeeding or settling whilst the mother is receiving medication of a sedative nature, more regular monitoring and support by staff is required.
- In addition, staff should consider the following:
  o Lowering the bed as far as possible;
  o Placing the call bell/buzzer as close as possible to the mother/parents;
  o Tucking the bed clothes firmly around the mother/parents and baby;
  o Removing loose bedding from the mother/parents bed.

Note: If bed rails/cot sides are used they must be of a design that does not present a danger of entrapment to the baby.
- If the father/partner or support person is assisting with feeding and/or settling of the baby, it is important to remind them of the need to return the baby to their own safe cot once fed and/or settled.

There may be instances where a mother refuses to follow advice about returning her baby to their own safe cot prior to falling asleep. If this is the case, a note of the advice received and the mother’s refusal to follow this advice needs to be documented in the clinical notes.

168(22/11/12)
6. SAFER SLEEPING PRACTICES - ON DISCHARGE

Discharge preparation for the mother and/or partner must include documentation in the clinical notes of the parent education provided about safer sleeping practices outlined throughout this Policy Directive. In addition, all new mothers/parents must be provided with the SIDS and Kids safe sleeping easy read brochure. They may also be given the ‘Sleep Safe, My Baby’ door, cot or change table hanger which reinforces the key safe sleeping messages and is available free at http://www.sidsandkids.org/wp-content/uploads/DoorH2012LR1.pdf

Further information and resources on safe sleeping practices and reducing the risk of SIDS and SUDI can be found on the SIDS and Kids website at http://www.sidsandkids.org or by phoning toll free 1300 308 307.
## ATTACHMENT 1: IMPLEMENTATION CHECKLIST

<table>
<thead>
<tr>
<th>Local Health District</th>
<th>Facility</th>
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<td><strong>Assessed by:</strong></td>
<td><strong>Date of Assessment:</strong></td>
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<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
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</thead>
<tbody>
<tr>
<td>1. Local protocol includes clinical risk assessment to ensure compliance with this Policy Directive</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>3. Provision of key messages and resources on safer sleeping practices are included in antenatal and postnatal education and on discharge to ensure compliance with this Policy Directive</td>
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<td>Notes:</td>
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<tr>
<td>4. Annual local audit of safer sleeping environment and practices to ensure compliance with this Policy Directive</td>
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<td>Notes:</td>
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Notes:
8. REFERENCES

1 Kidsafe NSW (June 2012) Cots Fact Sheet. Available at http://www.productsafety.gov.au/content/index.phtml/itemId/972363


16 Kidsafe NSW (June 2012) Cots Fact Sheet. Available at http://www.productsafety.gov.au/content/index.phtml/itemId/972363


19 Kidsafe NSW (June 2012) Cots Fact Sheet. Available at http://www.productsafety.gov.au/content/index.phtml/itemId/972363
MANAGEMENT OF CEREBRAL PALSY IN CHILDREN - A GUIDE FOR ALLIED HEALTH PROFESSIONALS

(GL2018_006 issued 14/3/2018)

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

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

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

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

296(14/03/18)
FEEDING DIFFICULTIES IN CHILDREN - A GUIDE FOR ALLIED HEALTH PROFESSIONALS

(GL2016_007 issued 18/2/2016)

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDE

Chief Executives must ensure:

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

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

To download this guideline go to

Feeding Difficulties in Children - A Guide for Allied Health Professionals

296(18/2/16)
INFANTS AND CHILDREN: MANAGEMENT OF ACUTE AND PROCEDURAL PAIN IN THE EMERGENCY DEPARTMENT

GL2016_009 issued 7/3/2016)

PURPOSE

The Infants and Children: Management of Acute and Procedural Pain in the Emergency Department 1st Edition Clinical Practice Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families.

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- This guideline is adopted or local protocols are developed based on the Infants and Children: Management of Acute and Procedural Pain in the Emergency Department 1st Edition, Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric patients with pain
- 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 guideline.

To download this guideline go to

Infants and Children: Management of Acute and Procedural Pain in the Emergency Department
2. PAEDIATRICS

CHILD RELATED ALLEGATIONS, CHARGES OR CONVICTIONS AGAINST NSW HEALTH STAFF (PD2016_025)

PD2016_025 rescinds PD2006_025

PURPOSE

This Policy Directive and the attached Procedures set out the mandatory requirements for managing child related allegations, charges and convictions involving NSW Health staff, which includes, for the purpose of this policy, anyone working in NSW Health, whether as a paid staff member or engaged in any other capacity, including as a volunteer, Visiting Practitioner, student attending clinical placement or anyone else appointed on an honorary or contractual basis. It also applies to staff of the NSW Ministry of Health.

Child related allegations and convictions include any alleged behaviour or criminal charges or convictions against NSW Health staff that may constitute reportable conduct, as specified under Part 3A of the Ombudsman Act 1974, where the alleged victim was under the age of 18 years at the time of the alleged behaviour; this extends to child pornography, non-work related and historical matters.

This Policy Directive includes the requirements of the Ombudsman Act 1974 and the requirements of Part 5 of the Child Protection (Working with Children) Act 2012.

MANDATORY REQUIREMENTS

All child related allegations and convictions against current NSW Health staff members must be:

- Reported to the Child Protection Helpline if there is suspected risk of significant harm relating to a child or a class of children:
  - Where there are concerns about a child that do not meet the threshold for a mandatory report, the NSW Health Child Wellbeing Unit must nevertheless be contacted.

- Reported to the NSW Police if there is alleged criminal conduct

- Notified to the employing Chief Executive (or Secretary, NSW Health in the case of NSW Ministry of Health staff), including where the person works in a different NSW Health organisation to where the allegation has been identified

- Notified to the NSW Ministry of Health via a Reportable Incident Brief (RIB) by the Chief Executive (or delegated person) within 24 hours

- Investigated (unless the facts are clear and uncontested), risk managed and findings made, consistent with the processes in the NSW Health policy on Managing Misconduct (or Government Sector Employment Act in the case of NSW Ministry of Health staff) and the requirements of this policy

- Notified to the NSW Ombudsman using Part A of the Ombudsman’s Notification Form as soon as possible and in any event within 30 days of the matter being brought to the attention of the NSW Health organisation (unless the matter falls outside of the definition of reportable conduct)
  - The NSW Ombudsman must also be notified of the outcome using Part B of the Ombudsman’s Notification form and, unless otherwise advised by the Ombudsman, be provided with the documentation relevant to the investigation and findings.

- Notified to the Children’s Guardian if the staff member is classified as a child related worker and there has been a finding of sexual misconduct committed against, with or in the presence of a child, or a serious physical assault of a child

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2. PAEDIATRICS

- Notified to the Australian Health Practitioner Registration Agency:
  - If there is a reasonable belief of notifiable conduct by a registered health practitioner. Under the Health Practitioner Regulation National Law (NSW) notifiable conduct includes practising while intoxicated by alcohol or drugs; sexual misconduct in the practice of the profession; placing the public at risk of substantial harm because of an impairment (health issue); or placing the public at risk because of a significant departure from accepted professional standards.
  - Any conduct of a registered health practitioner that the Chief Executive suspects on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct under the Health Practitioner Regulation National Law (NSW).

Service Check Register records must be created in accordance with the requirements of the NSW Health Service Check Register Policy.

Where a child related allegation, charge or conviction is work related and involves a former NSW Health staff member, the Chief Executive of the relevant NSW Health organisation must be notified, support offered to the alleged victim and reports made to external agencies as appropriate. Any available information should also be reviewed from a systemic perspective and a focus on ensuring the ongoing safety of children.

Records relating to child related allegations, charges and convictions must be kept securely and maintained for 100 years before being destroyed, noting that they may be subject to audit by the NSW Ombudsman.

IMPLEMENTATION

The following have key responsibilities in relation to this Policy Directive:

*Chief Executives* are required to:

- Have in place procedures for ensuring that all staff are made aware of their responsibilities for reporting child related allegations, charges or convictions involving anyone working in NSW Health.
- Have in place procedures for managing child related allegations, charges or convictions, including the requirement for the Chief Executive to be notified.

*Workforce Directorates / Human Resource Departments / Internal audit Units / Governance or Professional Conduct and Standards Units* are required to:

- Ensure provision of information, advice and monitoring as necessary to support effective implementation of this policy.

*All staff* are required to:

- Notify their line manager or supervisor, or other delegated position, as specified in local procedures, if they become aware of any child related allegations, charges or convictions involving a NSW Health staff member.
- Self-disclose any child related criminal charges and/or convictions against them.
1 BACKGROUND

1.1 About this document

Child related allegations, charges and convictions involving anyone engaged in work in NSW Health, whether for paid or unpaid work, must be managed in accordance with this Policy Directive and Procedures and consistent with the processes outlined in the NSW Health policy on Managing Misconduct, or in the case of staff of the Ministry of Health, the Government Sector Employment Act 2013, supported by the NSW Public Service Commission’s Employment Portal. These Procedures set out the requirements for managing child related allegations, charges and convictions, where the requirements vary from, or are in addition to, those of the NSW Health policy for Managing Misconduct.

This Policy Directive and Procedures should be read in conjunction with other relevant NSW Health policies, such as those on Child Wellbeing and Child Protection, Sexual Assault Services, Service Check Register for NSW Health, Managing Concerns or Complaints About Clinicians and Incident Management.

1.2 Key definitions

**Child** is, for the purpose of this policy, a person under the age of 18 years of age as defined by the Ombudsman Act 1974 and the Child Protection (Working with Children) Act 2012. Refer to section 1.3.3 of these Procedures for the definition of a child and young person under the Children and Young Person’s (Care and Protection) Act 1998.

**Child related allegation** is an allegation or criminal charge against a current NSW Health staff member that involves reportable conduct or misconduct that may involve reportable conduct.

**Child related conviction** is a conviction, including a finding of guilt without the court recording a conviction, against a NSW Health staff member, for an offence involving reportable conduct.

**Child-related worker** is defined by the Child Protection (Working with Children) Act 2012 and Child Protection (Working with Children) Regulation 2013. Refer to NSW Health’s policy on Employment Checks for further information.

**Class of children** is a group of children who may be at risk of harm from abuse because of a person or situation.

**NSW Health Child Wellbeing Units** are units staffed by child protection professionals who are able to provide telephone advice and support to NSW Health workers in determining the level of risk of harm and responding to the needs of vulnerable children, young people, pregnant women and families.

**NSW Health organisation** is, for the purposes of this policy, any public health organisation as defined under the Health Services Act 1997, NSW Ambulance, Health Infrastructure, HealthShare NSW, NSW Health Pathology, E-Health, any other administrative unit of the Health Administration Corporation, and Albury-Wodonga Health in respect of staff who are employed in the NSW Health Service, and the NSW Ministry of Health.

**NSW Health Service** includes all persons employed under Chapter 9, Part 1 of the Health Services Act 1997.

**JIRT** is a Joint Investigation Response Team made up of the Department of Family and Community Services (FACS), NSW Police Force and NSW Health Professionals working collaboratively to jointly manage statutory child protection matters (reports of sexual abuse and serious physical abuse and neglect of children and young people) that require a criminal justice and health response.
Reportable conduct is defined under Part 3A of the *Ombudsman Act 1974* as:

a. Any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence or an offence involving child abuse material) or

b. Any assault, ill treatment or neglect of a child or

c. Any behaviour that causes psychological harm to a child whether or not, in any case, with the consent of the child.

The Ombudsman Act also states that reportable conduct does not include:

- Conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards, or

- Use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures.

For further information about what constitutes reportable conduct, refer to the NSW Ombudsman’s Fact Sheet *Defining Reportable Conduct*.

Staff member, for the purpose of this policy, is anyone working in NSW Health, whether as a paid staff member or engaged in any other capacity, including as a volunteer, Visiting Practitioner, student attending clinical placement or anyone else appointed on an honorary or contractual basis.

1.3 Legal and Legislative Framework

1.3.1 Ombudsman Act 1974 and Ombudsman Regulation 2011

The *Ombudsman Act 1974* and the *Ombudsman Regulation 2011* prescribe the responsibilities of heads of agencies for preventing, and for responding to, child related allegations, charges and convictions against staff. Consistent with this Act, NSW Health Chief Executives are required to notify the NSW Ombudsman of all child related allegations, charges or convictions involving NSW Health staff as soon as is practical or at the latest within 30 days of becoming aware of the matter.

Child related allegations and convictions notifiable to the Ombudsman include conduct that has occurred outside of work or prior to the staff member’s engagement in NSW Health, including historic matters where the alleged victim may now be an adult.

NSW Health organisations are required to inform the Ombudsman of the results of their investigations into child related allegations and convictions and the action taken, or proposed to be taken, in response to such allegations or convictions.

Chief Executives are also required to ensure that all staff are informed of their obligation to notify the Chief Executive when they become aware of any child related allegation, charge or conviction against anyone working in NSW Health, and to ensure that there are clear internal reporting lines to facilitate this.

For further information, including contact details for the NSW Ombudsman’s office, refer to the Ombudsman’s website at [www.ombo.nsw.gov.au](http://www.ombo.nsw.gov.au)
1.3.2 The Child Protection (Working with Children) Act 2012

The Child Protection (Working with Children) Act 2012 requires notifications to the Office of the Children’s Guardian (the Children’s Guardian) of investigation findings where a child-related worker has been found to have engaged in either sexual misconduct (including sexual offences) committed against, with, or in the presence of a child, or a serious physical assault of a child.

The notification should be completed as soon as a final determination has been made by the NSW Health organisation that sexual misconduct or serious physical assault has occurred, even if appropriate disciplinary action in respect of the misconduct has not yet been determined or review or appeal processes remain available.

For further information about matters requiring notification to the Children’s Guardian, refer to their Fact Sheet ‘Information for Reporting Bodies: Reporting Certain Misconduct Involving Children’.

1.3.3 Children and Young Persons (Care and Protection) Act 1998

The Children and Young Persons (Care and Protection) Act 1998 provides for the care and protection of, and the provision of services to, children and young people. Under this Act, a child is defined as a person who is under the age of 16 years and a young person is a person who is aged 16 and above but under the age of 18 years.

A key object of this Act is for all institutions, services and facilities responsible for the care and protection of children and young people to provide an environment for them that is free of violence and exploitation. It prescribes the role of the Community Services and the role of families, agencies and communities in relation to child protection, and the role of mandatory reporters. It also provides the mechanisms by which prescribed bodies may exchange information relating to the safety, welfare or well-being of a particular child or young person or class of children or young persons. For further information, refer to the current NSW Health policies on Child Wellbeing Units and Child Protection Policies and Procedures for NSW Health.

2 INITIAL REVIEW AND RESPONSE

A child related allegation or conviction may arise or be identified through a number of sources, including:

- Information provided from a Child Wellbeing Unit, JIRT Referral Unit, local JIRT Unit, the Police, Family and Community Services, to the NSW Health organisation directly or via the NSW Ministry of Health’s Workplace Relations Branch
- Complaints or concerns, including those made by patients, their carers, or anonymously and including those relating to clinical procedures
- From a presentation to an Emergency Department or other NSW Health facility
- From a manager’s or colleague’s observations
- Self-disclosure by a staff member or
- From information in circulation in the public domain, either through formal channels arising from coverage of matters under investigation (i.e. press reporting) or informal channels (social media channels etc.).
The NSW Health policy on Child Protection should be referred to for guidance on how to respond to disclosures of child wellbeing concerns or abuse.

Once action has been taken to address any immediate risks, the information should be forwarded to the Workforce Director or equivalent of the NSW Health organisation, or other position as specified in local procedures, to determine if the matter constitutes a child related allegation or conviction requiring notification to the Chief Executive and to the Ombudsman.

### 2.1 Determining if a matter constitutes a child related allegation or conviction?

A child related allegation or conviction must contain the following three elements:

- A description of alleged behaviour or details of a criminal charge or conviction that may constitute reportable conduct, and
- The allegation or conviction is against a current NSW Health staff member as defined in section 1.2 of this policy, and
- The alleged victim was under the age of 18 years at the time of the alleged behaviour or incident.

Note that child related allegations and convictions include outside work matters, historical matters and child pornography.

### 2.2 Initial Notifications

All child related allegations and convictions are required to be:

- Reported to the Child Protection Helpline if there is suspected risk of significant harm relating to a child or a class of children (refer to the NSW Health policy on Child Protection)
  - A report to the Child Protection Helpline may also include information about the person’s role in NSW Health in relation to contact with children, any risk management action planned or being taken and a contact person for consultation and ongoing exchange of information.
  - Where there are concerns about a child that do not meet the threshold for a mandatory report, the NSW Health Child Wellbeing Unit must be contacted.
- Reported to the NSW Police if there is alleged criminal conduct; this reporting requirement is in addition to any report to the Child Protection Helpline, and includes matters that may not meet the threshold for a report to the Child Protection Helpline (for example, child pornography, historical abuse, etc.).
- Notified to the relevant NSW Health Chief Executive (or Secretary, NSW Health in the case of the NSW Ministry of Health staff).
  - Where the person works in a different NSW Health organisation to where the alleged reportable conduct has been identified, information must be immediately forwarded to the relevant other NSW Health organisation to manage the allegation against the staff member. This would usually be through the relevant Workforce Director or equivalent.
  - In these cases, the NSW Health organisation that identified the allegation is still responsible for ensuring any immediate safety or child protection issues are addressed, including reporting to the Child Protection Helpline, Child Wellbeing Unit, Police, referral to Sexual Assault Services, etc.
  - Information about any immediate risk action taken should be also provided to the NSW Health organisation where the staff member works.
2. PAEDIATRICS

Notified to the NSW Ombudsman using Part A of the Ombudsman’s Notification Form as soon as possible and in any event within 30 days of the matter being brought to the attention of the NSW Health organisation.

- Notified within 24 hours to the NSW Ministry of Health via a Reportable Incident Brief (RIB).

- If there is a reasonable belief that a registered health practitioner has behaved in a way that constitutes notifiable conduct, professional misconduct or unsatisfactory professional conduct under the Health Practitioner Regulation National Law (NSW), a notification is required to the Australian Health Practitioner Regulation Agency.

3 MANAGING RISKS

A risk assessment and ongoing risk management strategy must be put in place as soon as possible, consistent with the requirements in the NSW Health policy on Managing Misconduct, which outlines the options available for managing risk involving NSW Health employees. A Risk Assessment template is available on the NSW Health Intranet.

Where risk management action is required to be taken against the staff member, the NSW Health policy on the Service Check Register should be reviewed to determine any requirement for the creation of a Service Check Register record.

To ensure that child protection and patient safety issues and/or victim needs’ are considered and addressed, the management of child related allegations and convictions should include consultation with child protection workers, sexual assault services and/or senior clinical staff, as relevant.

3.1 Responsibilities to the alleged victim

The NSW Health organisation has a responsibility to ensure that, as far as possible, the needs of any alleged victims and their non offending family are being addressed, and appropriate crisis assessment and treatment, counselling, medical services or sexual assault services are offered, as appropriate.

The NSW Health organisation should ensure that the alleged victim and/or their non offending family are advised of the responsibilities of the NSW Health organisation in respect of child related allegations and convictions and that they are provided with information about the progress of any investigation, advised of the findings and are kept informed of any action planned or being taken in response to the alleged conduct.

They should also be advised of NSW Health’s reporting requirements to the NSW Ombudsman, the NSW Police and to Family and Community Services, as applicable and offered support in making a report to the NSW Police themselves, as appropriate. A nominated NSW Health contact should also be made available to them during the process.

The NSW Health organisation should liaise with the relevant contact officer of the NSW Police, JIRT or Community Services if they are involved in the matter, regarding the needs of the alleged victim and/or their non offending family.

3.2 Advising the staff member

The timing of advice to a staff member about a child related allegation should be part of the risk assessment and should involve consideration of the following factors:

- Does the information received require further clarification before it can be determined if it meets the threshold for reportable conduct?

- Are there any particular risks that would suggest the timing of the advice needs to be delayed (for example, a statement is yet to be obtained from an alleged victim)?

- Is immediate risk management action required necessitating advice to the staff member?
2. PAEDIATRICS

• Has an external agency, such as the Police or Family and Community Services, asked the NSW Health organisation to delay notifying the staff member?

• Has a notification been made to the Child Protection Helpline or the NSW Police, and if not, does this need to be completed before any advice is provided to the staff member?

• In all circumstances, the paramount responsibility of the NSW Health organisation is the protection of all children in its care; where there are identified risks requiring risk management action, this should be conveyed to the external agency, along with a timeframe for commencing the risk management action and the associated advice proposed to be provided to the staff member.

Any decision to delay notifying the staff member should be clearly documented.

The staff member should be advised of the responsibilities of the NSW Health organisation in responding to child related allegations and convictions, provided with information about the process, offered support as required and afforded procedural fairness. Refer to the Managing Misconduct policy for further information.

They should also be advised, at an appropriate time, of the notification requirements to the Ombudsman’s Office and at the conclusion of the investigation, be provided with details of any findings with regards to reportable conduct and any requirement to notify the Office of the Children’s Guardian.

4 INVESTIGATION

Irrespective of any action the Police or any other external agency may take, NSW Health organisations are required to investigate (unless the facts are clear and uncontested, such as with convictions) child related allegations and to make their own findings and decisions about any disciplinary action.

The NSW Health organisation should generally not commence an internal investigation until they have been given the clearance to do so by the external agency or until the external agency has completed their inquiries, and all child protection / criminal investigations have concluded or been closed. Consultation with any external agencies must take place to ensure that any external investigations are not compromised.

1.1 Concurrent Community Services, Police or JIRT investigation

Where NSW Police / JIRT / Family and Community Services are undertaking a criminal / child protection investigation, or have advised that they may undertake such an investigation, an ongoing liaison should be maintained to ensure that criminal, child protection and disciplinary investigations are coordinated effectively, and that information is exchanged as required to assist in the ongoing assessment and management of risk.

The NSW Health organisation must still complete all relevant notifications and continually assess and manage the risks based on available information but would generally not commence its internal investigation until the external investigations and any associated proceedings have concluded and the external agency has indicated that they have no objections to NSW Health commencing its investigation.

The NSW Health organisation should request information from any external agencies involved in the matter to assist in assessing potential workplace risk and to assist in completing its investigation, when appropriate to do so. In certain circumstances it may be necessary to clarify with the Police whether they have closed or suspended their investigation and the extent of the information that may be provided to the staff member.
2. **PAEDIATRICS**

Information requested may include details of the complaint or disclosure (including the name and age of the alleged victim if not already known), records of interview with the alleged victim or any other relevant parties and any other relevant information. A template letter is available on the [NSW Health Intranet](https://intranet.nsw.gov.au).

The NSW Health organisation must:

- Review the information provided by the external agency
- Identify and undertake any further enquiries or information as required
- Determine what needs to be put to the staff member for response, and
- Make its own findings.

Where the matter has been before the courts, information may also need to be requested about the court outcome; this should be done by asking the staff member to provide relevant documentation. It may also be appropriate to write to the court to request information. A template letter is available on the [NSW Health Intranet](https://intranet.nsw.gov.au).

In limited circumstances, if the NSW Health organisation is satisfied, after reviewing the information provided by the external agency, that it conclusively demonstrates that the allegation was false and that no further information is required, the matter may move directly to a finding and the staff member advised.

Where an external agency has substantiated an allegation, but there is no criminal conviction, the NSW Health organisation must still afford the staff member procedural fairness and make its own findings.

In exceptional circumstances, it may be appropriate to commence and conclude the employer investigation while the external criminal or child protection investigations are ongoing, noting that the Ombudsman’s office may still request that the NSW Health organisation monitor the outcome of the external proceedings. However, there must be close and ongoing liaison with the Police and / or Family and Community Services, as well as ongoing consideration and management of the risks associated with this course of action; these risks include the contamination of a criminal investigation as well as unnecessary interviewing of victims, not having access to all relevant evidence and management of a staff member’s right to silence in criminal matters, etc.

The reason for commencing the investigation in these circumstances must be documented and approved by the Chief Executive or their delegate.

4.2 **Managing Child Related Criminal Charges**

For child related criminal charges, it is generally appropriate to wait until the court process has been completed before finalising the employer investigation. All relevant notifications should still be made and a risk assessment completed.

To assist in the risk management decision making, the staff member should be asked for information and any relevant documentation regarding:

- The charges against them
- Any statements they have provided to the police
- Court dates
- How they intend to plead and
- Any other information that may be relevant to assess the risks.

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Information should also be requested directly from the Police, Family and Community Services and / or courts.

Should the matter not proceed to a conviction or finding of guilt, the matter should be dealt with as an allegation and the NSW Health organisation must complete its investigation and make its own findings.

Should the court proceedings result in a conviction or a finding of guilt, the NSW Health organisation should obtain details of the conviction or finding of guilt, complete its risk assessment to determine whether any action is required to be taken against the staff member, provide the staff member with procedural fairness regarding any proposed adverse action and finalise the matter in accordance with the requirements of this policy and consistent with the Managing Misconduct policy.

In certain limited circumstances it may be appropriate to finalise the investigation in terms of making findings and decisions about disciplinary action, subject to procedural fairness requirements as above, prior to the completion of the court process, for example, where a guilty plea has been entered, noting that the Ombudsman’s office may still request that the NSW Health organisation monitor the outcome of the external proceedings.

4.3 Interviewing children

For child related allegations, consideration must always be given to whether it is necessary to interview the child who is the alleged victim.

In certain situations, it may not be appropriate or necessary to interview the child. Where this decision is made, it must be clearly documented and included in the final investigation report. Factors that may affect the decision to interview the child include:

- Sufficiency of the available information about the alleged conduct, i.e. for a young child, it has been reported by a colleague / parent who directly witnessed the alleged behaviour and they have provided detailed information.
- The child has already been interviewed by an external agency and the NSW Health organisation has obtained details of the interview:
  - If there are concerns about the sufficiency of the information obtained, they should be raised with the external agency.
- The child’s age / developmental stage or other factors impact on the child’s ability to provide detailed information.
- Whether the child parents / guardians consent to their child being interviewed and for older children whether the child also consents.
- Any other factors that indicate an interview may result in further trauma or be detrimental to the welfare of the child.

A decision to interview a child must be made in consultation with child protection workers, and if a child is to be interviewed, it must only be by persons with sufficient skill or expertise in obtaining children’s evidence. Child protection staff and in some instances Aboriginal Health workers may be best placed to conduct an interview with a child.
5 ISSUES ARISING IN CHILD RELATED MATTERS

5.1 Allegations arising from clinical procedures

Where a child related allegation has arisen out of a clinical procedure, it must still be managed in accordance with this policy; however the NSW Health policy on Managing Complaints or Concerns about Clinicians should also be consulted.

In certain cases, to assist in the initial review in determining whether the allegation meets the definition of reportable conduct (see section 1.2), an appropriately qualified and independent clinician may need to review whether the conduct being alleged is reasonable for the purpose of the management or care of the child having regard to their age, maturity, health or other characteristics and to any relevant code of conduct or professional standard and therefore whether further investigation under this policy is warranted.

A decision that the allegation or complaint does not constitute an allegation of reportable conduct and therefore is not required to be managed as a child related allegation under this policy should be approved by an appropriately delegated person and the records maintained securely and centrally, noting that such records may be subject to audit by the NSW Ombudsman.

5.2 Anonymous allegations

Anonymous allegations must still be managed in accordance with this policy.

Action taken will depend on the level of detail provided, and the ability to obtain further detail. Where there is insufficient information or details to make any enquiries or take any action, this should be noted and the complaint filed in a secure and confidential place.

Where the information provided meets the definition of alleged reportable conduct, an Ombudsman notification is required and the NSW Health organisation is required to complete an investigation, make findings and decisions about any disciplinary action.

When assessing action to take in response to an anonymous complaint, the following factors should be considered:

- Any details in the allegation that can be confirmed or refuted (for example, was any context provided, were there details of the alleged behaviour, was there a time frame, was any workplace named or details of any alleged victims or witnesses or any physical or other evidence provided)

- Contact with the NSW Police and FACS to confirm if they have any information in relation to the allegation; and if so that they give their consent to that information being put to the staff member

- Is the complainant able to be identified and contacted if further clarification is required? Note that non identification of the complainant does not preclude action being taken

5.3 Non work related and historical child related allegations

Non work related and historical child related allegations, charges or convictions against current NSW Health staff, including matters where the alleged victim is now an adult, must still be managed in accordance with the requirements of this policy, including:

- Reporting to the Child Protection Helpline where there is a current risk of significant harm to a child or class of children. The Online Mandatory Reporter Guide or the NSW Health Child Wellbeing Units can assist identify in determining whether the risks meet the threshold for reporting to the Helpline. If they do not meet the threshold, a referral may still need to be made to the Child Wellbeing Unit.
2. **PAEDIATRICS**

- Reporting to the NSW Police where there is alleged criminal behaviour.
- Offering support to the alleged victim (or their family) in making a report to the NSW Police.
- Completing an investigation (unless the facts are clear and uncontested) and making findings and managing risk.
- Completion of all other notifications in accordance with the requirements of this policy, including to the NSW Ombudsman.

5.4 **What happens if the Police do not charge the NSW Health staff member or the Court makes a finding of ‘not guilty’?**

For child related allegations where Police involvement has not resulted in criminal charges or in a guilty finding at court, the NSW Health organisation must still manage workplace risks while any criminal proceedings are ongoing; once they are finalised, undertake its own investigation (unless the facts are clear and uncontested), and make its own findings and complete all relevant notifications.

The NSW Health organisation’s actions should include a review of information obtained from the Police or from the court (refer to section 4); the evidence considered and the rationale for decisions made, noting there are many reasons that matters do not proceed to charges or to a conviction, where the standard of proof required is ‘beyond reasonable doubt’, whereas in civil matters, the standard is the ‘balance of probabilities’, subject to the “Briginshaw v Briginshaw principle”, that is, the more serious the potential misconduct, and therefore the more serious the consequences for the staff member, the stronger the evidence must be to support an adverse finding.

The staff member should still be afforded procedural fairness and provided with an opportunity to respond to the allegations and any proposed adverse findings or action.

5.5 **Exchanging information with Family and Community Services / Police / JIRT**

Where Family and Community Services / Police or JIRT have involvement in a matter or may have information relevant to the NSW Health organisation's investigation and assessment of potential risk to the workplace, separate requests for information should be made to each external agency in accordance with Chapter 16A of the *Children and Young Persons (Care and Protection) Act*. A Template letter is available on the NSW Health Intranet.

Information may also need to be provided by the NSW Health organisation to Family and Community Services / Police or JIRT regarding risk management action it is taking or planning to take in response to the child related allegation and the nature of any potential risks in terms of the person’s role within the workplace.

For further information about exchanging information under Chapter 16A, refer to the NSW Health policy on Child Protection.

5.6 **Allegations involving child pornography or child abuse material**

Where an allegation involves child pornography or child abuse material, the NSW Police must be contacted immediately and advice sought before initiating an internal investigation or alerting the staff member. If the alleged use involves a NSW Health device, it should be quarantined without warning so that there is no opportunity for files to be deleted or the computer to be switched off or on or other evidence tampered with.

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2. PAEDIATRICS

Special care must be taken to ensure that any alleged child abuse material is not unnecessarily transmitted or disseminated within the NSW Health organisation, that it is contained and that only a limited number of nominated senior staff members are involved in any investigation and that the process for making any decisions or assessment of the material is clearly documented as part of the investigation.

As part of the response to an allegation involving child abuse material, the NSW Health organisation should audit the staff member’s use of NSW Health devices, subject to identifying any potential risks to the investigation.

The NSW Health organisation should be guided by the Police in respect of the classification of material as child pornography.

5.7 What happens if the staff member no longer works in NSW Health?

Where an allegation relates to conduct that has occurred within NSW Health by a former staff member who is not engaged in the NSW Health Service or in the NSW Ministry of Health at the time of receipt of the information, the relevant Chief Executive (or Secretary in the case of a matter relating to a person formerly engaged in the NSW Ministry of Health) must still be notified and appropriate reports to external agencies must be completed, including to the Child Protection Helpline if there is a risk of significant harm to a child or class of children, the Australian Health Practitioner Regulation Agency if the person is a registered health practitioner and the information received suggests such a notification is required, or the NSW Police if required.

The alleged victim should be offered support, as appropriate, which may include supporting them in reporting the matter to the NSW Police or to any other external oversight or investigative agency. Depending on the level of information available, the circumstances of the alleged conduct should be reviewed with a focus on ensuring the ongoing safety of children.

Refer to the NSW Health policy on Child Protection for further advice.

5.8 What if the alleged victim is now an adult?

If the allegation relates to a current NSW Health staff member, it must be managed in accordance with the requirements of this policy, regardless of the current age of the alleged victim (see section 5.3).

Refer to the NSW Health policies on Child Protection and Sexual Assault Services for further information on managing disclosures from adults.

5.9 What happens if the allegation is retracted, the complaint withdrawn, or the alleged victim wants no action taken?

In these circumstances, the NSW Health organisation is still required to fulfil the requirements of this policy, including notifying the Ombudsman, notifying Family and Community Services or the NSW Police, as warranted, providing the staff member with procedural fairness and making findings based on the available information.

Where an allegation has been retracted, a complaint withdrawn, or an alleged victim wants no action taken, whether or not another agency remains involved, the NSW Health organisation is required to seek information to understand the reasons for the retraction and consider this in the assessment of risk and evidence when making a finding.

Where the reasons relate to concerns around personal safety, the NSW Health organisation should explore with the person the different options for addressing those concerns, including the involvement of the NSW Police.
6  MAKING FINDINGS

6.1 Findings for the Ombudsman
For the purpose of the Ombudsman’s scheme, the following findings should be considered:

- **Substantiated** (i.e. a finding that the conduct occurred and is reportable conduct);
- **Not substantiated – insufficient evidence** (i.e. there is some evidence of weight however there is insufficient evidence available to reasonably establish that the alleged conduct did occur);
- **Not substantiated – lack of evidence of weight** (i.e. where the evidence is of such poor probative value or lacking in weight, such as to warrant a finding that, on the balance of probabilities, the conduct did not occur);
- **False** (i.e. where inquiries into the matter show reportable conduct or an act of violence did not occur).
  - Some of these matters may also be vexatious, for example where inquiries into the matter show the allegation was made without substance and to cause distress to the person against whom the allegation was made;
- **Not reportable conduct** (i.e. where inquiries into the matter show the conduct was not reportable).
  - For example; use of force that was trivial or negligible in the circumstances, conduct that was reasonable in the circumstances or found to be accidental. This may include ‘misconceived’ matters, where inquiries into the matter show that, even though the allegation was made in good faith, it was based on a misunderstanding of what actually occurred and the incident was not reportable conduct.

For further information, refer to the NSW Ombudsman’s Fact Sheet on making findings for child related matters.

6.2 Misconduct findings
In addition, the NSW Health organisation must make findings about whether any substantiated conduct constitutes misconduct and therefore whether remedial, disciplinary or other action (in the case of volunteers etc.) is required, consistent with the Managing Misconduct policy.
7 FINALISING THE PROCESS

7.1 Notifying affected parties of the outcome

The alleged victim and/or their family should be notified of any findings made by the NSW Health organisation and any action taken, including against the staff member in response to those findings and of any notifications made to external agencies.

7.2 Notifying the Australian Health Practitioner Regulation Agency

Where the staff member is a registered health practitioner, consideration must be given to any requirements to notify the Australian Health Practitioner Regulation Agency if such notification has not been completed already and there is a reasonable belief that the practitioner has behaved in a way that constitutes notifiable conduct, professional misconduct or unsatisfactory professional conduct under the Health Practitioner Regulation National Law (NSW).

Notifiable conduct is defined under the Health Practitioner Regulation National Law (NSW) as including:

- Practising while intoxicated by alcohol or drugs
- Sexual misconduct in the practice of the profession
- Placing the public at risk of substantial harm because of an impairment (health issue) or
- Placing the public at risk because of a significant departure from accepted professional standards.

Professional misconduct and unsatisfactory professional conduct are defined in sections 139B–139D of the Health Practitioner Regulation National Law (NSW).

7.3 Notifying the Children’s Guardian

Any findings of sexual misconduct or serious physical assault against a child involving a child-related worker must be notified to the Children’s Guardian.

This must be done using the pre-existing “Working with Children Check Employer log in” details for the NSW Health organisation.

In certain circumstances, NSW Health may also provide information to the Children’s Guardian under Chapter 16A of the Children and Young Person’s (Care and Protection) Act if that information is considered relevant to an assessment of risk that the staff member may pose of a child or class of children.

Refer to the NSW Health policies on Child Protection.

For further information about requirements for notifying the Children’s Guardian and how to make a notification, refer to their Fact Sheet “Information for reporting bodies: Reporting certain misconduct involving children” available on their website.
7.4 Final notification to the Ombudsman

Once the investigation or other action is finalised, and findings (including those related to convictions) and final decisions made, the Ombudsman’s office must be notified using Part B of the Ombudsman Notification Form available from its website.

Unless the Ombudsman has advised otherwise, the notification should be accompanied by copies of all material relevant to the investigation and decision making, including records of interview, memorandums or in-briefs, emails, file notes of conversations and correspondence related to the matter.

The Summary of Notifications Information Sheet available on the NSW Intranet also provides further guidance on other notification considerations.

7.5 Service Check Register

Service Check Register records must be created in accordance with the requirement so the NSW Health policy on the Service Check Register.

7.6 Other action required

As part of finalising child related matters, NSW Health organisations should always review the circumstances of the alleged or substantiated conduct from a systemic perspective with a focus on ensuring the ongoing safety of children.

8 KEEPING RECORDS

Records relating to child related allegations and convictions, including false, malicious or disproven allegations should be kept on a file that is separate to the staff member’s personnel file in a central secure location, and must be retained for a minimum of 100 years and then destroyed in accordance with the State Records guidance GA 28.

Related files should be cross-linked to each other, for the purposes of future management.

All records relating to child related allegations and convictions, including where a decision has been made that a matter is not reportable to the Ombudsman, may be audited by the NSW Ombudsman’s Office.

Records relating to the management of child related allegations are subject to the provisions of the Government Information (Public Access) Act 2009.

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MANAGING MISCONDUCT (PD2014_042)

PD2014_042 rescinds PD2006_026.

PURPOSE

This Policy Directive sets out the requirements for managing potential and/or substantiated misconduct by staff of the NSW Health Service and by visiting practitioners. Further guidance and support in managing misconduct are provided by non-mandatory Information Sheets, including flowcharts, checklists and templates, which are available online on the NSW Health intranet site.

MANDATORY REQUIREMENTS

- The protection of an organisation’s patients and clients, including the children for whom it is responsible, is to be the primary consideration when managing and making decisions related to potential and substantiated misconduct.
- Potential misconduct must be treated seriously and an initial review of any apparent or potential misconduct must take place without delay.
- Where an initial review indicates there is a credible allegation or possibility of misconduct, or that the matter involves a child-related allegation, charge or conviction, further action to pursue the matter in accordance with this policy should take place in a timely manner consistent with the requirements of procedural fairness.
- Any ongoing risks related to potential or substantiated misconduct must be identified, assessed, managed, and regularly reviewed throughout the management process, including any requirements arising from the Service Check Register policy.
- Those involved in a potential misconduct process have both the right to confidentiality and the responsibility for maintaining confidentiality, subject always to the overriding need to be able properly to undertake any inquiries or investigation that may be necessary, and to take the action required by this Policy Directive.
- A person who is subject of a misconduct process must be given adequate opportunity to respond to any allegations, adverse findings, and proposed disciplinary action, prior to any final decision being made.
- A person who is subject of a misconduct process must be afforded the right to a support person being present at any meetings. Other support may also need to be offered to all affected persons, where appropriate.
- Any findings made must be based on relevant available information that is established ‘on the balance of probabilities’.
- Any action to be taken as a response to a misconduct finding must be proportionate to the nature of the misconduct, after consideration of any extenuating circumstances, previous work performance and history, and any identified ongoing risks.
- A termination of employment in NSW Health Service following a finding of misconduct will apply to all roles or multiple assignments undertaken as an employee in the NSW Health Service unless the person can show cause as to why this should not occur. NSW Health organisations must provide dismissed staff access to the show cause mechanism outlined in Section 9.3 of the following Procedures.
2. PAEDIATRICS

- Where the appointment of a visiting practitioner is terminated following a finding of misconduct, the relevant Health organisation must notify any other Health organisation(s) where the visiting practitioner also holds an appointment contract to allow them to assess and manage any local risks.
- Any required internal or external notifications concerning potential or substantiated misconduct (such as to registration authorities) must be made without delay in accordance with the relevant statutory and/or policy provisions.
- Appropriate records of all stages of the process (including the initial review and any investigation) and outcomes must be kept and stored securely.

IMPLEMENTATION

This Policy Directive applies to all staff of the NSW Health Service and to visiting practitioners. It does not apply to staff employed in the NSW Health Executive Service, contractors who are not visiting practitioners, or to agency staff, students, volunteers or researchers who are not staff employed in the NSW Health Service. However, where it is decided to conduct an investigation into alleged misconduct by any person in these categories, this Policy Directive may nevertheless be used to guide the process.

Any complaints or concerns related to the clinical performance, practice or outcomes of a health practitioner or other health service provider (as defined under the Health Practitioner Regulation National Law (NSW)) must be managed in line with the NSW Health policy on managing a complaint or concern about a clinician.

The following staff have key responsibilities in relation to this Policy Directive:

**Chief Executives** are required to:
- Ensure that this Policy Directive is communicated to, and complied with by staff involved in managing potential or substantiated misconduct.

**Workforce Directorates/Human Resources Departments/Internal Audit Units/Governance or Professional Conduct and Standards units** are required to:
- Ensure provision of information and advice as necessary to support effective implementation of this policy.

**Supervisors/Managers** are required to:
- Comply with this Policy Directive in dealing with all cases of potential and substantiated misconduct.

1. BACKGROUND

1.1 About this document

These Procedures outline the requirements for managing potential or substantiated misconduct of staff of the NSW Health Service. Information Sheets have also been developed to provide guidance and support in meeting the requirements of this Policy Directive. Links to Information Sheets have been provided throughout the Procedures, and a complete list is available on the Ministry of Health’s intranet site at [http://internal.health.nsw.gov.au/jobs/conduct/index-conduct.html](http://internal.health.nsw.gov.au/jobs/conduct/index-conduct.html).
2. PAEDIATRICS

A summary flowchart of the overall process for managing potential misconduct is provided at Information Sheet 1. Suggested timelines are at Information Sheet 2. The rights and responsibilities of all parties involved in managing misconduct (including the need to maintain appropriate confidentiality throughout the process) are outlined in Information Sheet 3.

1.2 Key definitions

Misconduct – includes:

- Behaviour or conduct which seriously or repeatedly breaches expected standards, as identified in relevant legislation (such as the Health Services Act 1997 or the Health Practitioner Regulation National Law (NSW)), registration standards or codes/guidelines approved by a National Health Practitioner Board or NSW Health policies (such as the Code of Conduct).
- Refusal to carry out a lawful and reasonable direction given by a line manager or another member of staff authorised to give the direction.
- Reportable (ie child-related) conduct as defined under the Ombudsman Act 1974 (including allegations relating to conduct outside the workplace).
- Corrupt conduct as defined under the Independent Commission Against Corruption Act 1988
- Serious wrongdoing that could be the subject of a public interest disclosure under the Public Interest Disclosures Act 1994, ie relating to corrupt conduct, maladministration, serious and substantial waste, or failure to deal appropriately with Government Information.
- Criminal charges or convictions that have an adverse impact on the workplace or the role or performance of the staff member (including such offences committed outside the workplace and/or work hours, or prior to appointment to NSW Health).
- For staff of the Ambulance Service of NSW, misconduct as defined under Part 4 of the Health Services Regulation 2013
- Making vexatious allegations, or knowingly making false or misleading public interest disclosures.
- A failure to comply or cooperate with the processes for investigating or managing misconduct set out in this Policy Directive.

NSW Health organisation - For the purposes of this policy directive, any public health organisation as defined under the Health Services Act 1997, the Ambulance Service of NSW, Health Infrastructure, HealthShare NSW, NSW Health Pathology, any other administrative unit of the Health Administration Corporation, and Albury-Wodonga Health in respect of staff who are employed in the NSW Health Service.

NSW Health Service - All persons employed under Chapter 9, Part 1 of the Health Services Act 1997.

Staff member - For the purposes of this policy directive, any person who is employed in the NSW Health Service, or engaged in the NSW public health system as a visiting practitioner.

Note: Complaints or concerns about the clinical performance, practice or outcomes of a health practitioner or other health service provider must be managed under the current NSW Health policy on managing a complaint or concern about a clinician.
2. INITIAL REVIEW AND RESPONSE

2.1 Purpose of an initial review

A staff misconduct issue may arise or be identified from a number of sources, such as: internally or externally raised allegations; complaints or concerns; managers’ or colleagues’ observations; notifications including self-disclosure by a staff member; inquiries or investigations; or other workplace processes.

There must be an initial review of any allegation or concern about potential misconduct which is raised without delay (Information Sheet 4). An initial review seeks to gather all readily available information that may assist in clarifying an allegation or concern in order to:

- Identify any immediate risks to the safety and welfare of patients and/or staff (including any complainant) that need to be managed immediately.
- Determine, as far as practical, the credibility, nature and seriousness of the matter.
- Determine whether the matter should be managed under this policy or another policy (eg grievance etc) (Information Sheet 5).
- Identify and consult all relevant policy directives and their process requirements (Information Sheet 5).
- Identify any immediate internal and external notification requirements (Information Sheet 6), including the NSW Health Service Check Register. All allegations that involve possible criminal conduct must be reported to the NSW Police.

2.2 Determining further action

Where an initial review indicates that the matter does not involve a misconduct issue (eg is assessed as a low level, low risk grievance or Code of Conduct issue, a performance issue etc), this outcome is to be clearly documented and the provisions of this Policy Directive are no longer applicable. Any further action appropriate to the circumstances should be taken in accordance with any other relevant policies (Information Sheet 5).

Where an initial review indicates that an allegation is credible or there is an indication of apparent misconduct, or that the matter involves a child-related allegation, charge or conviction, appropriate action must be taken to address the matter in accordance with this Policy Directive (and, as appropriate, the current NSW Health policy on child-related allegations, charges and convictions).

Such action must be taken irrespective of whether the matter is being investigated by an external regulatory or investigative body (such as the Police and/or Community Services), and irrespective of the outcome of any such external proceeding. However, consultation with any external regulatory or investigative bodies must take place to ensure that any external investigations are not compromised.

In circumstances involving serious criminal allegations or child-related allegations, discussions should occur with NSW Police and/or Community Services at an early stage, which may result in a decision to defer any investigation by the NSW Health organisation pending the resolution of the criminal or child protection proceedings. Where this occurs the organisation must still undertake a risk assessment (see Section 3) to determine whether any immediate action is required to manage risks. This will normally involve a consideration of suspension of the staff member from duty or other available strategies in accordance with Section 3 and 4 of this document.

Where a matter relates to the clinical performance, practice or outcomes of a health practitioner or other health service provider, it must be assessed and managed in accordance with the current NSW Health policy on managing a complaint or concern about a clinician.
Where a matter relates to conduct outside the workplace, its relevance to the workplace must be assessed to determine if any action is required. (However, specific requirements apply to child-related matters outside the workplace - see the current NSW Health policy on child-related allegations, charges and convictions.)

An investigation into an allegation or apparent incident of misconduct should only occur where there is uncertainty about the relevant facts (Information Sheet 4). Where the facts are clear and uncontested, findings arising from the initial review can at that stage be provided to the decision-maker, who must either accept or reject them, and then decide what action should be taken in response to the findings. A staff member subject to an adverse finding in such circumstances must be provided with an opportunity to respond to such a finding, as well as to any proposed disciplinary action (refer to 7.5.2 for further information).

Appropriate documentation about an allegation or incident of potential misconduct, the initial review, and any recommendations for further action, or a decision not to proceed further, must be kept.

2.3 Advising the staff member

A staff member who is the subject of an initial review regarding potential misconduct should be informed that an issue has been raised about him or her as soon as credible details indicating potential misconduct have been identified, and it is deemed safe and appropriate to do so (Information Sheet 7). Any verbal advice should be confirmed in writing.

3. MANAGING RISKS

3.1 General

Where managing potential misconduct needs to involve more than just an initial review, a risk assessment must be conducted and a risk management strategy put in place as soon as possible. The purpose of a risk assessment is not to determine whether misconduct took place, but purely to assess whether there are any significant ongoing risks in the workplace that require managing (Information Sheet 8). The need to continue with any immediate risk response put in place at the time of the initial review should also be assessed as part of the risk assessment.

A suggested risk assessment template is available at Information Sheet 9.

Any action to manage the identified risks must be communicated to the staff member who is to be subject to that action in writing (Information Sheet 7) and include advice of any creation of a record in the NSW Health Service Check Register. It may also be necessary to manage communications to other affected staff, patients or others.

Appropriate support should be offered to a staff member who is subject to risk management action, and may also need to be provided to other affected staff/patients/other parties.

Any notification requirements must be attended to without delay.

The position of a staff member must not be permanently filled while that staff member is suspended or on interim work arrangements as a risk management measure.
2. PAEDIATRICS

3.2 Options to manage risks

Action to manage risks arising from a risk assessment must be specific and proportionate to the circumstances. Where risk management action is necessary, consideration must be given to appropriate and available administrative action by way of alternative interim work arrangements.

Suspension from duty is a last resort risk management strategy (see Section 4).

See also Section 4.3 regarding payment of shift-penalties and other allowances while undertaking alternative duties or during suspension on pay.

3.3 Ongoing review

While a potential misconduct matter is ongoing, any risk management measures must be reviewed and any risks reassessed, at a minimum every 30 days, or when new information, relevant to the risk management strategy in place, comes to light. Where the review results in a change in risk management measures, any relevant NSW Health Service Check Register record must also be reviewed and amended as appropriate.

3.4 Requests for review of risk management measures

A staff member subject to risk management action may request a review of the risk management measures by application in writing to the relevant manager or person who conducted the risk assessment, on the grounds that:

• The risks have not been identified or assessed appropriately or
• The risks have changed or no longer exist.

4. SUSPENSION OF STAFF

4.1 General

Suspension of a staff member from duty can only occur as a risk management strategy where:

• A risk assessment has been conducted.
• A potential risk is posed by the staff member remaining at his or her current work; and
• The potential risk cannot be appropriately managed in any other way.

In addition, Section 120A(1) of the Health Services Act 1997 outlines specific circumstances in which a staff member who is subject to actions taken by an external body can be suspended. Whether suspension is appropriate in these circumstances will depend on:

1) Whether the staff member can continue to perform the role for which he or she was employed, having regard to the following circumstances:
   (a) Suspension of the registration of a staff member as a registered health practitioner by a health professional council under s150 of the Health Practitioner Regulation National Law (NSW) - the staff member cannot practise as a health practitioner.
   (b) Conditions imposed on the registration of a staff member as a registered health practitioner imposed by a health professional council under s 150 of the Health Practitioner Regulation National Law (NSW) – the staff member may not provide some or all of the services which he or she was employed to provide, or cannot do so without adjustment to working arrangements.
2. PAEDIATRICS

(c) An interim prohibition order by the Health Care Complaints Commission during an investigation into a staff member as an unregistered health practitioner prohibiting the provision of health services or specified health services by that staff member – the staff member may not provide some or all of the services which he or she was employed to provide.

(d) An interim prohibition order by the Health Care Complaints Commission during an investigation into a staff member as an unregistered health practitioner that places conditions on the provision of health services – the staff member may not be able to provide all the services he or she was employed to provide, or cannot do so without adjustment to working arrangements.

(e) Charged with a serious criminal offence and is remanded in custody or has bail conditions imposed that prevent or restrict the ability to present for work – the staff member cannot fulfil the terms of his or her employment.

(f) Charge of a serious criminal offence (other than in the circumstances in (e) above) – a risk assessment must be conducted to determine whether it is appropriate for the staff member to continue to provide the services he or she was employed to provide.

2) Whether alternative interim work arrangements are appropriate, available and can be safely provided without adverse impact on the operational efficiency and budgetary constraints of the NSW Health organisation.

4.2 Whether suspension under s120A of the Health Services Act 1997 should be with or without pay

Where a staff member is suspended, the payment of salary at the applicable ordinary time rate (ie without shift penalties and other allowances, but refer to 4.3 regarding reimbursement in certain circumstances) should usually continue. Suspension may be without pay in the circumstances set out in Section 120A(1) of the Health Services Act 1997 if the Secretary of the Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), so directs.

A staff member who is suspended without pay must be allowed to access any paid annual or long service leave entitlements accrued prior to the suspension. While accessing such leave entitlements, his or her employment will remain suspended.

4.3 Final decisions regarding salary which has been withheld during suspension without pay

Where a staff member is suspended due to action taken against the staff member by an external body under s120A(1) of the Health Services Act 1997, and the staff member’s salary has been withheld during that action (under s120A(2)), and the outcome of the external body action is one of the following:

(a) The staff member’s registration is suspended or cancelled by the Civil and Administrative Tribunal under Section 149C of the Health Practitioner Regulation National Law (NSW).

(b) Conditions are imposed by the Tribunal on the registration of the staff member as a registered health practitioner under Section 149A (1) (b) of the Health Practitioner Regulation National Law that, in the opinion of the Secretary of the Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), are inconsistent with any of the inherent requirements of the terms of employment of the staff member.

(c) A prohibition order is made by the Health Care Complaints Commission in respect of the staff member as an unregistered health practitioner under Section 41A of the Health Care Complaints Act 1993 that prohibits the staff member from providing health services or specified health services.

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(d) A prohibition order is made by the Health Care Complaints Commission in respect of the member of staff under Section 41A of that Act that places conditions on the provision of health services or specified health services by the staff member that, in the opinion of the Secretary of the Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), are inconsistent with any of the inherent requirements of the terms of employment of the staff member, or

(e) The person is convicted of a serious criminal offence.

the Act provides that the staff member’s salary is to be forfeited to the State, unless the Secretary of the NSW Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), directs otherwise (s120A(3)).

Conversely, where the action against the staff member by the external body does not result in any of the final actions in (a)-(d) above being taken against the staff member, the Act provides that any salary withheld is to be paid to the staff member, unless the Secretary of the NSW Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), directs that the salary is to be forfeited to the State (s120A(4)).

Where withheld salary is paid to the staff member, it should include any relevant allowances and shift penalties (calculated as outlined in Section 4.3 of these Procedures). If the staff member had accessed any paid annual or long service leave while suspended without pay, this leave should be re-credited to him or her.

There may be circumstances where it is not appropriate to provide public money to a staff member for a job that he or she did not, and could not, perform, particularly where the Health organisation has incurred an additional expense to provide the services during the staff member’s period of suspension. In these circumstances the Secretary of the NSW Ministry of Health, or the Chief Executive of the relevant NSW Health organisation (acting under his or her delegated employer function), may, in accordance with the Act, direct that the withheld salary is to be forfeited to the State. Relevant considerations may include:

- The extent to which the conduct of the staff member contributed to the issue in the first place.
- Whether the staff member has complied with statutory duties to report certain criminal conduct and disciplinary matters.
- Where a risk assessment suggests that the continued employment of the staff member poses an unacceptable risk to the Health organisation.
- The length of the period the staff member was unable to meet the inherent requirements of his or her employment.

4.4 Reimbursement of shift penalties and other allowances following suspension on pay or alternative duties

Where a staff member is engaged as a shift worker on a permanent or regular basis, or has undertaken shift work regularly in the previous 3 months, and where

- The staff member is suspended or allocated alternative duties as a risk management strategy pending the outcome of an investigation and/or decision-making process in relation to a misconduct allegation against him or her, and
- The suspension or alternative duties result in a loss of shift penalties and/or other work related allowances, and
- No adverse finding is subsequently made against the staff member,
the staff member is to be reimbursed for the loss of shift penalties and/or work related other allowances. The reimbursement is based on the average of any shift penalties and/or other work related allowances for the preceding 6 months or, if the period of shift work is less than 6 months, the average for the period worked.

4.5 Suspension of visiting practitioners

The Visiting Medical Officer Determinations provide that an organisation may suspend the appointment of a visiting medical officer where it is considered necessary in the interests of the hospital to which the visiting medical officer is appointed. The suspension of any visiting practitioner is without pay. Note that the Health Services Act 1997 provides for an appeal mechanism for visiting practitioners whose appointment is suspended.

As visiting practitioner appointments are made under statutory powers and with statutory powers of appeal against suspension, it is important to be able to demonstrate procedural fairness in reaching any decision to suspend (which would usually involve providing notice to the visiting medical officer of the possibility of suspension and of reasons, and an opportunity to respond).

Further advice can be sought from each NSW Health organisation’s medical administration.

5. INVESTIGATION

5.1 The purpose of an investigation

An investigation is a formal process of collecting and analysing all available relevant information to ascertain facts in order to make findings. An investigation precedes, and is separate from, any final decision by a decision-maker about whether to accept or not accept findings, and about whether and what further action (disciplinary or other) is required.

The purpose of an investigation is to determine whether:

- The alleged or suspected misconduct has occurred and, if so, to put forward findings to that effect.
- The substantiated conduct breached expected standards, or relevant policies or legislation.
- There are any extenuating circumstances or other contributing factors that may need to be considered.

An investigation need only occur into potential misconduct where there is uncertainty about the relevant facts. Even where no investigation is necessary, the decision-making process set out in Sections 7 and 8 of these Procedures should be followed. The requirements of any additional relevant policies identified during the initial review must also be complied with (Information Sheet 5).

Any investigation must be completed as expeditiously as possible without compromising procedural fairness.

If a matter has been referred to an external regulatory or investigative body, ongoing liaison with that body must occur to coordinate, as appropriate, the timing and conduct of any internal investigation with any action being undertaken by the external body (see also Section 2.2 re serious criminal allegations and child-related allegations).
2. PAEDIATRICS

A flowchart of the investigation process is provided at Information Sheet 10. The following publications also provide guidance on conducting internal investigations:

- NSW Ombudsman: Investigating Complaints - A manual for Investigators

5.2 Selecting investigators

Investigators must have suitable skills and experience, an understanding of the investigation process, and, if an external investigator, no direct involvement with or interest in the matter under investigation.

In most cases, an investigation can be conducted by someone internal to the NSW Health organisation, supported by local HR, internal audit, governance, or professional conduct and standards units, as necessary.

External investigators may be used, for example, where a Health organisation considers that there is no one available within the organisation or elsewhere in NSW Health with the appropriate skills, or where very senior executive staff are involved. A government-wide panel of pre-qualified service providers is available and can be accessed through NSW Government ProcurePoint at https://www.procurepoint.nsw.gov.au/performance-and-management-services-scheme, although persons not on this panel can also be used.

External investigators must sign a contract (a standard services/consultancy contract is available at http://internal.health.nsw.gov.au/legal/goods.html), as well as a declaration that they understand the expectations for the investigation and have received information about any relevant NSW Health policies. Appropriate checks must also be conducted to confirm the capacity of an external investigator to carry out the investigation appropriately.

The decision-maker should not be involved in any investigation.

5.3 Advice to a staff member who is subject to a misconduct process

Written advice must be provided to the staff member about the allegations against him or her and about the investigation process. The advice must contain sufficient information about the allegations to allow the staff member to provide a considered response (Information Sheet 7).

5.4 Interviews

The investigator must put the substance of the allegations and any key relevant evidence to the staff member subject to the allegations as part of the interview process. In order to do this, it is usually best to interview any complainants and/or witnesses first to gain as much detail about the alleged misconduct as possible.

An investigator may decide to accept receipt of information in a written statement instead of, or in addition to, an interview, although an interview is usually preferable, particularly where additional detail is required or to explore issues in greater detail.

Reasonable notice of an interview must be given in writing (usually 48 hours). All persons to be interviewed must be advised that they may have a support person of their choosing present, and that the reasons for the interview and its content must remain confidential.

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The support person does not represent the staff member nor advocate or make representations on behalf of that person.

Records of interviews should be taken and kept. (Note that under the Surveillance Devices Act 2007, electronic/tape recordings can only be made with the agreement of all parties to the interview). Persons interviewed should be provided with a copy of a summary or record of interview for review and signature as soon as possible. See also Section 6.8 regarding disputes over interview records.

6. ISSUES ARISING DURING INITIAL REVIEW, INVESTIGATION OR DECISION-MAKING PROCESSES

6.1 Unreasonable conduct by complainants

Complainants may demonstrate unreasonable persistence, demands or arguments, lack of cooperation, aggression etc.
- Refer to the NSW Ombudsman publication Managing Unreasonable Complainant Conduct for guidance in managing complainants.
- Any aggression or threats of violence by staff are to be managed as a breach of the NSW Health Code of Conduct.

6.2 Frivolous, vexatious or misconceived allegations/concerns

If at any point in the process it becomes apparent that an allegation of, or concern about, misconduct is frivolous, vexatious, misconceived or otherwise lacking in substance:
- The process must stop.
- This must be communicated to the decision-maker for assessment.
- The decision to conclude the process must be recorded with reasons.
- If the staff member subject to the allegation or enquiry has already been notified, he or she must be advised as soon as possible that allegations or concerns were not supported (it may also be appropriate to provide an apology).
- Vexatious allegations amount to misconduct. If a complainant is a staff member, such an allegation must be separately managed in line with this policy directive.

6.3 When a staff member does not cooperate

All staff members are expected to cooperate in any process to manage potential misconduct.
- If a staff member fails or refuses to attend an interview or provide a written statement within the timeframe advised, any reasons for the failure put forward or otherwise identified must be considered, any reasonable accommodation made as required, and the staff member advised of a final date for the interview/written statement.
- If the staff member continues to refuse to attend an interview/provide a written statement without reasonable grounds, he or she is to be directed in writing to attend an interview or provide a written statement by a specific date and advised in writing that a refusal may constitute a breach of the NSW Health Code of Conduct with potential disciplinary consequences, and that the investigation will continue in any case and a decision will be made based on available information.
- If the staff member attends an interview but refuses to engage or to provide relevant information sought by the interviewer, he or she must be advised that the content of the interview will nevertheless be recorded, and that the investigation will continue and a decision will be made based on available information. This advice is to be confirmed in writing following the interview.
6.4 When a staff member is on approved leave during an investigation

It may be appropriate to recall the person from leave to be interviewed or seek a written statement from him or her where a timely completion of the investigation is necessary.

6.5 When a staff member is on sick leave/workers compensation leave during an investigation

Consideration must be given to whether the medical condition of a staff member reasonably prevents him or her from taking part in an interview or providing a written statement.

If the staff member is on workers compensation leave, any return-to-work restrictions in place must be considered.

If the staff member is on sick leave due to a non-work related injury or illness, the Health organisation should rely on the available medical advice from the employee’s treating doctor in the first instance to determine the staff member’s ability to participate in the investigation. Where there are ongoing concerns or a lack of clarity over the staff member’s prognosis, action may include seeking the staff member’s consent to discuss their prognosis with their treating doctor, or, if the staff member does not consent to this, referring them for a further medical assessment (the process is set out in the current NSW public sector procedures for managing non-work related injuries and health conditions).

If the staff member is not able to attend an interview, but is able to provide, or arrange for the provision of, a written statement, this should be formally sought on the basis that a timely completion of the investigation is necessary. In these circumstances, the staff member should be advised of the deadline for the provision of the written statement, and that the investigation will continue in any case, and a decision will be made based on available information.

6.6 Where the staff member resigns prior to completion of a misconduct management process

The process must still be completed, including making findings and decisions about any action that would have been taken against the staff member had he or she still been in the position, and all relevant notifications.

The management process must be fair to the former staff member (including the timely completion of any investigation and providing the former staff member with an opportunity to respond to any allegations or adverse findings).

An entry into the Service Check Register may have to be made or amended – see the current NSW Health policy on Service Check Register.

6.7 Delays in completing the management process

If the completion of the process is delayed beyond the recommended 12 weeks (Information Sheet 2) or any timeframe previously advised, all key parties must be advised of this in writing.

6.8 Disputes over interview records

Any issues about the content of the record of interview are to be discussed and resolved if possible, and the record altered to reflect any agreed changes.

If the issues cannot be resolved, the interviewee is to be asked to submit a statement giving reasons for not signing the record, the investigator must record reasons for not agreeing to the requested changes, and both statements must be appended to the interview record.
6.9 Complaints about the investigation/investigator

Complaints about the investigation or the investigator are to be referred for review to the manager responsible for the process and assessed without delay to ensure continued integrity of the process.

7. MAKING FINDINGS

7.1 Options for findings

Generally, the findings arising from an investigation or, in appropriate circumstances, an initial review, fall into one of the following:

- Misconduct is substantiated
- Misconduct is partially substantiated (e.g., part of an allegation is substantiated)
- Misconduct is not substantiated (no evidence that misconduct has occurred, or evidence that it did not)
- Misconduct is not substantiated due to insufficient or inconclusive information (i.e., not able to make a finding).

Note: Specific requirements apply to findings that can be made for child-related allegations that are notifiable to the Ombudsman (refer to current NSW Health policy on child related allegations, charges and convictions).

The strength, sufficiency, relevance and reliability of any information must be carefully assessed to determine whether it can support a finding, and where clarification is required, more information should be gathered.

7.2 Standard of proof

Findings of misconduct must be proved to the civil standard, that is, “on the balance of probabilities”. In other words, based on available evidence, it must be more probable that misconduct has occurred than that it has not.

In addition, consistent with the “Briginshaw v Briginshaw principle”, the more serious the potential misconduct, and therefore the more serious the consequences for the staff member, the stronger the evidence must be to support an adverse finding.

7.3 Investigation findings and investigation report

Where an investigation has been conducted, the person conducting the investigation should provide a report setting out findings arising from the investigation and the facts supporting those findings to the decision-maker (Information Sheet 11).

The investigation report should not contain information that is not relevant to the conduct under investigation. Where new allegations arise during an investigation, these must be assessed: allegations or concerns not closely related to the investigation, or any counter-allegations, must be managed separately in line with this Policy Directive. Where appropriate, an investigator should include in a report any material which may set out mitigating factors or be otherwise exculpatory in respect of the staff member subject to the investigation.

All supporting documentation should be available to be examined by the decision-maker.
7.4 Findings where no investigation has taken place

As set out in Section 2.2, an investigation is only necessary where there is uncertainty about the facts. Where an initial review determines that the facts are clear and/or uncontested, findings arising out the initial review should be set out together with the supporting facts in a report which should be provided to the decision-maker.

7.5 Final decisions about findings

7.5.1 The role of the decision-maker

The decision-maker should not have any direct conflict of interest involving the complaint. He or she must act in an objective and impartial manner, and have regard to procedural fairness requirements and risk management.

It is the role of the decision-maker to:

- Accept or reject findings arising from the investigation, or the initial review. The decision-maker may accept some but not all of the findings. Any decision to reject a finding, and the reason for it, must be documented.
  It is also open to the decision-maker to ask that the person or persons who conducted the investigation make further enquiries, or otherwise to initiate or undertake further enquiries, where he or she is concerned that more information is needed to support findings.
- Make decisions about any action to be taken by the Health organisation as a response to the findings (see Section 8).

7.5.2 Seeking a response to adverse findings

An adverse finding is a finding that is unfavourable to the staff member subject to a misconduct process, i.e. supports the allegation or apparent incident of misconduct. Adverse findings do not include inconclusive findings.

Where the decision-maker is proposing to support an adverse finding against a staff member, the staff member must be so advised and given an opportunity to provide any additional information, or raise any concerns about an investigation process or the proposed findings to the attention of the decision-maker.

In order to be able to provide a considered response, the staff member has a right to access relevant information that has been taken into consideration by the decision-maker in making an adverse finding. The material should be sufficient to enable the staff member to understand fully any alleged misconduct, but need not include all information in the possession of the decision-maker, particularly where the interests of other members of staff may need to be protected or the material is not relevant to the findings.

In certain circumstances (e.g. public interest disclosures, in respect of confidential information about third parties, or where there may be a potential risk to the wellbeing of the staff member or others) it may be appropriate to withhold some information. What information is withheld and for what reason should be appropriately recorded.

A response from the staff member should be required within a reasonable time period (usually two calendar weeks unless otherwise agreed).
Where the staff member’s response provides additional information that has not been raised before and may materially affect the findings, the findings should be reviewed accordingly. In some instances further investigative action may need to take place.

The staff member must also be provided with an opportunity to make submissions about any proposed disciplinary action. The response to proposed disciplinary action may be sought at the same time as the response to proposed adverse findings (after considering what may be appropriate action in line with Section 8). However, where the staff member’s response affects the findings, the proposed action will need to be reviewed accordingly, and the staff member must be given an opportunity to respond to any revised proposed disciplinary action.

8. MAKING DECISIONS ABOUT ACTION TO BE TAKEN

8.1 Considering an appropriate response to findings

The decision-maker must form a view of the appropriate outcome of the process based on the material available. In deciding what action is appropriate the following must be considered:

- As the paramount consideration, the protection of a NSW Health organisation’s patients and clients and of children for whom it is responsible. In particular, Section 119 of the Health Services Act 1997 specifies this as the paramount consideration in relation to determining whether to take disciplinary action against a member of staff in respect of serious sex or violence offences.
- The health, safety and well-being of the organisation’s staff.
- The seriousness of the misconduct, and the extent to which it constitutes a breach of any relevant legislation, registration standard or the Code of Conduct or any other NSW Health or Health organisation policies.
- Any penalties prescribed by legislation or other relevant policy directives (eg the hand hygiene policy, the policy on misuse of NSW Health communication systems).
- Any action taken by external regulatory bodies in relation to the staff member (eg deregistration etc).
- Whether the misconduct involved a pattern of behaviour or was an isolated incident.
- The staff member’s length of service and previous work history, including the period of time since any previous conduct issues (this may involve a review of the Service Check Register).

Where a NSW Health organisation becomes aware of similar substantiated misconduct by the staff member elsewhere in the NSW Health Service, further information is to be sought from the relevant Health organisation and considered by the decision-maker in determining the appropriate action to be taken (eg a pattern of behaviour may be shown). The information should only be used in determining the appropriate response to the current substantiated misconduct, not to weigh the balance of probability during an investigation.

- Any factors affecting the staff member’s behaviour. Where information obtained during the initial review or investigation suggests an underlying health issue may have caused or contributed to the conduct, it may be appropriate to refer the staff member to a medical assessment. For further information, refer to the current NSW public sector procedures for managing non-work related injuries and health conditions. Note also that employers have statutory notification requirements in relation to potential impairment of a health practitioner under the Health Practitioner Regulation National Law (NSW).
- Any matters raised by the staff member about the findings or about the penalty or action that should be taken in response to the misconduct (see Section 8.3 following).
- The impact of the conduct on the organisation and other staff.
- The potential impact that any action may have on the staff member’s personal circumstances and professional reputation.
8.2 Options for action in response to findings of misconduct

The following options exist for a decision-maker (refer also to Information Sheet 12):

- **No further action** – relevant where conduct did not seriously breach expected standards, or misconduct occurred but no further action is warranted because of mitigating circumstances.

- **Remedial (ie non-disciplinary corrective) managerial action** – may be relevant where findings of misconduct were made but not considered to warrant disciplinary action, or in conjunction with disciplinary action, or can be appropriate where allegations have not been substantiated as misconduct but the staff member’s conduct nevertheless needs to be addressed (eg low level breach of the Code of Conduct, performance issue, other policy requirements – refer to Information Sheet 5).

- **Disciplinary action**, which can take the following form:
  - A formal warning, clearly stating the improved standard of conduct that is required within a given timeframe and the possible consequences of failing to reach that standard, and indicating any assistance available to help the staff member meet the expectations.
  - An annulment of appointment, where a staff member is on probation.
  - For staff of the Ambulance Service of NSW only, reduction of the staff member’s classification or position.
  - Dismissal from the NSW Health Service, or termination of a visiting practitioner’s appointment. Termination of employment must be approved by the Chief Executive, who must be independently satisfied that this action is warranted. (See also Section 9.3 regarding other action arising from a termination of employment).

  Note that some other NSW Health policy directives (such as those dealing with hand hygiene, and misuse of NSW Health communication systems) also contain provisions for disciplinary action.

  Note also that specific provisions exist under the Health Services Act 1997 in relation to a member of staff (Section 118) or a visiting practitioner (Section 100) who has been convicted of a serious sex or violence offence.

- **Addressing systems/organisational issues** – these may be appropriate even where allegations have not been substantiated or findings are inconclusive.

Any action proposed must be proportionate to the seriousness of the conduct and any identified ongoing risks, after consideration of any mitigating circumstances. In some instances, more than one of the above responses may be appropriate.

8.3 Seeking a response from a staff member regarding proposed disciplinary action

Any disciplinary action proposed by a decision-maker in response to a staff member’s misconduct must be communicated to the staff member in writing. The staff member must be given an opportunity to make submissions to the decision-maker in relation to the proposed disciplinary action before a final decision about it is taken.

The decision-maker can seek a response to proposed adverse findings and proposed action at the same time (see also Section 7.5.2).

A reasonable period of time (usually two calendar weeks, unless otherwise agreed) must be allowed for a response. Any such response must be considered by the decision-maker before a final decision is made about the action to be taken.
9. IMPLEMENTING DECISIONS AND FINALISING THE PROCESS

9.1 Advice about the outcome

At the completion of the process a final risk assessment must be conducted regardless of the outcome to identify any issues requiring ongoing management.

All persons involved must be advised of the outcome of the process in so far as it relates to them, having regard to the confidentiality rights of other people involved in the matter. (Further guidance is provided by the NSW Ombudsman publication Managing information arising out of an investigation.) It may also be necessary to offer appropriate support (such as the employee assistance program) to affected persons.

The person subject to the misconduct process must be advised of any disciplinary or remedial action the NSW Health organisation will take (including its effective date), or any other outcome of the process (including any issues that will be referred to the relevant line manager for local management). He or she must also be advised of any final notifications made (including the NSW Health Service Check Register). (See also Section 9.3 regarding action arising from termination of employment or appointment.)

Where allegations or concerns were not substantiated, there should be a discussion with the staff member involved about any support he or she may require to continue with or resume his or her role in the organisation.

9.2 Visiting practitioner appeals

Visiting practitioners have a right of appeal regarding certain decisions against them. These are detailed in Part 4 of the Health Services Act 1997. Further advice can be sought from each NSW Health organisation’s medical administration.

9.3 Action arising from termination of employment or appointment

Where a staff member’s appointment is terminated in one part of the NSW Health Service following a finding of misconduct, the termination will apply to any other employment across the NSW Health Service. All other NSW Health organisations where the staff member holds employment must be notified of the termination.

However, a process is available to staff members to ‘show cause’ as to why the termination should not apply to their other employment in the NSW Health Service. The process is outlined in Information Sheet 13 (flow chart) and Information Sheet 14 (checklist), including advice to be provided to the staff member. Any decision made by a Health organisation about a show cause application must be endorsed by the Ministry of Health’s Director, Workplace Relations before implementation.

Where the contract of a visiting practitioner with one Health organisation is terminated following a finding of misconduct, any other Health organisation(s) where the visiting practitioner holds a contract must be advised of the termination to allow them to assess and manage any risks arising from the finding(s) for the other organisation. (See also current NSW Health policy on the Service Check Register.)
9.4 Finalising the process

Once any investigation and all decisions about findings and further action are finalised, any relevant final internal and external notification requirements as outlined in legislation and relevant policies must be attended to, including the NSW Health Service Check Register (Information Sheet 6).

Appropriate records of all stages of the process (including the initial review and any interviews) and outcomes must be kept. All documentation must be managed in line with State Records NSW requirements for keeping personnel records (General Retention and Disposal Authority GA28) and kept on a dedicated and confidential file, separate to a staff member’s personnel file (Information Sheet 15).
SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) MEDICAL PROTOCOL
(GL2014_012)

PURPOSE

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

KEY PRINCIPLES

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

USE OF THE GUIDELINE

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

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

NEONATAL ABSTINENCE SYNDROME GUIDELINES (GL2013_008)

GL2013_008 rescinds PD2005_494.

PURPOSE

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

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

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

KEY PRINCIPLES

The Guidelines concentrate on two main aspects of care:
1. The care of the opioid-dependent pregnant woman from a drug and alcohol perspective based on “Harm Minimisation” principles, and;
2. The care of the newborn from a child protection perspective.

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

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

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

USE OF THE GUIDELINE

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

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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 opioid-exposed infants must be educated in the appropriate application of these scores.

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

PURPOSE

These Clinical Guidelines provide a clear standard of initial care for children who present to Emergency Departments where Medical Officers are not immediately available. It is intended that the Clinical Guidelines will be used by Paediatric Advanced Clinical Nurses to facilitate the early and appropriate clinical management of children who present to Emergency Departments with acute and life threatening conditions and to relieve pain and discomfort. This is the second edition of the document which has been developed in line with current best practice and advice from expert reviewers.

This document is a companion document to the NSW Rural Adult Emergency Clinical Guidelines.

KEY PRINCIPLES

These NSW Rural Paediatric Emergency Clinical Guidelines are underpinned by the following principles:

A ‘graduated’ clinical response is required depending on the:

- Severity of the presenting emergency condition e.g. the clinical response to patients with mild to moderately severe asthma is different to that for patients with immediately life threatening asthma.
- Level of training and expertise of the nursing staff who initiate the management of the patient i.e. Registered Nurses with advanced clinical training will practice more advanced interventions. Nursing staff using these clinical guidelines are required to be appropriately educated, skilled and credentialed. The shaded portions contained in the treatment guidelines must only be used by RNs who are recognised as Advanced Clinical Nurses.
- Legal requirements for nurses who initiate treatment and administer medications based on medication standing orders.
- Need for flexibility to respond to input from senior clinical staff and medical officers to accommodate local circumstances.

The Clinical Guidelines reflect evidence based best clinical practice and expert consensus opinion, in regards to standardisation of initial clinical management of specific paediatric conditions and alignment with the principles outlined in the First Line Emergency Care Course (FLECC) for Registered Nurses.

Any medication standing orders contained in these clinical guidelines will have no legal basis unless they are approved by the Local Health District Drug Therapeutic Committee (or local hospital Drug Therapeutic Committee if there is no District Committee), as specified in NSW Health Policy Directive PD2013_043, Medication Handling in NSW Public Health Facilities, (Section 7.4 Standing Orders).

Each standing order must be signed and dated by an appropriate senior Medical Officer and by the Chairperson of the Drug Committee that is approving the standing order. The committee must review the standing order annually and re-endorse and date the standing order to confirm on-going approval.
2. PAEDIATRICS

USE OF THE GUIDELINE

These guidelines are to be used for children up to their 16th birthday only and have been formatted to follow the generally accepted Airway, Breathing, Circulation and Disability (ABCD) approach for managing emergency/critically ill patients.

Advanced Clinical Nurses have advanced knowledge and skills, have completed an advanced emergency or critical care nursing course or hold a graduate certificate/diploma in paediatric nursing – emergency stream and have been deemed competent to carry out these advanced roles using contemporary assessment and ongoing credentialing processes. Where an Advanced Clinical Nurse utilises these guidelines the:

- Designated medical officer will be notified as soon as practicable.
- Medical Officer will review any patient who has been given medications consistent with the standing orders contained within this document as soon as possible (must be within 24 hours). At the time of this review the Medical Officer must check and countersign the nurse record of administration on the medication chart.

A number of the incorporated procedures have been adapted from the NSW Health Acute Paediatric Clinical Practice Guidelines. Where applicable and advised, subsequent treatment and management should follow the NSW Health Paediatric Clinical Practice Guidelines.

The Guidelines can be downloaded at NSW Rural Paediatric Emergency Clinical Guidelines Second Edition
STANDARDS FOR PAEDIATRIC INTRAVENOUS FLUIDS: NSW HEALTH (SECOND EDITION) (GL2015_008)

GL2015_008 rescinds GL2014_009.

PURPOSE

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

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

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

KEY PRINCIPLES

The intended outcomes of the first edition of the standards regarding the content of IV fluids in children and neonates included:
• Reducing the risk of hyponatremia through increased sodium content and limiting the use of low sodium containing fluids.
• Addressing glucose requirements of children and neonates through increased glucose content.
• Consistent inclusion of potassium chloride as early as considered safe and appropriate.

The key changes in the second edition of the Standards regarding the content of IV fluids for children and neonates include:
• Incorporating further evidence supporting the use of isotonic saline solutions in IV maintenance therapy.
• Standardising the use of 1000mL bags in the care of children beyond the specialist children’s hospitals.
• Incorporating Special Care Nursery practice and clarification around IV fluids for neonates.

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

USE OF THE GUIDELINE

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

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

STANDARDS FOR PAEDIATRIC INTRAVENOUS FLUIDS (IB2014_066)

PURPOSE

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

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

KEY INFORMATION

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

Compounded IV Products

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

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

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

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

IV Bag Sizes

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

Potassium Chloride Products

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

Pre-Packaged Bags

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

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

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

**Paediatric Infusion Sets**

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

**Ordering enquiries**

For AHK and AHB Baxter IV fluid codes

Baxter Customer Service – Telephone - 1300 789646

For the compounded IVS.1000-5000 products Baxter Pharmacy Services:

- Telephone: 1800 227 487 or (02) 9848 1395
- Fax: 1800 025 887 or (02) 9848 1155.

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

Baxter – 2014 – Paediatric IV Fluids Order Form NSW
PUBLICATION OF GUIDELINES BY INFORMATION AND PRIVACY COMMISSION NSW - USE AND DISCLOSURE OF GENETIC INFORMATION WITHOUT CONSENT (IB2014_065)

PURPOSE

To notify NSW public health organisations and staff of the publication of the “Use and disclosure of genetic information to a patient’s genetic relatives: Guidelines for organisations in NSW” (the Guidelines) by the Information and Privacy Commission NSW and to advise that the Guidelines will take effect when the Health Legislation Amendment Act 2012 is proclaimed on 1 November 2014.

KEY INFORMATION

The Health Legislation Amendment Act 2012 was passed in June 2012 and made amendments to various miscellaneous Health Acts, including the Health Records and Information Privacy Act 2002 (HRIPA). The amendments to HRIPA, set out in Schedule 1.2 to the Health Legislation Amendment Act 2012, are intended to harmonise NSW and Commonwealth privacy legislation regarding disclosure of genetic information.

The amendments concern the use and disclosure of genetic information without consent and will allow genetic information to be used or disclosed by an organisation if the use or disclosure:

- Is reasonably believed by the organisation to be necessary to lessen or prevent a serious threat to the life, health or safety (whether or not the threat is imminent) of a genetic relative of the individual to whom the genetic information relates, and
- In accordance with guidelines, if any, issued by the Privacy Commissioner, and
- In the case of disclosure, is disclosed to a genetic relative of the person to whom the information relates.

The amendments also provide a definition of a genetic relative. A genetic relative is “a person who is related to an individual by blood, for example, a sibling, parent or descendant of the individual.”

The purpose of this Information Bulletin is to advise NSW public health organisations of the publication of Guidelines by the NSW Privacy Commissioner as anticipated by the amendment. NSW Health organisations and staff considering disclosing genetic information without consent must do so accordance with the Guidelines. The Guidelines are available online at [URL] and are attached to this document at Appendix 1.

Consistent with the aim to harmonise the NSW and Commonwealth privacy positions, the Guidelines are adopted from the National Health and Medical Research Council (NHMRC) Guidelines issued under section 95AA of the Privacy Act 1988 (Cth). The Guidelines are largely consistent with the NHMRC Guidelines, with amendments as appropriate to comply with NSW health privacy legislation.

It should be noted that the Amending Act specifically does not cover genetic risk to an unborn child. This is noted in the Guidelines at Part B: Summary and practical guide, page 5.

Use and disclosure of genetic information to a patient’s genetic relatives: Guidelines for organisations in NSW (Information and Privacy Commission, 2014).
INFANTS AND CHILDREN: ACUTE MANAGEMENT OF ALTERED CONSCIOUSNESS IN EMERGENCY DEPARTMENTS (GL2014_019)

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

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

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

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

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

GL2018_007 issued 16/03/2018 rescinds GL2015_005.

**PURPOSE**

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

**KEY PRINCIPLES**

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

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

**USE OF THE GUIDELINE**

Chief Executives must ensure:

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

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

To download the Guideline please go to

[Infants and Children: Acute Management of Community Acquired Pneumonia](#)
EMPLOYMENT CHECKS – CRIMINAL RECORD CHECKS AND WORKING WITH CHILDREN CHECKS (PD2016_047)

PD2016_047 rescinds PD2013_028

PURPOSE

This Policy Directive and the attached Procedures outline the mandatory requirements for National Criminal Record Checks (‘NCRCs’) and Working with Children Checks (‘WWCCs’) for persons engaged or employed within NSW Health and for persons seeking to be employed or engaged in NSW Health.

This policy includes the requirements of the Child Protection (Working with Children) Act 2012 and the Child Protection (Working with Children) Regulation 2013 that commenced on 15 June 2013 for child related workers, together with the requirements of the (Commonwealth) Aged Care Act 1997 for aged care workers.

SCOPE

This policy applies to all paid and to non paid workers in NSW Health.

It includes staff on rotation, overseas applicants, volunteers, students undertaking clinical or research placements, Visiting Health Practitioners, temporary or casual ‘locum’ or nursing or midwifery agency staff, contract staff, eligible midwives and nurse practitioners appointed to Public Health Organisations otherwise than as employees and honorary appointments.

This policy applies to all public health organisations and all other bodies and organisations under the control and direction of the NSW Minister for Health or the Secretary NSW Health, including the NSW Ministry of Health and Albury Wodonga Health in respect of staff employed in the NSW Health Service and affiliated health organisations in respect of their recognised establishments and services.

MANDATORY REQUIREMENTS

- NSW Health agencies must identify the type of checks required for each position and ensure that workers have the required NCRC and WWCC, in accordance with this policy.
- NCRCs are mandatory for preferred applicants for positions in NSW Health, including for visiting health practitioners and for volunteers as specified in this policy. The mandatory requirement for a NCRC is subject to the exemption for existing staff members, and the special arrangements around the use of the NSW Health Criminal History Declaration and WWCC probity flag.
- For new child related workers (paid or unpaid), a signed NSW Health Criminal History Declaration stating no criminal history and a WWCC probity flag that indicates no criminal history meets the requirement for a NCRC.
- The use of the Criminal History Declaration and WWCC probity flag may only be used in strict accordance with the requirements of this policy.
- All applicants for positions in the NSW Health Service, including for Visiting Health Practitioners and volunteers, must complete a NSW Health NCRC consent form and provide the associated 100 points of identification, regardless of whether or not they are existing staff members.
- Existing staff members or volunteers moving to new role within the NSW Health Service are not required to undergo a NCRC unless otherwise specified in this policy.
2. PAEDIATRICS

- Students attending clinical placements within NSW Health agencies are exempt from the WWCC requirements but must have a valid NCRC.
- Any person seeking to work in NSW Health in ‘child-related work’ must have a valid WWCC number in addition to any requirements for a NCRC.
- Locum or nursing and midwifery agencies must provide evidence that staff supplied to NSW Health have a valid NCRC and a valid WWCC, as required.

NSW Health agencies must validate and keep records of WWCC numbers obtained from the Children’s Guardian.
- Existing staff members and volunteers are not required to obtain a WWCC until the phase-in dates in the Transition Schedule (Appendix 2).
- NSW Health agencies must ensure compliance with the Transition Schedule (Appendix 2) for existing child related workers to obtain a WWCC.
- All aged care workers must have a NCRC every three years in accordance with the (Commonwealth) Aged Care Act 1997.
- Community transport drivers are required to have NCRCs every three years in accordance with funding arrangements with Transport for NSW.
- All child related workers must have a WWCC every five years in accordance with the (NSW) Child Protection (Working with Children) Act 2012.
- NSW Health agencies must register designated risk assessors, to manage criminal history risk assessments, with HealthShare’s Employment Screening and Review Unit.
- NSW Health agencies must manage and assess criminal history identified through criminal record checks in accordance with this policy, and any requirements specified by the Employment Screening and Review Unit.
- NSW Health agencies must determine the need for criminal record checks for positions not mandated by this policy on the basis of risk.

IMPLEMENTATION

Roles and responsibilities

Chief Executives

Are to ensure that their organisation has systems in place to implement this policy.

Workforce Directorates / Human Resource Departments

Are to ensure the provision of instruction, information and training as necessary to support establishment of local procedures for effective implementation of this policy.

Workers

All workers in NSW Health are required to comply with the mandatory requirements of this policy.
1. BACKGROUND

The safety, welfare and wellbeing of NSW Health clients and patients is paramount. NSW Health is committed to ensuring that there are effective systems for protecting patients, clients and assets. One way to do that is to ensure that any person engaged to work in NSW Health has undergone appropriate criminal record checks, in addition to all other pre-employment screening requirements detailed in relevant NSW Health recruitment policies.

Apart from the special legislative provisions for children and older persons, NSW Health also has a duty of care to other vulnerable patients and clients.

A person’s prior convictions may be relevant to the performance of their duties. Therefore, all preferred applicants for engagement within NSW Health agencies must undergo criminal record checks prior to engagement to ensure that any identified relevant criminal convictions may be assessed in terms of potential risk.

This document provides the mandatory procedures for the criminal record checking of preferred applicants for paid and unpaid positions (including for volunteers and students) in NSW Health and includes the legislative requirements relating to ‘child related work’ and to ‘aged care work’.

This document also provides the mandatory criminal record check requirements for existing NSW Health workers.

2. KEY DEFINITIONS

For the purpose of this Policy Directive, the following definitions apply:

The Australian Criminal Intelligence Commission (ACIC) provides, on behalf of Australian Police Services, national criminal history record checking services to accredited third party agencies for the purpose of employment risk management.

Children’s Guardian refers to the Office of the Children’s Guardian, who have responsibility for the issuing of Working With Children Check clearances. The Working With Children Check functions were previously held by the Commission for Children and Young People.

Child related roles are:

- An approved provider or manager of an education and care service
- A certified supervisor of an education and care service
- An authorised carer
- An Assessment Officer within the meaning of section 27A of the Children and Young Persons (Care and Protection) Act 1998
- The Principal Officer of a designated agency, as defined by the Children and Young Persons (Care and Protection) Act 1998
- The Principal Officer of an accredited adoption service provider within the meaning of the Adoption Act 2000.

Child related work is work in a child related role or in paid or unpaid work, involving face to face or physical contact with anyone under the age of 18 years, in an area prescribed as child related work. These areas include but are not limited to:

- Work as a health practitioner providing health services in wards of hospitals where children are treated or elsewhere if the work includes the provision of health services to children; this includes work in paediatric or adolescent health services and in adult health services (including wards of hospitals) that include the provision of health services to under 18 year olds
- Work by persons (other than health practitioners) who provide health and care services in paediatric or adolescent health services
2. PAEDIATRICS

- Administrative, corporate, clerical, maintenance, or other ancillary work in paediatric or adolescent health services if the work involves contact with children for extended periods.
- Work in mentoring and counselling services for children if the mentoring and counselling services are provided to children as part of a formal mentoring program.
- Work in providing family welfare services is child-related work, if clients to whom the services are provided ordinarily include children.
- Work in child protection services.
- Work in education and care services, child care centres, nanny services and other child minding services provided on a commercial basis.
- Work at sporting, cultural or other entertainment venues where services, activities or entertainment is provided on a commercial basis primarily for children.
- Work that involves providing entertainment services primarily for children on a commercial basis.
- Work at detention centres and juvenile correctional centres.
- Work for a residential parent and child program involving inmates or detainees, and their children, at a correctional centre, juvenile correctional centre or detention centre or other place.
- Work for a religious organisation where children form part of the congregation or organisation if the work is carried out as a minister, priest, rabbi, mufti or other like religious leader or spiritual officer of the organisation, or in any other role in the organisation involving activities primarily related to children, including youth groups, youth camps, teaching children and child care.

**Children** means persons under the age of 18 years as defined in the *Child Protection (Working with Children) Act 2012*.

**Clinical Placement** is also known as a student placement or fieldwork education and refers to the provision of supervised tertiary or post graduate education or research in a clinical setting by University / TAFE / other Registered Training Organisation students.

**Existing child related workers** are persons who are engaged or employed in child related work as at 15 June 2013 and who remain with the same employer.

**Health Practitioner**, for the purpose of this policy are persons registered under the *Health Practitioner Regulation National Law (NSW)*, and any other individual who provides a health service where a health service includes the following:

- Medical, hospital and nursing and midwifery services
- Dental services
- Mental health services
- Pharmaceutical services
- Ambulance services
- Community health services
- Health education services
- Welfare services necessary to implement health services
- Services provided in connection with Aboriginal and Torres Strait Islander health practices and medical radiation practices
- Chinese medicine, chiropractic, occupational therapy, optometry, physiotherapy, podiatry and psychology services
- Optical dispensing, dietician, massage therapy, naturopathy, acupuncture, speech therapy, audiology and audiometry services
- Services provided in other alternative health care fields.
National Criminal Record Check (‘NCRC’) is an Australian-wide check of a person’s criminal history, which may be in the form of a ‘National Police Certificate’ or ‘Police Certificate’ prepared by the Australian Federal Police, a State or Territory police service, or an ACIC accredited agency (such as NSW Health); or which may also be referred to as an ‘Aged Care Check’ if being undertaken for the purpose of working in an Australian Government subsidised aged care service.

National Police Certificate is a National Criminal Record Check, see above.

NSW Health, for the purpose of this policy, consists of NSW Health agencies and the NSW Ministry of Health.

NSW Health agency refers to a local health district, a statutory health corporation, the Ambulance Service of NSW, NSW Health Pathology and Health Infrastructure and Public Health System Support Divisions of the Health Administration Corporation, and Albury Wodonga Health.

NSW Health Service consists of all persons employed under Chapter 9, Part 1 of the Health Services Act 1997.

Overseas Applicant is a person who is employed or engaged directly from overseas, including from New Zealand.

Police Certificate is a National Criminal Record Check, see above.

Preferred Applicant is an individual who is the recommended or preferred person for a vacant or volunteer position, but who has not yet been formally offered that position.

Staff member, for the purpose of this policy, refers to any person who is employed or engaged in paid work in the NSW Ministry of Health or the NSW Health Service (including as a temporary or casual), or as a visiting practitioner. It does not include locum and nursing agency staff, students or volunteers.

Student Supervisor / Facilitator is a person nominated by the education provider and approved by the NSW Health agency to provide education and supervision to students on clinical placement.

Visiting Practitioner is a medical practitioner or dentist, appointed to practice (otherwise than as a staff member) at an agency under section 76 of the Health Services Act 1997.

Volunteer includes, for the purpose of this policy, anyone engaged to work in NSW Health without being paid or renumerated except for out of pocket expenses.

Working With Children Check (‘WWCC’) is a State based legislative requirement, managed by the Children’s Guardian, for anyone in child related work in NSW. The NSW Working with Children Check consists of a national criminal history check and a review of reported workplace misconduct. Individuals are given either a clearance to work with children for five years, or a bar against working with children. The Children’s Guardian monitors individuals for the duration of the clearance for any “trigger” or “disqualifying” charges or convictions arising in NSW, as defined in Schedules 1 and 2 of the Child Protection (Working with Children) Act 2012.

Valid WWCC is either a WWCC application or clearance number or a WWCC provided for an existing child related worker by NSW Health or the Catholic Commission for Employment Relations.

WWCC Application number is the WWCC number that has been activated at the NSW Motor Registry Office/NSW Council Agency that provides Roads and Maritime Services as part of the person’s application for a clearance to work with children.

WWCC Clearance number is the number provided by the Children’s Guardian clearing the person to work with children.

WWCC Exemptions are workers who are exempt from the requirements of the WWCC and include:

- A worker who provides administrative, clerical or maintenance services, or other ancillary services, if the work does not ordinarily involve contact with children for extended periods.
2. PAEDIATRICS

- A health practitioner who is working in and visiting New South Wales from outside the State, if the period of work does not exceed a total of five days in any period of three months
- A worker who is working in and visiting New South Wales from outside the State for the purpose of child-related work if the worker is the holder of an interstate working with children check in the jurisdiction in which the person ordinarily resides, or is exempt from the requirement to have such a check in that jurisdiction, and the period of the child-related work in New South Wales does not exceed a total of 30 days in any calendar year
- A health practitioner who works exclusively in the provision of geriatric health services
- A worker who works for a period of not more than a total of five working days in a calendar year, if the work involves minimal direct contact with children or is supervised when children are present
- A worker who carries out the work in the course of an informal domestic arrangement that is not carried out on a professional or commercial basis
- A worker whose work involves direct contact only with children who are close relatives of the worker, other than a worker who carries out the work in the capacity of an authorised carer;
- A parent, or close relative, of a child who attends a school, an education and care service or other educational institution when volunteering at or for activities of the school, service or institution
- A worker who is under the age of 18 years
- A worker who is a health practitioner in private practice, if the provision of services by the practitioner in the course of that practice does not ordinarily involve treatment of children without one or more other adults present
- A worker who is a co-worker of a child or who is a work supervisor or work placement supervisor of a child; A visiting speaker, adjudicator, performer, assessor or other similar visitor at a school or other place where child-related work is carried out if the work of the person at that place is for a one-off occasion and is carried out in the presence of one or more other adults or
- Students attending clinical placements are not in child related work and are not required to obtain a WWCC. They are however required to sign a declaration that they have read and understood the NSW Health Code of Conduct and that they will notify NSW Health if they are charged with any criminal offences.

Worker is any person who is employed or engaged in paid or unpaid work in NSW Health, (including as a temporary, casual, or ‘locum’ or nursing or midwifery agency staff member), visiting practitioners, students, volunteers, agency staff, contractors etc.

2.1 Legal and Legislative Framework

This policy outlines the:
- Working with Children Check requirements for work defined as ‘child related’ in accordance with the (NSW) Child Protection (Working With Children) Act 2012 and Child Protection (Working with Children) Regulation 2013 and
- Police Certificate requirements for work in NSW Health services and aged care facilities that receive Australian Government funding in accordance with the (Commonwealth) Aged Care Act 1997.

3. GENERAL CRIMINAL RECORD CHECK REQUIREMENTS

NCRCs are required for all new appointments to NSW Health (the requirements for existing NSW Health workers are dealt with in Section 9).
In addition to a NCRC at the time of appointment:

- Workers in ‘child related work’ must have a valid WWCC (renewed every five years) in accordance with the requirements of the (NSW) Child Protection (Working With Children) Act 2012 and Child Protection (Working with Children) Regulation 2013.
- Workers in ‘aged care work’ must have a new NCRC every three years in accordance with the (Commonwealth) Aged Care Act 1997.

To ensure appropriate criminal record checking and compliance with relevant legislation, all positions, including for volunteers, should be categorised as one of the following:

- Child related work – requiring a valid WWCC and NCRC on appointment and thereafter a WWCC every five years – refer to Section 5
- Aged care work – requiring a valid NCRC (for aged care purposes) on appointment and thereafter every three years - refer to Section 6
- Child related work and aged care work – requiring a valid WWCC and NCRC (for aged care purposes) on appointment and thereafter a WWCC every five years and a NCRC (for aged care purposes) every three years – refer to Sections 5 and 6
- Non child related (and non aged care) work – requiring a NCRC on appointment only – refer to Section 7
- Other work - roles not mandated by this Policy to have NCRCs – requiring a position risk assessment to determine the need for NCRC – refer to Section 8.

Applicants for positions in NSW Health must be advised of the criminal record check requirements as part of the recruitment process.

Refer to Appendix 12 for a summary of NCRC and WWCC recruitment requirements for staff members and volunteers, and Appendix 13 for the requirements for locum, nursing and midwifery agency staff.

4. NSW HEALTH’S ROLE IN CRIMINAL RECORD CHECKING

NSW Health only conducts NCRCs on preferred applicants for positions in NSW Health, including for visiting health practitioners and volunteers, or on existing staff members in permanent, temporary or casual positions. This is done as part of pre-employment screening during recruitment or every three years for existing workers where required under the Aged Care Act 1997.

NSW Health does not conduct the NCRCs on workers engaged through a locum or nursing and midwifery agency, or on other workers not employed by NSW Health or otherwise employed by a third party organisation. In these circumstances, it is the responsibility of the locum or nursing and midwifery agency, the individual or the third party organisation.

The Employment Screening and Review Unit (ESRU) in HealthShare NSW has responsibility for the lodgement of NCRCs for NSW Health and for coordinating the appropriate management of criminal history information in accordance with its contract with ACIC.

ESRU’s responsibilities include ensuring NSW Health’s compliance with contractual requirements around access to, and management of, criminal history information across NSW Health.

Criminal history information may only ever be viewed or accessed by designated NSW Health risk assessors that are registered with ESRU, who are aware of, and who have agreed to abide by, the strict confidentiality requirements around the management of the information and who have responsibilities in managing the associated risk assessment process.
4.1 Obtaining Consent for a NCRC

NCRCs may not be lodged without informed consent from the individual and the required evidence of their identification.

All applicants for positions within the NSW Health Service or NSW Ministry of Health whether new or existing staff members or volunteers must, at the time of application, complete the NCRC consent form (Appendix 7) and provide 100 Points of Identification (Appendix 8).

NSW Health agencies must ensure that existing staff members or volunteers have a valid NCRC for the role for which they have applied. Refer to Section 9 for information about NCRC requirements for existing staff members or volunteers.

4.2 Identification Checking Requirements for the NCRC

The NSW Health agency must complete the 100 Point Identification Checklist after sighting the applicant’s original documentation. There is no requirement to keep copies of identification documents.

For overseas applicants who are not in the country at the time of their application, verified copies of the original documents may be accepted until the applicant arrives in Australia at which time the original copies must be sighted and the 100 Point Identification Checklist completed (Appendix 8).

4.3 The NSW Health Criminal History Declaration (Appendix 4)

The NSW Health Criminal History Declaration ('Declaration') may be used in place of conducting separate NCRCs in recruitment for child related work, for new staff members or volunteers when supported by the WWCC probity flag and where there is no requirement for a NCRC for aged care purposes. The Declaration requires applicants to make a declaration about criminal history (including pending charges).

The use of the Declaration must comply with all the following mandatory requirements:

- It may only be used for new child related workers and not for existing workers
- It may only be used if the WWCC validation process has access to the WWCC probity flag
- It must not be accessible or disclosed to the selection panel or used as part of the process for selecting the preferred applicant
- It must be maintained securely and confidentially
- It should only be accessible to staff with responsibility for processing NCRCs and may only be used after the person has been selected as a preferred person and for the purpose of determining whether a separate NCRC is required.

When a Declaration indicates no criminal history and the WWCC probity flag confirms that the person has no criminal history, there is no further need to undertake a NCRC unless one is required for aged care purposes.

A Declaration indicating no criminal history must be retained on a successful applicant’s personnel file or on the recruitment file for unsuccessful applicants.

Declarations where the applicant has indicated criminal history must be retained in a secure file along with the documented risk assessment or file note confirming that either no actual criminal history was disclosed in the NCRC or that the disclosed criminal history was not relevant to the inherent requirements of the position.

4.3.1 Information disclosed in the Declaration

Applicants are only required to disclose criminal history as lawfully allowed in accordance with the relevant State or Territory spent convictions legislation. They are not required to disclose spent criminal history, and NSW Health may not consider spent criminal history in its assessment of the person’s suitability for work.

Spent convictions are not disclosed in the NCRC undertaken by NSW Health.

The Declaration requires applicants to state whether they have any of the following matters recorded against their name (including bonds but excluding minor traffic offences, matters that have been quashed, dismissed, withdrawn or which are otherwise spent):

- convictions in the last 10 years or
- convictions for sexual offences or
- convictions for which a prison sentence of more than 6 months was imposed or
- criminal charges which are yet to be finalised or heard in court.

A NCRC must be obtained if the person has disclosed that they have criminal history. The disclosure of criminal records or charges does not automatically preclude a person from a position; each case must be considered on its merits and in accordance with the requirements of this Policy.

If an applicant is found to have deliberately withheld or provided false information in the Declaration about convictions or pending charges that are subsequently identified as relevant to the inherent requirements of the role, the application may be rejected or if the person has been appointed, it may be grounds for dismissal.

4.3.2 The WWCC probity flag

When NSW Health validates WWCC clearances with the Children’s Guardian through designated web servers, including the eRecruit system, the WWCC probity flag may identify whether or not the person has criminal history.

The WWCC probity flag indicating no records is equivalent to a NCRC undertaken at the date of the WWCC clearance. The flag indicates if the person had any charges or convictions (including non child related matters) at the time of their WWCC clearance or any “trigger” or “disqualifying” charges or convictions (as listed in Schedules 1 and 2 of the Child Protection (Working with Children) Act 2012) in NSW after the date of the WWCC clearance.

The WWCC probity flag does not distinguish between spent and disclosable criminal records, all released as part of the WWCC. A NCRC conducted as a result of a WWCC probity flag may be returned clear because the person does not have records that are disclosable in a NCRC.

The WWCC probity flag indicating no records is only available if the applicant has provided consent for this information to be released to NSW Health. In the absence of consent, the flag defaults to the position that the person may have criminal history.

The WWCC probity flag is not available for validations conducted manually through the website of the Children’s Guardian.

4.3.3 Use of the Declaration and WWCC probity flag instead of a NCRC

The WWCC probity flag indicating no records may be used instead of a NCRC for new staff members and volunteers only when it is attached to a WWCC clearance number and the person has signed the Declaration stating that they have no criminal history.
NCRCs are still required for new child related staff members or volunteers if:

- the WWCC probity flag is not available in the recruitment process (because the validation process is being managed manually or not through eRecruit or another designated web server); or
- the applicant has not completed the Declaration; or
- there is information indicating that the preferred applicant may have criminal history (for example, from the Declaration or from the WWCC probity flag); or
- the person is going into aged care work and their last NCRC (including from the WWCC probity flag) was undertaken three or more years ago.

For preferred applicants for positions identified as ‘child related work and aged care work’, if the WWCC probity flag is under three years old and indicates the person had no criminal records, and the Declaration states they have no criminal history, there is no further requirement for a NCRC.

Refer to Section 9 for the requirements for existing workers.

4.4 Where the NCRC reveals criminal records

Where a NCRC reveals criminal records, ESRU will identify whether the convictions or pending charges may be relevant to the position and, if so, forward them to the designated risk assessor within the NSW Health agency for further assessment.

The NSW Health agency’s risk assessor must determine if the records are relevant and if they are likely to affect the individual’s ability to undertake the key responsibilities of the position for which they are being considered.

If it is determined that the risks are not relevant or do not impact on the individual’s ability to undertake the key responsibilities of the position, the appointment should proceed.

If it is determined that the risks may be relevant and may impact on the role, the applicant must be contacted, and a risk assessment undertaken.

4.5 Contacting the applicant

The applicant must be asked to confirm their full name, date of birth and current address and be told of the purpose of the NCRC. Once the person’s identity has been confirmed, they may verbally be given a summary of the substance of the police history information, including dates, and asked to confirm the accuracy of the information. The applicant must not, under any circumstances, be given a copy of the criminal history information.

If the applicant states that the record does not belong to them or is inaccurate, ESRU must be contacted for further advice.

If the applicant confirms the criminal records, they should be advised of the relevance of the record to the position for which they are being considered, the type of information that may assist the risk assessment, and be given an opportunity to provide additional information to support their application.

At all times, the principles of procedural fairness, privacy and confidentiality must be maintained when conducting employment risk assessments.

4.6 Conducting the risk assessment

The risk assessment may only be carried out by designated risk assessors; those persons, who are registered as risk assessors with the ESRU, have undergone NCRCs and met any other requirements as specified by ESRU. No other persons may be involved in the management of the risk assessment process.
Only designated NSW Health risk assessors may sight or have access to criminal records or documents used in an employment risk assessment. This information must not to be given, sent or disclosed to any third party person including to any other NSW Health agency worker.

The following information may be considered as part of the risk assessment:

- The seriousness and nature of the convictions, and how they relate to the key responsibilities of the position (including ensuring they are not precluding convictions if in aged care work)
- The number of convictions, whether it was a pattern or an isolated matter
- The period of time that has elapsed since the last offence
- The amount and type of penalty awarded by the court may be indicative of the seriousness of the offence
- Any mitigating information in relation to the offences. These might include such factors as peer pressure, difficult family circumstances or other stress factors in the person’s life at the time such as drug or alcohol abuse etc
- Submissions from the applicant regarding action they have taken or changes to their circumstances that may have contributed to the offending
- References – the type of reference will depend on the nature and circumstances of the offence(s), but could include workplace references as well as information from professionals from whom the applicant has sought treatment, counselling or other help. This may include references from probation or parole officers
- The degree of direct or unsupervised contact the person will have with patients, clients’ confidential information, property, finances etc, whether the person will be working alone or as part of a team and the environment in which the work will be conducted.

Based on the information obtained, a determination must be made about whether any risks arising from the criminal record or charges, identified as relevant to the position for which the person is being considered, affect their ability to undertake the full range of responsibilities and tasks associated with the role, including whether any such risks can be, or have already been, satisfactorily mitigated.

4.7 Outcome of the risk assessment

Once the risk assessment is completed, the NSW Health agency must advise the applicant of its determination.

The NSW Health agency must also inform ESRU of the determination and provide any other information as required by ESRU, including confirmation that all criminal history information has been destroyed.

The NSW Health agency should document in a risk assessment report its reasons either to continue with the appointment or to decline the appointment because of the criminal history.

4.8 The risk assessment report

The risk assessment report should include a summary of the criminal records (including the nature of the convictions or charges, their date, and the penalty), their relevance to the key responsibilities of the role, any mitigating or risk factors associated with the role, a summary of any information provided by, or obtained from, the applicant or referees or any other body, and an analysis of the resulting risks and the decision whether or not to appoint.

4.9 Management of criminal history

Only designated risk assessors are allowed access to information about criminal history, which must be kept securely and confidentially at all times.
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Information obtained about a person’s criminal history must not be used for any purpose other than for determining their suitability for engagement or ongoing engagement within NSW Health.

4.10 Retention of records

Criminal history information must be deleted as soon as the risk assessment is complete or within three months at the latest; this includes criminal history information sent or received or stored electronically.

All other records, including Declarations and Risk Assessment Reports, created or obtained in connection with NCRCs or WWCCs (including for volunteers and students) must be kept in accordance with the requirements of the NSW State Records General Retention and Disposal Authority. For the current requirements for retaining records obtained during the recruitment and selection of staff members, refer to the NSW Policy Directive ‘Recruitment and Selection of Staff of the NSW Health Service’, accessible at http://www.health.nsw.gov.au/policies/pages/default.aspx.

5. CHILD RELATED WORK

5.1 Definition of Child Related Work

Refer to the definitions of Child Related Work and WWCC exemptions in Section 2.


5.2 Recruitment requirements for child related work

People seeking to be employed or engaged in NSW Health in child related work are required to have the following two criminal record checks as part of the recruitment process:

1. A valid WWCC number from the Children’s Guardian:
   - A WWCC number should be validated as a WWCC clearance before the person commences in NSW Health, subject to the emergency provisions in Section 5.4 and

2. A satisfactory NCRC:
   - For all direct NSW Health engagements, the applicant (whether an existing worker or not) is required to complete a NCRC consent form and provide 100 points of identification as required in the 100 Point Identification Checklist and
     - The applicant should also complete a NSW Health Criminal History Declaration if they are not an existing worker and the recruitment process meets the requirements specified in Section 4.3.
   - The NCRC should be finalised before the person commences in NSW Health, subject to the emergency provisions in Section 5.4.
   - For locum or nursing and midwifery staff, it is the responsibility of the locum or nursing and midwifery agency to ensure that the person has a valid NCRC before they commence placements in NSW Health (refer to Section 5.6).

The following exceptions apply:
- A NCRC is not required if the applicant’s WWCC probity flag indicates they do not have any criminal history and they have completed a Declaration stating that they have no criminal records or pending charges (subject to any further requirements relating to aged care work - refer to Section 6).
- There are special arrangements for existing NSW Health Service workers changing roles. Refer to Section 9.

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5.3 Obtaining a Working with Children Check

WWCCs are only available from the Children’s Guardian. Individuals wishing to be engaged in child related work are responsible for obtaining and paying for their WWCC number from the Children’s Guardian.

NSW Health agencies may not apply for or pay for WWCCs on behalf of individuals.

The individual requiring a WWCC clearance must apply to the Children’s Guardian for a non volunteer clearance which will allow them to be engaged in either paid or unpaid work; or a volunteer clearance which will only allow them to be engaged in unpaid child related work.

Applicants are required to apply on line for a WWCC number, which then must be activated and paid for (if for paid work), in person, with identification at a NSW Motor Registry Office or a NSW Council Agency that provides Road and Maritime Services (for the full list, refer to the NSW Guardian’s “Fact Sheet: How to apply” available at https://www.kidsguardian.nsw.gov.au/)

Individuals should include their activated WWCC number with their application, at interview or as otherwise directed in the recruitment process. Information for applicants about obtaining the WWCC is available from https://www.kidsguardian.nsw.gov.au/

5.4 Emergency conditional appointments - child related workers

Child related workers are required to have a WWCC clearance before they commence work in NSW Health, except in the following circumstances:

1. Where the person has been unable to lodge their application at the NSW Motor Registry Office or NSW Council Agency before commencing work because they are an overseas or interstate applicant and a delay to them commencing work is likely to significantly affect service delivery or
2. Where there are other reasons for the person being unable to lodge an application before commencing work that the NSW Health agency determines are valid and the engagement of that worker is necessary in the circumstances to prevent an increased risk to the safety and wellbeing of children or
3. Where the person has lodged the application at the NSW Motor Registry Office or NSW Council Agency but has not yet received a clearance and a delay to them commencing work is likely to significantly affect service delivery.

The NSW Health agency is responsible for determining if the criteria for an emergency conditional appointment has been met, and for mitigating any risks associated with the applicant commencing work without a WWCC clearance, including ensuring that only delegated staff authorise such conditional appointments, and that all other relevant pre-employment screening checks are completed, including, where possible, a NCRC.

Further exemptions from the NSW WWCC apply to interstate and overseas workers (Refer to Section 5.7).

5.4.1 Emergency conditional appointments – requirements when appointing workers without a WWCC clearance

Where a new staff member or volunteer commences work without a WWCC clearance for the reasons cited in Section 5.4, they should have either completed a Declaration stating that they have no criminal history or undergone a NCRC, and the appointment must be conditional on a WWCC clearance being provided (and a satisfactory NCRC if waiting on the WWCC probity flag to support the Declaration). If the WWCC probity flag will not be available through the WWCC validation process, the NSW Health agency must immediately lodge a NCRC.
Where the emergency appointment relates to locum or nursing and midwifery agency staff, they should have met the NCRC requirements (Section 5.6) before commencing work; the Declaration and WWCC probity flag are not available for locum and nursing or midwifery agency staff.

If the person has been unable to obtain a WWCC application number from the NSW Motor Registry Office or the NSW Council Agency before commencing work, they must provide one within five days of commencing work. If after five days the person has not provided a valid WWCC number, the appointment should be suspended until the person has provided one.

Additional requirements relate to emergency appointments in aged care work - refer to Section 6.

The NSW Health agency must ensure that the ongoing appointment of all child related workers in NSW Health is dependent on valid WWCC clearance numbers and satisfactory NCRCs.

Individuals who do not have a valid WWCC number must not be engaged in child related work except in the circumstances outlined in Section 5.4.

There are penalties under the Child Protection (Working with Children) Act 2012 for employers and for individuals who fail to comply with the WWCC requirements.

5.4.2 Emergency conditional appointments without a NCRC

The NSW Health agency is responsible for determining if the criteria for an emergency conditional appointment has been met and for mitigating any risks associated with an applicant commencing work without a finalised NCRC, including ensuring that only delegated staff authorise such conditional appointments, and that all other relevant pre-employment screening checks are completed, including, where required a WWCC clearance.

Where a person has neither a WWCC clearance nor a finalised NCRC, the criteria in Section 5.4 must be met for the appointment to proceed.

A WWCC clearance probity flag and Declaration both indicating no criminal history meet the requirement for a finalised NCRC.

5.5 Validation of WWCCs

NSW Health agencies must validate WWCCs numbers with the Children’s Guardian for all new child related workers, including for agency and locum staff.

For each child related worker, records must be kept of the:

- Worker’s full name
- WWCC number
- Date and outcome of the WWCC validation and
- WWCC clearance expiry date.

These records may be electronic or in hard copy format, but must be made available to the Children’s Guardian if required for audit and monitoring purpose.

NSW Health agencies must use the “log on” details provided by the ESRU.

For existing workers, where it is identified as part of the recruitment process that the applicant’s WWCC from the Children’s Guardian has previously been validated, and is still current and valid for the work being undertaken (eg, for paid workers the WWCC is a non-volunteer WWCC) there is no further requirement to revalidate the number.

Once a worker has been validated, should the Children’s Guardian withdraw the WWCC clearance, they will contact ESRU, who will identify whether the person is still currently engaged in NSW Health and provide advice to the relevant NSW Health agencies.

If a worker’s WWCC is withdrawn by the Children’s Guardian, they must immediately be removed from child related work.
5.6 Locum and nursing and midwifery agency staff

All locum, nursing and midwifery agency staff must have a valid WWCC and NCRC before commencing in a NSW Health agency (unless they are only working in aged care work in which case they are only required to have a valid NCRC for aged care purposes – refer to Section 6), or unless the criteria in Section 5.4 has been met for emergency appointments, or they fall within the exemptions for short term overseas or interstate workers referenced in Section 5.7.

The locum or nursing and midwifery agency is required to provide confirmation to the NSW Health agency that the person has a valid WWCC and NCRC, in accordance with this policy.

For the purpose of locum or nursing and midwifery agency staff, a valid WWCC may be one from NSW Health or a WWCC number from the Children’s Guardian, depending on when the person registered with the locum or nursing and midwifery agency.

For WWCC numbers from the Children’s Guardian, the NSW Health agency must validate the WWCC number with the Children’s Guardian.

For the purpose of locum or nursing and midwifery agency staff, a valid NCRC is:

- A National Police Certificate obtained within the last three years and a Declaration relating to any offences committed since the date of the Certificate (if the Certificate was obtained before registration with the agency) or
- A NCRC obtained by the locum or nursing and midwifery agency as part of the person’s engagement with the agency or
- A NCRC included in a WWCC obtained from NSW Health (NSW Health WWCCs lodged by agencies before March 2012 included a NCRC; NSW Health WWCCs lodged by agencies after March 2012 did not include a NCRC).

The NSW Health Criminal History Declaration and WWCC probity flag may not be used for locum and nursing and midwifery agency staff.

It is the responsibility of the locum or nursing and midwifery agency to sight the person’s relevant documentation and to assess any criminal history to determine the person’s suitability for the placement.

The locum or nursing and midwifery agency must provide the NSW Health agency with the reference number for the Police Certificate or the NCRC, the date it was undertaken and confirmation that they have assessed any identified criminal records and there is nothing in the person’s criminal record history preventing them from undertaking all the key responsibilities of the role.

The Police Certificate is not required to be provided to the NSW Health agency. Locum and nursing agencies may use the ‘Template Letter for Locum and Nursing and Midwifery Agencies’ at Appendix 3.


The table at Appendix 13 summarises the NCRC and WWCC requirements for locum and nursing and midwifery agency staff.

5.7 Overseas and Interstate applicants

WWCC application numbers are only available from NSW Motor Registry Offices or NSW Council Agencies that provide Roads and Maritimes Services located in New South Wales.
Overseas and interstate applicants, including those appointed through locum or nursing and midwifery agencies, may be unable to obtain a WWCC application number until after they have commenced work in a NSW Health agency.

The NSW Health agency should consider whether the person is exempt from the WWCC for the reasons provided in Sections 5.7.1 or 5.7.3.

If the position is not exempt from the WWCC, and the criteria in Section 5.4 has been met, the appointment may proceed, but be conditional on a WWCC clearance. The person must attend the NSW Motor Registry Office or NSW Council Agency and provide the NSW Health agency with the WWCC application number within five days of commencing work.

Interstate and overseas applicants are subject to the same Australian NCRC requirements as other applicants.

Refer to Sections 5.6 and 9.3 for further information about locum, nursing and midwifery agency staff.

5.7.1 Overseas applicants

Overseas workers engaged in child related work in NSW Health are required to obtain a WWCC, unless they will be working for fewer than five days in any three month period.

If the appointment needs to proceed, conditionally, in the absence of a WWCC application number, the applicant must still meet the requirements for overseas criminal record checks and have an Australian NCRC, in accordance with this policy.

NCRCs may be lodged before the person arrives in Australia as long as they complete the NSW Health NCRC consent form with verified copies of original documents for the 100 Point ID Check. Once they arrive in NSW, the original documents must be sighted by the NSW Health agency and the 100 Point ID Checklist completed.

Certified copies are copies authorised, or stamped as being true copies of originals, by a person or agency recognised by the law of the country in which the person is currently residing as having the authority to authorise or stamp such documents.

Department of Immigration and Citizenship (‘DIAC’) offices outside Australia may have the facility to certify or witness documents. A ‘Service Delivery Partner’ may be able to provide this service on behalf of the department if there is an agreement in place with the Australian Office. Applicants can visit the DIAC website for more information on offices outside Australia: www.immi.gov.au/contacts/overseas/.

5.7.2 Additional requirements for overseas applicants

In addition to requirements for the WWCC and Australian NCRC, applicants recruited directly to NSW Health from overseas (including New Zealand) must provide:

- A Police Clearance from their home country and any country they have been citizens or permanent residents since turning 16 years of age (incorporating any charges the preferred applicant may have against their name)
- If unable to provide a Police Clearance from any country they have lived in, they must complete a Statutory Declaration stating they have no pending criminal charges or convictions from any country they have been citizens, permanent residents since turning 16. If they do have such records, they must list date of offence, type of offence and court outcome (refer to Appendix 5).

Any criminal record check in a language other than English must be accompanied by a ‘certified copy’ of an English translation of the criminal record.
5.7.3 Interstate applicants
Interstate workers engaged in child related work in NSW Health are required to have a NSW WWCC if they will be working for more than five days in any three month period or more than 30 days in a calendar year.

If the appointment needs to proceed conditionally, in the absence of a WWCC application number, the applicant should still have a NCRC, in accordance with this policy.

The following exemptions from the WWCC relate to interstate workers:

- Interstate health practitioners engaged by a NSW Health agency for fewer than five days in any three month period do not require a NSW WWCC.

- Health practitioners/workers working in NSW for more than five days in a three month period but fewer than 30 days in a calendar year do not require a NSW WWCC if they have an interstate WWCC number or they are exempt from the WWCC in their home State or Territory. Health practitioners in Queensland and ACT are currently exempt from their local WWCC requirements.

NSW Health agencies must ensure that interstate workers are compliant with the WWCC requirements.

5.8 Volunteers
Volunteers in paediatric or adolescent health services are in child related work if they are providing health and care services or if they are in an administrative, clerical, maintenance or ancillary role and the role involves contact with children for extended periods.

In other health services, volunteers providing health and care services are not in child related work unless they are in one of the other specified categories of child related work (refer to the definitions of ‘child related work’ and ‘WWCC exemptions’ in Section 2).

From 15 June 2013, all new volunteers engaged to work in child related work must have a valid WWCC number from the Children’s Guardian, and a valid NCRC in accordance with Section 5.

6. AGED CARE WORK

6.1 Definition of aged care work
The Australian Government’s Department of Health is responsible for the legislative criminal record checking requirements for workers in aged care work. Further information may be obtained from their website at:


Aged care workers include all paid staff members aged 16 years or over and relevant volunteers in NSW Health services and aged care facilities that receive Australian Government funding. These include:

- Residential aged care facilities
- Flexible Care services, such as:
  - Home Care Packages (formerly known as Community Aged Care Packages, Extended Aged Care at Home & Extended Aged Care at Home-Dementia Packages)
  - Multi-Purpose Service residential aged care services and
  - Transitional Aged Care services.

6.2 Requirements for aged care workers
Aged care staff members and volunteers are required to have a valid NCRC on appointment to NSW Health. The NCRC must be identified as being for the purpose of aged care and be repeated every three years for those:
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- Staff, contractors (including agency staff) or consultants within a residential aged care facility, who have, or are reasonably likely to have, access to care recipients or with access to the care recipient’s own home through a Home Care Package or other community service
- Volunteers visiting care recipients under the Community Visitors Scheme and
- Volunteers who have or are reasonably likely to have, unsupervised access to care recipients, and have turned 16 years of age or, if for full-time students, have turned 18 years of age.

The following are not aged care workers for the purpose of the Australian Government’s criminal record check requirements:

- Visiting medical practitioners, pharmacists and other allied health professionals who have been requested by, or on behalf of, a care recipient but are not contracted by the approved provider or
- Tradespeople who perform work otherwise than under the control of the approved provider (that is, independent contractors). For example, plumbers, electricians or delivery people who are utilised on an ‘adhoc’ basis
- Visiting people who attend the service at the invitation of a care recipient (e.g. family and friends) and
- Aged Care Assessment Teams who are visiting professionals not contracted by the approved provider.

People are precluded from working in Australian Government funded aged care services if they have a conviction for murder or sexual assault or a conviction for, and sentence to imprisonment (including one that is suspended) for any other form of assault.

The NSW Health agency must undertake NCRCs on all new staff members and volunteers to aged care. Refer to Section 4.3 for further information about the use of the Declaration and WWCC probity flag for preferred applicants for positions identified as ‘aged care work and child related work’.

NSW Health agencies must ensure that aged care workers have NCRCs every three years, and that persons with convictions precluding their employment are not engaged or allowed to continue to work in aged care.

6.3 Additional requirements for aged care applicants who have resided overseas

In addition to the Australian NCRC, if staff members or volunteers have been citizens or permanent residents of a country other than Australia since turning 16 years of age, they must make a Statutory Declaration before starting work stating that they have never been convicted of murder or sexual assault, or been convicted of, and sentenced to imprisonment for, any other form of assault.

The template Statutory Declaration for aged care must be used (Appendix 11).

6.4 Locum and nursing agency staff

For aged care workers engaged through a locum or nursing and midwifery agency, the locum or nursing and midwifery agency must ensure that the person has a valid NCRC, including in relation to the requirements for applicants who have resided overseas, before being placed in the NSW Health agency.

The NSW Health agency is responsible for confirming that locum or nursing and midwifery agency staff members have NCRCs in accordance with the aged care requirements.

The table at Appendix 13 summarises the NCRC and WWCC requirements for locum and nursing and midwifery agency staff.
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6.5 Emergency appointments in aged care

A person may commence conditionally in aged care work without a valid NCRC only if:

- The care or other service to be provided by the person is essential and
- An application for a NCRC or police certificate has been made before the date on which the person first becomes a staff member or volunteer and
- The person will be subject to appropriate supervision during periods when the person has access to care recipients and
- The person makes a statutory declaration (Appendix 11) stating that they have never been convicted of murder or sexual assault or convicted of, and sentenced to imprisonment for, any other form of assault.

7. NON CHILD RELATED WORK

Non child related work is any work that is not child related or aged care work and includes, but is not limited to:

- Administrative, corporate, clerical, maintenance, ancillary, volunteer work or any work by persons other than health practitioners in paediatric or adolescent health services where the work does not involve contact with children for extended periods, or
- Administrative, clerical, maintenance, corporate, ancillary or volunteer work or any work by persons other than health practitioners in all other health services (other than those defined as aged care work in Section 6) or in the NSW Ministry of Health.

All new staff members and volunteers engaged to work in NSW Health in non-child related roles must undergo a NCRC through NSW Health as part of the appointment process.

As long as the person remains in non-child related work within the NSW Health Service with no break in service, there is no requirement for a further NCRC.

As long as the person remains in non-child related work within the NSW Health Service with no break in service, there is no requirement for a further NCRC.

7.1 Agency staff - non clinical

Long term non clinical agency staff should have a NCRC. For short term non clinical agency staff, the NSW Health agency should determine whether a NCRC is necessary based on a risk assessment of the position (refer to Section 8).

7.2 Contractors - Service/Utilities (non-clinical services)

For short term/one off delivery/repair work, no criminal record checking is required. If a contractor is required to enter hospital wards or premises for the delivery or repair of equipment, the person is to be supervised and informed of the areas they are permitted to enter.

For long term contracts/tendered agreements where the company/organisation is contracted for building services and where the contractor is not providing any direct services to clients or patients, NSW Health does not undertake any criminal record checking.

If as a result of a risk assessment, it is determined that the workers engaged by the contractor should undergo NCRCs, it is the responsibility of the contracted company to organise them.

7.3 University/TAFE/other Registered Training Organisation (‘RTO’) students undertaking clinical placements in NSW Health agencies

All students are required to obtain a National Police Certificate for the purpose of undertaking clinical placements in NSW Health agencies, regardless of whether or not they are an existing NSW Health worker.
Students are responsible for obtaining their own Police Certificate. Overseas students, whether enrolled in an Australian or Overseas Tertiary Institution, must in addition to obtaining an Australian National Police Certificate, also obtain Police Certificates from their home country or any country that they have been permanent residents of or citizens in since turning 16 years of age (translated in to English). If they are unable to obtain a Police Certificate, the student must complete the Template Statutory Declaration at Appendix 5 that details whether or not they have a criminal history from their home country or any country that they have resided in, or been a citizen of since turning 16 years of age.

The name on the Police Certificate must match the name on the student’s ID card from the Tertiary Institution.

The Template Statutory Declaration at Appendix 5 must be completed once the student is in New South Wales.

Students attending clinical placements are not in child related work and are not required to obtain a WWCC. They are however required to sign the Code of Conduct Agreement for Students Undertaking a Clinical Placement at Appendix 6 stating that they have read and understood the NSW Health Code of Conduct and that they will notify NSW Health if they are charged with any criminal offences.

Students must provide NSW Health with original documentation to meet compliance requirements.

7.3.1 Students with criminal history or pending charges

Criminal history does not necessarily constitute a barrier to clinical placement. Each application is considered on its merits, and its relevance to undertaking clinical placements in NSW Health facilities. Mitigating factors, including but not limited to, the length of time since the convictions, the nature of the convictions and action taken since by the student will be considered.

Students with criminal history or pending charges are not allowed to commence or continue in clinical placements in NSW Health agencies until they have obtained a Clinical Placement Authority Card (or Conditional Letter) from HealthShare NSW’s Employment Screening and Review Unit (ESRU).

Students must apply directly to ESRU, by completing the ‘Application for authority to undertake clinical placements in NSW Health facilities’ at Appendix 10 if convictions are disclosed in a Police Certificate or Statutory Declaration or if they are charged with, or convicted of, an offence after the issuing of their Police Certificate.

If the risks relating to the criminal history are not relevant or are sufficiently mitigated, the student will be provided with a Clinical Placement Authority Card or a Conditional Letter with authority to undertake clinical placements subject to certain conditions.

If the risks relating to the criminal history are unacceptable, or the student has not provided the required documentation, NSW Health may decline the application or withdraw authority for the student to undertake placements if it had been previously provided. The student will be informed of this decision in writing and of the requirement to inform the Tertiary Institution’s Clinical Placement Supervisor or Facilitator.

ESRU will notify the ClinConnect Application Manager if it determines that a student, previously identified as clear to undertake clinical placements should now be refused authority to undertake placements.

7.3.2 Managing student compliance

NSW Health agencies must ensure that all students attending clinical placement are compliant with the requirements of this and other relevant polices, including those relating to immunisation status.

264(20/10/16)
Original documentation must be sighted and checked against the student’s Tertiary Institution’s ID card.

If the student fails to provide the required compliance documentation, which includes original documentation or the NSW Health facility is not able to manage the placement in accordance with any conditions stipulated by ESRU, they should not be allowed to commence their placement. Students should be referred to their Tertiary Institution.

One way of managing compliance is through the use of ClinConnect, a web-based application to assist in the management of clinical placements for Nursing and Midwifery, Dental and Oral Health, Allied Health and Medical students.


The Student Clinical Placement Checklist (Appendix 9) may also be used to assist in managing student compliance requirements.

### 7.4 Other students

Students from High School or TAFE completing work experience for their secondary school qualifications at a NSW Health agency do not require NCRCs as they must be supervised at all times by a staff member of the service who is allocated responsibility for them.

### 7.5 Student Supervisors/Facilitators

Student supervisors/facilitators, who are engaged by a Tertiary Institution or a recruitment agency, must provide evidence of a NCRC. This NCRC must have been completed either in the last three years or at the time of their appointment with the Tertiary Institution or recruitment agency.

Student supervisors/facilitators who are existing NSW Health workers are not required to undergo a further NCRC to undertake the role of student supervisor/facilitator.

Student supervisors/facilitators are required to have a WWCC number if the work meets the definition of child related work. Refer to the definitions of child related work and WWCC exemptions in Section 2, as well as the special arrangements for existing workers in Section 9.

Where student supervisors/facilitators are required to have a WWCC, the NSW Health agency must validate the number with the Children’s Guardian.

### 7.6 Volunteers (non child related)

NCRCs are required for all volunteers who are engaged to provide services in NSW Health facilities, in clients’ or patients’ homes or in other services where they are required to have direct face to face or physical contact with patients or clients or have access to confidential information about NSW Health patients, clients or staff, or high level access to finances.

### 7.7 Community Transport

Any drivers engaged to provide community transport in connection with a funding contract with Transport for NSW Health under the Home and Community Care Program or the Community Transport Program must every three years have NCRCs, satisfactory driving records verified by a driving record check and health assessments.

NSW Health agencies with funding contracts with the NSW Government Department ‘Transport for NSW’ for community transport services should check their contracts for full details of the requirements.
8. OTHER WORK

There may be some roles that fall outside the mandatory requirements of this Policy in relation to NCRCs. In these cases, the decision to undertake a NCRC will be based on a risk assessment in relation to the level of inherent risk to client safety, service delivery and community confidence.

The decision to undertake a NCRC for any roles not mandated by this Policy should include the following considerations:

- Whether the person is, or will be, a staff member or a volunteer in a NSW Health agency. NSW Health may only undertake NCRCs on persons it directly engages. If a NCRC is required but the person is employed by another organisation, it is the responsibility of the employing agency, or of there is no other employer, it is the responsibility of the individual
- The length of time of the engagement, e.g. engagements that are for less than two weeks or one-off engagements may not require a NCRC, unless there are particular risks inherent in the position
- The type of work being undertaken, including whether it requires direct contact with patients/clients, whether it involves the handling of confidential information such as that relating to patients/clients, the level of supervision involved, any protective factors that mitigate any risks relating to the role, the consequences to clients and to the organisation of any incident, and any other factors that will affect the level of risk.

A NCRC would normally be required if the role usually involves one or more of the following:

- The care of vulnerable persons
- Working in the immediate vicinity of, or having regular access to, vulnerable persons
- High levels of financial accountability
- High level access to information about staff, clients or patients, or
- Access to drugs.

NSW Health agencies should document decisions around NCRC requirements for roles not mandated by this Policy.

9. EXISTING NSW HEALTH WORKERS

There are special arrangements in the Child Protection (Working With Children) Regulation 2013 for existing child related workers to be transitioned to the new WWCC.

Existing child related workers (i.e. those employed or engaged in child related work as at 15 June 2013 but not including Visiting Medical Officers) are not required to apply for a WWCC number from the Children’s Guardian when changing roles for as long as they continue to be employed or engaged in NSW Health, or until the compliance date relevant to that worker (as specified in Appendix 2), whichever is sooner.

NSW Health agencies must ensure existing child related or aged care workers renew their WWCC or NCRC when required.

9.1 Visiting Medical Officers

Visiting Medical Officers are required to obtain a WWCC from the Children’s Guardian on renewal of their contract, or by 31 March 2018 if their contract is not due for renewal until after March 2018.

9.2 NSW Health staff members and volunteers

Existing NSW Health child related staff members and volunteers are not required to obtain a WWCC until the compliance date relevant to that worker.
Existing NSW Health staff members or volunteers changing roles (whether child related or not) are not required to undergo a further NCRC, unless:

- it has been identified that they have never previously had a criminal record check (NCRC or NSW Health WWCC) or
- a criminal record check has never been undertaken on the person’s correct or full name or aliases or
- a NCRC is required for the purpose of aged care work or
- they are undertaking a tertiary qualification and wish to undertake clinical placements in NSW Health facilities (students must obtain their own police certificate).

Once an existing staff member or volunteer has obtained a WWCC from the Children’s Guardian and it has been validated by a NSW Health agency, it does not need to be revalidated with the Children’s Guardian every time the person changes roles within NSW Health, however, the employing NSW Health agency must ensure that it is not has not expired and that it is the correct type of WWCC (i.e. a non volunteer WWCC for paid workers).

9.3 Locum and nursing and midwifery agency staff

Locum and nursing agency staff, including from interstate and overseas, are not required to obtain a WWCC clearance from the Children’s Guardian until they move to a new locum or nursing and midwifery agency or until the relevant compliance date in the Transition Schedule at Appendix 2, unless they are commencing a placement in NSW Health for the first time, and the agency has not previously obtained a NSW WWCC for that person.

The relevant compliance date for existing locum and nursing and midwifery agency staff will be determined by their placement within NSW Health.

From 15 June 2013, locum or nursing and midwifery agency staff are required to demonstrate that they have either a NSW Health WWCC or a WWCC number from the Children’s Guardian depending on when they registered with the locum or nursing and midwifery agency – refer to Section 5.6 and Appendix 13 for further information.

9.4 Overseas and interstate workers

Existing Interstate or overseas workers directly engaged by NSW Health agencies (i.e. those who are on existing contracts or appointments as at 15 June 2013 and remain within NSW Health) are not required to obtain a WWCC until the compliance date in the Transition Schedule at Appendix 2.

9.5 Medical officers on rotation

Medical officers on rotation to NSW Health from external host employers are not required to obtain a WWCC clearance from the Children’s Guardian for the period of their contract with the host employer if they were an existing child related worker with the host employer at 15 June 2013.

Refer to the requirements of the NSW Health policy on ‘Medical Officers - Employment arrangements in the NSW Public Health System’, which is accessible at:

9.6 Volunteers

Existing volunteers (i.e. those already engaged as at 15 June 2013 in paediatric or adolescent services) are not required to have a WWCC until the relevant compliance date in the Schedule at Appendix 2.
10. **List of Attachments**

Appendix 1: [Policy Directive checklist for implementation](#)

Appendix 2: [WWCC transition schedule for existing workers](#)

Appendix 3: [Template letter for Locum and Nursing and Midwifery agencies](#)

Appendix 4: [NSW Health Criminal History Declaration](#)

Appendix 5: [Statutory Declaration (overseas applicants/ students)](#)

Appendix 6: [Code of conduct agreement for students undertaking clinical placement](#)

Appendix 7: [National Criminal Record Check consent form](#)

Appendix 8: [100 Point ID checklist](#)

Appendix 9: [Student clinical placement checklist](#)

Appendix 10: [Application for authority to undertake clinical placements in NSW Health facilities](#)

Appendix 11: [Statutory Declaration for aged care purposes](#)

Appendix 12: [Table of requirements for staff members and volunteers](#)

Appendix 13: [Table of requirements for locum and nursing and midwifery agency staff](#)
APPENDIX 1

Checklist for the implementation of the Employment Checks – Criminal Record Checks and Working with Children Checks Policy Directive

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Self Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In development</td>
</tr>
</tbody>
</table>

A. STRATEGIC FUNDAMENTALS

1. A plan has been developed to implement the requirements of this policy.

2. There are resources and support to implement the requirements of the policy and an appropriate officer has been identified as responsible for the regular monitoring of progress.

3. Key Performance indicators are developed to monitor and measure the implementation.

B. INTEGRATION INTO NORMAL BUSINESS SYSTEMS

4. The requirements of this Policy Directive are included in all recruitment processes.

5. Preferred applicants for positions are given information about the requirements of this policy.

6. There are documented procedures in place regarding the management of students undertaking clinical placements and volunteers in accordance with this Policy Directive.

7. ‘Designated officers’ are all registered with ESRU, have undergone the appropriate checks, training etc and are deregistered with ESRU when they leave the position.

8. Documentation collected as part of the criminal record checking process is maintained and deleted in accordance with the requirements outlined in the

September 2016
APPENDIX 1

Checklist for the implementation of the Employment Checks – Criminal Record Checks and Working with Children Checks Policy Directive

<table>
<thead>
<tr>
<th>Requirement:</th>
<th>Self Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment and Selection of staff Policy Directive PD2012_028</td>
<td></td>
</tr>
<tr>
<td>9. Federally funded Aged Care Facilities have procedures for ensuring that all staff have valid National Criminal Record Checks.</td>
<td></td>
</tr>
<tr>
<td>C. ORGANISATIONAL IMPLEMENTATION</td>
<td></td>
</tr>
<tr>
<td>10. Information about the requirements of this policy is provided to interview convenors</td>
<td></td>
</tr>
<tr>
<td>11. There a systems in place to identify the criminal record check requirements on positions being recruited for</td>
<td></td>
</tr>
</tbody>
</table>

September 2016
## Working With Children Checks
### Transition Arrangements For Existing Child Related Workers
Child related work is work involving face to face contact with under 18 year olds in an area prescribed as child related work.

<table>
<thead>
<tr>
<th>Category of child related work</th>
<th>Sub category</th>
<th>Compliance period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justice Centres</td>
<td>Work at detention centres and juvenile correctional centres</td>
<td>By 31 March 2014</td>
</tr>
<tr>
<td>Child Protection</td>
<td>Work in child protection services</td>
<td>By 31 March 2014</td>
</tr>
<tr>
<td>Child development and family welfare services, and mentoring and counselling services for children</td>
<td>Work in mentoring and counselling services for children as part of a formal mentoring program. Work in providing family welfare services if the clients to whom the services are provided ordinarily include children.</td>
<td>1 April 14 - 31 March 2015</td>
</tr>
<tr>
<td>Children’s Health Services -</td>
<td>Central Coast Local Health District, Hunter New England Local Health District, Illawarra Shoalhaven Local Health District, Mid North Coast Local Health District, Northern NSW Local Health District, South Eastern Sydney Local Health District</td>
<td>1 April 2016 - 31 March 2017</td>
</tr>
<tr>
<td>Children’s Health Services -</td>
<td>Northen Sydney Local Health District, Sydney Local Health District, South Western Sydney Local Health District, Western Sydney Local Health District, Nepean Blue Mountains Local Health District, Murrumbidgee Local Health District, Southern NSW Local Health District, Western NSW Local Health District, Far West Local Health District, The Sydney Children’s Hospitals Network, Justice Health and Forensic Mental Health Network, Ambulance Service of New South Wales</td>
<td>1 April 2017 - 31 March 2018</td>
</tr>
<tr>
<td>Any remaining Children’s Health Services -</td>
<td>not captured in the groupings above.</td>
<td>1 April 2017 - 31 March 2018</td>
</tr>
<tr>
<td>Early Education and child care</td>
<td>Work in education and care services, child care centres, nanny services and other child minding services provided on a commercial basis</td>
<td>1 April 2017- 31 March 2018</td>
</tr>
</tbody>
</table>

Refer to Policy Directive Employment Checks – Criminal Record Checks and Working with Children Checks
Based on Schedule 1 of the Child Protection (Working with Children) Regulation 2013
September 2016

264(20/10/16)
APPENDIX 3

Template Agency Letter - Evidence of NCRC and WWCC Compliance

To whom it may concern,

This letter confirms that the person detailed below has a valid National Criminal Record Check ('NCRC') and a valid Working With Children Check ('WWCC') for undertaking working in NSW Health facilities.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Check type</th>
<th>Check number</th>
<th>Date of check</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>WWCC</td>
<td></td>
<td>clearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The letter confirms that the person named above has either:

a) Provided to us a National Police Certificate (NPC) issued to them within the last three years and has signed a declaration regarding any criminal charges or conviction since the date of the NPC, or

b) Been subject to a NCRC obtained as part of the employment /engagement / registration process with [Name of Employer/Agency], and

c) That [Name of Employer/Agency] is satisfied that there is no information on the person's record (or in any declaration provided by the person) to indicate any risks preventing them from undertaking work in NSW Health facilities.

This letter is also confirmation that the person does / does not have any convictions precluding them from working in facilities that receive aged care funding from the Australian Government in accordance with the requirements of the Aged Care Act 1997 (Commonwealth).

This letter confirms that the person named above has either:

a) Been with the agency since prior to June 2013 and has a Working with Children Check clearance obtained from NSW Health (attached) which did / did not include a NCRC or

b) A Working With Children Check clearance issued to them by the Children’s Guardian, which [Name of Employer/Agency] has verified online with the Children’s Guardian.

Any questions regarding this letter should be directed to [Name, Position and Contact Number].

Yours sincerely

Name
Position, Employer/ Agency

September 2016

June 2013
Criminal History Declaration
For child related work in NSW Health

This declaration supports NSW Health’s requirements for new starters to NSW Health to undergo a National Criminal Record Check as part of the recruitment process. This declaration is only for applicants for child related work; it is not for existing workers already engaged in NSW Health.

Personal details

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MIDDLE NAME(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>ALIASES/PREVIOUS NAMES (if any)</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>ROLE APPLIED FOR</th>
<th>NSW HEALTH ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Declaration
I understand that:

- It is a condition of engagement with NSW Health that I disclose any criminal history as lawfully allowed in accordance with the relevant State or Territory Spent Convictions legislation, noting that I am not required to disclose spent criminal history.
- I have separately provided consent for NSW Health to undertake a National Criminal Record Check (NCRC) to confirm information I have provided in this declaration, and that a NCRC may be undertaken should I be selected as a preferred person for this role.
- The disclosure of criminal records does not automatically preclude me from this role, and I understand that each case is considered on its merits.
- If disclosed criminal records are considered relevant to the requirements of the role, I may be asked to provide additional information in support of my application.
- Information disclosed in this declaration will be treated in strict confidence and will only be viewed by authorised staff; it will only be considered if I am a preferred person for this role and for the purpose of determining if further information is required in respect of any criminal records.
- If I have deliberately withheld or provided false information about convictions or pending charges that are subsequently identified as relevant to the inherent requirements of the role, my application may be rejected or if I have been appointed, it may be grounds for dismissal.

I make the following declaration in relation to criminal records recorded against my name:

<table>
<thead>
<tr>
<th>I have had one or more of the following recorded against my name (including bonds but excluding minor traffic offences, matters that have been quashed, dismissed, withdrawn or which are otherwise spent):</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>convictions in the last 10 years, or</td>
<td></td>
</tr>
<tr>
<td>convictions for sexual offences, or</td>
<td></td>
</tr>
<tr>
<td>convictions for which a prison sentence of more than 6 months was imposed, or criminal charges which are yet to be finalised or heard in court.</td>
<td></td>
</tr>
</tbody>
</table>

I confirm that the information I have given in this declaration is true and complete to the best of my knowledge and belief.

Name:  

Signature:  

Date:  

Last reviewed September 2016
STATUTORY DECLARATION
OATHS ACT 1900, NSW, EIGHTH SCHEDULE
(for overseas applicants or students)

I, ...................................................................................................................................................

(date)

do solemnly and sincerely declare that I have not have (listed below) any criminal convictions/pending
charges in my country of origin or any country, outside of Australia, which I have resided in or been a citizen of
since turning 16 years of age.

<table>
<thead>
<tr>
<th>Date of</th>
<th>Details of pending charge or conviction</th>
<th>Country</th>
<th>Penalty / Sentence</th>
</tr>
</thead>
</table>

and I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of
the Oaths Act 1900.

Declared at: ................................................................. on .................................................................

(place)

[signature of declarant]

in the presence of an authorised witness, who states:

I, ...................................................................................................................................................

[qualification of authorised witness]

[signature of authorised witness]

certify the following matters concerning the making of this statutory declaration by the person who made it:

1. *I saw the face of the person OR *I did not see the face of the person because the person was wearing a face
covering, but I am satisfied that the person had a special justification for not removing the covering, and

2. *I have known the person for at least 12 months OR *I have not known the person for at least 12 months, but I
have confirmed the person’s identity using an identification
document and the document I relied on was .................................................................

[signature of authorised witness]

[signature of authorised witness]

document relied on]

* Cross out any text that does not apply

NOTE 1.- A person who intentionally makes a false statement in a statutory declaration is guilty of an offence, the punishment for which is imprisonment
for a term of 5 years—see section 25 of the Oaths Act 1900 (NSW).

NOTE 2.- A statutory declaration under the Oaths Act 1900 (NSW) may be made only before a Justice of the Peace, a Legal Practitioner, a Judicial Officer,
or a person authorised to witness a declaration in the jurisdiction in which it is sworn.

NOTE 3.- Identification document means either a primary identification document within the meaning of the Real Property Regulation 2008, or a
Medicare card, pensioner concession card, Department of Veterans’ Affairs’ entitlement card or other entitlement card issued by the Commonwealth or a
State Government, a credit card or account (or a passbook or statement of account) from a bank, building society or credit union, an electoral enrolment
card or other evidence of enrolment as an elector, or a student identity card, or a certificate or statement of enrolment, from an educational institution.

NOTE 4.- Applicants for aged care work must use the Commonwealth Aged Care Statutory Declaration

September 2018

264(20/10/16)
Code of Conduct Agreement
for Students undertaking Clinical Placements

Instructions for Students:
Complete this form and provide it to the NSW Health organisation when requested.

SECTION A: PERSONAL DETAILS
(Name details provided must be same as the details on the Student ID)

Family Name: ____________________________  Given Names: ____________________________

Address: _________________________________

________________________________________

Student ID: ____________________________  Phone Number: ____________________________

Date of Birth: ____________________________  Gender: ____________________________

University/TAFE: ____________________________

SECTION B:

I undertake that if I am charged or convicted of any criminal offence after the date of issue of my National Police Certificate or while I am completing my course, I will notify NSW Health before continuing with any clinical placement.

and agree to abide by the provisions set out in the Code of Conduct at all times during all of my clinical placements within NSW Health Facilities. Failure to do so may lead to withdrawal of my clinical placements within NSW Health.

Name: ____________________________________ (please print)

Signature: ____________________________________

Date: ____________________________________

September 2016
# NATIONAL CRIMINAL RECORD CHECK CONSENT FORM

Please read the General Information sheet attached and complete all sections of this Form. Provide all names which you are currently known by, or have ever been known by, including aliases and any name changes, including by Marriage or by Deed Poll. NSW Health is required to sight your original identifying documents as per NSW Health’s 100 point ID Checklist.

**Is this a renewal check (Aged Care Only):**
- Yes
- No

<table>
<thead>
<tr>
<th>Primary Name</th>
<th>Given Name (Primary)</th>
<th>Given Name 2</th>
<th>Given Name 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maiden Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous/Alias Name 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous/Alias Name 2</td>
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<tr>
<td>Previous/Alias Name 3</td>
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<th>Place of Birth</th>
<th>Suburb/Town:</th>
<th>State:</th>
<th>Country:</th>
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<table>
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<tr>
<th>Current Residential Address</th>
<th>No/Street:</th>
<th>Suburb/Town:</th>
<th>State:</th>
<th>Postcode:</th>
<th>Country:</th>
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<table>
<thead>
<tr>
<th>Postal Address</th>
<th>(If same as Residential Address, write &quot;As Above&quot;)</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Previous Address (over the last 5 years) - If full details of previous addresses are unavailable, name of towns and States/Territories of residence will suffice.</th>
</tr>
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<tbody>
<tr>
<td>Previous Address (if any)</td>
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<thead>
<tr>
<th>Previous Address (if any)</th>
<th>No/Street:</th>
<th>Suburb/Town:</th>
<th>State:</th>
<th>Postcode:</th>
<th>Country:</th>
<th>Period of Residence:</th>
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<td></td>
<td>From: To:</td>
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<table>
<thead>
<tr>
<th>Previous Address (if any)</th>
<th>No/Street:</th>
<th>Suburb/Town:</th>
<th>State:</th>
<th>Postcode:</th>
<th>Country:</th>
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<td>From: To:</td>
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<th>Telephone No</th>
<th>Mobile:</th>
<th>Business:</th>
<th>Private:</th>
<th>Type of Position</th>
<th>Paid</th>
<th>Volunteer</th>
<th>Other</th>
</tr>
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<table>
<thead>
<tr>
<th>Driver’s Licence (Number)</th>
<th>Issuing State:</th>
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<table>
<thead>
<tr>
<th>Firearms Licence (Number)</th>
<th>Issuing Agency:</th>
</tr>
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<table>
<thead>
<tr>
<th>Passport Details (Number)</th>
<th>Type: Private</th>
<th>Government</th>
<th>UN Refugee</th>
<th>Issuing Country:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

1. I acknowledge that I have read the General Information sheet and understand that Spent Convictions Legislation, in the Criminal Records Act 1991 in the Commonwealth and many States and Territories protects "spent convictions" from disclosure and understand that the position for which I am being considered may be in a category for which exclusions from Spent Convictions legislation apply.

2. I have fully completed this Form, and the personal information I have provided in it relates to me, contains my full name and all names currently and previously used by me, and is correct;

3. I acknowledge that the provision of false or misleading information is a serious offence and acknowledge NSW Health is collecting information in this Form to provide to Australian Criminal Intelligence Commission (ACIC) (an Agency of the Commonwealth of Australia) and the Australian Police Agencies.

4. I consent to:
   - NSW Health forwarding details obtained from this Form to ACIC and to Australian police agencies or other relevant law enforcement agencies, if required.

ESRU74 last Updated September 2016

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264(20/10/16)
5. I consent to:
   i. ACIC disclosing personal information about me to the Australian police agencies;
   ii. The Australian police agencies disclosing to ACIC: from their records, details of convictions and outstanding charges, including findings of guilt or the acceptance of a plea of guilty by a court, that can be disclosed in accordance with the laws of the Commonwealth and States and Territories and, in the absence of any laws governing disclosure of this information, disclosing in accordance with the policies of the police agency concerned; and
   iii. ACIC providing the information disclosed by the Australian police agencies, to NSW Health in accordance with the laws of the Commonwealth so that NSW Health may assess my suitability in relation to my employment.

6. I acknowledge that any information provided by me on this form and information provided by the Australian police agencies or ACIC relates specifically to the position detailed above.

7. I acknowledge that it is usual practice for an applicant's personal information to be disclosed to the Australian police agencies for them to use for their respective law enforcement purposes including the investigation of any outstanding criminal offences.

I am aware that if any such records are identified, NSW Health may seek additional information relating to that record from sources such as courts, police, prosecutors and past employers. I understand that the purpose of seeking this information is to enable a full and informed employment risk assessment and that where other information is available, NSW Health will obtain that information for employment risk assessment purposes only. I acknowledge that any information obtained as part of this process may be used by Australian Police Services for law enforcement purposes including the investigation of any outstanding criminal offences.

Note: The information you provide on this form, and which ACIC provides to NSW Health on receipt of this form, will only be used for the purposes stated above, unless statutory obligations require otherwise.

Applicant's Details
Name: ___________________________ Signature: ___________________________ Date: __________

Parent/Guardian Consent - If you are under 18 years of age, a parent or guardian must provide consent.

Parent/Guardian Details
Name (printed in full): ___________________________ Signature: ___________________________ Date: __________
GENERAL INFORMATION - National Criminal Record Check Consent Form

This Form is used by NSW Health as part of the assessment process to determine whether a person is suitable for employment or other engagement for work.

Unless statutory obligations require otherwise, the information provided on this Form will not be used without your prior consent for any purpose other than in relation to the assessment by NSW Health of your suitability for the position identified in the consent form. You may be required to complete another consent form in the future in relation to employment in other positions.

NATIONAL CRIMINAL RECORD CHECK

a) National criminal record checks are an integral part of the assessment of your suitability. You should note that the existence of a record does not mean you will be assessed automatically as being unsuitable. Each case will be assessed on its merit, so it is in your interest to provide full and frank details on this form. Information extracted from the Form will be forwarded to ACIC and to the Australian State and Territory police agencies for checking action. By signing this Form you are consenting to these agencies accessing their records to obtain and to disclose criminal history information that relates to you to NSW Health.

Criminal history information may include outstanding charges, and criminal convictions/findings of guilt recorded against you that may be disclosed according to the laws of the relevant jurisdiction and, in the absence of any laws governing the release of that information, according to the relevant jurisdiction’s information release policy.

SPENT CONVICTION SCHEMES

The aim of Spent Convictions legislation is to prevent discrimination on the basis of certain previous convictions. Spent conviction legislation limits the use and disclosure of older, less serious convictions and findings of guilt.

Spent convictions of specific offences will be released where the check is required for certain purposes regardless of how old the convictions are. Each Australian police agency will apply the relevant Spent Convictions legislation/information release policy prior to disclosure. If further information or clarification is required please contact the individual police agency directly for further information about their release policies and any legislation that affects them.

COMMONWEALTH

Part VIIIC of the Crimes Act 1914 (Cth) deals with aspects of the collection, use and disclosure of old conviction information. The main element of this law is a “Spent Convictions Scheme.” The aim of the Scheme is to prevent discrimination on the basis of certain previous convictions, once a waiting period (usually 10 years) has passed and provided the individual has not reoffended during this period. The Scheme also covers situations where an individual has had a conviction “quashed” or has been “pardoned.” A “spent conviction” is a conviction of a Commonwealth, Territory, State or foreign offence that satisfies all of the following conditions:

- It is 10 years since the date of the conviction (or 5 years for juvenile offenders); AND
- the individual was not sentenced to imprisonment or was not sentenced to imprisonment for more than 30 months; AND
- the individual has not re-offended during the 10 years (5 years for juvenile offenders) waiting period; AND
- a statutory or prescribed exclusion does not apply. (A full list of exclusions is available from the Office of the Australian Information Commissioner).

NEW SOUTH WALES

In New South Wales the Criminal Records Act 1991 (NSW) governs the effect of a person’s conviction for a relatively minor offence if the person completes a period of crime-free behaviour, and makes provision with respect to quashed convictions and pardons.

A “quashed” conviction is a conviction that has been set aside by the Court. A “pardon” means a free and absolute pardon that has been granted to a person because they were wrongly convicted of a Commonwealth, Territory, State or foreign offence.

In relation to NSW convictions, a conviction generally becomes a “spent conviction” if a person has had a ten year crime-free period from the date of the conviction. However, certain convictions may not become spent convictions. These include:

- where a prison sentence of more than 6 months has been imposed (periodic or home detention is not considered a prison sentence);
- convictions imposed against companies and other corporate bodies;
- sexual offences pursuant to the Criminal Records Act 1991; and
- convictions prescribed by the Regulations.
GENERAL INFORMATION - National Criminal Record Check Consent Form

Queensland
Under the Criminal Law (Rehabilitation of Offenders) Act 1986 (Qld) a conviction automatically becomes spent upon completion of the prescribed rehabilitation period. This period is:

- 10 years for convictions of indictable offences where the offender was an adult at the time of conviction; and
- 5 years for other convictions (summary offences or where the offender was a juvenile).

Where a person is convicted of a subsequent offence (an offence other than a simple or regulatory offence) during the rehabilitation period, the period runs from the date of the subsequent conviction.

Convictions where the offender is sentenced to more than 30 months imprisonment (whether or not that sentence is suspended) are excluded from the regime.

Once the rehabilitation period has expired, it is lawful for a person to deny (including under oath) that the person has been convicted of the offence, and the conviction must be disregarded for occupational licensing purposes (subject to certain exceptions, see below). It is unlawful for any person to disclose the conviction unless:

- the convicted person consents;
- the Minister has granted a permit authorising disclosure (where there is a legitimate and sufficient purpose for disclosing);
- the disclosure is subject to an exemption.

South Australia
Release of information on a National Police Check is governed by the Spent Convictions Act 2009 (SA). It is an offence to release information regarding the convictions of a person if those convictions are deemed to be 'spent' under the Act.

A spent conviction is one that cannot be disclosed or taken into consideration for any purpose. Eligible convictions become spent following a 10-year conviction and proven offence-free period for adults, and a 5-year conviction and proven offence-free period for juveniles. The Act defines a conviction as:

- a formal finding of guilt by a Court;
- a finding by a Court that an offence has been proved.

Certain convictions can never be spent. These include but are not limited to:

- convictions of sex offences;
- convictions where a sentence is imposed of more than 12 months;
- imprisonment for an adult, or 24 months imprisonment for a juvenile.

Schedule 1 of the Act sets out a number of exceptions to the rule where spent convictions can be released. Some examples of this include: the care of children; the care of vulnerable people (including the aged and persons with a disability, illness or impairment); activities associated with statutory character tests for licensing.

Interstate offences are released in accordance with that State or Territory’s spent conviction / rehabilitation legislation and policy. Intelligence-type information is not released.

Victoria Police
For the purposes of employment, voluntary work or occupational licensing/ registration, police may restrict the release of a person’s police record according to the Victoria Police Information Release Policy. If you have a police record, the “Information Release Policy” may take into account the age of the police record and the purpose for which the information is being released. If 10 years have elapsed since you were last found guilty of an offence, police will, in most instances, advise that you have no discloseable court outcomes. However, a record over 10 years may be released if:

- it includes a term of imprisonment longer than 30 months;
- it includes a serious, violent or sexual offence and the check is for the purpose of working with children, elderly people or disabled people;
- it is in the interests of crime prevention or public safety.

Findings of guilt without conviction and good behaviour bonds may be released. Recent charges or outstanding matters under investigation that have not yet gone to court may also be released.

Western Australia
Under Section 7(1) of the Spent Convictions Act 1988 (WA) only "lesser convictions" can be spent by Western Australia Police, after a time period of 10 years plus any term of imprisonment that may have been imposed. A lesser conviction is one for which imprisonment of 12 months or less, or a fine of less than $15,000 was imposed.

All other convictions, such as "serious convictions" applicable under Section 6 of the Act can only be spent by applying to the District Court. At the time of sentencing, the Court may make a "spent conviction order" under the Sentencing Act 1995 (WA) that the conviction is a spent conviction for the purposes of the Spent Convictions Act 1988 (WA).
GENERAL INFORMATION - National Criminal Record Check Consent Form

Northern Territory
Under the Criminal Records (Spent Convictions) Act 1992 (NT), a conviction becomes spent automatically (in the case of an adult or juvenile offender convicted in a Juvenile Court) and by application to the Police Commissioner (in the case of a juvenile convicted in an adult court) upon completion of the prescribed period. The prescribed period is:
- 10 years for offences committed while an adult; and
- 5 years for offences committed as a juvenile.
The period starts on completion of any sentence of imprisonment. A subsequent traffic conviction is only taken into account for prior traffic offences (except more serious traffic offences which cause injury or death).
Once a conviction becomes spent:
- a person is not required to disclose the existence of the conviction;
- questions relating to convictions and a person's criminal record will be taken only to apply to unspent convictions;
- it is unlawful for another person to disclose the existence of a spent conviction except as authorised by the Act;
- spent convictions are not to be taken account in making decisions about the convicted person's character or fitness.

Australian Capital Territory
Generally, under the Spent Convictions Act 2000 (ACT), a conviction becomes spent automatically at the completion of the prescribed (crime-free) period. This period is:
- 10 years for convictions recorded as an adult; or
- 5 years for convictions recorded as a juvenile.
The period begins to run from the date a sentence of imprisonment is completed, or, where no sentence of imprisonment is imposed, from the date of conviction. A person must not be subject to a control order or convicted of an offence punishable by imprisonment during this period. If a person is convicted of an offence, which was committed in the crime-free period, but the conviction is not incurred until after the crime-free period, the spent conviction may be revived and will not become spent again until the offender has achieved the relevant crime-free period in respect of the latter offence.
The effect of conviction becoming spent is that:
- the convicted person is not required to disclose any information concerning the spent conviction;
- any question concerning criminal history is taken only to apply to unspent convictions;
- information in the order or statutory instrument to convictions or character or fitness does not include spent convictions, and it is an offence to disclose information regarding spent convictions; it is unlawful for a person who has access to a person's criminal record held by a public authority to disclose a spent conviction; it is unlawful for a person to fraudulently or dishonestly obtains information about a spent conviction from records kept by a public authority.

Tasmania
Under the Annulled Convictions Act 2003 (Tas) a conviction is annulled upon completion of the prescribed period of good behaviour. This period is:
- 10 years where the offender was an adult at the time of conviction; or
- 5 years where the offender was a juvenile at the time of conviction.
A person is taken to be of good behaviour for the required period if, during that period, he or she is not convicted of an offence punishable by a term of imprisonment. If the person is so convicted, the qualifying period (for the original offence) starts to run from the date of the subsequent conviction. A subsequent traffic conviction is only taken into account for prior traffic offences (except more serious traffic offences which cause injury or death).

Only "minor" convictions can become annulled. A minor conviction is a conviction other than one for which a sentence of imprisonment of more than 6 months is imposed, a conviction for a sexual offence or a prescribed conviction.
A minor conviction is also annulled if the offence ceases to be an offence. Once an offence is annulled the convicted person is not required to disclose any information concerning the spent conviction. Any question concerning criminal history is taken only to apply to unspent convictions, and references in Acts or statutory instruments to convictions or character or fitness do not include spent convictions. An annulled conviction or the non-disclosure of the annulled conviction is not grounds for refusing the person any appointment, post, status or privilege or revoking any appointment, post, status or privilege.

- a person is not required to disclose the existence of the conviction;
- questions relating to convictions and a person's criminal record will be taken only to apply to unspent convictions;
- it is unlawful for another person to disclose the existence of a spent conviction except as authorised by the Act;
- spent convictions are not to be taken account in

PROVISION OF FALSE OR MISLEADING INFORMATION
You are asked to certify that the personal information you have provided on this form is correct. If it is subsequently discovered, for example as a result of a check of police records, that you have provided false or misleading information, you may be assessed as unsuitable or, if already employed, may lead to your dismissal.
It is a serious offence to provide false or misleading information.
100 Point Identification Checklist

Appendix 8

Instructions

(a) The 100 point identification check must be completed and checked against the applicant's completed NSW Health National Criminal Record Check Consent Form prior to lodgement of a National Criminal Record Check (or National Criminal Record Check for Aged Care purposes).

(b) Employers are required to sight original identifying documents (scanned or photocopied certified copies are not acceptable), as listed on page 2, and ensure that an appropriately delegated officer checks the details and completes the record of identifying documents below. There is no requirement to retain copies of the identifying documents.

(c) Identification must be current and must include at least one type of photographic ID and identification that contains a signature and date of birth. Passport and/or Driver’s License are preferred.

(d) The point score of documents produced must total at least 100 points (refer to page 2).

(e) The applicant must provide evidence of ability to work in Australia: If their documents do not include an Australian or New Zealand passport or an Australian birth or citizenship certificate, an appropriate visa or work permit allowing the person to work in Australia must be sighted.

Applicant’s Full Name: ________________________________

<table>
<thead>
<tr>
<th>Description of document</th>
<th>Full name on document</th>
<th>Date issued</th>
<th>Place/Office of issue/issuing organisation</th>
<th>Expiry date</th>
<th>Checked Against Consent Form *</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Mandatory record of document sighted that confirm person’s ability to work in Australia

|                         |                       |             |                                          |             |                                |        |
|                         |                       |             |                                          |             |                                |        |

Total points

I have checked the details provided above against the applicant’s National Criminal Record Check consent form as required at point (a) above, and I confirm:
The names in the ID documents are included in the consent form, and
Any reference numbers for documents detailed in the consent form match those I have sighted today, and
The applicant has provided evidence that they are allowed to work in Australia, as required at point (e) above.

I have also confirmed with the applicant that all aliases / former / middle names are included in the consent form.
(Note: Failure to include all names may warrant the check invalid).

Name: ________________________________
Position: ________________________________
Signature: ____________________________ Date: ________________

100 Point ID Checklist September 2016

264(20/10/16)
## 100 Point Identification Checklist

### Appendix 8

<table>
<thead>
<tr>
<th>DOCUMENTS</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary</strong> - Only one form of identification accepted from this category:</td>
<td></td>
</tr>
<tr>
<td>- Birth Certificate/Birth Extract</td>
<td>70</td>
</tr>
<tr>
<td>- Australian Citizenship Certificate</td>
<td></td>
</tr>
<tr>
<td>- Australian passport (current or expired within the past two years but not cancelled)</td>
<td></td>
</tr>
<tr>
<td>- International passport (current or expired within the past two years but not cancelled)</td>
<td></td>
</tr>
<tr>
<td>- Other document of identity having same characteristics as a passport e.g. diplomatic passport/Photo or signature</td>
<td></td>
</tr>
<tr>
<td><strong>Secondary</strong> - the initial secondary document will score 40 points, any additional documents will be awarded 25 points each:</td>
<td></td>
</tr>
<tr>
<td>- Current Licence or Permit (Government issued)</td>
<td>40 or 25</td>
</tr>
<tr>
<td>- Current driver photo licence issued by an Australian state or territory</td>
<td></td>
</tr>
<tr>
<td>- AUSNETS Card</td>
<td></td>
</tr>
<tr>
<td>- Working with Children/Teachers Registration Card</td>
<td></td>
</tr>
<tr>
<td>- Public Employees Photo ID (Government issued)</td>
<td></td>
</tr>
<tr>
<td>- Department of Veterans Affairs Card</td>
<td></td>
</tr>
<tr>
<td>- Centrelink Pensioner Concession Card or Health Care Card</td>
<td></td>
</tr>
<tr>
<td>- Current Tertiary Education Institution Photo ID</td>
<td></td>
</tr>
<tr>
<td>- Reference from a Doctor (must have known the applicant for a period of at least 12 months)</td>
<td></td>
</tr>
<tr>
<td>- Foreign driver’s licence</td>
<td></td>
</tr>
<tr>
<td>- Proof of aged card (Government issued)</td>
<td></td>
</tr>
<tr>
<td>- Medicare Card / private Health Care Card</td>
<td></td>
</tr>
<tr>
<td>- Council rates notice</td>
<td></td>
</tr>
<tr>
<td>- Property Lease/rent agreement</td>
<td></td>
</tr>
<tr>
<td>- Property Insurance Papers</td>
<td></td>
</tr>
<tr>
<td>- Tax Declaration</td>
<td></td>
</tr>
<tr>
<td>- Superannuation Statement</td>
<td></td>
</tr>
<tr>
<td>- Seniors Card</td>
<td></td>
</tr>
<tr>
<td>- Electoral roll completed by the Australian Electoral Commission</td>
<td></td>
</tr>
<tr>
<td>- Motor Vehicle Registration or Insurance Documents</td>
<td></td>
</tr>
<tr>
<td>- Professional or Trade Association Card</td>
<td></td>
</tr>
</tbody>
</table>

If more than one of these documents are used, they must be from different organisations:

<table>
<thead>
<tr>
<th>DOCUMENTS</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Current Utility bills (e.g. telephone, water, gas or electricity)</td>
<td>25</td>
</tr>
<tr>
<td>- Credit / Debit card</td>
<td></td>
</tr>
<tr>
<td>- Bank Statement /Passbook</td>
<td></td>
</tr>
</tbody>
</table>

### SPECIAL PROVISIONS ONLY TO BE USED IF 100 POINT CHECK ABOVE CANNOT BE MET

- The full 100 point check is required when the applicant has been in Australia for longer than 6 weeks.
- For recent arrivals in Australia (6 weeks or less) - proof of arrival date required + current passport.
- **Aboriginal person or Torres Strait Islander resident in remote area** (Use "Proof of identity for Aboriginal and Torres Strait Islander People" NSW Health internet [http://tinyurl.health.nsw.gov.au/pbwh](http://tinyurl.health.nsw.gov.au/pbwh), for more details).

<table>
<thead>
<tr>
<th>DOCUMENTS</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Child under 18 years of age</td>
<td>100</td>
</tr>
<tr>
<td>- Birth Certificate/Birth Extract</td>
<td></td>
</tr>
<tr>
<td>- Australian Citizenship Certificate</td>
<td></td>
</tr>
<tr>
<td>- Australian passport (current or expired within the past two years but not cancelled)</td>
<td></td>
</tr>
<tr>
<td>- International passport (current or expired within the past two years but not cancelled)</td>
<td></td>
</tr>
<tr>
<td>- Other document of identity having same characteristics as a passport e.g. diplomatic passport/Photo or signature</td>
<td></td>
</tr>
<tr>
<td>Or: Statement from an educational institution, signed by the principal or deputy principal, confirming that the child attends the institution (statement must be on the institution’s letterhead).</td>
<td></td>
</tr>
</tbody>
</table>

100 Point ID Checklist | September 2016

264(20/10/16)
**STUDENT CLINICAL PLACEMENT CHECKLIST**

**CRIMINAL RECORD CHECKS AND IMMUNISATION STATUS**

for NSW Health

---

**Section 1: Complete either Part A or Part B**

<table>
<thead>
<tr>
<th>Criminal Record Checks</th>
<th>Reference Number</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian National Police Certificate with no convictions / charges dated within the last three years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A For Overseas Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Along with the Australian National Police Certificate, an original of one of the following has also been sighted and a copy is attached for the records:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Police Certificate with no convictions / charges from their home country or any country that they have resided in (translated into English); or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Signed Statutory Declaration with no convictions / charges complete and signed in Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinical Placement Authority card issued by NSW Health pre 1 June 2010 (no expiry date) but which is valid for the duration of the course; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinical Placement Authority card issued by NSW Health post 1 June 2010 (with expiry date); or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Conditional letter issued by NSW Health (with expiry date).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Conditions on student’s placement**: 1

---

**Section 2: Code of Conduct**

<table>
<thead>
<tr>
<th>Code of conduct</th>
<th>Date signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student has signed the NSW Health Code of Conduct Agreement.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Section 3: Complete either Part A or Part B**

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>Date assessed/sighted</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>The student has been assessed by the LHD for compliance with the requirements of the Occupational assessment, screening and vaccination against specified diseases policy directive: Information Sheet 2</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
</tr>
<tr>
<td>A Certificate of Compliance has been sighted.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Section 4: To be completed by the person sighting the documents**

I confirm that I have sighted original documents as detailed above and kept copies.

---

**Name:**

**Position Title:**

**Signature:**

**Date:**

**Organisation:**

**Health Facility:**

Note: Police certificates are valid for three years from the date they were issued. All other documents are valid for the duration of the student’s course unless otherwise stated on the document.

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Updated September 2016

Workplace Relations

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264(20/10/16)
Application for authority to undertake clinical placements in NSW Health facilities

Students must apply to NSW Health for authority to undertake Clinical Placements within the NSW Health Service, or authority to continue with Clinical Placements if they:

- have offences or pending charges disclosed in their National Police Certificate, Overseas Police Certificate or Statutory Declaration; or
- have been charged or convicted of offences after the issuing of their Police Certificate.

The following documents must be submitted:

- a completed ‘Application for Clinical Placement Authority’ form;
- a certified copy of the National Police Certificate (issued within last 3 years);
- a certified copy of overseas Police Certificate/s and/or Statutory Declaration (for overseas students only);
- a certified copy of the Student ID issued by the Tertiary Education Institution;
- relevant supportive documents such as independent references, evidence that you have successfully completed relevant training, education or treatment courses etc.

Students are required to send the required documentation to:

Employment Screening and Review Unit
Westmead Service Centre
NSW Health (HealthShare NSW)
PO Box 292
WESTMEAD NSW 2145

Ph: (02) 8848 5175
Fax: (02) 8848 5185
Email: hnswe-esrienuinquiries@health.nsw.gov.au

Criminal history does not necessarily constitute a barrier to clinical placement. Each application is considered on its merits, and its relevance to undertaking clinical placement in NSW Health facilities. Mitigating factors, including but not limited to the length of time since the convictions, the nature of the convictions and action taken since by the student will be considered.

If the risks relating to the criminal history are not relevant or are considered sufficiently mitigated, NSW Health will provide a Clinical Placement Authority Card or a Conditional Letter with authority to undertake clinical placement subject to certain conditions.

If the risks relating to the criminal history are unacceptable, or the student has not provided the required documentation, NSW Health may decline the application and withdraw such authority if it had been previously provided. The student will be informed of this decision in writing and of the requirement to inform the educational institution’s Clinical Placement Supervisor or Facilitator.

Students should allow sufficient time (a minimum of 15 working days) for NSW Health to process the Clinical Placement Authority Card or the Conditional Letter.


September 2016
## SECTION A: PERSONAL DETAILS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Given Names:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other Name/s:</strong></td>
<td>(including alias and previous)</td>
</tr>
<tr>
<td><strong>Home Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Country:</strong></td>
<td><strong>Contact Number:</strong></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Postal address if different from home address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>University/TAFE:</strong></td>
<td><strong>Name of Course:</strong></td>
</tr>
<tr>
<td><strong>Student ID:</strong></td>
<td><strong>Date of Enrolment:</strong></td>
</tr>
<tr>
<td><strong>National Police Certificate No:</strong></td>
<td><strong>Issued on:</strong></td>
</tr>
<tr>
<td><strong>Previous Risk Assessment Completed:</strong></td>
<td><strong>☐ Yes ☐ No</strong></td>
</tr>
</tbody>
</table>

## SECTION B – PLEASE CIRCLE WHICH BEST REPRESENTS YOU

- **Australian Student:** Enrolled in Australian Tertiary Institution
- **Overseas Student:**
  1. On Exchange Program; or
  2. Enrolled in Australian Tertiary Institution
SECTION C – STATEMENT AND CONSENT

Instructions:
• For additional offences, photocopy and complete Section E as required and attach additional pages if there is insufficient space.
• If assistance is required in completing the statement, please contact Employment Screening & Review Unit on (02) 8848 5175 or email hsmw-enquiries@health.nsw.gov.au.

Charge / Conviction (No.1)

1. Details of the charge/conviction (e.g. drink driving – High PCA; Shoplifting, etc) including the court date.

2. Please describe the event/s that led to you being charged:

3. Were there any mitigating circumstances at the time of the offence/s (i.e. personal difficulties, relationship issues etc) that you think should be considered as part of this risk assessment? If so, describe them.

4. State how your life has changed or what action you have taken that demonstrates your commitment to avoiding criminal charges in the future.

I give consent to NSW Health to obtain any additional information, relating to any offences or pending charges shown on the National Police Certificate that I have provided, from sources such as courts, police and prosecutors. I understand that the purpose of seeking this information is to enable a full and informed risk assessment and that where other information is available, NSW Health will obtain that information for clinical placement risk assessment purposes only.

Signature: __________________________  Date: __________________________

September 2016

264(20/10/16)
SECTION D – ATTACH DOCUMENTS

Please attach original certified copy (photocopied or emailed certified copies are not acceptable) of the following documents where applicable, that have been certified as a true copy of an original by a person listed in Schedule 2 of the Statutory Declarations Regulations 1993 (Cth) which is available from www.comlaw.gov.au.

(Do not send original POLICE CERTIFICATES / STATUTORY DECLARATION and STUDENT ID CARD)

- Valid National Police Certificate (issued within last 3 years) *
- Overseas Police Certificate/s or Statutory Declaration (for overseas student) *
- Student ID card *
- Additional pages for statement (if applicable)
- Character reference (optional)
- Evidence of relevant training, education or treatment courses completed following the offence/s that demonstrate your commitment to avoiding criminal charges in the future (optional)

Please send the completed documentation to:

Post: Employment Screening and Review Unit
Westmead Service Centre
NSW Health (HealthShare NSW)
PO Box 292
WESTMEAD NSW 2145

Fax: 02 8848 5188

Email: hssnw-esruenquiries@health.nsw.gov.au

* Compulsory documents to be attached with your application. The name on your National Police Certificate must match the name on your Student ID card. Your application will not be processed if the name on your National Police Certificate does not match the name on your Student ID card and you will not be allowed to commence clinical placement with a NSW Public Health Facility.
SECTION E – STATEMENT AND CONSENT (ADDITIONAL PAGE) – Photocopy if required

Charge / Conviction (No. ___)

1. Details of the charge / conviction (e.g. drink driving – High PCA; Shoplifting, etc) including the court date.

2. Please describe the event/s that led to you being charged:

3. Were there any mitigating circumstances at the time of the offence/s (i.e. personal difficulties, relationship issues etc) that you think should be considered as part of this risk assessment? If so, describe them.

4. State how your life has changed or what action you have taken that demonstrates your commitment to avoiding criminal charges in the future.

I give consent to NSW Health to obtain any additional information, relating to any offences or pending charges shown on the National Police Certificate that I have provided, from sources such as courts, police and prosecutors. I understand that the purpose of seeking this information is to enable a full and informed risk assessment and that where other information is available, NSW Health will obtain that information for clinical placement risk assessment purposes only.

Signature: ___________________________  Date: ________________________________

September 2016

264(20/10/16)
Commonwealth of Australia
STATUTORY DECLARATION
Statutory Declarations Act 1959

I, [name], make the following declaration under the Statutory Declarations Act 1959:

1. I declare that (place a tick or cross in applicable box):

☐ Since turning 16 years of age, I have been a citizen or permanent resident of a country/countries other than Australia.
☐ Since turning 16 years of age, I have never been a citizen or permanent resident of a country/countries other than Australia.

2. I declare that I have never been:

(a) convicted of murder or sexual assault; or
(b) convicted of, and sentenced to imprisonment for, any other form of assault.

I acknowledge that continued employment with a NSW Health agency is conditional upon a satisfactory outcome of the check which I have consented to.

I understand that a person who intentionally makes a false statement in a statutory declaration is guilty of an offence under section 11 of the Statutory Declarations Act 1959, and I believe that the statements in this declaration are true in every particular.

Signature of person making the declaration

Place
Day
Month and year

Declared at on of

Before me,

Signature of person before whom the declaration is made (print in block letters)

Note 1: A person who intentionally makes a false statement in a statutory declaration is guilty of an offence, the punishment for which is imprisonment for a term of 4 years — see section 11 of the Statutory Declarations Act 1959.

Note 2: Chapter 2 of the Criminal Code applies to all offences against the Statutory Declarations Act 1959 — see section 5A of the Statutory Declarations Act 1959.
A statutory declaration under the Statutory Declarations Act 1959 may be made before—

(1) a person who is currently licensed or registered under a law to practice in one of the following occupations:

- Chiropractor
- Dentist
- Legal practitioner
- Medical practitioner
- Nurse
- Optometrist
- Patent attorney
- Pharmacist
- Physiotherapist
- Psychologist
- Trademarks attorney
- Veterinary surgeon

(2) a person who is enrolled on the roll of the Supreme Court of a State or Territory, or the High Court of Australia, as a legal practitioner (however described); or

(3) a person who is in the following list:

- Agent of the Australian Postal Corporation who is in charge of an office supplying postal services to the public
- Australian Consular Officer or Australian Diplomatic Officer (within the meaning of the Consular Fees Act 1950)
- Bailiff
- Bank officer with 5 or more continuous years of service
- Building society officer with 5 or more years of continuous service
- Chief executive officer of a Commonwealth court
- Clerk of a court
- Commissioner for Affidavits
- Commissioner for declarations
- Credit union officer with 5 or more years of continuous service
- Employee of the Australian Trade Commission who is:
  - (a) in a country or place outside Australia; and
  - (b) authorised under paragraph 3(d) of the Consular Fees Act 1950; and
  - (c) exercising his or her function in that place
- Employee of the Commonwealth who is:
  - (a) in a country or place outside Australia; and
  - (b) authorised under paragraph 3(c) of the Consular Fees Act 1950; and
  - (c) exercising his or her function in that place
- Fellow of the National Tax Accountants' Association
- Finance company officer with 5 or more years of continuous service
- Holder of a statutory office not specified in another item in this list
- Judge of a court
- Justice of the Peace
- Magistrate
- Marriage celebrant registered under Subdivision C of Division 1 of Part IV of the Marriage Act 1961
- Master of a court
- Member of Chartered Secretaries Australia
- Member of Engineers Australia, other than at the grade of student
- Member of the Association of Taxation and Management Accountants
- Member of the Australian Institute of Mining and Metallurgy
- Member of the Australian Defence Force who is:
  - (a) an officer; or
  - (b) a non-commissioned officer within the meaning of the Defence Force Discipline Act 1984 with 5 or more years of continuous service; or
  - (c) a warrant officer within the meaning of that Act
- Member of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants or the National Institute of Accountants
- Member of:
  - (a) the Parliament of the Commonwealth; or
  - (b) the Parliament of a State; or
  - (c) a Territory legislature; or
  - (d) a local government authority of a State or Territory
- Minister of religion registered under Subdivision A of Division 1 of Part IV of the Marriage Act 1961
- Notary public
- Permanent employee of the Australian Postal Corporation with 5 or more years of continuous service who is employed in an office supplying postal services to the public
- Permanent employee of:
  - (a) the Commonwealth or a Commonwealth authority; or
  - (b) a State or Territory or a State or Territory authority; or
  - (c) a local government authority;
  - with 5 or more years of continuous service who is not specified in another item in this list
- Person before whom a statutory declaration may be made under the law of the State or Territory in which the declaration is made
- Police officer
- Register, or Deputy Register, of a court
- Senior Executive Service employee of:
  - (a) the Commonwealth or a Commonwealth authority; or
  - (b) a State or Territory or a State or Territory authority
- Sheriff
- Sheriff's officer
- Teacher employed on a full-time basis at a school or tertiary education institution
### NSW Health National Criminal Record Check (‘NCRC’) and Working with Children Check (‘WWCC’) requirements for staff members and volunteers

**Appendix 12**

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Sub category of work (includes paid and unpaid work)</th>
<th>Category of worker</th>
<th>New Workers</th>
<th>Declaration &amp; WWCC Probity Rág</th>
<th>Existing workers</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| **Child related work** | Work involving face to face or physical contact with under 18 year olds for:  
- health practitioners in wards of hospitals where children are treated or elsewhere if the work includes the provision of health services to children  
- non health practitioners providing health and care services in paediatric or adolescent services  
- administrative, clerical, maintenance or ancillary workers in paediatric or adolescent services only where the work involves contact with children for extended periods.  
For full list of other workers, refer to Section 2. | Staff members & volunteers (not VMOs) | Section 5 | Yes | Yes | Yes | No WWCC until phase in-Appendix 2. No new NCRC (subject to Section 9.2.) |
| | | VMOs | Section 5 | Yes | Yes | Yes | WWCC on renewal of contract. No new NCRC (subject to Section 9.2) |
| | | Overseas applicants | Section 6.7 Appendix 5 | Yes | Australian NCRC plus Overseas Police Certificates or Statutory Declaration | Yes | See relevant category of worker |

| **Aged Care Work** | All paid staff members aged 16 years or over and relevant volunteers in NSW Health services and aged care facilities that receive Australian Government funding.  
Refer to Section 6.1 | Staff members, including VMOs & volunteers | Section 6.2 | No | Yes | No | NCRC every three years or if criteria in Section 9.2 met. |
| | | Applicants who have resided overseas | Section 6.3 Appendix 11 | No | Australian NCRC plus Statutory Declaration | No | NCRC every three years or subject to Section 9.2. |
| | | Aged Care & Child Related | Sections 5.6 & 6 | Yes | Yes | Subject to Section 4.3 | No WWCC until phase in-Appendix 2. NCRC every three years or subject to Section 9.2. |

| **Non Child related work** | Non child related work is any work that is not child related or aged care work and includes, but is not limited to:  
- any non health practitioners, administrative, clerical, maintenance, corporate, ancillary or volunteer work in adult health services or in the Ministry of Health;  
- administrative, corporate, clerical, maintenance, or other ancillary or work in paediatric or adolescent services where the work does not involve contact with children for extended periods.  
Refer to Section 7. | Staff members or volunteers | Section 7 | No | Yes | No | No new NCRC (subject to Section 9.2) |
| | | Contractors – non clinical | Section 7.2 | No | Risk assessment – refer to Section 8 | No | No new NCRC subject to Section 9.2. |
| | | Students on clinical placements | Section 7.3 | No | Yes – provided by student | No | NCRC still required for placements |
| | | Students on work experience | Section 7.4 | No | No | No | No |
| | | Student Supervisors /Facilitators | Section 7.5 | Only if child related work | Yes – either by the Recruitment Agency (Refer to Section 8), Tertiary Institution or a Police Certificate | No | No WWCC until transition schedule Appendix 2. No new NCRC for existing workers. |

*This table should be read in conjunction with the relevant sections of the NSW Health Policy Employment Checks – Criminal Record Checks and Working With Children Checks available from [link](http://www.health.nsw.gov.au/police/Check/Default.aspx). Refer to Appendix 13 for Locum and Nursing and Midwifery agency requirements. Last reviewed September 2016*
Employment Checking – National Criminal Record Check (’NCRC’) & Working with Children Check (’WWCC’) requirements for locum and nursing and midwifery agency staff in NSW Health facilities

<table>
<thead>
<tr>
<th>Type of work</th>
<th>WWCC requirement</th>
<th>Information required by NSW Health</th>
<th>NCRC</th>
<th>Information required by NSW Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child related work</td>
<td>NSW Health WWCC clearance obtained pre March 2012</td>
<td>Copy of NSW Health WWCC clearance</td>
<td>No additional requirement as included in WWCC</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>NSW Health WWCC clearance obtained between March 2012 and June 2013</td>
<td>Copy of NSW Health WWCC clearance (which states no NCRC included)</td>
<td>A National Police Certificate (under three years old) plus a declaration of any convictions/pending charges if the Certificate was obtained before registration with agency or a NCRC by the agency</td>
<td>The NCRC/Police Certificate number: the date it was conducted and confirmation that the agency is satisfied that there is no information on the person’s record (or in any declaration provided by the person) to indicate any risks preventing them from undertaking work in NSW Health facilities.</td>
</tr>
<tr>
<td></td>
<td>WWCC clearance obtained from Children’s Guardian from 15 June 2013 validated by the agency</td>
<td>The WWCC number, the date of its clearance and its expiry date</td>
<td>NSW Health also validates the number with the Children’s Guardian</td>
<td></td>
</tr>
<tr>
<td>Overseas staff (including from New Zealand)</td>
<td>WWCC as above</td>
<td>As above</td>
<td>As above plus police clearances from their home country and any country that they have been citizens or permanent residents of since turning 16 years of age; or a Statutory Declaration Appendix 4</td>
<td>In addition, if the role is in aged care work, the date of expiry of the Police Certificate NCRC is required and confirmation that the person does not have any convictions precluding them from working in facilities that receive aged care funding from the Australian Government.</td>
</tr>
<tr>
<td>Aged care work</td>
<td>No requirement</td>
<td>No requirement</td>
<td>Either a Police Certificate (under three years old) plus a declaration of any convictions/pending charges if the Certificate was obtained before registration with the agency; or a NCRC by the agency undertaken within the last three years.</td>
<td>Confirmation that overseas clearances or Statutory Declarations have been completed as required.</td>
</tr>
<tr>
<td>All paid staff members aged 16 years or over in NSW Health services and aged care facilities that receive Australian Government funding</td>
<td>Staff who have resided overseas</td>
<td>No requirement</td>
<td>As above, plus a Statutory Declaration stating that they have never been convicted of murder, sexual assault or been convicted and sentenced to prison for any other assault</td>
<td></td>
</tr>
</tbody>
</table>

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

PURPOSE

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

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

KEY PRINCIPLES

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

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

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

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

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

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

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

USE OF THE GUIDELINE

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

80(18/02/10)
2. **PAEDIATRICS**

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


**SAFETY AND SECURITY OF CHILDREN AND ADOLESCENTS IN NSW ACUTE HEALTH FACILITIES** (PD2010_033)

**PD2010_033 rescinds PD2005_546.**

**PURPOSE**

To provide statewide policy direction to assist the development of local guidelines/protocols by Health Services to address the safety and security of children and adolescents whilst in NSW acute health facilities and/or during inter-facility transfers. This policy is intended to protect children and adolescents from harm, including self-harm and harm from others whilst in a NSW Public Health acute facility, with particular consideration to some specific patient groups.

**MANDATORY REQUIREMENTS**

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage the care of children and adolescents.

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.

This document should be read in conjunction with:


**IMPLEMENTATION**

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical and security areas.

Note: this policy has been informed by relevant documents developed by Area Health Services and NSW Child Health Networks.

90(03/06/10)
BACKGROUND

Children and adolescents who present to NSW Acute Healthcare facilities need to receive care and management that addresses their specific physiological, psychosocial and development needs. Reasonable steps must be taken to ensure children and adolescents are not placed at risk of harm from other patients, staff, and visitors. Such harm could be physical, psychological or sexual in nature. NSW Health has a comprehensive range of policies and guidelines that address the safe clinical and/or medical requirements for children and adolescent’s care. This policy aims to outline the necessary non-clinical aspects of safety and security of children that Area Health Services [AHSs] must address through local policies and procedures for children in acute health facilities and during inter-facility transfers.

PURPOSE

To provide statewide policy direction to assist the development of local policies/procedures by AHSs to address the safety and security of children and adolescents whilst in NSW acute health facilities and/or during inter-facility transfers. This policy is intended to protect children and adolescents from harm, including self-harm and harm from others whilst in a NSW Public Health acute facility, with particular consideration to some patient groups including those affected by Drugs and Alcohol and with a Mental Health issue.

IMPLEMENTATION

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical and security areas.

ASSOCIATED DOCUMENTS

Children And Young Persons (Care And Protection) Act 1998, NSW Government Legislation
NSW Health Frontline Procedures for the Protection of Children and Young People, NSW Health Department 2000.
Same Gender Accommodation, PD2015_018 NSW Ministry of Health
Guidelines for the Care of Children and Adolescents in Acute Care Settings, PD2010_034 NSW Department of Health.
Management of Admission of Children and Adolescents to Services Designated Level 1-3 Paediatric Medicine & Paediatric Surgery, PD2010_032 NSW Department of Health.
Inter-Facility Transfers of Children and Adolescents, PD2010_031 NSW Department of Health

SAFETY AND WELFARE ISSUES

Designated safe beds for children

All children must be accommodated in paediatric safe beds. A paediatric safe bed must satisfy a range of criteria, including the capacity to be easily observed and supervised at all times, the requirement for nursing staff to have appropriate paediatric competencies and the need for attention to a range of aspects of physical safety. Minimum requirements for a paediatric safe bed can be found in section 7. Paediatric wards in Level 3 and above role delineation facilities must also satisfy minimum requirements for a safe paediatric area. Minimum requirements can be found in section 7. If a paediatric safe bed is not available a child should not be cared for in the facility.

90(03/06/10)
Facilities may consider the use of ‘swing beds’ [beds that can alternate between different types of care] in service considerations and capital redevelopments, particularly to allow for the seasonal variability of paediatric admissions. Swing beds allow the temporary closure of beds during non-peak periods without a reduction in optimum staff/patient ratios. The bed/s are located within the ‘ward or unit’ and are satisfactorily shielded from the general ward area to ensure privacy from other patients. The beds are readily accessible to staff from either the general or paediatric ward area.

**Collocation of adults and children in NSW Health facilities**

To avoid potential risk, children admitted to NSW Health acute facilities are not to be accommodated with adult patients. It is acknowledged that not all facilities will have designated paediatric units, however, all children must be accommodated in designated paediatric safe beds as outlined above.

Children need to be protected from unwanted exposure, including casual overlooking and overhearing. To facilitate this:

- Children must have separate bathrooms, that is they do not have to share bathroom facilities with adults;
- Adult patients must not have to pass through areas caring for children to reach their own facilities; and
- Children must not be required to pass through an adult ward to access facilities.

Appropriate security measures should be installed where appropriate, for example secure doors with swipe card access.

It is acknowledged that the borderline between childhood and adulthood is not distinct. Where possible adolescent patient preferences should be sought, recorded and respected. In addition, discretion may need to be applied in consideration of co-location of a young child with and adolescent aged 14-15, which may constitute a risk in some cases. If staff have queries or concerns related to transitional issues they can contact the Transition Coordinators attached to the Greater Metropolitan Clinical Taskforce [or through their local Child Health Network].

**Gender specific accommodation**

Respecting the privacy and dignity of children and adolescents at all times during their health care experience involves the assumption that they do not have to sleep in the same room or ward bay as adult patients, or share bathroom or recreational facilities. Further, adult patients should not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents should not be asked to pass through an adult ward to access facilities. This is intended to protect children and adolescents from unwanted exposure, including casual overlooking or overhearing.

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

Where possible adolescent patient preference should be sought, recorded and where possible respected.

Bathroom facilities do not need to be designated as gender specific as long as they accommodate only one patient at a time, and can be locked by the patient (with an external override for emergency use only). Parents accompanying children must use adult visitor bathroom facilities, except where their child is in a single room with an ensuite bathroom.
Child protection issues

Every facility providing care to children is responsible for mandatory child related screening of employees and for ensuring all staff receive education and training regarding the protection of children and young people. Staff must be aware of their roles and responsibilities with regard to child protection legislation.

It is recognised that there will be occasions when staff find themselves alone with paediatric patients and effort should be made to avoid being alone in situations that involve intimate procedures. Staff are expected to make an assessment of the patient and the relative risks and should avoid being alone with any patient where the assessment predicts a likelihood of either a perceived assault or an allegation of assault. No staff should be alone with a child in situations that involve intimate examination.

A child presenting with injuries considered to be non-accidental should be discussed with a general paediatrician or child protection paediatrician either locally or at a higher-level facility and a notification needs to be made to the Department of Community Services [DoCS]. In addition a child with a suspected intracranial injury resulting from an inflicted head injury must be referred to a child protection paediatrician (consistent with PD2011_024, Infants and Children - Acute Management of Head Injury).

In circumstances where a child is admitted to a Paediatric Unit for non-medical reasons [for example because safe, appropriate emergency care or temporary alternatives such as foster care cannot be arranged] it is important that:

- A social work consultation is arranged as soon as is practical to review alternate care options and further assess risk of harm concerns;
- All risk of harm issues are reported to DoCS;
- Care Plans are developed in consultation with all relevant stakeholders, including DoCS; and
- The length of stay is as short as possible given that paediatric units are not able to provide the most appropriate environment for children for whom medical care is not required.

Staff should refer to local policies or protocols related to overnight stays of parents on wards.

SECURITY ISSUES

The security of children and adolescents in hospital is the responsibility of each AHS. AHSs are required to develop and implement guidelines to cover the security of all hospitalised children and particularly in relation to:

- The need for identification of custodial parents/legal guardians or designated proxy.
- The temporary removal and/or discharge of children from a ward or hospital; and
- The care of Children under Orders in a ward or hospital.

Temporary removal and/or discharge of children from a ward or hospital

AHSs must ensure guidelines are in place that address issues pertaining to:

- The need for identification of custodial parents/legal guardians of children.
- Authorisation for removal of children from the Ward and/or discharge and retention of consent forms as part of the clinical record.
- Minimum staffing levels.
- Notification of security incidents to Management and where appropriate to Child Protection Authorities.

90(03/06/10)
Care of Children under Orders in a ward or hospital

AHSs must ensure guidelines are in place that address issues pertaining to:

- Admission procedures for Children Under Orders, including an outline of the responsibilities of the facility’s designated responsible staff member for such admissions.
- Communication of relevant information to health service staff involved in treatment and security of the child.
- The need for any special procedures related to the degree of risk in individual cases.
- Security and surveillance requirements, for example identification of custodial parents/legal guardians, authorisation of people with legal right to remove the child, the degree of risk of other persons removing or harming the child and the retention in clinical records of documentation such as Family Court Orders, Children’s Court Orders or Bail conditions.
- Minimum staffing levels.
- Notification of security incidents to Management and to the responsible DoCS Officer.
2. DEFINITIONS

Child
Age up to 16th birthday

Parent/Primary carer
Parent/s or person living with the child and assuming legal responsibility for, and providing direct care. This includes birth parent, step-parent, foster parent, legal guardian, custodial parent or safe and appropriate primary care giver.

Adolescent
Person aged 16-18 years of age. Discretion should be applied in considering when an adolescent is suitable for accommodation in a paediatric unit.

Adult
Person over the age of 18.

Paediatric Safe bed
Not all facilities will have a paediatric unit, however, all children must be located in a paediatric safe bed. A paediatric safe bed is a bed that can be located anywhere within a facility [including ED, Imaging or a general ward] that meets the criteria for ensuring the safety of the child. A paediatric safe bed must meet the following minimum conditions:

- Must be able to be observed.
- The bed area must be immediately accessible to paediatric specific emergency equipment.
- Must have sufficient nurses allocated per shift to ensure adequate supervision and care relevant to admitted patient acuity.
- Nursing staff caring for the child must be familiar with local NSW Health paediatric guideline protocols and be competent in using recognition of the sick child skills and tools.
- Nurses caring for children during prolonged observation should have skills equivalent to that of the ‘competent paediatric nurse’ as defined in the document Competencies for the Specialist Paediatric and Child Health Nurses [available at: http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf]
- Must be physically safe for children with any potentially dangerous equipment, medications, chemicals or fluids out of reach or in locked cupboards.
- Has appropriate furniture that is child safe and meets appropriate Australian Standards for children, e.g. appropriate cots for children 2 years of age or less.
- Parents/visitors must not take hot drinks to children’s bedsides.
- The facility should comply with the requirements of the NSW Breastfeeding Policy for the care of paediatric patients and support continued breastfeeding among infants and children by providing facilities and breastfeeding advice to mothers as well as breast milk collection and breast milk storage facilities. Provision must be made for the safe preparation of infant formula if necessary.
- It should be possible for parents or primary carers to stay with their children during admission.
- Parent’s current contact details must be ascertained at presentation.
- Other patients in the hospital must not pose a significant psychological, physical or sexual risk to the child.
- Basic equipment should be present to allow age appropriate play, for example a TV and video/DVD/games console with age appropriate media, books or board games.

Paediatric Safe ward/area
In addition to the criteria outlined above for paediatric safe beds, a paediatric ward/area must also meet the following minimum conditions:

- Must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.
- Must be covered by a 24-hour medical roster with doctors credentialed in the care of paediatric patients.
- Must have a NUM, preferably with post basic clinical qualifications, or access to a CNC.
- Parents or primary carers should have access to bedside sleeping facilities and ideally a kitchenette with fridge and microwave to allow them to provide for there own and children’s nutritional needs when appropriate.
- Physical safety requirements must include regulated hot water temperature and secure electrical outlets
- Must have facilities available to allow age appropriate play including a designated and appropriately equipped play area.

ACKNOWLEDGEMENTS

The NSW Department of Health extends its appreciation to the members of the Paediatric Inpatient Advisory Working Group for their input, advice and assistance in production of this document.

90(03/06/10)
GUIDELINES FOR HOSPITALS AND MATERNITY STAFF IN THEIR RESPONSE TO PARENTS CONSIDERING THE ADOPTION OF THEIR CHILD (PD2005_545)


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

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

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

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

The NSW Department of Community Services is currently preparing new adoption legislation which will repeal, replace and consolidate the Adoption of Children Act 1965 and the Adoption Information Act 1990. In addition, it is anticipated that the new Children and Young Persons (Care and Protection) Act 1998 will be proclaimed in the second half of 2000, and will replace the Children (Care and Protection) Act 1987. This circular has been written to reflect the directions of this new legislation. Following the proclamation of these new Acts this circular will be reviewed and updated.
GUIDELINES FOR HOSPITALS AND MATERNITY STAFF IN THEIR RESPONSE TO PARENTS CONSIDERING THE ADOPTION OF THEIR CHILD

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

1. PRINCIPLES

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

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

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

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

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

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

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

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

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

2.1 NSW Health System

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

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

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

2.2 Department of Community Services and licensed private adoption agencies

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

Making adoption arrangements involves:

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

and, facilitating the appropriate provision of:

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

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

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

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

3.1 General

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

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

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

3.2 Adoption

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

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

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

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

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

3.2.5 Adoption orders are made through the NSW Supreme Court.

3.3 Adoption Consent

3.3.1 The Department of Community Services or the licensed private adoption agency is responsible for making the arrangements for a qualified person, under the legislation, to witness the adoption consent.
3.3.2 For the mother of a child, consent to adoption may legally be given at any time on or after the fifth day of the child’s birth. (Section 31 (2) ACA)

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

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

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

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

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

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

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

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

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

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

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

- to be satisfied of the identity of the person giving consent;
- to ensure the parent received, at least 72 hours before signing consent, written information about the effect of giving consent and the rights of the parties concerned in an adoption;
- to afford the parent ample opportunity to read the consent documents;
- to be satisfied the parent understands the effect of signing the consent; and
- if the parent is under the age of 16, before consent is given, a report of a registered psychologist, or other appropriate expert, is required of the capacity of the parent to understand the effect of signing an adoption consent.
2. PAEDIATRICS 2.211

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

   a) Consent is revoked by the parent notifying in writing the Deputy Registrar of the NSW Supreme Court of their intention to revoke their consent.
   b) A form for revocation is included in the parent’s consent documents.
   c) The Department of Community Services or the licensed private adoption agency will notify the parent of the impending expiry of the revocation period at least 7 days before its expiry. (ACA Regulation 26)
   d) On revocation, the parent resumes their guardianship of the child.
   e) If a parent has revoked their consent, but is unable to resume the care of their child, a temporary care agreement will need to be signed while the parent considers the child’s future.

3.4 Leaving Hospital

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

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

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

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

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

3.5 Contact

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

3.5.2 As a general rule, prior to adoption consent the child’s parent/s decide on the level of contact they wish with the child, whether the child is to room in with the mother, or be cared for in the nursery etc. However, if an assessment of risk for the child has led to the Department of Community Services assuming the care of the child under the Children (Care and Protection) Act (Section 62A), the level of contact should be determined by the Department of Community Services.
3.5.3 Once all required adoption consents have been given, because the guardianship of the child has
changed, the level of contact should be negotiated between the parent/s, Department of
Community Services/licensed private adoption agency and the hospital.

3.6 Registering the birth and naming the child

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

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

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

3.7 Records

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

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

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

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

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

4. HOSPITAL PRACTICE

4.1 Antenatal care

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

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

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

4.2 Birth

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

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

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

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

4.3 Consent to medical treatment of the child

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

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

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

4.4 Postnatal care

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

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

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

4.5 Mementos

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

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

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

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

4.6 Discharge

4.6.1 Temporary Foster Care

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

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

4.6.2 Medical Report Forms

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

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

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

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

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

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

5. ADOPTION SERVICES

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

The contact details for these agencies are:

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

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

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

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

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

6. **MEDICAL FORMS**

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

- Medical Report following Birth of a Child
- Medical Report on a Child
ADOPTION OF CHILDREN ACT 1965
REGULATION 29 (1)

Medical Report Following Birth of Child

NAME OF CHILD: ____________________________
Sex: ____________________________

Date of child’s birth: ____________________________
Time of birth: ____________________________

Place of child’s birth: ____________________________

Birth Weight: ____________________________
Length at birth: ____________________________

Head circumference at birth: ____________________________

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


APGAR RATING: (see overleaf)

<table>
<thead>
<tr>
<th>Score</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
<td>A - 9 to 10</td>
</tr>
<tr>
<td>Respiratory effort</td>
<td>B - 7 to 8</td>
</tr>
<tr>
<td>Muscle tone</td>
<td>C - 5 to 6 This baby is</td>
</tr>
<tr>
<td>Colour of infant</td>
<td>D - 3 to 4</td>
</tr>
<tr>
<td>Reflex irritability</td>
<td>E - 0 to 2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

MOTHER’S NAME: ____________________________

Age: ____________________________

Parity: ____________________________

Height: ____________________________

Ethnic group: ____________________________

Serological tests for syphilis done on the mother in puerperium: ____________________________
2. **PAEDIATRICS**

Result: 

Details of labour and delivery:

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

Name and address of doctor: 

Date of examination: 

Signature: 
APGAR RATING -- at one minute

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

<table>
<thead>
<tr>
<th>HEART RATE</th>
<th>0</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td></td>
<td>No beat seen, felt or heard</td>
<td>Rate of under 100</td>
<td>Rate 100-140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY EFFORT</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apnoeic at 60 secs. (including one or more gasps, then apnoea)</td>
<td>Irregular shallow ventilation</td>
<td>Breathed and cried lustily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCLE TONE</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completely flaccid</td>
<td>Poor tone</td>
<td>Good tone, spontaneously flexed arms and legs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLOUR</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cyanosed deeply</td>
<td>Slightly cyanosed</td>
<td>Entire child pink</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REFLEX IRRITABILITY</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No response</td>
<td>Feeble cry</td>
<td>Vigorous cry</td>
</tr>
</tbody>
</table>

A heart rate of 100-140 is considered good and given a score of two, a rate of under 100 receives a score of one, and if no heartbeat is seen, felt or heard, the score is zero.

An infant who is apnoeic at 60 seconds after birth receives a score of zero, while one who breathes and cries lustily receives a two rating. All other types of respiratory effort, such as irregular, shallow ventilation are scored one. An infant who has gasped once at thirty or forty-five seconds after birth and who then becomes apnoeic, receives a zero score, since he is apnoeic at the time decided upon for evaluation.

A completely flaccid infant receives a zero score and one with good tone and spontaneously flexed arms and legs, which resist extension, is rated two points.

A score to two is given only when the entire child is pink.

Response to external stimuli-lactile or thermal.
ADOPTION OF CHILDREN ACT 1965
REGULATION 29 (1)

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

Note for the Guidance of Examining Doctor:

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

NAME OF CHILD: ________________________________
Sex: ________________________________

Date of Birth: ________________________________
Estimated Gestation: ________________________________

Present Weight: ________________________________
Present Length: ________________________________
Present head circumference: ________________________________

BEHAVIOUR: Startle reflex:  ________________________________
General activity and vigour:  ________________________________
Capacity to take feedings:  ________________________________
Abnormal behaviour or posture:  ________________________________

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

LABORATORY DATA

( ) H.B. Film  ________________________________
( ) Serological Tests for Syphilis  ________________________________
2. PAEDIATRICS

Reducing substances

Urine

Albumin

Phenyl Pyruvic Acid (or Guthrie Blood Test)

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

Name and address of doctor:

Date of examination:

Signature:

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

At any age
Capacity of infant to focus eyes on object held about 30 cms. from face and moved from side to side.
Mouth and Palate.
Evidence of developing head control.  Size and tension of fontanelle.
Descent of testes.  Hernia.  Naevi.  Abdominal tumour or enlargement or organs.
Evidence of Mongolian defect.
Pubescence, Menstruation.
Central or peripheral Cyanosis.  Heart murmur or abnormal rhythm.  Femoral pulse.

Additional matters in respect of child over three months of age:
Capacity to respond to invitation to smile; to follow movement of examiner; to grasp and hold rattle etc.
Excessive rhythmical activity (e.g. head rolling, banging).  Developing power to maintain sitting posture, with support.

Let_135A
GL2017_002 rescinds GL2016_021, PD2005_240

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

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

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

USE OF THE GUIDELINE
The Chief Executives of NSW LHDs are responsible to:

- Select either a routine antenatal culture-based approach or a risk factor-based approach
- Ensure the development and implementation of local protocols or operating procedures in line with the approach chosen across all maternity facilities offering maternity services
- Ensure the chosen approach is consistently applied and neonatal morbidity and mortality associated with EOGBS sepsis is monitored and reviewed as per NSW Health PD2011_076 Deaths - Review and Reporting of Perinatal Deaths and NSW Health Policy Directive PD2009 003 Maternity - Clinical Risk Management Program.

The guideline can be downloaded here:-
Maternity - Maternal Group B Streptococcus (GBS) and minimisation of neonatal early-onset GBS sepsis
INFANTS AND CHILDREN: MANAGEMENT OF ACUTE GASTROENTERITIS, FOURTH EDITION (GL2014_024)

GL2014_024 rescinds PD2010_009.

PURPOSE

The Infants and Children: Management of Acute Gastroenteritis, fourth edition Clinical Practice Guideline has been revised to align with the Standards for Paediatric Intravenous Fluids. This Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- Local protocols are developed based on the Infants and Children: Management of Acute Gastroenteritis, fourth edition Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with gastroenteritis.
- 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.

2.  **PAEDIATRICS**

**NSW CRITICAL CARE TERTIARY REFERRAL NETWORKS (PAEDIATRICS)**  
(PD2010_030)

**PURPOSE**

This Policy Directive relates to critically ill children requiring inter-hospital transfer and should be read in conjunction with [PD2005_157 Emergency Paediatric Referrals - Policy](#).

Pursuing ‘best practice’ paediatric care across NSW requires services to embrace an integrated model of care that recognises the need for effectively linked and networked services across primary (role delineation 1-3), secondary (role delineation 3-4) and tertiary (role delineation 5-6) levels of care, as described in the NSW Health Guide to Role Delineation of Health Services - 2002.

This Policy Directive defines the linkages between referring hospitals and specialist Children’s Hospitals, taking into account unit capacity; specialist service requirements; and, established paediatric clinical referral relationships.
MANDATORY REQUIREMENTS

Each Health Service is required to make certain that there are escalation plans in place to ensure the appropriate accommodation of a sick or injured child. In the first instance, local escalation plans should promote a tiered network of services within the Health Service and relevant Child Health Network. In circumstances where, owing to periods of very high demand, there may be no appropriate beds available within the Network, there should be procedures for Clinicians to seek advice and/or support beyond their designated Network.

Local escalation plans should include direction for clinicians regarding review of all inpatients to determine whether a transfer of patients within a facility, or across facilities, would improve access to required beds. Where, after timely exploration of local resources, it is determined that Area or Network service provision is not possible, it is expected that clinicians will escalate their concerns to the regional specialist paediatric service or, if intensive care is required, involve NETS, and involve the Newborn and Paediatric Emergency Transport Service (NETS - NSW) where advice or transfer is required.

IMPLEMENTATION

In situations where it is declared that no paediatric intensive care beds are temporarily available and tertiary care is necessary, the Default Paediatric Intensive Care Policy may be invoked. This step is taken only after thorough assessment of statewide Paediatric Intensive Care capacity and where inter-state transfer is being contemplated. Inter-state transfer may be the option of choice. However, if inter-state transfer is not a viable option for the child, the Default Paediatric Intensive Care Policy may be invoked.

Every hospital is linked with a nominated tertiary hospital paediatric intensive care which is networked to a group of referring hospitals to provide critical care for their patients. When the default system is activated, the tertiary referral hospital designated as being responsible for the referring hospital in which the patient is located must accept the patient.

90(03/06/10)
2. PAEDIATRICS 2.226

INTRODUCTION

Owing to the level of complexity and specialist service requirements, paediatric intensive care and/or high dependency services are not available in all Area Health Services (AHS’s). These are offered through a network to ensure access for all residents of NSW. Statewide networks were developed in 2002 when the three Child Health Networks were established. Each Network comprises the Area Health Service Partners, and each Network is linked with a Paediatric Tertiary Referral Hospital.

Paediatric intensive care services operate in this statewide network, with Paediatric Intensive Care Units (PICUs) located at The Children’s Hospital Westmead, Sydney Children’s Hospital and John Hunter Children’s Hospital, supported by the Newborn and paediatric Emergency Transport Service (NETS - NSW). Day to day coordination is undertaken between the service providers with strategic direction provided through the Paediatric Intensive Care Advisory Committee.

This Policy Directive relates to critically ill children requiring inter-hospital transfer and should be read in conjunction with PD2005_157 Emergency Paediatric Referrals - Policy

Pursuing ‘best practice’ paediatric care across NSW requires services to embrace an integrated model of care that recognises the need for effectively linked and networked services across primary (role delineation 1-3), secondary (role delineation 3-4) and tertiary (role delineation 5-6) levels of care, as described in the NSW Health Guide to Role Delineation of Health Services - 2002.

This Policy Directive does not replace the requirement of all Area Health Services to establish and maintain tiered networks to ensure the provision of timely access to higher levels of paediatric support for children as the need arises.

This Policy Directive defines the linkages between referring hospitals and specialist Children’s Hospitals, taking into account unit capacity; specialist service requirements; and, established paediatric clinical referral relationships.

Operating in tandem with the NSW Critical Care Tertiary Referral Networks (Paediatrics) there are clinical super-specialty referral networks which are also defined within this policy directive and include the:

1. NSW Severe Burn Injury Service (Paediatric)
2. NSW Major Trauma Referrals (Paediatrics)
3. NSW Spinal Service Plan

Each AHS is required to make certain that there are escalation plans in place to ensure the appropriate accommodation of a sick or injured child. In the first instance, local escalation plans should promote a tiered network of services within the Area Health Service and relevant Child Health Network. In circumstances where, owing to periods of very high demand, there may be no appropriate beds available within the Network, there should be procedures for Clinicians to seek advice and/or support beyond their designated Network.

Local escalation plans should include direction for clinicians regarding review of all inpatients to determine whether a transfer of patients within a facility, or across facilities, would improve access to required beds. Where, after timely exploration of local resources, it is determined that Area or Network service provision is not possible, it is expected that clinicians will escalate their concerns to the regional specialist paediatric service or, if intensive care is required, involve NETS, and involve the Newborn and paediatric Emergency Transport Service (NETS - NSW) where advice or transfer is required.

90(03/06/10)
NETS provides statewide coordination of neonatal and paediatric retrieval. Children living near NSW borders may be appropriately referred to the adjoining state. This practice is supported by NSW Health. Patient transport will be arranged by the referring facility with relevant Ambulance services or through NETS.

To Contact NETS
Call: 1300 36 2500
Press 1 for emergency retrieval
Press 4 for elective referral

The NSW Critical Care Tertiary Referral Networks (Paediatric) are supported by NETS; the Paediatric Intensive Care Advisory Group (PICAG); the Perinatal and Paediatric Resources System; evidence-based practice and policy and guideline development, along with statewide education resources.

It is expected that AHSs ensure the provision of clinical support, cooperation and appropriate education between units using current clinical and education staff. Appendix 1 of this Policy Directive details the Guidelines for the Stabilisation of Patients Prior to Medical Retrieval.

**PAEDIATRIC INTENSIVE CARE TERTIARY REFERRAL NETWORKS & THE CHILD HEALTH NETWORKS**

Patients requiring Paediatric Intensive Care are referred to these units based on clinical requirements and bed availability. Children with severe burn injury are referred to The Children’s Hospital at Westmead (CHW). Cardiac surgery is available at both CHW and Sydney Children’s Hospital (SCH). Children with major trauma may be referred to one of the three Tertiary paediatric Hospitals (that is, CHW, SCH or John Hunter Children’s Hospital (JHCH). Children with spinal injuries may be referred to relevant statewide services at either CHW or SCH. The information below describes the Child Health Network:

**The Northern Child Health Network**

**Principal Referral Hospital: John Hunter Children’s Hospital**

- Hunter New England Area Health Service
- North Coast Area Health Service
- North of Grafton will usually refer to Brisbane owing to proximity
- Private hospitals and day-surgery facilities in the above geographical regions
## PAEDIATRICS

### The Greater Eastern and Southern Child Health Network

**Principal Referral Hospital:** Sydney Children’s Hospital

- Greater Southern Area Health Service
- Northern Sydney Central Coast (Manly, Mona Vale, Royal North Shore Hospitals)
- **South Eastern Sydney Illawarra Area Health Service**
- Sydney South West Area Health Service (Balmain, Bankstown, Bowral, Camden, Campbelltown, Canterbury, Royal Prince Alfred)
- Australian Capital Territory (ACT)
- Private hospitals and day-surgery facilities in the above geographical regions
- Referrals from Greater Southern Area Health Service may go to Victoria owing to proximity

### The Western Child Health Network

**Principal Referral Hospital:** Children’s Hospital at Westmead

- Greater West Area Health Service
- Sydney South West Area Health Service (Liverpool, Fairfield, Concord)
- Sydney West Area Health Service
- Northern Sydney Central Coast Area Health Service (Gosford, Hornsby, Ryde, Wyong)
- The Southern and Western sectors of Greater Western may refer to Adelaide owing to proximity
- Border regions of this Network may refer to Adelaide owing to proximity
- Private hospitals and day-surgery facilities in the above geographical regions

### CLINICAL APPROPRIATENESS

In specific cases, the referring consultant, medical retrieval consultant and the receiving consultant may decide to refer a patient to a hospital outside of the usual network arrangements, as this may be considered more clinically appropriate for the patient’s definitive care.

### NEWBORN AND PAEDIATRIC EMERGENCY TRANSPORT SERVICE (NETS - NSW)

NETS operates 24-hours a day, 7 days a week, providing an advice and coordination service. They are the major provider of neonatal and paediatric retrievals. NETS services include:

- Clinical advice from a critical care medical retrieval consultant;
- A “one phone call” referral which uses conference call facilities;
- Mobilisation of an appropriate retrieval team or ambulance escort;
- Support to hospitals having difficulties referring high risk obstetric patients;
- Support for Ambulance Service dealing with pre-hospital emergencies;
- Liaison with interstate high risk obstetric, neonatal and paediatric emergency transport services.
- Assistance with Intensive Care support when usual neonatal and paediatric hospital intensive care beds are unavailable;
- Assistance with any emergency where routine patterns of referral are unavailable or delayed.
- Statewide Neonatal and Paediatric (SNaP) Bed - this is a mobile solution whereby NETS mobilise a NETS nurse with equipment to a paediatric or neonatal unit for a short period of time (up to 48 hours) when there is no further capacity within the State (see page 8 for a broader definition of the SNaP Bed).

90(03/06/10)
2. **PAEDIATRICS**

**OPERATIONAL PRINCIPLES**

The core responsibilities of NETS are described in Table 1. The key principles of NETS operation are:

2. Statewide coordination of neonatal and paediatric retrieval services, using teams based in Sydney (paediatric and newborn), Canberra (newborn) and Newcastle (newborn) and in collaboration with specialist Paediatric Retrieval Services located at:
   - Newcastle
   - Victoria (Melbourne - NETS for newborns and PETS for children)
   - Queensland (Brisbane - hospital-based services coordinated by QNETS);
   - South Australia (Adelaide Women’s and Children and Flinders Medical Centre); and
   - Regional adult retrieval services in Canberra, Orange, Tamworth, Lismore, Sydney and Wollongong.

3. Single point of access for referring hospitals (public and private) anywhere in NSW. All paediatric critical care transfer requests, or consultation where a critical care transfer is contemplated, must be made through NETS.

3. Use of conference call facilities to:
   - bring the referring clinician in direct contact with the medical retrieval consultant, preferred referral consultant, Pregnancy Advice Line Consultant, and other clinicians as appropriate. The patient’s IMMEDIATE treatment requirements are the highest priority.
   - consult with various teams, coordination centres, ambulance services and vehicle operators.
   - facilitate full use of local resources in referring hospitals; to ensure that patients are not unnecessarily moved.  

4. NETS will *facilitate* the bed-finding process for critically ill or high risk patients to more complex or definitive care. NETS does not locate beds for patients being electively transferred between hospitals.

7. Where there is variance in view regarding the clinical appropriateness of a medical retrieval, the final decision will be made by the NETS medical retrieval consultant following a conference call with the referring clinician and receiving medical consultant. For other transfers the responsibility for determining the appropriateness and safety of the transport plan lies with the referring clinician and accepting clinician in conjunction with the ambulance service.

8. If a medical retrieval is planned, NETS will determine the most appropriate transport vehicle to effect the retrieval

90(03/06/10)
TABLE 1 – Summary of NETS core roles

NETS 1300 36 2500
www.nets.health.nsw.gov.au

- Clinical Co-ordination
- Teleconferencing
- Connection with tertiary specialist(s) for advice
- Arrange Medical Retrieval
- Advice on appropriate non-NETS escort
- Problem solving (including critical care beds)
- Advice for Clinicians uncertain about the process
- Ensuring retrieval is not an alternative to effective local care
- Reporting systems “failures”

WHICH CHILDREN MAY NEED MEDICAL RETRIEVAL TO A PAEDIATRIC ICU?

It is impossible to provide an exhaustive list of potential referrals to a tertiary facility; Table 2 offers cues that may facilitate clinical decision-making. Any of the conditions in Table 2 are likely to require consultation regarding patient management and or transfer:

TABLE 2 - Conditions Requiring Consultation Regarding Management and/or Transfer

| Airway | • All intubated patients  
• Actual or threatened airway obstruction |
|---|---|
| Breathing | • Respiratory distress, persistent beyond 4 hours  
• Apnoea  
• Cyanosis, despite oxygen therapy  
• Oxygen requirement > 40% |
| Circulation | • Shock  
• Significant blood loss  
• Heart failure or arrhythmia |
| Disability | • Intractable Seizures  
• Surgical conditions requiring specialty surgery  
• Severe Burns - greater than 10% body surface burnt; genital region burnt; palms of hands, soles of feet or joints involved in burns; inhalation likely  
• Major Trauma  
• Spinal Injury |

Early Notification will enable Early Assistance.
In a time-critical emergency, notification can occur prior to full patient assessment and investigation

NETS: 1300 36 2500
www.nets.health.nsw.gov.au

90(03/06/10)
CLINICAL SUPER-SPECIALTY REFERRAL NETWORKS

Several statewide clinical super-speciality networks operate in tandem with the NSW Tertiary Referral Networks (Paediatrics).

These networks are largely determined by the location of the clinical super-specialty services, and in some cases, the imperative to achieve early clinical intervention such as for those patients with major trauma.

The following clinical super-specialty referral networks that may be required for children:

1. **NSW Severe Burn Injury Service Referral Network (Paediatric)**
   
The Children’s Hospital at Westmead is the designated Centre for severe burns for children (up to the 16th birthday). Transfer of patients with severe burns are facilitated by NETS.

2. **NSW Major Trauma Services (Paediatric)**
   
   Each of the Children’s Hospital’s is a designated paediatric major trauma service. Paediatric trauma referral networks are aligned in accordance with the Child Health Networks.

   The majority of paediatric trauma cases presenting to hospital emergency departments will have minor to moderate injury and can be managed appropriately at the nearest hospital.

   Children with major trauma should be managed at a paediatric major trauma service. Children aged up to their 16th birthday fitting criteria as per the pre-hospital ‘MIST’ Protocol T1 (with due consideration given to paediatric physiological changes) should be considered for direct transfer to a paediatric major trauma service.

3. **Spinal Services**

   NSW State Spinal Cord Injury Service (Paediatric) Both the Children’s Hospital at Westmead and the Sydney Children’s Hospital are designated referral centres for spinal cord injury up to the 16th birthday. Referral networks are aligned in accordance with the Child Health Networks for major trauma.

   Paediatric patients who have sustained a spinal cord injury with neurological deficit are to be transferred to a designated referral centre at the earliest opportunity once medically stable. Transfer of paediatric patients with spinal cord injury with neurological deficit is facilitated by NETS.

90(03/06/10)
NSW STATEWIDE ICU TRANSFER PATHWAY

2. Referring Hospital
   Critically ill or injured child
   Assessment by senior medical clinician (paediatric/ED/surgery/ICU etc.)

2.1 Specialist Paediatric Service required?
   Yes → Medical escort required?
   No → Call Regional Centre (Appendix 2)

2.2 Paediatric ICU bed potentially required?
   Yes → Contact NETS 1300 36 2500
   No → Conference call with NETS Consultant and preferred destination paediatric ICU and/or paediatric ED

3. Contact NETS
   NETS arranges transport or retrieval as required.

4. Regional Centre "accepts" patient
   Referring Hospital arranges transport

5. Advice given and decisions made about management and a plan for transfer

6. If there is a deterioration in the patient's condition, call NETS.

In case of stress with ICU capacity, NETS will assist the designated referral hospital (see Appendix 2) with a conference call with other potential receiving hospitals. The designated referral hospital has the primary responsibility for accepting patients from their region but can be connected to other units to discuss the patient's needs. If after exploring all options, there is no capacity in the system, the SNAIP bed may be used to facilitate admission to a Paediatric ICU which is designated to accommodate SNAIP.
In situations where it is declared that no paediatric intensive care beds are temporarily available and tertiary care is necessary, the Default Paediatric Intensive Care Policy may be invoked. This step is taken only after thorough assessment of statewide Paediatric Intensive Care capacity and where inter-state transfer is being contemplated. Inter-state transfer may be the option of choice. However, if inter-state transfer is not a viable option for the child, the Default Paediatric Intensive Care Policy may be invoked.

Every hospital is linked with a nominated tertiary hospital paediatric intensive care which is networked to a group of referring hospitals to provide critical care for their patients. This Child Health Network Matrix has been developed following consultation with Area Health Services; the NETS; and other key stakeholders and is attached to this policy (attachment 3).

When the default system is activated, the tertiary referral hospital designated as being responsible for the referring hospital in which the patient is located must accept the patient.

Where the condition of a child is critical and requires immediate emergency treatment, the default referral hospital has a responsibility to accept a call from the referring hospital, offer clinical advice and, ultimately, accept the patient. Should the default referral hospital have difficulty in accepting the patient, this should not prevent initiation of transportation; including the timely dispatch of a retrieval team or other appropriate ambulance team. It is the responsibility of the default referral hospital to seek an alternative destination; should this be necessary. If no other destination is possible, the default referral hospital must accept the patient.

No patient should be refused admission without discussion involving the senior specialist at the default referral hospital. NETS can provide clinical conference facilities to assist this process but clinical leadership of the process rests with the tertiary hospital involved. Discussions with NETS regarding the need for urgent transfer of a child to the default facility may also lead to initiation of the SNAP bed (Statewide Neonatal and Paediatric bed) - a mobile intensive care bed initiated and staffed by NETS as a short-term solution to a temporary lack of paediatric/neonatal intensive care resources.
APPENDIX 1 Guidelines for Facilities for the Stabilisation of Patients prior to Medical Retrieval

These Guidelines are issued to assist Hospitals using a medical retrieval team to transfer a patient requiring intensive care. It sets out the resources that are required for the safe and efficient stabilisation of patients of all ages. These resources are required at those hospitals at or above role delineation Level 2 for Maternity Services (newborn infants) and at or above Level 1 for all other age-groups.

These Guidelines are designed to assist referring hospitals offer optimal care using the combined resources of the referring hospital and the retrieval team to manage, stabilise and prepare patients for transport.

The Guidelines were developed by NETS in collaboration with the Medical Retrieval Unit, regional advisory/retrieval services and referring hospitals.

Background

Guidelines were first issued in 1997 for newborn patients to promote an effective mechanism for the stabilisation prior to transfer, from referring hospitals. It was recognised that the scope of these Guidelines needed to be expanded to offer advice encompassing all age groups and include new aspects of clinical networking such as telemedicine. Accordingly, this document covers all age groups.

Communication

Acute patient transfer is regularly complicated by communication errors. The facilities for communication by telephone and other media should be readily accessible and permit timely, accurate and constructive communication. A telephone which the referring clinician can directly call a tertiary centre or retrieval service is essential. It should be usable from the bedside, from the charts or images but flexibly move to a quieter area if required.

Space

It is acknowledged that not all hospitals will be able to immediately provide the physical space specified in this Guideline. Hospitals are advised that, if there is currently no suitable space within the ED, ICU, children’s ward or neonatal nursery, alternative resuscitation areas can be provided in an appropriate area. However, when a hospital is being refurbished or rebuilt, the requirements listed in this circular should be followed and reference made to the functional space requirements contained in the current “Health Facility Guideline”.

Where specific essential equipment items listed below are not available at present, provision should be made to include these items in forward planning cycles as soon as possible.

Ventilatory Support

Facilities that have medical officers formally trained in managing ventilated patients may have ventilators capable of supporting Adults, Children, Infants and Neonates - depending on caseload of patients requiring ventilatory support. Where such ventilators are available, they must be complemented by the capacity to measure airway pressure, expiratory tidal or minute ventilation, and end tidal CO₂ (or skin CO₂ monitoring).
Medical Imaging facilities

If medical imaging facilities are available in the referring facility, an X-Ray viewing box or Picture Archiving and Communication System (PACS) system must be in a location that allows use without losing visual contact with the patient. In addition, diagnostic images of the patient must be available to accompany the patient to their destination hospital without delay.

Pathology Services

If Pathology Services are available in the referring facility, a viewing system to check pathology results must be in a location that allows access without losing visual contact with the patient.

Access by the mother to her newborn

After resuscitation of a newborn and prior to transport, it should be possible for the NETS Infant Transport Module to be wheeled to the mother’s bedside (or vice versa). Sufficient room is required for the mother to be able to see and touch her baby in the NETS transport system from her bed, where necessary.
## APPENDIX 2 Requirements for Stabilisation of Patients Prior to Medical Retrieval

### Essential Facilities

- An area or room that can be dedicated to the patient for retrieval and the workings of the Team (minimum size $21m^2$ for child/adult; $15m^2$ for a newborn). This area may be created from existing areas for those occasions when a medical retrieval team is present, for instance, by temporarily combining two patient care areas into one.
- Easy, uncluttered access for a stretcher or hospital trolleys used by the retrieval team (size 900mm x 2000mm) from hospital to patient care area without obstruction to other functions.
- Procedure light (angle-poise type)
- Resuscitation trolley with appropriate drugs and equipment for those age-groups being treated
  - Infant resuscitation trolley (open care system for body weight < 5kg):
    - Integrated overhead lighting
    - Variable radiant heat source
    - Swing-away hinge for overhead modules for mobile x-ray access
    - Space available for retrieval team module to be positioned adjacent and at right angles
    - Polyethylene wrap for very preterm infants (< 28 weeks gestation)
  - Panel fixtures:
    - Oxygen x 2 (reticulated preferred, cylinder supply will suffice in some locations)
    - Medical Air x 2 (reticulated preferred, cylinder supply will suffice in some locations)
    - Suction x 2 (one regulated for low/controlled suction, one high flow (reticulated supply and second high flow preferred)
    - Body-protected GPOs x 10 (2 for retrieval team use, 8 for referring hospital equipment)
- Height adjustable trolley to facilitate the loading and unloading of the patient/transport stretcher/medical equipment
- Counter, bench top or table (min. 550 x 1200mm) for additional treatment equipment
- Wash sink, soap dispenser, paper towel and alcohol/chlorhexidine hand rub dispenser
- Waste receptacle of large capacity with large aperture orifice; positioned close to resuscitation area
- Sharps disposal container, preferably mobile
- Procedure trolley (900mm x 450mm minimum)
- Ice packs for therapeutic cooling
- Telephone:
  - Capable of direct call to relevant retrieval services (without using an operator)
  - Handset usable at the bedside of the patient (may use cordless technology)
  - Programmed for 1-key dialling to Regional Advisory/Retrieval Service, NETS, MRU
  - Capable of direct in-dial with that number displayed on handset prominent
- Facsimile machine:
  - In a location that allows use without losing visual contact with the patient
  - Programmed for 1-key dialling to Regional Advisory/Retrieval Service, NETS, MRU
  - Capable of direct in-dial with that number displayed on device prominently
- Photocopier with contrast and brightness adjustment
- Digital camera for clinical photography (including simple connection to computer for file transfer)

### Desirable Facilities

- Lighting to meet standards of operating theatre, with adjustable intensity
- Infant resuscitation trolley (open care system for body weight < 5kg):
  - In built frame for X-Ray plate positioning without disturbing the patient for contact-less imaging
- Computer:
  - In a location that allows use without losing visual contact with the patient
  - That allows access to clinical email services
  - That allows access to approved clinical web-based services (eg. CIAP, NETS, etc.)
  - That allows electronic transmission of digital images
- Capacity to export clinical data from local information systems to retrieval coordination centres and/or receiving hospitals
- Capability of continuously monitoring a patient’s ECG, pulse oximetry and automated non-invasive blood pressure measurements
- Interview room readily accessible to resuscitation area, for family conferences
CHILDREN AND INFANTS - RECOGNITION OF A SICK BABY OR CHILD IN THE EMERGENCY DEPARTMENT (PD2011_038)


PURPOSE

The Recognition of a Sick Baby or Child in the Emergency Department clinical practice guideline (attached) 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 Department of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess children.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the recognition of the sick baby or child. 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.

IMPLEMENTATION

Chief Executives must ensure:

- Local protocols are developed based on the Recognition of a Sick Baby or Child in the Emergency Department clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage sick babies or children.
- 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 the revised protocols.


128(16/06/11)
INFANTS AND CHILDREN - ACUTE MANAGEMENT OF BACTERIAL MENINGITIS: CLINICAL PRACTICE GUIDELINE (GL2014_013)


PURPOSE

The Infants and Children: Acute Management of Bacterial Meningitis: Clinical Practice Guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state.

The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- Local protocols are developed based on the Infants and Children: Acute Management of Bacterial Meningitis Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with bacterial meningitis.
- 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 the revised protocols.

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF ABDOMINAL PAIN
(PD2013_053)

PURPOSE

The *Infants and children: acute management of abdominal pain* clinical practice guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state.

The clinical practice guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires the Chief Executives of all Local Health Districts to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities required to assess or manage children with abdominal pain.

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

IMPLEMENTATION

Chief Executives must ensure:
- Local protocols are developed based on the *Infants and children: acute management of abdominal pain* clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with abdominal pain.
- 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 the revised protocols.

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

PURPOSE

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

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

KEY PRINCIPLES

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

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

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

USE OF THE GUIDELINE

Chief Executives should ensure:

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

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

2. PAEDIATRICS

INFANTS AND CHILDREN, OTITIS MEDIA: ACUTE MANAGEMENT OF SORE EAR, SECOND EDITION (GL2014_023)


PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:
- Local protocols are developed based on the Infants and Children: Otitis Media, Acute Management of Sore Ear, second edition Clinical Practice Guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with otitis media.
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

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

INFANTS AND CHILDREN - ACUTE MANAGEMENT OF ASTHMA (PD2012_056)

PD2012_056 rescinds PD2012_030.

PURPOSE

The Infants and Children: Acute Management of Asthma Clinical Practice Guideline has been developed to provide direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state.

The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of the statewide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage children with asthma.

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

IMPLEMENTATION

Chief Executives must ensure:

▪ Local protocols are developed based on the Infants and Children: Acute Management of Asthma Clinical Practice Guideline.

▪ Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with asthma.

▪ 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 the revised protocols.

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF BRONCHIOLITIS (GL2018_001)

GL2018_001 issued 10/01/2018 rescinds PD2012_004.

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

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

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

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

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

The Guideline can be downloaded from Infants and Children - Acute Management of Bronchiolitis
CHILDREN AND INFANTS WITH FEVER - ACUTE MANAGEMENT (PD2010_063)


PURPOSE

The infants and children: acute management of fever clinical practice guideline (attached) 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 Department of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage children with fever.

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

IMPLEMENTATION

Chief Executives must ensure:

- Local protocols are developed based on the infants and children: acute management of fever clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with fever.
- 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 the revised protocols.

INFANTS AND CHILDREN: ACUTE MANAGEMENT OF SEIZURES (GL2016_005)

GL2016_005 rescinds PD2009_065

PURPOSE
The *Infants and Children: Acute Management of Seizures, third edition* Clinical Practice Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families.

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

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

USE OF THE GUIDELINE
Chief Executives must ensure:

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

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

The document, *Infants and Children : Acute Management of Seizures*, can be downloaded at [Infants and Children: Acute Management of Seizures](#).
INTER-FACILITY TRANSFERS OF CHILDREN AND ADOLESCENTS (PD2010_031)

PURPOSE

The purpose of this policy is to provide a framework to facilitate the safe and timely transfer of children and adolescents whose medical condition requires care at a different level from that of the presenting hospital.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or admit children.

IMPLEMENTATION

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

Note: this policy has been informed by relevant documents developed by AHSs.

Background

The NSW Health system covers a large geographical area and includes multiple and diverse acute health facilities across metropolitan, regional, rural and remote regions. It is not possible for all services to be provided by all facilities and at times children and adolescents need to be transferred to a different facility for appropriate and necessary treatment.

NSW Health has established three Child Health Networks; each includes one of the State’s tertiary children’s hospitals as well as many other hospitals and Multi-Purpose Services providing acute care to children and adolescents. The requirement to transfer children and adolescents between hospitals is a necessary and routine occurrence to ensure that care is provided in the most appropriate facility and in a timely manner. The plan for transport used when transferring children and adolescents should be integral to any treatment discussion.

The NSW Health Guide to Role Delineation of Health Services (2002) outlines six possible levels of paediatric medical and surgical service delivery, which broadly describes the paediatric care that can be delivered at a facility.

Purpose

The purpose of this policy is to provide a framework to facilitate the safe and timely transfer of children and adolescents whose medical condition requires care at a different level from that of the presenting hospital.

Implementation

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

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Associated documents

- Guidelines for the Care of Children in Acute Care Settings, PD2010_034 NSW Department of Health revised 2010.
- NSW Clinical Practice Guidelines for Paediatric Care, various http://www.nchn.org.au/clinical_guidelines.htm
- Guidelines for Networking of Paediatric Services in NSW, NSW Department 2002.

Determining the Need for Transfer

Inter-hospital transfer of a child is indicated in the following circumstances:

- The child requires a level or type of treatment beyond the capacity of the presenting hospital. AHSs are responsible for providing guidance for staff as to which treatments are available and/or not available in their facilities.; [Refer to the criteria for calling NETS at Appendix 1]
- To allow the child to be treated closer to home following treatment in a higher-delineated service within or outside the AHS; or
- The patient presents in a hospital without inpatient service for children and needs to transfer for inpatient care.
- The child requires ongoing inpatient management and there is no appropriate paediatric ward or paediatric safe beds available at the presenting facility.

In the majority of cases the necessary paediatric acute emergency and inpatient services will be available within the AHS and transfer of children and adolescents to a higher-delineated care facility can be accommodated within the AHS. Transfer of a child to a Children’s Hospital is indicated when the condition requires a tertiary level of care or where designated by NSW Health policies, eg need for intensive care, severe burns, major trauma.

Determining the need for transfer is a joint responsibility between the transferring and receiving hospitals.

Transferring hospital responsibilities

It is the responsibility of the most senior attending Medical Officer or delegate to assess and determine the need for transfer of a child to a higher level of care, in consultation with the local or network Paediatrician on-call and a Paediatrician and/or Emergency Department physician at the receiving hospital. Staff should refer to any local AHS protocols regarding escalation and/or requirements for Medical Officers to attend the patient for assessment. The Medical Officer should:
• Identify the need for escalation of clinical care for children and adolescents who are at risk of their condition deteriorating and/or have complex health conditions.
• Identify the level of care required and the most appropriate destination hospital.
• Consult with relevant clinicians at the destination hospital and make arrangements for the appropriate timing of transfer [ensuring that consultation occurs with an appropriately senior clinician].
• Involve NETS as part of the clinical consultation in the case of the seriously ill child or infant and identify the most appropriate transport plan, including level of escort (ambulance, regional retrieval, NETS retrieval), degree of urgency and appropriate vehicle type.
• Agree on a desirable time-frame for the patient to leave the referring hospital (departure goal) and a plan for any changes if the patient’s condition changes pre-transfer.
• Book the transfer with the ambulance service or patient transport service; indicating a desired time-frame for the ambulance to commence the transfer and/or to be at the destination hospital.
• Document the agreed treatment plan required whilst awaiting transfer, and communicate this to nursing staff involved in the child’s care.
• Inform the parent/carer as appropriate with consent of the child, where appropriate.
• Ensure that the destination hospital has full details of the child’s medical condition and requirements.
• Ensure that the child’s condition has been assessed and stabilised as much as possible prior to transfer [in consultation with a clinician at the receiving hospital].
• Ensure the child’s safety at all times with regard to transfer decisions.
• At the time of transfer, document any treatment not commenced or incomplete with respect to the agreed treatment plan [in consultation with a clinician at the receiving hospital].

Nursing staff are responsible for:
• Obtaining a full copy of the patient record to accompany the child during transfer, including relevant x-rays scans and pathology. [Note if it is determined that the receiving hospital has eMR then a summary of the full record can be used.]
• Informing the destination hospital (nursing staff) that the patient has left their hospital, with an estimate of arrival time at the receiving hospital.
• Providing a documented discharge/transfer summary to the destination nursing staff.
• If the need for a nurse escort is identified, select appropriately skilled and trained nurses as required to accompany the patient.
• Ensuring a full explanation is given to parent/carer and patient (age appropriate).

Where there is no on-site medical officer, for example in small rural facilities, the most senior nursing staff member should act as a proxy for the medical officer in determining and arranging transfer in consultation with regional/on-call Paediatrician and an appropriate Medical Officer or Paediatric Specialist at a higher level facility.

The physical and emotional wellbeing of the child is paramount at all times and staff should never feel obliged to keep paediatric patients because of pressure from carers or others when the child’s clinical needs or safe conditions cannot be met.

NSW Health has published Clinical Practice Guidelines for the most common paediatric presentations to the Emergency Department. Decisions about transfer should be consistent with the care described for these specific health conditions; or according to clinical need where no Guideline exists.
Where relevant, contact should be made with the AHS Patient Flow Unit to assist in communication and coordination of transfers. If the patient needs a medical escort or medical retrieval, NETS should be called instead.

**Receiving hospital responsibilities**

It is important to ensure that consultations about potential transfer of paediatric patients occurs with appropriate senior clinicians at the receiving hospital. Locally developed protocols must indicate the need for timely involvement of appropriate senior medical staff in decision-making about the need for transfer and the mode of transport required. Protocols should reflect who is responsible for handling paediatric transfer/retrieval calls, and how communication will occur between departments at the referring and receiving hospitals.

The Medical Officer at the receiving hospital should:

- Undertake an assessment of the patient and their condition via phone or telemedicine and document the findings, with consideration of the use of a standardized assessment tool. [see Appendix 3 for an example].
- Provide advice and assistance to the referring Medical Officer and relevant clinicians to ensure that the inter-hospital transfer is appropriate.
- Provide ongoing support to the referring hospital until the transfer occurs.
- Ensure there is an onsite plan of clinical management until the transfer occurs.
- Provide feedback about the retrieval/transfer to the referring facility and a discharge summary to the referring doctor, the child’s General Practitioner and allied health and community health staff where relevant.
- Ensure the child’s safety at all times with regard to transfer decisions.

Receiving hospitals should provide feedback and patient outcome information on request to the transporting service (NETS, ASNSW, RFDS).

**Urgent/emergency transfers**

Urgent/emergency transfer applies to children and adolescents:

- Whose condition is critical, serious or unstable;
- Who are at risk of their clinical condition deteriorating during transport and/or whilst awaiting transfer; or
- Who require intensive care.

NETS needs to be consulted in all children with a triage category of 1 and 2 and all children with a triage category of 3 who are not improving.

Whilst awaiting transfer, the child’s condition should be continually monitored and re-evaluated.

Clinicians at the transferring hospital need to institute necessary treatment or continue treatment of the child or infant prior to transfer. This includes:

- 1:1 care and close monitoring of the child’s condition:
  - Full cardio-respiratory monitoring (pulse, respirations, blood pressure)
  - Temperature
  - Neurological Observations (if clinically relevant)
  - Neuro-vascular (if clinically relevant)
  - Oxygen saturation
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- Blood loss (if clinically relevant)
- State of consciousness (including Paediatric Modified Glasgow Coma scale or AVPU [in young children] as required)
- Pain assessment
- Blood glucose levels for infants and unwell children
- Hydration
- Urinary output [weigh nappies to accurately assess UO where relevant].

- Continuation or initiation of treatment as required such as:
  - Oxygen therapy administration
  - Intravenous access, intraosseous access and fluid administration
  - Administration of prescribed medication
  - Pain management
  - Tubes & drains including nasogastric tubes; catheters etc
  - Temperature maintenance/regulation

- Management of wounds/injuries
  - Wound dressing
  - Burn injury – continuation of wound cooling, covering in clingwrap according to the NSW Health Paediatric Burn Management Guidelines and advice from a paediatric Burns Unit

- Documentation of care.

Retrieval

Medical retrieval is the process of transferring critically ill patients using a team that travels to the patient location from a central location or the destination hospital. If medical retrieval is indicated transport and staffing should be coordinated by NETS using:

- The NSW neonatal & paediatric Emergency Transport Service [NETS] – the statewide emergency service for medical retrieval of critically ill or injured newborns, infants and children in NSW [Phone 1300 36 2500], or
- A designated retrieval team from a regional or interstate centre.

The principles of medical retrieval are to:

- Assist in triaging and local treatment of the clinical problem.
- Send to the place of referral a level of medical expertise akin to that of the destination hospital.
- Assess the clinical problem in the place of referral.
- Stabilise the patient’s condition using intensive care therapies prior to transportation.
- Transport the patient with physiological support and monitoring appropriate to their condition.
- Provide uninterrupted surveillance and care from ‘bed-to-bed’.
- Be able to deal with foreseeable en route deteriorations as competently as the working environment allows.
- Monitor, document and review the quality of the process.

The NETS team will be sent out by ambulance, helicopter or fixed wing aircraft (determined by location and patient needs).

NETS can link multiple parties by phone to discuss clinical issues. Based on that discussion, an appropriate clinical escort (retrieval team or other escort) will be selected, and a vehicle tasked. NETS may recommend a plan of care to be implemented in the interim until the NETS team arrives.

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Acute care plans for many conditions are available from NETS. The Medical Officer will document and implement this plan of care. The plan should include appropriate monitoring and surveillance of the patient. If the clinical circumstances change after the initial call [either deterioration or improvement] the Medical Officer must notify NETS to review the transfer plan and/or discuss any appropriate changes in treatment prior to the NETS team’s arrival. Area Health Services are responsible for ensuring appropriate resources are available to assist in the management of the deteriorating child until the retrieval team arrives.

Prior to transfer children should be stabilised in accordance with NETS Guidelines For Facilities For The Stabilisation Of Patients Prior To Medical Retrieval (Appendix 2).

**Transfer (without Retrieval)**

If retrieval is not indicated, but urgent transfer is still required, this can be provided by Ambulance Service NSW, either by road or fixed wing aircraft. Children and adolescents may be transported by Ambulance if their condition is serious but has been sufficiently stabilised by staff at the referring facility. Urgent transfers require a medical, nursing or paramedic escort who is experienced and skilled in paediatric resuscitation and airway management. If uncertain about the type of escort required, discuss with NETS. Medical and nursing staff should consult with Ambulance officers in decisions about transfer and clarify the responsibilities of key staff during the transfer.

**Non-Urgent Transfer**

**AHS Transport Units**

Non-emergency inter-facility transfer services are used for transporting admitted patients between health facilities. Transport for Health provides the policy framework for this mode of transport. All AHSs have established a Health Transport Unit to assist in coordinating non-urgent health related transport, either via AHS vehicle or NSW Ambulance Service. Referring clinical staff should be familiar with the local procedures for organising non-urgent patient transport through the Health Transport Unit. Non-urgent health transport is indicated if a child is stable but requires care on route, for example:

- Ongoing intravenous therapy, intravenous medication administration or nebulised therapy.
- Oxygen therapy.
- Patient Controlled Analgesia.
- Suctioning.
- There is suspicion of risk, i.e. non-accidental injury.

Non-urgent health transport may or may not require an escort.

**Private transport**

The decision to allow private transport [car or taxi] for an inter-hospital transport is the responsibility of the Emergency Clinicians at the destination hospital in consultation with the senior Medical Officer of the transferring hospital and the patient’s parent/carer. The transporting parent/carer should consent to this transport method. The Medical Officer should document that the issue has been discussed with the parents and they have agreed to transport the child.

Children and adolescents are not to be transported by private car if:

- They are at risk of their clinical condition deteriorating requiring urgent medical care as agreed between the referring and receiving hospitals.

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- They require oxygen, suctioning, ongoing intravenous medications or fluids.
- They require any type of emergency procedure.
- They have received paediatric life support measures or intravenous sedative medications.
- They have a fracture which is not stabilised with approved splinting and/or the potential for neurovascular disruption is high.
- Their pain score prior to administering analgesia indicates moderate or greater pain levels.
- The safety of the child is of concern due to child protection issues.

Children can only be transported in vehicles that have age appropriate safety equipment installed [eg child restraints]. For information about current legislative requirements regarding safety of children in cars go to: http://www.kidsafe.com.au/crguidelines

Prior to private transportation the transporting parent/guardian should be instructed not to detour and must have access to:
- Contact details of the destination health facility and staff.
- Directions or maps to the health facility.
- Transfer documents and relevant investigations.
- Information about local car parking facilities.
- A functioning telephone - in the event of an acute deterioration in the child’s/infant’s condition.

**Back transfer**

It is important that the discharge plan for children and adolescents admitted to a higher-level of care facility includes the option of transfer to their local hospital for ongoing management.

Decisions about transfer back to a local hospital should take into consideration:
- The level of care and service delivery required for the child.
- The role delineation of the local service.
- The availability of appropriate staffing and resources to provide the necessary care for the child.

There should be effective communication between clinicians at the transferring and local hospital to ensure that back-transfers are well planned, timely and enable local clinicians to have the necessary resources available to meet the needs of the child. This is particularly important for children and adolescents with high-level, complex and ongoing needs, physical or intellectual disability, mental illness or a life-limiting illness. The child’s local GP [and Paediatrician if involved] is to be informed of any planned transfers and provided with a written discharge summary.

All relevant documentation of the patient’s history, treatment and management plan should be forwarded to the local hospital, including guidelines or information to assist staff at receiving hospitals in the care of children and adolescents with complex/ongoing needs [eg tracheostomy; gastrostomy].

**Parents and carers**

The transferring hospital Medical Officer should discuss the need for transfer with the parent/guardian and patient (age-appropriate). Although not specifically requiring informed consent, the plan for transfer should be discussed with the parent/guardian as part of the overall treatment plan for which informed consent was obtained. The parent/carer should be provided with advice concerning:
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- The reason for transfer and anticipated time of transfer.
- Mode of transport, approximate travel time and estimated time of arrival at the destination hospital.
- Any treatment that may be required during transport.
- Escort if required.

The parent/guardian must be provided with appropriate information regarding the destination hospital. This information should be provided in writing and include directions to destination hospital and contact details for key staff at the destination hospital. The parent/guardian should continue to be informed on transfer arrangements, particularly if there is change to departure time.

Whenever possible, a parent/guardian should be offered the option of travelling with their infant/child to the destination hospital. Parents/guardians should be informed at the outset that there may be circumstances that prevent them being able to accompany their child, for example due to weight restrictions on aircraft.

**Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>Age up to 16th birthday</td>
</tr>
<tr>
<td>Parent/Primary carer</td>
<td>Parent/s or person living with the child and assuming legal responsibility for, and providing direct care. This includes birth parent, step-parent, foster parent, legal guardian, custodial parent or safe and appropriate primary care giver.</td>
</tr>
<tr>
<td>Inter Area hospital transfer</td>
<td>Transfer of a paediatric patient to a facility in another Area Health Service or interstate.</td>
</tr>
<tr>
<td>Intra Area hospital transfer</td>
<td>Transfer of a paediatric patient to another facility in the same Area Health Service</td>
</tr>
<tr>
<td>Back-transfer</td>
<td>The transfer of a paediatric patient following presentation or treatment at another facility within or outside the Area Health Service for the purpose of continuing care closer to home.</td>
</tr>
<tr>
<td>Transferring hospital</td>
<td>The hospital identifying the need for and initiating the transfer</td>
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<tr>
<td>Destination hospital</td>
<td>The hospital to which the child or infant is being transferred</td>
</tr>
<tr>
<td>NETS</td>
<td>The Newborn &amp; paediatric Emergency Transport Service which transfers all infants, children and adolescents who are condition critical/serious/unstable/at risk of deterioration or requires intensive care.</td>
</tr>
<tr>
<td>Health Transport Unit</td>
<td>Unit established in all AHSs to coordinate health related transport. Each AHS will have local protocols for using the Health Transport Unit to assist with inter-hospital transfers.</td>
</tr>
<tr>
<td>Retrieval</td>
<td>Medical retrieval is the process of transferring critically ill patients using a team that travels to the patient location from a central location or the destination hospital.</td>
</tr>
<tr>
<td>Role delineation</td>
<td>Role delineation is a process which determines what support services, staff profile, minimum safety standards and other requirements are provided to ensure that clinical services are provided safely and appropriately supported. The role delineation of a service describes the complexity of the clinical activity undertaken by that service, and is chiefly determined by the presence of medical, nursing and other health care personnel who hold qualifications consistent with the defined level of care. (NSW Health 2003)</td>
</tr>
<tr>
<td>Paediatric Safe Bed</td>
<td>Not all facilities will have a paediatric unit, however, all children must be cared for in a paediatric safe bed. A paediatric safe bed is a bed that can be located anywhere within a facility [including ED, imaging, or a general ward] that meets the criteria for ensuring the safety of the child. A paediatric safe bed must meet the following minimum conditions:</td>
</tr>
</tbody>
</table>
  - Must be able to be observed appropriately in line with the child’s clinical acuity. |
  - The bed area must be immediately accessible to paediatric specific emergency equipment. |
  - Must have a dedicated staffed nursing station with sufficient nurses allocated per shift to ensure adequate supervision and care relevant to admitted patient acuity. |
  - Nursing staff caring for the child must be familiar with local NSW Health paediatric guideline protocols and be competent in using recognition of the sick child skills and tools. |
  - Nurses caring for children and adolescents during prolonged observation [as prescribed in relevant policies/protocols] should have skills equivalent to that of the ‘competent paediatric nurse’ as defined in the document Competencies for the Specialist Paediatric and Child Health Nurses [available at: http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf] |

90(03/06/10)
2. PAEDIATRICS

- Must be physically safe for children and adolescents with any potentially dangerous equipment, medications, chemicals or fluids out of reach or in locked cupboards.
- Has appropriate furniture that is child safe and meets appropriate Australian Standards for children. e.g. appropriate cots for children 2 years of age or less.
- Parents/visitors must not take hot drinks to children’s bedsides.
- The facility should comply with the requirements of the NSW Breastfeeding Policy for the care of paediatric patients and support continued breastfeeding among infants and children by providing facilities and breastfeeding advice to mothers as well as breast milk collection and breast milk storage facilities. Provision must be made for the safe preparation of infant formula if necessary.
- It should be possible for parents or primary carers to stay with their children during admission.
- Parent’s current contact details must be ascertained at presentation.
- Other patients in the hospital must not pose a significant psychological, physical or sexual risk to the child.
- Basic equipment should be present to allow age appropriate play, for example a TV and video/DVD/games console with age appropriate media, books or board games.

Paediatric Safe Ward area

In addition to the criteria outlined above for paediatric safe beds, a paediatric ward/unit/area must also meet the following minimum conditions:

- Must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.
- Must be covered by a 24-hour medical roster with doctors credentialed in the care of paediatric patients.
- Must have a designated Paediatric NUM.
- Parents or primary carers should have access to bedside sleeping facilities and ideally a kitchenette with fridge and microwave to allow them to provide for their own and children’s nutritional needs when appropriate.
- Physical safety requirements must include regulated hot water temperature and secure electrical outlets.
- Must have facilities available to allow age appropriate play including a designated and appropriately equipped play area.

90(03/06/10)
Appendix 1: Criteria for calling NETS - Infants & Children


NETS Clinical Coordination receives calls about children with life-threatening or potentially life-threatening conditions. A NETS team or adult medical retrieval team may be selected for certain older children depending on the nature of the clinical problem and the availability of resources. This decision is the responsibility of the paediatric intensive care consultant.

The following are conditions that NETS would normally expect to be called about and then possibly retrieve:

1. Head injury (symptomatic).
2. Altered level of consciousness (for any reason).
3. Hypoxia despite oxygen therapy.
4. High oxygen requirement.
5. Respiratory failure (e.g. bronchiolitis, severe asthma, apnoea).
6. Upper airway obstruction.
7. Near drowning (especially with neurological depression or respiratory symptoms).
8. Ingestion with risk of circulatory, airway or neurological compromise.
10. Burns (see Department of Health Burns Transfer Guidelines July 1996)
    a) > 10%
    b) Encircling the neck or involving the airway, face, hands, feet, perineum, or inner joint surfaces.
    c) Associated other significant injury
    d) Electrical or chemical burns
11. Seizures (with persisting neurological depression)
12. Major trauma (including spinal injury)
13. Metabolic disturbance eg.
    a) Diabetic Keto-acidosis
    b) Acidemia
    c) Severe biochemical abnormality
14. Heart failure or Arrhythmia (symptomatic)
15. Shock (requiring treatment with volume replacement or inotropes) eg.
    a) Blood or fluid loss
    b) Dehydration
    c) Septicaemia
16. Other causes of neurological depression:
    a) CNS infection
    b) Acute Life Threatening Episode
17. Any condition with the potential for sudden cardiovascular or neurological deterioration.

Team composition options for paediatric retrieval include:

1. NETS team
2. Adult team (metropolitan)
3. Adult team (regional).
4. Combination of the above.

While a NETS team transports the majority of older children, there are alternative options for selecting a team. However, only a NETS team can transport a sick newborn or infant. Therefore, at times of high team usage, NETS teams are preferentially committed to newborns and infants.
Appendix 2 – Guidelines for Facilities for the Stabilisation of Patients prior to Medical Retrieval

These Guidelines are issued to assist Hospitals using a medical retrieval team to transfer a patient requiring intensive care. It sets out the resources that are required for the safe and efficient stabilisation of patients of all ages. These resources are required at those hospitals at or above role delineation Level 2 for Maternity Services (newborn infants) and at or above Level 1 for all other age-groups.

These Guidelines are designed to assist referring hospitals offer optimal care using the combined resources of the referring hospital and the retrieval team to manage, stabilise and prepare patients for transport.

The Guidelines were developed by NETS in collaboration with the Medical Retrieval Unit, regional advisory/retrieval services and referring hospitals.

Background
Guidelines were first issued in 1997 for newborn patients to promote an effective mechanism for the stabilisation prior to transfer, from referring hospitals. It was recognised that the scope of these Guidelines needed to be expanded to offer advice encompassing all age groups and include new aspects of clinical networking such as telemedicine. Accordingly, this document covers all age groups.

Space
It is acknowledged that not all hospitals will be able to immediately provide the physical space specified in this Guideline. Hospitals are advised that, if there is currently no suitable space within the ED, ICU, children’s ward or neonatal nursery, alternative resuscitation areas can be provided in an appropriate area. However, when a hospital is being refurbished or rebuilt, the requirements listed in this circular should be followed and reference made to the functional space requirements contained in the current “Health Facility Guideline”.

Where specific essential equipment items listed below are not available at present, provision should be made to include these items in forward planning cycles as soon as possible.

Ventilatory Support
Facilities that have medical officers formally trained in managing ventilated patients may have ventilators capable of supporting Adults, Children, Infants and Neonates - depending on caseload of patients requiring ventilatory support. Where such ventilators are available, they must be complemented by the capacity to measure airway pressure, expiratory tidal or minute ventilation, and end tidal CO₂ (or skin CO₂ monitoring).

Medical Imaging facilities
If medical imaging facilities are available in the referring facility, an X-Ray viewing box or Picture Archiving and Communication System (PACS) system must be in a location that allows use without losing visual contact with the patient. In addition, diagnostic images of the patient must be available to accompany the patient to their destination hospital.

Pathology Services
If Pathology Services are available in the referring facility, a viewing system to check pathology results must be in a location that allows access without losing visual contact with the patient.
## REQUIREMENTS - for Stabilisation of Patients Prior to Medical Retrieval

### Essential Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An area or room that <strong>can</strong> be dedicated to the patient for retrieval</td>
<td>This area may be created from existing areas for those occasions when a medical retrieval team is present, for instance, by temporarily combining two patient care areas into one.</td>
</tr>
<tr>
<td>Easy, uncluttered access for a stretcher or hospital trolleys used by</td>
<td>Access for the retrieval team (size 900mm x 2000mm) from hospital entry to patient care area without obstruction to other functions.</td>
</tr>
<tr>
<td>Procedure light (angle-poise type)</td>
<td></td>
</tr>
<tr>
<td>Resuscitation trolley with appropriate drugs and equipment for</td>
<td></td>
</tr>
<tr>
<td>Infant resuscitation trolley (open care system for body weight &lt; 5kg)</td>
<td></td>
</tr>
<tr>
<td>Panel fixtures</td>
<td></td>
</tr>
<tr>
<td>Height adjustable trolley to facilitate the loading and unloading of</td>
<td></td>
</tr>
<tr>
<td>Procedure trolley (900mm x 450mm minimum)</td>
<td></td>
</tr>
<tr>
<td>Ice packs for therapeutic cooling</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Facsimile machine</td>
<td></td>
</tr>
<tr>
<td>Photocopier with contrast and brightness adjustment</td>
<td></td>
</tr>
<tr>
<td>Digital camera for clinical photography (including simple connection to</td>
<td></td>
</tr>
<tr>
<td>Desirable Facilities</td>
<td></td>
</tr>
<tr>
<td>Lighting to meet standards of operating theatre, with adjustable</td>
<td></td>
</tr>
<tr>
<td>Infant resuscitation trolley (open care system for body weight &lt; 5kg)</td>
<td></td>
</tr>
<tr>
<td>Computer</td>
<td></td>
</tr>
<tr>
<td>Capacity to export clinical data from local information systems to</td>
<td></td>
</tr>
<tr>
<td>Capacity of continuously monitoring a patient’s ECG, pulse oximetry</td>
<td></td>
</tr>
<tr>
<td>Interview room readily accessible to resuscitation area, for family</td>
<td></td>
</tr>
<tr>
<td>Source: NETS, 2006</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: Sample assessment tool for receiving hospitals

Time [HH:MM] Date [DD/MM/YY] Caller [Name] Hospital [Name]

Patient Name [Name] M/F Callers Ph No [Number]

Stated Problem [Description]


Apgar Scores [Score] Score deficits

Gestational age [Weeks]

Vital Signs

Temp [Celsius] pa/pr/tymp Warming methods?

HR [Heart Rate] Cap refill [Secs] Pules [Pulse Rate]

RR [Respiration Rate] Resp effort - Recession / Grunt / Tug /

Flare


BP [Blood Pressure] BSL [Systolic Blood Pressure] mmHg

Pupils [Appearance] GCS [Glasgow Coma Score] AVPU / Activity / Tone

Current Management

Airway Support Guedel's / NP Airway / ETT Size [Size] @ lips [Size] cm’s


IV or IO [Intravenous or Intrathecal] Gastric Tube [Placement] X-ray [Imaging]

Fluid type [Type] Fluid Rate [Rate] mls/hr Bolus [Bolus] mls

Drugs Given [List of Drugs]

Advice / Plan

Call end Time [HH:MM] Taken by [Name] Sign [Signature]
Appendix 4:  Acknowledgement

The NSW Department of Health extends its appreciation to the members of the Paediatric Inpatient Advisory Working Group for their input, advice and assistance in production of this document.
INFANTS AND CHILDREN: ACUTE MANAGEMENT OF SORE THROAT (GL2014_021)


PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with sore throat.
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

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

2. PAEDIATRICS

CHILDREN AND INFANTS - ACUTE MANAGEMENT OF HEAD INJURY (PD2011_024)


PURPOSE

The infants and children: acute management of head injury clinical practice guideline (attached) 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 Department of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all health services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage children with head injury.

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

IMPLEMENTATION

Chief Executives must ensure:

- Local protocols are developed based on the infants and children: acute management of head injury clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with head injury.
- 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 the revised protocols.

2. PAEDIATRICS

INFANTS AND CHILDREN - ACUTE MANAGEMENT OF CROUP (PD2010_053)


PURPOSE

The infants and children: acute management of croup clinical practice guideline (attached) 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 Department of Health by an expert clinical reference group under the auspice of the state wide Paediatric Clinical Practice Guideline Steering Group.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage children with croup.

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

IMPLEMENTATION

Chief Executives must ensure:
- Local protocols are developed based on the infants and children: acute management of croup clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage paediatric patients with croup.
- 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 the revised protocols.


101(26/28/10)
YOUTH HEALTH AND WELLBEING ASSESSMENT GUIDELINE
(GL2018_003 issued 1/2/2018)

PURPOSE

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

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

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

KEY PRINCIPLES

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

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

The most widely used youth health and wellbeing assessment tool in Australia and internationally is known as a HEEADSSS assessment. Each letter of HEEADSSS reflects a major domain of a young person’s life. Capturing information in each domain helps reveal risks, behaviours and protective factors. It helps to identify areas of intervention where the clinician can work with the young person to achieve better health outcomes.

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

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

Clinical judgement should be used to determine the appropriateness of the assessment for 12-24 year olds. This includes considering the young person’s health condition, maturity, the environment and health service context (for example, sufficient time or privacy may not be available in an Emergency Department context).
In general an assessment is done through conversation with a young person. On some occasions, where it is more appropriate a young person can be asked to complete the Youth Health and Wellbeing Assessment Chart (Appendix 1).

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

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

**USE OF THE GUIDELINE**

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

This document outlines the -

- approach that should be taken by NSW Health staff when conducting a youth health and wellbeing assessment (Sections 7 - 10)
- 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.

To download the guideline go to [Youth Health and Wellbeing Assessment](#)
INFANTS AND CHILDREN: INITIAL MANAGEMENT OF FEVER OR SUSPECTED INFECTION IN ONCOLOGY AND STEM CELL TRANSPLANTATION PATIENTS
(GL2015_013)

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

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

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

USE OF THE GUIDELINE
Chief Executives must ensure:

- Hospitals and facilities either adopt this protocol or adapt local protocols to comply with the Infants and Children: Initial Management of Fever or Suspected Infection in Oncology and Stem Cell 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.

The guideline Infants And Children: Initial Management Of Fever Or Suspected Infection In Oncology And Stem Cell Transplantation Patients can be downloaded at the following link –
Infants and Children: Initial Management of Fever/Suspected Sepsis in Oncology /Transplant Patients
INFANTS AND CHILDREN: ACUTE MANAGEMENT OF THE UNSETTLED AND CRYING INFANT (GL2016_010)

PURPOSE
The *Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition* Clinical Practice Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families.

KEY PRINCIPLES
This guideline is primarily targeted to clinicians caring for infants and managing any task related to the unsettled and crying infant. 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 unsettled and crying infants.

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

USE OF THE GUIDELINE
Chief Executives must ensure:

- This guideline is adopted or local protocols are developed based on the *Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition* Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage unsettled and crying infants
- Ensure that all staff treating infants and children are educated in the use of locally developed protocols for infants and children.

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

The guideline *Infants And Children: Acute Management Of The Unsettled And Crying Infant* can be downloaded at the following link –

[Infants and Children: Acute Management of the Unsettled and Crying Infant](#)
PAEDIATRIC PROCEDURAL SEDATION - GUIDE FOR EMERGENCY DEPARTMENTS, WARDS, CLINICS AND IMAGING

(GL2018_011 issued 4/5/2018)

PURPOSE

Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The guide was prepared for the NSW Ministry of Health by an expert clinical reference group.

KEY PRINCIPLES

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

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

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

USE OF THE GUIDELINE

Chief Executives must ensure:

- This guide is adopted or local procedures are developed based on the Paediatric Procedural Sedation Guide for Emergency Departments, Wards, Clinics and Imaging.
- Local protocols are in place in all hospitals and facilities likely to be required to manage paediatric patients requiring procedural sedation
- Ensure that all staff treating paediatric patients are educated in the use of the locally developed paediatric protocols.

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

To download this guidelines go to

Paediatric Procedural Sedation - Guide for Emergency Departments, Wards, Clinics and Imaging
NEONATAL - JAUNDICE IDENTIFICATION AND MANAGEMENT IN NEONATES ≥ 32 WEEKS GESTATION (GL2016_027)

GL2016_027 incorporates content from obsolete Guideline GL2007_001 Neonatal Exchange Transfusions in NSW as notified in IB2016_062.

PURPOSE

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

• Local processes and operating procedures are developed in line with this document to manage neonates ≥ 32 weeks gestation to ensure:
  o Prompt appropriate identification, management and escalation of neonatal jaundice
  o Equipment is used, maintained and its effectiveness is monitored
  o Discharge is planned and follow up processes are in place
  o Assessment and appropriate escalation of care for neonatal jaundice > 14 days of age in a term neonate and beyond 21 days in a preterm neonate.

• The Directors of Clinical Governance inform relevant staff in maternity, neonatal services and biomedical departments of this new Guideline

• Morbidity and mortality associated with neonatal jaundice is monitored and reviewed.

To download the Guidelines please go to
Neonatal - Jaundice Identification and Management in Neonates ≥ 32 Weeks Gestation

270(24/11/16)
WHOLE BODY COOLING FOR NEONATES ≥ 35 WEEKS GESTATION WITH MODERATE OR SEVERE HYPOXIC ISCHAEMIC ENCEPHALOPATHY (HIE)  
(PD2010_006)

PURPOSE

This policy statement and attached protocol has been developed to provide direction to clinicians regarding therapeutic hypothermia (whole body cooling) for neonates greater than 35 weeks of gestation who may be at risk of hypoxic ischaemic encephalopathy (HIE). The policy statement is applicable to the management of babies born in a hospital without a Neonatal Intensive Care Unit (NICU) who meet the criteria set out in the attached protocol.

Generally, therapeutic hypothermia should usually not be undertaken if the birthing hospital does not have a designated area for the care of newborn babies, e.g., a special care nursery (SCN). However, if the hospital does not have a SCN, then it may be reasonable to commence passive cooling prior to transfer after specialist consultation with a neonatologist.

MANDATORY REQUIREMENTS

If a baby appears to meet the criteria for cooling as set out in the attached procedure for Special Care Nurseries in Non-tertiary Centres under the heading ‘Primary Principles’, urgent discussion is required with the duty consultant at NETS 1300 36 2500, who will consult with a tertiary neonatologist.

The Primary Principles for Special Care Nurseries in Non-tertiary Centres regarding methodology for baby selection, body cooling, temperature monitoring, and communication with NETS/neonatologist as set out in the attached protocol must be followed.

IMPLEMENTATION

Directors of Clinical Governance are required to inform relevant clinical staff in special care nurseries and maternity services of the policy.

Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

Changes from previous version:
1. The difference in target temperature range between rectal and axillary measurements has been removed. For both, the target range is now 33°C to 34°C

BACKGROUND

Moderate/severe HIE following perinatal asphyxia contributes significantly to neonatal mortality and morbidity including long-term neurodevelopmental sequelae in 25%-60% of survivors.

Evidence from high quality studies indicates that “Active Cooling” of neonates ≥ 35 weeks gestation with moderate to severe HIE begun within 6 hours of birth and continued in a NICU setting is safe and reduces the risk of death or disability at 18 to 22 months of age. There is no evidence to support cooling of infants with mild HIE or those born before 35 weeks.
This guideline is designed for use with babies who are born in a hospital without a NICU and who meet the criteria listed below. Therapeutic hypothermia should usually not be undertaken if the birthing hospital does not have a designated area for the care of newborn babies, e.g., a special care baby nursery (SCN). However if the hospital does not have a SCN, then it may be reasonable to commence passive cooling prior to transfer after specialist consultation as described below.

If a baby appears to meet the criteria for cooling as described below, urgent discussion is required with the duty consultant at NETS who will contact a tertiary neonatologist.

GUIDELINE FOR SPECIAL CARE NURSERIES IN NON-TERTIARY CARE CENTRES

Primary Principles

1. Of primary importance in a situation where whole body cooling is being considered is to ensure appropriate resuscitation of the neonate. Therefore, attention to airway, breathing and circulation takes priority over cooling. See NSW Health PD2008_027.

2. ALL infants who meet the eligibility criteria should be considered for cooling. Refer to inclusion and exclusion criteria in next section.

3. There is nearly always time to discuss the possibility of cooling with the parent(s) before cooling is commenced.

4. Cooling must NOT be commenced without discussion through NETS with a tertiary centre neonatologist. Since a decision to cool must be made within the first 6 hours after birth, this discussion may be required before a destination bed is finalised.

5. The continuing management of a baby who requires cooling should occur in a neonatal intensive care unit (NICU). Therefore all babies for whom cooling is commenced should be transferred to a NICU by NETS.

6. Cooling is only for neonates born after 34 weeks gestation, in other words 35 weeks and above. Cooling should not be undertaken for preterm neonates born before 35 weeks.

7. Cooling is an adjunct therapy. The ability to commence cooling of neonates should NOT influence decisions to cease resuscitation attempts at birth.

8. The preferred method of temperature monitoring during hypothermia is by continuous monitoring with a rectal probe but intermittent axillary temperatures are acceptable if skills and/or equipment are not available for continuous rectal temperatures.

ELIGIBILITY CRITERIA FOR COOLING (ACTIVE OR PASSIVE)

All of the following four criteria must be met

1. More than or equal to 35 weeks gestational age.
2. Less than 6 hours post birth.
3. Evidence of asphyxia as defined by the presence of at least two of the following:
   a) Apgar less than 6 at 10 min or continued need for resuscitation with positive pressure ventilation +/- chest compressions at 10 mins.
2. PAEDIATRICS

b) Any acute perinatal event that may result in HIE (ie. abruptio placentae, cord prolapse, severe FHR abnormality etc).
c) Cord pH less than 7.0 or base excess of -12 mmol/l or less.
d) If cord pH is not available, arterial pH less than 7.0 or BE less than -12mmol/L within 60 mins of birth.

4. The presence of moderate/severe HIE; defined as seizures OR presence of signs in at least three of the six categories given below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Moderate encephalopathy</th>
<th>Severe encephalopathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of consciousness</td>
<td>Lethargy</td>
<td>Stupor/coma</td>
</tr>
<tr>
<td>Spontaneous activity</td>
<td>Decreased activity</td>
<td>No activity</td>
</tr>
<tr>
<td>Posture</td>
<td>arms flexed, legs extended (decorticate)</td>
<td>arms and legs extended (decerebrate)</td>
</tr>
<tr>
<td>Tone</td>
<td>Hypotonia</td>
<td>Flaccid</td>
</tr>
<tr>
<td>Primitive reflexes</td>
<td>Weak suck, incomplete Moro</td>
<td>Absent suck, absent Moro</td>
</tr>
<tr>
<td>Autonomic system (any one of)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td>Constricted</td>
<td>Dilated/non-reactive</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Bradycardia</td>
<td>Variable heart rate</td>
</tr>
<tr>
<td>Respirations</td>
<td>Periodic breathing</td>
<td>Apnoea</td>
</tr>
</tbody>
</table>

Exclusion Criteria

1. Oxygen requirement greater than 80%
2. Major congenital abnormalities
3. Uncontrolled severe clinical coagulopathy (low platelet count or clinical evidence of abnormal clotting and/or clotting studies which has not responded to appropriate therapy).
4. Baby unlikely to survive. This should be discussed with NETS and the receiving neonatologist.

Risks and complications

In meta-analysis of the randomised trials, the following effects were reported with significantly higher frequency in the cooled arm of the trials; sinus bradycardia, hypotension requiring inotropes and thrombocytopenia. These are unlikely to occur in the time prior to transfer to a NICU unless there is a significant delay. Sinus bradycardia may be seen in this early time and is not a concern as long as the blood pressure is adequate, the oxygenation is good and the temperature is not below the target range.

GENERAL MANAGEMENT BEFORE COOLING COMMENCES

1. Ensure adequate resuscitation (see NSW Health PD2008_027) and support for the neonate including Airway, Breathing, Circulation, and Dextrose.
2. Assess eligibility criteria.
3. Call NETS to discuss suitability for cooling with NETS consultant and receiving neonatologist; either “Passive Cooling” or “Active Cooling”.

4. Discuss with parents the option of cooling. **But note that it is recommended that discussion with NETS should usually occur before talking with parents.**

**PASSIVE COOLING**

- Should be commenced in a non-tertiary setting when there is agreement between NETS and the receiving neonatologist.
- No active processes (such as fans or wet cloths) for cooling the infant should be undertaken unless the two criteria described in the next section on ‘Active cooling’ are met.

This is a process of allowing the infant to cool down of their own accord through the removal of the usual interventions undertaken to keep infants warm. The eventual goal is a **rectal or axillary** temperature between 33°C and 34°C. To achieve this, follow these steps:

1. Nurse the infant on a radiant warmer with warmer off. Do not nurse in incubator.
2. Do not nurse on a sheepskin.
3. Nurse infant naked: Do not; dress, or use a hat, or use any form of wrap (plastic or cloth)
4. Leave nappy unfastened.
5. Full cardiopulmonary monitoring.
6. If nursed in headbox oxygen, do not humidify or warm the air/oxygen gas mixture.
7. If ventilated, use normal humidifier settings.
8. Record time of commencement of passive cooling and record temperature every 15 minutes.
9. All other documentation/care/treatment should be the same as in any asphyxiated infant waiting for transport by NETS.
10. If **rectal** or **axillary** temp drops below 33.5°C, set radiant warmer on manual and gradually adjust heater output to maintain **rectal** or **axillary** temp in the range 33°C - 34°C.

**ACTIVE COOLING**

Only to be commenced if the following 2 points are met:

1. There is agreement between NETS and the receiving neonatologist.
2. Passive cooling has been underway for one hour and the rectal or axillary temperature is still above 35.5°C. (Infants are likely to be at least 90 minutes of age before this could begin.)

**Protocol and algorithm for Active Cooling:**

1. Use cold packs (Nexcare™ First Aid, 3M, Sydney) from the fridge, never use frozen.
2. Cold packs should be wrapped in cotton or equivalent. They should never be applied directly to the skin.
3. The cold packs can be placed under the shoulders/upper back, under the head and/or across the chest/body.
4. If using continuous rectal temperature monitoring, insert **rectal thermistor/probe** into anus at least 5cm: tape at the 10cm (first) mark to the upper inner thigh.
2. **PAEDIATRICS**

a. It is very important that the probe is in at least this far to accurately measure the baby’s core temperature - the probe is designed for this purpose and will not cause mucosal trauma.

b. Leave the probe in until change over with NETS.

5. Connect rectal probe to cable, temperature module and monitor.
   a. Set temperature alarm limits at 33°C (low) and 34°C (high) during the cooling period.
   b. Record time of initiating *active cooling* and monitor rectal temperatures every 15 minutes.

6. If using intermittent axillary temperature measurements then ensure that observations are taken at least every 15 minutes

**Temperature algorithm: Aim for 33 - 34°C**

<table>
<thead>
<tr>
<th>Temperature algorithm</th>
<th>Number of cool packs to be applied</th>
<th>Areas to apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 35.5°C</td>
<td>2*</td>
<td>Under shoulders, across chest</td>
</tr>
<tr>
<td>34.0 – 35.5°C</td>
<td>1</td>
<td>across chest</td>
</tr>
<tr>
<td>&lt; 34.0°C</td>
<td>0</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Having more than 2 packs prevents radiant loss of heat into the environment and makes it more difficult to cool the baby.

7. If rectal or axillary temperature drops below 33.5°C, remove all cool packs and repeat temperature in 15 minutes. If the temperature continues to fall, set radiant warmer on manual and gradually adjust heater output to maintain rectal or axillary temp at 33.0°C - 34.0°C

8. Aim is to achieve target temperature range within 1 hour but more importantly continue to manage airway, breathing, circulation.

9. Advise/reassure parents about baby’s appearance and that he/she will feel cool to touch.

10. The transport team will bring all the necessary equipment to continue the cooling process during transport.

**References**


**HYPOTHERMIA GUIDELINE REFERENCE GROUP**

Dr Adam Buckmaster, Paediatrician, Gosford Hospital representing the NSW Perinatal Services Network Level 4 SCN Working Group.

A/Prof Nick Evans, Neonatologist, Royal Prince Alfred Hospital, Sydney.

Prof William Tarnow-Mordi, Neonatologist, Westmead Hospital, Sydney

Dr Sue Jacobs, Neonatologist, Royal Women’s Hospital, Melbourne.

77(28/01/10)
Baby of $\geq$ 35 weeks and < 6 hours after birth probable intrapartum hypoxia. (see protocol)

Does baby meet eligibility criteria for probable moderate or severe HIE? (see chart in protocol).

- Yes: Discuss with NETS and Tertiary Centre NICU Consultant.
- No: Continue to observe and maintain normothermia.

Decision made to start passive cooling. Transfer to NICU arranged.

Commence Passive Cooling (see protocol).
- Monitor rectal or axillary temperature.
- Aim for rectal or axillary temperature in range 33 – 34°C

One hour after commencing Passive Cooling, is the temperature still above 35.5°C?

- Yes, > 35.5°C: After discussion with NETS and NICU, commence Active Cooling. See protocol.
- No, < 35.5°C: Continue Passive Cooling. See protocol.

If rectal or axillary temperature drops below 33.5°C

Remove any cool packs and repeat temperature in 15 minutes. If temperature continues to fall, set radiant warmer on manual and gradually adjust heater output to maintain rectal or axillary temp at 33°C – 34°C.
MANAGEMENT OF ADMISSION OF CHILDREN AND ADOLESCENTS TO SERVICES DESIGNATED LEVEL 1-3 PAEDIATRIC MEDICINE & PAEDIATRIC SURGERY

PURPOSE (PD2010_032)

This policy provides information and guidance to clinicians and hospital administrators regarding appropriate assessment and admission of presenting patients for paediatric medicine and paediatric surgery in NSW Health facilities with paediatric services designated as levels 1-3 in line with the *Guide to the Role Delineation of Health Services*, *NSW Department of Health, third edition, 2002*.

The purpose of the policy is to:

- Provide paediatric role delineated medical/surgical services 1-3 with a framework within which to provide paediatric patients appropriate and safe care at all times.
- Encourage appropriate treatment for children and adolescents as close as possible to their home.
- Ensure timely escalation of care for children and adolescents requiring higher levels of care due to deteriorating and/or complex health conditions.
- Facilitate the development and implementation of appropriate local AHS policy and procedure for levels 1-3 paediatric medical and surgical services.

MANDATORY REQUIREMENTS

This policy applies to all facilities where paediatric patients are managed. It requires all Health Services to have local guidelines/protocols based on the attached clinical practice guideline in place in all hospitals and facilities likely to be required to assess or admit children.

IMPLEMENTATION

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas. Facilities that regularly provide paediatric care would benefit from the development of local protocols to encourage appropriate paediatric involvement for all children, including those under the care of an adult clinician.

Note: this policy has been informed by relevant documents developed by AHSs and the NSW Child Health Networks.

BACKGROUND

Level 1-3 paediatric services play an important role in local communities in the provision of healthcare to children and adolescents, particularly in rural and remote areas. Whilst aiming to provide the best possible care as close as possible to where children live, it is not feasible to provide all services at all facilities. The *NSW Health Guide to Role Delineation of Health Services* (2002) outlines six possible levels of paediatric medical and surgical service delivery, and broadly describes the paediatric care that can be delivered at a facility.

Given variations in the configuration of level 1-3 services in terms of staffing, resources and available clinical expertise, it is important that Area Health Services [AHSs] recognise these differences and tailor local paediatric service provision accordingly. Support for local clinicians to maintain and further develop their paediatric clinical skills is also important through:
2. PAEDIATRICS

- Providing a safe and appropriate range of local paediatric medical and surgical services.
- Ensuring effective paediatric networking arrangements are in place across the AHS.
- Ensuring effective mechanisms for monitoring clinical safety and quality.
- Ensuring staff have access to ongoing professional and clinical education opportunities to ensure their skills are maintained and appropriately updated.

The definition of a child in this policy document is any person under the age of 16 years, neonates excluded. It is acknowledged that adolescents are defined as those of an age 12-18 years. Discretion should be applied in relation to adolescents older than 16 years. Clinical judgement/previous paediatric admissions should be considered when deciding if the older adolescent is suitable for accommodation in a paediatric unit.

For a list of definitions for specific terms used in this document, refer to Appendix 1.

PURPOSE

This policy provides information and guidance to clinicians and hospital administrators regarding appropriate assessment and admission of presenting patients for paediatric medicine and paediatric surgery in NSW Health facilities with paediatric services designated as levels 1-3 in line with the Guide to the Role Delineation of Health Services, NSW Department of Health, third edition, 2002 (see Appendix 2 & 3).

The purpose of the policy is to:
- Provide paediatric role delineated medical/surgical services 1-3 with a framework within which to provide paediatric patients appropriate and safe care at all times.
- Encourage appropriate treatment for children and adolescents as close as possible to their home.
- Ensure timely escalation of care for children and adolescents requiring higher levels of care due to deteriorating and/or complex health conditions.
- Facilitate the development and implementation of appropriate local AHS policy and procedure for levels 1-3 paediatric medical and surgical services.

IMPLEMENTATION

Area Health Service Chief Executives or delegated officers are required to communicate the information contained within this Policy to relevant facilities and staff. Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas. Facilities that regularly provide paediatric care would benefit from the development of local protocols to encourage appropriate paediatric involvement for all children, including those under the care of an adult clinician.

NSW HEALTH PAEDIATRIC SERVICE ROLE DELINEATION LEVELS 1-3

The following definitions are taken from the Guide to the Role Delineation of Health Services, NSW Department of Health, third edition, 2002.

Role delineation Level 1

*Role delineation Level 1 Paediatric Medicine*

No planned inpatient paediatric medical service or designated beds. Provides primary and emergency care; and stabilisation for children prior to moving to appropriate higher level of service. Quality assurance activities. Interpreters as per Policy Directive PD2006_053.
Role delineation Level 1 Paediatric Surgery
No planned inpatient paediatric surgical service. Provides primary emergency care; and stabilisation for children prior to moving to an appropriate higher level of service. Quality assurance activities. Interpreters as per Policy Directive PD2006_053.

Role delineation Level 2

Role delineation Level 2 Paediatric Medicine
Designated paediatric inpatient in a general hospital in an outlying and geographically isolated area. May have isolation capacity. Accredited Medical Practitioner on call. Formal consultative links with paediatrician. Would be used for only minor medical conditions or convalescence following referral from a higher level unit. RNs with skills consistent with a competent Paediatric Nurse. Continuing nursing educational programs available. Able to provide accommodation for parents or carers.

Note there is no role delineation Level 2 for Paediatric surgery

Role delineation Level 3

Role delineation Level 3 Paediatric Medicine
As Level 2, plus designated paediatric ward/area with patient amenities. Has isolation capacity in separate rooms. Provides for common medical conditions. NUM, preferably with post basic clinical qualifications or access to CNC within the area and RN’s with skills consistent with a competent Paediatric Nurse. Some RNs undertaking relevant post graduate studies. Has 24 hour access to Medical Officer on site or available within 10 minutes. Access to allied health professionals. Formal link to community child and family health service. Formal quality assurance program.

Role delineation Level 3 Paediatric Surgery
Except in emergencies, children under the age of one year should not be admitted. Minor elective and selected moderate surgical procedures on ASA category 1 and 2 children over the age of 1 year performed by General Surgeons or Accredited Medical Practitioners credentialed in paediatric surgery, and Specialist Anaesthetists or Medical Practitioners with appropriate paediatric anaesthetic experience and/or qualification as determined by the credentialling process involving the relevant colleges. Appropriate surgical, anaesthetic and resuscitation equipment available. Has 24 hour access to Medical Officers on site or available within 10 minutes. RN with skills consistent with a competent Paediatric Nurse caring for the child. Continuing nursing educational programs available specific to the needs of the service. Formal consultative links with Paediatrician and Paediatric Surgeons. Amenities for parents or carers. Operating suite and recovery room provider for the special needs of children and carers. Formal quality assurance program.

ASSOCIATED POLICIES AND GUIDELINES

- *Guidelines for the Care of Children in Acute Care Settings*, PD2010_034 NSW Department of Health revised 2010.
- *NSW Clinical Practice Guidelines for Paediatric Care*, various
- *NSW Health Paediatric Surgery Model for Designated Area Paediatric Surgical Sites*, NSW Surgical Services Taskforce Paediatric Surgery Sub Group 2008.

90(03/06/10)
Children presenting to the Emergency Department will be triaged as per the Australasian Triage Scale (ATS) (2000 ACEM). This will occur as soon as possible after arrival by the Registered Nurse. The NSW Health ‘Recognition of a Sick Child in Emergency Departments’ Clinical Practice Guideline should be used as an adjunct to the triage process; as well as consultation with the parent/carer.

All infants and children presenting to the emergency department must have a full set of observations taken and recorded at the point of triage based on the presenting symptoms. The minimum data recorded should include temperature, weight, heart rate (by palpation, auscultation or ECG) respiration rate and respiratory effort (any patient with a respiratory condition should also have pulse oximetry with air entry, breath sounds and respiratory effort assessed). A blood pressure must be recorded at some stage during the presentation and should be taken as soon as practicable in ATS 1 & 2 patients. The recording of some observations may be deferred if doing so may compromise the patient’s airway for example in epiglottitis or life threatening croup.

In specific clinical presentations additional observations must be documented. In cases involving head injuries and altered level of consciousness, a Paediatric Glasgow Coma Score must be recorded as clinically indicated. A validated age-appropriate pain score must be documented for all paediatric patients. If a child presents with a suspected fracture then neurovascular observation must be commenced on the affected limb or digit.

**Presentation for routine admission**

For children being admitted for routine medical procedures [eg IV antibiotics] or elective surgery in a designated Level 3 Paediatric Surgical facility, routine paediatric admission procedures are to be undertaken.

**Assessment**

NSW Health has published *Clinical Practice Guidelines* for the most common paediatric presentations to the Emergency Department. Clinicians should refer to these for assessment and care of children with these specific health conditions.

**Facilities with on-site medical cover available**

All paediatric patients presenting to the health facility should be assessed by the Attending Medical Officer (AMO) or ED doctor rostered on duty.
Facilities without on-site medical cover available

All paediatric patients presenting to the Emergency Department should be assessed as soon as possible by a registered nurse (RN) with current First Line Emergency Care (FLEC) course or other current recognised emergency or paediatric accreditation who will:

- Make an assessment to determine the reason for presentation and the clinical condition of the patient and document findings.
- Commence nursing interventions appropriate to the competency of that RN.
- Contact the on-call AMO about all children less than 3 months of age and coordinate an assessment of the infant by an AMO in a time appropriate to their triage category.
- Ensure the on-call AMO is consulted or made aware of all paediatric presentations in a timely manner according to their clinical condition. This consultation process should follow a site specific protocol.
- Where the child’s condition is considered to be non-urgent and it is deemed safe and appropriate by the AMO, the patient/carer may be given the choice to see the AMO at a later time as an alternative to waiting in the ED to be seen.

Consultation with the On Call Specialist Paediatrician

In accordance with the AHS established networking arrangements, consultation with an on call specialist paediatrician and/or appropriate other specialist should occur if the infant or child:

- is unstable.
- has no definitive diagnosis.
- has no clear signs of clinical improvement following initial treatment.
- is subject to any suspicion of child protection issues.
- is subject to any degree of concern for a safe patient outcome.
- has significant co-morbidity.

Clinicians should refer to any relevant local AHS protocols with regard to consultation pathways and escalation processes.

All paediatric acute mental health presentations should be discussed with appropriate paediatric mental health staff or mental health staff with paediatric experience. In addition a risk management assessment should occur in relation to the physical environment prior to admission to a general paediatric unit for children under twelve years with behaviour and or mental health issues.

Paediatric Safe Beds/Areas

Not all facilities will have a paediatric unit, however all children must be located in paediatric safe beds. A paediatric safe bed is a bed that can be located anywhere within a facility [including ED, Imaging or a general ward] that meets the criteria for ensuring the safety of the child. A paediatric safe bed must meet minimum conditions, including ensuring that the child can be observed appropriately in line with clinical acuity, that clinical care is provided by staff who are experienced in providing paediatric care and there is attention to issues related to the physical safety of children. A list of the minimum requirements for a paediatric safe bed can be found in Appendix 1. If a paediatric safe bed is not available a child should not be cared for in the facility.

Paediatric wards in Level 3 services must also satisfy additional minimum requirements for a safe paediatric ward/unit/area, including:

- The area must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.

90(03/06/10)
2. **PAEDIATRICS**

- There must be a designated Paediatric NUM.
- There must be facilities available to allow age appropriate play including a designated and appropriately equipped play area.

A list of the minimum requirement for paediatric wards can be found at Appendix 1.

In addition, facilities should note the requirements for safety and security of children as specified in the *Policy: Safety and Security of Children in NSW Acute Health Facilities*, PD2010_033 NSW Department of Health 2010.

**Medical Plan of Care**

Any paediatric patient in a health facility must have a clearly defined and documented medical plan which specifically states:

- Medical requirements (consistent with the relevant NSW Health Acute Paediatric Clinical Practice Guideline; or according to clinical need where no Guideline exists).
- Fluid hydration and nutrition needs with paediatric fluid balance chart maintained.
- Observation type and frequency (this will be determined by patient acuity) should include, pulse, temperature, respirations, level of activity, colour and capillary refill. Frequency of observations must, at a minimum, be consistent with the expectations of the paediatric Between the Flags policy.
- The changes in patient condition that need to be notified to the AMO (the management plan must include the AMO’s contact details for staff to use if there are concerns).
- Expected review intervals & estimated date of discharge.

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

**Length of Stay**

**Level 1 Facilities**

Paediatric patients may be observed in the Emergency Department [or paediatric safe bed], in consultation with the Nurse Manager (or delegate) if their condition is stable and they are expected to be discharged home within 8 hours. Eight hours is the maximum observation period, however, AHSs may introduce local protocols mandating reduced observation time if required due to limitations in resources and staffing.

If it is considered at any point during the observation period that it is unlikely the child will be able to be discharged within 8 hours, consultation should occur between local medical/nursing staff and the Paediatrician on call and/or other appropriate specialist, to make a decision about transfer to a higher level paediatric unit. Consideration should be give to transferring to a facility that can provide definitive care. Where relevant, contact should be made with the AHS Patient Flow Unit to assist in communication and coordination of transfers.

The only exception to the above is in circumstances where the child is deemed to be clinically fit for discharge, but there are extenuating social circumstances that warrant an extension of the time the child remains in hospital. This refers to logistical rather than clinical factors such as availability of the AMO, time of day/night, availability of transport etc, which may dictate a slightly longer stay in the otherwise well patient who is clinically ready for discharge.

90(03/06/10)
Paediatric patients will only be observed as described above in the Emergency Department [or paediatric safe bed] if there are appropriate staffing levels and skill mix to meet care and observation requirements. Consideration should be given to:

- The number & acuity of patients in the ED and facility.
- The experience and expertise of rostered medical and nursing staff in managing and caring for paediatric patients (including the oncoming shift if relevant).
- The type of equipment and level of care required for safe clinical practice.
- The level of medical support available.
- The presence of an appropriate plan of care documented in the medical record.

During the observation period consultation with the on call paediatrician, emergency physician or appropriate other specialist should occur if:

- The infant or child’s condition becomes unstable.
- There are no expected signs of clinical improvement during treatment.
- There are any concerns/uncertainty regarding the patient’s condition.
- The clinical symptoms no longer support the presumptive diagnosis.

No paediatric patient will be discharged unless they have been medically reviewed and the AMO has specified the discharge requirements in writing. Parents should be given relevant discharge information.

**Level 2 Facilities**

Paediatric patients may be observed in the Emergency Department [or paediatric safe bed], in consultation with the Nurse Manager (or delegate) if their condition is stable and they are expected to be discharged home within 12 - 24 hours. This is the maximum observation period, however, AHSs may introduce local protocols mandating reduced observation time if required due to limitations in resources and staffing. The considerations outlined above for level 1 facilities related to decisions to keep a child for observation also apply to level 2 facilities.

If it is considered at any point during the observation period that it is unlikely the child will be able to be discharged within 12-24 hours, consultation should occur between local medical/nursing staff and the Paediatrician on call and/or other appropriate specialist, to make a decision about transfer to a higher level paediatric unit. Consideration should be given to transferring to a facility that can provide definitive care. Where relevant, contact should be made with the AHS Patient Flow Unit to assist in communication and coordination of transfers.

The only exception to the above is in circumstances where the child is deemed to be clinically fit for discharge, but there are extenuating social circumstances that warrant an extension of the time the child remains in hospital. This refers to logistical rather than clinical factors such as availability of the AMO, time of day/night, availability of transport etc, which may dictate a slightly longer stay in the otherwise well patient who is clinically ready for discharge.

During the observation period consultation with the on call paediatrician, emergency physician, or appropriate other specialist should occur if:

- The infant or child’s condition becomes unstable.
- No expected signs of clinical improvement during treatment.
- There are any concerns/uncertainty regarding the patient’s condition.
- Clinical symptoms no longer support the presumptive diagnosis.
Decisions to keep a child for observation should take into consideration the current resources such as nursing skills as well as the projected skills and experience available in the following shift/s.

No paediatric patient will be discharged unless they have been medically reviewed and the AMO has specified the discharge requirements in writing.

**Level 3 Facilities**

The maximum length of stay for paediatric patients in a level 3 paediatric medical facility is generally not expected to exceed 3 days. Children with a longer expected length of stay should be discussed between the local medical/nursing staff and a paediatrician or appropriate other specialist as there may be circumstances under which it is deemed appropriate for a child to stay longer than three days, for example a child who requires long term antibiotics in the absence of significant acute illness and who may be appropriately managed with paediatric support. AHSs may also introduce local protocols mandating reduced LOS if required due to limitations in resources and staffing.

Consultation with the on call specialist paediatrician or appropriate other specialist should reoccur to establish the need for transfer to higher care if:

- The infant or child’s condition becomes unstable;
- The child has no clear signs of clinical improvement during ongoing treatment;
- There is any degree of concern for a safe patient outcome; or
- Discharge is not immediately imminent at 72 hours.

Consideration should be given to transferring to a facility that can provide definitive care. Where relevant, contact should be made with the AHS Patient Flow Unit to assist in communication and coordination of transfers.

No paediatric patient will be discharged unless they have been medically reviewed and the AMO has specified the discharge requirements in writing.

**Surgical Admissions**

Access to non-tertiary paediatric surgical services at Level 3 facilities is an important component in the timely treatment of paediatric patients as close as possible to home. Children over the age of 12 months may be admitted for surgery to a designated level 3 paediatric surgical service provided that:

- The scope of surgery is minor elective and/or selected moderate surgical procedures. An indicative list of paediatric surgical procedures is at Appendix 6.
- Children fall into ASA (American Society of Anesthesiologists) pre-operative evaluation of physical status category 1 or 2. The ASA Level of Risk classification is at Appendix 7.
- Paediatric surgery is provided by surgeon(s) with experience and/or qualifications in the relevant fields of paediatric surgery as determined by the facility’s credentialling process.
- Anaesthesia and related post-operative treatment including pain management is provided by an anaesthetist with appropriate experience and/or qualifications in paediatric anaesthesia, as determined by the facility’s credentialling process; unless a life threatening emergency makes this impossible.
- There is appropriate paediatric medical and surgical equipment in the operating room. A list of requirements is outlined in Appendix 4.
- There are arrangements for separation of adult and child patients both in operating theatres and recovery wards (eg. through use of screens, or scheduling of cases).
- The facility has 24 hour access to Medical Officers on site or available within 10 minutes.
- A Registered Nurse with skills consistent with a competent Paediatric Nurse cares for the child.

90(03/06/10)
**Security of Children**

The physical and emotional wellbeing of the child and adolescent is paramount at all times and staff should never feel obliged to keep patients because of pressure from carers or others when the child or adolescent’s clinical needs or safe conditions as outlined in this policy cannot be met. AHSs must ensure that all medical and surgical services including levels 1-3 have in place local policies and procedures consistent with the requirements set out in the NSW Policy: *Safety and Security of Children in Acute NSW Health Facilities* PD2010_033 with respect to such issues as:

- Child protection.
- Physical environment including the use of paediatric safe beds.
- Ensuring children are not collocated with adults.
- Temporary removal and/or discharge of children.
- Care of children under orders.

**Parents/carers**

It should be possible for a parent/primary carer or designated proxy to remain with the infant or child at all times and have informed participation in all decisions involving their health care. Preferences of adolescent patients should be respected with respect to having a parent present.

Parents/primary care giver are to be notified of any pending transfer arrangements for their child.

Amenities should be provided to facilitate the comfortable stay of parents/primary carers at the child’s bedside.

Parents/primary carers are to be orientated to the relevant areas within the facility and relevant practices to assist them to safely assist with the basic care needs of their child.

Parents/primary carers of children requiring surgery should be able to accompany their child to the operating theatre and have access to the recovery room. When agreed with the attending anaesthetist, parent/primary carers should be offered the choice to be present at the induction of the child’s anaesthetic, unless medically not indicated.

**Resources**

**Staffing**

All attending medical officers providing assessment, treatment or observation of paediatric patients must have appropriate credentialling for paediatric and/or emergency patients by the Area Health Service or local network to do so. Medical Officers should refer to their local AHS credentialing protocols for more information. It is highly recommended that attending medical officers caring for paediatric patients maintain currency in an accredited paediatric advanced life support course.

Nursing staff caring for children in level 1 services without doctors on site should have completed a current First Line Emergency Care [FLEC] course or other current recognised emergency or paediatric accreditation course and undertake annual accreditation as required.

Nursing staff caring for children in services designated 2 and 3 should satisfy the criteria of a ‘competent paediatric nurse’ as outlined in *Competencies for the Specialist Paediatric and Child Health Nurses* [available at: http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf]. In addition they must be familiar with NSW Health Paediatric Clinical Practice Guidelines and local paediatric clinical pathways and protocols. They should also have experience in using clinical skills and tools to recognise a sick child. [NSW Paediatric Clinical Practice Guidelines, NSW PD2011_038: Children and Infants - Recognition of a Sick Baby or Child in the Emergency Department.]
All sites that regularly care for children must ensure both medical and nursing staff attend paediatric education. All staff are required to attend Basic Life Support education every 12 months and staff involved in active resuscitation are also required to attend Paediatric Advanced Life Support or Advanced Resuscitation/Skills days at least every 3 to 5 years. Staff should also comply with education requirements mandated by their AHS and the NSW Department of Health.

In level 3 services, a schedule of paediatric education provided by those with paediatric expertise within the unit and from outside sources should be occurring regularly.

**Physical Resources**

AHS paediatric medical and/or surgical sites must have a minimum of paediatric medical equipment required for their designated level. Requirements for levels 1-3 are set out in Appendix 5.

Localised flowcharts, paediatric forms and policies for the care of children must be in place.

*Designated Level 1 and 2 services*

Level 1 & 2 services must identify suitable beds in the ED that meet the criteria of a ‘paediatric safe bed’.

*Designated Level 3 services*

Level three services must have designated areas specifically designed for the safe care of children that comply with the requirements of the NSW Health document *Guidelines for Care of Children and Adolescents in Acute Care Setting PD2010_034* revised June 2010. Play equipment, designated play areas and appropriately screened volunteer play facilitators should be available.

A treatment room should be available for all invasive and potentially painful procedures.

Paediatric linen, clothing and nappies will need to be available. Facilities for the preparation, cleaning and storage of formula and associated equipment should be available. Paediatric age appropriate meals must be available.
APPENDICES

Appendix 1: Definitions

Competent Paediatric Nurse

The Nurse:

- Assesses a child’s normal parameters, recognises the deviations from the normal and acts appropriately on the findings.
- Demonstrates a broad knowledge of growth and development.
- Calculates and administers medications and other preparations to children safely.
- Demonstrates an understanding of the effects of hospitalisation on children and families.
- Communicates effectively and works in partnership with children and families.
- Demonstrates knowledge of conditions and their management relevant to their area of childhood clinical practice.
- Commences and maintains effective basic paediatric life support.
- Recognises and challenges management that compromises the child’s safety.
- Utilises contact with the child and family to promote child health i.e. immunisation, child safety.
- Demonstrates an awareness of appropriate Federal and State legislation and policies and acts accordingly.

For a more comprehensive explanation of paediatric nursing competencies go to http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf

Paediatric Safe Bed

Not all facilities will have a paediatric unit, however, all children must be located in a paediatric safe bed. A paediatric safe bed is a bed that can be located anywhere within a facility [including ED, Imaging or a general ward] that meets the criteria for ensuring the safety of the child. A paediatric safe bed must meet the following minimum conditions:

- Must be able to be observed.
- The bed area must be immediately accessible to paediatric specific emergency equipment.
- Must have sufficient nurses allocated per shift to ensure adequate supervision and care relevant to admitted patient acuity.
- Nursing staff caring for the child must be familiar with local NSW Health paediatric guideline protocols and be competent in using recognition of the sick child skills and tools.
- Nurses caring for children should have skills equivalent to that of the ‘competent paediatric nurse’ as defined in the document Competencies for the Specialist Paediatric and Child Health Nurses [available at: http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf]
- Must be physically safe for children with any potentially dangerous equipment, medications, chemicals or fluids out of reach or in locked cupboards.
- Has appropriate furniture that is child safe and meets appropriate Australian Standards for children. e.g. appropriate cots for children 2 years of age or less.
- Parents/visitors must not take hot drinks to children’s bedsides.
- The facility should comply with the requirements of the NSW Breastfeeding Policy for the care of paediatric patients and support continued breastfeeding among infants and children by providing facilities and breastfeeding advice to mothers as well as breast milk collection and breast milk storage facilities. Provision must be made for the safe preparation of infant formula if necessary.

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2. PAEDIATRICS

- It should be possible for parents or primary carers to stay with their children during admission.
- Parent’s current contact details must be ascertained at presentation.
- Other patients in the hospital must not pose a significant psychological, physical or sexual risk to the child.
- Basic equipment should be present to allow age appropriate play, for example a TV and video/DVD/games console with age appropriate media, books or board games.

**Paediatric safe ward/area**

In addition to the criteria outlined above for paediatric safe beds, a *paediatric ward/area* must also meet the following minimum conditions:

- Must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.
- Must be covered by a 24-hour medical roster with doctors credentialed in the care of paediatric patients.
- Must have a NUM, preferably with post basic qualifications or access to a CNC.
- Parents or primary carers should have access to bedside sleeping facilities and ideally a kitchenette with fridge and microwave to allow them to provide for their own and children’s nutritional needs when appropriate.
- Physical safety requirements must include regulated hot water temperature and secure electrical outlets.
- Must have facilities available to allow age appropriate play including a designated and appropriately equipped play area.

**Paediatrician**

- Fellow of the Royal Australian College of Physicians and/or other specialist recognition as approved in the *Staff Specialists [State] Award* and/or who is a specialist as a defined in the *Health Insurance Act 1973* [Commonwealth].

**Parent/Primary carer**

Parent/s or person living with the child and assuming legal responsibility for, and providing direct care. This includes birth parent, step-parent, foster parent, legal guardian, custodial parent or safe and appropriate primary care giver.


## 39 PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Path</td>
</tr>
<tr>
<td>1</td>
<td>No planned inpatient paediatric medical service or designated beds. Provides primary and emergency care; and stabilisation for children prior to moving to appropriate higher level of service. Quality assurance activities[^6]. Interpreters as per Circular 94/10.</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Designated paediatric inpatient in a general hospital in an outlying and geographically isolated area. May have isolation capacity. Accredited Medical Practitioner[^1] on call. Formal consultative links with Paediatrician. Would be used for only minor medical conditions or convalescence following referral from a higher level unit. RNe[^3] with skills consistent with a competent Paediatric Nurse[^1]. Continuing nursing educational programs available. Able to provide accommodation for parents or carers.</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>As Level 3. Designated Director of Paediatric Medical Services, plus provides integrated hospital inpatient unit, non-inpatient family and child health services, and community health services for most paediatric medical conditions. Designated adolescent area. Specialist Paediatrician on call 24 hours. Paediatric support offered to other units within the Area. Designated Medical Officer[^1]. May have Paediatric Registrar[^3], NUM[^1], or access to CNC within the Area. Access to Audiology services. Allied health professionals on site.</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>As Level 4, plus Specialised Paediatric Inpatient Unit. May have some paediatric subspeciality skills. Designated adolescent unit. Has Paediatric Registrar[^3] on site 24 hours. Active program of undergraduate and postgraduate teaching and research coordinated with a Level 6 service. Access to CNC[^5] is desirable. Rostered allied health professionals on staff, including recreational therapy. School teacher available.</td>
<td>5</td>
</tr>
</tbody>
</table>

[^6]: 90(03/06/10)
## 39 PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>As Level 5, plus most paediatric medical and surgical sub-specialties available. Designated Adolescent Ward. Clinical and diagnostic services provided by appropriately trained Paediatric Specialists. Provides some statewide services. Subspecialty consultant on call 24 hours. Has designated Subspeciality Registrar. Provides 24 hour Child Protection Services with consultant Paediatrician and Social Worker. School service for inpatients provided by Department of Education. Has research and specialist paediatric teaching role.</td>
<td>Path 6  Phr 6  Imag 6  NMed 4  Anas 5  ICU  *  CCU  2</td>
</tr>
</tbody>
</table>

---

(1) See "Medical and Nursing Staff Definitions" in Appendix 1
(2) See "Glossary" in Appendix V
* Adult CCU - not applicable
## Appendix 3: Role Delineation – Paediatric Surgery

### 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Path</td>
</tr>
<tr>
<td>1</td>
<td>No planned inpatient paediatric surgical service. Provides primary and emergency care; and stabilisation of children prior to moving to appropriate higher level of service. Quality assurance activities&lt;sup&gt;(6)&lt;/sup&gt;. Interpreters as per Circular 94/10.</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Except in emergencies, children under the age of one year should not be admitted. Minor&lt;sup&gt;(1)&lt;/sup&gt; elective and selected moderate&lt;sup&gt;(1)&lt;/sup&gt; surgical procedures on ASA category 1 and 2&lt;sup&gt;(6)&lt;/sup&gt; children over the age of 1 year performed by General Surgeons or Accredited Medical Practitioners&lt;sup&gt;(6)&lt;/sup&gt; credentialed in paediatric surgery, and Specialist Anaesthetists or Medical Practitioners&lt;sup&gt;(6)&lt;/sup&gt; with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process involving the relevant Colleges. Appropriate surgical, anaesthetic and resuscitation equipment available. Has 24 hour access to Medical Officers&lt;sup&gt;(6)&lt;/sup&gt; on site or available within 10 minutes. RN&lt;sup&gt;(6)&lt;/sup&gt; with skills consistent with a competent Paediatric Nurse&lt;sup&gt;(6)&lt;/sup&gt; caring for the child. Continuing nursing educational programs&lt;sup&gt;(6)&lt;/sup&gt; available specific to the needs of the service. Formal consultative links with Paediatrician and Paediatric Surgeons. Amenities for parents or carers. Operating suite and recovery room provide for the special needs of children and carers. Formal quality assurance program&lt;sup&gt;(6)&lt;/sup&gt;.</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Except in emergencies, children under the age of one month should not be admitted. Designated children's ward with parent amenities. Moderate&lt;sup&gt;(1)&lt;/sup&gt; and selected major&lt;sup&gt;(1)&lt;/sup&gt; surgical procedures on ASA categories 1 and 2&lt;sup&gt;(6)&lt;/sup&gt; children performed by Surgeons&lt;sup&gt;(6)&lt;/sup&gt; credentialed in paediatric surgery, and Specialist Anaesthetists&lt;sup&gt;(6)&lt;/sup&gt; with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process. Medical Officer&lt;sup&gt;(3)&lt;/sup&gt; on site 24 hours. Consultation available from specialist paediatrician. Facility to isolate in single room. Has NUM&lt;sup&gt;(3)&lt;/sup&gt; and RNs&lt;sup&gt;(6)&lt;/sup&gt; with skills consistent with a competent Paediatric Nurse&lt;sup&gt;(6)&lt;/sup&gt;. Some RNs&lt;sup&gt;(6)&lt;/sup&gt; undertaking relevant postgraduate studies. Has access to allied health professionals. May have a role in providing paediatric support to other units within the Area.</td>
<td>4</td>
</tr>
</tbody>
</table>

90(03/06/10)
## 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>As Level 4 plus specialised paediatric inpatient unit with nominated Director of Paediatric Surgical Services. Provides most major diagnostic and treatment procedures on ASA categories 1 to 8 children excluding complex major (^{(1)}) paediatric surgery on rare complex congenital malformations (frequency of less than one in 2,500 births). Specialist Surgeons (^{(2)}) (paediatric), General Surgeons (^{(3)}) credentialed in paediatric surgery, and Specialist Anaesthetists (^{(4)}) (paediatric) on call 24 hours. Participates in undergraduate and postgraduate teaching. Paediatric support offered to other units within the Area. Training positions for Paediatric Nurses. Paediatric Registrar (^{(5)}) on call 24 hours. Surgical Registrar (^{(6)}) on call 24 hours. Access to CNC (^{(7)}) is desirable. May have teaching and research role. Rostered allied health professionals, including recreational therapy and educational services.</td>
<td>Path: 5 5 5 5 5 5 5 5 6</td>
</tr>
<tr>
<td>6</td>
<td>As Level 5 plus has subspecialty units in most areas of Paediatric Surgery (e.g., may have paediatric neurosurgery, cardiac surgery). Provides a statewide service. Active program of undergraduate and postgraduate teaching, research and development. Paediatricians and Specialist Surgeons (^{(8)}) (paediatric) with subspecialty interests on call 24 hours. Designated Paediatric Surgical Registrars (^{(9)}) in subspecialty units. Has research and specialist paediatrics teaching role.</td>
<td>Path: 6 6 6 6 5 5 6 6</td>
</tr>
</tbody>
</table>

---

\(^{(1)}\) See "Indicative List of Paediatric Surgical Procedures" in Appendix III

\(^{(2)}\) See "Levels of Anaesthetic Risk - Children" in Appendix II

\(^{(3)}\) See "Medical and Nursing Staff Definitions" in Appendix I

\(^{(4)}\) See "Glossary" in Appendix V

\(^{(5)}\) Adult CGU - not applicable
## Appendix 4: Equipment Requirements In Designated Level 1-3 Paediatric Medical Facilities

### General Essential Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broselow™ Tape</td>
<td></td>
</tr>
<tr>
<td>Infant Scales</td>
<td></td>
</tr>
</tbody>
</table>

### Airway

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposable Oropharyngeal Airway (Guedels)</td>
<td>00, 0, 1, 2</td>
</tr>
<tr>
<td>Nasopharyngeal Airway</td>
<td>Sizes 6,7</td>
</tr>
<tr>
<td>Introducer</td>
<td>Small and medium paediatric Bougie or Introducing Stylet (6FG, 10FG)</td>
</tr>
<tr>
<td>ETT</td>
<td>2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 &amp; 6.0</td>
</tr>
<tr>
<td>Laryngoscope</td>
<td>Small handle with batteries blade sizes 0,1, 2, 3</td>
</tr>
<tr>
<td>Oropharyngeal rigid sucker</td>
<td>Yankeur Sucker - sizes small and large</td>
</tr>
<tr>
<td>Y Suction Catheters</td>
<td>Sizes FG6, FG8, FG10</td>
</tr>
<tr>
<td>Suction Tubing</td>
<td></td>
</tr>
<tr>
<td>Suction Unit</td>
<td></td>
</tr>
<tr>
<td>Tape</td>
<td>Leukoplast ‘Zinc Oxide’ (Brown) 1 inch roll</td>
</tr>
<tr>
<td>Magill’s Forceps</td>
<td>Infant (18cm) and Child (20cm)</td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>Laerdal Stifneck™ Pedi-Select Collar, Baby ‘No-neck’</td>
</tr>
<tr>
<td>Nasogastric Tube</td>
<td>FG 8, FG 10, FG 12</td>
</tr>
</tbody>
</table>

### Breathing

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen Mask (Hudson)</td>
<td>Paediatric</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
</tr>
<tr>
<td>Nasal Prongs</td>
<td>Infant</td>
</tr>
<tr>
<td></td>
<td>Paediatric</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
</tr>
<tr>
<td>Oxygen Head Box</td>
<td>Non-disposable or disposable Infant Head Box</td>
</tr>
<tr>
<td>Non – Rebreather Oxygen Mask</td>
<td>Paediatric</td>
</tr>
<tr>
<td></td>
<td>Adult</td>
</tr>
<tr>
<td>Self-inflating Resuscitation Bags</td>
<td>Preterm (240ml)</td>
</tr>
<tr>
<td></td>
<td>Paediatric (450ml)</td>
</tr>
<tr>
<td></td>
<td>Adult (1500ml)</td>
</tr>
<tr>
<td>Transparent Silicon Resuscitator Masks</td>
<td>Sizes 00, 0, 1, 2, 3, 4</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>Paediatric</td>
</tr>
<tr>
<td>Pulse Oximeter with Pleth (waveform)</td>
<td>Sensors (Probes): Infant, ear, finger and or forehead sensor’ Disposable infant, child sensors</td>
</tr>
<tr>
<td>Oximeter Tape [eg Coban™]</td>
<td></td>
</tr>
<tr>
<td>Volume Spacer Mask</td>
<td>Large and small; with mouthpiece and facemask</td>
</tr>
<tr>
<td>Nebuliser Mask</td>
<td>Paediatric &amp; adult</td>
</tr>
<tr>
<td>Oxygen tubing</td>
<td></td>
</tr>
</tbody>
</table>
## Circulation

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amethocaine 4% and EMLA</td>
<td></td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Paediatric friendly</td>
</tr>
<tr>
<td>Antimicrobial Swipes</td>
<td></td>
</tr>
<tr>
<td>Cannula</td>
<td>14g, 16g, 18g, 20g, 22g &amp; 24g</td>
</tr>
<tr>
<td>Syringes</td>
<td>2ml, 5ml, 10ml, 20ml</td>
</tr>
<tr>
<td>Pathology Tubes</td>
<td>Paediatric tubes &amp; Blood Culture Bottles</td>
</tr>
<tr>
<td>Needleless T Piece Extension Tubing</td>
<td>X 3</td>
</tr>
<tr>
<td>Indwelling Urinary Catheter</td>
<td>FG6, FG8, FG10, FG12</td>
</tr>
<tr>
<td>Arm Boards (’Parker Babyboards’)</td>
<td>Paediatric</td>
</tr>
<tr>
<td>IV Giving Set</td>
<td>(To suit IV infusion device)</td>
</tr>
<tr>
<td>Burette</td>
<td></td>
</tr>
<tr>
<td>Intravenous Solutions (500ml bags)</td>
<td>0.9% Saline, N/2 + 2.5% Dextrose</td>
</tr>
<tr>
<td>Intravenous infusion pump</td>
<td></td>
</tr>
<tr>
<td>Intraosseous Needle</td>
<td>EZ-IO™ Paediatric (3-39kg) and Adult (39KG+)</td>
</tr>
<tr>
<td>Three Way Tap</td>
<td>X3</td>
</tr>
<tr>
<td>Extension Tubing</td>
<td></td>
</tr>
<tr>
<td>Adhesive Tapes</td>
<td>Brown Tape ½ inch, 3” Elastoplast™, Paediatric IV site dressing</td>
</tr>
<tr>
<td>Manual Sphygmanometer</td>
<td>Child &amp; infant cuff</td>
</tr>
<tr>
<td>Oscillometric Sphygmanometer (eg ‘Dynamap’)</td>
<td>Neonatal, Infant, Child, Small Adult, Adult Size</td>
</tr>
<tr>
<td>Cardiac monitor</td>
<td>Paediatric ECG electrodes &amp; leads</td>
</tr>
<tr>
<td>Defibrillator</td>
<td>ECG Paper</td>
</tr>
<tr>
<td>Glucometer</td>
<td>Paediatric Paddles &amp; Pads</td>
</tr>
</tbody>
</table>

## Disability

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Scale</td>
<td>Modified (paediatric)</td>
</tr>
<tr>
<td>Neuro Torch</td>
<td></td>
</tr>
</tbody>
</table>

## Environment, Comfort & Safety

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thermometer</td>
<td>Axilla Probe, Braun™ (Welch-Allen) Tympanic Thermometer</td>
</tr>
<tr>
<td>Heat Source</td>
<td>Over Head Heater or other heat source (optional)</td>
</tr>
<tr>
<td>Distraction Activities Box (eg ‘TLC’)</td>
<td>1ml, 3ml, 5ml, 10ml</td>
</tr>
<tr>
<td>Oral use only Medication Syringes</td>
<td>Bunny Rugs, cot sheet &amp; blankets</td>
</tr>
<tr>
<td>Cot/Bed with rails insitu</td>
<td>Disposable Bottle &amp; teat, feeding cup</td>
</tr>
<tr>
<td>Infant formula</td>
<td>Ice blocks and solution</td>
</tr>
<tr>
<td>Oral Rehydration Solution [Gastrolyte™, Hydrolyte™ or similar]</td>
<td></td>
</tr>
<tr>
<td>Trial of Oral Fluids Chart</td>
<td>Ice blocks and solution</td>
</tr>
<tr>
<td>Scales (1g increments)</td>
<td>To weigh nappies</td>
</tr>
<tr>
<td>Disposable nappies</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Anaesthetic Equipment Required By Designated Level 1-3 Paediatric Surgical Services

Anaesthesia equipment must comply with the Australian and New Zealand College of Anaesthetists Professional Document T1 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites and Other Anaesthetising Locations*. Specific requirements to include:

- Appropriate equipment for the needs of infants and children.
- Climate control and equipment designed to meet the special needs of small children so that body temperature is maintained throughout the perioperative period.
- Monitoring equipment which complies with College Professional Document PS18 *Monitoring during Anaesthesia* and is suitable for use with infants and children.
## Appendix 6: Indicative List of Paediatric Surgical Procedures & ASA Classification

<table>
<thead>
<tr>
<th>MINOR SURGICAL PROCEDURES</th>
<th>MAJOR SURGICAL PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suture of laceration</td>
<td>• Neonatal surgery</td>
</tr>
<tr>
<td>• Excision of skin lesion</td>
<td>• Major reconstructive surgery (anorectoplasty, rectosigmoidectomy, etc)</td>
</tr>
<tr>
<td>• Drainage of abscess</td>
<td>• Pyeloplasty</td>
</tr>
<tr>
<td>• Circumcision (ie any operation which in competent hands takes less than half an hour)</td>
<td>• Thoracotomy</td>
</tr>
<tr>
<td></td>
<td>• Lymphangioma</td>
</tr>
<tr>
<td></td>
<td>• Ureteric reimplantation</td>
</tr>
<tr>
<td></td>
<td>• Fundoplication</td>
</tr>
<tr>
<td></td>
<td>• Splenectomy</td>
</tr>
<tr>
<td></td>
<td>• Cleft lip/palate surgery</td>
</tr>
<tr>
<td>MODERATE COMPLEXITY</td>
<td>• Herniotomy in the first year of life</td>
</tr>
<tr>
<td>• Pyloromyotomy</td>
<td>• Orchidopexy in the first year of life</td>
</tr>
<tr>
<td>• Herniotomy after the first year of life</td>
<td>• Burns grafting</td>
</tr>
<tr>
<td>• Orchidopexy after the first year of life</td>
<td>• Urethroplasty</td>
</tr>
<tr>
<td>• Appendicectomy</td>
<td>• Operative reduction of intussusception</td>
</tr>
<tr>
<td></td>
<td>• Closure of colostomy</td>
</tr>
<tr>
<td></td>
<td>• Insertion of central line in first two years of life (ie any procedure which in the hands of competent surgeon takes more than one hour)</td>
</tr>
</tbody>
</table>

**Note:** The procedures listed are indicative of the complexity of surgical activity in each category.

The actual range of procedures which may be performed by individual practitioners appointed to a general or subspecialty surgical services of a given level will be determined through the credentialing process at which clinical privileges are granted.

*Acknowledgement is given to the Royal Australasian College of Surgeons (Paediatric Surgeons) for assistance with the indicative list of paediatric surgical procedures. The procedures and their ranking are based on complexity definitions of the Board of Paediatric Surgery of the PAVS.*

**Source:** NSW Health (2002) *Role delineation of Health Services 3rd Edition* p.99
Appendix 7: Level of Risk (0 – 14 yrs Inclusive)

Classification of physical status for pre-operative assessment

| ASA 1 | Healthy child |
| ASA 2 | Child with mild systemic disease – no functional limitation |
| ASA 3 | Child with severe systemic disease – definitive functional limitation |
| ASA 4 | Child with severe systemic disease – that is a constant threat to life |
| ASA 5 | Moribund child not expected to survive 24 hours without an operation |

*With acknowledgement to the American Society of Anaesthetists*

*Source: NSW Health (2002) Role delineation of Health Services 3rd Edition p.94*

Appendix 8: Acknowledgements

The NSW Department of Health extends its appreciation to the members of the Paediatric Inpatient Advisory Working Group for their input, advice and assistance in production of this document.
CHILDREN AND ADOLESCENTS - CARE IN ACUTE CARE SETTINGS

PURPOSE

This policy and the attached Guidelines for the Care of Children and Adolescents in Acute Care Settings are aimed at achieving the best possible paediatric care in all parts of the State. Hospitals, in partnership with clinicians, should aim to ensure services are provided at a level equivalent to that described in the Guidelines. Each patient should be individually evaluated and a decision made as to where the child should be hospitalised in order to achieve the best clinical outcome.

MANDATORY REQUIREMENTS

This policy applies to all facilities that provide services for children and adolescents. It requires all Health Services to have local protocols or operating procedures based on the attached guideline in place in all hospitals and facilities where services for children and adolescents are provided.

IMPLEMENTATION

Roles and Responsibilities

Directors of Clinical Governance are required to inform relevant clinical staff in all departments that provide services for children and adolescents of the policy.

Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

Health professionals should use the Guidelines to ensure that local communities have access to a range of services which are appropriate to their needs. The Guidelines for the Care of Children and Adolescents in Acute Care Settings should be read in conjunction with relevant documents from the Department such as the Guide to the Role Delineation of Health Services NSW Health Department, (2002).

INTRODUCTION


The NSW Department of Health, in collaboration with the Paediatric Inpatient Advisory Working Group, believed it was timely for the Guidelines to be reviewed and revised to incorporate contemporary practice issues for the care of children and adolescents in acute care settings.

The Guidelines are aimed at achieving the best possible paediatric care in all parts of the State. The document should not be seen as a stringent set of rules to be applied without the clinical input and discretion of the managing professionals. Health professionals should use the Guidelines to ensure that local communities have access to a range of services which are appropriate to their needs. Hospitals, in partnership with clinicians, should aim to ensure services are provided at a level of safety equivalent to that described in the Guidelines. Each patient should be individually evaluated and a decision made as to where the child should be hospitalised in order to achieve the best clinical outcome.

The Guidelines for the Care of Children and adolescents in Acute Care Settings should be read in conjunction with relevant documents from the Department such as the Guide to the Role Delineation of Health Services (NSW Health Department, (2002). The paediatric section of the Guide to the Role Delineation of Health Services is included in the list of resource documents provided at Appendix 2.
Role delineation allows for flexibility in order for Health Service Managers to respond to local health needs. Similarly, the Guidelines are not intended to be followed uncritically and inflexibly by hospital administration and clinicians. Instead, consideration should be given to the distance from a major centre, severity of illness, availability of local expertise and services available through networking and the needs of the child and family. This is of particular relevance in the rural setting.

The definition of a child in this planning document is any person under the age of 16 years, neonates excluded. It is acknowledged that adolescents are defined as those of an age 12-18 years. Discretion should be applied in relation to adolescents older than 16 years. Clinical judgement/previous paediatric admissions should be considered when deciding if the older adolescent is suitable for accommodation in a paediatric unit.

Services should deliver safe and appropriate care, and meet the cognitive needs of the child or adolescent. The Guidelines do not address the special needs of adolescents or services for the newborn. Some resource documents which address these age groups are listed in Appendix 3.

Issues for Consideration When Caring for Children and Adolescents in NSW Health Facilities

- Children and adolescents account for 23% of presentations to emergency departments and for 14% of admissions to public hospitals in NSW.\(^8\)

- In order to best meet the needs of these children and adolescents and their carers, a number of models of care have been developed in NSW health facilities and are supported by the Child Health Networks. Many of these models incorporate significant components of ambulatory care linked with programs such as Hospital in the Home. While these Guidelines focus on meeting the needs of children and adolescents in acute health care settings, planning and service delivery should not be done in isolation of ambulatory care and other service models.

- Technology is increasingly used to support the delivery of health care to children and young people. Telehealth can be a valuable tool in linking local services with more specialised services, to enable safe and effective delivery of services in addition to staff training and support.

- The Child Health Networks have a critical role in facilitating ongoing staff development and education opportunities in order to build local capacity.

- Health care delivery should be multidisciplinary and shared care models developed to address the needs of children and adolescents with chronic and complex health problems.

- Opportunities to engage consumers and carers in service planning and delivery should be explored. Parent and family advisory groups and consumer engagement through Area Health Advisory Councils are two approaches that are in place in NSW. Special needs of groups from other cultures and religions should also be considered.

- Inpatient units for children and adolescents have different requirements from those focussed on the care of adults. There are a range of factors impacting on the physical layout, staffing levels and skills, treatments and length of stay including developmental stage and ability, dependence, supervision, relationships between the patient and staff and the family and staff, child protection issues, education requirements and co-morbidities.

\(^8\) Source: HIE (ED_Visit); Date Extracted: 13th July, 2009
2. PAEDIATRICS

- Health facilities should accommodate children and adolescents in the most appropriate setting. Services with role delineation of Level 3 and above for Paediatric Medicine need to have a designated paediatric ward.

- All staff working with children must engage in staff development activities. These may be undertaken locally or could be linked, through the Child Health Networks, to more specialised facilities. Specific education and training is required to become, and maintain the status of, a competent paediatric nurse.

- All staff working with Aboriginal children must consider their specific needs, consult with experts to seek advice and support and utilise the NSW Health Aboriginal Health Impact Statement and Guidelines to guide policy and service delivery.

**Definition of Key Terms**

- **Child**: For the purposes of these Guidelines, a child is defined as anyone under the age of 16 years.

- **Adolescents**: Adolescents are defined as those of an age 12-19 years.

- **Acute care facility**: An acute care facility provides immediate care for trauma and injuries, severe or sudden illness, or recovery from surgery. Generally, stays are brief in acute care and patients are sent home, are managed through ambulatory care or are transferred to non-acute facilities.

- **Ambulatory care**: All care, including diagnosis, observation, treatment and rehabilitation that are provided outside the inpatient setting. Ambulatory care services include programs such as Hospital in the Home (HITH) and Paediatric Outreach Services.

- **Swing beds**: Facilities may consider the use of ‘swing beds’ [beds that can alternate between different types of care] in service considerations and capital redevelopments, particularly to allow for the seasonal variability of paediatric admissions. Swing beds allow the temporary closure of beds during non-peak periods without a reduction in optimum staff/patient ratios. The bed/s are located within the ‘ward or unit’ and are satisfactorily shielded from the general ward area to ensure privacy from other patients. The beds are readily accessible to staff from either the general or paediatric ward area.

- **Role delineation**: Is a process which determines what support services, staff profile, minimum safety standards and other requirements are provided to ensure that clinical services are provided safely and appropriately supported.

- **Child Health Networks**: Networked paediatric services which enable high quality clinical care as close as possible to home for all children and adolescents, supported by common care guidelines, with staff training and development.

- **Competent Paediatric Nurse**: A definition of a Competent Paediatric Nurse, defined by the Australian Confederation of Paediatric and Child Health Nurses, in *Competencies for the Specialist Paediatric and Child Health Nurses* is available at: [http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf](http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf)

**AIMS AND OBJECTIVES**

The aims and objectives of the Guidelines are:

- To provide safe, effective and appropriate care for children and adolescents in acute care settings.

- To concentrate those paediatric services requiring special facilities or skills in hospitals which can provide those services more effectively and efficiently, offering a network of support for hospitals in rural and remote areas.

90(03/06/10)
To recognise the special requirements of children and adolescents in ambulatory services (such as emergency, x-ray and pathology), operating theatres and allied health services.

To recognise the special psychological needs of children and adolescents in hospital and encourage the carer\(^9\) to participate in the child’s care as appropriate, especially in the provision of emotional support during times of high stress.

GUIDELINES

General

A child or adolescent should only be hospitalised if clinically appropriate and necessary.

Community-based services, hospital in the home programs and other ambulatory care/outreach services, if available, should be used to assist in the care of children and adolescents at home.

Hospital admission should not be a strategy solely for providing supervised care placements for children and adolescents. Children and adolescents in the predicaments of homelessness or breakdown in care should only be admitted if there are specialist health assessment requirements or therapeutic goals that are best achieved by inpatient care.

The use of single rooms for children and adolescents, especially under the age of five years, should be considered with respect to clinical need, developmental stage and risk management strategies.

In cases of unplanned or emergency admissions to hospitals with paediatric medicine or surgery services delineated at levels 1 - 3, consultation with a specialist paediatrician should occur without delay if there is any degree of concern, especially in a situation where the child is not improving, as per NSW Health Policy ‘Management of Paediatric Inpatient Admission in Designated Level 1 - 3 Paediatric Medicine and Paediatric Surgery Services’. For a child whose condition is unstable, this consultation should occur immediately.

This enables a decision to transfer a child to a higher level facility, if clinically appropriate, to be set in place early. This decision will consider the child’s clinical condition, the degree of isolation, the medical and nursing expertise, the hospital’s delineated role and the advice of a specialist paediatrician.

Where children and adolescents require family respite care rather than clinical treatment, collaboration with NGOs, the Department of Ageing, Disability and Home Care or the Department of Community Services in more appropriate arrangements should be pursued.

A hospital admitting children and adolescents must have at least one registered nurse delivering care or directly supervising the nursing care of children and adolescents with skills consistent with the following\(^{10}\):

- is able to assess a child’s normal parameters, recognise the deviations from the normal and act appropriately on the findings.
- demonstrates a broad knowledge of growth and development.
- demonstrates an understanding of the effects of hospitalisation on the child and family.

90(03/06/10)

\(^{9}\)A carer refers to a parent, guardian or significant other caregiver.

\(^{10}\)Refer to the description of a ‘Competent Paediatric Nurse’ by the Australian Confederation of Paediatric and Child Health Nurses available at: [http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf](http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf)
communicates effectively and works in partnership with children and adolescents and families.
• demonstrates knowledge of paediatric medical and surgical conditions and their management relevant to their casemix.
• is able to commence and maintain effective Basic Paediatric Resuscitation.
• is able to calculate and administer medications safely to children and adolescents.
• recognises and challenges management that compromises the child’s safety.
• utilises contact with the child and family to promote child health; ie. Immunisation, child safety.
• demonstrates an awareness and acts accordingly to the Children and Young Persons’ (Care and Protection) Act, 1998, NSW.
• integrates the philosophy of Partnership in Care into their clinical practice.
• demonstrates psychological assessment skills to identify children and adolescents at risk of harm.

The duration of a hospital stay, particularly for a young child, should be as brief as possible.

Day surgery and ambulatory clinics can play a valuable role in minimising the period of hospitalisation. Day of Surgery Admission (DoSA) should be the preferred mode of admission for planned surgical procedures, if clinically appropriate. These services should utilise preparatory material to assist the child in preparing for the surgery, such as online software, DVDs etc as per the NSW Health Policy ‘Management of Paediatric Inpatient Admission in Designated Level 1 - 3 Paediatric Medicine and Paediatric Surgery Services’.

Availability of a range of primary health care, paediatric ambulatory care and other services, such as Hospital in the Home enables earlier discharge from hospital, as does the involvement of carers.

Adequate, relevant and timely information should be provided by hospital staff to carers and other significant family members.

Appropriate integration and coordination of hospital and community-based services will both improve the care for children and adolescents and decrease the need for hospital admission.

Coordinated case management of children and adolescents with chronic and complex conditions should be aimed at improving the care the child and carer(s) receive and reducing the need for hospitalisation.

Special Needs of Children and Adolescents in Acute Care Settings

Special needs of children, adolescents and their families, whether in-patients or outpatients, must be addressed to minimise physical and emotional distress. Special needs may include the use of Aboriginal liaison officers, interpreters for children, adolescents and their families from culturally and linguistically diverse backgrounds, addressing the needs of adolescents and children with developmental delay or other special family circumstances.

The special needs of the unaccompanied child should be recognised and provided for, including the provision of an alternative care giver (eg. the Hospital Ward Grandparent Scheme coordinated by the Association for the Wellbeing of Children in Healthcare where available).

The acuity of a sick child will determine the nursing care requirements and the observations required.
2. **PAEDIATRICS**

Emergency departments and outpatient departments of all hospitals treating children and adolescents:

a. should ensure that the security and safety needs of children and adolescents are addressed.

b. should minimise waiting time for children and adolescents taking into account the guidelines stated in the National Triage Scale.

c. should ensure that processes for fast-tracking the care of children and adolescents are in place. This will include discussion with a paediatrician or a FACEM.

d. require appropriate staffing levels for times of peak demand.

e. should ensure the skills and competence of staff who are treating children and adolescents.

f. should ideally have a separate children’s waiting areas with play equipment that can be easily observed from a staff base and at least provide appropriate recreational activities for children and adolescents.

g. must have a separate area equipped with paediatric-sized equipment to conduct procedures such as correct sized oximeter probes, blood pressure cuffs, scales and thermometers.

h. utilise NSW Health Paediatric Clinical Practice guidelines where clinically relevant.

i. should ensure that planning for major events is undertaken and considers the needs of children and adolescents, eg. major sporting events being held.

j. should address infection control issues for paediatrics.

k. should develop appropriate models of care for addressing the needs of children and adolescents, similar to the Aged care Services in Emergency Teams (ASET) models.

l. design briefs for new or refurbished Emergency Departments should include the elements described above (3.2.4 f. and j.) with input from appropriately skilled medical and nursing personnel.

Hospitals admitting children and adolescents:

a. must not accommodate children and adolescents with adult patients. This means that adults and children and adolescents are not to be nursed in adjoining beds.

b. must have a child safety and security policy in place. Facilities should utilise the NSW Health policy on ‘Safety and security of children in NSW Acute Health Facilities’.

c. should not separate children and adolescents from their carer(s) at the time of admission, especially in the emergency situation, unless clinically indicated or due to child protection/parental inability to adhere to requests or aggression.

d. respect the privacy and dignity of children and adolescents at all times during their admission which involves the assumption that they do not have to sleep in the same room or ward bay as adult patients, or share bathroom or recreational facilities. Further, adult patients should not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents should not be asked to pass through an adult ward to access facilities. This is intended to protect children and adolescents from unwanted exposure, including casual overlooking or overhearing.

e. must consider the issue of gender specific accommodation. For many children and adolescents, clinical need, age and stage of development will usually take precedence. Many children and adolescents take comfort from sharing with others of their own age and this may outweigh any concerns about mixed gender accommodation.

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f. may utilise a multi-purpose ward with the potential of changing function according to needs can be used to accommodate fluctuation in demand for paediatric beds. For example, “swing beds” can be positioned between two units (e.g. Paediatric and medical), capable of being transferred from one unit to another and remain fully operational.

The main issue with multi-purpose wards is the provision of appropriately skilled nursing staff. Health services should have polices, guidelines and risk management strategies in place to ensure the safety of children and adolescents when admitted.

g. should allow access for carers at all times if clinically appropriate while the child is receiving care and during procedures while the child is conscious, as agreed between the carer and the health professional.

h. should provide facilities for at least one adult carer to stay at the bedside or in reasonable proximity, e.g. lounge chair, sofa bed or folding bed, and amenities including shower/toilet facilities and access to a kitchenette.

i. should regard the carer as an integral part of the multidisciplinary team and a primary care-giver, though not as a replacement for a health professional.

j. should have a flexible visiting policy with regard to hours and number of visitors, encouraging family members to visit when possible.

k. should aim to allocate consistent nursing services that promote continuity of care and includes shared care with the carer.

l. should have a daily hospital routine flexible enough to allow the child to engage in structured and spontaneous play activities at times as close as possible to their home routines.

m. should enable schooling to be continued using media such as books, the internet, video or appropriately qualified personnel where the child’s condition allows. Children and adolescents with chronic health conditions should have an integrated approach to the delivery of their education needs in partnership with the NSW Department of Education. Level 4 - 6 facilities for children and adolescents should have generalist teachers available to deliver at least some of the school curriculum where this is achievable in the context of the child or adolescents health care plan.

n. will provide access to interpreters when necessary.

o. should provide access to the appropriate multicultural health worker/Aboriginal health worker when necessary.

p. should have a menu designed with appropriate input from a hospital dietitian taking into account the specific nutritional requirements of sick and growing children and adolescents as well as any ethnic/cultural food preferences/requirements of children and adolescents.

q. should notify and encourage carers to be present when a child is to be transferred between wards or hospitals.

r. should develop pathways to appropriate community and sub-speciality services, and transfer to appropriate local services for ongoing care when clinically indicated.

s. should fully inform carers at discharge about the diagnosis, medication and future management of the child. A summary of the child’s hospitalisation should be provided to the carer(s), general practitioner and/or specialist medical officer.

t. should provide for the special needs of the dying child and his/her family.

90(03/06/10)
2. PAEDIATRICS

u. should have a policy on and guidelines for transition to adult care\(^\text{1}\) which:
   - requires that, at least by the age of 16, an individual plan to appropriate adult services is prepared. This plan may link to regional/remote services and must include communication pathways
   - identifies that from 16 - 18 years is the ‘active transition phase’
   - recognises the importance of family centred care while assisting the young person to establish independence
   - considers the developmental issues of the young person
   - describes resources to support the child, family and health professionals with the transition and considers the availability of services especially multidisciplinary services
   - describes the methods for clinical handover
   - identifies the age range of 18 years or after a child has completed high school as when the transition should be completed

A hospital routinely admitting children and adolescents for elective procedures should, in addition to the above:

a. consider the design of the accommodation for children and adolescents to ensure it meets safety and risk management requirements. This may include having separate accommodation areas for adults and children and adolescents. If a separate area is not available, staff should consider scheduling children and adolescents having elective surgery at a time which is different to procedures being performed on adults.

b. provide carers and, where appropriate, the child with adequate information about the admission.

c. offer pre-procedure preparation, eg. pre-admission visits, videotape, DVD, or pamphlets providing information about the intended procedures appropriate to the child’s age, development and understanding.

d. have trained salaried play specialists and/or voluntary play specialists and/or appropriate resources.

e. has at least one registered nurse delivering care or directly supervising the nursing care of children and adolescents with skills consistent with a competent paediatric nurse\(^\text{2}\).

A hospital with an Area role in providing paediatric support to other units should, in addition to the above:

a. have at least one paediatric Clinical Nurse Consultant.

A designated children and adolescents’ area or ward should:

a. address special safety and security aspects for accommodating children and adolescents.

b. be easily observed and supervised at all times (preferably through staff attendance at the child’s bedside or treatment area)

c. have treatment areas that:
   - are functionally separate and minimise access to distressing sights and sounds which are not appropriate to their age or stage of development

\(^{1}\) NSW Health: Transition Care - Helping young people move successfully from child to adult health services. Available at: http://www.aci.health.nsw.gov.au/networks/transition-care

\(^{2}\) Refer to the description of a ‘Competent Paediatric Nurse’ by the Australian Confederation of Paediatric and Child Health Nurses available at: http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf

90(03/06/10)
2. **PAEDIATRICS**

- include a separate area for conducting painful procedures.

d. provide play facilities in and out of the ward, including outdoor areas.
e. have appropriate decorations, furniture, equipment and ample light.
f. provide communication access for the child if age appropriate eg telephone or computer access.

A designated adolescent area or ward should have:
a. consulting and examination areas which enable privacy and confidentiality.
b. suitable recreation facilities.
c. educational access.
d. skilled nurses with developmental and psychosocial expertise.
e. multidisciplinary team support
f. age appropriate rest and meal times.

### Children and Adolescents Requiring Surgery

Paediatric surgery should be provided by surgeon(s) and anaesthetists with experience and/or qualifications in the relevant fields of paediatric surgery as determined by the hospital’s credentialling process. The surgeon(s) and anaesthetists should be involved in appropriate continuing education activities relevant to their clinical paediatric practice.

Surgery for children under the age of one month should be carried out in a hospital with delineated role of level 5 or above for paediatric surgery and for children over the age of one month but under the age of 12 months should be carried out in a hospital with delineated role of level for paediatric surgery service of 4 or above by medical staff with appropriate paediatric experience and/or qualifications as determined by the hospital’s credentialling process; and at least one registered nurse with skills consistent with a competent paediatric nurse delivering care or directly supervising the nursing care of children.

Hospital staff need to consider, and as appropriate arrange for, the follow-up care required for the child or adolescent to receive after discharge, such as allied health and community nursing, to enable safe discharge home.

The advice of a paediatrician or paediatric surgeon should be readily available. There should be a medical officer available within 10 minutes. For any surgical procedure in this age group, adequate monitoring by both medical and nursing staff is essential to prevent complications of either surgery or anaesthesia intra and post-operatively.

There should be arrangements for separation of adult and child patients both in operating theatres and recovery ward (eg. through use of screens).

There should be adequate paediatric medical and surgical equipment in the operating room including:
a. appropriate heating facilities in the operating room. An overhead heater and humidicrib for the younger infants

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1 Refer to the description of a ‘Competent Paediatric Nurse’ by the Australian Confederation of Paediatric and Child Health Nurses available at: [http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf](http://www.chnwa.org.au/Portals/0/docs/ACPCHN.pdf)
b. a separate instrument tray for children and adolescents (assembled with advice from a surgeon with appropriate experience and/or qualifications in paediatric surgery)
c. mobile x-ray facilities should be available.
d. a defibrillator with adaptors for paediatric use
e. suitable anaesthetic equipment for special paediatric use
f. paediatric resuscitation equipment
g. adequate adaptors for all other surgical and recovery equipment needed to perform paediatric surgery and permit safe recovery

Anaesthesia and related post-operative treatment including pain management should be provided by an anaesthetist with appropriate experience and/or qualifications in paediatric anaesthesia, as determined by the hospital’s credentialling process; unless a life threatening emergency makes this impossible.

Hospitals in which surgery is performed on children and adolescents should have ready access to appropriate radiology and pathology services.

Carers should be able to accompany their child to the operating theatre and have access to the recovery room. In addition, when agreed between anaesthetist and carer, the choice is offered to the carer to be with the child at the induction of the child’s anaesthetic, unless medically not indicated.

All hospitals admitting children and adolescents should provide a comprehensive range of resuscitation equipment and inhalation therapy equipment suitable for children and adolescents. Local policy should be developed regarding the specific equipment and staff training in its use. Guidelines from the Australian and New Zealand College of Anaesthetists can assist with development of local policy.

Paediatric infusion sets with an inline burette must be used for all children requiring intravenous therapy. An infusion pump should be used for all children.

All intravenous fluids should be administered from containers of 500mls or less.

All facilities undertaking surgery should have contingency arrangements for the transfer of a child to a specialised paediatric unit (level 5 or 6) in case of an emergency.

When clinically appropriate children admitted under the care of non paediatric surgeons should be assessed by a paediatrician (to assess for non-surgical-related general paediatric condition/s).

**Mental Health**

The great majority of children and young people with mental health problems who receive treatment do so in a community setting. Child and adolescent mental health services (CAMHS) must be strongly integrated across community and hospital settings.

**Day programs**

Day programs are a means of providing more intensive treatments in a community-based setting.

This level of care can provide a “step-up or step-down” approach between usual community programs and inpatient care or can be a less restrictive option to inpatient care in some circumstances. For some young people, day programs may obviate the need for more restrictive inpatient care. For some, they may afford “step-down” rehabilitation following acute inpatient care.
Like all other CAMHS, day programs need to be family-focussed.

Planning for day programs also requires collaboration with the Department of Education and Training to provide educational and vocational options and access to specialist education expertise.

**Inpatient care**

It is imperative to provide mental health treatment in the least restrictive setting, close to home wherever possible, with minimal disruption to the patient’s family, community supports, networks and relationships.

While acknowledging the three geographical network arrangements for paediatric services, with their hubs at the three paediatric hospitals (Sydney Children’s, John Hunter Children’s and The Children’s Hospital at Westmead), CAMHS inpatient unit role delineation is a separate process.

**Telepsychiatry and outreach**

Telepsychiatry can be a useful tool and is encouraged to improve continuity of care across services especially in planning transitions to and from inpatient care and to provide specialist consultation and support.

**Consultation-liaison to non-specialist settings**

When young people are admitted for mental health assessment and treatment to a setting other than a specialist child and adolescent mental health inpatient unit, there should be liaison with the supporting CAMHS. The clinical arrangements will vary according to local staffing profiles. Where child and adolescent psychiatrists are available in an Area, children or adolescents could be admitted under their care. In many sites, this arrangement is not feasible and it is more appropriate for patients to be admitted under the care of paediatricians or general (adult) psychiatrists with identified CAMHS consultation.

- The “Whatever Info Guide” has been developed for children and adolescents who are experiencing a mental health problem and have been admitted to a paediatric unit or other inpatient setting. It is an interactive guide to support the young person by providing them with important information about the ward, what to expect while they are in hospital, and to assist them in planning for their discharge. The guide has been distributed for use in paediatric, mental health and general inpatient settings around NSW.

In addition to support for children and adolescents whose primary presentations are mental health problems, Areas need to provide other forms of consultation-liaison mental health support for high-risk groups, including advice for those caring for children and adolescents with:

- comorbid mental health and physical health problems;
- comorbid mental health problems and problems related to alcohol and other drugs;
- mental health problems complicating their physical health care;
- chronic or severe physical health problems, especially neurological disorders;
- psychosomatic presentations.

**“Specialling” or 1:1 nursing care**

The fact that a child requires 1:1 nursing care (sometimes known as “nurse specialling”) for a period is not automatically an indication that the child needs to be transferred to a specialist mental health unit.
In specialist child and adolescent mental health inpatient units, where specialling can lead to an escalation of high-risk behaviour amongst other young patients, the emphasis is on high staffing levels for the whole unit, to minimise escalating risk behaviour and decrease the need for specialling.

Nurses providing specialling should be appropriately qualified.

Non-Mental Health wards in paediatric hospitals

The range of specialist staff available in paediatric hospitals means that these settings are the most appropriate for some children and adolescents with severe and complex problems or physical presentations requiring investigation and/or treatment. This care option complements the more intensive multi-component mental health interventions that can be provided in declared specialist acute child and adolescent mental health units in paediatric and other hospitals.

As an example, The Children’s Hospital at Westmead provides specialist inpatient treatment for a number of young patients with eating disorders in their Adolescent Medical Ward rather than the specialist acute mental health unit on Hall Ward. The service model is an integrated shared care program between Adolescent Medicine and the Department of Psychological Medicine.

Specialist Acute CAMHS Inpatient Units

Specialist child and adolescent mental health inpatient services are subspecialty programs, providing more intensive multidisciplinary assessment and treatment. The combinations of effective treatments required in these settings necessitate a higher level of staffing than for adult units, both in absolute numbers and in level of expertise.

Higher staffing levels create flexibility to tailor treatment and observation for patients and allow a mix of children and adolescents with a more diverse range of problems and requirements. This flexibility can minimise the need to transfer some patients to other treatment settings including the potential to decrease some transfers and admissions to adult units.

Specialist inpatient units for children and adolescents have different requirements from those focussed on the care of adults. Factors impacting on physical layout, staffing levels and skills, treatment components and length of stay include:
- Mobility and physicality of patients;
- Peer relationships and group dynamics;
- Developmental stage and ability including cognitive ability;
- Dependence, supervision and staff responsibility;
- Working relationships between the patient and staff and the family and staff;
- Child protection issues and interagency care coordination;
- Sexuality;
- Family relationships, separation and visiting;
- Education requirements;
- Lack of symptom specificity/undifferentiated problems;
- Co-morbidity;
- Availability of post-discharge accommodation, supervision and treatment options.

All specialist CAMHS inpatient units should be integrated with special education services.

Inpatients in specialist units require access to a range of therapeutic interventions including group, family and individual assessments and treatment and tailored special education support. Exposure to appropriate expectations, social interactions and care by staff also provides modelling for young people and their families.
CAMHS teams should have the capacity to address co-morbidities and use interventions informed by available evidence. Interventions may include group, individual, family, pharmacological and systems interventions, separately, in combination or in sequence. Provision of the full range of interventions requires multidisciplinary expertise from a range of professions including:

- psychologists;
- nurses from relevant subspecialties;
- social workers;
- community/cultural mental health workers;
- psychiatrists;
- trainees in these disciplines; and
- access to expertise in occupational therapy, dietetics, physiotherapy, speech therapy, health promotion, drug and alcohol, paediatrics, general practice and other related specialties.

In addition to the above staffing profile, CAMHS inpatient units also require access to expertise from pharmacists, paediatric consultation-liaison and other subspecialties to provide comprehensive assessment and treatment for children and adolescents with more severe and complex problems.

There should be clear arrangements for specialist paediatric consultations, where required.

Conduct disorders, substance misuse and homelessness in childhood and adolescence are not absolute contraindications for inpatient care however the aims of hospitalisation should be clearly defined when admission is being considered. There is little evidence to suggest that treatments delivered during inpatient care are effective for children and adolescents with uncomplicated disruptive behaviour disorders however admission may be required to clarify diagnoses and to treat comorbid problems.

**Children’s Units**

The separation of children and adolescents receiving mental health inpatient care has been considered. The demand for mental health assessment and/or treatment for younger children (under 12 years) in an inpatient setting is less than for adolescents. The number of beds required statewide for this age-group is relatively small, however these children are likely to have more severe and complex problems and high needs.

For most children under 12 who require individual admission, care in a paediatric ward is indicated, with access to mental health consultation-liaison support to the treating paediatric team. The few who require more specialised inpatient mental health care than that available on a paediatric ward are likely to be best treated in a combined child and adolescent mental health unit.

Family/carer contact is an especially important requirement for the younger age-group.

**NSW Child Health Networks**

Acute care facilities providing services to children and adolescents should have established networks which focus on improving the quality of care to children and adolescents.¹²

The network should promote an integrated model of service delivery through the development of integrated service networks and common protocols.

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¹² NSW Health, Guidelines for Networking of Paediatric Services in NSW, 2002
Networks have been established to support local services through the provision of specialist clinical outreach services, development of shared treatment protocols and guidelines, staff rotation between services, professional training and development opportunities, support in times of peak demand and smoother transfer and referral of patients between services.

Networks should provide a mechanism to ensure the involvement of consumers, local clinicians, nurses, allied health and other children and adolescents’ service providers in service planning.

The networks should also assist in the provision of services across the continuum of care, including developing links between hospitals and must include GPs, private paediatricians and allied health service providers, community health and primary care services, early childhood services and other agencies with a responsibility for children and adolescents’ health and welfare.

The Child Health Networks’ have a pivotal role in developing and piloting innovative models of care to ensure care provided as close to home as possible and/or to avoid admission to hospital at all where clinically safe to do so.

**Education For Health Professionals**

Those involved in the care of children and adolescents should have special training to recognise and meet the special health, psychological and developmental needs of children and adolescents, and include training on recognition of the sick and deteriorating child.

Policies and procedures should be in writing and easily accessible by staff that are trained in their use.

Hospitals with an Area role in providing paediatric support and networking to other units should provide education and support for clinical activities for other facilities within the network.

Relevant and ongoing staff development programs should be:

a. child-oriented rather than task-oriented;
b. promote family-centred care and partnership in care; and
c. include initiatives to address the needs of carers as they become more involved with the child’s care in hospital.

All staff involved in the care of children should undertake cultural respect training to ensure that mainstream services are accessible and culturally secure and to increase the capacity of mainstream services to engage with Aboriginal children.

**Evaluation**

Continuing evaluation by the hospital of policies, programs for and outcomes of the care of children and adolescents is essential. This should:

a. involve staff at all levels and disciplines,
b. include the recipients of care, and
c. involve the community in general.

Elements of the evaluation should address the six dimensions of quality care outlined in the NSW Health document: *A Framework for Managing the Quality of Health Services in NSW*:

- Safety
- Consumer participation
PAEDIATRICS

Evaluation activities may include:

a. measurement of outcomes of care and service
b. peer review and morbidity and mortality meetings
c. patient and carer satisfaction
d. facilitated incident monitoring
e. sentinel event management
f. the effective use of clinical indicators
g. ad hoc audits/reviews
h. retrospective chart review.

APPENDICES

4.1 Acknowledgments

The NSW Department of Health extends its appreciation to the members of the Paediatric Inpatient Advisory Working Group and the Paediatric Inpatient Advisory Working Group Sub-Committee for their input, advice and assistance in production of this document.
### 39 PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Path</td>
</tr>
<tr>
<td>1</td>
<td>No planned inpatient paediatric medical service or designated beds. Provides primary and emergency care; and stabilisation for children prior to moving to appropriate higher level of service. Quality assurance activities. Licensed interpreters as per Circular 94/10.</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Designated paediatric inpatient in a general hospital in an outlying and geographically isolated area. May have isolation capacity. Accredited Medical Practitioner on call. Formal consultative links with Paediatrician. Would be used for only minor medical conditions or convalescence following referral from a higher level unit. RNs with skills consistent with a competent Paediatric Nurse. Continuing nursing educational programs available. Able to provide accommodation for parents or carers.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>As Level 2, plus designated paediatric ward/area with patient amenities. Has isolation capacity in separate rooms. Provides care for common medical conditions. NUM, preferably with post basic clinical qualifications or access to CNC within the Area and RNs with skills consistent with a competent Paediatric Nurse. Some RNs undertaking relevant postgraduate studies. Has 24-hour access to Medical Officer on site or available within 10 minutes. Access to allied health professionals. Formal link to community child and family health service. Formal quality assurance program.</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>As Level 3, Designated Director of Paediatric Medical Services, plus provides integrated hospital inpatient unit, non-inpatient family and child health services, and community health services for most paediatric medical conditions. Designated adolescent area. Specialist Paediatrician on call 24 hours. Paediatric support offered to other units within the Area. Designated Medical Officer. May have Paediatric Registrar or access to CNC within the Area. Access to Audiology services. Allied health professionals on site.</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>As Level 4, plus Specialised Paediatric Inpatient Unit. May have some paediatric subspecialty skills. Designated adolescent unit. Has Paediatric Registrar on site 24 hours. Active program of undergraduate and postgraduate teaching and research coordinated with a Level 6 service. Access to CNC is desirable. Rostered allied health professionals on staff, including recreational therapy. School teacher available.</td>
<td>5</td>
</tr>
</tbody>
</table>
### 39 PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>As Level 5, plus most paediatric medical and surgical sub-specialties available. Designated Adolescent Ward. Clinical and diagnostic services provided by appropriately trained Paediatric Specialists. Provides some statewide services. Subspecialty consultant on call 24 hours. Has designated Subspecialty Registrar. Provides 24 hour Child Protection Services with consultant Paediatrician and Social Worker. School service for inpatients provided by Department of Education. Has research and specialist paediatric teaching role,</td>
<td>Path: 6  Phar: 6  NPh: 6  NMed: 4  Anaes: 5  ICU: 2  CCU:</td>
</tr>
</tbody>
</table>
# 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Path</td>
</tr>
<tr>
<td>1</td>
<td>No planned inpatient paediatric surgical service. Provides primary and emergency care; and stabilisation of children prior to moving to appropriate higher level of service. Quality assurance activities(6). Interpreters as per Circular 94/10.</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Except in emergencies, children under the age of one year should not be admitted. Minor(1) elective and selected moderate(2) surgical procedures on ASA category 1 and 2(2) children over the age of 1 year performed by General Surgeons or Accredited Medical Practitioners(3) credentialed in paediatric surgery, and Specialist Anaesthetists or Medical Practitioners(3) with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process involving the relevant Colleges. Appropriate surgical, anaesthetic and resuscitation equipment available. Has 24 hour access to Medical Officers(3) on site or available within 10 minutes. RNs(3) with skills consistent with a competent Paediatric Nurse(3) caring for the child. Continuing nursing educational programs(3) available specific to the needs of the service. Formal consultative links with Paediatrician and Paediatric Surgeons. Amenities for parents or carers. Operating suite and recovery room provide for the special needs of children and carers.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Except in emergencies, children under the age of one month should not be admitted. Designated children's ward with parent amenities. Moderate(3) and selected major(3) surgical procedures on ASA categories 1 and 2(3) children performed by Surgeons(3) credentialed in paediatric surgery, and Specialist Anaesthetists(3) with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process. Medical Officers(3) on site 24 hours. Consultation available from specialist paediatrician. Facility to isolate in single room. Has NUM(3) and RNs(3) with skills consistent with a competent Paediatric Nurse(3). Some RNs(3) undertaking relevant postgraduate studies. Has access to allied health professionals. May have a role in providing paediatric support to other units within the Area.</td>
<td>4</td>
</tr>
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90(03/06/10)
## 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Path</td>
</tr>
<tr>
<td>5</td>
<td>As Level 4 plus specialised paediatric inpatient unit with nominated Director of Paediatric Surgical Services. Provides most major diagnostic and treatment procedures on ASA categories 1 to 5 (children excluding complex major) paediatric surgery on rare complex congenital malformations (frequency of less than one in 2,500 births). Specialist Surgeons (paediatric), General Surgeons (paediatric), and Specialist Anaesthetists (paediatric) on call 24 hours. Participates in undergraduate and postgraduate teaching. Paediatric support offered to other units within the Area. Training positions for Paediatric Nurses. Paediatric Registrar on call 24 hours. Surgical Registrar on call 24 hours. Access to CNC is desirable. May have teaching and research role. Rostered allied health professionals, including recreational therapy and educational services.</td>
<td>5 5 5 5 5 5 * 6</td>
</tr>
<tr>
<td>6</td>
<td>As Level 5 plus has subspecialty units in most areas of Paediatric Surgery (e.g. may have paediatric neurosurgery, cardiac surgery). Provides a statewide service. Active program of undergraduate and postgraduate teaching, research and development. Paediatricians and Specialist Surgeons (paediatric) with subspecialty interests on call 24 hours. Designated Paediatric Surgical Registrars in subspecialty units. Has research and specialist paediatric teaching role.</td>
<td>6 6 6 6 5 6 * 6</td>
</tr>
</tbody>
</table>

(1) See "Indicative List of Paediatric Surgical Procedures" in Appendix III
(2) See "Levels of Anaesthetic Risk - Children" in Appendix II
(3) See "Medical and Nursing Staff Definitions" in Appendix I
(4) See "Glossary" in Appendix V
* Adult CCU - not applicable
2. PAEDIATRICS

PART 4
APPENDIX I
MEDICAL AND NURSING STAFF DEFINITIONS

MEDICAL OFFICER
Medical officers are registered medical practitioners employed/contracted by hospitals. They are usually responsible to the medical superintendent, and to the senior clinicians contracted in the service in which they perform their duties.

They do not require experience specific to the area of practice and may be a career medical officer, a full-time or part-time resident medical officer, a general practitioner, etc.

REGISTRAR
Registrars are experienced medical officers appointed to positions in hospitals or community health services. They may participate in a formal training program approved by a learned college and may have prior experience in the relevant specialty area. Medical officers may occupy registrar positions in some circumstances provided they are experienced in the relevant specialty area.

ACCRREDITED MEDICAL PRACTITIONER
Is a general practitioner appointed to a hospital and to whom specific clinical privileges have been granted e.g. in surgery, anaesthetics, obstetrics, endoscopy, etc.) Following review of his/her training and continuing skills, by the hospital's credentials committee. The committee will have given regard to medical practitioners' documented post-graduate training and the volume, and type of past and recent clinical practice considered to be essential for the maintenance of skills in the requested privileges. In the case of infrequently performed procedures, skills maintenance should be through exchange release programs at base hospitals with level 4, 5, or 6 of appropriate service. In addition, there should be a demonstrated level of special skills, a commitment to continuing education, and a continuing assessment of the ready availability of specialist medical practitioners in the sphere of practice in which privileges are requested.

SPECIALIST ANAESTHETIST
Is a medical practitioner whose training has been acknowledged by the award of Fellowship in the Australian and New Zealand College of Anaesthetists (ANZCA); or one who holds an equivalent post-graduate qualification accepted by the College.

ACCRREDITED SPECIALIST ANAESTHETIST
Is a specialist anaesthetist as defined and who, as a result of additional training and acquisition of skills, has been granted additional clinical privileges by the hospital's credentials committee beyond the usually accepted parameters of specialist anaesthetic practice.

GENERAL PHYSICIAN
Is a registered medical practitioner whose training has been acknowledged by the award of the accolade of Fellowship in the Royal Australasian College of Physicians, or one who holds an equivalent post-graduate qualification accepted by the College.

SPECIALIST GENERAL PHYSICIAN WITH SUB-SPECIALTY INTEREST
Is a specialist general physician as defined who, as a result of further training and acquisition of skills, has been granted privileges by the hospital's credentials committee in areas of medical practice usually considered to be sub-specialties outside the accepted field of general medicine.

90(03/06/10)
Education for the purpose of this definition refers to staff development, continuing education or any orientation and inservice course specific to the needs of the service.

**NURSING UNIT MANAGER** means a registered nurse in charge of a ward or unit or group of wards or units in a hospital or health service. Preferably will have completed in service management course as minimum. May be attaining a management qualification.

**CLINICAL NURSE SPECIALIST**
In hospitals of 250 A.D.A. and above and in country base hospitals the definition of a clinical nurse specialist is:

A registered nurse with a minimum of two years post basic registration experience including one year experience in the relevant specialist field together with an approved formal post basic qualification in that field,

or

A minimum of four years post basic registration experience including three years experience in the relevant specialist field.

In other hospitals the definition is:

A registered nurse with a minimum of two years post basic experience including one year experience in the relevant specialist field together with an approved formal post basic qualification in that field.

**CLINICAL NURSE CONSULTANT** is a position approved by the Department of Health and must be filled by a registered nurse who has had at least five years post basic registration experience and who has in addition approved post basic qualifications relevant to the field in which such appointment is made, or such other qualifications or experience deemed appropriate by the Department.

4.1.3
2. PAEDIATRICS

- demonstrates an understanding of the effects of hospitalisation on the child and family.
- communicates effectively and works in partnership with children and families.
- demonstrates knowledge of medical and surgical conditions and their management relevant to their casemix.
- is able to commence and maintain effective Basic Paediatric Resuscitation.
- is able to calculate and administer medications safely.
- recognises and challenges management that compromises the child's safety.
- utilises contact with the child and family to promote child health, i.e. immunisation, child safety.
- demonstrates an awareness and acts accordingly to the Children's (Care and Protection) Act 1987, NSW.
- integrates the philosophy of Partnership in Care into their clinical practice.

Adopted by the Australian Confederation of Paediatric & Child Health Nurses (NSW Branch) Executive Committee, 7 November 1994 and revised February 1998.
2. PAEDIATRICS

Levels of Risk – Children

The ASA Physical Status Classification

<table>
<thead>
<tr>
<th>ASA</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA 1</td>
<td>Healthy Child</td>
</tr>
<tr>
<td>ASA 2</td>
<td>Child with mild systemic disease – no functional limitation</td>
</tr>
<tr>
<td>ASA 3</td>
<td>Child with severe systemic disease – definite functional limitation</td>
</tr>
<tr>
<td>ASA 4</td>
<td>Child with severe systemic disease – that is a constant threat to life</td>
</tr>
<tr>
<td>ASA 5</td>
<td>Moribund child not expected to survive 24 hours with or without an operation</td>
</tr>
</tbody>
</table>

From the ‘Guide to Role Delineation of Health Services’

Resource Documents

1. Australian and New Zealand College of Anaesthetists: Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice – 2013


4. Australian Confederation of Paediatric and Child Health Nurses, 2006, Competencies for the Specialist Paediatric and Child Health Nurses
   Available at: http://www.cmwh.org.au/Portals/0/docs/ACPCHN.pdf

5. Guidelines for Networking of Paediatric Services in NSW

6. NHS Scotland, Better Health, Better Care – Hospital Services for Young People in Scotland, 2009
   Available at: http://www.scotland.gov.uk/Publications/2009/05/07130749/10

7. NSW Health, Aboriginal Health Impact Statement and Guidelines (PD2007_082), Available at:

8. NSW Health, Aboriginal Workforce Strategic Framework 2011-2015 (PD2011_048), Available at:

9. NSW Health, Children and Young People’s Health Priority Taskforce, September 2008, Framework for Policy and Planning of Services for Children and Young People in New South Wales
   Available at: NSW Health, Statewide Services Development Branch

10. NSW Health, NSW Surgical Services Taskforce Paediatric Surgery Sub Group, 2008, Paediatric Surgery Model for Designated Paediatric Surgical Sites

11. NSW Health: Transition Care - Helping young people move successfully from child to adult health services


13. RACP Standards for the Care of Children and Adolescents in Health Services
    Available at: https://www.racp.edu.au/index.cfm?objectid=393E4ADA-CDAA-D1AF-0D541B5DC13C7B46

14. Resuscitation Council (UK), Suggested Equipment for the management of Paediatric Cardiopulmonary Arrest (0 - 16 years) (excluding resuscitation at birth)
    Available at: https://www.resus.org.uk/quality-standards/docs

    Available at: http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4bf687729&query=rights-of-the-child

90(03/06/10)
**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.

  - 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;
2. **PAEDIATRICS**

- 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*.

STATEWIDE EYESIGHT PRESCHOOLER SCREENING (StEPS) PROGRAM (PD2012_001)

PURPOSE

The purpose of this policy directive is to detail requirements for the consistent implementation and management of the Statewide Eyesight Preschooler Screening (StEPS) program in Local Health Districts (LHDs).

This policy directive describes the roles and responsibilities of StEPS personnel and training requirements, identifying and targeting 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, reporting and data management must be complied with (Section 2).
- All four year old children in LHDs must be targeted to be offered the StEPS program, including targeting priority groups 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 the vision screening (Section 4 - 5).
- All standardised templates attached to this policy must be utilised by LHDs when administering the StEPS program (Section 6).
- Locally arranged LHD operating processes developed to maximise screening and meet local needs in LHDs in line with this policy directive.

IMPLEMENTATION

The Ministry of Health provides annualised funding to LHDs to implement 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 of Health:
- provides mandatory requirements and guidelines for the implementation and management of the StEPS program
- evaluates the overall efficiency and performance management of the StEPS program in LHDs across NSW
- conducts regular meetings with all LHDs through StEPS Coordinators Meetings to review overall progress and implementation of the StEPS program in LHDs
- ensures that the content of this StEPS policy directive is effectively communicated to all LHD staff involved in implementing the StEPS program in NSW

Local Health Districts must:
- actively identify and target 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
2. **PAEDIATRICS**

- ensure that appropriate vision screening staff are employed, that vision screening staff are trained to undertake the StEPS vision screen and are provided with appropriate equipment and resources to carry out the functions of the StEPS program
- ensure the successful implementation and compliance of this policy directive in their LHD
- ensure that the budget provided for the StEPS program is expended on implementing the StEPS program and that financial reports are provided quarterly in line with this StEPS policy
- provide all required documents to the Ministry of Health relating to referrals, assessments, follow up and monitoring and reporting
- ensure that StEPS performance benchmarks are maintained in order to offer all NSW children a free StEPS vision screening (Section 3.3)
- promote the provision of the StEPS program to ensure that all four year old children in the LHD are offered a free StEPS vision screen
- ensure that the content of this StEPS policy directive is effectively communicated to all staff involved in implementing the StEPS program in the LHD

1. **BACKGROUND**

The Statewide Eyesight Preschooler Screening (StEPS) program is a universal, scientifically based, free vision screening program for four year old children in NSW. The StEPS program meets the World Health Organisation\(^{13}\) and the National Health and Medical Research Council\(^{14}\) (NHMRC) criteria for a screening program.

The program actively identifies and targets all four year old children in NSW to offer them a free StEPS vision screen and is designed to identify childhood vision problems early, prior to school entry, so that treatment outcomes can be maximised.

The StEPS program is an important component of the NSW Personal Health Record (PHR), the ‘Blue Book’. The NSW PHR recommends a vision examination at the newborn health check. Vision surveillance at the 1-4 weeks, 6-8 weeks, 6 months, 12 months, 18 months, 2 years and 3 years child health check and a monocular visual acuity screen with an assessment at the 4 year child health check.

Vision develops from birth to approximately eight years of age, however by the time a child commences school some aspects of visual development will already be complete. Best treatment outcomes can be gained if childhood vision problems are detected and treated prior to school entry.

It is important that all children receive a vision screen prior to school entry to:
- identify eye and vision problems that may cause permanent vision loss
- identify eye and vision problems that can affect a child’s learning
- maximise treatment outcomes by identifying and treating childhood vision problems early, during the critical visual development period
- prevent avoidable vision loss and/or blindness later in life

While eye health surveillance can monitor a child for outward signs of eye or vision problems, the two most common childhood vision problems, amblyopia and refractive error, cannot be detected by family history, vision surveillance or observing a child’s behaviour or appearance. These common childhood vision problems can only be detected if a monocular visual acuity screen is conducted by a trained vision screener.


\(^{14}\) National Health and Medical Research Council (NHMRC) report on *Child Health Screening and Surveillance: A Critical Review of the Evidence* (2002)
2. PAEDIATRICS

2. VISION SCREENING PROTOCOLS

2.1 StEPS Referral Pathway Flowchart

The figure below outlines the StEPS Referral Pathway:

- **Obtain Parent/Carer Consent**
  - **No**
    - Vision not screened – Consent declined
  - **Yes**
    - Vision Screened
      - Not Returned (Follow up offered (A minimum of two attempts))
      - Follow up offered (A minimum of two attempts)
  - **Yes**
    - Refer to GP or Eye Health Professional
      - LHD to follow up outcome of Referral

- **Parent/Carer Informed**
  - Vision within Normal Limits for Age
  - To seek further assessment

- **Refer**
  - Referral
  - High Priority Referral
  - Refer to GP or Eye Health Professional

- **Pass**
  - Parent/Carer Informed
  - Vision within Normal Limits for Age

- **Borderline Pass**
  - Parent/Carer Informed
  - To seek further assessment

- **LHD to follow up**
  - Not Returned

2.2 Pathway for screening, referral, assessment and follow up

LHDs must have clearly documented protocols for approaching services to offer the StEPS vision screening program, offering parents/carers the StEPS vision screen for their child, the provision of the vision screening service, documenting the outcome of the vision screen, informing parent/carers of the outcome of the vision screen, referral and follow up of referrals consistent with the StEPS Policy Directive.

When a clinical pathway for screening, referral, assessment and follow up is reviewed or updated, LHDs are responsible for providing the NSW Ministry of Health with an updated version of vision screening protocols.

Standardised templates attached to this policy (Section 6) must be used to implement and administer the StEPS program in NSW.

2.3 Consent

Consent from the parent/carer for their child to participate in the StEPS program at a preschool, child care centre or other service must be obtained prior to undertaking the StEPS vision screen. The following standardised consent information and consent form is to be used to obtain signed consent:

- StEPS Consent Important Notice for all Parents/Carers (Attachment 1)
- StEPS Consent and Results Form (Attachment 2)

The ‘NSW PHR - 4 year check’ may be used to record the outcome of the StEPS vision screen if the parent/carer is present, e.g. Child and Family Health clinic, General Practice, Aboriginal Medical Service etc. In such circumstances referral criteria and follow-up procedures must be in accordance with this StEPS Policy Directive. Where possible, the StEPS Coordinator should liaise with the above services to collect and report on this StEPS data in accordance with LHD protocols.

Consent forms, including information pamphlets about the StEPS program and LHD privacy information should be provided to the preschool/child care centre where the screening will occur at least two weeks prior to the screening date. Completed and signed consent forms must be collected prior to the screening date or on the day of screening. Additional consent may be accepted by the StEPS vision screener up to and including the day of screening. If verbal consent is provided, this must be witnessed and documented by the screener and the preschool director or teacher.

If a consent form is not returned or the child is absent on the day of screening then a follow-up screening offer should be made. At least two vision screening follow up offers should be made where a screening is not conducted.

Where possible, LHDs are to identify children whose parents/carers have not returned a consent form. If consent is not provided by parents/carers for their child to participate in the StEPS program, this must be recorded appropriately.

To monitor and assist in accurately recording the number of StEPS vision screenings offered, it is recommended that LHDs enquire about the number of children who are four years of age or who will be turning four years of age and eligible to attend school in the following calendar year attending the centre where the StEPS vision screening will take place and provide the correct corresponding number of consent forms. Children attending the preschool/children care centre who are five years of age and have not previously received a StEPS vision screen are also eligible to be offered the StEPS program.
Where an accurate number of children cannot be obtained, an approximate number of consent forms are to be provided to the preschool/child care centre with the request that any consent forms not distributed be returned to the StEPS coordinator. An accurate number of children attending the centre should again be sought on the day of the screening. The number of children offered the StEPS should then be accurately recorded in the StEPS key performance indicators. Children provided with more than one consent form should be recorded as a single offer of consent.

2.4 Vision Screening

LHDs must coordinate and organise the StEPS vision screening with relevant parties at a suitable screening location. Consideration should be given to preschools/childcare centres with specific attendance patterns such as split week attendance to ensure a high uptake of screening and the number of screening days required to screen all children appropriately. StEPS vision screening staff should arrange an appropriate area to conduct the StEPS vision screening in consultation with the preschool/child care centre.

Wherever possible, StEPS vision screening staff must conduct a monocular visual acuity screening test using the approved 6 metre Sheridan Gardiner Linear Chart. If the screening location does not have the required space available for the 6 metre chart, the approved 3 metre Sheridan Gardiner Linear Chart can be used. A matching board is to be provided to all children to enable children to match the letter indicated by to the vision screener with the letter on the matching board.

To conduct a monocular visual acuity test, the screener must occlude the left eye first using the recommended black plastic eye patch (this is to ensure that the right eye is tested first and minimise the inaccurate recording of test results). A folded tissue is placed beneath the patch and LHD infection control procedures must be followed.

Vision screeners should also review the consent form carefully noting any parental/carer concerns, perform a visual inspection of the eyes and observe the child carefully (e.g. does the child constantly close one eye in sunlight, do both eyes move together equally in all direction of gaze, does the child consistently tilt their head or turn their face to one side etc) to determine if any abnormalities may be present which could affect either the vision or the child’s general eye comfort. If there are concerns following visual inspection of the eyes eg, red eyes, red lid margins, excessive watering etc, the child should be referred to their General Practitioner. Vision screeners should vigilantly observe and refer any possible eye or vision abnormalities even if the visual acuity is within normal range.

The test results for each eye must be accurately recorded by the vision screener on the StEPS Consent and Results Notification Forms as appropriate (Attachment 2).

2.5 Documenting Results of the Vision Screening

2.5.1 Consent and Results Form

The vision screener must complete the results section of the StEPS Consent and Results Form (Attachment 2) to document the vision screening results.

All sections of the Consent and Results Form must be completed, signed and dated. Relevant actions relating to completing a ‘StEPS Results Notification Form’ and ‘Referral Letter’ must be identified on the form. All StEPS Consent and Results Forms (Attachment 2) must be promptly forwarded to the StEPS Co-ordinator as per LHD procedures.
2.5.2 StEPS Results Notification Form

A StEPS Results Notification Form (Attachment 3) is used to inform parents on the outcome of the vision screening and must be completed and forwarded to all parents/carers of children who participated in the StEPS program.

Notification of the vision screening result should be provided as soon as practical, preferably on the day of the screening.

If the parent/carer has indicated on the StEPS Consent and Results form (Attachment 2) that the child is under the care of an eye health professional, the vision screener must advise on the StEPS Notification Form (Attachment 3) for parent/carer to continue care. If there are any concerns about the child’s current treatment, vision screeners must discuss this with their LHD StEPS Coordinator. LHDs should encourage parents/carers to add the StEPS results notification to their child’s Personal Health Record.

2.5.3 Confidentially

All results must be confidential and must not be provided to or discussed with others (including staff at the preschool or child care centre) without parent/carer consent. To ensure privacy, all StEPS Results Notification Forms (Attachment 3) is to be placed in a sealed envelope with the child’s name on the outside of the envelope. Vision screeners must liaise with relevant parties (e.g. preschool/child care director) at the screening location to determine the most appropriate mechanism for providing the results of the StEPS vision screen to parents/carers.

2.5.4 StEPS Referral Letter

All parents/carers of children who require a referral must be provided with a StEPS Referral Letter (Attachment 4). The referral letter may be completed by the vision screener, StEPS Coordinator or Administration Officer as per LHD procedures.

2.6 Referral Criteria

The StEPS program uses pass/fail criteria to a specific standard to assess the appropriate level of acceptable visual acuity. Following the StEPS vision screen, the criteria for making a referral based on the visual screening result is:

a) **Pass - visual acuity of 6/9 (3/4.5) or above**
   - visual acuity of 6/9 (3/4.5) or above in both eyes is considered to have passed the StEPS visual acuity screen
   - referral is not required

b) **Borderline Pass - visual acuity of 6/9-1 (3/4.5-1) or 6/9-2 (3/4.5-2)**
   - visual acuity of 6/9-1 (3/4.5-1) or 6/9-2 (3/4.5-2) in one or both eyes is considered a borderline pass
   - parents/carers are advised to re-test in twelve months by an Eye Health Professional

c) **Refer - visual acuity of less than 6/9-2 (3/4.5-2) in one or both eyes**
   - visual acuity of less than 6/9-2 (3/4.5-2) in one or both eyes is considered to have not passed the StEPS visual acuity screen
   - parents/carers are advised to have their child’s eyes tested by a General Practitioner or Eye Health Professional

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d) Refer – obvious pathology
- obvious pathology on observation of external eye and adnexa that is currently untreated
- parents/carers are advised to have their child’s eyes reviewed by a General Practitioner

e) High Priority Referral – visual acuity of 6/18 (3/9) or less in one or both eyes
- Visual acuity of 6/18 (3/9) or less in one or both eyes is considered a high priority referral
- Parents/carers are advised to have their child’s eyes tested by an General Practitioner or Eye Health Professional as a matter of urgency
- Referral may be made to Paediatric Ophthalmic Outpatient Clinics (POOCs) according to Referral Protocols for POOCs at Attachment 5

2.7 Follow-up of referrals

All referrals from the StEPS Program must be actively followed up by the StEPS Coordinator as per LHD procedures. Wherever possible, StEPS Coordinators should ensure that High Priority Referrals receive a diagnostic vision assessment within one month and General Referrals within three to six months.

StEPS Coordinators are to offer assistance to families in ensuring the child receives a diagnostic eye assessment within the appropriate timeframe. This may include but is not limited to offering secondary screening Orthoptic services and/or referral to the StEPS Paediatric Ophthalmic Outpatient Clinics (POOCs). StEPS Coordinators are to consider any barriers to receiving a diagnostic assessment and subsequent treatment and assist families wherever possible to access appropriate services.

StEPS Coordinators must monitor all follow up referrals and report on the referral outcomes. If no eye health professional report is received and the outcome is unknown, the family must be contacted to determine the outcome and the result recorded.

The StEPS Outcomes of Referrals – Outcome Report and Diagnosis Report (Attachment 10) must be completed to record the outcome of the referral as a result of the StEPS vision screening. These reports can be used to demonstrate the accuracy of vision screening undertaken and the effectiveness of the StEPS program.

2.8 Mandatory Reporting for the StEPS program

LHDs StEPS Coordinators must complete and submit the following reports for the StEPS program to the NSW Ministry of Health as required:
- Quarterly StEPS Key Performance Indicator Spreadsheet (Attachment 8)
- Quarterly StEPS Financial Acquittal Report (Attachment 9)
- StEPS Outcome of Referrals - outcome report and diagnosis report (Attachment 10)

2.9 Data Management

LHDs are responsible for developing and maintaining a database to record all children who have participated in the StEPS program. This will enable ease of tracking referrals, follow up referrals, reporting on referral outcomes and responding to enquires from parents/carers on the vision screening.

At a minimum the database should include the child’s details, parents contact details, screening location, date of screening, result of screening and outcome of referral where applicable. It is recommended that terminology used to record the outcomes of referrals is consistent with language used in the diagnosis report.

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2.9.1 Related NSW Ministry of Health Policy Directives and guidelines

The NSW Ministry of Health has recommended guidelines and policy directives on mandatory requirements for data management.

LHDs must have systems in place to ensure that mandatory requirements relating to data management are complied with. The following Policy Directives on data management that apply to the StEPS program are:

- **Client Registration Policy**
  The Client Registration Policy Directive provides guidance on mandatory requirements for registering clients/patients who receive a health care service, or who are booked to receive a health service. While it is not a mandatory requirement to register people receiving group immunisation or screening services, it is advised that a ‘record including details of the people receiving these services needs to be kept for medico-legal and follow-up purposes’.

  All children who have participated in the StEPS program must be recorded on a database developed and maintained by LHDs.


- **General Retention and Disposal Authority – Public Health Services: Patient/Client Records**
  Client records of children who have participated in the StEPS program must be kept in line with the NSW State Records ‘General Retention and Disposal Authority – Public Health Services: Patient/Client Records’ (GDA 17).

  For children who received a StEPS vision screening and no abnormality was detected, the *StEPS Consent and Results Form* (Attachment 2) should be retained until the child turns six years of age, after which time it can be destroyed as per LHD document retention and destruction procedures.

  Where children were identified with a possible vision problem and referred to an eye health professional for further assessment following a StEPS vision screening, the *StEPS Consent and Results Form* (Attachment 2) must be incorporated into the main Community Health client record system and retained until the child attains or would have attained the age of 25 years, then destroyed.

  The NSW State Records ‘General Retention and Disposal Authority – Public Health Services: Patient/Client Records’ (GDA 17) provides the following guidance on record retention and disposal actions for baby/child health care screening records:
  - client records relating to documenting the screening and monitoring of the health of infants from birth to 4-5 years where there is no abnormality detected, records are retained until the child attains or would have attained the age of 6 years, after which they can be destroyed
  - client screening records where there is an abnormality detected, should be incorporated into the main Community Health client record system and retained for a:
    - a minimum of 7 years after last official contact or access by or on behalf of the client, or
    - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy
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3. **IDENTIFYING AND TARGETING FOUR YEAR OLD CHILDREN**

3.1 **Targeting Four Year Old Children**

All four year old children in NSW are to be actively identified and targeted to be offered a free StEPS monocular visual acuity screen by LHD StEPS Coordinators within their designated LHDs. Strategies to identify and target four year old children may include, but not limited to, contacting the following services to offer the StEPS program:
- preschools
- child care centres
- early intervention services
- refugee services
- Child and Family Health Services
- playgroups
- immunisation clinics
- Department of Education and Communities, Schools for Specific Purposes
- Community vision screening days
- School Orientation programs (this strategy should only be used where the eligible child was not able to be identified and targeted through alternative strategies)

Five year old children who have not previously received a vision screen prior to school entry or at school orientation are deemed to be eligible for the StEPS program.

3.2 **Targeting disadvantaged groups of children and children with special needs**

Disadvantaged groups of children and children with special needs are to be targeted and prioritised to be offered a free StEPS monocular visual acuity screen. Follow up referrals are to be closely monitored. For the purposes of the StEPS program, the following groups of children are classified as ‘disadvantaged groups of children’:
- Aboriginal and Torres Strait Islander children
- Children attending ‘Early Intervention Services’
- Children attending ‘Schools as Community Centres (SACCs) Playgroups’
- Children whose parents attend Mental Health Services
- Children in ‘Out of Home Care’
- Refugee children
- Socioeconomically disadvantaged children

‘Children with special needs’ are classified as children who have been identified with developmental delay and/or neurological deficits.

LHD StEPS Coordinators are to develop local processes to meet the unique needs of their LHD in order to ensure maximum vision screening and equity of access to the StEPS program. This may involve:
- arranging dedicated screeners to meet the needs of Aboriginal and Torres Strait Islander children, children from a culturally and linguistically diverse background, children with a disability, children with special needs and children from disadvantaged groups
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- tailoring vision screening tests or comprehensive vision assessment based on the clinical judgement of the eye health professional
- targeting local areas and opportunities to return to local areas of socioeconomically disadvantaged children
- providing services early in the calendar year
- identifying strategies to target local needs

3.3 Key Performance Indicator

The Key Performance Indicator of the StEPS program is:

- minimum of 90% of four year old children offered a vision screening

Wherever a parent/carer completes a StEPS consent form and agrees to their child participating in the StEPS program the LHD must make every effort to ensure that the child’s vision is screened according to StEPS protocols.

LHDs are to ensure that the StEPS Key Performance Indicator of 90% of four year old children offered a vision screening is maintained according to the population numbers of four year olds in their LHD and provided by the Ministry of Health.

4. StEPS PERSONNEL

4.1 Vision Screening Staff

StEPS vision screening staff are employed by Local Health Districts (LHDs), under the supervision of LHD StEPS Coordinators to conduct monocular visual acuity screening assessments for four year old children.

StEPS vision screening must be conducted by suitably trained staff competent in using the StEPS vision screening equipment to undertake vision screening for four year old children. Screening assessments are undertaken in locations deemed appropriate by LHDs and can include settings such as preschools, child care centres, community settings and Child and Family Health Services.

StEPS vision screening staff are responsible for:

- liaising effectively with preschool and child care centre staff, parents, team members and other health care professionals in a professional and caring manner
- conducting the vision screening according to vision screening protocols in conjunction with this StEPS policy directive relating to obtaining consent, referral processes, appropriate test distance/lighting and required equipment and information utilised to conduct the vision screening
- ensuring the vision screening process creates minimal disruption to the location where the vision screening is undertaken
- ensuring the confidentiality and privacy of the child is maintained at all times and all relevant information about the screening process and vision screening results is provided to parents/carers
- ensuring all mandatory requirements and reporting mechanisms relating to the vision screening, consent, referrals processes, notification of results and LHD protocols are undertaken
- adhering to all LHD Occupational Health and Safety and Infection Control protocols
- maintaining vision screening equipment and reporting malfunctioning equipment to the StEPS Co-ordinator
- advising the StEPS Co-ordinator of any issues, incidents, problems or concerns that arise during a vision screening session
StEPS Coordinators are employed by LHDs to implement, coordinate and manage the day to day operations of the StEPS program.

StEPS Coordinators develop and maintain strong links with all relevant stakeholders such as child health services in LHDs, parents and carers, early childhood education and care providers, eye health professionals, general practitioners, medical specialists, Aboriginal Medical Services, early intervention and coordination programs and other government and non-government agencies to promote the StEPS program and to ensure the StEPS program is delivered effectively in their respective LHDs.

StEPS Coordinators are responsible for:
- ensuring all four year old children in their LHD are identified and actively targeted to offer them a StEPS vision screen, including providing screening services as required
- recruitment, training and/or arranging the training to be provided by a suitably qualified health professional to StEPS vision screeners
- supervision and professional development of StEPS vision screeners to ensure competency in vision screening and all applicable LHDs protocols are followed
- locally managing transportation arrangements for StEPS vision screeners to screening locations within the resources available in the LHD. This may include access to a motor vehicle or approval to use private vehicles with the provision of a mileage allowance according to LHD protocols
- ensuring all appropriate supplies and maintenance of equipment, relevant forms and promotional material is available to conduct the StEPS vision screen
- maintaining the confidentiality and privacy of the children screened and providing support to parents as appropriate in the period between vision screening and diagnostic assessment
- developing vision screening protocols for screening, referral, assessment and follow up consistent with the StEPS Policy Directive
- developing local processes to ensure that disadvantaged groups of children and children with special needs are targeted and prioritised for the StEPS program
- data management and monitoring of key performance indicators, vision screening referral rates, referral outcomes, follow up referrals and submitting of relevant reports to the NSW Ministry of Health as required
- setting up and maintaining a database to record information on all four year old children who participated in the StEPS program for quality management
- effectively managing the LHD StEPS budget to ensure the program is implemented efficiently in the LHD including all related printing costs relating to information pamphlets, brochures and forms on the StEPS program
- attending NSW Ministry of Health StEPS Co-ordinators meetings as required and being the main point of contact for the StEPS program in their LHDs

4.3 StEPS Administration Officer

StEPS Administration Officers are employed by LHDs to provide administrative duties as deemed appropriate by the StEPS Co-ordinator. Duties may include but are not limited to, arranging and confirming vision screening bookings, organising consent form packages, data entry and general office tasks.

4.4 Orthoptist

Orthoptists may provide comprehensive secondary vision screening for children referred via the StEPS program. Orthoptists can also provide vision screening services for children identified with ‘special
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needs’ and undertake additional vision screening tests considered appropriate to a child’s individual developmental level. Orthoptists can also investigate and diagnose ocular motility disorders and assist in transitioning the family to timely diagnostic assessment services where appropriate.

4.5 **StEPS Outpatient Clinics**

Dedicated tertiary Paediatric Ophthalmic Outpatient Clinics (POOCs) have been established for children identified with potentially significant vision loss and referred as a ‘High Priority Referral’. POOCs will ensure that these children receive a diagnostic vision assessment in a timely manner so that treatment outcomes can be maximised. Ongoing management and treatment of a child diagnosed with a vision problem via POOCs should be at the discretion of the eye health professional in consultation with the parent/carer.

Referrals to POOCs are available from anywhere in NSW and can be referred according to *StEPS Referral protocols for Paediatric Ophthalmology Outpatient Clinics (POOCs).*

See Attachment 5 for *StEPS Referral Protocols for (POOCs)* and Attachment 6 for *StEPS Referral Form for (POOCs)*

5. **Training**

5.1 **StEPS Training Package**

To be certified as competent, vision screening staff must:

- complete module 1 and module 2 of the *StEPS Training Package.* While module 1 can be completed as pre-reading, it is highly recommended that both modules to be presented face to face
- complete a minimum of 4 hour practical experience at a screening location with the StEPS Coordinator or an Orthoptist if possible
- be assessed as competent after three months of screening using the *StEPS Competency Checklist* (Attachment 7) and annually thereafter

5.2 **Supervision and Professional Development**

Following completion of module 1 and 2 and supervised practical experience, ongoing professional development and mentoring opportunities for vision screeners should be locally arranged by LHDs as appropriate. This may involve opportunities to work with an experienced vision screener for the first three months of vision screening wherever possible, participation in Orthoptic clinics or other professional development opportunities identified by the LHD.

It is the responsibility of the StEPS Coordinator to ensure that all StEPS vision screening staff, and all LHD staff who undertake the StEPS vision screen, are proficient in undertaking a StEPS vision screen prior to being deemed qualified to undertake a StEPS vision screen unsupervised.

Ongoing supervision and performance management of vision screening staff, and health staff who provide the StEPS vision screen, is to be undertaken by LHDs according to LHD protocols. This should include performance reviews of vision screening staff referral rates and where appropriate, actions undertaken to address performance factors, areas of improvement or skill development.

**GLOSSARY OF TERMS**

**Adnexa**

For the purposes of this document the adnexa refers to the appendages of the eye. These include but are not limited to the eyelids, conjunctiva, lacrimal apparatus and orbit.
Amblyopia
Amblyopia is reduced or ‘dim’ vision in an eye which appears to be normal. It is sometimes called ‘Lazy Eye’. This is a serious eye defect which often goes undetected in childhood. If amblyopia is not diagnosed and treated early, preferably before school entry, the vision in the affected eye may be permanent and cannot be corrected with glasses or surgery.

Eye Health Professional
For the purposes of this document, an Eye Health Professional refers to registered ophthalmologists, orthoptists and optometrists.

Refractive Error
A refractive error occurs when the shape of an eye is abnormal or does not bend (or refract) light properly, which results in blurred vision. The three most common refractive errors are myopia (short sightedness), hyperopia (long-sightedness) and astigmatism.

Sheridan Gardiner Linear Chart
The visual acuity screening test used in the StEPS program

Visual Acuity Screening
Vision screening is the testing of visual acuity using pass/fail criteria to a specific standard which indicates an age appropriate level of acceptable vision.

Vision Surveillance
Vision surveillance is defined as the monitoring of vision development for signs of eye or vision problems and includes observation, family history, questions around visual behaviours and some vision tests, e.g. corneal reflections, ocular movements and response to occlusion.

To view attachments please go to:

Attachment 1 - StEPS Consent Important Notice for all Parents/Carers
Attachment 2 - StEPS Consent and Results Form
Attachment 3 - StEPS Results Notification Form
Attachment 4 - StEPS Referral Letter – 3m and 6m
Attachment 5 - StEPS Referral Protocols for Paediatric Ophthalmology Outpatient Clinics
Attachment 6 - Referral Form for Paediatric Ophthalmology Outpatient Clinics
Attachment 7 - Competency Checklist for Vision Screeners
Attachment 8 - StEPS Key Performance Indicator Spreadsheet
Attachment 9 - StEPS Quarterly Financial Acquittal
Attachment 10 - StEPS Outcomes of Referrals - Outcome Report and Diagnosis Report
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