Patient Matters Manual for Public Health Organisations

Chapter 6 – Emergency Care

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Note

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

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

Emergency Department Patients Awaiting Care

Document number PD2018_010 rescinds PD2010_075.

PURPOSE

The purpose of this Policy is to outline the mandatory requirements and procedures for emergency department (ED) staff for patients, their families and carers immediately following the triage process and while awaiting the commencement of clinical care and medical assessment in the ED.

Although this Policy seeks to provide guidance on the clinical safety and care of patients while they are waiting; of equal importance is the outcome of patient satisfaction related to the waiting environment. Factors identified by patients, families and carers related to poorer waiting experience include lack of communication in general whilst waiting, uncertainty about waiting times and lack of information about the functions of the ED. Communication and early symptom management have been identified as key measures to prevent patients from leaving without being seen following triage[1]; which is an important monitoring measure of quality in the ED environment. Medical, nursing, clerical, allied health and other ED support staff all have a role in ensuring clear communication for patients and their families.

This Policy does not seek to outline the triage process – please refer to NSW Health policy PD2013_047 Triage of Patients in NSW Emergency Departments for information on triage in NSW.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy and support the mandatory requirements detailed here:

- This Policy applies to all adult and paediatric patients, following triage in the ED waiting for clinical care to commence and/or medical assessment, regardless of their location.

  In addition to the parameters of this Policy; people brought to the ED involuntarily for the purpose of initial health assessment, care and treatment, will be cared for in accordance with the relevant legislative framework for example The Mental Health Act 2007 (NSW) or the Crimes (Administration of Sentences) Act 1999.
- Undifferentiated patients can be at risk of deterioration – for those located in the waiting room, lack of supervision adds to this risk. Ensuring the safety of patients in the waiting room is the responsibility of the senior medical and nursing staff in charge of the shift.
- The ED waiting room should be a pleasant, safe environment where patients, families and carers can be comfortable. When designing or redesigning ED waiting rooms, emphasis should be on ensuring that adequate signage, a culturally appropriate setting and access to toilets and refreshments are accommodated.
- Regular communication with waiting patients is essential, particularly in relation to ED processes and waiting times. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified.
- Patients waiting for clinical care to commence and those accompanying them may become frustrated, particularly in the absence of regular communication. Local practices that focus on taking action to recognise and respond to escalating behaviour are safer, for both

1 Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? Emerg Med J 2011, 28: 945-947

patients and staff, than those that rely solely on managing behaviour that has already become aggressive or violent.

NSW Health has a zero tolerance policy[2] to violence and aggression where, as far as reasonably practicable, action will be taken to prevent and mitigate aggressive behaviour and violence. Appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour, while ensuring clinical services continue to be provided.

- Clinical care of waiting patients may commence according to locally endorsed and statewide clinical pathways whilst the patient is in the waiting room or other area of ED awaiting medical assessment. Regular reassessment of the patient's clinical condition should occur, particularly if the waiting time exceeds the allotted triage category maximum waiting time. Documentation of all assessments and clinical care commenced must be entered into the patient's health care record.
- During triage and any interaction with ED staff, patients and families/carers should be encouraged to speak up if they feel their condition is deteriorating whilst waiting for examination, this is especially true in departments where constant patient observation is not possible in the waiting room. Where a patient's deterioration in condition has been detected by ED staff, established local clinical emergency response system processes should be followed.
- ED clinicians retain responsibility for the overall clinical management of patients transported to ED via Ambulance; this occurs as soon as the patient enters the ED. In recognition of occasions of Transfer of Care delays between Ambulance and ED staff, this Policy outlines a shared care responsibility for the care of patients.
- Local processes should be in place to monitor numbers of patients who 'Did not Wait' for treatment following triage, including rates for Aboriginal and nonAboriginal patients. Strategies to address issues identified should be implemented and evaluated.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

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

ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for patients awaiting care. This should include nomination of an executive sponsor to support staff responsible for implementation of this policy.

iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management, and clinical staff.

2 NSW Health Policy 2015 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach (available at http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015_001)

Emergency Department - Notification of Specialist or VMO Regarding Patients Admitted through the ED

Document number GL2011_003 rescinds GL2005_026.

PURPOSE

The purpose of these guidelines is to provide advice on the development of hospital mechanisms for the notification of Specialists or Visiting Medical Officers of patients admitted through the Emergency Department.

KEY PRINCIPLES

Mechanisms should be in place for the appropriate Visiting Medical Officer or Staff Specialist to be notified of each hospital admission through the emergency department. The notification should be made by the rostered medical officer attending to the patient in the emergency department, prior to the end of his or her shift. In hospitals with specialty registrars, this notification can be made to the appropriate registrar.

All relevant medical practitioners should be educated regarding the need for compliance with the above guideline.

USE OF THE GUIDELINE

Following the recommendation of the State Coroner, these guidelines should be incorporated into written hospital policy in relation to the notification of admitting Visiting Medical Officers or Staff Specialists regarding patients admitting through the emergency department.

119 (10/02/11)

Triage of Patients in NSW Emergency Departments

Document number PD2013_047 rescinds PD2008_009.

PURPOSE

The purpose of this policy is to outline the key components of triage of patients presenting to Emergency Departments in NSW hospitals including the role, key responsibilities and the processes that support efficient and safe triage.

This policy does not seek to outline the clinical components of this process; clinical information related to triage is as indicated by the Australasian College for Emergency Medicine's (ACEM) policy[3] and guideline[4] on triage and the College of Emergency Nursing Australasia (CENA) Position Statements on Triage.[5,6]

This policy should be read in conjunction with NSW Health Policy PD2010_075 Emergency Department Patients Awaiting Care.

MANDATORY REQUIREMENTS

- Triage is an essential function of an Emergency Department (ED). Triage (or an alternative local 'sorting' process by a senior ED clinician) should be the first interaction a patient has in the ED.
- ED and hospital processes must support the ability of triage to be carried out within five minutes or less so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED
- The triage process encompasses a brief clinical assessment of the patient on arrival to the ED to determine the priority for clinical care. Assignment of triage category reflects the clinical urgency of the patient's condition.
- The patient's level of urgency is indicated using the Australasian Triage Scale (ATS) and the Triage Nurse determines (in consultation with relevant ED and Ambulance staff if required) the most appropriate place for the patient to commence or wait for further treatment.
- It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes or deteriorates prior to being seen by a treating clinician.
- The physical location and environment of triage must ensure the safety of staff and patients and accommodate privacy for the assessment of patients.
- The process of Triage involves the application of high-level patient assessment skills and knowledge to determine the patient's degree of urgency to see a treating clinician – it is for this reason that triage in NSW EDs should be carried out by Registered Nurses. It is not appropriate for clerical/administrative staff to undertake triage. In Hospitals with ED role delineation level 1 & 2, there may be occasional circumstances where an Enrolled Nurse is the first point of contact for a patient arriving in the ED. Contingencies for this occurring are described in section 2.5 -Triage Education.

3 ACEM Policy on the Australasian Triage Scale
http://www.acem.org.au/media/policies_and_guidelines/P06_Aust_Triage_Scale_-_Nov_2000.pdf
4 ACEM Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments
http://www.acem.org.au/media/policies_and_guidelines/G24_Implementation__ATS.pdf
5 CENA Position Statement: Triage Nurse http://cena.org.au/CENA/Documents/CENATriageNursePSJuly2009.pdf
6 CENA Position Statement: Triage and the Australasian Triage Scale
http://cena.org.au/CENA/Documents/2012_06_14_CENA_-_Position_Statement_Triage_FinalD2-1.pdf

- Registered Nurses undertaking the triage role must demonstrate and maintain clinical expertise in emergency nursing and have appropriate training in the triage role; the requirements of which will be determined locally. Please see section 2.5 Triage Education for further information on ‘expertise in emergency nursing.

IMPLEMENTATION

Local Health District and Specialty Health Networks are responsible for:

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

ii. Establishing mechanisms to ensure that the essential criteria are applied, achieved and sustained as usual processes for triage; this should include nomination of an executive sponsor

iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with responsible executive, Clinical Governance unit, ED senior management, and senior clinical staff.

iv. Providing opportunity for Registered Nurses to complete local triage education programs; ensure adequate supervision for Registered Nurses learning the triage role and demonstrate local processes for the ongoing evaluation of triage practice.

196 (12/12/13)

Emergency Department - Direct Admission to Inpatient Wards

Document number PD2009_055.

PURPOSE

Timely and efficient handover of clinical care of admitted patients from the Emergency Department medical staff to in-patient medical staff is essential for the safe and effective care of each patient and for maintaining the effective operation of the Emergency Department. An essential component of this transition of responsibility for the clinical care of the patient is timely confirmation of acceptance of the clinical handover by the relevant inpatient clinical team.

This policy directive seeks to avoid delays in the admission of patients from the Emergency Department through the application of a clear local protocol in each hospital. As smaller rural hospital Emergency Departments do not have full time separate Emergency Department medical staff and are supported by general practitioners who also care for admitted patients, this policy directive applies to public hospitals with Emergency Departments designated as level 3 or above.

The key benefit of the development and use of a local protocol is that it provides a prior written agreement developed locally by clinicians setting out which clinical unit/team accepts which patients.

Application of this policy directive will enable a timely and clinically appropriate direct admission of a patient from the Emergency Department where an inpatient clinical team has not confirmed acceptance of the admission of the patient under that team within two hours of the clinical decision that the patient requires admission to the hospital.

MANDATORY REQUIREMENTS

Each hospital must have in place by 31 October 2009 an agreed written local protocol that sets out a decision framework for the transfer of care of a patient requiring admission from the Emergency Department to an inpatient clinical team/unit.

The key components of the local protocol are set out in the Associated Document – Key Components Local Protocol – Admission Decision Framework. Where a hospital already has a local protocol, the protocol should be reviewed to ensure that it complies with this policy directive.

The local protocol should be reviewed on a six monthly basis and also updated when the clinical service mix of the hospital materially changes.

IMPLEMENTATION

Chief Executives are to ensure a written local protocol as described in this policy and its associated documents is in place for all hospitals designated level 3 or above with Emergency Departments.

Local protocols should be developed by a local hospital executive lead governance group with input from Emergency Department senior medical staff, clinical units/teams and the Medical Staff Council. This consultative process will ensure that gaps in the draft framework are identified and addressed and that the requisite clinical engagement and commitment occurs.

NSW Rural Adult Emergency Clinical Guidelines

Document number GL2022_004 rescinds GL2020_004.

GUIDELINE SUMMARY

This Guideline is provided to assist early appropriate clinical management of acute and lifethreatening conditions, and to relieve pain and discomfort, for patients at hospitals where medical officers are not immediately available.

KEY PRINCIPLES

The Guidelines reflects evidence based best clinical practice and expert consensus opinion to standardise initial clinical management of specific adult conditions.

A graduated clinical response is required, dependant on:

- Severity of the presenting emergency condition e.g. the clinical response to patients with mild to moderately severe asthma is different to that of a patient 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.
- 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

Alignment with the principles outlined in the First Line Emergency Care Course (FLECC) for Registered Nurses. These nurses have advanced knowledge and skills; and have been deemed competent to carry out these advanced roles using contemporary assessment and ongoing credentialing processes.

The Guidelines can be used by any First Line Emergency Care Course (FLECC) credentialed nurse in the following settings:

- Emergency Department in the absence of a medical officer
- In inpatient areas where a medical officer is not immediately available for patients who fall into the “Clinical Review” or “Rapid Response” criteria of the NSW “Between the Flags” program. Implementation is to occur in conjunction with the activation of the local clinical emergency response system (CERS).

When a Registered Nurse who is recognised as a First Line Emergency Care Course credentialed nurse uses these Guidelines, the designated Medical Officer will be notified immediately.

Medication standing orders contained and utilised in the Guideline will be reviewed and authorised by the designated medical officer as soon as possible (within 24 hours) and the medical officer will countersign the record of administration on the patients’ medication chart.

Enrolled Nurses and Registered Nurses who are not First Line Emergency Care Course credentialed can use these Guidelines to inform assessment and management, however are not permitted to undertake shaded interventions that require First Line Emergency Care Course credentialing unless formal previous recognition of prior learning has been granted.

These Guidelines can be commenced on any adult patient who meets the clinical severity prompt criteria on any specific condition within the guidelines.

In circumstances where the patient meets more than one guideline the most life-threatening condition must take priority and the most appropriate corresponding guideline commenced.

341 (20/04/22)

Responding to Sexual Assault (adult and child) Policy and Procedures

Document number PD2020_006 rescinds PD2005_614 and PD2005_607.

PURPOSE

This Policy Directive provides policy and practice guidance to NSW Health services in responding to children, young people and adults who have, or may have, been sexually assaulted and their families, carers and significant others. It details the functions and governance of NSW Health Sexual Assault Services and clarifies the responsibilities of other NSW Health services in responding to sexual assault.

SUMMARY OF MANDATORY REQUIREMENTS

This Policy requires that Local Health Districts (districts) and Speciality Health Networks (networks):

- Prioritise the health, safety and wellbeing of people who have experienced sexual assault (adult and child).
- Provide an integrated response to sexual assault within a public health approach.
- Adhere to the identified principles of intervention for responding to sexual assault.
- Comply with key reporting requirements related to sexual assault.
- Follow identified procedures and protocols for responding to sexual assault in Emergency Departments.
- Deliver services in ways that increase health, safety and wellbeing and minimise harm. This includes services seeking to prevent re-traumatisation and to ameliorate the impact of sexual assault on the person who has experienced it and their families/significant others.
- Deliver services in a way that is culturally safe and responds sensitively to people's needs, including the experiences of identified population groups with specific vulnerabilities and additional barriers to accessing services.
- Collaborate with interagency partners at local and district levels in responding to sexual assault.
- Ensure every district has at a minimum one Level 4 (or Level 6) Sexual Assault Service (SAS) within their geographic boundaries which provides 24 hour integrated psychosocial, medical and forensic crisis responses for both adults and children as well as the full range of other identified elements of the SAS service model.[7] For a SAS to qualify as a Level 4 as per the NSW Health *Guide to the Role Delineation of Clinical Services* it will meet the identified minimum requirements.
- Apply the clinical processes, practices and management requirements for SASs set out in the *Responding to Sexual Assault (adult and child) Policy and Procedures*, including information sharing and records requirements.
- Comply with the NSW Health Violence, Abuse and Neglect (VAN) Service Standards.

IMPLEMENTATION

Chief Executives are responsible and accountable for:

7 An exemption for existing service delivery arrangements that do not meet this requirement may be granted by the Secretary, Ministry of Health in writing.

- establishing mechanisms to ensure the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are applied, achieved and sustained;
- ensuring NSW Health staff understand and are aware of their obligations in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures* and related policies and procedures;
- ensuring resources are available to deliver and meet the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- ensuring that NSW Health staff are trained to operationalise and implement the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures*; and
- ensuring NSW Health staff are advised that compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures* is part of their patient / client care responsibilities.

Managers of NSW Health SAS and other NSW Health services specified in the *Responding to Sexual Assault (adult and child) Policy and Procedures* are responsible for:

- ensuring the requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are disseminated and implemented in their service; and
- monitoring implementation and compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures*.

NSW Health workers are responsible for:

- implementing and complying with the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*.

327 (07/02/20)

Domestic Violence - Identifying and Responding

Document number PD2006_084 rescinds PD2005_413.

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) http://internal.health.nsw.gov.au/pubs/p/pdf/procedures_dom_violence.pdf provides a framework for informing domestic violence responses for staff in hospitals and community health services. This document's child protection focus has been improved by amendments as detailed below.

It is important to note the inclusion of the following additional text in section 3.1 Identification of domestic violence (page 9), procedures section after the paragraph commencing *"Ask about safety"*:

"Ask about child safety:

- *Do you have children? (If so) have they been hurt or witnessed violence?*
- *Who is/are your child/ren with now? Where are they?*
- *Are you worried about your child/ren's safety?*
- *Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm."*

Procedures in Section 3.2.2, Counselling interventions with victims (page 13) have also been amended by deleting and replacing dot point six under "Assess safety" with the following text:

> *"Are there children involved? Who is/are your child/ren with now? Are they safe? Was/were your child/ren nearby when your partner was violent to you?" Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm (refer to Section 4.5 – Children and domestic violence)"*

It is recommended that any hard copies of the document *Policy and Procedures for Identifying and Responding to Domestic Violence* (2003) in circulation also be amended accordingly.

Living with domestic violence has a serious impact on short- and long-term psychological, emotional and physical health of victims and their children. The aim is to help reduce the incidence of domestic violence through the provision of primary and secondary prevention health care services, and to minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches including ongoing treatment and follow-up counselling.

The term "domestic violence" is used to refer to abuse and violence between adults who are partners or former partners. NSW Health has existing policies and strategies that address other forms of violence that are commonly experienced. Health workers may find this policy can provide guidance in responding to situations where similar dynamics occur, in particular the section on legal responses for domestic violence.

The policy and procedures were developed by the NSW Department of Health in consultation with Area Health Services, interagency partners and non-government organisations.

A core component of the policy is routine screening for domestic violence, which is to be implemented for women attending antenatal and early childhood health services and women aged 16 years and over attending mental health and alcohol and other drugs services in accordance with the policy. Routine screening for domestic violence in NSW Health: an implementation package provides the screening protocol, guide for managers and the learning program: http://internal.health.nsw.gov.au/policy/hsp/domesticviolence/routine_screening.htm

Domestic Violence – Men's Behaviour Change Programs

Document number IB2014_003.

PURPOSE

To provide information about Men's Domestic Violence Behaviour Change Programs.

This information should be read in conjunction with the *Policy and Procedures for Identifying and Responding to Domestic Violence* PD2006_084. Where the information differs, the information in this bulletin applies.

The Policy and Procedures for Identifying and Responding to Domestic Violence are being reviewed in 2013 and the advice in this Information Bulletin will be incorporated into any new Policy Directive.

KEY INFORMATION

In NSW, there are a range of men's domestic violence behaviour change programs, provided by Government and non-government services. These are provided in custodial settings, by welfare groups and by counselling services, and are a valuable service to men seeking to change their abusive behaviour.

The NSW Government has introduced minimum standards for men's domestic and family violence behaviour change programs. The standards will significantly improve the safety of victims of domestic violence and assist those attending programs to stop the violent behaviour. The minimum standards aim to reflect good practice, and foster programs that are safe and effective in changing behaviour.

The standards apply to all group programs for male perpetrators of domestic and family violence in NSW. This includes programs run by government agencies, including NSW Health agencies. It also includes programs run by non-government agencies.

NSW Health responsibilities

The minimum standards are NSW Government policy, and the Director General has signed a formal agreement with the Department of Attorney General and Justice to implement the minimum standards. To comply:

- NSW Health staff should only refer patients/clients to complying programs listed at http://www.domesticviolence.lawlink.nsw.gov.au/,
- Where any NSW Health agency provides funding to Men's Behaviour Change Programs, any new or revised funding agreement should require compliance with the minimum standards,
- Where any NSW Health agency provides funding to relevant community services, new or revised funding agreements should include a clause requiring those NGO staff to refer clients/patients only to programs complying with the Minimum Standards. These services may include Aboriginal Medical Services, Women's Health Centres, multicultural services, Family Planning services, Lifeline, mental health & drug and alcohol services, health services for the homeless, youth services, and victim support services,
- NSW Health staff with concerns or complaints about programs, should report this directly to the Domestic and Family Violence Unit, Crime Prevention Division, Department of Attorney General and Justice at http://www.domesticviolence.lawlink.nsw.gov.au/ or 02 8688 3277

The Principles and Minimum Standards

1. **Principle**: The safety of women and children must be given the highest priority.

1.1.**Standard**: Program providers will develop and operate from written procedures that address risks to women and children.

1.2.**Standard**: Program providers will ensure that current partners of program participants are provided with support prior to and during the program.

1.3.**Standard**: Partner support workers will prepare women for the participation of their partners in the behaviour change group program.

1.4.**Standard**: Partner support workers will complete individual risk assessments and safety plans.

1.5.**Standard**: The contact worker is to disclose to women any new expressed or perceived threat to their safety.

1.6.**Standard**: Where women and children express an interest in having ongoing contact from a partner support worker, additional contact will occur for the duration of the program.

1.7.**Standard**: Group facilitators and partner support workers will have approach knowledge and training about the impact of domestic and family violence on women and children.

1.8.**Standard**: Partner support workers must have relevant knowledge, training and experience to enable them to support and advocate for women and children.

2. **Principle**: Victim safety and offender accountability are best achieved through an integrated, systemic response that ensure that all relevant agencies work together.

   2.1.**Standard**: To ensure program transparency, accountability and integration program providers will develop a formal relationship with relevant local agencies.

3. **Principle**: Challenging domestic and family violence requires a sustained commitment to professional and evidence-based practice.

   3.1.**Standard**: Group facilitators must have relevant knowledge and training.

   3.2.**Standard**: All programs will have a minimum of two group facilitators.

   3.3.**Standard**: Group facilitators must undertake supervision.

   3.4.**Standard**: Program providers will develop policies to ensure that group facilitators undertake ongoing professional development.

   3.5.**Standard**: Behaviour Change Group Programs will have a duration of at least 24 hours over 12 weeks.

   3.6.**Standard**: Program providers will complete an operational review of each program focussing on process and content.

   3.7.**Standard**: Program providers will evaluate the impact of programs on the behaviour and attitude of group participants.

   3.8.**Standard**: Program providers will contribute to an evidence base for behaviour change programs.

4. **Principle**: Perpetrators of domestic and family violence must be held accountable for their behaviour.

   4.1.**Standard**: Programs must be grounded in an evidence-based theory of change.

   4.2.**Standard**: Program providers will document and implement thorough participant assessment procedures.

   4.3.**Standard**: Program provider will have procedures for engaging participants which challenge them to acknowledge their abusive behaviour.

4.4.**Standard**: Program content will include explicit information about the impact of domestic and family violence on women and children and women's disproportionate experience of domestic violence.

4.5.**Standard**: Program content will include information on different forms of domestic and family violence and provide opportunities for participants to come to an understanding about the nature of their offending behaviour.

4.6.**Standard**: Program providers will develop procedures for non-attendance of mandated participants.

4.7.**Standard**: Program providers will have procedures for group facilitators to prevent their implicit or explicit collusion with participants' attitude that support violence against women.

4.8.**Standard**: Program providers will offer appropriate referrals to meet participants' additional needs.

4.9.**Standard**: Program providers must comply with the requirements of a referring agency for a report on the participant's completion of a program.

5. **Principle**: Programs should respond to the diverse needs of the participants and partners.

5.1.**Standard**: Program facilitators must undertake training to ensure culturally competent practice.

5.2.**Standard**: Programs addressing other forms of family violence will be specific to the participant's needs.

Further information can be found at http://www.domesticviolence.lawlink.nsw.gov.au/.

200 (30/01/14)

Domestic and Family Violence Migration Regulations: Relevance for Health Workers

Document number IB2018_017 rescinds IB2005_004.

PURPOSE

This Information Bulletin outlines the special provisions relating to domestic and family violence (DFV) contained in the *Migration Regulations 1994* (the provisions) of the *Migration Act 1958*. It also describes support which can be offered to victims of DFV, in addition to clinical services, by certain professional experts within NSW Health.

This Information Bulletin expands on issues raised in the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence 2006*, regarding clients from culturally and linguistically diverse backgrounds affected by DFV, who hold certain temporary visas.

KEY INFORMATION

The provisions ensure that persons in Australia on certain temporary visas do not feel compelled to remain in abusive relationships in order to stay in Australia.

The provisions are usually invoked by persons on temporary partner visas or prospective marriage visas, who are in the process of applying for a permanent partner visa. The provisions allow these persons to remain in Australia and apply for permanent residence, even though, as a result of DFV and a relationship breakdown, they do not meet the ordinary requirements to obtain a permanent partner visa.

The provisions can also be invoked by persons on certain skilled stream visas in some circumstances.

Victims of DFV seeking to invoke the provisions must substantiate their claims by proving their relationship was genuine until it ended and that DFV took place during the relationship in Australia.

If the victim's claim of DFV has not been heard by a court, that person can provide the following as evidence that DFV took place during their relationship:

- a statutory declaration (form number 1410 for DFV claims first made on or after 24 November 2012, or form number 1040 for claims made on or after 15 October 2007); and
- two items of evidence from **professional experts**.

The *Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116* (IMMI 12/116) provides information on acceptable items of evidence from **professional experts**. Victims of DVF must present at least two of the types of evidence listed in IMMI 12/116 in support of their claim. They cannot present two items of evidence of the same type.

NSW Health workers categorised as **professional experts** include registered medical practitioners, nurses or psychologists and members or eligible members of the Australian Association of Social Workers. Professional experts within NSW Health may provide a statement in a statutory declaration or an official letter with relevant supporting documents in their professional capacity, including a medical report, hospital report or a discharge summary. Their evidence must include:

- details of the violence, identifying all individuals involved;
- evidence or reasons for any opinion or assessment;
- details about their professional relationship with the victim; and
- information regarding services and support offered or provided to the victim.

Professional experts within NSW Health should proactively follow up by asking about the safety of the victim - if they are safe to go home, if they need assistance to go home or a safe place as per the NSW Health policy on *Identifying and Responding to Domestic Violence* PD2006_084.

Professional experts within NSW Health should also identify if children are involved in the violence by asking victims directly. If so, questions should be asked about this - if children have been hurt or witnessed violence, where and who are the children with, and if victims are worried about the children's safety. Professional experts within NSW Health are also required to follow mandatory reporting protocols if they suspect that a child is at risk of significant harm. The NSW Mandatory Reporting Guide should be used as part of this assessment and reports to the Child Protection Helpline should be made where indicated.

REFERENCES

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New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)

Document number PD2014_012 rescinds PD2009_008.

PURPOSE

NSW HEALTHPLAN details the health emergency management arrangements to ensure that health resources in NSW are effectively and efficiently coordinated in the event of emergencies through prevention, preparation, response and recovery.

MANDATORY REQUIREMENTS

NSW HEALTHPLAN is the NSW Health Services Functional Area Supporting Plan to the NSW State Emergency Plan (EMPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

The plan outlines the agreed roles and functions of the eight key contributing health services (Medical Services, Ambulance Services, Mental Health Services, Public Health Services, Health Communications, HealthShare NSW, NSW Health Pathology and The Sydney Children's Hospital Network), which constitute a whole of health response incorporating an all-hazard approach.

NSW Health is designated as the Combat Agency for all health emergencies within NSW under the NSW State Emergency Plan (EMPLAN).

The principal position holder for health emergency management is the State Health Services Functional Area Coordinator (State HSFAC) who is contactable on a 24 hour basis.

The policy directive Emergency Management Arrangements for NSW Health PD2012_067 outlines the mandatory requirements, governance and operational arrangements for the Local Health Districts and the Health Service Functional Area Coordinators.

IMPLEMENTATION

New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) will replace NSW HEALTHPLAN PD2009_008 (v3.5 December 2009).

An e-learning package has been developed and distributed to the Local Health Districts to support the release of this policy and an online learning package is available through Interaction Pulse for NSW Ambulance.

211 (08/05/14)

Major Incident Medical Services Supporting Plan

Document number GL2018_017 rescinds PD2009_048, GL2010_011, PD2009_080.

PURPOSE

The attached plan is the NSW Health Major Incident Medical Services Supporting Plan supporting the NSW Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

The purpose of the NSW MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (NSW MEDPLAN) is to enable medical service resources to be varied from business as usual arrangements and effectively and efficiently coordinate the resources in the event of major incidents requiring a significant and coordinated medical response.

The NSW MEDPLAN details the arrangements to be adopted by NSW Health in order to coordinate all of the hospitals and medical services resources available in NSW (both government and non-government) to the State HSFAC and State Medical Controller for the response and recovery from the impact and effects of a major incident.

The arrangements in this plan will also provide guidance for the preparation of the Local Health District/Network medical services arrangements and procedures of the LHD HEALTHPLAN.

KEY PRINCIPLES

The following principles underpin the NSW MEDPLAN:

1) The Plan shall be read in conjunction with NSW HEALTHPLAN.
2) The provisions defined in the NSWHEALTHPLAN (Part 3) for prevention and preparation responsibilities in a health emergency for NSW Medical services apply.
3) The provisions of the NSW MEDPLAN should not inhibit the LHD instigating a local response, if required.

The plan assigns responsibility to the State Medical Services Controller for hospitals and medical services once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (HSFAC) such that:

a. the management of multiple casualties and potential casualties is centrally coordinated (both government and non-government)
b. definitive care is provided as rapidly as possible. This may require deployment to the incident, receiving hospitals or other emergency centres.

The plan identifies recommended actions under four phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are identified in the NSW HEALTHPLAN and are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases (Parts Three and Four) are recommended to be carried out once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (State HSFAC).

The primary role for medical services in the response phase will be to manage multiple casualties and potential casualties using central coordination to ensure the provision of definitive care as rapidly as possible.

USE OF THE GUIDELINE

The NSW MEDPLAN:

a. Covers the governance structure for standby, response and recovery for major incident management [Part Three – Four].
b. Addresses the coordination of all hospitals and medical services in NSW (both government and non-government) for response to and recovery from major incidents [Annex One].
c. Assigns responsibility to the State Medical Services Controller for the statewide coordination of hospitals and medical services so that the management of multiple casualties is centrally coordinated. This ensures that definitive care is provided as rapidly as possible.
d. May require deployment of Scene Medical Commander(s) and Emergency Medical Teams either to assist hospitals overwhelmed by casualties or to the incident.
e. Represents the first hours of a major incident and not a protracted event.

Responsibilities of key parties are detailed in Part Two of the NSW MEDPLAN. Action Cards for specific position holders are listed in Annex Three with specific actions. Details for the Concept of Operations for LHDs are listed in Annex Four. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

Reporting and Governance of this Plan and key parties are outlined in Annex One.

319 (25/06/18)

Mass Casualty Triage – Smart Triage Packs

Document number PD2017_037 rescinds PD2011_044.

PURPOSE

This policy specifies the use of Mass Casualty Triage - SMART Triage Packs in a mass casualty situation to denote the priority for treatment under the Medical Service Supporting Plan (GL2010_011).

MANDATORY REQUIREMENTS

This policy sets the requirements for the use of the SMART Triage Packs for mass casualty triage, documentation in the field and when patients are immediately transported to hospital. The SMART Triage Tags form part of the patient's health record.

In Local Health Districts, the SMART Triage Packs form part of the Health Response Team Medical Equipment list requirements (PD2009_080). NSW Ambulance carries SMART Triage Packs across all ambulance vehicles for use in mass casualty incidents.

IMPLEMENTATION

This policy replaces PD2011_044 Mass Casualty Triage Pack – SMART Triage Pack which was implemented across Local Health Districts and NSW Ambulance in 2011.

SMART Triage Packs are included in the HealthShare NSW catalogue.

Local Health Districts

Local Health Districts are responsible for:

- Ensuring that the policy is brought to the attention of staff who are responsible for maintenance, storing, management and use of the SMART Triage Packs.
- Ensuring staff are appropriately trained in the use of the Kits.
- Ensuring Health Response Team Kits within the Local Health District are stocked with two (2) SMART Triage Packs.

NSW Ambulance

NSW Ambulance is responsible for:

- Ensuring that the policy is brought to the attention of staff who are responsible for maintenance, storing, management and use of the SMART Triage Packs.
- Ensuring staff are appropriately trained in the use of the Kits.
- Replacing and maintaining the stock of SMART Triage Pack items in NSW Ambulance fleet.

NSW Health Emergency Management Unit

NSW Health Emergency Management Unit is responsible for:

- Reviewing and updating this policy every three (3) years or earlier if any request is made to NSW Health Emergency Management Unit following a mass casualty incident or operation.
- E-learning package for Mass Casualty Triage Training.

Closed Head Injury in Adults - Initial Management

Document number PD2012_013 rescinds PD2008_008.

PURPOSE

The purpose of this policy is to advise that the *Initial Management of Closed Head Injury in Adults* clinical practice guideline has been updated to reflect the latest evidence based practice for the management of adults with a closed head injury. The guideline provides clinicians with practical evidence based recommendations to assist in the initial management of adults with mild, moderate and severe head injury.

The policy is to ensure that all Local Health Districts have protocols in place based on the key principles of the guideline.

The clinical practice guideline was prepared for the Ministry of Health by an expert clinical reference group under the auspice of the NSW Institute of Trauma and Injury Management.

MANDATORY REQUIREMENTS

This policy requires all health services to have local guidelines/protocols based on the clinical practice guideline in place in all hospitals and facilities likely to be required to assess or manage patients with a closed head injury.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the acute management of head injury. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. The 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 Initial Management of Closed Head Injury in Adults clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage patients with a closed head injury.
- Ensure that all staff treating patients with a head injury are educated in the use of the locally developed protocols.

Directors of Clinical Governance are required to inform relevant clinical staff treating patients of the revised protocols.

147 (09/02/12)

NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements

Document number PD2023_019 rescinds PD2010_030, PD2010_031, PD2005_157.

POLICY STATEMENT

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

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

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

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

If a bordering jurisdiction's retrieval team is conducting the transfer, NETS will maintain contact with the referring treating team and provide clinical leadership until NETS confirms that the

bordering retrieval team has taken over direct patient care. On handover, governance of the transport process moves to the bordering jurisdiction's transport/ retrieval service.

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

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

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

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

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

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

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

347 (07/08/23)

Departure of Emergency Department Patients

Document number PD2014_025 rescinds PD2005_082.

PURPOSE

For the purpose of this policy, '**Departure from Emergency Department**' refers to patients leaving the Emergency Department (ED) whether they are to be discharged, admitted or transferred to another facility.

This policy outlines the principles for implementing a standardised approach to determining whether a patient is ready for departure from NSW EDs once the ED phase of their care is complete. These principles are to be implemented by NSW Public Health Organisations.

For information on patients awaiting care or commencement of clinical treatment please see PD2013_047 '*Triage of Patients in NSW Emergency Departments*' and PD2010_075 '*Emergency Department Patients Awaiting Care*'.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations must:

- Ensure that local processes are in place which comply with this policy and support the four principles of readiness for departure from ED described here
- Confirm that processes are in place in each ED to ensure that all patients are ready for departure from ED upon completion of the ED phase of their treatment and have been authorised as ready to depart. Readiness for departure from ED encompasses the following four principles:
    - The patient is safe for departure from a clinical and functional perspective.
    - The patient has had appropriate risk assessments undertaken prior to departure.
    - Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
    - Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred. Patients should be given post-discharge care instructions in plain language which is relevant to the individual and provides information that adequately desc ribes follow up treatment. Communication must be undertaken with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED, particularly if there is a requirement for them to provide patient care or a request to follow up outstanding care requirements.
- Ensure all staff are aware of the 'Departure of Emergency Department Patients' policy and their responsibilities in relation to managing the departure from ED of patients.
- Ensure that the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists are utilised to support implementation of this policy as per NSW Health policy PD2013_049 'Recognition and Management of Patients who are Clinically Deteriorating'. If the ED charts specifically are not used, that alternate local processes must be in place which demonstrate all information on the checklist being collected for patients.
- Ensure that local evaluation of compliance with this policy is undertaken. This should include internal review of incidents related to departure of patients from ED and review of consistency of use of the Adult and Paediatric ED Observation chart 'Departure and Discharge from ED' checklists (or equivalent local process).

IMPLEMENTATION

Local Health District and Specialty Health Network Chief Executives are responsible for:

- Assigning responsibility, personnel and resources to implement this policy
- Establishing mechanisms to ensure that the mandatory requirements are applied, achieved and sustained as usual processes for departure of patients from ED; this should include nomination of an executive sponsor
- Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management and other relevant staff
- Ensuring that hospital and ED processes support the minimisation of delays for patients departing the ED, including limiting delays which may occur as a result of the requirement to complete the ED departure process.

220 (24/07/14)

Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS)

Document number PD2018_011 rescinds PD2010_021.

PURPOSE

This Policy Directive refers to critically ill or injured adult patients and those **at risk of critical deterioration** requiring referral and transfer of care to a higher level facility.

The policy defines the links between Local Health Districts (LHDs) and tertiary referral hospitals and takes into account established functional clinical referral relationships.

The policy outlines the roles of state clinical specialty referral networks that operate in conjunction with the NSW Critical Care Tertiary Referral Networks (Section 10). It describes the process for time urgent and non-time urgent patients, referral process for retrieval services, the default adult intensive care unit (ICU) bed policy and the requirement for LHD escalation processes.

MANDATORY REQUIREMENTS

- Access to emergency care and/or surgical intervention for time urgent critically ill or injured patients must not be delayed due to “no-available” ICU or specialty bed e.g. burns, cardiac or spinal. Should this situation arise Aeromedical Control Centre (ACC) is to be contacted immediately.
- Requirements for transfer of critically ill obese patients outlined in Section 6 must be applied.
- Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of critically ill or injured patients. This should include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review and referral of non-time urgent critical patients (Section 8). Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the network or difficulties are experienced with patient acceptance and placement.
- Every hospital is linked to a designated tertiary referral hospital which is networked to a group of referring hospitals to provide critical care for their patients. In situations where no adult intensive care beds are available across NSW, the default adult ICU bed policy may be invoked (Section 12). When the default policy is invoked the designated tertiary hospital is responsible for providing critical care, irrespective of bed status, to a specified group of referral hospitals. This responsibility includes assisting with patient placement to an appropriate alternative location for treatment and care.
- In time urgent situations the ACC has the authority to transport the patient directly to the designated tertiary hospital regardless of available bed state. If there is a closer hospital that can provide the time urgent treatment required, ACC may elect to transport the patient there. This may include referral across LHD boundaries. In each case the ACC Consultant must notify the receiving clinician.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

- Ensuring implementation of the policy directive and the delegation of a single point of arbitration and decision making to ensure clinically appropriate transfers in appropriate timeframes.

- Meeting the critical care and intensive care needs of that LHD and linked rural LHD, where specified. This includes the provision of clinical advice and ensuring access to appropriate treatment.
- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe.
- Ensuring that all options for placement of the critically ill patient within the originating LHD have been explored. This includes appropriate transfers from ICUs within the LHD to inpatient areas to create capacity.
- Ensuring the continued effective operation of the NSW Critical Care Tertiary Referral Network.
- Ensuring formalised intra and inter-LHD referral and/or cross jurisdictional arrangements exist for critically ill or injured patients needing a higher level of definitive care and include ongoing formal communication with review and feedback.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Intensive Care Units are responsible for:

- Ensuring the information in the Critical Care Resource management System (CCRS) or Patient Flow Portal (PFP) is current and correct at each shift handover.
- Bed finding for non-time urgent critically ill or injured patients

Patient Flow Units/Bed/ After Hours Managers are responsible for:

- Facilitating referrals for all non-time urgent critically ill patients.

The NSW Aeromedical Control Centre (ACC) (**1800 650 004**) is responsible for:

- Coordination of adult medical retrieval for time urgent critically ill patients in collaboration with the Regional Retrieval Services across NSW.

298 (28/03/18)

Maternity - Resuscitation of the Newborn Infant

Document number GL2018_016 rescinds PD2008_027.

PURPOSE

This Guideline aims to optimise, facilitate and standardise newborn resuscitation by endorsing the Australian and New Zealand Committee on Resuscitation (ANZCOR) Guidelines - Section 13: Neonatal Guidelines (2016- 17) for use by NSW Health.

KEY PRINCIPLES

This Guideline applies to all clinicians who care for newborn infants in maternity and related environments and to the resuscitation of the newborn immediately following birth and during the birth admission.

USE OF THE GUIDELINE

This Guideline:

- replaces the Policy Directive PD2008_027 Maternity - Clinical Care and Resuscitation of the Newborn Infant
- endorses ANZCOR Guidelines (2016-2017) Section 13 - Neonatal guidelines 13.1-13.10 and the Newborn Life Support algorithm (Attachment 1)
- outlines local health district responsibilities to develop systems to ensure:
    - clinicians are appropriately targeted to complete mandatory and recommended newborn basic life support education, training and proficiency requirements
    - locally determined clinicians complete newborn advanced life support education, training and proficiency requirements, and are in attendance at the birth of newborn infants who are at higher risk of requiring resuscitation at birth
    - standardised newborn resuscitation equipment is available and operational and clinicians are familiar with the equipment
    - local procedures are in place to review resuscitation interventions and outcomes to monitor patient safety and quality of care and improve training and performance.

Hospital Response to Pandemic Influenza Part 1: Emergency Department Response

Document number PD2007_048.

This document describes the emergency department component of a broader area health service response to pandemic influenza. This document should be read in conjunction with an individual area health service's pandemic influenza plan, which will describe how the area health service will support emergency departments' response to the required additional duties of rapid identification, isolation, and management of suspected and actual pandemic influenza cases.

64 (2/08)

Public Health Real-time Emergency Dept Surveillance System (PHREDSS) Public Health Unit Response

Document number GL2010_009.

PURPOSE

These guidelines describe the purpose and activities of the ED Surveillance Team in monitoring PHREDSS and reporting to Public Health Units (PHUs). It also describes the reasons that a PHREDSS Situation Report will be sent to a PHU and provides guidance for PHUs in considering activity in response to a PHREDSS Situation Report.

KEY PRINCIPLES

PHREDSS provides daily monitoring of ED visits presenting with various health problems grouped into syndromes. Each PHREDSS signal is assessed by the ED Surveillance Team before further reporting. The ED Surveillance Team issue a Situation Report via electronic mail to relevant Departmental and Area Health Service public health authorities for consideration if one or more of the following criteria are met:

- A higher than expected or sustained increase in ED visits (an unseasonal increase) for a syndrome;
- A significant change in the epidemiology of a syndrome (such as the age or sex distribution);
- An increase in the severity or urgency of the ED visits for a syndrome (based on admission status or triage category);
- An increase in an inherently severe syndrome such as meningitis/encephalitis, critical care admissions or deaths in ED; or
- An increase in a syndrome of particular interest to a stakeholder or stakeholder group (eg. influenza-like-illness, gastrointestinal illness, annual childhood asthma epidemics, drug or alcohol misuse).

USE OF THE GUIDELINE

The level of response from a PHU to a PHREDSS Situation Report should be graded according to:

- the apparent size of the increase in the syndrome reported;
- the severity of the illness being caused;
- the opportunity for intervention by the PHU;
- and any existing local knowledge.

NSW Department of Health may direct or provide guidance for a coordinated response.

Retrieval Handover (Adults)

Document number PD2012_019.

PURPOSE

The purpose of this Policy is to confirm the process to ensure a coordinated handover and transfer of care between hospital clinicians and medical retrieval teams. Compliance with this Policy will minimise the chances of adverse events during handover of adult retrieval patients between hospital and retrieval teams.

A medical retrieval is defined as the interhospital transfer of an acutely or critically ill patient by a team that includes a medical (physician) escort. The majority of medical retrievals are done by teams with specific training, equipment and experience in out-ofhospital care for critically ill patients. These teams belong to medical retrieval services that are recognised and authorised by NSW Health.

This policy is intended for use by senior clinical medical and nursing staff in critical care areas of hospitals, particularly the Emergency Department and Intensive Care Units. The procedures for retrieval handover are regarded as a safe and appropriate approach for the efficient handover of clinical care of adult patients between the retrieval team and the senior clinician at the hospital.

Timely and efficient handover of clinical care of patients between the retrieval team and the senior clinician at the hospital should occur before the transfer of management begins (unless urgent resuscitation is required) to ensure a systematic transfer of patient care. The full transfer of care is completed once all monitoring and therapies are safely established and this is verbally confirmed by the team who are taking over the care of the patient.

This Policy is complements Clinical Handover – Standard Key Principles (PD2009_060) which mandates the implementation of standard principles for all types of clinical handover.

MANDATORY REQUIREMENTS

This policy requires all health services to have local guidelines/protocols for retrieval handover in place for all hospitals and facilities involved in the transfer of care of adult patients between hospital and retrieval teams.

IMPLEMENTATION

Chief Executives must ensure that health facilities implement a process for retrieval handover to ensure the safe transfer of patient care between retrieval teams and hospitals.

Emergency Department Short Stay Units

Document number PD2014_040.

PURPOSE

This policy outlines the mandatory requirements for the use of Emergency Department Short Stay Units (EDSSUs) in NSW Hospitals. EDSSUs are Inpatient Units, managed by Emergency Department (ED) staff, designated and designed for the short term (generally up to 24 hours) treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department.

The National Partnership Agreement on Improving Public Hospital Services clearly states the requirements for EDSSUs in Australia. However further detail is required for NSW Hospitals to ensure correct implementation of these requirements.

MANDATORY REQUIREMENTS

Emergency Department Short Stay Units in NSW must adhere to the following principles:

- EDSSUs are Inpatient Units attached to emergency departments, managed under the clinical governance of the ED senior clinical management team located at the hospital.
- EDSSUs are designated and designed for the short term treatment, observation, assessment and reassessment of patients with selected conditions, initially triaged and assessed in the ED.
- The aim of EDSSU is to improve care of ED patients, improve the flow of patients through the ED, thereby improving ED bed access and reducing inpatient ward length of stay for EDSSU appropriate patients.
- EDSSUs must have specific admission and discharge criteria and policies. General principles for admission to EDSSU should focus on patients that are:
    - Clinically stable AND
    - Anticipated to require a period of observation or treatment less than 24 hours.

  In some facilities, it may be appropriate for clinically stable ED patients being transferred to another facility, after confirmation of timely availability of a bed at the accepting facility has occurred, to be admitted to EDSSU pending transport to the accepting facility.
- The design of the EDSSU should be a purpose built facility which allows it to be physically separated but in close proximity to the ED, have a static number of beds with oxygen suction and include its own patient bathroom and shower facilities.
- EDSSUs are not a temporary ED overflow area nor used to keep admitted patients who are solely awaiting an inpatient bed nor awaiting treatment in the ED prior to medical assessment.
- EDSSUs are staffed by dedicated Medical, Nursing and Allied Health staff with appropriate skills and knowledge to manage EDSSU patients. Patients are admitted under the care of the designated Specialist Emergency Physician rostered for EDSSU. In facilities with no Specialist Emergency Physician, other Specialist Medical Officers credentialed to admit patients to the hospital as a treating Specialist may be designated as responsible for EDSSU admissions.
- Patients admitted to EDSSU whose condition changes and therefore require a bed on an appropriate inpatient ward should have timely allocation of the bed through hospital patient

flow processes. This is to ensure timely access to appropriate care and flow of ED patients into EDSSU is not impeded.

- Regular monitoring of EDSSUs is important to ensure efficient and appropriate use of EDSSU beds. An admission rate (from EDSSU into the hospital) of 10%- 15% is considered acceptable.
- Regular review of incidents should be undertaken as per the EDs procedure for compliance with PD2014_004 Incident Management Policy and be included in ED Morbidity and Mortality meetings.
- Two specific measures for patients admitted to EDSSU (Bed Type 59) which are monitored on a state-wide level are:
    1. Length of Stay in the EDSSU, reported as:
        - Percentage of all patients admitted to EDSSU with a LOS (in the EDSSU) less than or equal to 24 hours (calculated in minutes), and
        - Percentage of all patients admitted to the EDSSU with a length of stay less than 4 hours (calculated in minutes).
    2. Destination on departure from the EDSSU
        - Percentage of all patients admitted to EDSSU who were either:
            - Discharged home
            - Transferred to another admitted patient setting in the same service
            - Discharged to another health service.

Local teams should review adherence to these monitoring measures.

IMPLEMENTATION

Local Health District Chief Executives are responsible for:

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

ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for admission of patients to EDSSU. This should include nomination of an executive sponsor

iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance unit, ED senior management, and clinical staff.

Emergency Department, Nurse Delegated Emergency Care, Medication Standing Orders

Document number PD2015_024.

PURPOSE

The Nurse Delegated Emergency Care (NDEC) patient care model has been developed to support rural and remote facilities provide care for patients presenting to Emergency Departments with low-risk, low-acuity conditions. Under NDEC the care of these patients is managed entirely by an appropriately trained and credentialed Registered Nurse (RN), under the explicit delegation of the site Medical Officer/s.

The statewide Standing Order authorises an appropriately trained and credentialed Registered Nurse to administer and / or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the NDEC patient care model. The Standing Orders describe procedures for ordering, storing, administering, and supplying (for take-home use) the specified medication. Any medication Standing Order must be used in conjunction with the applicable NDEC Nursing Management Guideline.

The statewide Standing Order for Nurse Delegated Emergency Care applies where the provision of medication is required to treat patients in the Emergency Department with certain less-urgent, low-risk conditions.

MANDATORYREQUIREMENTS

This policy is for the management of patients presenting to Emergency Departments with certain less-urgent, low-risk conditions by appropriately trained and credentialed registered nurses practicing under the NDEC model.

When the implementation requirements outlined in this policy are met, the statewide Standing Order provides the basis for Institutional / Local Health District (LHD) Drug and Therapeutics Committees (DTC) to adopt the NDEC patient care model. DTCs must review and endorse Standing Orders locally.

IMPLEMENTATION

In order to fulfil the standing order, supply of medications will need to be arranged with a public hospital pharmacy department, on behalf of the public health organisation, and at the request of the Public Health Officer (if a medical officer) or a medical officer designated by the District's Public Health Unit Director / Public Health Officer.

The standing order authorises a registered nurse to administer and supply medications to patients with defined conditions for the purpose of treatment of defined low-risk conditions. Administration or supply may only be carried out in Emergency Departments by registered nurses trained and credentialed to operate the Nurse Delegated Emergency Care patient care model.

Safe Assessment Rooms

Document number GL2020_001.

PURPOSE

The purpose of this Guideline is to outline the requirements for the design and use of Safe Assessment Rooms (SARs) in NSW Emergency Departments (EDs). A SAR is designed to accommodate the needs of patients with, or at risk of developing, acute severe behavioural disturbance (ASBD) who require assessment in a therapeutically supportive environment.

KEY PRINCIPLES

- All NSW Health Organisations with a SAR should have local processes in place which comply with this Guideline and support the principles detailed here.
- The SAR is a staffed clinical area for the purposes of ED staffing allocation, staff establishment and clinical governance
- ED capacity relies on the flexible use of treatment spaces, and no individual patient group is identified as being the sole user of the SAR. The room may be used for a variety of clinical purposes.
- SARs have a number of design features which allow the patient to be managed in a safe environment while also optimising the safety of other patients and staff.
- The use of co-design methodology is a key principle to inform and support development, design and use of the SAR.
- SARs are not intended to be used for seclusion
- SARs should not be the default pathway in the ED for people presenting with mental health conditions.
- A collaborative approach between the ED and mental health (MH), drug and alcohol, and security services on the governance, safe practice, and use of SARs is beneficial for good patient outcomes.
- Police and NSW Ambulance are key stakeholders.

USE OF GUIDELINE

This Guideline should be used as a resource to support NSW Health organisations to co-design clinical spaces and local guidelines and policies to support management of patients with or at risk of developing ASBD.

Early Evidence Collection

Document number GL2022_010.

GUIDELINE SUMMARY

Early evidence collection is the process of supporting a patient who has or may have experienced a recent sexual assault to self-collect early forensic and/or toxicology samples to support the criminal justice process.

The Guideline provide clinicians with guidance for facilitating, storing, and documenting early evidence collection.

KEY PRINCIPLES

Early evidence collection is offered as part of an integrated crisis response when a person has or may have experienced a recent sexual assault.

Early evidence kits are to be offered to adults, young people and children who are able to self-collect samples.

Early collection of forensic and toxicology samples is to be offered in all sexual assault services and Level 3-6 Emergency Departments. This may also be offered in other NSW Health settings at the discretion of Local Health Districts (districts) and Specialty Health Networks (networks).

A person's physical and emotional health, safety and wellbeing must be prioritised even when particular time frames exist in the gathering of forensic evidence.

When offering early evidence collection, NSW Health workers must provide responses that:

- are respectful, non-judgmental and validating
- assist the person to regain their sense of dignity and control
- help access information and resources
- promote choice and control over actions taken
- increase safety
- support the person in reconnecting with the self and to those who provide safe support.

All settings offering early evidence collection must consult with the district or network's sexual assault service to draft local processes that follow the principles and processes within this Guideline. Local processes must include a pathway for involving a sexual assault service in the collection, storage, release and destruction of forensic and toxicology samples to ensure psychosocial support for the patient is prioritised.

344 (28/09/22)

Managing non-fatal strangulation in the emergency department

Document number IB2023_038.

PURPOSE

This Information Bulletin advises local health districts and specialty health networks of the publication of the Agency for Clinical Innovation Clinical Practice Guide *Managing non-fatal strangulation in the emergency department*.

The Clinical Practice Guide outlines the necessary assessment and clinical management of non-fatal strangulation, including medical imaging for patients presenting with non-fatal strangulation and mandatory reporting requirements along with addressing the psychosocial factors that need to be addressed as part of care in the emergency department.

KEY INFORMATION

The Clinical Practice Guide *Managing non-fatal strangulation in the emergency department* provides clinical support to those managing adult and paediatric patients presenting to the emergency department with non-fatal strangulation.

The Clinical Practice Guide has been developed to improve patient care by increasing healthcare workers' awareness of the potential risks and injuries resulting from non-fatal strangulation, and by outlining appropriate assessment and management or care coordination of an episode of non-fatal strangulation.

The Clinical Practice Guide emphasises the importance of follow up for people who have experienced non-fatal strangulation who are a population at high risk of poor outcomes.

The Clinical Practice Guide is supported by the *Non-fatal strangulation facility contact list* which is a document for facilities to populate with psychosocial support services, referral pathways, specialist advice and employee support details for staff.

347 (04/09/23)