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CHAPTER 12 – MEDICAL CARE

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INCIDENT MANAGEMENT (PD2020_047)

PD2020_047 rescinds PD2020_020

PURPOSE

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

SUMMARY OF POLICY REQUIREMENTS

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

Notify incidents and escalate

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

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

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

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

Open disclosure

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

Clinical incident review

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

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

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

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

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

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

Corporate incident review

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

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

A corporate Harm Score 1 review must be undertaken following a corporate Harm Score 1 incident, using a review method determined by the type of corporate incident.

The review is to identify any underlying factors as to why the incident occurred and make recommendations to prevent and minimise risk of recurrence.

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

Implementation and feedback

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

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

The complete Incident Management Policy and Procedures is available from
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_047

333(14/12/20)

OPEN DISCLOSURE (PD2023_034)

PD2023_034 replaced PD2014_024

The Open Disclosure Policy Directive sets out the minimum requirements for implementing open disclosure within NSW Health facilities and services.

The complete Open Disclosure policy is available from:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_034

347(18/10/23)

SAFETY ALERT BROADCAST SYSTEM (PD2013_009)

PURPOSE

The NSW Ministry of Health Safety Alert Broadcast System (SABS) is the mechanism to provide a systematic approach to the distribution of patient safety information to the NSW health system and includes a mechanism to ensure the required action and management of patient safety issues by health services.

The SABS includes three tiers of notifications to provide NSW health services with early warnings of issues, namely:

- Safety Alert
- Safety Notice
- Safety Information

MANDATORY REQUIREMENTS

Safety Alerts

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to staff identified in the Alert (and other staff as relevant).
- Acknowledge receipt of the SAB within the defined timeframe.
- Ensure completion of required actions within the designated timeframe.
- Submit required responses to the CEC within the designated timeframe.

Safety Notices

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to staff identified in the Alert (and other staff as relevant).
- Consider the relevance of the information to the Local Health District.
- Review relevant policies and procedures to address the issues.
- Identify any actions required and implement those actions.
- Submit required responses to the CEC within the designated timeframe.

Safety Information

Local Health Districts/Specialty Health Networks must:

- Distribute the SAB to all staff.
- Consider the relevance of the information to the Local Health District.
- Identify any actions required and implement those actions (if appropriate).
- Submit required responses to the CEC within the designated timeframe.

IMPLEMENTATION

NSW Clinical Excellence Commission is responsible for

- assessment of information received and production of SABS document
- distribution of SABS notifications to NSW health services in a timely manner
- monitoring State-wide implementation of requested actions
- providing reports to the Clinical Risk Action Group (CRAG) on compliance of mandatory actions with SABS
- reviewing the SABS Policy Document in accordance with PD2014_043, NSW Health Policy Directives and Other Policy Documents.

Chief Executives are responsible for establishing an efficient and effective process for

- receipt, distribution, implementation and effectiveness for SABS notifications,
- ensuring distribution of SABS notifications to the appropriate people within the health service,
- acknowledging receipt of SABS Safety Alerts within a time frame defined at the time of release, ideally within 2 days.

Directors of Clinical Governance are responsible for

- ensuring implementation of nominated action/s, where relevant,
- monitoring the effectiveness of the SABS within the health service.

1. BACKGROUND

1.1 About this document

The NSW Ministry of Health and the Clinical Excellence Commission are made aware of issues affecting patient safety from a variety of sources. These include but are not limited to:

a. Incident Information Management System (IIMS) incident notifications.

b. Reportable Incident Brief (RIB) information and Root Cause Analysis (RCA) reports.

c. Health Care Complaints Commission (HCCC) and Coroners reports.

d. Information from Health Services, the Clinical Excellence Commission (CEC), the Australian Commission on Safety and Quality in Healthcare, and other jurisdictions.

e. Safety alerts, product recalls and notices issued by organisations including the Therapeutic Goods Administration (TGA), international authorities such as the US Food and Drugs Administration (FDA) and the UK Medicines and Healthcare Products Regulatory Agency (MHRA).

This Policy Directive outlines the NSW Ministry of Health's approach to the communication and management of statewide patient safety issues raised through these sources.

The Safety Alert Broadcast System (SABS) aims to:

a. Provide a coordinated approach to the management and distribution of patient safety information within NSW Health Services.

b. Ensure that SABs notifications have been received by the Chief Executive of each Local Health District/Specialty Health Network or service and that appropriate distribution of the information occurs.

c. Monitor NSW Health service implementation of risk management strategies.

SABs policy does not apply to:

a. Public Health alerts issued by the Chief Health Officer (CHO) about environmental health issues, food safety, or consumer products or public health events related to communicable diseases such as SARs or pandemic influenza.

b. Corporate alerts relating to areas such as equipment (other than medical devices), power supply and information technology.

c. WorkCover alerts and notices.

Compliance with this policy is mandatory for all health service staff.

Private health facilities should review the information provided in SABS and implement any action as appropriate to ensure patient safety.

Key definitions

CEC	A board governed statutory health corporation established under the Health Services Act as part of the NSW Patient Safety and Clinical Quality Program (PSCQP). It builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001.
Clinical Governance	Clinical governance can be considered as the responsibility of governing bodies to demonstrate sound strategic and policy leadership in clinical safety and quality, to ensure appropriate safety and quality systems are in place and to ensure organisational accountability for safety and quality.
The Ministry	NSW Ministry of Health.
DCG	Director, Clinical Governance.
Health Services	For the purposes of this policy, the term "health services" refers to Public Health Organisations, Justice and Forensic Mental Health Network and the Ambulance Service of NSW
HCCC	Health Care Complaints Commission.
IIMS	Incident Information Management System
IRR	Information Risk Rating
Local Health Districts, Specialty Health Networks and Services	Organisations constituted under the *Health Services Act 1997* that are principally concerned with the provision of health services to residents within a designated geographic area and/ or service type.
Private Health Facilities	Private health facilities licensed under the *Private Health Facilities Act 2007.*
Public Health Organisations (PHO)	This term refers to Local Health District, statutory health corporations or an affiliated health organisation in response of its recognised establishments and recognised services as defined in the *Health Services Act 1997*.
PSCQP	Patient Safety and Clinical Quality Program (PD2005_608)
RIB	Reportable Incident Brief
RCA	Root Cause Analysis
SABS	Safety Alert Broadcast System
TGA	Therapeutic Goods Administration

2. SABS NOTIFICATIONS

The SABS notifications provide a systematic three-tiered approach to the distribution, prioritisation and management of patient safety information. This includes a standardised system for monitoring the implementation of required actions by health services.

The three notifications issued under the SABS use the following colour coding to indicate the level of urgency.

1. **Safety Alert** (Red)
2. **Safety Notice** (Amber)
3. **Safety Information** (Green)

2.1 Safety Alert (Red)

The aim of the **Safety Alert** is to quickly disseminate information to Local Health Districts (LHDs)/Specialty Health Networks about a safety matter needing **immediate attention and action.** The Safety Alert will specify **mandatory** action/s to be taken by health services and the timeframes in which such actions should occur and assign responsibility for action. The colour coding for Safety Alerts is **RED**. This Alert takes precedence over any contrary policy/procedure/ guideline contained in a Policy Directive or Guideline. On receipt of a Safety Alert, LHDs/ Specialty Health Networks are to ensure local policies/procedures/guidelines comply with the information contained therein.

2.2 Safety Notice (Amber)

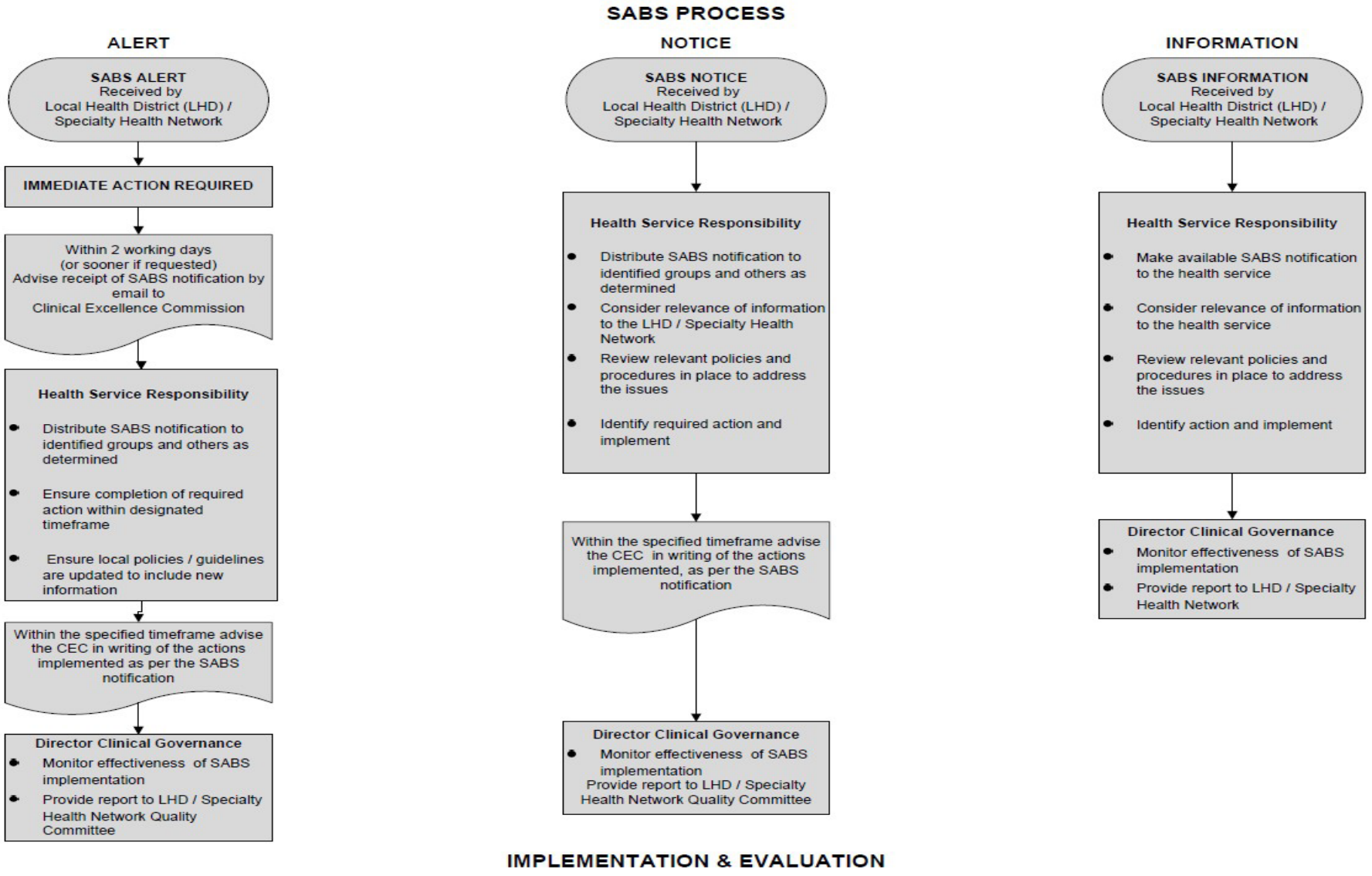
The aim of the **Safety Notice** is to inform Local Health Districts/Specialty Health Networks about potential quality and safety issues requiring **risk assessment at the local level** to determine appropriate action/s regarding any identified problems. The colour coding for Safety Notices is **AMBER**.

2.3 Safety Information (Green)

The aim of the Safety Information is to disseminate quality and safety information to health services to ensure lessons learned from State-wide, national and international sources are shared across the NSW Health System in an active manner. The Safety Information may include items such as updates on State-wide initiatives implemented under the NSW Patient Safety and Clinical Quality Program, information about Policy Directives and Guidelines and access to the most current information focusing on clinical quality and patient safety issues and research. The colour coding for Safety Information is GREEN

Table 1 Easy Guide to health service responsibilities for receipt and management of a SABS notification

SABS document	Aim	Distribution strategy*	Health service response on receipt of SABS document
Safety Alert	Alert LHDs/Specialty Health Networks to a safety matter needing **immediate attention and mandatory action.** The colour coding for Safety Alerts is **RED**.	The CEC distributes SABS to: • The Chief Executive; and • The officer responsible for designated action/s (indicated on the SABS). The LHD/Specialty Health Network distributes SABS to: • staff identified in the Alert; and • other relevant staff.	• Acknowledge receipt within a defined time frame, usually 2 working days. • Ensure completion of required action/s within designated timeframe. • Ensure local policies and guidelines are updated to include new information if required. • Submit required responses to the CEC within the designated timeframe at quality@cec.health.nsw.gov.au.
Safety Notice	Informs LHDs/Specialty Health Networks or services about potential quality and safety issues requiring **risk assessment at the local** level to determine appropriate action regarding any identified problems. The colour coding for Safety Notices is **AMBER**.	The CEC distributes to: • The Chief Executive; and The officer responsible for suggested action/s. The LHD/Specialty Health Network distributes SABS to: • staff identified in the Notice; and • other relevant staff.	• Consider relevance of information to the LHD/Specialty Health Network or service. • Review relevant policies and procedures in place to address the issues. • Identify required action/s and implement. • Submit required responses to CEC within the designated timeframe at quality@cec.health.nsw.gov.au.
Safety Information	Disseminates quality and safety news to LHDs/ Specialty Health Networks or services to ensure lessons learned are shared across health services. May include updates on initiatives implemented under the NSW Patient Safety and Clinical Quality Program, information about policy directives and guidelines and provide access to the latest information and research focusing on clinical quality and patient safety. The colour coding for Safety Information is **GREEN**.	The CEC distributes to: • The Chief Executive and the Director of Clinical Governance. The LHD/Specialty Health Network ensures: • the availability of Safety Information to all staff.	• Consider relevance of the information to LHD/Specialty Health Network. • Identify any action/s and implement (if any).


SABS PROCESS
ALERT
SABS ALERT
Received by
Local Health District (LHD) /
Specialty Health Network
IMMEDIATE ACTION REQUIRED
Within 2 working days
(or sooner if requested)
Advise receipt of SABS notification by email to
Clinical Excellence Commission
Health Service Responsibility
Distribute SABS notification to identified groups and others as determined
Ensure completion of required action within designated timeframe
Ensure local policies / guidelines are updated to include new information
Within the specified timeframe advise the CEC in writing of the actions implemented as per the SABS notification
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network Quality Committee
NOTICE
SABS NOTICE
Received by
Local Health District (LHD) /
Specialty Health Network
Health Service Responsibility
Distribute SABS notification to identified groups and others as determined
Consider relevance of information to the LHD / Specialty Health Network
Review relevant policies and procedures in place to address the issues
Identify required action and implement
Within the specified timeframe advise the CEC in writing of the actions implemented, as per the SABS notification
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network Quality Committee
INFORMATION
SABS INFORMATION
Received by
Local Health District (LHD) /
Specialty Health Network
Health Service Responsibility
Make available SABS notification to the health service
Consider relevance of information to the health service
Review relevant policies and procedures in place to address the issues
Identify action and implement
Director Clinical Governance
Monitor effectiveness of SABS implementation
Provide report to LHD / Specialty Health Network
IMPLEMENTATION & EVALUATION

3. DISTRIBUTION OF SABS NOTIFICATIONS TO LOCAL HEALTH DISTRICTS/SPECIALTY HEALTH NETWORKS

The Clinical Excellence Commission will ensure that the SABS notification is distributed by the following process:

1. Email to all Chief Executives.
2. Copy of the email to each Chief Executive nominated person.
3. Copy of email to all Directors of Clinical Governance.
4. Copy of email to position assigned responsibility for action in the SABS document.
5. Copy of email to Director, Private Health Care for distribution to licensed private health facilities.
6. Copy of email internally to Clinical Excellence Commission staff.
7. Copy of email to Corporate Governance and Risk Management Branch.
8. Copy of email to Strategic Relations and Communications Branch.

Available on the Department's website http://www.health.nsw.gov.au/quality/sabs

3.1 Distribution of Safety Alerts out of normal business hours

The CEC will contact the Chief Executive by telephone should there be need to disseminate a Safety Alert or an emergency drug recall out of business hours. The distribution of the formal Safety Alert will be on the first day of the CEC's normal business hours.

3.2 Local Health District/Specialty Health Network Distribution of SABS notifications

Each SABS notification will include a recommended distribution list for use by the CEC. Local Health Districts/Specialty Health Networks are responsible for ensuring an effective internal distribution strategy is in operation.

3.3 Local Health District/Specialty Health Network or Services request for response from SABS notification

When Local Health Districts/Specialty Health Networks are required to respond back to the CEC, then it is the **responsibility of the Chief Executive** or equivalent of that entity to ensure that:

a. Responses back (where requested) are received within the stipulated timeframe.
b. A system is developed so that only one response from each Local Health District/Specialty Health Network is returned back to the CEC.

The response should be emailed to the CEC at quality@cec.health.nsw.gov.au

3.4 Local Health District/Specialty Health Network responsibility for actions arising from SABS notification

When LHDs/Specialty Health Networks are required to take action resulting from a SABS notification then it is the **responsibility of the Director of Clinical Governance** to ensure that:

a. the nominated actions have been implement in the stated timeframe;
b. a written response has been returned to the CEC (where requested) of the actions taken arising from the SABS notification;
c. the response should be emailed to the CEC at quality@cec.health.nsw.gov.au
d. the Directors of Clinical Governance are to report the implementation status of actions arising from SABS notifications to the local peak Quality Committee.

3.5 Review of SABS Notifications

All Safety Alerts will have a mandatory review date consistent with other Policy Directives. This review establishes if the document remains active, requires updating or is obsolete.

The Clinical Excellence Commission will review and update all Safety Alerts and Notices as new information becomes available.

4. EVALUATION OF SABS

The Director of Clinical Governance is responsible for monitoring the effectiveness of the SABS at the local level to ensure compliance with the CEC Quality Systems Assessment Program.

5. RELEVANT NSW HEALTH POLICY DIRECTIVES AND REFERENCES

5.1 Relevant NSW Health Policy Directives

NSW Health Policy Directive, Guidelines and Information Bulletin can be accessed at:
http://www.health.nsw.gov.au/policies/pages/default.aspx

NSW Policies Directives	Document No.
Lookback Policy	PD2007_075
Open Disclosure Policy	PD2014_028
Patient Safety and Clinical Quality Program	PD2005_608
NSW Health Policy Directives and Other Policy Documents	PD2014_043
Complaint Management Policy	PD2006_073

5.2 References

Department of Health Safety Alert Broadcasting System (UK) available at
http://webarchive.nationalarchives.gov.uk/20060904193721/info.doh.gov.uk/sar/cmopatie.nsf/

Medicines and Healthcare products Regulatory Agency (MHRA) available at
http://www.mhra.gov.uk

US Food and Drug Administration FDA available at http://www.fda.gov/

6. ATTACHMENTS

6.1 Safety Alert Template

NSW GOVERNMENT Health

Safety Alert 00#/YY

Title

(dd month year)

Distributed to:
- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- xxxxx

Action required by:
- Chief Executives
- Directors of Clinical Governance
- Xxxxx

We recommend you also inform:
- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxxx
- Xxxxxx

Deadline for completion of action

(dd month year)

Expert Reference Group

Content reviewed by:
- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxx
- Xxxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email:
quality@cec.health.nsw.gov.au

Internet Website:
http://www.health.nsw.gov.au/quality/sabs

Intranet Website
http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Para text text

1. step

Heading

Para text text....

- bullet

Actions required by Local Health Districts / Specialty Health Networks

1. text text style step2
2. text text

6.2 Safety Notice Template

NSW GOVERNMENT Health

N

Safety Notice 00#/YY

Title

(dd month year)

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- xxxxx

Action required by:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx

We recommend you also inform:

- Xxxxxxxxxxx
- Xxxxxxxxxx
- Xxxxxx
- Xxxxxx

Expert Reference Group

Content reviewed by:

- xxxxxxxxxxx
- xxxxxxxx
- Xxxxx
- xxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email:
quality@cec.health.nsw.gov.au

Internet Website:
http://www.health.nsw.gov.au/quality/sabs

Intranet Website
http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Para text text

1. step

Heading

Para text text....

- bullet

Suggested actions by Local Health Districts / Specialty Health Networks

1. Forward information to appropriate area for action.
2. Ensure a system is in place to document actions taken.

6.3 Safety Information Template

NSW GOVERNMENT Health

Safety Information 00#/YY

Title

(dd month year)

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Xxxxx
- Xxxxxx

Expert Reference Group

Content reviewed by:

- Xxxxxxxxxxx
- Xxxxxxxxx
- Xxxxx
- Xxxxxx

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email:
quality@cec.health.nsw.gov.au

Internet Website:
http://www.health.nsw.gov.au/quality/sabs

Intranet Website
http://internal.health.nsw.gov.au/quality/sabs/

Review date

month year

Heading

Paragraph

Paragraph

Suggested actions by Local Health Districts / Specialty Health Networks

1. Forward information to appropriate area for action.
2. Ensure a system is in place to document actions taken.

ADULT AND PAEDIATRIC HOSPITAL IN THE HOME GUIDELINE (GL2018_020)

GL2018_020 rescinds GL2013_006

PURPOSE

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

KEY PRINCIPLES

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

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

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

USE OF THE GUIDELINE

Districts and networks should use this Guideline to:

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

To download the Guideline please go to
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2018_020

GUIDELINES FOR ANIMAL VISITS AND INTERVENTIONS IN PUBLIC AND PRIVATE HEALTH FACILITIES IN NSW (GL2012_007)

GL2012_007 rescinds GL2006_012.

PURPOSE

The purpose of the guideline is to outline protocols for implementing and supporting assisted animal visits and interventions for patients in NSW public and private health facilities in NSW.

KEY PRINCIPLES

Animal visits and interventions are patient-driven and implemented to create a better health experience.

All types of animal visitation programs are to be conducted in accordance with relevant NSW Health policies and legislation relating to best practice in healthcare, infection control, patients rights and animal welfare.

Health facilities and health organisations are responsible for informing all staff about the roles and responsibilities associated with managing and coordinating animal visits/intervention activities.

Health services and animal agencies have responsibilities for hosting animal visitation programs and maintaining an animal's health and well-being.

USE OF THE GUIDELINE

In support of the principles outlined above, Chief Executives and delegated officers are expected to ensure compliance with relevant legislation and government and health policies by communicating and implementing the guideline to all health service personnel and relevant non-government organisations with direct or indirect responsibilities associated with animals visiting patients in public and private health facilities in NSW.

The Guideline includes the following sections:

- Animal Visitations Programs (Which type of program/animal visitation)
- Implementing Effective Animal Visitation Programs (Identifying animals for patient interaction Consultation, Communications and Planning)
- Key Elements of Animal Visitation Programs
- Personal Pet Visitations
- Resident Animals
- Therapy Animal Organisations
- NSW Health Policies and Legislation

To access the attachment to this Policy Directive please go to
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_007.html

ELECTIVE SURGERY ACCESS (PD2022_001)

PD2022_001 rescinds PD2012_011.

POLICY STATEMENT

NSW Health organisations that manage elective surgery services must ensure clinically appropriate, consistent and equitable management of access for patients across the state**.**
Arrangements must be in place to provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

SUMMARY OF POLICY REQUIREMENTS

All local health districts and specialty health networks with surgical services must have local procedures in place that are consistent with the principles and requirements identified in this Policy. Referring patients to the elective surgery list occurs with receipt of the Recommendation for Admission (RFA) form in a timely manner by the treating doctor.

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

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

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

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

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

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

ELECTIVE SURGERY ACCESS: PROCEDURES

1. BACKGROUND

Each year more than 220,000 patients have elective surgery or procedures in NSW public hospitals. People who need surgery are placed on an elective surgery list according to the urgency of their clinical need.
Managing patients on elective surgery lists is a key priority for the NSW Government and NSW Health so that the community has timely access to high-quality and patient-centred surgical services.
Elective surgery management is a challenging, dynamic and complex process requiring input from and coordination by a multidisciplinary team.
Public hospitals across NSW must actively manage all aspects of elective surgery lists with transparent and patient-focused processes for:

- Referring patients for surgery
- Assigning to patients the appropriate clinical urgency category (CUC)
- Accepting referrals for surgery
- Registering patients onto the elective surgery list
- Compiling and maintaining the elective surgery list
- Booking patients for surgery under the principals of treating patients in turn and treating patients within clinically appropriate timeframes
- Ensuring patients have timely and effective communication about their elective surgery
- Removal of patients from the elective surgery list
- Accurate data collection documentation, auditing and reporting
- Regular system evaluation, monitoring and improvement
- Well-informed patients and staff (clinical and non-clinical) who understand the process and their roles and responsibilities

1.1 About this document

The elective surgery access Policy Directive is the reference guide for facilities to manage elective surgery lists. The Policy covers the procedures that facilities are required to follow and adequately manage surgery lists.
All medical and surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites, must be added to the elective surgery list.

1.2 Key definitions

Admission
The process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment.

Admission date
Date on which an admitted patient commences an episode of care.

Clinical review
A review of a patient on the elective surgery list to ensure that their waiting time remains appropriate for their clinical condition.

Clinical urgency category
A clinical assessment of the timeframe in which a patient requires elective admission. Urgency categories 1, 2 and 3 referred to in this document align with clinical urgency categories.

Cosmetic surgery
Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the consumer's appearance and self-esteem. These procedures do not attract a Medicare rebate.

Decline
A Planned Admission/Planned Procedure Date outcome where the offer is not accepted by the patient due to non-clinical personal reasons.

Deferred patient
Patients that are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

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

Discretionary surgery
Surgical procedures that must not be undertaken in public hospitals in NSW unless essential. They must meet an identified clinical need to improve the physical health of the patient.

Elective surgery list
A list that contains the names and details of all patients who have submitted a Recommendation for Admission (RFA) and have been added to the elective surgery list contained in the Patient Administration System (PAS) at a hospital. The term elective surgery list in this policy will include both surgical and medical lists.

Indicator Procedure Code (IPC)
This is an administrative coding used for the procedure or treatment the patient is to undergo when admitted.

Listing date
The date the Recommendation for Admission Form was received. Calculation of waiting time starts from this date.

Listing status
Indicates the status of the person on the elective surgery list that is the extent to which a patient is ready and available for admission. This may change while the patient is on the elective surgery list for example, after a clinical review.

Non-admitted patient
A patient who does not undergo a hospital's formal admission process.

Not ready for care
Patients who are not able to be admitted to hospital. These patients are either staged patients or deferred patients.

Planned Admission Date (PAD)
The date on which it is proposed that a patient on the elective surgery list will be admitted for an episode of care.

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

Planned procedure date
The date on which it is proposed that a patient on the elective surgery list will have their procedure completed.

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

Ready for care
A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission and surgery. The process leading to surgery could include investigations/procedures or other preoperative preparation.

Specialty
Treating doctor's area of clinical expertise. Where the doctor undertakes surgical procedures, which can be classified into different specialities. The doctor will have a different list for each specialty (for example, Obstetrics/Gynaecology).

Hospitals may have many more specific clinical areas identified, but these must be categorised under the main specialty headings for central reporting.

Staged
A suspension period applied where the patient is clinically not ready for care. This may be indicated by either the doctor or the patient.

Status Review Date
This is the date determined for an assessment (clinical or administrative) as to whether a deferred or staged person (i.e. Not Ready for Care) has become ready for admission to the hospital at the first available opportunity (i.e. Ready for Care).

Surgery
Procedures listed in the surgical operations section of the Commonwealth Medical Benefits Schedule. Surgery is classified as either emergency surgery, elective surgery or other surgery based on a patient's presentation and subsequent care, not by time periods to surgery.

Emergency surgery
Surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery later following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission.
Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).

Elective surgery
Planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery list.

Other surgery
The procedure cannot be defined as either emergency surgery or elective surgery, for example, transplant surgery and planned obstetrics procedures.

Waiting Time
The total time a patient spends on the elective surgery list.

2. SUMMARY OF KEY RESPONSIBILITIES

2.1 Admissions / booking staff

Admissions / Booking Clerks are expected to enter required data on the elective surgery list 'system' within three working days of receipt of the completed RFA. They need to check allocated clinical urgency categories against the list of recommended clinical urgency categories and ensure all documentation and electronic data input is accurate, legible and complete.

2.2 Elective surgery list coordinators

Elective surgery list coordinators have efficient oversight and management of patients requiring elective surgery to ensure that all relevant audits are completed and provide operational advice on the achievement of elective surgery performance.

2.3 Senior manager

Senior managers who are involved with coordination of surgical services and have decision-making responsibility in ensuring the appropriate application of this policy and ensuring that patients have timely access to care. Surgical services are administered according to local need at Local Health Districts and Specialty Health Networks across NSW.

Not all positions will be the same across NSW, individual facilities need to establish processes and points of escalation to ensure safe, clinically appropriate and equitable access of elective surgery programs.

2.4 Treating doctors

Treating doctors will provide clinical care in the best interests of patients informed by current evidence and best practice. They will have a clear understanding of the clinical capability of the service where the procedure is to be undertaken to ensure the right care is available and occurs in a setting with access to the necessary supportive care for example; imaging, pathology or access to intensive care.

They will only conduct procedures in keeping with the role delineation of the service and the credentials the doctor holds for surgical or other invasive procedures. They must be contracted and appropriately credentialed with the district, network or facility and have a clear understanding of the clinical networks available should the patient require transfer to a higher level of care.

Written informed consent from the patient must be obtained after fully informing the patient of the proposed surgery, procedure or treatment, any potential complications and expected length of hospital stay. The treating doctor must also inform the patient that under Medicare principles, public patients are allocated to a doctor by the hospital and that if the patient elects to be a public patient, their surgery may be performed by another surgeon or hospital. The treating doctor must also inform the patient that they are prioritised for surgery based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

A fully completed and legible RFA must be submitted to the hospital within five working days of the patient agreeing to the proposed procedure/treatment. If the treating doctor is unable to perform the procedure within the clinical urgency category timeframe, they must in conjunction with the hospital, make arrangements for another clinician to perform the procedure within the patient's clinical urgency category.

The treating doctor must also review their elective surgery list provided by the hospital at least monthly and maintain timely clinical record keeping and record sharing and comply with mandatory reporting requirements. They must also participate in quality improvement initiatives including morbidity and mortality reviews and organise ongoing clinical care for patients in their absence.

2.5 Hospital clinical directors of surgical services or equivalent
This position must promote efficient and effective elective surgery list management by clinicians within their hospital and liaise with the district/network program director of surgical services or equivalent, for escalation of any issues. Specific responsibilities include the management of assigned clinical urgency categories not in accordance with the list of recommended clinical urgency categories and where insufficient evidence has been provided by the treating doctor and in the review and management of applications to perform cosmetic and discretionary procedures or exceptions to the policy.
For smaller sites that may not have a hospital clinical director of surgical services or equivalent, these responsibilities should be undertaken by the district/network Program Directors of Surgical Services or equivalent.

2.6 District / Network program directors of surgical services or equivalent
This position must ensure that clear administrative and clinical procedures/protocols, are in place to implement this policy and promote efficient, equitable and effective list management within all levels of hospital management. This includes the provision of adequate facilities/staff/work environment to facilitate the surgical management of patients referred to the hospital. They are also required to address issues arising with the management of the patient with the treating doctor and General Practitioner as required.

2.7 Chief executives
The chief executive is required to regularly review elective surgery performance across individual hospitals and engage relevant clinicians to ensure consistent application of policy requirements across the organisation. They would also ensure that there is provision for training and education programs for staff involved in managing elective patients and lists

3. ELECTIVE SURGERY LIST

To place a patient on an elective surgery list, the treating doctor must have fully informed the patient about the planned surgery or procedure/treatment and obtained their written consent in line with NSW Health Consent to Medical and Healthcare Treatment Manual.

The treating doctor must complete a Recommendation for Admission form (RFA) legibly and accurately and forward the completed RFA form to the facility within five working days of the patient agreeing to the proposed procedure or treatment.

To ensure that patient information is protected and secure, the RFA must be submitted to the facility in the most appropriate way for example, mail, hand delivery by the treating doctor, patient or carer or electronically if there is an approved system in place. Unsecure or unencrypted transfer of RFA forms through email is not permitted.

Facsimiles (fax) of an RFA form must not routinely be used and must only be accepted for urgent admissions for example, patients in clinical urgency category 1 where there is limited time to send a hard copy. A hard copy or an electronic version (if approved eRFA system is used) must follow as soon as possible.

At the time of lodgement of the RFA form, a patient must be ready for care and be able to accept an assigned planned admission or planned procedure date (excluding staged procedures).

3.1 Completion of the Recommendation for Admission (RFA) form

The following minimum data set on the RFA must be completed.

Treating Doctor must provide:	
• Patient's full name • Patient's address • Patient's email address where provided • Patient's contact information (home, mobile and/or work telephone) • Patient's gender • Patient's date of birth • Patient's Medicare number • Clinical urgency category • If classified as staged, the time interval when the patient will be ready for care must be indicated • Discharge intention (i.e. day only, or indication of number of nights in hospital) • Presenting problem/diagnosis	• Significant medical history (including allergies, infection risk and disability) • Treating doctor (if different) • Date the RFA is completed • General Practitioner's name and address • Interpreter requirements • Estimated operating time, including anaesthetic • Specific preadmission requirements. • Special operating theatre equipment. • Requirement for an intensive care or high dependency bed post-procedure • Planned procedure/treatment
Admission/booking staff must provide:	
• Planned Admission Date / Planned Procedure Date (if allocated) • Short notice / Standby offers	• Aboriginal and Torres Strait Islander Origin • Status Review Date (for staged patients) • Anticipated election status e.g. Medicare/public or private

3.2 Clinical urgency categories

Categorisation of elective patients by clinical urgency category is required to ensure they receive care in a timely, equitable and clinically appropriate manner.

A clinical urgency category must be assigned by the treating doctor and be based on the patient's clinical need, regardless of their health insurance status. It must be appropriate to the patient and their clinical condition and not influenced by the availability of hospital or surgeon resources.

When allocating a clinical urgency category, reference must be made to the *NSW Recommended Clinical Urgency Categories*.

	Procedures that are clinically indicated within
Category 1 - Urgent	30 days
Category 2 - Semi-urgent	90 days
Category 3 - Non-urgent	365 days
Category 4 - Not ready for care or patient suspension	Patient not currently available for surgery • Staged – section 6.4.1 • Deferred – section 6.4.2

A departure from the recommended clinical urgency category may be warranted for sound clinical reasons, including in circumstances where the procedure is for diagnosis or treatment of a proven or suspected malignancy.

For individual patient exceptions to the recommended clinical urgency category, the treating doctor must supply supporting documentation and discuss this with the district/network program director of surgical services or the equivalent.

If there is no supporting clinical information supplied, the admissions/booking staff must contact the treating doctor to provide the required information to support the selected change in clinical urgency category and ensure that the patient is added to the elective surgery list within three working days from receipt of the RFA.

The NSW Recommended Clinical Urgency Categories must be used until clarification is sought from the treating doctor.

Where the procedure is not within the NSW Recommended Clinical Urgency Categories treating doctors must follow the principles outlined in this policy when assigning the clinical urgency category.
There must be a review and escalation process at each facility for hospital clinical directors of surgical services or equivalent to review all variations from the recommended clinical urgency category to ensure appropriate prioritisation of patients

3.2.1 Inclusions and exclusion criteria for category 1 – urgent surgery

The allocation of clinical urgency category 1 is specifically reserved for those patients whose clinical condition has been assessed as requiring the procedure or treatment within 30 days.

This category is not to be used to advance the date for elective surgery patients whose clinical condition does not require the procedure or treatment to be completed within 30 days for example, vasectomy, joint replacement surgery, routine cataract surgery, routine tonsillectomy.

3.2.2 Reclassification of clinical urgency category

Only the treating doctor or their delegate may undertake reclassification of patients between categories. To reclassify a patient, the treating doctor must ensure documented evidence is readily available to validate any changes to a patient's clinical urgency category.

Documentation is to include the name and signature of the relevant staff member documenting the change, the date and time of notification of the category change, the person notifying the category change and the reason for the category urgency category change. The documentation is to be attached to or form part of the RFA and will become part of the patient's medical record.

If a patient is reclassified to a higher clinical urgency category, for example from a category 3 to a category 2, the count of days waiting will restart from the date the change was made.

If a patient is reclassified to a lower clinical urgency category, the waiting days will continue from the listing date, for example from a category 2 to a category 3.

The elective surgery list is to be updated with any changes and the treating doctor advised of the changes in writing to confirm completion of the change in patient category.

3.2.3 NSW colonoscopy categorisation

High quality, timely colonoscopy is critical to the early detection and treatment of bowel cancer and other gastrointestinal conditions.

For detailed information on criteria for the categorisation and prioritisation of patients presenting to NSW public hospital colonoscopy services please refer to the Agency for Clinical Innovation's *NSW Colonoscopy Categorisation Clinical Practice Guide*.

3.2.4 Cosmetic and discretionary surgery

The following list of surgical procedures must not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient's physical health and the procedure has been approved by the district/network program director of surgical services or equivalent.

Cosmetic/Discretionary Procedure	Exception
Bilateral breast reduction	Severe disability due to breast size Gross breast asymmetry in patients under 21 years old Virginal Hyperplasia/Hypertrophy
Bilateral breast augmentation	Nil
Replacement breast prosthesis	Replacement for post-cancer patients only
Bilateral mastectomy	Genetic risk such as BRCA1, BRCA2, TP53 or PTEN Cancer in the other breast
Breast reconstruction	Post cancer and genetic risk patients
Hair transplant	Disfiguring hair loss due to severe burns
Blepharoplasty/reduction of upper or lower eyelid	Documented severe visual impairment/obstruction
Total rhinoplasty	Nasal fracture/major facial trauma Congenital abnormality due to a documented syndrome as referred from a Consultant Paediatrician (paediatrics only)
Liposuction	Nil
Abdominal lipectomy (abdominoplasty)	Nil
Meloplasty/facelifts	Nil
Correction of bat ear (>16 years old)	Nil
Tattoo removal procedure	Nil
Removal of benign moles	Nil
Candela laser	Congenital abnormality – paediatrics < 17 years old
Varicose veins	CEAP Grade > C3 CEAP Classification System
Laser photocoagulation	Nil
Gender affirming surgery	Congenital abnormalities in children
Lengthening of penis procedure	Congenital abnormalities in children
Insertion of artificial penile prosthetic devices	Post cancer, major trauma and severe burns Patients with neurological erectile dysfunction
Reversal of sterilization	Nil
Circumcision	Phimosis, paraphimosis, balanitis
Temporomandibular joint arthrocentesis	Nil
Labiaplasty	Congenital abnormality in paediatrics < 17 years
Knee arthroscopy when the main indication is osteoarthritis and the patient is 50 years or older.	Only after approval by district/network program director of surgical services (or equivalent) and local selection criteria has been met

The treating doctor must obtain approval from the program director of surgical services or equivalent, in consultation with senior management before submitting the RFA.

They must document on the RFA form at the time a patient is referred objective medical criteria supporting the decision for surgery for all procedures that may be considered cosmetic or discretionary. This requirement supports appropriate documentation of clinical decision making and the review process. For procedures not appearing in section 3.3, or where there is doubt about the nature of the proposed surgery, the request must be referred to the program director of surgical services or equivalent for review prior to the patient being added to the elective surgery list.

The patient must be advised by the treating doctor when the RFA form is going through the approval process together with an estimated time for review.

Clinical directors of surgical services or equivalent, must review the addition of cosmetic and discretionary procedures to the elective surgery list to ensure their addition was in accordance with this Policy.

3.4 Dental surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the NSW Health Policy Directive *Priority Oral Health Program and Elective Surgery List Management* (PD2017_023).

3.5 Introduction of new procedures and technologies

Each district or network must have a process in place to formally approve new procedures not previously undertaken at the hospital. The clinician must be appropriately credentialed by a relevant committee and have privileges to undertake the procedure before the patient is added to the elective surgery list.
For additional information, refer to:

- NSW Health Guideline *NSW Framework for New Health Technologies and Specialised Services* (GL2018_023)
- Australian Safety and Efficacy Register of New Interventional Procedures – Surgical – RACS/ASERNIP-S
- RACS General Guidelines for Assessing, Approving & Introducing New Surgical Procedures into a Hospital or Health Service.

3.6 Planned procedure / treatment not available at the hospital

An RFA form must not be accepted and must be returned to the treating doctor if the procedure or treatment is not provided at the nominated hospital.
The treating doctor must be informed that the RFA is not accepted and make alternative arrangements for the patient.

3.7 Patient consent and communication

Patients must be fully informed about the risks and benefits of the proposed surgery by the treating doctor, procedure/treatment and have consented to the treatment offered.
Consent must be obtained in accordance with the requirements outlined in the NSW Health *Consent to Medical and Healthcare Treatment Manual*.

3.7.1 Information to be provided to the patient

Treating doctors must explain the elective surgery list, including:

- Reason for referral to the elective surgery list
- Elective surgery list process, including clinical urgency categories
- That prioritisation for surgery is based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

Treating doctors must also explain the difference between admission as a public or private patient and provide the patient with information to enable them to elect to be treated as a private or public patient. When a patient chooses to be treated as a public patient, treating doctors must explain the circumstances in which care might be provided by another doctor or health service.

Under the Medicare principles, public patients are allocated to a doctor by the hospital. While in most instances public patients will be admitted under the care of the original treating doctor, this is not always guaranteed.

In keeping with the principle of providing the earliest access and optimal care, surgery may be performed by another treating doctor if this would result in the patient receiving an earlier date for surgery.

When a patient chooses to be treated as a private patient, the treating doctor must also ensure the patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical need regardless of insurance status.

4. ACCEPTANCE OF RECOMMENDATION FOR ADMISSION FORM

4.1 Standard bookings

When RFA forms are received from the treating doctor, elective surgery admissions/ booking office staff must date stamp the hard copy form or document on electronic RFA.
They must ensure that the form is legible and the minimum data set (see section 3.1) is included before acceptance of the RFA form. For further information, refer to the NSW Policy Directive *Health Client Registration* (PD2007_094).

A locally agreed process must be in place to manage incomplete forms. Where information is missing on the RFA or the form is not legible, the treating doctor must be contacted by telephone or in writing as soon as possible to provide the required information. If the RFA is to be returned to the doctor, then the original RFA must remain in the booking office after acceptance and a copy of the RFA must be used to return to the treating doctor for missing information.

RFA forms are to be returned to the treating doctor if the RFA states the patient's surgery is required beyond 12 months.

If an RFA is not presented to the elective surgery booking office within three months of the date the RFA was signed, acceptance of the form must be discussed with the treating doctor to ensure the patient's clinical condition has not changed. A review of the patient's clinical condition may be required before the form is accepted.

An example of a letter regarding an incomplete RFA is available on the Elective Surgery Program Resources webpage.

4.2 Variations from standard bookings

4.2.1 Bilateral procedures

An RFA must only be accepted for one procedure unless the bilateral procedure is occurring in the same admission. This is to ensure that the patient has been reviewed and that they are clinically ready to undergo the subsequent procedure.

Bilateral procedures include, right and left cataract extractions, right and left hip replacements.

4.2.2 Multiple admission forms received for one patient

Multiple RFAs can be accepted if the treatments/procedures are independent of each other for example, cholecystectomy and tonsillectomy.

The treating doctor must assign a clinical urgency category for each procedure. Where categories differ, the procedure with the more urgent category takes precedence. Where categories are the same, the treating doctor/s must specify the priority.

4.2.3 Duplicate bookings

An RFA for the same procedure with different treating doctors at the same hospital; or for the same procedure at a different hospital must not be accepted. The patient must be asked to decide which elective surgery list they wish to remain on.

5 NOTIFICATION

Admissions/booking staff must use the date that is stamped on the RFA as the listing date and add the patient to the elective surgery list within three working days of receiving the RFA.

5.1 Notification to the patient

Admissions/booking office staff must inform the patient in writing within three working days of them being added to the elective surgery list and of their clinical urgency category timeframe. They must also be advised of any other relevant information of their hospitalisation, which may include the anticipated length of stay, discharge procedures and post-operative follow up. The patient must also be informed of how to advise the hospital of any changes to their contact details or condition.
Any additional information for the patient's admission should be attached to the RFA as appropriate

5.4 Notification to the patient's general practitioner

The treating doctor or hospital must provide a notification letter to the patient's referring general practitioner advising them that the patient has been added to the elective surgery list as a result of their referral. The notification letter is to be sent within three working days of the patient being added to the list and is to include the patient's:

- full name and address
- placement on the elective surgery list
- the date of placement on the elective surgery list
- the proposed procedure
- the clinical urgency category and definition
- hospital contact information, including who to contact if the patient's condition changes

A copy of this notification letter must be sent to the treating doctor or hospital. Admissions/booking staff are to add this letter to the patient's medical record.
An example letter of notification to the general practitioner is available on the Elective Surgery Program Resources webpage.

6 MANAGING PATIENTS

6.1 Access to elective surgery

Access to elective surgery in NSW public hospitals must be managed according to clinical urgency, resource availability and time of a patient's placement on the elective surgery list (treat in turn principle).

6.2 Privately referred non-admitted patients

All medical and elective surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites must be added to the elective surgery list regardless of admission type. Privately referred non-admitted patients are also to be managed as per this policy and added to the elective surgery list in the Patient Administration System.

For further information on elective surgery list reporting requirements see the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.3 Delayed and declined patient outcomes

A delayed or declined outcome can be applied against a planned admission/planned procedure date where the procedure was not performed; however, the patient remains on the elective surgery list.

6.3.1 Delayed patient

A delayed outcome must be reported where a patient's planned admission/planned procedure has been delayed to a later date by reasons initiated by the hospital, for example, unavailability of doctor or unavailability of bed.

The patient must remain on the elective surgery list as being ready for care and a suspension must not be applied.

Admissions/booking office staff must record the reason the patient is being delayed on the patient administration system and RFA and offer the patient a new planned admission/planned procedure date within five working days of the delay.

6.3.2 Declined patient

A declined outcome must be reported where a patient has not accepted a planned admission/planned procedure date for reasons due to their own choice or unavailability, for example, they do not accept an alternate surgeon, or they are unavailable at that time.

Admissions/booking office staff must record the reason the patient is declining the planned admission or procedure date on the patient administration system and on the RFA. They must also review the reason for a declined planned admission/planned procedure date to determine:

- If a new date is to be offered
- If a 'deferred' suspension should to be applied (see section 6.4.2)
- If the patient is to be removed from the elective surgery list

A 'deferred' suspension must not be applied where a patient declines a planned admission/planned procedure date offer with an alternate surgeon or at an alternate hospital. Patients who decline two genuine offers are to be informed that they may be removed from the elective surgery list in consultation with their treating doctor.

6.4 Suspension

A person on the elective surgery list who experiences a period of time where they are clinically not ready for care ('**staged**') or personally unavailable ('**deferred**') but is expected to become ready for care or available in the future must have a suspension applied for the period they are not ready for care or unavailable.

At the time of registration on the elective surgery list all patients must be available to be admitted to hospital or begin the process leading directly to admission, except for patients who are 'staged' (see section 6.4.1).

Where a patient is required to be 'staged' for a prolonged period of time to achieve a desired outcome for surgery to occur for example, significant weight loss, the patient must not be placed on the elective surgery list, or they must be removed from the elective surgery list in consultation with the treating doctor.

Admissions/booking office staff must record the reason for staging or deferring a patient on both the electronic Patient Administration System and the RFA. Patients with current suspensions must be regularly reviewed to ensure they become 'ready for care/available' or are removed from the elective surgery list (see section 6.12).

6.4.1 Staged (Clinically 'not ready for care')

A person on the elective surgery list who is not presently available for treatment due to clinical reasons, or patients whose medical condition will not require or be amenable to surgery until some future date is Staged. An example of a Staged patient is a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time.

The treating doctor must identify the 'not ready for care' timeframe and a 'ready for care' clinical urgency category must be indicated for admission on the RFA.

Admissions/booking staff must first register the patient in their intended clinical urgency category, then record the Staged suspension period.

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.4.2 Deferred (patient unavailable for non-clinical reasons)

A suspension may only be applied where the period of unavailability is greater than one day.

Where a patient is clinically ready for treatment, however they are unavailable for surgery due to personal reasons, admissions/booking staff must record the unavailable period in the waitlist record as a deferred suspension. Any clinical urgency category 1 patient who requests deferral must be brought to the attention of the treating doctor.
The patient listing status should be returned to 'ready for care' once the unavailable/suspension timeframe is complete.

If a patient is unavailable on more than two occasions or exceeds the maximum cumulative number of unavailable/suspension days, consider removing the patient from the elective surgery list (see section 6.12).
The maximum cumulative of unavailable/Suspension days does not include days accrued as staged.

Clinical urgency category	Maximum cumulative days
Category 1 - Urgent	15
Category 2 - Semi-urgent	45
Category 3 - Non-urgent	180

6.5 Status review date

Admissions/booking office staff must set the status review date each time a patient's status changes from 'ready for care' to 'not ready for care/suspended' or where their status remains 'not ready for care/suspended' after assessment.

6.5.1 Status review report

Admissions/booking staff must, at least weekly, generate a report listing the details of each patient whose status review date will become due in the following month. During this review, patients can:

- Be assigned another status review date
- Be returned to ready for care with the appropriate clinical urgency category
- Have a planned admission date scheduled (see section 6.8.1)
- Be removed from the elective surgery list (see section 6.12)

6.6 Clinical review

The condition of the patient may change while the patient is awaiting treatment. Patients and general practitioners can initiate a review to ensure that the waiting time is appropriate for their clinical condition.

Patient listing status must remain in their current clinical urgency category while undergoing a clinical review and must not be moved into 'not ready for care'.

The clinical review must be arranged by the hospital at no cost to the patient and conducted by the treating doctor, a specialist consultant, or their delegates.

Examination may result in the patient being assigned a different clinical urgency category from the initial category that was assigned (see section 3.2.2). An authorised change in the clinical urgency category must be documented in the patient administration system and on the RFA. The name and signature of the relevant staff member who documented the change is also to be included.

If a patient declines an appointment or fails to attend a clinical review the admissions/booking staff must discuss the patient's status on the elective surgery list with the treating doctor or their delegate and senior management.

6.7 Changes to the patient's planned procedure

When changes are made to the originally listed procedure for the treatment of the same condition, admissions/booking office staff must document evidence to validate any change to a patient's listed procedure including:

- Name and signature of the relevant staff member
- Date and time of notification of the change
- Name of the person notifying of the change to the originally listed procedure
- Reason for the change

Where the changes are minor, and the principal procedure remains the same (for example a left total knee replacement replaces a right total knee replacement) the admissions/booking office must edit the procedure description field of the elective surgery list entry screen and a notation regarding the changes are to be made in the comments field.

Where the principal procedure changes, admissions/booking office must remove the original elective surgery list entry as "no longer required" and the treating doctor must submit new RFA for the new procedure. As this is a new procedure the listing date is the date as on the new RFA.

6.8 Admission process

To ensure equity and priority of access, when choosing patients from an elective surgery list for admission, admissions/booking office staff must treat all patients in accordance with the clinical urgency categories and in the order as they are added to the elective surgery list.
Staff must consider:

- Resource availability e.g. theatre time, staffing, post-operative bed requirements, equipment and hospital capacity
- Previous delays
- Pre-admission assessment issues and factors e.g. elderly people living alone or those having to travel long distances

Staff must also consult with relevant staff to meet individual patient needs including:

- Treating doctor
- Operating Theatres Manager
- Admissions
- Pre-admission clinic
- Elective surgery list coordinator
- Other departments if relevant e.g. medicine or radiology
- Community care and post discharge services for an effective communication to handover patient care to their general practitioner or other relevant community services as required
- Aboriginal liaison officer
- Interpreter

6.8.1 Allocating a date for surgery

When a patient is selected from the elective surgery list for surgery, admissions/ booking office staff must determine a planned admission date on which it is proposed that a patient will be admitted for their planned procedure. This may be the same as the planned procedure date, or it may be different.

The patient must be contacted by phone or patient's preferred contact method to determine acceptance of admission. Once a date is accepted, an admission letter must be sent to the patient.

A planned admission date can be arranged when a patient is in the 'not ready for care/suspended' category. The patient must be returned to 'ready for care' status prior to admission.

For patients allocated a 30-day clinical urgency category, a planned admission date must be given to the patient on registration.

For an example patient letter allocating a date for surgery to patients, please see the Elective Surgery Program Resources webpage.

6.8.2 Pre-admission assessment

All RFA forms must be reviewed for the need for a pre-admission clinic appointment to confirm the patient's suitability and safety to undergo the intended surgery. This optimises and supports management of the patient's perioperative risks associated with their planned surgery.

If the patient meets the local criteria that they are required to attend a pre-admission appointment and then fail to attend, their risk for surgery remains undetermined. Any decision to go ahead with the surgery must be discussed with the treating doctor prior to rescheduling the appointment and surgery.

For further information on pre-admission clinics please see the Agency for Clinical Innovation's Perioperative Toolkit.

6.8.3 Short-notice list

When offering dates at a short notice, admission/booking staff must consider the need for a pre-admission clinic appointment and be managed "in turn" within clinical urgency category as much as possible.

Patients must be given as much notice as possible about their proposed advancement on the list. Once a patient has been called in as a 'short-notice' list patient and their ensure the patient is not inconvenienced further.

A patient must not be marked as 'deferred' if they are unable to make a short notice offer.

6.9 Hospital-Initiated Delays

Postponements or delays to surgery must be avoided and only occur when all alternative options are exhausted. Decisions to delay a patient must involve relevant medical and operating theatre staff, bed manager, the elective surgery list manager and senior hospital management. The decision must consider the:

- Reason for the delay
- Clinical urgency category
- Patient's delay history
- Patient's length of time on the elective surgery list
- Medical input from treating doctor or delegate
- Patient's proximity to the facility

When a patient's planned admission date is delayed and needs to be rescheduled, administration/ booking office staff must record the reason for the delay and reschedule the patient on the next available list according to their clinical urgency category. The record is to include the original listing date and history of any previous admission dates and delays.

The patient must be advised of a new planned admission date within five working days of the delay.

Where possible, delayed patients must be prioritised on the procedure/treatment list to minimise the chance of further delay for example, placed first on list.

If a patient has been delayed twice and cannot be treated within the appropriate clinical urgency category timeframe, admissions/booking office staff must escalate to district/network senior management and a plan made to treat the patient within their clinical timeframe (see section 6.11).

For an example of a patient delay letter, please see the Elective Surgery Program Resources webpage.

6.9.1 Informing patients of delays

When communicating the surgery delay, admissions/booking office staff must provide the patient with the maximum possible notice. Category 1 patients must be notified of their delay by a senior member of the surgical/medical team or senior hospital manager.

6.9.2 Delay on the day of surgery or after admission

When a patient's surgery, procedure or treatment is delayed by the hospital on the day of their planned admission or their planned procedure date the patient must be informed by a senior member of hospital or district management and/or treating doctor or their delegate.

Offers of support that can be offered to the patient include	
Contacting a family member or friend	Counselling services
Aboriginal Liaison Officer support	Access to a complaint service
Social Worker support	Arranging and paying for transport home, accommodation, food etc

Admission / Booking Office staff must	
Admit and discharge the patient	Record the reason for the delay
Return the patients record to the elective surgery list with the original listing date and history	Reschedule the patient on the next available list according to their clinical urgency category
Advise the patient of a new PAD within 5 working days of the delay	

An example letter informing a patient of a necessary delay is available on the Elective Surgery Program Resources webpage.

6.10 Patient-initiated deferral

When a patient defers an agreed date for surgery or procedure for personal or social reasons, admissions/booking staff must record the reason the patient is declining the planned admission or procedure date on the elective surgery list and on the RFA. They must also review the reason for a declined admission date to determine whether:

- A new date is to be offered
- The patient is to be categorised as 'not ready for care/suspended' deferred
- The patient is to be removed from the elective surgery list

Patients are only permitted to defer maximum of two times for personal or social reasons.

6.10.1 Patient deferral after admission

If a patient arrives for surgery, treatment/procedure and decides to defer after admission, admissions/booking office staff must advise the treating doctor, admit and discharge the patient, then record the reason for deferral
The treating doctor or delegate must discuss the requirement for surgery with the patient.
If the surgery is still clinically required and the patient agrees, the patient's elective surgery list record must be returned to the list (rebooked) with the original listing date and history, including urgency categories and delays etc.
If the patient does not agree to have surgery after discussion with the treating doctor, then the patient's elective surgery list record must be reinstated with the original listing date and history, including urgency categories and delays. The record is then removed from the elective surgery list using the appropriate reason.

6.11 Demand management to treat patients on time

Patients added to the elective surgery list must be treated within their clinical urgency category timeframe through proactive surgical service demand and capacity management.

Admissions/booking office staff must review the elective surgery list weekly and identify patients that are likely to exceed or have already exceeded their clinical urgency category timeframes (see section 7). Treating doctors must ensure that they are available to perform procedures within the assigned clinical urgency category timeframes or in consultation with the hospital, arrange for another clinician to perform the procedure within the assigned clinical urgency category timeframe.

Hospital clinical directors of surgical services or equivalent must monitor the volume of each treating doctor's elective surgery list plus additions to the elective surgery list to ensure that there is capacity to undertake required surgery. If the treating doctor has insufficient capacity and/or a patient is identified as having exceeded or likely to exceed their clinical urgency category timeframes the hospital clinical directors of surgical services or equivalent should consider the following solutions in conjunction with the treating doctor, patient, and senior management:

- Additional theatre time at same or other facility
- Pooled lists where it is clinically appropriate for doctors in the same specialty to agree to include their public patients on a combined list for that specialty. Patients may be treated by any one of the doctors belonging to the group
- Transfer of patients to another treating doctor with a shorter elective surgery list at the same facility (see section 6.11.1).
- Transfer of patients to another treating doctor with a shorter elective surgery list at another facility (see sections 6.11.2 and 6.11.3).
- Private sector options where the district or network is responsible for expenses incurred (see section 6.11.4).

The patient must be informed of any change of surgeon or hospital and this contact must be recorded on the RFA form.

All patients requiring elective surgery/procedure (with an allocated surgical indicator procedure code) regardless of admission type are recorded on the inpatient patient administration system which holds the elective surgery list.

6.11.1 Transfer of patients to doctors with a shorter waiting time

The new treating doctor will determine the requirement to review the patient prior to surgery, procedure or treatment. If a review is required, it must be facilitated by the hospital at no cost to the patient. The patient's listing date and history must be that of the original booking. The patient's current clinical urgency category must be maintained, unless altered after clinical review by the new treating doctor.

The planned admission offer to the patient must be considered 'reasonable'. This must be determined for each patient and consider the circumstances of the patient for example, age, available support, public transport, physical condition and the required procedure.

The offer must be specific and include the name of the clinician, hospital and planned admission date or an estimate of the likely waiting period must be provided to the patient.

The offer must also be a credible alternative and be available if the patient decides to accept the offer. Where the patient does not accept two genuine offers of treatment (excluding offers made at short notice (within 24hrs) but including an offer with another doctor or at another hospital), the patient must be advised that they may be removed from the elective surgery list.

Hospital clinical directors of surgical services or equivalent must review the patient's status on the elective surgery list in consultation with the original treating doctor prior to the patient being removed from the elective surgery list.

6.11.2 Transferring patients to another facility in the same district or network

When a patient is booked at one hospital and subsequently has the procedure carried out at a different hospital within the same district or network, admissions/booking office staff at the receiving hospital must enter the booking with the same listing date, history and current clinical urgency category as the original hospital booking.

They must also inform the original hospital admissions/booking office staff that the booking has been accepted and added to the receiving hospitals elective surgery list.

Admissions/booking office staff at the original hospital must send the original RFA form to the receiving hospital and retain a copy for auditing at the original hospital. The booking at the original hospital must be removed using the relevant reason code on receiving confirmation of the patient's booking at the receiving hospital.

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.11.3 Transferring patients to another district or network

Where an agreement exists with another district or network to undertake public patient surgery, the new facility/receiving hospital admissions/booking office staff must add the patient to the elective surgery list with the new listing date and advise the original hospital when the procedure is undertaken.

Original facility admissions/booking office staff must send the original RFA form to the new facility and keep a copy for auditing purposes. Staff must keep the patient on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

6.11.4 Contracts with private hospitals

Where a contract exists with a private hospital to undertake elective surgery, treatment or procedures for the district or network, the contracted hospital must be managed as per the requirements of this Policy. The public hospital must be advised when the procedure is undertaken.

Admissions/booking staff of the original facility must send the original RFA form to the new facility and keep a copy for auditing purposes. The patient is to remain on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

The date of the removal from the public hospital elective surgery list is the date of the admission at the contracted private facility.

For further information on the reporting requirements for the elective surgery list please see the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.12 Removing patients from the elective surgery list

Patients may be removed from the elective surgery list for reasons other than admission.

Hospitals must exercise discretion on a case by case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances.

Patients must not be removed from the elective surgery list if they decline an offer that was made at short notice.

An example letter for informing a patient that they have been removed from the elective surgery list is available on the Elective Surgery Program Resources webpage.

<table>
<tr><th>Reason</th><th>Admissions / Booking Office staff must</th></tr>
<tr><td>Patient declines treatment/clinical review or requests removal for other reasons for example patient has surgery elsewhere.</td><td rowspan="3">• Obtain authority from the treating doctor or delegate for clinical urgency category 1 patients prior to removal from the elective surgery list
Once the decision is made to remove a patient from the elective surgery list:
• Document discussions with the patient and treating doctor on the RFA
• Remove the patient from the elective surgery list on the PAS
• Document the reason for the removal and date of removal
• Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list
• Advise the general practitioner that the patient has been removed
• Inform patient if they have any further questions on their healthcare needs to contact the treating doctor / GP</td></tr>
<tr><td>Patient defers treatment on 2 occasions (including genuine offers of another doctor/hospital) or in deferring exceeds the maximum number of Not Ready for Care/Suspended days:
Category 1 > 15 days
Category 2 > 45 days
Category 3 > 180 days</td></tr>
<tr><td>Patient fails to arrive for treatment on > 1 occasion without giving prior notice and with no extenuating circumstances.</td></tr>
</table>

Patient not contactable on 2 occasions (one by telephone and one by letter)	• Obtain, where possible, the patient's correct contact details via treating doctor; general practitioner; medical records; next of kin; person responsible; and telephone directory search • Record any evidence such as patient letters returned to sender • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Advise treating doctor and general practitioner that the patient has been removed • Document actions on RFA and electronic record
Patient deceased	• Obtain verification (usually verbally from the patient's relative, general practitioner or treating doctor) • Record the name of the person who has notified the hospital that the patient is deceased • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Document action on the RFA
Treating doctor advises surgery no longer required	• Once the decision is made to remove a patient from the elective surgery list: • Document discussions with the patient and treating doctor on the RFA • Remove the patient from the elective surgery list on the PAS • Document the reason for the removal and date of removal • Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list. • Advise GP that the patient has been removed • Inform patient of the potential risks to their health and advise them to contact the treating doctor / GP to discuss

Hospitals must have a documented process for removing patients from the elective surgery list and retain the RFA form in the medical record of the patient.

6.12.1 Adding a patient to the elective surgery list who was recently removed

If a patient was removed from the elective surgery list, and in the following thirty days the elective surgery list record for the patient is to be re-activated for the same procedure, the patient must be re-booked with the original listing date and history, including clinical urgency category.

Admissions/booking office staff must consult the treating doctor for confirmation before adding the patient to the list.

7. RECORD KEEPING AND REPORTING

Hospitals must keep accurate records of elective surgery list information. Any changes made to a patient's booking must be validated with documented evidence, reason for change and be signed by the relevant staff member. Changes may include planned admission dates or planned procedure dates and treating doctor or hospital.

Accurate records are to be maintained for patient delays and deferrals and include the reason on both the Patient Administration System and the RFA form. RFA forms must have a dedicated section to record all changes and/or a designated form attached to the RFA.
Admissions/booking office staff must generate and review a weekly report to identify overdue patients (see section 8.1.1).

They must also provide monthly reports to the hospital general manager or their delegate with the following information:

- Patients who incurred a delay during the month (previous month)
- Patients on the list who have had two or more delays to their admission
- All delayed patients who have not had a rescheduled planned admission date allocated within five days

8. AUDITING THE ELECTIVE SURGERY LIST

8.1 Clerical audit

Clerical audit of the elective surgery list ensures that accurate information is provided to patients, clinicians and administrators when required.

Hospitals must identify a person responsible for conducting clerical audits of the elective surgery list and reporting the outcome of the audit to a senior manager. Records related to clerical audits are to be kept for a minimum three years.

At a district/network level, a person must be nominated to be responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits within their district/network.

8.1.1 Weekly clerical audit

A clerical audit must be conducted weekly which includes:

- Checking for duplicate bookings
- Ensuring a clinical urgency category is appropriately assigned
- Reviewing listing status of patients whose status review date will become due in the next week
- Reviewing exceeded planned admission and planned procedure date,
- Ensuring a delayed patient has been rescheduled for the next available theatre session in consultation with the treating doctor
- Identifying patients on elective surgery list admitted through the emergency department for the same procedure
- The number of patients removed from the elective surgery list and the reason for removal
- Identifying overdue patients

8.1.2 Clerical audit report

On completion of clerical audits, a report signed by the person responsible for conducting the audit must be sent to a senior manager and tabled at an appropriate surgery committee meeting.
This report must include the type of audit conducted, problems identified and recommendations for improvement.

8.1.3 Quarterly evaluation

Elective surgery list managers and coordinators must evaluate the local audit process quarterly including:

- Reviewing compliance with weekly and monthly audits
- Weekly and monthly audit reports are tabled at the relevant committee
- Availability of clerical audit records

8.1.4 Not ready for care / suspended patient audit

A 'not ready for care/suspended' patient audit must be conducted twice a year. A report must be provided to the NSW Ministry of Health's Systems Purchasing Branch for review.

8.2 Review of elective surgery list by treating doctor

Admissions/booking staff must provide a comprehensive list of their patients monthly to each treating doctor, or more frequently as requested**.**

Treating doctors must confirm this elective surgery list with elective surgery coordinators and make any changes required.

Where a district or network uses pooled lists, the hospital must nominate a medical officer to confirm patients on list and make any changes required as above.

8.3 Patient follow up audit

All patients on the elective surgery list for greater than six months from their listing date with no planned admission date or planned procedure date, must be contacted to ascertain if they still require admission.

Two contacts must be attempted, one by letter/email and if no response is received, a follow up telephone call to determine the patient's status on the elective surgery list. Correspondence must include:

- Information on alternative options where available
- Advice for clinical reassessment by treating doctor or general practitioner
- Hospital and district/network contact details

Patient responses must be documented in the patient 's medical record.

An example of a patient audit letter is available on the Elective Surgery Program Resources webpage.

9. DOCTOR'S LEAVE

A patient's clinical urgency category and listing date does not change because of doctor's leave. To ensure appropriate theatre scheduling, doctors must provide notice of intended leave.

A management plan must be implemented for all patients who, during the leave period already had a planned admission/planned procedure date or will exceed their clinical urgency category timeframe.

9.1 Types of leave

Type of leave	Action
Planned Leave e.g. Annual, Study, Extended Leave and parental Leave	Treating doctors must: • Provide at least six weeks' notice of intended leave • Develop management plan for affected patients. • Not add any patients to their elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent. Admissions/booking office staff must: • With the treating doctor, develop management plans for affected patients • Consult with relevant personnel including Head of Unit or specialty, Medical Administrator, Clinical Director, Divisional Manager, Operating Theatre Manager, Elective surgery list coordinator, Hospital Executive Officer and District/Network Chief Executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Unplanned leave e.g. sick leave, bereavement leave	Admissions/booking office staff must: • Develop management plans for affected patients in conjunction with relevant personnel including head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Planned resignation e.g. resignation from hospital or retirement	Treating doctors must: • Develop management plan for affected patients with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. Maintain patients on the resigning doctor's list if they are not immediately transferred. • With the treating doctor, develop management plans for affected patients • Notify affected patients of the doctor's intention to leave and provide information about the patient's management plan • Not add any patients to the doctor's elective surgery list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the district/network program director of surgical services or equivalent. Hospital executive must: • Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another surgeon in consultation with senior clinicians and management. • Organise clinical review as required for patients remaining on the departing doctor's elective surgery list. • Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the elective surgery list.

Type of leave	Action
Planned resignation e.g. resignation from hospital or retirement	Treating doctors must: • Develop management plan for affected patients with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. Maintain patients on the resigning doctor's list if they are not immediately transferred. • With the treating doctor, develop management plans for affected patients • Notify affected patients of the doctor's intention to leave and provide information about the patient's management plan • Not add any patients to the doctor's elective surgery list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the district/network program director of surgical services or equivalent. Hospital executive must: • Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another surgeon in consultation with senior clinicians and management. • Organise clinical review as required for patients remaining on the departing doctor's elective surgery list. • Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the elective surgery list.
Unplanned resignation or death	Admissions/booking office staff must: • Transfer patients to a replacement treating doctor's elective surgery list (see section 6.11.1) and maintain the treat in turn principle. If they are not immediately transferred, place patients on a list for an appropriate doctor or specialty. • Develop management plans for affected patient with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. • Not add any patients to the doctor's elective surgery list • Notify relevant general practitioners of the resignation/death Hospital executive must: • Locate replacement of treating doctor in consultation with senior clinicians and management. Clinical review is at the discretion of the accepting treating doctor.

An example of a notification to a general practitioner of resignation/death letter is available on the Elective Surgery Program Resources webpage.

9.2 Patient management plan for treating doctor's leave

Admissions / booking office staff must inform patients:

- Their position on the elective surgery list will not be affected
- The name of the replacement doctor (if available)
- If a clinical review is required
- About their expected waiting time
- Who to contact for more information

All contact with patients must be documented and be part of, or attached to, the patient's RFA form

10. APPENDIX

Clinical urgency categories reference list

Please note that IPC changes are made yearly. For an up to date searchable list please see the NSW Health Elective Surgery Program Resources webpage.

VERIFICATION OF DEATH AND MEDICAL CERTIFICATE OF CAUSE OF DEATH (PD2023_014)

PD2023_014 replaced PD2021_029

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

Medical Certificate of Cause of Death

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

In situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the Medical Certificate of Cause of Death form and the name of the medical practitioner who will complete the Medical Certificate of Cause of Death form is not known, the registered nurse/ registered midwife may write "transfer to <name of NSW Health facility>" in the Medical Certificate of Cause of Death section on the Verification of Death form.

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

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

Medical Certificate of Cause of Death: Procedures

1 BACKGROUND

1.1 About this document

This Policy Directive outlines the process for the assessment and documentation to verify death (previously referred as extinction of life), and the medical certification of death of patients within the NSW Health system. It describes the roles of medical practitioners, registered nurses/ registered midwives and qualified paramedics employed by NSW Health in relation to assessment and documentation when patients die within the NSW Health system.

Medical practitioners must comply with the death certificate requirements outlined in the Births, Deaths and Marriages Registration Act 1995 (NSW).

This Policy Directive does not apply to the Justice Health and Forensic Mental Health Network.

NSW Ambulance staff may only verify death in accordance with NSW Ambulance Protocol A13 Verification of Death.

This Policy Directive supports registered nurses and registered midwives to verify death across practice settings. The Nursing and Midwifery Board of Australia (NMBA) advises that "the extent of a nurse or midwife's scope of practice is determined by the individual's education, training and competence. The extent of an individual's scope of practice is then authorised in the practice setting by the employer's organisational policies and requirements."[1]

All staff must comply with the legislative requirements in the Coroners Act 2009 regarding the certification of death.

1.2 Key definitions

Intention to complete and sign a Medical Certificate of Cause of Death

In circumstances where there may be a delay in completion of the Medical Certificate of Cause of Death by a medical practitioner, it may be appropriate following verification of death by a registered nurse/ registered midwife or qualified paramedic, for a medical practitioner to provide a notice of intention to complete a Medical Certificate of Cause of Death which will allow a funeral director to remove the body. The certification as to the cause of death must take place within 48-hours of the death.

Medical Certificate of Cause of Death

The form issued by the NSW Registry of Births, Deaths & Marriages in which a medical practitioner notifies the Registrar, Registry of Births, Deaths & Marriages of a death and the cause of that death, pursuant to legislative requirements in Section 39 of the Births, Deaths and Marriages Registration Act 1995 (NSW).

Notification of deaths by medical practitioners to the Registrar at the Registry of Births, Deaths & Marriages

A requirement of the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death under the Births, Deaths and Marriages Registration Act 1995 (NSW). For further details see Section 2.2.

Public Health Organisation

A public health organisation is defined in Section 7 of the Health Services Act 1997 (NSW) as: a local health district and specialty health network, or a statutory health corporation, or an affiliated health organisation in respect of its recognised establishments and recognised services.

Verification of Death

A clinical assessment process undertaken to establish that a person has died.

1.3 Legal and legislative framework

NSW legislation relevant to this Policy Directive:

- *Births, Deaths and Marriages Registration Act 1995*
- *Coroners Act 2009*
- *Human Tissue Act 1983*
- *Health Services Act 1997.*

1.4 Policy framework

NSW Health policy documents relevant to this Policy Directive:

- NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054)
- NSW Health Policy Directive Conduct of Anatomical Examinations and Anatomy Licensing in NSW (PD2011_052)
- NSW Health Policy Directive Organ and Tissue Donation, Use and Retention (PD2022_035).

1.5 NSW State Forms

NSW Health State Forms relevant to this Policy Directive:

- Medical Certificate of Cause of Death (SMR010509) [NSW Registry of Births, Deaths and Marriages]
- Coronial Checklist (SMR010.513)
- Verification of Death (SMR010530)
- Death Certification Arrangements for Expected Home Death (SMR010531)

2 DOCUMENTATION REQUIREMENTS WHEN A PATIENT DIES

2.1 Reporting a death to the Coroner

To determine if a death should be reported to the coroner refer to the Coronial Checklist available from the hospital/ local health district, in conjunction with the NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054). The Coronial Checklist includes details of how to seek advice where there is uncertainty and provides contacts for the NSW State Coroner's Office or the Duty Pathologist, NSW Health Forensic Medicine (Sydney, Newcastle and Wollongong).

Nursing, midwifery and medical staff managing cases reportable to the Coroner must follow the steps outlined in the NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (PD2010_054). For deaths reportable to the Coroner, verification of death (extinction of life) is documented within Report of a Death of a Patient to the Coroner (Form A) (SMR010.510). No additional documentation relating to death is required.

It is advisable to seek advice from the Coroner regarding the mandatory reporting of deaths which fall within the requirements of Section 24 of the Coroners Act 2009 (NSW) which covers jurisdiction concerning deaths of children and disabled persons.

2.2 Medical certification of death

2.2.1 Legal responsibilities of medical practitioners

Death certificates certify the facts and circumstances of the death of a person. Under the Births, Deaths and Marriages Registration Act 1995 (NSW) the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, **must**, within 48-hours of the death:

a) Give the Registrar of Births, Deaths and Marriages, notice of the death and cause of death, and

b) If the medical practitioner is of the opinion that it is impracticable or undesirable to give notice of the cause of death of the person within that time, give the Registrar notice of the death, and of the medical practitioner's intention to sign a death certificate with the cause of death notified as soon as possible after that.

In NSW public health organisations, the *Medical Certificate of Cause of Death* Form must be used to give notice of death. This form asks for the date of death or range of dates where the exact date is not known.

A medical practitioner cannot give notice based on review of medical records only. The body must be viewed, or, the medical practitioner must have been treating the person prior to death.

If another medical practitioner has given notice, or the death has been reported to the Coroner under the *Coroners Act 2009, a* medical practitioner is not required to give repeat notice of death to the Registrar.

A medical practitioner must only certify the cause of death if a diagnosis of cause of death can be made. If the cause of death is uncertain, reasonable steps are to be taken to obtain sufficient information to enable the medical practitioner to determine the cause of death. Reasonable steps would include reviewing the medical record or contacting other health professionals involved in the recent care of the deceased person.

If the medical practitioner is unable to ascertain the cause of death or the death is otherwise reportable to the Coroner (see Section 2.1.), the matter must be referred to the Coroner and a Medical Certificate of Cause of Death must not be completed.

If the medical practitioner is a relative of the deceased, they should not complete the certificate unless they are the only medical practitioner in a remote area. Medical practitioners must also disclose any property, pecuniary or other benefit(s) that they anticipate acquiring from the death. Notification of death certificates may be requested from the Registrar of Births, Deaths and Marriages via phone 13 77 88.

2.2.2 Responsibilities for certification of death in NSW Health facilities

When a patient dies in a NSW Health facility where there are medical practitioners on site, it is preferable that a medical practitioner conducts the verification of death assessment. If verification of death is completed by another health professional, a medical practitioner is to certify the death as soon as practicable.
In the case of facilities where there is not 24-hour medical coverage, the medical practitioner is to certify death at the commencement of duties. Only a medical practitioner can complete the *Medical Certificate of Cause of Death*

2.3 Verification of Death

2.3.1 Roles of medical practitioners, registered nurses, registered midwives and qualified paramedics

A medical practitioner must conduct the verification of death assessment in situations where medical tests are required to declare death (for example, prior to organ donation).

In all other cases, where there is no medical practitioner available to verify death, registered nurses, registered midwives and qualified paramedics can do so. Qualified paramedics must only verify death as outlined in NSW Ambulance Protocol A13*Verification of Death*.

2.3.2 Clinical procedure for verifying death

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

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

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

In cases of expected deaths at home, the clinical assessment process for the verification of death must be completed.

Where a verification of death assessment has been completed and the practitioner is not certain if the person is deceased, they are to seek the opinion of a second health professional.

In a hospital setting, a medical practitioner should be called, if available. In the case of a registered nurse attending an expected death in a community setting, it is reasonable for the attending nurse to wait and repeat the verification of death assessment after a clinically appropriate time period has elapsed. A second opinion may be sought from a qualified paramedic by calling an ambulance if necessary.

Note that a different clinical procedure is conducted when a patient is certified dead for the purpose of organ donation. Such an assessment is conducted according to the NSW Health Guideline Organ Donation After Circulatory Death (GL2021_012).

In situations where the person has injuries incompatible with life (such as decapitation, severe incineration or extensive trauma), or has been deceased for some time (as evidenced by rigor mortis, dependent lividity or tissue decomposition), the death is considered obvious and no clinical assessment is required. This situation is most likely to occur when a body is brought to a hospital by a government contractor (see Section 2.4.).

2.3.3 Documentation

Registered nurses / registered midwives

Registered nurses/ registered midwives who are assessing and documenting death must use the Statewide Verification of Death (SMR010.530). The original form is provided to the funeral director and a copy is kept in the health care record.

In remote sites, in situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the Medical Certificate of Cause of Death and the name of the medical practitioner who will complete the Medical Certificate of Cause of Death is not known at the time the Verification of Death is being completed, the registered nurse or registered midwife may write "transfer to <name of NSW Health facility>" in the Medical Certificate of Cause of Death section on the Verification of Death. Local procedures must be in place to ensure that the Medical Certificate of Cause of Death is completed within 48-hours of the death.

Qualified paramedics
Qualified paramedics are to provide the funeral director with the *Verification of Death* form and record details of the clinical procedure to verify death in the NSW Ambulance clinical record.

2.3.4 Tissue or body donation for deaths outside a health facility

Tissue and body donation may be relevant for some deaths outside of a health facility.
Tissue Donation

A potential donor of tissue for corneal, musculoskeletal and cardiac tissue (heart valve) transplantation is a deceased person for whom retrieval is possible within 24 hours after death.

In order to provide opportunities for families / carers to support the donation of tissues for transplantation, the staff member who verifies the death should sensitively inquire whether the deceased had indicated their wish to be a tissue donor. If so, they are to prompt the family / carer to contact the NSW Tissue Bank via the Lions NSW Eye Bank on (02) 9382 7288 (24 hours a day) to notify them of the death. For more information see the NSW Health Policy *Organ and Tissue Donation, Use and Retention (PD2022_035)*

Donation of Bodies to a School of Anatomy / Medical Science

The deceased person may have decided in their lifetime to donate their body after death to a School of Anatomy for the purposes of anatomical examination and medical research and will usually have completed a consent form during their lifetime to document this decision. Again, the family / carer should be prompted to contact the relevant School of Anatomy body donation program to notify them of the potential donor's death and to make arrangements for the transfer of the body. Further information is available in the NSW Health Policy *Conduct of Anatomical Examinations and Anatomy Licensing in NSW: Procedures and Guidelines* (PD2011_052).

2.3.5 Medical certification following Verification of Death

A medical practitioner must complete the *Medical Certificate of Cause of Death* within 48 hours of death. The contact details of the medical practitioner who will complete the *Medical Certificate of Cause of Death* must be included in the *Verification of Death* form to ensure this occurs.

For patients cared for at home where death is anticipated (e.g. patients known to NSW Health palliative care and affiliated or contracted palliative care services or hospital in the home patients with a resuscitation plan in place), it is recommended that there is agreement in advance on who will complete the medical certification of death. In such cases, the patient's general practitioner may agree to this responsibility (see Section 2.5).

2.4 Bodies transported for verification of death assessment by government contractors (individuals not under the care of NSW Health at the time of death)

In some circumstances, a body may be transported by a government contractor, Ambulance or the Police to a hospital for Verification of Death. If a qualified paramedic is involved in the case prior to a decision to transport the body, it is recommended that they complete the *Verification of Death* form as outlined in Section 2.3. This will assist with transfer of the body to a more suitable location.

Where a qualified paramedic is not involved and the body is transported to a hospital for Verification of Death, a medical practitioner, registered nurse or registered midwife can assess death and complete the *Verification of Death* form. The Coroner will issue a death certificate in such cases. A copy of the signed *Verification of Death* form does not need to be provided to the police.

2.5 Optional considerations for expected home deaths in regional and rural settings

Within regional and rural settings, there may be specific challenges in organising a medical practitioner to complete the *Medical Certificate of Cause of Death* due to greater distances involved and limited medical workforce. Local Health Districts may elect to put in place local policy and / or procedures to designate the medical practitioner responsible for completing the *Medical Certificate of Cause of Death* in advance of an expected death. This approach is encouraged by the State Coroner. Local procedure or policy development must involve consultation with primary care providers, funeral directors and potentially the Police and Coroner.

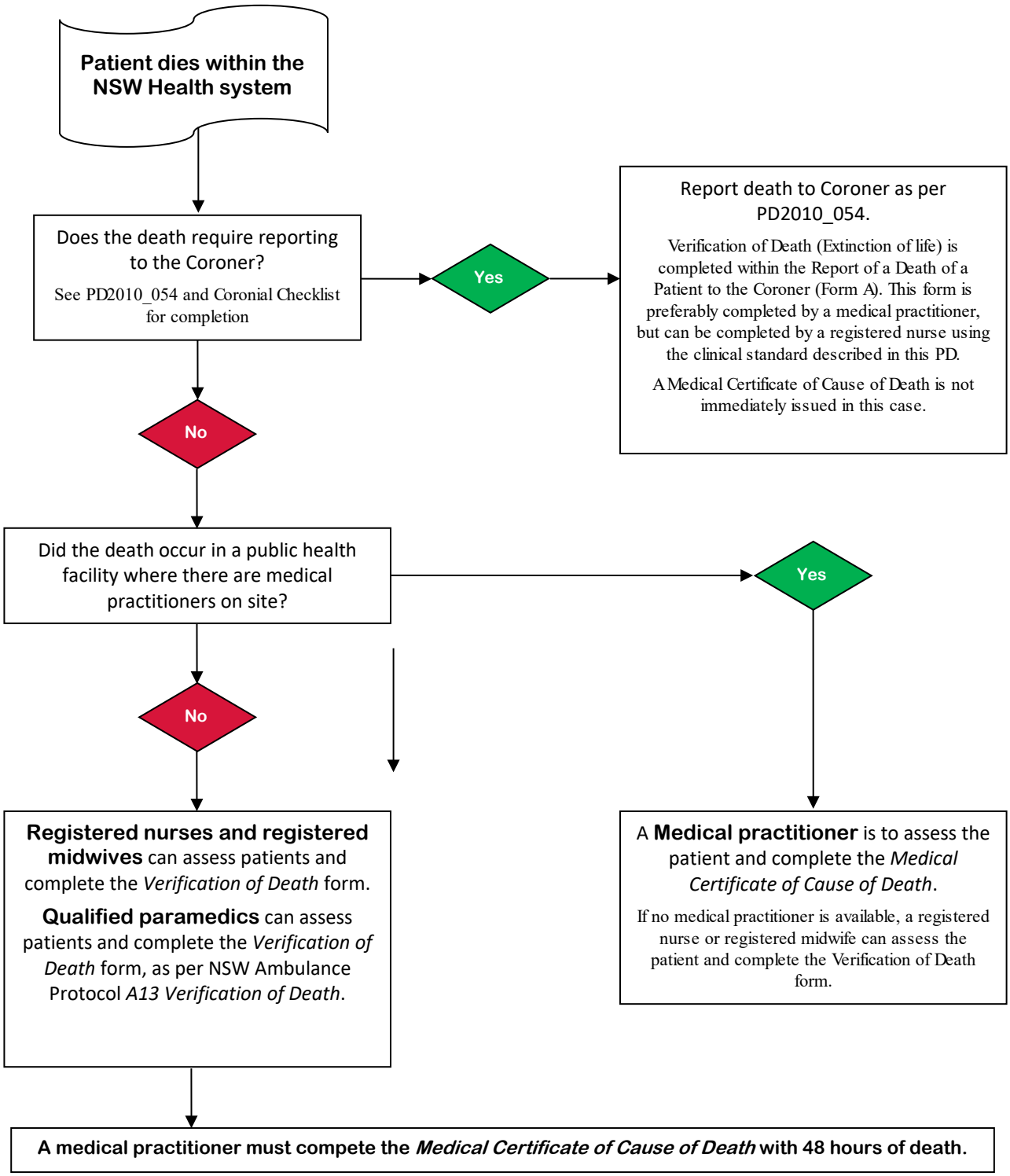
In many cases the patient's general practitioner will be a key part of the healthcare team for patients approaching and reaching the end of their lives who choose to be cared for and die at home.

It is recommended that general practitioners are involved in discussions about planning for completion of the *Medical Certificate of Cause of Death* as part of care planning. In many cases these discussions will be recorded in the patient's health record, however some local health districts and specialty health Networks may elect to formalise the agreement. To assist with formalising this process, a model *Death Certification Arrangements for Expected Home Death* form (see Appendix 2) has been developed and endorsed by the NSW Health State Forms Management Committee. Use of this form is encouraged, but not mandated where local health districts and specialty health networks have elected to develop a process for managing expected deaths in this way.

3APPENDICES

1. Roles and responsibilities for documentation when a patient dies within the NSW Health system
2. StateForm *Death Certification Arrangements for Expected Home Death*

3.1 Appendix 1: Roles and responsibilities for documentation when a patient dies within the NSW Health system



3.2 Appendix 2: State Form Death Certification Arrangements for Expected Home Death

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH

SMR010531

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

PURPOSE:

This form is recommended for use where Local Health Districts / Specialty Health Networks have put in place local policy and/or procedures to designate the medical practitioner responsible for completing the Medical Certificate of Cause of Death (MCCD) in advance of an expected home death. This form will assist with timely removal of the body from the patient's home and give certainty about who will complete the MCCD.

- The first section of the form is for completion by Local Health District / Specialty Health Network staff.
- The second section of the form is for completion by the GP or medical practitioner who agrees to complete the Medical Certificate of Cause of Death within 48 hours of the patient death. The GP or medical practitioner should return this form to the requesting service as soon as possible.

FOR COMPLETION BY REQUESTING SERVICE

Patient details

Family name _____ Given name(s) _____

DOB _____ Phone _____ MRN _____

Address _____

Patient Contact Person: _____ Relationship: _____

Palliative or Life-limiting Diagnosis: _____

Palliative Care Phase: ☐ Deteriorating ☐ Terminal

Details of requesting service:

☐ Specialist Palliative Care Service ☐ Community Health ☐ Aged Care ☐ Multipurpose Service (MPS)

Staff member requesting form: Print Full Name: _____ Signature: _____

Designation: _____ Date: _____

Organisation: _____ Phone: _____

FOR COMPLETION BY GP OR MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body and complete MCCD?

☐ Yes ☐ No

Comment: _____

Can you be contacted after hours? ☐ Yes ☐ No

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours if the death is not a reportable death under the Coroners Act 2009?

☐ Yes ☐ No

GP/Medical practitioner's details:

A/H or Mobile No (if available): _____ Surgery Ph: _____

Print Full Name: _____ Signature: _____ Date: _____

ON COMPLETION, RETURN COMPLETED FORM TO:

Contact person/service _____

FAX _____ or EMAIL _____

NH700037 260815

DEATH CERTIFICATION ARRANGMENTS FOR EXPECTED HOME DEATH

SMR010.531

Original - Funeral Director Photocopy - Medical Record Page 1 of 1

DO NOT PRINT

WILL MAKING IN PUBLIC HEALTH FACILITIES (GL2023_006)

GL2023_006 replaced IB2018_002

GUIDELINE SUMMARY

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

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

KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact Details

NSW TRUSTEE & GUARDIAN	
Trustee Services	1300 364 103
Managed Clients	1300 360 466
THE LAW SOCIETY OF NSW	
Sydney	(02) 9926 0300
Outside Sydney	1800 422 713

ADVERTISING LEGAL SERVICES (IB2015_066)

IB2015_066 rescinds IB2013_060

PURPOSE

This Information Bulletin sets out changes in legislation relating to the advertising of personal injury legal services.

KEY INFORMATION

The prohibition on the advertising of personal injury legal services in NSW that was referred to in Information Bulletin IB2013_060 has been repealed.

Lawyers may advertise legal services in the circumstances described in Rule 36 of the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015*:

- a solicitor or principal of a law practice must ensure that any advertising, marketing, or promotion in connection with the solicitor or law practice is not false, misleading or deceptive or likely to mislead or deceive, offensive or prohibited by law; and
- a solicitor must not convey a false, misleading or deceptive impression of specialist expertise and must advertise or authorise advertising in a manner that uses the words "accredited specialist" or a derivative of those words unless the solicitor is a specialist accredited by the relevant professional association.

The practical effect of these changes is that agencies should treat the advertising of legal services, including personal injury legal services, in a similar way to the advertising of any other services.

ADMISSION TO DISCHARGE CARE COORDINATION (PD2022_012)

PD2022_012 rescinds PD2011_015.

POLICY STATEMENT

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

1. BACKGROUND

1.1 About this document

Care Coordination is the process where patient care needs are identified and managed. The patient/carers must be involved in care planning from admission through to discharge.

This Policy Directive applies to clinical staff involved in the care of inpatients across all NSW Health Hospitals. It outlines a five-stage process to inform staff and patients throughout their hospital stay. Implementation of this approach will enhance patient outcomes, safety and experience.

A patient's discharge from hospital demonstrates that a patient's care continues beyond the treatment they receive in hospital as they continue to receive care from another service/facility/or in the community. This could be by a patient's General Practitioner (GP), community health providers, including Aboriginal Community Controlled Health Services (ACCHS), or other organisations by the patient and/or their carer's.

1.2 Key definitions

Multidisciplinary Team (MDT) Care	When professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. *Mitchell G.K., Tieman, J.J., and Shelby-James T.M. (2008), Multidisciplinary care planning and teamwork in primary care, Medical Journal of Australia, Vol. 188, No. 8, p.S63.*
Estimated Date of Discharge (EDD)	The EDD predicts the likely date that a patient will be **clinically ready** to leave the hospital, defined as all members of the treating MDT agree when active care is completed, and the patient will be safe to transition to their next phase of care or discharge home. It provides everyone involved in the patient's care, including the patient and their family/carers, with a date to coordinate the patient's needs and discharge planning.

2. PRE-ADMISSION/ADMISSION

At the time of first contact with the patient (pre-admission clinic or admission to an inpatient ward) a locally developed 'Discharge Risk Assessment' or equivalent must be completed by the treating nurse or midwife. A discharge risk tool is used to identify those patients who may have needs that require further assessment and follow-up before they are discharged home or to ongoing care from the acute hospital service.

Health Services are responsible for ensuring that a discharge risk is completed for all admitted patients. The results from this discharge risk tool are to be used to inform the overall management of the patient. Each Health Service, Hospital, and clinical units must develop a process for flagging those patients who have been identified as having a discharge risk with the multidisciplinary team and to implement procedures for contacting the appropriate health professionals to provide a discharge risk assessment.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) standard has identified that organisations develop electronic discharge tools to mitigate risk. An electronic discharge summary (eDS) must be used where available.

The 'Discharge Risk Assessment' must be used to gather information on all appropriate patients at admission or pre-admission. The key areas to be addressed are:

1. Is the patient likely to have self-care problems?
2. Does the patient live alone, is the patient homeless?
3. Does the patient have responsibilities to care for others?
4. Has the patient used community services before admission?
5. Are there other psychosocial factors that may impact on the patient's recovery?
6. Does the patient usually take three or more medications and have their medications changed in the last two weeks?
7. Is the Patient at risk of/or suffering from a current mental illness?
8. Is the patient of Aboriginal background?

This is important in the context of identifying potential service providers located in an Aboriginal Controlled Community Health Service. This will prompt an immediate inpatient referral to an Aboriginal Hospital Liaison Officer, identifying risk criteria for specific diseases as well as cultural considerations.

The 'Discharge Risk Assessment' must be completed on initial presentation and whenever the patient's clinical or social status changes and whenever further information becomes available.
When a discharge risk is identified by any member of the multidisciplinary team, it must be documented and ensure that procedures are in place to highlight risks to the multidisciplinary team and make referrals to the relevant health professions for further assessments and intervention.

2.1 Pre-admission

For planned admissions, discharge planning must begin before the patient is admitted. The discharge risk assessment is to be conducted during this time.
Patients with an identified risk must be referred early to the relevant inpatient allied health service and/or community teams, including Aboriginal Controlled Community Health Service so planning for transfer can begin. This must include the proposed length of admissions and the goals for admission.

2.2 Planned patients

Discharge planning must occur for patients having day-only procedures. Facilities may nominate their own processes to ensure the discharge risk assessment is completed. For example:

- utilising a pre-admission preparation toolkit,
- nominating staff responsible for assessment of day-only patients, ideally this is to occur prior to the day of their procedure.

2.3 Planned patients

All patients with a planned admission must have their discharge risk assessment completed by the treating clinician at presentation or before admission to hospital, such as at a pre-admission clinic.

Completion of this assessment will allow the identification of discharge risks. The treating clinician is responsible for ensuring that all necessary referrals are made before admission, where possible, and confirmed during the acute phase of care.

2.4 Non-planned patients

For non-planned patients who are admitted to hospital through the emergency department or through direct admission, their discharge risk assessment must be completed within the *first 24 hours* of admission by the inpatient treating nurse or midwife.

2.5 Rural and remote patients

Consideration must be given to time, distance and dislocation involved for rural patients (and their carers / families) when hospitalised in a larger facility a long way from home.

Early identification of rurality or displacement will enable early mobilisation of support for carers and families who are isolated from support networks and are vulnerable. A needs assessment on admission would enable care planning sensitive to rurality to decrease hardship (emotional, social, financial and environmental), increase access to information and improve communication. This includes using telehealth as an option for family involvement in multidisciplinary team rounding and at discharge for follow up appointments and rehabilitation closer to home.

In some rural settings, and with some models of care local medical practitioners and allied health professionals are not always available. Local Health Districts (districts) and Speciality Health Networks (networks) must ensure patients can access these services if they are required with local processes in place to ensure appropriate input into decision making regarding assessment, treatment and discharge planning.

2.6 Homeless patients

All districts / networks have a duty of care to ensure that patients have a safe and appropriate discharge plan, including discharge to appropriate accommodation.
Where a patient does not have a general practitioner and requires follow up treatment and ongoing management in the community, options of general practitioners and outreach service providers must be given.

For homeless patients or those patients identified as at risk of being homeless, plans need to be put in place prior to discharge to ensure that no patient exits an NSW Health facility into homelessness. Access and referral to specialist outreach services and support information must be provided and can be found at NSW Family & Community Services website (Housing NSW).

3. MULTIDISCIPLINARY TEAM

3.1 Roles and responsibilities

All members of the multidisciplinary team are expected to work collaboratively across disciplines to ensure improved patient outcomes and have defined roles and responsibilities in assisting in the care coordination process.

Health Services, hospitals and departments will need to ensure local procedures are in place to support a designated time for the multidisciplinary team care in inpatient wards/units to meet.

3.2 Team huddles

Multidisciplinary huddles are to take place daily throughout the working week thus ensuring short stay patients' needs are met.

The multidisciplinary team members must agree on the treatment plan, incorporate the discharge risks into the patient care plan, and set or review and update each patient's estimated date of discharge.
In some models of care (particularly in rural settings) regular participation from some members of the multidisciplinary team may be limited. Local processes need to be in place to ensure appropriate input into decision making regarding discharge planning.

Multidisciplinary huddles are a daily action planning tool and *do not* replace patient rounding, or in depth 'case review' meetings, patient rounding in which a patient care and treatment are discussed in more detail and a patient and their family carer are invited to actively participate.

Multidisciplinary huddle stages

Multidisciplinary Huddles	
Start of the day huddle	High level view of the predicted demand for the day, using the information in the Patient Flow Portal (PFP). Average of 30 seconds to share and highlight numbers.
Main body of the huddle	Progression of each patient towards the next transition of care and discharge (average of 30 seconds per patient – note that some patients will take longer than others). Discussing the patient's clinical plan and reviewing and updating the patients EDD is pivotal. To assess the need for Allied Health interventions from Day 1. Any other clinical concerns to be raised.
End the huddle	Raising ward related matters such as staff, any need for escalation of issues e.g. about particular complex patients, and opportunities to bring outliers back to the ward. Average of 30 seconds to close the huddle.
Follow-up	A range of actions after the huddle, such as updating the EPJB, actioning appropriate clinical care and referrals, i.e., allied health, medical consults and updating the patient/carer.

3.2.1 Positive multidisciplinary team huddles

The multidisciplinary team huddle is a quick daily meeting discussing care coordination requirements and discharge decisions. The huddle will discuss every patient on the ward, including outliers where appropriate. The huddle can also be known by other names, such as care coordination rounding, rapid huddle or electronic patient journey board rapid round.

The huddle must have a *forward outlook*, with a focus on the treatment plan and the tasks need for safe discharge, a discussion and amendment of each patient's estimated date of discharge, agreement about what is required next and key actions for team members in the *next 24-48 hours* including confirmation of discharges for today and tomorrow.

It must be led by a senior clinician such as the Nursing Unit Manager, Nursing Team Leader, and/or Senior Allied Health / Medical Consultant to ensure the meetings maintain structure and efficiency and be conducted at the Electronic Patient Journey Board (EPJB) or equivalent.

Patients who have been identified for discharge on the day of the huddle must be prioritised for early review and management.

Detailed clinical discussion about complex patient requirements can occur in case conferencing or handover, rather than in the huddle. Consider developing an 'multidisciplinary team huddle' script / template to provide structure and consistency to the meeting.

3.2.2 Preparation for multidisciplinary team huddles

Team members must decide on key roles to perform within the huddle. This must be established based on the professions involved in the patients care (e.g. Medical, allied health and nursing).

An agreed time must be decided for the huddle, frequency and duration. The duration of the rapid huddle is to be approximately 30 seconds each patient. (e.g. 15mins for 30-bed ward).

Ground rules must be established with the team, thus providing good communication and efficiency.

- Mandatory attendance by these key roles
- Ensure handovers are completed before the huddle, so that the most up-to-date information is provided to the multidisciplinary team.
- Start on time and finish on time
- Turn off phones: minimising interruptions
- Nominate a team member to respond to urgent correspondence

- Discussion centres around the electronic patient journey board (which means the electronic patient journey board must be set up in a way that facilitates meaningful discussion)
- Every member of the huddle has the opportunity to raise quality and safety issues that may affect patient outcomes.
- A nominated person updates the electronic patient journey board during the rapid huddle or afterwards.

4. ESTIMATED DATE OF DISCHARGE

The estimated date of discharge will be set based on the multidisciplinary team plan of care. It must be reviewed and updated as required during the electronic patient journey board rapid multidisciplinary team huddle or equivalent, and communicated to the patient, family/carers and relevant community service providers.

This process of capturing and reviewing a patient's estimated date of discharge is not required for patients admitted in an Emergency Department or an Emergency Department Short Stay Unit (EDSSU).

For many patients, the estimated date of discharge will change due to clinical issues. Discussions with the patient and their family/carer/s, general practitioner's community health and service providers must occur early and updated regularly for effective care planning. The estimated date of discharge is to be reviewed in the multidisciplinary team huddle and updated in the patient flow portal as changes occur. Any changes to the estimated date of discharge for clinical reasons or delays in transfer beyond the estimated date of discharge are to be recorded and relevant staff informed. In this situation it is necessary to contact any relevant community service providers to advise them of the updated estimated date of discharge.

Hospitals must ensure an agreed local process is developed identifying the clinician/s responsible to ensure that the estimated date of discharge is updated in the patient flow portal or patient administration system (PAS).

- A patient's estimated date of discharge must be visible near their bed, reminding staff of the date they are working towards and informing the patient and their family or carer.
- The estimated date of discharge must be updated in the NSW Health patient flow portal (or PAS) within the first 24 hours of the patient's admission then reviewed and updated daily.
- The multidisciplinary team must use the estimated date of discharge to synchronise referrals to other teams and/or disciplines that are not involved in regular multidisciplinary team reviews.
- The estimated date of discharge is used by patient flow managers and hospital executive teams for predictive planning and management of patient flow.

The patient flow portal reports module provides the hospitals with the tools to review their estimated date of discharge compliance and accuracy for review and management.

Hospitals are to have in place a business continuity plan (BCP) in the unlikely event that the patient flow portal is off-line.

4.1 Inter-ward transfers

In the case of inpatient units such as Intensive Care, Coronary Care, Medical Assessment and Short Stay Units (Surgical Short Stay / 23hr units), the estimated date of discharge will be the predicted date that the patient will be clinically appropriate and ready for an inter-ward transfer to another inpatient unit.

If the patient's clinical plan is to be discharged from any of the units mentioned above (rather than transferred to another inpatient unit) then the estimated date of discharge will be the predicted discharge date for the patient.

4.2 Inter-hospital transfers

Patients awaiting transfer to another facility must have their estimated date of discharge set as the date that the accepting hospitals medical team has accepted care of the patient and the patient is clinically appropriate for safe transfer to the accepting facility.

This includes waiting for a transfer to a Residential Aged Care Facility (RACF), rehabilitation services and respite accommodation.

4.3 Patient detained for involuntary treatment

The estimated date of discharge for patients detained for involuntary treatment is the date that the multidisciplinary team believes the patient will be clinically fit for discharge/transfer from the current inpatient unit.

If the patient has an Involuntary Patient Order (IPO) or dependency certificate any expiry/review dates relating to this order can also be recorded in the patient flow portal.
In line with principles of least restrictive care, the Order expiry date is not the estimated date of discharge for the patient unless the team believe the patient will be clinically fit for discharge on this date.

4.4 Setting and estimated date of discharge for patients with complex needs

When setting and estimated date of discharge for patients with complex clinical needs the following things may help to determine a likely date of discharge/transfer:

- If the patient has had previous admissions how long where they?
- What is the patient's diagnosis and what is the average length of admission for patients with similar diagnosis?
- What is the treatment plan? If commencing/restarting medications how long is anticipated this will have a therapeutic effect
- What is the patient's provisional discharge plan?
- What is likely level of recovery and function for the patient, does their current social circumstance support this?
- What are the patients' goals? Establishing the patients previous baseline function, including their detailed social situation.

The estimated date of discharge for patients with complex needs will usually require assessments by several multidisciplinary team members and therefore the patients estimated date of discharge may require several revisions throughout the patient's admission.

4.5 Non-clinical delays

If a patient is unable to be transferred or discharged due to non-clinical delays then the estimated date of discharge *must not* be changed.

The patients estimated date of discharge will remain as the date that the patient was clinically ready to leave the hospital but was therefore unable to be discharged on their estimated date of discharge. This is primarily due to non-clinical delays such as waiting for a residential aged care facility to have capacity or waiting for a transfer to another hospital etc.

The patients estimated date of discharge days (EDD#) will then display as a negative number, each day the EDD# column will be indicating the number of days that the patients estimated date of discharge has lapsed. This will identify the number of days that a patient has been waiting for discharge/transfer and provides an opportunity for the facilities to identify and understand the non-clinical delays to discharge in their facility.

The patient flow portal 'Waiting for What' tool assists clinicians in identifying the delays to discharge and therefore by definition every patient with an estimated date of discharge in the past must have a non-clinical delay. Therefore, these patients must have an attached 'Waiting for What' (W4W) entry in the NSW Health Patient Flow Portal.

These delays include waits for:

- Out of Hospital Services
- Suitable Accommodation
- Guardianship
- National Disability Insurance Scheme (NDIS)
- Aged Care Assessment Teams (ACAT)
- Residential Aged Care Facilities (RACF)
- Respite service
- Community Service
- Home modification
- Discharge Equipment
- Family / Carer to pick up the Patient
- Inter-Hospital or Inter-ward Transfers and Transport
- Inter Hospital transfer to Tertiary/specialist hospital for acute services
- Return to sender post specialist care
- Waiting for rehabilitation bed
- Waiting for respite bed
- Palliative Care Services
- Community Treatment Orders

The free-text sections in the 'waiting for what' entry can be used to document delayed transfer times e.g. when a bed is ready, or when home modifications are due to be completed.
Facilities and Health Districts must have robust processes in place to open, manage, escalate 'waiting for what' delays and review data trends.

If a patient's condition changes or deteriorates whilst they are waiting for a service, then the estimated date of discharge will need to be revised and updated in the patient flow portal to reflect their new estimated date of discharge.

4.6 Good to Go

The Good to Go (G2G) is used in either the patient flow portal, electronic patient journey board or bed board list to show that a confirmed patient is ready for discharge from the hospital.

Discharge includes transfers to other hospitals and care facilities. A good to go must *not be* used to flag patient ready for transfer within the same hospital (IWTs).

Districts and hospital patient flow teams can see confirmed and potential good to go in the patient flow portal bed board and allocations module to make decisions about capacity and demand planning.
Good to go must be used to flag patient discharges 24/7, 7 days a week, and is the responsibility of the treating Nurse in the following scenarios:

- discharge confirmed - **select G2G 'Yes'** and the likely discharge time.
- discharge is a potential- **select G2G 'Query'** where a final review, test or action is needed before confirmation.
- discharge delayed - **select G2G 'No'** for patients with an estimated day of discharge is delayed (e.g. Transfer W4W or Out of Hospital W4W's).
- patient deemed unsuitable for discharge - - **select G2G 'No'** e.g.
  - previously discharge confirmed update G2G 'Yes' to 'No'
  - previously a potential for discharge update G2G 'Query' to 'No'

Good to go entries on patients who have not been discharged will be cleared at midnight each day.

5. REFERRALS AND LIAISON

5.1 Referring to service providers

Service providers are to be involved in planning for the patient's transfer from the acute setting. Liaison will need to occur with all appropriate providers including the patient's general practitioner and any additional health providers the patient currently receives services from.

The needs of the patient's children and family members must also be considered. All family members' needs are identified and planned for with appropriate referrals made to care providers to family/dependents (as needed).

Once a patient's requirements are identified, discussions with the appropriate providers *must occur* using the estimated date of discharge as the start date.

Discussions with providers must occur early to provide enough time to make the appropriate arrangements.

Where the patient's service provider is located in an Aboriginal Controlled Community Health Care Service (ACCHS) or a general practitioner clinic where the patient may not see the same provider on each occasion, the organisation must be asked to nominate an alternate contact to ensure that transfer /discharge care arrangements are managed appropriately.
During the acute episode of care, it is important to identify what services the patient will require upon discharge. *Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers.*

Multidisciplinary team members are to undertake assessments early in the admission to determine the services required upon discharge. Referral details must be recorded in one place in the patient's medical record, and on any relevant individual referrals (e.g. general practitioner and community health) and the referral status flagged on your ward's electronic patient journey board.

It may not be possible to complete a patient assessment in hospital prior to the transfer of care. The multidisciplinary team must look for opportunities for early discharge where acute, rehabilitation and subacute care can continue to be provided in the community.

If a need for services has been identified, a referral to the appropriate community service provider or general practitioner must be made. Follow-up by the organisation with the patient will then take place on their return to the community. This follow up may include the need for a more complete assessment in the home environment.

6. TRANSFERRING HOME

6.1 Discharge checklist

Staff must use their locally developed discharge checklist to meet the needs of patients before leaving the hospital. The nurse unit manager / midwifery unit manager is responsible for ensuring that these details are checked and completed by the treating nurse/ midwife and agreed to by the patient and / or carer before leaving the hospital.

The Discharge Checklist must cover the following information:

- Estimated Date of Discharge
- Destination of Transfer
- Notification/Transport Booked
- Personal Items Returned
- Referral Services Booked
- Care Plan
- Assistive Technology (equipment)
- Patient Educational Resources

Discharge summary provided to patient that includes medication information, community and general practitioner referral information, follow up appointments and patient educational resources. This must be provided in plain language and explained to the patient.

Staff are strongly encouraged to use an electronic checklist if available. Each individual Health Service, Hospital and Clinical Unit are to build on these fundamentals in the checklist to address specific local circumstances.

Shared care roles and responsibilities are to be clearly defined for the various services providers involved in the patient's care. Joint care planning with Community Managed Organisations, National Disability Insurance Scheme (NDIS) and private service providers must be undertaken.

NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045). Provides an example Transfer of Care / Discharge Checklist for those being discharged from Mental Health Inpatient Units.

6.2 Discharge medications

Patients with an identified medication risk as per the check list or advice from the multidisciplinary team are to be prioritised for the pharmacist's review over non-urgent cases.
Each Pharmacy department will need to establish a system to effectively prioritise patients to facilitate safe discharge and meeting the estimated date of discharge.

Patient transport needs are to be considered in the discharge planning processes. This is particularly important in the case of regional or remote patients as some patients may be eligible for subsidies for the cost of long-distance travel.

6.3 Patient transport

The Patient Transport Service (PTS) manages non-emergency patient transport bookings through the patient flow portal. Bookings on the day of Inter Hospital Transfer or day of discharge are only to be made in exceptional circumstances.

Early booking for the next available patient transport service ambulance will prevent patients waiting long periods for the transport to arrive by improving resource management and ensuring appropriate transport is available for patients when required.

7. IMPLEMENTATION

7.1 Health Service Chief Executives are responsible for

Establishing mechanisms to ensure that the essential stages of care coordination are applied in each facility and are sustained as part of the normal care coordination and discharge planning.

7.2 Patient flow systems framework

The Patient Flow Systems Framework was developed through state-wide collaboration that used Redesign Methodology to identify elements that contribute to good patient flow.

The seven key elements, Quality, Standardised Practice, Care Coordination, Demand and Capacity Planning, Variation Management, Demand Escalation and Governance have been developed to enable a system wide approach to identify and resolve delays within the current system to create capacity. Care Coordination has been identified as one of the seven key elements in the patient flow systems framework.

8. FURTHER EDUCATION

The PFP Care Coordination webpage includes advice and direction on how to improve Care Coordination. This includes definition of care coordination, links to policy directives, PDF Care Coordination factsheet for printout and general overview of the importance of care coordination to patient outcomes.

Completing a specific training module is no longer a mandatory requirement however completing the current My-Health Learning module titled *Care Coordination (46356692)* would meet these requirements and will continue to be available.

A link to Care Coordination training resource in My Health Learning will also be available on this page. My-Health Learning module online titled *Care Coordination (46356692)* will be available to support staff with clinical practice requirements.

Please liaise with your line Manager, Clinical Nurse Educator, Midwife or Patient Flow Manager for further education and support.

A number of education materials and resources are also available on the NSW Health PFP to support clinical staff in meeting their obligations under this Policy Directive.

9. REFERENCES

Online resources are available via:

- My-Health Learning module titled Care Coordination (46356692)
- Patient Flow Portal website
- Clinical Care Coordination Rounds: Presentation by A/Prof Golo Ahlenstiel
- Behavioural Insights Unit V1.0 Newsletter April 2016; Ideal Patient Journey
- NHS England » Principle 1: Plan for discharge from the start to setting expected dates of discharge and clinical criteria for discharge
- The NSW Family Focused Recovery Framework 2020-2025: A framework for NSW Health services provides a guide for services to improve support to families where a parent lives with mental health issues and has dependent children through implementing a family focused approach.

10. GLOSSARY OF TERMS

Listed in alphabetical order and in context to this policy document	
Discharge	The relinquishing of patient care in whole or part by a health care provider or organisation.
Discharging clinician	The medical officer, nurse practitioner, midwife or suitably authorised healthcare employee responsible for discharging the patient.
Discharge documentation	Refers to both the discharge summary and the patient directed discharge letter.
Discharge referral	A referral occurring in the context of discharge, see ‘referral’.
Discharge report	An additional document to the discharge summary usually completed by Allied Health professionals to provide greater detail on discharge.

Discharge summary	A collection of information about events during care by a provider or organisation as outlined in section 2.
Electronic Patient Journey Board (EPJB)	The Electronic Patient Journey Board (EPJB) is designed to help NSW Health staff to coordinate patient care as part of the Patient Flow Systems Framework. The EPJB is customised for each ward based on their specific needs and provides information about every patient relating to their care coordination and patient flow management.
Estimated date of Discharge (EDD)	The estimated date of discharge (EDD) predicts the likely date that a patient will be clinically ready to leave the hospital, defined as all members of the treating MDT agree when active care is completed and the patient will be safe to transition to their next phase of care or discharge home.
Good to Go (G2G)	Good to Go (G2G) is used in either the PFP EPJB or Bed Board list to show a confirmed patient discharge today from the hospital.
Inter Hospital Transfer (IHT)	An inter hospital transfer (IHT) of a patient from a sending facility to an accepting facility under the care of an accepting Doctor.
Inter Ward Transfer (IWT)	An inter ward transfer (IWT) occurs when a patient is transferred from one ward to another ward within the same facility.
Multidisciplinary team (MDT)	Involves a range of health professionals from different disciplines or organisations working together to deliver comprehensive patient care.
Patient directed discharge letter	A personalised letter or documentation for the patient written in plain English, summarising their hospital admission.
Patient Flow Portal (PFP)	The Patient Flow Portal (PFP) provides access to a suite of modules used by NSW Health Hospital Staff and administration support and executive teams to monitor and manage patient flow.
Presenting problem	Most relevant symptom/s, disorder/s, or concern/s expressed by the patient when seeking care.
Primary care provider	Discharge summary recipient including the patient's nominated General Practitioner (GP), Residential Aged Care Facility (RACF), Aboriginal Medical Service (AMS), Justice Health, agency or community-based clinician or other community-based service provider.
Principal diagnosis	The diagnosis established after study to be chiefly responsible for occasioning the patient's care at the facility.
Residential Aged Care Facility (RACF)	This is the term used to describe a residential aged care facility (RACF) or aged care home operated by an approved provider.
Referral	The communication, with the intention of initiating care transfer, from the provider making the referral to the receiver. Referral can take several forms, most notably: a) Request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment. b) Notification of a problem with hope, expectation, or imposition of its management, e.g. a discharge summary in a setting which transitions care responsibility on the recipient.
Waiting For What (W4W)	Waiting for What (W4W) is used in the PFP to record delays to care or discharge so that they can be fixed and analysed to improve patient care.

11. APPENDIX LIST

11.1 Implementation / Compliance checklist

Implementation checklist and compliance self-assessment

Local Health District / Facility:	

Assessed by:	Date of Assessment:		
Development and use of an admitted patient 'Discharge Risk Assessment' Tool'. All departments (including the emergency department) must have guidelines in place for care of discharged patients at risk especially between the hours of 2200hrs and 0800hrs. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this policy.	❑	❑	❑
	Notes:		
Structured (set time, duration and frequency) multidisciplinary team reviews (Electronic Patient Journey Board MDT rapid huddle) in each ward/unit with an allocated responsible person for the administration/coordination of the meetings.	❑	❑	❑
	Notes:		
An Estimated Date of Discharge (EDD) is allocated, documented and displayed near the bedside and on the Patient Flow Portal (PFP) electronic patient management tools (EPJB), and reviewed for each patient. The patient and carer must be kept informed of the EDD during their stay.	❑	❑	❑
	Notes:		
Ensuring the Discharge Checklist or equivalent is completed for all relevant admitted patients before they return to the community.	❑	❑	❑
	Notes:		
All referrals, appointments, and follow-up information including medication advice is discussed and provided to the patient, carer and appropriate service prior to transfer of care, in plain language.	❑	❑	❑
	Notes:		

INTRAVASCULAR ACCESS DEVICES INFECTION PREVENTION AND CONTROL INSERTION AND POST INSERTION CARE (PD2019_040)

PD2019_040 rescinds GL2013_013

PURPOSE

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

MANDATORY REQUIREMENTS

All clinical staff who insert IVADs or care for a patient with an IVAD must comply with this Policy Directive. For each insertion a record of insertion must be completed.
Every IVAD insertion, management and removal must be documented at the time of care or as soon as possible afterwards.
HO's must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices for clinicians.
HO's must support clinicians to ensure adherence with this Policy Directive.
Aseptic technique must be adhered to during each IVAD insertion, management and removal to reduce the risk of local or systemic infection.

IMPLEMENTATION

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

Clinical Excellence Commission

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

Health Education and Training Institute (HETI)

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

Chief Executive of Local Health District and Specialty Health Network

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

Directors of Clinical Governance

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

Clinical leaders and senior managers

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

Infection prevention and control professionals

- Provide leadership in infection prevention and control surveillance and reporting.
- Provide advice on compliance with the insertion, management and removal of IVADs policy within their health organisation.

-

- Provide leadership in the management of HAIs or other transmission risks and in the communication of these risks to health workers, patients, volunteers, carers and visitors.

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

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

Intravascular Access Devices (IVAD) – Infection Prevention and Control Procedures

BACKGROUND

Background

Intravascular access devices (IVADs) are commonly used in a variety of settings. They are used to provide a route for administering intravenous medications, fluids, blood products and nutrients and may be used for haemodynamic monitoring, short to long term intravascular access, renal therapies and blood specimen collection.
Intravascular access devices provide direct access to the patient's bloodstream and therefore pose a serious risk for infection of microorganisms to be introduced either at the time of insertion or while the device is in situ. Device-related infections are associated with increased morbidity and mortality, prolonged hospital stay and additional healthcare costs.
Central Venous Access Devices (CVAD) pose a risk of air embolism in patients during insertion and removal (1).
Correct use and management of IVADs minimises the risks of device related infection to patients (2).
The health service organisation must have a process for the appropriate use and management of invasive medical devices (3).

About This Document

This Policy outlines the minimum infection prevention and control requirements for IVADs for NSW Health Organisations (HOs). It has been developed for clinicians who insert, use/manage and remove devices and for persons responsible for surveillance and control of infections in hospital, outpatient, and home healthcare settings. It is recognised that in a clinical emergency, the principles of insertion outlined in this Policy may be difficult to meet. In these situations a risk assessment should be undertaken and the intravascular device replaced as soon as clinically appropriate.
This Policy integrates evidenced-based knowledge with clinical expertise to:

- Support appropriate device management within NSW HOs
- Prevent device related infections
- Prevent adverse events
- Assist NSW HOs to meet the requirements for Standard 3 of the National Standards for Quality Healthcare Services

Scope

This Policy focuses on infection prevention and control (IP&C) for IVADs. Some aspects outside of IP&C are also included to assist in guiding the overall management of IVADs.
This Policy sets out the minimum standards to ensure the safe use of devices and should be used in conjunction with the manufacturer's instructions relating to individual catheters, connections, administration set dwell time, and compatibility with antiseptics, medications and other fluids. HO's who use these devices must have local guidelines or procedures in place to support the technical and procedural aspects for using and managing these devices.
The Policy is applicable to all patient care settings in which devices are inserted, managed or removed.
This Policy is applicable across all patient populations (e.g. adults, ambulance, pre-hospital, hospital in the home, paediatrics and neonatology).
The following devices have been included in this Policy:

- Peripheral intravenous cannula (PIVC)
- Midline catheters
- Central venous access devices (CVAD)
    - Peripherally inserted central catheter (PICC)
    - Tunnelled cuffed and non-cuffed central venous catheter
    - Non-tunnelled central venous catheter
    - Implantable Venous Ports (Port)
- Umbilical catheters
- Peripheral artery catheters
- Pulmonary artery catheters
- Haemodialysis catheters

The following items are out of scope for this Policy:

- Technical or procedural aspects related to the above devices
- Sub-cutaneous devices
- Arteriovenous (AV) fistulas
- Anticoagulants
- Intraosseous devices

Key definitions

A detailed glossary of terms can be found at the back of the Policy

Central Venous Access Device (CVAD)	• A catheter inserted through an upper or lower peripheral or central vein where the catheter tip terminates in:
	  ○ For upper body access: superior vena cava/right atrial (SVC/RA) cavo-atrial junction.
	  ○ For lower body access: the common iliac vein or abdominal vena cava
	• These catheters are used for the administration of parenteral fluids and medications that are typically not suitable via a short peripheral catheter. They are also used for the measurement of central venous pressure in critical care setting.
	  ○ *Centrally*- inserted central venous catheters have a skin entry point in the neck or trunk.
	  ○ *Peripherally*- inserted central catheters have a skin entry point on a limb or the scalp.
	  ○ *Non-Tunnelled*- the catheter insertion and exit points are the same
	• *Tunnelled* - the catheter is inserted through one point and then "tunnelled" under the skin to a remote exit point**.**

Implantable Venous Port (port):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. Ports consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in the cavo-atrial junction. Also known as a port-a-cath or a venous port.
Intravascular access device (device)	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow.
Midline Catheter	A long peripheral catheter inserted into the upper arm via the basilic, cephalic, or brachial vein, with the internal tip located at or near the level of the axilla and distal to the shoulder.
Non-tunnelled CVAD- Also known as Percutaneous CVAD	A device that enters the venous system. Non-tunnelled catheters are generally used for short term therapy and in emergency situations.
Peripheral Artery Catheter	An arterial line (also art-line or a-line) is a thin catheter inserted into an artery.
Peripheral intravenous cannula (PIVC)	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Peripherally inserted central catheter (PICC)	A catheter inserted through the veins of the upper extremities in adults and children; upper or lower extremities in neonates, catheter tip is located in the superior or inferior vena cava, preferably in the cavo-atrial junction
Health Organisation (HO)	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient services.
Pulmonary Artery Catheter	Also known as a Swan-ganz catheter, is a catheter inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of drugs, frequent blood sampling and to infuse medication.
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel.
Umbilical Catheter	Catheter that is inserted into one of the two arteries or vein of the umbilical cord.

1 EDUCATION & DOCUMENTATION

1.1 Staff Education and Training

- All staff involved in the insertion, management and removal of IVADs must complete an educational program that is appropriate for the care being provided as determined by their HO.
- Clinicians are responsible and accountable for attaining and maintaining currency of skills for device insertion, management and removal within their scope of practice (4).
- HOs should have systems in place to recognise prior competence/skills assessment of the clinician from other HOs.
- The role, responsibilities and accountability for each type of clinician involved with these devices must be clearly defined in organisational policy or procedure (4).

1.1.1 Competency Assessment for Intravascular Access Devices (IVADs)

- Clinicians who insert, manage and remove IVADs must undergo training and formal competency assessment, as determined by the HO and is consistent with best practice.
    - Competency assessment must be conducted to establish proficiency to perform these skills independently and may be undertaken on an ongoing basis as necessary.
    - Competency validation must be documented in accordance with organisational policy.
- Clinicians working towards formal competency must be supervised by an experienced and competent clinician

1.2 Patient Education

- The level of the education program provided to the patient and/or caregiver should be determined by the:
    - criticality of the patient
    - cognition of the patient
    - ability to manage the IVAD
    - type and duration of the IVAD
- The clinician should educate the patient and/or caregiver while in hospital or hospital in the home and before discharge on:
    - the procedure and need for the device
    - signs and symptoms of infection
    - signs of air embolism
    - what to do if it becomes disconnected or accidentally removed
    - practice and principles of caring for the device
    - infection prevention strategies for their device
- **Patients and/or carers in the community must be provided with appropriate material that includes who to contact for advice or in the case of an emergency**

1.3 Documentation

- Documentation in health care records must provide an accurate description of each patient/client's episodes of care or contact with health care personnel NSW Policy Directive Health Care Records - Documentation and Management (5).
- Each HO must determine where clinical information relating to devices is to be documented in the patient's health record and that this is applied consistently so that clinical information can be readily accessed as needed. This is particularly important for devices with a longer dwell time.
- All clinical incidents must be reported and documented as per the NSW Health, PD2014_004 Incident Management Policy (6).
- Follow Australian Commission on Safety and Quality in Health Care (ACSQH) guidelines for labelling requirements. NSW Health Policy Directive User-applied Labelling of Injectable Medicines, Fluids and Lines (7)

1.3.1 Insertion

- Minimum documentation requirements at insertion by the proceduralist/procedure assistant are: A Central Venous Line Insertion Record or equivalent must be completed by the proceduralist inserting the device or their assistant for all CVADs which should include the below information:
    - Patient education and consent, refer to Consent to Medical Treatment (8).
    - Date and time of insertion, number of attempts, reason for insertion, local anaesthetic (if used), and the technique used, including visualisation and guidance technologies.
    - Site preparation, infection prevention and safety precautions taken.
    - The type, length, and gauge/size of the device (for PIVC); including the lot number for all CVADs and implanted devices.
    - Identification of the insertion site by anatomical descriptors and landmarks.
    - Confirmation of the location of the catheter tip for all CVADs prior to initial use.
    - Confirmation of patency and ready for use.
- This Record must be placed in the patient's health care record.

1.3.2 Post-Insertion

While the patient is admitted to hospital the condition of every IVAD must be documented at least once per nursing shift. The documentation must detail (4):

- Condition of the site, dressing, catheter securement, dressing change details, site care, and any changes related to the device or site.
- Length of CVAD catheter from skin to hub (to assess potential migration).
- Patient reported symptoms.
- Device function (e.g. patency, lack of resistance when flushing, presence of a blood return upon aspiration).
- Equipment/infusion type used for administration of Intravenous (IV) therapy.
- The Visual Infusion Phlebitis (VIP) score if used or any signs of infection

1.3.3 Administration Sets

All labelling of administrations sets used in continuous infusion must be documented in accordance with NSW Health Policy Directive User-applied labelling of injectable medicines, fluids and lines (7). If the lumen has an indwelling lock solution, the lumen must be clearly labelled so that it is not inadvertently flushed into the patient (7).

1.3.4 Removal

Minimum documentation requirements on removal of devices is:

- Date and time of device removal, reason for removal, condition of the site, and whether the catheter length and/or tip were complete and intact.
- Dressing applied.

Any continuing management of complications including site observation and documentation post removal.

2.3.5 Infection

Incidents of infection/phlebitis at the insertion site must be reported to Incident Information Management System (IIMS) or as per other local reporting requirements (6).

If a catheter related site infection or Blood Stream Infection (BSI) is suspected or confirmed this must be documented clearly in the patient medical record, if cultures are obtained, document the source of culture(s). The documentation should include a management plan and actions taken.

If IVAD site infections are suspected to have progressed to a systemic infection (bacteraemia) then notify as a Safety Assessment Code (SAC 2; all staphylococcus aureus bacteraemia must be recorded as a SAC 2).

Compliance with reporting mandatory Key Performance Indicators (KPIs) including routine reports on IVAD associated infections should be communicated to relevant stakeholders, peak organisational, governing and executive committees (6, 9).

2 PRE-INSERTION

2.1 Considerations when Choosing a Device

The risk of infection can be dependent on device site and selection. The following should be considered (10) as contributing to this risk: (see Section 4.2 for more information).

- Comorbidities, prolonged use and sites with frequent movement.
- History of mastectomy, arteriovenous (AV) fistula or graft, haematological disorders, history of device complications, obesity, coagulopathy, previous surgery, failed or difficult device access or immunocompromised.
- Therapeutic purpose: the infusate characteristics, complexity of infusion regime, availability of peripheral access sites.
- Estimated length of time: long-term intermittent therapy, treatment anticipated for more than 3 weeks.
- Vein status: veins may be difficult to access, torturous, fragile, hidden or deep.

3.1.2 Bundles

Infection prevention and control bundles reduce the risk of healthcare associated infections (11, 12). Facilities should develop bundles that are both evidence based and include local clinical risks. The principles for developing a bundle include:

- A manageable list of interventions that are descriptive and meet local requirements.
- Processes for documentation and assessment that considers clinical judgment in decision making.
- Input from the multidisciplinary team in developing the bundle.
- Monitoring and communication to clinical teams.

3 INSERTION

3.1 Prophylaxis, antimicrobial impregnation, coating or bonding

- The following should not routinely be used for the prevention of infection when inserting an intravascular device:
    - Systemic antibiotic prophylaxis (13-17).
    - Antibiotic or antiseptic ointment (13, 18).
    - Antimicrobial-impregnated catheters may be considered for specific population based on patients' risk factors and clinical presentation (19-21).
- The use of bonded connections and valves are beneficial in reducing the risk of air embolism and infection (22).

1. Device Selection, Site Selection, and Device Securement

3.1.1 Peripheral Intravenous Cannula (PIVC)

Device Selection

- Clinicians should use the smallest gauge and shortest length PIVC that will accommodate the anticipated therapy to reduce the risk of phlebitis.
- See Attachment 1 PIVC Device Selection Guide more information.

Site Selection

- Optimal site selection for PIVC is the distal areas of the upper extremities (e.g. Forearms) (3, 13).
- Basilic or cephalic veins on the posterior (dorsal) forearm are the preferred site for catheterisation (3).
- The site selected should be accessible and functional during surgery and procedures.
- Veins should be selected on the non-dominant forearm if practical (especially if the catheter is to remain in position for any length of time) (3).
    - Avoid veins of the lower extremities unless necessary, due to risk of tissue damage, thrombophlebitis, and ulceration.
    - Rotate PIVC site and arm where possible for repeated cannulations.
    - Replace a catheter inserted in a lower extremity, to an upper extremity as soon as possible.
    - Avoid compromised areas, areas of flexion e.g. antecubital fossa and areas of pain on palpation.

- For paediatrics, preference should be given to sites that are long lasting for duration of therapy (e.g. hands, forearm and upper arm).
    - Upper or lower extremities or the scalp (last option) can be used as the catheter insertion site (13).
    - Avoid hand or fingers, or the thumb/finger used for sucking in infants.
    - Avoid the right arm of infants and children after procedures treating congenital cardiac defects that may have decreased blood flow to the subclavian artery.

Securement

- The catheter should be stabilised with a transparent dressing and sterile adhesive tape or sterile adhesive/wound closure strips, to prevent catheter dislodgement (13, 23).
- For paediatrics use of IV board/splints are recommended to secure PIVC placed in or adjacent to areas of flexion. Follow local policy or guidelines for strapping and securement of PIVCs.

3.1.2 Midline Catheters

Device Selection

- Use the smallest gauge of midline catheters that will accommodate the prescribed therapy to reduce the risk of phlebitis and thrombosis (24, 25).

Site Selection

- Vein selection should be based on the biggest and most superficial vein above or directly below the antecubital fossa to allow normal arm movement and function. The catheter should not be placed at the antecubital fossa crease/fold or pass the axillary crease/fold.

Securement

- A sutureless securement device is preferred to reduce the risk of infection (26).

3.1.3 Central Venous Access Device (CVAD)

Device Selection

- Use the smallest gauge of CVAD that will accommodate the anticipated therapy to reduce the risk of phlebitis (27).
- The minimum necessary number of lumens and add-ons (manifolds, stopcocks and multi-extension sets) should be used.
- Heparin-coated catheters are not recommended (28).

Site Selection

- For PICCs select the basilic (preferred), cephalic, and brachial veins (with sufficient size) of the antecubital space or brachial veins (29, 30).
- In neonates the upper and lower extremities have similar complication rates.
- Use a subclavian or internal jugular site rather than a femoral site where possible, in adult patients to minimise infection risk for non-tunnelled CVC placement (31).
    - If the patient has chronic kidney disease, consider the internal jugular vein or, secondarily, the external jugular vein, weighing benefits and risks for each access site due to the risk of central vein stenosis (32).
    - Subclavian vein should be avoided for temporary access in patients with chronic renal failure due to the risk of central vein stenosis (33).
    - In patients with chronic renal failure be aware if a limb is being preserved for future haemodialysis access.

- For internal jugular sites, the right side of the patient is favoured as vessel anatomy allows direct access to the superior vena cava/inferior vena cava and provides a shorter and easier route for the practitioner inserting the device (34).

Securement

The CVAD must be secured (26) at the skin insertion point and anchor point (if present) by:

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.4 Implanted Venous Port (port/IVP)

Device Selection

- Catheters made of radiopaque silicone rubber or polyurethane are preferred.
- Ports made of various materials including plastic, titanium, silicone rubber, polyurethane, and a combination of these substances can be used.
- The life of the septum is dependent on the gauge of needles used to access the port and the type of needle used i.e. if a larger needle is used, the septum will wear out after fewer punctures than when a smaller gauge needle is used (35).

Site Selection

- Port pocket site selection should allow for placement in an area that provides good port stability, does not interfere with patient mobility, does not create pressure points or interfere with clothing (36).

Securement

- The suture line closing the port should not be located over the septum of the port (36).
- Umbilical catheters are commonly secured using the goalpost method, refer to local guideline or procedures for more information.

3.1.5 Peripheral Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The radial artery is preferred due to its accessibility and good collateral flow, however the femoral, brachial or pedal artery may also be used (1).
- The brachial site should not be used in paediatrics (13).

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.1.6 Pulmonary Artery Catheter

Device Selection

The catheter must be flexible, resistant, as radiopaque as possible, thin walled with a high internal to external diameter ratio (37).

Site selection

- The preferred site is the right internal jugular vein followed by the left subclavian vein.
- The femoral and antecubital veins should be avoided if possible.

Securement

- A sutureless securement device (preferred to reduce the risk of infection) OR
- Direct suturing at the hub and three-way bifurcation anchor point.

3.2 Confirmation of Tip Position for Central Catheters

The catheter tip position must be confirmed when a device is inserted, by any of the following techniques prior to use (38, 39):

- ECG CVAD tip confirmation
- Chest x-ray or image intensifier
- Fluoroscopy imaging and Digital Subtraction Angiography (DSA)
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Pressure monitoring of the central venous waveform in operating theatre until formal confirmation post-surgery

Once the CVAD distal tip position is confirmed via any of the above, the "final Tip position" of the catheter must be documented (the total catheter length and external/inserted length (skin to hub) in the patients' medical record. This then becomes the clinician's primary referral source for written confirmation of tip position.

- This must be completed by the clinician inserting the device, their assistant or delegate for all insertions.

3.3 Standard Precautions (At Insertion)

Standard precautions are the minimum precautions required and must always be applied when caring for patients (4).

- *During an emergency situation (e.g. rapid deterioration and ambulance) time does not always permit use of aseptic technique or full maximal barrier precautions, the clinician should make every effort within their environment to maintain asepsis and adhere to standard precautions. If inserted in an emergency, the IVAD must be replaced as soon as the patient is stable (within 24 hours).*

The precautions outlined in sections 4.4.1 to 4.4.4 are the minimum requirements when inserting a device.

3.3.1 Hand Hygiene

- Perform hand hygiene before insertion procedures, refer to table 2 below.
- Hand hygiene should be performed before and after palpating catheter insertion sites as well as before and after inserting*, replacing, accessing, repairing, or dressing.*
- Palpation of the PIVC insertion site should not be performed after the application of antiseptic, unless non-touch technique is maintained or sterile gloves are used. If you need to palpate the planned insertion site after skin antisepsis to confirm anatomy, repeat the application of antiseptic.

The use of gloves does not eliminate the need for hand hygiene (before putting on gloves and after removal).

Table 2: Hand Hygiene for Device Insertion

Activity		Hand Cleansing Product*	Duration of Hand wash*
Aseptic Procedure	Insertion of PIVC	ABHR*	30-60 seconds
		Liquid antimicrobial soap and running water	40-60 seconds
	Peripheral Arterial Catheter	ABHR*	60 seconds minimum
		Liquid antimicrobial soap and running water	
	Insertion of CVAD, Midline and Umbilical Catheters	Liquid antimicrobial soap and running water	2 minutes
		Alcohol Based Surgical Hand Rub (ABSHR*)	Refer to manufacturer's instructions. Note: Prior to surgical rub, wash hands, forearms and nails using a non-medicated soap and running water.

Manufacturers recommendations should be followed for the amount of solution and duration

3.3.2 Aseptic Technique

- All clinicians involved in the insertion of devices must have appropriate training and assessment of aseptic technique, refer to section 2.1 Staff Education and Training.
- Aseptic technique must be maintained for the duration of the procedure, this includes:
  - Hand hygiene.
  - Maintaining aseptic fields.
  - Once insertion site has been prepped aseptic technique must be maintained and the site must not be touched (unless sterile gloves are worn).
  - Procedures must be performed using non-touch technique protecting key sites and key parts. The cap/cover must remain on the device to maintain asepsis.
  - Personal protective equipment (PPE) must be worn as per standard precautions.
  - Ensure a logic, efficient and safe order of the procedure.
  - Equipment or items dropped on the floor must be discarded (even if there is a cap/cover on) and replaced.
  - Ultrasound transducers used for imaging the vascular system for insertion of venous access devices should be used with a sterile probe cover and sterile gel. The transducer probe must be cleaned and disinfected adequately in between use. Follow manufacturers' instructions for use.
  - A clean environment must be maintained throughout the procedure. Environmental controls to achieve this include; IVAD insertion trolley or procedure tray is to be cleaned, no room cleaning (buffing or polishing) immediately prior to, or during the procedure. The procedure should take place in a closed room or with curtains drawn around the patient zone to minimise air currents.

3.3.3 Personal Protective Equipment

Clinicians should wear appropriate personal protective equipment based on risk assessment and likelihood of exposure to bodily fluids.

Glove Use

- The use of non-sterile examination or sterile gloves will depend on the procedure being undertaken, contact with susceptible sites or clinical devices, the risks involved and the HO guidelines or procedures that are in place.
- For PIVC insertion gloves should be worn immediately after performing hand hygiene.
    - HOs should have in place local guidelines or procedures determining the type of gloves for PIVC insertion based on local needs and clinical risk.
    - Gloves considered in local guidelines or procedures may include; sterile procedural gloves, sterile gloves, non-sterile gloves.
- See below 4.4.4 Maximal Barrier Precautions for more information (4).

3.3.4 Maximal Barrier Precautions

- Use maximum sterile barrier precautions. This involves:
    - Except for PIVC and arterial line insertions, mask, hair covering including beard if necessary, sterile gown and sterile gloves are required to be worn by all personnel involved in the procedure.
    - PIVC and arterial lines insertion require compliance with asepsis.
    - The insertion site is to be covered with a large sterile drape during catheter insertion.

3.4 Skin Preparation

- Hair at the insertion site should be removed using clippers to improve adherence of the dressing.
- The skin should be physically cleaned with soap and water (if necessary) prior to applying the antiseptic solution before inserting the catheter.
- The same antimicrobial agent must be used for all phases of the patient's skin preparation, to ensure full residual benefit and consistent action (17).
- Palpation of the insertion site should not be performed after the application of antiseptics, unless aseptic technique is maintained.
    - **If the health worker needs to re-establish the identification of the vein, the site should be re-prepped with the antiseptic solution and allowed to thoroughly dry (17).**

Table 3: Skin Preparation for Adults and Children ≥ 2 months (40, 41)

Skin cleansing prior to ***PIVC*** insertion	0.5-2% chlorhexidine gluconate (CHG) and 70% isopropyl alcohol
Skin cleansing prior to all other device insertions	2% chlorhexidine gluconate (CHG) in 70% isopropyl alcohol
If there is a contraindication to chlorhexidine, povidone iodine 10% in 70% alcohol can be used as an alternative.	

- The application of antiseptic should be a measured quantity and avoid over application. If the site is accessed prior to full evaporation of the product, this can lead to reduced efficacy.
- All solutions must be allowed to dry before beginning insertion, do not wipe or blot.
- Some of the alcoholic chlorhexidine solutions now contain colour to allow easier identification.
- Sterile saline or water solutions alone are not acceptable antiseptic solutions and should only be used to clean the skin of gross contaminants prior to applying antiseptic solution.
- Take care when applying liquid solutions to minimise the risk of eye injury to the patient due to splashes.
- Care should be taken during internal jugular approaches that solutions containing chlorhexidine are not introduced to the ear canal as this can lead to deafness.

4.5.1 Skin preparation in neonates

NSW public health organisations who care for **neonates** must have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants. This should consider:

- Using topical antiseptics with extreme caution, particularly alcohol based preparations.
- The risk of chemical burns in premature babies.
- Avoiding Povidone Iodine for skin antisepsis.

4 POST INSERTION MANAGEMENT

4.1 General Information

- If Total Parenteral Nutrition (TPN) is being administered, where possible, health workers should utilise one lumen exclusively for that use (42, 43).
- Consider use of an extension set between an IVAD and needleless connector to reduce catheter manipulation (4).
- Refer to section 2.3 Documentation for minimum documentation requirements.

4.2 Daily Review for In-patients

- All intravascular devices must be checked (table 4) at each shift for ongoing need and promptly removed when no longer required.
- The insertion site must be visually inspected by the clinician at least hourly with continuous infusion, at least every eight hours if no infusion (15). For further information refer to Intentional Patient Rounding - Information for Clinicians and Health Professionals (44). For high-risk medicine clinicians should refer to the local protocols or Australian Injectable Drugs Handbook (AIDH) - 7th Edition (45).
- Ensure medical staff review the need for IV therapy including antimicrobials on a daily basis and switch to oral administration as clinically appropriate.

Table 4: Daily Assessment

Daily Assessment			
Phlebitis - Erythema - Tenderness - Swelling - Pain - Palpable venous cord - Purulent discharge	Systemic Infection - Rigor - Fever - Tachycardia - Hypotension - Malaise - Nausea/vomiting	Infiltration/extravasation • Insertion Site - Blanched, taut skin - Oedema - IV fluid leaking - Burning/stinging pain • Change in infusion flow	• Catheter position • Integrity of suture • Dressing integrity • Occlusion/patency • Ongoing need for line
For PICCs & Midlines, if limb swelling is suspected, compare the mid-upper limb circumference with the initial value recorded on the CVAD Insertion Record to quantify this. If a significant increase in circumference is confirmed, venous thrombosis should be considered and investigated appropriately.			

(Source: I-care QLD (15, 17, 28, 36, 46-48)

5.3 Patients in the Community

- All intravascular devices should be checked (refer to table 4) at every clinical visit and removed when no longer required.
- Patients should be educated to visually inspect the insertion site when continuous infusions are running. This must include signs and symptoms of complications and who to contact if needed.

5.4 Transferring and transporting patients with CVADS

- There is an increased risk of CVAD dislodgment and falling out during transfer or transportation of patients.
- Devices should be visually inspected and secured before transfers occur.
- Consideration should be given to the weight of lumen sets and lines must be supported with additional fixation to reduce the risk of unplanned dislodgement.
- If catheter is not in use, check that the catheter is clamped prior to commencing transport.

5.5 Accessing Devices

- To reduce the risk of infection, manipulations of an intravascular device should be kept to a minimum and use a continuous flow system wherever possible.
- Where continuous flow is not possible, then the device should be flushed and locked as per local guidelines and procedures.
- The catheter lumen should be kept sterile and should never be left open to the air.
- Aseptic technique must be maintained at all times.
- Ensure line clamps are used when accessing a CVAD to reduce the risk of air embolism (22).

Table 5: Accessing Devices

<table>
<tr><th colspan="2">PIVC, Midline, PICC, CVC (tunnelled & non-tunnelled), Umbilical Catheters, Pulmonary Artery & Peripheral Artery Catheters, Port</th></tr>
<tr><td>Aseptic Technique Principles (49), relevant to the procedure.
Sequencing
Hand Hygiene
Environmental control
Maintain asepsis
PPE</td><td>Antiseptic
70% isopropyl alcohol swab OR
0.5-2% chlorhexidine gluconate & 70% isopropyl alcohol
PORT/IVP with needle insertion
2% chlorhexidine gluconate & 70% alcohol</td></tr>
<tr><td colspan="2">Accessing a Catheter
All intravenous access ports should be meticulously cleaned with a large wipe (scrub the hub) for at least 15 seconds generating friction by scrubbing in a twisting motion with a single-use 70% alcohol-impregnated swab or alcoholic chlorhexidine or if allergic 10% povidone-iodine and allowed to air dry prior to accessing the system (50, 51).
The catheter should be accessed with a sterile single-use device.
Accessing a Port
Only a non-coring (e.g. Huber) needle should be used to access implanted ports. Safety needle is preferred.
Use a new needle for each access attempt.
Needles should be changed every seven days or more frequently for continuous infusions if necessary.
Reinsertion through the immediately preceding needle site should be avoided.</td></tr>
</table>

(Source: I-care QLD (15, 17, 28, 36, 46, 47))

4.3 Blood Collection

- Blood sampling via a CVAD is appropriate for some patient populations based on individual patient risk assessment prior to collection.
- Risks of venepuncture can include anxiety, pain, damage to skin and nearby nerves, and hematoma in patients receiving anticoagulants or with bleeding disorders (4).
- Limit drawing blood from IVADs as it increases hub manipulation and the potential for contamination (4).
- Blood samples from PIVC should not be drawn due to the risk of haemolysis, unless it is directly after insertion.
- Blood cultures should never be collected through a PIVC due to the increased rate of contamination at the time of collection.
- PICC in newborns should not be used for blood sampling or infusing blood products.

4.4 Dressings

- Use a sterile, transparent semi-permeable dressing to protect the insertion site from contamination. Allow continuous observation of the site and to stabilise and secure the device.
- For patients aged ≥18 years with a CVAD (CVC and PICC), chlorhexidine-impregnated dressings may be used to protect the insertion site from contamination (51, 52).
- Use of chlorhexidine impregnated dressings in infants and children may require individual risk assessment and prescription, should be considered in local guidelines (53-55).
- When the patient is diaphoretic or has excessive bleeding or oozing from the site, use sterile gauze secured with a sterile transparent, semi-permeable dressing until this is resolved (51, 56).
- Umbilical catheters do not routinely use an occlusive dressing over the insertion site, refer to local guideline or procedure for more information.
- When the patient has multiple devices, each should be dressed separately unless the puncture sites are too close together.
- All equipment used for the dressing of the insertion site must be sterile.
- Dressing must be placed so the insertion site is visible for regular inspection, therefore do not place non-sterile or opaque tape directly over the insertion site.
- All dressings must be replaced if it becomes damp, loosened, no longer adherent, soiled, there is evidence of inflammation and/or there is an accumulation of fluid.

Table 6: Dressing Change Intervals

Dressing Type	Replacement Intervals
Transparent, semi-permeable, self-adhesive polyurethane	Every 7 days or sooner if the dressing is no longer intact, evidence of inflammation or moist
Gauze	Every 24 - 48 hours or whenever loose, soiled or moist
Chlorhexidine-impregnated	Every 7 days or at each dressing change

(Source (13, 47, 57)

4.5 Needleless Injection Ports

- Removal of a needleless injection port must be performed using aseptic technique.
- Anytime a needleless injection port is removed from the catheter, this is to be discarded and a new sterile injection port should be attached, using appropriate aseptic technique.
- Needleless injection ports that are not bonded to the central line should be changed(17, 42):
    - At least every 7 days (coinciding with administration set changes) OR
    - At the frequency recommended by the manufacturer OR
    - If the integrity of the needleless injection port is compromised (e.g. residual blood remains within the port).

Needleless Injection Ports can also be known as: needleless IV catheter systems, swabable capless valves, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.

4.6 Arterial Catheters

- Replace disposable or reusable transducers at 96-hour intervals or when clinically indicated. Replace other components of the system (including the tubing, continuous-flush device, and flush solution) at the time the transducer is replaced (13).
- Keep all components of the pressure monitoring system (including calibration devices and flush solution) as a closed system (13).

4.7 Administration Sets

- IV administration sets include both the IV lines and any additional attachments such as needleless injection ports, sideline syringe infusion pumps, three-way stopcocks, multi-flow adaptors and extension tubing that may be added.
- IV administration sets must be attached to the patient so that no tension is applied to the catheter to reduce the risk of dislodgement.
- Ensure all components of the administration system are compatible (including sideline syringe infusion pump or burettes and needleless injection ports) to the devices to minimise leaks and breaks in the system.
    - All connections must be luer-lock.
- Refer to section 2.3 Documentation for labelling requirements.

Disconnection of Administration Sets

- A continuous circuit should be maintained as intermittent disconnections of administration sets increases the risk of infection.
- All administration sets must be replaced;
    - After being disconnected.
    - If the catheter is changed or
    - After blood has refluxed into the administration set and the blood is unable to be cleared by flushing.
- When an administration set is changed, the IV fluid bag must also be changed.

NB: infusions with blood and blood products and high value medicines, consideration may require on the continuation of the product and a risk assessment should be conducted to assess if product should be discarded and replaced with new lines or continue with existing set. Where an obvious contamination has occurred all lines must be changed.

- Disconnection of administrations sets must be avoided for routine care, such as showering, changing nightwear/gowns. If disconnected, IV lines must be replaced.
- Controlled disconnections where reconnection of the set is immediate may be appropriate in certain situations based on clinical requirements (e.g. changing IV access or infusions in operating theatres, administration of blood products or medical imaging departments).
    - For transient controlled disconnections, aseptic technique must be maintained to prevent contamination of the set.
    - If disconnection becomes more than transient or if the ends become contaminated in any way they must be discarded and replaced.

In-line Filters

In-line filters are not recommended for prevention of BSI, however certain agents such as chemotherapeutic, immunological drugs etc. require filtering for other reasons (15, 17, 46, 58).

Table 7: Frequency of Line Change

Administration Set Use	Frequency of Change
Continuous use (NOT containing lipids, blood or blood products)	Do not need to be replaced more frequently than every 96 hours unless device-specific recommendations from the manufacturer indicate otherwise (51). Change intermittent infusion sets without a primary infusion every 24 hours or whenever their sterility is in question (59).
Blood and blood products	Must be changed when the transfusion is complete, or every 12 hours if the transfusion is not complete (60). The maximum number of blood products as per the manufacturer's recommendations has been reached. Any number of red cell units may be transfused during a 12-hour period, provided the flow rate remains adequate (60). Platelets must be transfused via a new blood administration set. Note: Manufacturer's recommendations defining the maximum number of units per blood administration set must not be exceeded.
Lipid containing solutions and parenteral nutrition	Changed every 24 hours or as recommended by the manufacturer.
Lipid containing medications (e.g. Propofol, Clevidipine)	Changed at minimum every 12 hours or as per the manufacturers' instruction (61).
Chemotherapeutic agents	Remove immediately after use. On completion of infusion including the line flush. The chemotherapy infusion episode may include more than one agent, it is common practice to utilise the same administration set, with line flush in between in order to ensure the full dose has been administered.

4.8 Flushing

- Flushing is recommended to promote and maintain patency and prevent the mixing of incompatible medical solutions. Sterile 0.9% sodium chloride for injection must be used by clinicians, unless the manufacturer recommends flushing with an alternate solution (15-17, 46, 47, 62)**.**
- Clinicians must flush catheters immediately:
    - After placement
    - Before and after each fluid infusion or injection
    - Prior to and after drawing blood
- PIVCs must be flushed at least every 8hrs, for hospital patients or every 24 hours for patients in the community, if not on a continuous infusion.
- CVADs not being accessed must be flushed and locked every 7 days.
- Ports/IVP not being accessed must be flushed and locked every four to six weeks.

4.9 Locking

- Sterile 0.9% sodium chloride for injection should be routinely used to lock a catheter no longer required for continuous infusions, unless the manufacturer recommends catheter lumens be locked with an alternate solution (17).
    - HO's who determine a need to use alternative locking solutions (e.g. heparin, antibiotic, antimicrobial and antiseptic), must have local policy or guidelines to support the appropriate use of these solutions.
- Locks containing medication must be prescribed by a Medical Officer or Nurse Practitioner.
- Refer to NSW Health Policy, Medication Handling in NSW Public Hospitals (63).
- Catheters with a medicine 'in situ' to lock the catheter must be labelled as per NSW Health Policy, User- applied labelling of Injectable Medicines, Fluids and Lines (7).

4.10 Catheter Migration

- A catheter that has migrated externally must not be re-advanced (64). The treating medical team must be notified immediately if this has occurred.
- If a CVAD is noted to have migrated inwards from the documented marking point, the CVAD must be retracted to the original insertion measurement as documented on the insertion form (65).
    - The medical team must be notified and a risk assessment for infection/contamination should be conducted.
    - This procedure can only be done by a clinician who has achieved CVAD competency. Refer 2.1 Staff Education and Training for more information.

5 REPLACEMENT AND REMOVAL

5.1 Device Duration

- All devices must be checked at each shift and removed when no longer required or if mechanical complications occur (42).
- Assess any devices in patients transferring from other healthcare facilities who may have a documented or non-documented device in situ. The clinician should inspect for infection, mechanical complications and correct distal tip position. Correct position can be determined through previous documentation and correct external lengths comparison, or via radiological confirmation.

- When adherence to aseptic technique is compromised (i.e. catheters inserted during a medical emergency, ambulance), replace the catheter as soon as possible (e.g. when the patient is stable or within 24 hours) (66-68).
- Devices should be removed based on the following clinical indications:
    - The catheter is no longer required
    - Evidence of systemic infection
    - Damaged catheter
    - Evidence of local infection (redness, swelling, oozing or pain at catheter exit site)
    - Persistent catheter occlusion
    - Confirmation of thrombosis

5.1.1 PIVC

The routine replacement of PIVC may not prevent infection or phlebitis (69, 70). Current research supports replacing a PIVC on clinical indication but the device should not be left in indefinitely and in most cases PIVC dwell time should not exceed 72-96 hours (71). A PIVC should not be used for an extended period. The need for a PIVC beyond short term vascular access should defer to a suitable long term device (refer to section 4.2). The decision to implement PIVC replacement on clinical indication must be based on a formal risk assessment.

Criteria for clinical indication based PIVC replacement

- There is good availability of staff appropriately trained in the insertion and maintenance of devices on each shift.
- There is an assurance that PIVC surveillance in the healthcare facility is adequate, including regular inspection of the site and device, and of PIVC-related Staphylococcus aureus bacteremia (SAB).
- There is consistent documentation regarding device insertion (site ease and date), site appearance and complications experienced with devices.
- Remove PIVC if patient develops signs of local infection, pain or tenderness and follow local reporting guidelines (e.g. IIMS)

Criteria for routine replacement of PIVC

- Replacement is likely to be uncomplicated and the risk is judged to be less than retention.
- May be appropriate in the context of high rates of PIVC related complications
- The PIVC is likely to be needed for another 24 hours.
- The decision should be document in the patient's health record.
- PIVC replacement in neonates and children should be based on clinical indication and ongoing need for the device.

5.1.2 Midline Catheters

- Midline catheters that are inserted at the bedside using sterile technique may stay in place for 2 to 4 weeks (72).

5.1.3 Umbilical Catheters

- This will be determined by the clinical condition of the baby and availability of alternative access (73).

- Remove and do not replace the umbilical catheter if there any signs of catheter-related BSI, vascular insufficiency in the lower extremities, or thrombosis are present.
- An umbilical catheter may be replaced if it is malfunctioning, breaks or splits, and there is no other indication for catheter removal.
- Refer to local policy or guideline for further information.

5.1.4 Peripheral Arterial and Pulmonary Artery Catheters

- Do not routinely replace arterial catheters to prevent infections. Replace only when there is a clinical indication (74).

5.1.5 CVADS

- Do not routinely replace CVADs or haemodialysis catheters. Replacement should be based on clinical indication and need (51, 75).
- Do not remove CVADs on the basis of fever alone. Use clinical assessment to determine whether infection is evident elsewhere or if there is another non-infectious cause of the fever, refer 7 Diagnosis of Infection & Surveillance.

5.1.6 PORTS

- Ports are a long term vascular access solution.
- The life of a port is limited to the number of needle punctures. The number of punctures varies depending on the gauge of the needle used but is approximately 1000-2000 (follow manufacturers instruction) (76).
- Replace ports based on clinical indications.

5.2 CVAD Guidewire Exchange

- Guide-wire exchanges to replace catheters is not recommended. A small number of patients may benefit from this in exceptional circumstances based on patient assessment, risk and suitable environment. Not advised for haemodialysis and tunnelled catheters.
- Guidewire exchanges must not be performed in the presence of BSI (77).

5.3 Catheter Removal

- Processes must be in place to ensure appropriate authority or order/instruction and written documentation to remove devices. HOs should develop standing orders or local protocols/processes for the routine removal of PIVCs (e.g. nurse initiated PIVC removal).
- Standard precautions and aseptic technique must be used to prevent catheter site infections (4).
- Following device removal, the site must be sealed with a sterile airtight dressing until the site is healed.
    - Umbilical catheters are not routinely dressed on catheter removal, but must be clean and dry.
    - If the patient is being discharged the patient or carer should be educated on the signs and symptoms of infection and complications and advised what to do if symptoms present.
- On removal the clinician should visually check the integrity of the line.
- Routine collection of the tip is not required except in circumstances where infection is suspected. Refer section 7 Diagnosis of Infection and Surveillance.

- PORT/IVP and tunnelled cuffed CVADs are only to be removed by a Medical Officer or Nurse Practitioner/Clinical Nurse Consultant who has been deemed competent in this skill.
    - Ports require surgical removal in theatre or interventional radiology.

Table 8 Requirements for Removal of CVADs

Requirements for Removal of CVADs: To prevent air embolism during CVAD removal HOs must have CVAD removal detailed in their local guideline or procedure.

- Refer to Clinical Focus Report- Central Venous Access Devices and Air Embolism (1)
- Removal of CVAD must only be undertaken by trained or supervised clinicians. Refer to 2.2.1 Competency Assessment for CVAD.
- Removal of the CVAD must be undertaken using an aseptic technique that will minimise the risk of infection.
- The patient is to be positioned supine with head slightly down (if tolerated) during CVAD removal. This is to increase the pressure in the large veins to above that of atmospheric pressure, which reduces the risk of aspirating air into the venous circulation.
- Following CVAD removal, the site must be sealed with an airtight dressing which remains insitu for at least 24 hours to reduce the risk of late air embolism. Refer to Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD). The patient must remain in the supine position (or Semi-Fowlers if supine not tolerated) for between 30 and 60 minutes following CVAD removal (78). At least one set of observations should be done during this period, as well as immediately prior to retrieving the patient to the upright position. Observe for sign of respiratory distress, assess site for bleeding or haematoma and report any changes in status immediately.
- The removal of the CVAD and the presence of an intact tip must be noted in the patient's health record.
- Following removal, the CVAD site will require daily review and dressing until healed.
- Routine observations are to be conducted after the removal of the IVAD.

5.3.1 Removal of Catheter in Suspecting Line Infection

- Do NOT remove a functioning device based solely on temperature elevation (4).
- Remove PIVC if patient develops signs of local infection, pain or tenderness(4).
- If an infection is suspected the treating medical team must be notified and an assessment made for the ongoing need of device, persisting relapse of catheter related BSI, patient deterioration and alternative IV access.
- Patients transferring from other healthcare facilities with a documented device insitu should have the device reviewed upon arrival by a clinician for infection, mechanical complications and correct distal tip position, either through previous documentation and correct external lengths comparison, or via radiological confirmation. Without documentation, consider removal.

6 DIAGNOSIS OF INFECTION AND SURVEILLANCE

6.1 Diagnosis of Infection

- For a suspected catheter related BSI (79), obtain blood cultures (see 7.1.1).
- If pus, exudate or erythema is present at the insertion site, swab the site prior to removal of the device and send for culture.

- Catheter tip cultures are not a substitute for blood cultures for the determination of a bacteraemia, a negative tip culture does not exclude infection (79, 80).

6.1.1 Blood Cultures

- Two sets (4 bottles) of blood cultures should be collected in suspected infection for each new episode. This should occur prior to commencement of antimicrobials treatment. If patient is hemodynamically unstable, take 1 set prior to commencement of antimicrobials. Do not delay the administration of antimicrobials in patients with severe sepsis or septic shock.
- Collect one set from the pre-existing device and one set from a peripheral site.
    - If a peripheral set is not possible, a blood culture set from each of 2 or more lumens is required.
- The bottle should be well filled with a minimum 10mL per bottle (for adult patients only)
    - If volume of blood to be collected is an issue, preference should be given to aerobic bottles.
    - In neonates, collect an aerobic blood culture with 0.5-1mL, refer to local policy or guideline for additional information.
- Note the collection site on the request form at the time of collection.
- For further information, refer to local policy or guideline and Sepsis Kills Adult Blood Culture Guideline, Sepsis Kills Paediatrics Blood Culture Guidelines and Sepsis Kills Neonatal Blood Culture Guidelines.

6.1.2 Culturing of Tips

- Do not send catheter tips for culture on routine line removal, unless infection is suspected.
- Catheter tips should be cut using an aseptic technique.
- Ensure the site and type of catheter are noted on the request form as well as the appropriate clinical information.

6.1.3 Reporting of Catheter-related BSI

- HOs must have procedures in place for the timely reporting of all positive cultures to the treating medical and infection prevention and control teams.
- Open disclosure should be performed for all suspected or actual catheter related infections, as per the NSW Health Open Disclosure Policy.
- For healthcare associated BSIs (Staphylococcus aureus and Vancomycin resistant enterococcus) HO should follow internal reporting and escalation processes and key performance indicator requirements (e.g. IIMS). The NSW health incident management process must be followed for identification, investigation and management of these incidents as SAC 2 (6).

LIST OF ATTACHMENTS

1. PIVC Size & Use Guide
2. Related Documents
3. Additional Resources
4. Implementation Checklist

Attachment 1: PIVC Device Selection Guide

This is a guide for PIVC device selection and should be used whenever practical. However clinical risks and patient characteristics may require a different size to be used (e.g. paediatrics and neonates).

PIVC Size	Use
14G	Trauma patients Rapid, large-volume replacement
16G	Trauma patients Major surgery Intra-partum or post-partum GIT Bleeding Multiple line access Multiple blood transfers High volume of fluids
18G	Blood products Multiple line access Large volume of fluids Major surgery Imaging requiring power injection of CT contrast
20G	General use IV maintenance IV antimicrobials IV analgesia Power Injection
22G	Small or Fragile veins Cytotoxic therapy
24G	Small or Fragile veins Cancer services Day only infusion services Paediatrics
Delivery of Irritant medications: Use the most appropriate cannula size for the vein as use of a peripheral intravenous cannula that is too large for the vein increases the risk of phlebitis. Refer Safety Notice 009/16 Avoiding thrombophlebitis with intravenous amiodarone (revised 10 Feb 2017).	

Attachment 2: Related Documents

- NHMRC, Australian Guidelines for the Prevention and Control of Infections in Healthcare (3)
- NSW Health Policy Directive, Infection Prevention and Control Policy (81)
- Clinical Excellence Commission, Infection Prevention and Control Practice Handbook (49)
- Clinical Excellence Commission, Healthcare Associated Infection: Clinical Indicator Manual version 2.0 (9)
- NSW Health Policy Directive, Medication Handling in NSW Public Health Facilities (63)
- NSW Health Policy Directive, Clinical Procedure Safety (82)
- ACSQHC, National Safety and Quality Healthcare Service Standards (second edition) (83)
- NSW Health Policy Directive, User-applied labelling of injectable medicines, fluids and lines (7)
- ACSQHCs, National standard for user-applied labelling of injectable medicines, fluids and lines (84)
- Clinical Excellence Commission, Clinical Focus Report- Central Venous Access Devices and Air Embolism (1)
- NSW Health, Health Care Records-Documentation and Management (5)

Attachment 3: Additional Resources

- Australian Injectable Drugs Handbook (AIDH) - 7th Edition https://www.shpa.org.au/australian-injectable-drugs-handbook-aidh-7th-edition
- Cancer Institute NSW, eviQ Cancer Education Online- Central Venous Access Devices
- Cancer Institute NSW, eviQ Cancer Education Online- Clinical Resources, Central Venous Access Devices
- Clinical Excellence Commission- Training framework for clinicians new to inserting central lines in NSW
- My Health learning - Central Venous Access Devices
- My Health Learning -Invasive Device Protocols
- Intensive Care NSW- Central venous Access Device Post Insertion Management Guideline
- NSW Health Multicultural Service- Patient Information Sheets
- Sepsis Kills Paediatrics Blood Culture Guidelines http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/259419/paediatric-blood-culture-guideline.pdf
- Sepsis Kills Neonatal Blood Culture Guidelines
- Safety Notice 004/14 Removal of Central Venous Access Devices (CVAD)
- Centers for Disease Control and Prevention- Central Line-associated Bloodstream Infections
- Health Protection Surveillance Centre- Central Vascular Catheters
- Health Protection Surveillance Centre- Peripheral Vascular Care Bundles
- Health Protection Scotland- Preventing infections when inserting and maintaining a peripheral vascular catheter (PVC)
- The Joint Commission- CLABSI Toolkit
- Association for Professionals in Infection Control- CLABSIs

Attachment 4: Implementation Checklist

Note: This implementation planner is NOT mandatory – it is a tool for HOs to use to monitor implementation of this policy.

LHD/ Facility:	**Assessed By:**				**Date:**
Implementation Requirements	**Not Applicable**	**Not Started**	**Partial Compliance**	**Full Compliance**	**Action Required**
Local guideline or procedures in place for Peripheral Intravenous Catheters (PIVC)	☐	☐	☐	☐	
Local guideline or procedure in place for Midline Catheters	☐	☐	☐	☐	
Local guideline or procedure in place for Central Venous Access Devices (CVADs), including implanted venous ports (ports).	☐	☐	☐	☐	
Local guideline or procedure in place for Umbilical Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Peripheral Artery Catheters.	☐	☐	☐	☐	
Local guideline or procedure in place for Pulmonary Artery Catheters	☐	☐	☐	☐	
Roles and responsibilities for each type of clinician involved with these devices is clearly defined in the guideline or procedure.	☐	☐	☐	☐	
Clinicians who insert, manage and remove CVADs have undergone training and formal competency assessment. Assessments are documented and accessible for review	☐	☐	☐	☐	
Facility wide monitoring of clinician CVAD insertion practices to ensure only trained/experienced clinicians undertake or supervise CVAD insertion.	☐	☐	☐	☐	
All staff involved in the insertion, management and removal of devices have completed periodic educational program and assessment.	☐	☐	☐	☐	
Ongoing education is provided to HWs on preventing and controlling infection risks in relation to intravascular devices.	☐	☐	☐	☐	
Patients are provided with infection prevention and control education on their device and this education is documented.	☐	☐	☐	☐	
It has been determined where devices are to be documented in the patient health record. The CVAD Insertion Record or equivalent is completed for every CVAD insertion.	☐	☐	☐	☐	
There is an evaluation method to ensure that insertion sites are assessed and documented daily in the patient health record.	☐	☐	☐	☐	

Processes are in place to support and evaluate the appropriate use of alternative locking solutions (e.g. heparin or antimicrobial). Locks containing medication are prescribed by a medical officer or nurse practitioner.	□	□	□	□	
Confirmation of tip position is documented on the central venous line insertion record or equivalent for all central device insertions.	□	□	□	□	
HOs who care for neonates have a local policy or guideline in place for skin preparation and/or antisepsis for pre-term infants.	□	□	□	□	
Criteria for PIVC replacement based on clinical indication has been met by the HO.	□	□	□	□	
Processes are in place to ensure appropriate authority to remove devices.	□	□	□	□	
Procedures in place to investigate positive cultures that are attributed to devices.	□	□	□	□	
All reportable device related BSI events are reviewed at the HO on a case by case basis to identify potential opportunity for clinical practice improvement.	□	□	□	□	
Surveillance systems are in place to monitor adverse events and incidents related to devices.	□	□	□	□	
Compliance with this Policy Directive and Procedures is monitored and reported to the nominated peak committee.	□	□	□	□	

9 GLOSSARY

Administration Set	A tubing set composed of components that is used to deliver infusions.
Air Embolism	The presence of air in the vascular system that obstructs venous blood flow primarily to the lungs and brain (85).
Alcohol Based Hand Rub (ABHR)	An alcohol-containing preparation (gel, foam or liquid) designed for reducing the number of viable microorganisms on dry, unsoiled hands.
Alcohol Based Surgical Hand Rub (ABSHR)	Hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora.
Antimicrobial	A chemical substance , usually a medicine, that inhibits or destroys bacteria, viruses fungi or protozoa (81).
Antiseptics	Antimicrobial substances that are applied to the skin to reduce the number of micro flora (e.g. topical alcohols, chlorhexidine and iodine).
Asepsis	Free from infection or infectious (pathogenic) material.

Aseptic Technique	Aseptic technique consists of a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during clinical procedures. The five essential principles of aseptic technique are sequencing, environmental control, hand hygiene, maintenance of aseptic fields and personal protective equipment (PPE). While the principles of aseptic technique remain constant for all procedures, the level of practice will change depending upon a standard risk assessment (81)
Assistant	A trained or experienced clinician who supports or aids a clinician inserting a CVAD.
Arteriovenous Fistula (AV)	Vascular access used to access the blood for haemodialysis treatment.
Blood stream infections (BSIs)	The presence of live pathogen(s) in the blood, causing an infection.
Catheter Exchange	Replacement of existing central venous access device (CVAD) with a new CVAD using the same catheter tract (4).
Central Related Blood Stream Infection (CR-BSI)	A laboratory-confirmed, primary blood stream infection in a patient with a intravascular access device in place, and the BSI is not related to an infection at another site (4)
Central Venous Access Device (CVAD) **Also called a central venous line or central venous catheter (CVC).**	A catheter introduced via a large vein into the superior vena cava or right atrium for the administration of parenteral fluids, medications or for the measurement of central venous pressure, this includes femoral venous catheters. • Centrally- inserted central venous catheters have a skin entry point in the neck or trunk. • Peripherally- inserted central catheters have a skin entry point on a limb or the scalp. • Non-Tunnelled- the catheter insertion and exit points are the same • Tunnelled - the catheter is inserted through one point and then “tunnelled” under the skin to a remote exit point.
Clinician	For the purpose of this policy, a clinician is defined as a medical practitioner (including Locum Medical Officers), nurse or midwife. Experienced Clinician- A clinician with a high level of competence in CVAD insertion and a comprehensive understanding of the management of potential complications. Trained Clinician- Clinician who has completed a training program consistent with best practice for the insertion of CVADs. Untrained Clinician- Clinician who has commenced, but not completed, a training program consistent with best practice for the insertion of CVADs.
Competency	Competence- Capability of the individual to apply knowledge, critical thinking, interpersonal, decision making, and psychomotor skills to intravascular access devices (4). Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance (86) For the purpose of the guideline, a competent clinician is one who has completed a training program in the insertion of PIVCs or who is in, or has completed, a specialist medical training program Competency- An integration of behaviours in the varied circumstances of the work environment demonstrating the individual’s ability to perform the desired job related activities and tasks (4). Competency Assessment- The process of reviewing and documenting the individual’s demonstrated ability to perform a job, role, specific tasks, or other patient care activities (4).

Electrocardiogram **ECG**	Is a test that measures and records the electrical activity of the heartbeat
Erythema	Redness of skin along a vein track that results from vascular irritation or capillary congestion in response to irritation, may be a precursor to or indication of phlebitis (4).
Extravasation	Inadvertent infiltration of vesicant solution or medication into surrounding tissue; rated by a standard tool (4).
Flushing	The act of moving fluids, medications, blood, and blood products out of the vascular access device into the bloodstream; used to assess and maintain patency and prevent precipitation due to solution/medication incompatibility (4).
Guidewire	A long, flexible metal structure, composed of tightly wound coiled wire in a variety of designs; contains safety mechanisms that allow it to be inserted into the vein or artery (4).
Hand Hygiene	A general term applying to processes aiming to reduce the number of microorganisms on hands. This includes application of a waterless antimicrobial agent (e.g. ABHR) to the surface of dry unsoiled hands; or use of soap / solution (plain or antimicrobial) and running water (if hands are visibly soiled), followed by patting dry with single-use towels (81)
Healthcare Associated Infection (HAI)	Refers to infections acquired in healthcare facilities and infections that occur as a result of healthcare interventions and which may manifest after people leave the healthcare facility (81)
Health Organisation	For the purpose of this Policy a Health Organisation is: Local Health District, Speciality Health Networks, Statutory health corporation that provides inpatient services, or Affiliated health organisation in respect of its recognised establishments that provide inpatient service
IIMS	The NSW Health Incident Information Management System
Implantable Venous Port (port/IVP):	Long term CVAD, which is surgically placed under the skin from the insertion site to a separate exit site. The exit site is typically located in the chest, but can be also located elsewhere for comfort and aesthetic reasons (e.g. inner bicep, abdomen and thigh). They can be multi lumen. TIVPs consist of two main parts: the portal reservoir and a catheter. The tip of the catheter resides in either the superior or inferior vena cava. Also known as a port-a-cath or a venous port.
Infection	The presence and growth of a pathogenic microorganism(s) having a local or systematic effect (49).
Infiltration	Inadvertent administration of a non-vesicant solution or medication into surrounding tissue (4).
Intravascular device (device):	Catheters, tubes, or devices inserted into the vascular system, including veins, arteries, and bone marrow (4).
Key Parts	Key parts are those parts of equipment / instruments / consumables that if contaminated by infectious material increases the risk of infection. Contamination may occur by direct or indirect contact with the key site(s), other key-parts, or liquid infusions (81).
Key Sites	The area on the patient that must be protected from pathogenic microorganisms. Key Sites are medical device access sites, surgical sites or open wounds (81).

Locking	The instillation of a solution into an intravascular access device (device) used to maintain patency in between device use and/or reduce risk of catheter related BSI.
Maximum Barrier Precautions	Surgical mask, hat (head and facial hair cover), eye protection, sterile gown and sterile gloves. Equipment and clothing used to avoid exposure to pathogens, including sterile coverings for the clinicians and patient: mask, gown, protective eyewear, cap, gloves, large or full body drapes, and towels (4).
Midline Catheter	Catheter used in a vascular access procedure that is inserted inside a major vein for a period of weeks so that blood can be repeatedly drawn or medication and nutrients can be injected into the patient's bloodstream on regular basis
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
Must:	Indicates a mandatory action
Needleless Injection Port	A device that allows intermittent access to a device with an administration set or syringe without the use of needles (4). Also known as: Needleless IV catheter systems, Swabable capless valve, swabable capless access device, needleless access ports, needle-free injection port, needleless connector and needle-free connector.
Neonate	Pertaining to the first 4 weeks of life.
Non-tunnelled CVAD **Also known as Percutaneous CVAD**	Enter the venous system at the point of insertion and are fixed in place at this site, with the catheter and attachments protruding. Non-tunnelled CVADs are also known as percutaneous CVADs. Non-tunnelled catheters are generally used for short term therapy and in emergency situations. A vascular or nonvascular access device inserted by puncture directly through the skin and the intended location without a portion of the device allowed to remain in a subcutaneous tract (4).
Osmolality	The number of osmotically active particles in a solution (4).
Palpation	Examination by application of the hands or fingers to the surface of the body in order to detect evidence of disease or abnormalities in the various organs; also used to determine location of peripheral superficial veins and their condition (4)
Peripheral Arterial Catheter	An arterial line inserted in radial artery; can be placed in femoral, axillary, brachial, posterior tibial arteries.
Peripherally Inserted Central Catheter (PICC)	A medium to long term CVAD inserted in a large peripheral vein, preferably the basilic vein, and then advanced until the tip rests in the superior vena cava or cavo-atrial junction
Peripheral Intravenous Cannula (PIVC):	A catheter (small, flexible tube) placed into a peripheral vein for intravenous access.
Personal Protective Equipment (PPE):	Refers to a variety of infection prevention barriers and respirators used alone, or in combination, to protect mucous membranes, skin, and clothing from contact with recognised and unrecognised sources of infectious agents in healthcare settings. The equipment worn to minimize exposure to a variety of hazards, including blood-borne pathogens; examples of PPE include items such as gloves, eye protection, gown, and face mask (81) .
Phlebitis	Inflammation of a vein; may be accompanied by pain, erythema, oedema, streak formation, and/or palpable cord (48).

Pulmonary Artery Catheter (PA)	Also known as a Swan-ganz catheter, is a CVAD inserted into a large central vein, with the tip residing in a pulmonary artery. Its purpose is diagnostic and therapeutic; it is used to detect heart failure or sepsis, monitor therapy, evaluate the effects of drugs, and infuse medication.
Should	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.
Sterile Technique	Is a set of specific practices and procedures performed to make equipment and areas free from all microorganisms and to maintain that sterility
Supervisor	An experienced clinician (also refer to definition of experienced clinician).
Surveillance	Active, systematic, ongoing observation of the occurrence and distribution of disease within a population and of the events or conditions that increase or decrease the risk of such disease occurrence.
Total Parenteral Nutrition (TPN)	The intravenous provision of total nutritional needs for a patient who is unable to take appropriate amounts of food enterally; typical components include carbohydrates, proteins, and/or fats, as well as additives such as electrolytes, vitamins, and trace elements (4).
Tunnelled CVAD	A central vascular access device (CVAD) with a segment of the catheter lying in a subcutaneous tunnel with the presence of a cuff into which the subcutaneous tissue grows to offer security for the catheter; indicates that the skin exit site and vein entry site are separated by the subcutaneous tunnel (4)
Vesicant	An agent capable of causing tissue damage when it escapes from the intended vascular pathway into surrounding tissue.
Visual Infusion Phlebitis (VIP) score	

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PATIENTS WITH INHERITED BLEEDING DISORDERS IN HOSPITALS WITHOUT A HAEMOPHILIA TREATMENT CENTRE (PD2023_005)

PD2023_005 replaced PD2022_013

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

a) the patient or person responsible for the patient has been made aware of the potential risks attached to having surgery in a hospital with no designated Haemophilia Treatment Centre, and
b) the director (or assigned delegate) of a designated Haemophilia Treatment Centre approves the alternative arrangement.

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

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

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

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

and

2. notify the hospital blood transfusion staff that they can order the clotting factor from Lifeblood using BloodNet. Staff must include the wording:
"Endorsed by [Name] Haemophilia Treatment Centre Director [Name] or delegate [Name] on [Date]" in the free text "comments" section of the BloodNet order form. Failure to include the completed statement will lead to a delay in receiving product.

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

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

The entire Patients with inherited bleeding disorders in hospitals without a Haemophilia Treatment Centre policy is available at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_005

345(14/02/23)

VICTIMS RIGHT ACT 1996 (PD2005_287)

1. INTRODUCTION

1.1 This circular provides information on the *Victims Rights Act 1996* which was proclaimed on 2 April 1997 and the concomitant requirements on the NSW Health system.

1.2 This circular should be read in conjunction with the **NSW Health Victims of Crime Policy** released in 1995. Copies of the policy are available from the Health Services Policy Branch of the Central Office of the Department.

2. THE *VICTIMS RIGHTS ACT 1996*

2.1 This Act establishes:

- a statutory **Charter of Victims Rights**;
- the **Victims of Crime Bureau** as a branch of the Attorney General's Department;
- the **Victims Advisory Board**; and
- amendment to the *Criminal Procedure Act 1986*, by inserting legislative changes relating to victim impact statements.

3. CHARTER OF VICTIMS RIGHTS

3.1 The Charter

3.1.1 Victims of crime in New South Wales now have a **statutory** (ie enshrined in legislation) Charter to protect and promote their rights. The new Charter is similar to the non-statutory charter which it replaced and is consistent with the NSW Health Victims of Crime Policy. The new Charter, established in the *Victims of Crime Act 1996*, establishes standards for the appropriate treatment of victims of crime and is overseen by the Victims of Crime Bureau.

3.1.2 Any agency or person exercising official functions in the administration of the affairs of the State (other than judicial functions) must, to the extent that it is relevant and practicable to do so, have regard to the Charter of Victims Rights in addition to any other relevant matter. (*Victims Rights Act 1996*, Part 2, Section 7 (2))

3.1.3 The Charter of rights of victims of crime, provides among other things:

- that a victim should be treated with courtesy and compassion, and that the rights and dignity of the victim are respected;
- a victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim; and
- a victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

3.2 Breaches of the Charter

3.2.1 If a victim considers a Government agency has not abided by its statutory obligations under the *Charter*, a victim can complain to the Victims of Crime Bureau about the agency.

3.2.3 The Bureau has the responsibility to take all necessary action to resolve the matter. Where the Bureau receives a complaint relating to a Health Service, the Bureau will contact the nominated Complaints Contact Officer in the Health Service, for investigation and a report on the complaint.

3.2.4 Where the Bureau is unable to resolve the matter satisfactorily, the Bureau will be obliged to make a report to the Attorney General, who can table this in Parliament.

3.3 Full details of the **Charter of Victims Rights** are attached at *appendix 1*,

3.4 Additional information on the Charter of Victims Rights, is attached at *appendix 2.* This attachment provides information on:

- Why Do We Need A Charter?
- Who Is A Victim?
- What Does The Charter Do?
- What Specific Rights Are Protected?

4. THE ROLE & FUNCTIONS OF THE VICTIMS OF CRIME BUREAU

4.1 Establishment of Victims of Crime Bureau

4.1.1 The Victims of Crime Bureau (VCB) has been established within the Attorney General's Department under the *Victims Rights Act 1996.* The primary goal of the VCB is to coordinate the delivery of appropriate services to meet the needs of victims of crime.

4.2 What Is The Role Of The VCB?

4.2.1 The VCB is responsible for:

- providing support and referral services to victims of crime;
- coordinating the delivery of victims' support and counselling services by government and community agencies; and
- overseeing the implementation of the statutory *Charter of Victims Rights.*

4.2.2 The VCB will also be an information resource for victims of crime and for community and victim support agencies. This role will ensure that information about the range of victim support services operating across the State is readily available and accessible to all.

4.2.3 It will also ensure that victims have access to information which will help them to understand, and participate in, the criminal justice system.

4.3 How Will The VCB Receive Referrals?

4.3.1 While victims of crime will be able to directly contact the VCB for assistance, the VCB will also receive referrals from police and other services who have contact with the victim at the time of the crisis.

4.4 What Happens Once A Victim Is Referred To The VCB?

4.4.1 Once contact has been established with a victim, staff at the VCB will make an assessment of the victim's needs.

4.4.2 Information will be supplied to a victim based on this assessment, and, if necessary, a referral made to attend other agencies for specialist services.

4.4.3 The overall aim will be to provide an integrated counselling/referral service so that a victim will have immediate access to counselling and other necessary assistance.

4.4.4 It is important to note that the VCB does **not** offer or provide on-going counselling services, but coordinates the delivery of such services by government and community agencies.

4.5 Further information on the following is attached at *appendix 3*:
- Other Functions Of The VCB
- The VCB And Other Agencies
- Education & The VCB

5. THE VICTIMS ADVISORY BOARD

5.1 The Victims Advisory Board established under the Act, has the following functions:
- to advise the Minister on policies and administrative arrangements relating to support services and compensation for victims of crime;
- to consult victims of crime, community victim support groups and Government agencies on issues and policies concerning victims of crime; and
- to promote legislative, administrative or other reforms to meet the needs of victims of crime.

5.2 NSW Health is represented on the Board.

6. NSW HEALTH VICTIMS OF CRIME POLICY

6.1.1 The goal of the **NSW Health Victims of Crime Policy** is:

> *To ensure that counselling, support and information is available to victims of crime and their families as soon as possible after a crime to minimise secondary trauma and assist in recovery.*

6.1.2 The role of the Department/Area Health Services, hospitals, specialist teams and units and Community Health Centres is clearly set out in the Policy, and is summarised in *appendix 4* for information.

7. AREA HEALTH SERVICE RESPONSIBILITIES

7.1 Under the NSW Health Victims of Crime Policy, Services are required to nominate a position to coordinate the planning and implementation of local protocols. A list of Area Health Service *Contact Officers* for Victims of Crime is attached at *Appendix 5*.

7.2 The Department, in conjunction with the Victims of Crime Bureau, Area Health Services and other Services will be developing protocols for the management of complaints from victims of crime. In the meantime, Area Health Services have nominated a person to whom complaints about the implementation of the Charter can be referred. A list of Complaints Officers is attached at *Appendix 5*.

8. FURTHER INFORMATION

8.1 For further information, please contact Ms Melissa Gibson, Manager, (02 9391 9506) Health Services Policy Branch, NSW Health Department.

8.2 Further information on the Victims of Crime Bureau, including information kits on the VCB, can be obtained from Ms Marianne Curtis, Manager, of the Bureau on 02 9374 3000.

(Nov 1997)

Appendix 1

CHARTER OF VICTIMS RIGHTS

The following comprises the Charter of rights of victims of crime, as listed in the *Victims Rights Act 1996*, Part 2:

Courtesy, compassion and respect
A victim should be treated with courtesy, compassion, and respect for the victim's rights and dignity.

Information about services and remedies
A victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim.

Access to services
A victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

Information about investigation of the crime
A victim should, on request, be informed of the progress of the investigation of the crime, unless the disclosure might jeopardise the investigation. In that case, the victim should be informed accordingly.

Information about prosecution of accused
A victim should, on request, be informed of the following:
(a) the charges laid against the accused or the reasons for not laying charges,
(b) any decision of the prosecution to modify or not to proceed with charges laid against the accused, including any decision for the accused to accept a plea of guilty to a less serious charge in return for a full discharge with respect to the other charges,
(c) the date and place of hearing of any charge laid against the accused,
(d) the outcome of the criminal proceedings against the accused (including proceedings on appeal) and the sentence (if any) imposed.

Information about trial process and role as witness
A victim who is a witness in the trial for the crime should be informed about the trial process and the role of the victim as a witness in the prosecution of the accused.

Protection from contact with accused
A victim should be protected from unnecessary contact with the accused and defence witnesses during the course of court proceedings.

Protection of identity of victim
A victim's residential address and telephone number should not be disclosed unless a court otherwise directs.

Attendance at preliminary hearings
A victim should be relieved from appearing at preliminary hearings or committal hearings unless the court otherwise directs.

Return of property of victim held by State
If any property of a victim is held by the State for the purpose of investigation or evidence, the inconvenience to the victim should be minimised and the property returned promptly.

Protection from accused
A victim's need or perceived need for protection should be put before a bail authority by the prosecutor in any bail application by the accused.

Information about special bail conditions
A victim should be informed about any special bail conditions imposed on the accused that are designed to protect the victim or the victim's family.

Information about outcome of bail application
A victim should be informed of the outcome of a bail application if the accused has been charged with sexual assault or other serious personal violence.

Victim impact statement
A relevant victim should have access to information and assistance for the preparation of any victim impact statement authorised by law to ensure that the full effect of the crime on the victim is placed before the court.

Information about impending release, escape or eligibility for absence from custody.
A victim should, on request, be kept informed of the offender's impending release or escape from custody, or of any change in security classification that results in the offender being eligible for unescorted absence from custody.

Submissions on parole and eligibility for absence from custody of serious offenders
A victim should, on request, be provided with the opportunity to make submissions concerning the granting of parole to a serious offender or any change in security classification that would result in a serious offender being eligible for unescorted absence from custody.

Compensation for victims of personal violence
A victim of a crime involving sexual or other serious personal violence should be entitled to make a claim under a statutory scheme for victims compensation.

(Nov 1997)

Appendix 2

The Charter of Victims Rights

1 Why Do We Need A Charter?

1.1 The *Charter of Victims Rights* builds upon principles already adopted by government agencies throughout New South Wales.

1.2 These principles value the needs of victims, and recognise these needs as factors to be taken into consideration in the decision making processes related to the administration of justice in this State.

1.3 By incorporating these principles into a statutory charter, the government is ensuring a recognised position for victims within the NSW criminal justice system.

2 Who Is A Victim?

2.1 Under the *Charter*, a victim includes a person who, as a direct result of a criminal offence suffers physical or emotional harm, or loss or damage to property.

2.2 Where the criminal offence results in the death of the person, a member of that person's immediate family will also be included as a victim of crime for the purposes of the *Charter*.

3 What Does The Charter Do?

3.1 The *Charter* places a statutory obligation upon government agencies to ensure that a victim is at all times treated with courtesy and compassion, and that their rights and dignity are respected.

3.2 The Victims of Crime Bureau is currently liaising with all relevant government agencies to establish guidelines and protocols in the treatment of victims and the effective delivery of services to meet the needs of victims and compliance with *Charter* obligations.

4 What Specific Rights Are Protected?

4.1 The *Charter* recognises rights of victims to:

- information about, and access to, welfare, health and counselling services;
- privacy and protection;
- information about the investigation of the crime, the prosecution of the accused and the trial process;
- assistance with the preparation of a victim impact statement where relevant;
- information about an offender's release, escape or eligibility for unescorted absence from custody;
- make submissions concerning parole and eligibility for unescorted absence from custody of serious offenders.

5 What Happens If There Is A Breach Of The Charter?

5.1 If a victim considers a Government agency has not abided by its statutory obligations under the *Charter*, a victim can complain to the Victims of Crime Bureau about the agency.

5.2 The Bureau has the responsibility to take all necessary action to resolve the matter. Where the Bureau is unable to resolve the matter satisfactorily, the Bureau will be obliged to make a report to the Attorney General, who can table this in Parliament.

Appendix 3

VICTIMS OF CRIME BUREAU

1 Other Functions Of The VCB

1.1 Advice and assistance will also be offered by the Bureau with regard to:

- ensuring that victims are aware of their rights to claim compensation for injuries suffered;
- completing victim compensation applications, where necessary;
- providing victims with an information kit to assist in the preparation of a victim impact statement.
- assisting a victim to have their details recorded in the Victim's Register to ensure the victim is informed by the Department of Corrective Services of an offender's impending release or escape from custody; and,
- to oversee the approved counselling scheme.

2 The VCB And Other Agencies

2.1 The VCB is intended to complement and enhance existing services by promoting the development of a cohesive and comprehensive network of victim support services in NSW. It will assist with inter-agency co-ordination of victims' services, as well as the development of co-operative strategies between agencies at the local level.

2.2 A close working relationship will be developed with this and other community support groups.

3 Education & The VCB

3.1 The VCB will provide an educational role by organising seminars and training sessions for both Government and non-Government agencies, to promote awareness of victims' needs and their position within the criminal justice system.

(Nov 1997)

Appendix 4

NSW HEALTH VICTIMS OF CRIME POLICY

1 What Is the Role of the NSW Health Department?

1.1 To ensure that victims of crime receive appropriate counselling and information as soon as possible after the crime, through either local health services or through referral services. To promote the development of local networks that will ensure appropriate referrals and maximise access. The local networks will include such resources as private therapists, the Sydney City Mission Victims of Crime Telephone Counselling Service, the New South Wales Police Service and the Victims of Crime Bureau amongst others.

2 What Is the Role of Area Health Services?

2.1 Area and Rural Health Services are responsible for the development of local operational plans or protocols. These protocols should recognise the Charter of Victims Rights in both their formulation and implementation. Local protocols should be developed with involvement from Hospital staff, including medical staff, nursing staff and social work departments. The protocols should recognise specialist units, private therapists and other relevant services in the Area skilled in the treatment and care of victims of crime. The protocols should recognise the need for both information and counselling services to be made available for victims of crime.

2.1.1 Protocols should include:

- the provision of culturally appropriate counselling by staff trained in trauma counselling and critical incident stress debriefing or referral to other appropriate services;
- the provision of information to the victim, including information on the VCB;
- procedures for networking with both government and non government agencies; and
- programs to raise community awareness about the needs of victims of crime and of consequent health services.

3 What Is the Role of Hospital Staff?

3.1 Many victims of crime enter the Health system via public hospitals, where they will receive treatment and subsequent referral. The role performed by hospital staff is vital in ensuring that victims are given access to counselling and information. Staff employed in these areas should be involved in the design and implementation of local protocols.

4 What Is the Role of Specialist Teams and Units?

4.1 There are numerous specialist teams and units throughout NSW. These teams are staffed by highly trained and experienced individuals. Teams such as those which specialise in the counselling of children, the treatment of the aged, the care of the mentally ill and the care of the disabled should be involved in the implementation of local protocols. The victim is more likely to receive optimal care with input from these professionals.

5. What Is yhe Role of Community Health Centres?

5.1 Community Health Centres should be involved in the development of protocols as they have multidisciplinary staff who provide counselling and therapy services and who are skilled in community development.

(Nov 1997)

Appendix 5

Area Health Service	V. of Crime Contact Officer	Complaints Contact Officer
Central Coast Area Health Service	Ms Dorothy MacLean Director, Social Work Central Coast Area Health Service PO Box 361 GOSFORD NSW 2250 Ph (02) 4320 3613 Fax (02) 4325 0566	Mr Jon Blackwell Chief Executive Officer Central Coast Area Health Service PO Box 361 GOSFORD NSW 2250 Ph (02) 4320 2111 Fax (02) 4325 0566
Central Sydney Area Health Service	Ms Anne Connolly Women's Health Coordinator Central Sydney Area Health Service C/- Royal Prince Alfred Hospital 59 Missenden Road CAMPERDOWN NSW 2050 Ph (02) 9515 3272 Fax (02) 9515 3282	Ms Annette Gardner Complaints Manager Central Sydney Area Health Service C/- Royal Prince Alfred Hospital 59 Missenden Road CAMPERDOWN NSW 2050 Ph (02) 9515 9600 Fax (02) 9515 9611
Far West Health Service	Ms Voula Smith Young Persons Mental Health Worker Far West Health Service PO Box 457 BROKEN HILL NSW 2880 Ph (08) 8087 8800 Fax (08) 8088 2926	Ms Voula Smith Young Persons Mental Health Worker Far West Health Service PO Box 457 BROKEN HILL NSW 2880 Ph (08) 8087 8800 Fax (08) 8088 2926
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RESEARCH GOVERNANCE IN NSW PUBLIC HEALTH ORGANISATIONS (GL2011_001)

GL2011_001 rescinds PD2005_207.

PURPOSE

The purpose of this guideline is to facilitate and support the responsible conduct of quality research in NSW Public Health Organisations through an effective research governance framework.

KEY PRINCIPLES

Health and medical research is integral to quality health care systems. It leads to improved health outcomes through enhanced prevention and treatments, and changes in professional practice. Engaging in research activities to advance health and wellbeing is encouraged and supported by NSW Health as part of its overall commitment to improving the health of the people of New South Wales (NSW). While investing in health and medical research can lead to far-reaching benefits for the wider community, it also has the potential to involve risk; risk to participants, institutions, and investigators. Public support, confidence and trust in research conducted in NSW Health is reliant upon an effective governance framework which manages these risks and ensures that all research meets the highest ethical, scientific, regulatory and professional standards.

USE OF THE GUIDELINE

This guideline summarises the principles, standards and requirements for the responsible conduct of quality research. It also clarifies the responsibilities and accountabilities of key parties involved in research taking place in NSW Public Health Organisations. Public Health Organisations are responsible for using this guideline to develop their local operating procedures which clearly define the roles, responsibilities and accountabilities of parties involved in research taking place within their premises. The local operating procedures should also define systems and processes to ensure compliance with the principles, standards and requirements of associated legislation and NSW Health policy directives as outlined in this document.

Chief Executives of Public Health Organisations are responsible for ensuring that appropriate research governance personnel, systems and structures are in place (section 4.1).

Specific responsibilities and accountabilities apply to **investigators** (section 4.2). **Directors of research** or their equivalent, **Research Governance Officers**, **heads of departments** who host and support research and **managers of investigators** all play a key role in research governance (section 4.3).

All parties involved in research taking place in Public Health Organisations, regardless of their position, employment status and level of engagement in the research are responsible for familiarising themselves with and adhering to the principles, standards and requirements outlined in this guideline.

The Guideline can be downloaded from
http://www.health.nsw.gov.au/policies/gl/2011/GL2011_001.html

PRESSURE INJURY PREVENTION AND MANAGEMENT (PD2021_023)

PD2021_023 rescinded PD2014_007

POLICY STATEMENT

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

Pressure Injury Prevention and Management: Procedure.

1 BACKGROUND

1.1 About this document

Pressure injuries are a frequently occurring health problem and reduce quality of life through pain and discomfort. They are a costly, and often preventable with many individuals at risk due to aging, frailty, and multimorbidity.[1,2,3] *The Australian Commission on Safety and Quality in Health Care (ACSQHC)* has designated pressure injuries as a Hospital Acquired Complication (HAC). HAC is a complication for which clinical risk mitigation strategies may reduce, but not necessarily eliminate, the risk of a complication occurring.4 Prevention of pressure injuries is the responsibility of all staff who work in health, regardless of location and position. Staff, patients and carers have a role to play in the prevention of pressure injuries.[3]

The Policy Directive is revised in accordance with the International Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, 2019.[3] The Guideline is a collaboration between three partner organisations – the European Pressure Ulcer Advisory Panel (EPUAP), the National Pressure Injury Advisory Panel (NPIAP) and the Pan Pacific Pressure Injury Alliance (PPPIA). The goal of the guideline is to provide an update of evidence-based recommendations for the prevention and treatment of pressure injuries.[3]

The National Safety and Quality Health Service Standards (NSQHSS), Comprehensive Care Standard [5], describes the systems and strategies to provide comprehensive care and identify risk of harm including the development of pressure injuries. This Policy also aligns with the Partnering with Consumers Standard, which ensures that systems are in place to design, deliver and evaluate care in partnership with consumers.[5]

The Comprehensive Care Standard requires that:

- Systems are in place to support clinicians to deliver comprehensive care
- Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed, comprehensive care plan
- Safe care is delivered based on the comprehensive care plan, in partnership with patients, carers and family, including patients who are at the end of life
- Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.[5]

Evidence-based approaches to pressure injury prevention and management include:

- Timely identification of risk factors
- A standardised and documented risk screening process to identify if an individual is at risk of developing a pressure injury and guide clinical decision making
- Regular skin assessment for individuals with identified risk factor/s
- Communication of identified risk
- Engaging with patients and their carer/s in a culturally sensitive manner
- Developing, implementing and reviewing of a plan of care that is:
    - Tailored to the individual's goal of care, preferences and addresses their risk factors
    - Focused on prevention and wound healing if a pressure injury is present
    - Comprehensive and interdisciplinary
    - Delivered by staff with appropriate knowledge and skills who use evidence based prevention and management strategies and resources
    - Inclusive of access to appropriate products and equipment
- Systems to monitor and analyse pressure injury data, and to implement quality improvement activities.[3,5]

It should be noted that even when all appropriate prevention strategies are consistently implemented to reduce the risk, in some cases pressure injuries are unavoidable, e.g. patients with skin failure at end of life.[3,12]

Pressure Injury Prevention and Management resources are available on the Clinical Excellence Commission website for different care settings, including flowcharts Prevention and Management of Pressure Injuries for:

- Inpatients
- Residents of Multi-Purpose Service (MPS) Long Stay Facilities and NSW Health Residential Aged Care (RAC) Facilities
- Non-Inpatients (Community Services, Ambulatory Care or Clinics).

1.2 Key definitions

Active support surface
A powered support surface that produces alternating pressure through mechanical means, providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternating of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface.[3]

Bony prominence
An anatomical projection of bone.[3]

Carers
People who provide care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.

Carers provide emotional, social or financial support.[6] Carers provide support for activities of daily living and include parents and guardians caring for children.

Classification of pressure injuries
Pressure injuries are classified using the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) 2009/2014 classification system cited in the Australian Wound Management Association *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, 2012.*[7]

Community Services
Services provided in the community setting and include but not limited to, Generalist Community Health Services, Palliative Care Services, Hospital in the Home, Child and Family Health Services, Chronic Care Services, Continence Services, Ostomy Services, Diabetes Services and Podiatry Services.

Mucosal pressure injury
Mucosal membrane pressure injuries are pressure injuries of the moist membranes that line the respiratory, gastrointestinal and genitourinary tracts. Mucosal pressure injuries are primarily caused by medical devices exerting sustained compression and shear forces on the mucosa. Classification systems for pressure injuries of the skin and underlying tissue cannot be used to categorize mucosal pressure injuries.[3]

NSW public health facility
Any clinical unit or service that delivers public healthcare services. Health facilities include hospitals, multi-purpose services, emergency services, ambulatory care services, Aboriginal Medical Services and community health services and clinics.

Plan of care
Outlines the types and frequency of services required and the service provider details to meet care needs and mitigate identified risk factors.

Pressure Injury
Localised damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear and friction. Pressure injuries usually occur over a bony prominence but may also be related to a medical device or other object.[3,10]

Pressure injury risk identification
A process to support identification of an individual's risk of developing a pressure injury.

Primary Care Provider
Primary healthcare providers include but are not limited to – General Practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal Health Workers.

Risk screening
A process to support identification of an individual's risk of developing a pressure injury.[3]

Reactive Support Surface
Powered or non-powered support surface with the capability to change its load distribution properties in response to an applied load.[11]

Skin assessment
Examination of the entire skin surface from head to toe to check integrity and identify any characteristics indicative of pressure damage/injury. This entails assessment for erythema, blanching response, localised temperature changes compared to surrounding skin, oedema, induration and skin breakdown. Consider different skin tones. The skin beneath devices, prosthesis and dressings are to be checked when practical and safe to do so.[3]

Staff
Any person working within the NSW Health system including clinicians, contractors, students and volunteers.

Unavoidable Pressure Injuries
Pressure injuries which occur despite consistent application of pressure injury prevention interventions. The implemented interventions were consistent with the patient's needs, goals, and recognised standards of practice, and there is evidence of monitoring and evaluation/revision of the interventions.[12]

Wound-related pain
An unpleasant sensory and emotional experience associated with a pressure injury. Patients may use different words to describe pain including discomfort, distress and agony.[8] Patients with cognitive impairment or expressive dysfunction may be unable to communicate their pain.

2 GOVERNANCE

Health services are to have a senior manager and/or a governance group responsible for the health service pressure injury policies, procedures and protocols, ensuring there are systems and processes in place to monitor and analyse pressure injury data and conduct/support relevant quality improvement activities.[5]

3 PARTNERSHIP WITH PATIENTS AND/OR CARERS

Health services are to have systems to engage and partner with consumers and carers in care, to the extent that they choose. Education is to be provided to patients and their carers to address their pressure injury risk factors, and appropriate prevention and management strategies. This is to be supplemented with written information in plain language and resources for culturally and linguistically diverse populations. Information is easy to understand which will support partnerships.

Interpreters may be required for patients who are hearing impaired, those not fluent in English or whose preferred language is a language other than English.

Document partnering with patients and carers in the medical record when developing care/management plans and have open disclosure when a pressure injury develops during an episode of care.

Information to support the ongoing management of risk factors is to be provided on transition of care/discharge.[5]

4 CLINICAL PRACTICE REQUIREMENTS

4.1 Conduct screening

Health services are to have systems and processes appropriate for their patient populations, which identify risk factors and support care planning and shared decision making.

Patients are to be screened for pressure injury risk as early as possible on presentation/admission:

- Within 8 hours of presentation to a health facility for inpatient and Multi-Purpose Service (MPS) long stay facilities and NSW Health Residential Aged Care (RAC) facilities
- At the first home visit or presentation for non-inpatient (community services, ambulatory facilities or clinics with clients at high risk) services.

Risk screening must consider the three primary predictors of pressure injury development:

1) Mobility/activity and neurological status - which can be restricted by the following but is not limited to physical limitations, over/under weight, sensory deficits, impaired cognition, low affect, demotivation, medication/anaesthetic or pain.
2) Perfusion – related to diabetes, peripheral artery disease, venous insufficiency, respiratory disease, organ failure, medication.
3) Skin status (as reported by the patient or the carer):
   a) General skin status relating to factors which may make the skin more vulnerable to pressure injury, e.g., redness, moisture, dryness, oedema
   b) Skin integrity including current and previous pressure injuries.[9]

Patients with a history of or if a current pressure injury exists may be at risk of developing further pressure injuries.

4.2 Conduct skin assessment

When pressure injury risk factor/s are identified through the initial screening process, the patient is to have a documented skin assessment. Where skin assessment is outside the clinician's scope of practice, referral for skin assessment may be required. Ongoing, regular skin assessment appropriate to the care setting is required. See table 1 below.

In some situations, the patient may not give consent or is unsuitable to undergo a full skin assessment. The clinician must record in the medical record the reason why the skin assessment was not undertaken. In clinical situations when the risk of doing a skin assessment is outweighed by other risks to the patient or staff, the assessment is to take place as soon as practical after the risk is mitigated. Risks include:

- Clinical instability e.g. acute spinal cord injury, unstable fractures, active bleeding
- Medical device patency e.g. extracorporeal membrane oxygenation (ECMO), intraarterial lines/sheaths
- Dressing wear time e.g. severe burn injury, negative pressure wound therapy
- Potential for physical harm to the patient or staff e.g. delirium, behavioural disturbance, psychological trauma e.g. sexual assault, cultural sensitivity, trauma history, mental illness
- Imminent death.

The skin assessment is to include a comprehensive head to toe assessment, focusing on skin overlying bony prominences including the occiput, sacrum, buttocks, heels, hips, pubis, thighs and torso. When the patient has a medical device the skin assessment is to include the skin under and around the device. For neonates, young children and critically unwell patients, the occiput requires careful attention.[3,10]

Patients are to be reviewed if there is a change to a patient's health status or mobility, pre-operatively, as soon as feasible after surgery, postnatally prior to leaving the birthing setting, at transition of care, prior to discharge and if a pressure injury develops. If risks are identified, the plan of care is to be reviewed and ongoing skin assessment is required. If pressure injury risk factors are no longer present regular skin assessment is not required.

Table 1: Identification of risk factors, skin assessment and care plan review requirements based on the care setting1.

	Inpatients	Multi-Purpose Service (MPS) long stay facility residents and NSW Health Residential Aged Care (RAC) facility residents.	Non-inpatients (community services, ambulatory care or clinics with clients at high risk)
First pressure injury screening and skin assessment to guide clinical decision making	1. Screened as soon as possible - no later than 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened within 8 hours of presentation 2. Skin assessment on identification of risk factors	1. Screened at the first home visit or presentation 2. Skin assessment (if practicable) on identification of risk factors
Identified risk factor/s	Skin assessment and plan of care reviewed daily, and: • Change in health status or mobility • Pre-operatively, and as soon as feasible after surgery • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Skin assessment daily and plan of care reviewed regularly (on agreed review date), and: • Change in health status or mobility • Clinical change impacts on the needs, goals or preferences of the consumer • Transition of care • If a pressure injury develops • Based on clinical judgement	Skin assessment and review of plan of care monthly (as a minimum) and: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
No identified risk factor/s	Reassess: • Change in health status or mobility • Post operatively • Postnatally, prior to leaving the birthing setting • Transition of care • Prior to discharge • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement	Reassess: • Change in health status or mobility • Transition of care • If a pressure injury develops • Based on clinical judgement
Pressure injury/ies - skin assessment and pain assessment completed and documented	During each shift as a minimum	During each shift as a minimum	At each home visit/appointment

[1] NB. Community services who are not the primary care provider for clients/consumers identified at risk for pressure injury are to provide education to the client/consumer and/or carer and primary provider. This will increase awareness and understanding of risk factors and their role in ongoing monitoring of skin integrity and the plan of care. People with spinal cord injury and other neurological disorders are at life-long high risk for pressure injuries. The plan of care is to be reviewed regularly, particularly if there is a change in health status or mobility.

4.3 Develop a prevention plan

For patients/clients who are at risk of, or have an existing pressure injury, the plan of care needs to:

- Be developed with the person, and/or their carer (when able) and documented in their medical record
- Include strategies aimed at preventing pressure injury/injuries and optimising healing and preventing complications of current pressure injury/injuries
- Document how the patient and/or carer are involved in the pressure injury prevention and management care planning process
- Have input from the interdisciplinary team about additional assessment, recommendations and treatment
- Be communicated via documentation in the medical record
- Be communicated during handover at the end of every shift in an acute, MPS long stay facility or NSW Health RAC facility, and within twenty-four hours of initial home visit for community services
- Have risk communicated, e.g. through the use of patient journey boards and care boards
- Be verbally communicated during bedside handover, intentional-rounding, safety huddles, journey board meetings and at transition of care.

4.4 Prevention Strategies

Patients with risk factors for pressure injury, either with or without pressure injury, are to have:

- Evidence based prevention strategies implemented as a priority within two hours of risk identification
- Targeted interventions/strategies based on the risk factor(s) identified and reviewed regularly for their effectiveness.

Repositioning and/or early mobilisation schedule to prompt or assist repositioning as clinically indicated and using appropriate manual handling techniques and equipment. Patients are to be educated and encouraged to perform independent, pressure relieving manoeuvres when able.

- A 30-degree side lying position is to be used when repositioning individuals in bed. Keep the head of the bed as flat as possible at no greater than 30-degrees elevation unless clinically necessary to facilitate breathing and/or prevent aspiration and ventilator-associated pneumonia.3

The knee break function is to be used to prevent the patient from sliding down the bed to reduce shear forces. The torso to thigh angle is to be no greater than 30-degrees.[3]

Pressure redistribution

- Mattress support surfaces which meet individualised requirements (i.e. weight, moisture, temperature, width, static or active surface types) are to be considered and regularly reviewed.
- Support surfaces (such as active and reactive) are to be used during care, including emergency departments, operating room, intensive care, dialysis units, and during transportation when clinically indicated and appropriate.

NB: In unstable spinal or pelvic fracture, active support surfaces are contra-indicated.
This is regardless of the patient having identified risk factors for pressure injury or an existing pressure injury. Patients with unstable spinal or pelvic fracture are to stay on the appropriate non-powered support surface and receive regular pressure relief through lifting, as per spinal and pelvic fracture protocols.

- Seating support surfaces which meet the individualised requirements are to be considered and regularly reviewed.
- Other pressure redistribution and offloading equipment (e.g. repositioning devices or aids) are to be used according to individualised requirements and goals of care.
- Heels, Achilles tendon and popliteal vein are to be offloaded completely to distribute the weight of the leg along the calf.[3]

Medical devices
- Devices/orthoses, compression therapy/stockings, casts/splint and other devices are to be correctly fitted, repositioned or removed regularly to have underlying skin inspected. Devices and orthosis need to be checked within 1-2 hours of first application to ensure there is no pressure.10 The paediatric population is at increased risk of device related pressure injury.

Reduction of shear and friction:
- Prophylactic dressings - note dressing products do not reduce pressure
- Appropriate manual handling techniques and equipment

Pain Management ensures patients have adequate pain management to support early mobilisation and repositioning.

Education of patients/carers on the importance of regular repositioning and other prevention strategies which address risk factors.

Skin protection and moisture balance:
- Skin is cleaned and hydrated
- Skin is protected from excessive moisture with a barrier product
- Vigorous massage or rubbing of the skin is to be avoided as this can cause damage from shear and friction.

Continence management for persons with incontinence
- A continence management plan is to be developed that facilitates individualised toileting, change of continence aids, and regular skin care.
- Highly absorbent continence products to protect the skin in individuals with or at risk of pressure injuries who have urinary and/or faecal incontinence. These need to be checked and changed regularly.
- Skin is to be cleansed after each episode of incontinence.

Adequate nutrition and hydration, is to be provided, including:
- Consideration of adequacy of total energy (calorie), protein, fluid, vitamin and mineral intake
- Screening for nutritional deficiencies
- Nutrition assessment by a Dietitian (where available) if with or at risk of malnutrition or for those with severe pressure injuries (stage 3, stage 4, Unstageable and Suspected Deep Tissue). Risk factors for malnutrition may include unintentional weight loss, poor appetite, reduced oral intake, and increased gastrointestinal losses (e.g. diarrhoea, vomiting)
- Consideration of high energy high protein supplements, and/or arginine if recommended by a Dietitian or Medical Officer
- Feeding assistance, if required.

Referral to health disciplines are to be made as clinically indicated for additional assessment and treatment.

4.5 Assess existing pressure injuries

Classification and assessment of pressure injuries is to occur when a pressure injury is identified, during serial wound management and on transfer of care (at the next dressing change). Pressure injuries are classified using the EPUAP/NPUAP 2009/2014 classification system.

Pain assessments are to be conducted to include pain management in the plan of care.

4.6 Managing existing pressure injuries

Plan of care that addresses risk factors and includes wound and pain assessment and management. The plan of care is to be reviewed by the multidisciplinary team within twenty-four hours of pressure injury identification wherever possible. If a pressure injury develops or an existing pressure injury significantly deteriorates (progresses to a more severe stage) the patient is to be reviewed.

Wound Management is to be provided or supervised by clinicians with knowledge, skills, and resources to provide treatment in accordance with best practice.

4.7 Monitor and document

Document in the medical record and complete wound chart(s) for pressure injuries, including if they were present on presentation or developed during the episode of care.

Pressure injuries are to be notified through the incident management system if the injury was acquired during the current episode of care. Documentation is to include a pressure injury classification, anatomical location and dimensions. Capture and upload an image of the pressure injury as part of the documentation to monitor outcomes.

Wound reassessment is to occur as frequently as required, but at least weekly. Severe or a pressure injury that is not healing as anticipated, i.e. 25% reduction in four weeks3 are to be reviewed by a clinician with expertise in wounds.

Consultations are to occur in a timely fashion with clinicians with expertise in wounds, medical or other health disciplines for their assessment, management and interventions. The use of virtual health to facilitate the consultation and reduce the need for patient or clinicians to travel is to be considered.

Pain is to be assessed and managed using best practice guidelines (using a validated pain tool) and documented.

Nutritional support is to be provided in accordance with NSW Health Nutrition Care Policy.

Prevention of additional pressure injuries as patients with a pressure injury are at a high risk of the injury worsening or developing other pressure injuries. See section 4.4 on prevention strategies.

4.8 Transition of Care

Transition of care for a patient at risk or with a pressure injury requires timely communication with health care providers taking over/resuming care, the patient and/or their carers, other community or residential services, equipment suppliers, and allied health clinicians.

Communication is to include:

- Goals of care (healing, maintenance, or palliation)
- Classification, anatomical location and dimensions of the pressure injury
- Wound management
- Ongoing prevention/management strategies
- Follow-up care.

Prevention strategies are to be used during transportation or transition of care for patients at risk or with an existing pressure injury.[3]

5 RESOURCES

All health services are to have systems in place so that adequate expertise and resources, including equipment, devices and products, are available and accessible to provide best practice in pressure injury prevention and management.

Pressure injury prevention products, devices and equipment are to be purchased in accordance with NSW Health Procurement Guidelines and used in accordance with:

- The manufacturers' instructions
- NSW Health Infection Control Policies
- NSW Health Workplace Health & Safety Policy.

6 EDUCATION AND TRAINING

Clinical staff providing care to patients at risk of or with pressure injuries are to undertake training in pressure injury prevention and management, modules are available on My Health Learning.

Health services are to have:

- Orientation and ongoing training programs related to pressure injury prevention and management available to ensure staff have the knowledge, skills and resources to deliver quality care
- Health professionals with expertise are available to provide clinical education for pressure injury prevention and management for staff caring for patients with complex needs
- Targeted education available for:
    - Clinical coders on pressure injury classification and condition onset
    - Auditors who conduct audits related to pressure injuries
- Systems in place to monitor education and records of training for staff on preventing and managing pressure injuries.

7 REPORTING

7.1 Pressure injury incidents

Hospital/health service-acquired pressure injuries, which have developed after eight hours of presentation, are to be notified in the incident management system and communicated to the admitting medical team or primary care provider. Notification is also a requirement for pressure injuries that have deteriorated (progressed to a more severe pressure injury) since admission. Unstageable pressure injuries and suspected deep tissue injuries require review for definitive staging.[13] Where definitive staging is likely to occur after the transition of care, the health service is to communicate with the ongoing care provider to confirm staging. Definitive staging is to be entered into the medical record and the incident management system particularly for unstageable pressure injuries or suspected deep tissue injuries that are staged as a stage 3 or stage 4.

Hospital/Health Service-acquired pressure injuries are reviewed and recommendations reported and monitored in accordance with the NSW Health Policy Directive *Incident Management* (PD2020_047). When a pressure injury occurs or deteriorates to a more severe injury during an episode of care, the patient and/or carer are informed in accordance with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028).

Stage 3, stage 4, unstageable and suspected deep tissue pressure injuries which are hospital/health service-acquired are to have a clinician with expertise in wound management on the Incident Review Team, where possible.

Pre-existing pressure injuries do not require notification in the incident management system. These are to be documented in the medical record and wound chart.

7.2 Monitoring

Health services are to have systems in place to:

- Identify pressure injuries that develop during the episode of care
- Review pressure injury data regularly, at a minimum quarterly
- Ensure pressure injury data is communicated to the health service executive and those responsible for governance of clinical care
- Analyse pressure injury data to inform care, quality improvement activities and monitor progress.

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9 RELATED LITERATURE, DOCUMENTS AND RESOURCES

- NSW Procurement Guidelines
- NSW Health polices and guideline (i.e. incident management, nutrition care, open disclosure, infection control and workplace health and safety) can be found at: https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx
- Leading Better Value Care Standards for Wound Management September 2019 http://eih.health.nsw.gov.au/__data/assets/pdf_file/0010/558352/NSWHealth_Wound-Standards_September-2019.PDF
- Australian Commission on Safety and Quality in Health Care March 2018 https://www.safetyandquality.gov.au/sites/default/files/migrated/Pressure-injuryshort-clinician-fact-sheet.pdf

CARE TYPE POLICY FOR ACUTE, SUB-ACUTE AND NON-ACUTE AND MENTAL HEALTH ADMITTED PATIENT CARE (PD2016_039)

PD2016_039 rescinds PD2014_010

PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding. This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using the Australian Diagnosis Related Groups (AR-DRGs)
- Sub-Acute and Non-Acute care is classified using Australian National Subacute and Non-Acute (AN-SNAP) classification
- Mental health care is classified using the Australian Mental Health Care Classification.

This version of the Policy Directive introduces the mental health care type.

MANDATORY REQUIREMENTS

Local Health Districts (LHD) and Specialty Health Networks (SHN) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes so must the care type.

The care type to which the episode is allocated must always be evidenced by documentation in the patient health record.

IMPLEMENTATION

Chief Executives are required to ensure that:

- Staff responsible for entering care type changes are made aware of and gain an understanding of the provisions of this policy directive, and
- Relevant staff comply with this Policy Directive.

1 BACKGROUND

1.1 About this document

NSW Health Services have an obligation to count and classify activity in a meaningful and consistent manner. The Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care provides a framework to ensure assignment to and changes in care type occur appropriately and correctly. Implementation of this policy will contribute to ensuring that information reflecting the patient's episode of care is accurate and reflects the type of care provided to the patient.

In 2013 the Australian Institute of Health and Welfare (AIHW) developed a revised set of National care type definitions. This work was commissioned by the Independent Hospital Pricing Authority in order to achieve consistency in classification of admitted patient activity.

There are currently eleven (11) care types in use in New South Wales, they are:

- Acute Care
- Rehabilitation
- Palliative Care
- Maintenance Care
- Newborn Care
- Other Care (note: this category is included for completeness, but is not applicable for admitted patients in NSW. This care type generally applies to residential aged care patients only)
- Geriatric Evaluation and Management (GEM)
- Psycho-geriatric
- Organ Procurement
- Hospital Boarder
- Mental Health.

1.2 Key definitions

Care Type (previously known as 'service category')

Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care.

Care Type Change

An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient. For example, a patient who is receiving acute intervention for a stroke will have a care type change to rehabilitation if and when the main focus of care changes from acute management to functional improvement.

When the intensity of treatment or resource utilisation changes but the primary clinical purpose or treatment goal does not change, a care type change is *not* warranted.

A reduction in the intensity of acute care does not trigger a change to a sub-acute care type if the patient is not receiving care that meets the definition of a sub-acute care type. It is therefore essential that any care type change reflects a *clear change* in the primary clinical purpose or treatment goal of care provide.

With respect to the mental health care type, for 2016/17 a type change is to occur when a patient is transferred into or out of a specialist mental health unit. Transfers between specialist mental health units will not trigger a care type change.

All care type changes must be clearly documented.

The 11 Care Types are defined below. A full list of definitions is also provided at Appendix 2.

2 PURPOSE

'Care type' refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care.

Admitted patient care is provided in a variety of settings. The care type allocated to an episode of care is independent of the location of the patient, and reflects the primary clinical purpose of the care provided.

Correct assignment of care type for admitted patient episodes will ensure that each episode is classified appropriately for Activity Based Funding (ABF). This is vital as the classification used will also determine how the episode is reported, weighted, costed and funded:

- Acute care is classified using AR-DRGs
- Sub and Non-Acute care is classified using AN-SNAP.
- Mental Health care is classified using AR-DRGs(for 2016/17).

The care type to which the episode is allocated must be evidenced by documentation in the patient health record, i.e. if an episode is allocated to a rehabilitation care type, there must be evidence in the medical record that rehabilitation care, meeting the National Definition (refer below) is occurring.

The care type allocated *should not* reflect the care that is intended for the patient to receive at some time in the future when, for example, another service takes over care of the patient or when the patient is moved to a different ward.

3 INTENDED AUDIENCE

This policy applies to all staff responsible for the clinical care and / or admission details of patients at all facilities within NSW providing admitted patient care. This includes all medical, nursing, allied health staff and relevant administrative staff such as ward clerks, admission officers, admitted patient data co-ordinators, clinical coders and health information managers.

4 EXPECTED OUTCOMES

The expected outcomes are:

- The care type of all episodes in NSW Health facilities accurately reflects the care provided.
- Statistical information is accurate and timely.
- NSW Health submission requirements for the Admitted Patient Data Collection are met.
- NSW Health submission requirements for the AN-SNAP Data Collection are met.
- NSW Health submission requirements to the Activity Based Funding: Mental Health Care DSS are met.
- Data will be available to assist in ensuring facilities will receive appropriate funding for the care they provide.
- NSW Health submission requirements to the National Hospital Cost Data Collection (NHCDC) are met.

5 PURPOSE

Local Health Districts (LHDs) and Specialty Health Networks (SHNs) are responsible for accurately reporting the clinical activity within their facilities to the NSW Ministry of Health in order to meet State and Commonwealth reporting requirements.

In order to do so, clinical services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided.

When the clinical purpose or treatment goal changes, so must the care type.

6 NATIONAL CARE TYPE DEFINITIONS

6.1 Acute care type

Acute care type

The primary clinical purpose or treatment goal is to:

- Manage labour (obstetric)
- Cure illness or provide definitive treatment of injury
- Perform surgery (other than when the exceptions documented in the included guidelines apply)
- Relieve symptoms of illness or injury (excluding palliative care)
- Reduce severity of an illness or injury
- Perform diagnostic or therapeutic procedures, and / or
- Protect against exacerbation and / or complication of an illness and / or injury which could threaten life or normal function.

6.2 Rehabilitation care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition.

The patient will be capable of actively participating. Rehabilitation is always:

- Delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified time frames and formal assessment of functional ability.

6.2.1 Rehabilitation care guidelines

- When an acute patient is waiting for Rehabilitation, but Rehabilitation care has not yet commenced, a care type change to Rehabilitation cannot occur. The patient must remain in an acute care type until rehabilitation care begins. In some instances a care type change to maintenance may be warranted.
- If Rehabilitation is occurring on an acute ward, the Rehabilitation care type should be used, as care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example, the final 1-2 days after a joint replacement) is not necessarily a separate episode and should not trigger a care type change to rehabilitation. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of Rehabilitation (as stated above) is met, the care type remains acute.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day interventions, such as dialysis, during the course of a Rehabilitation episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the Rehabilitation episode of care.

6.3 Palliative care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and / or spiritual needs. Palliative care is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in palliative care, and
- Evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, which covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

6.3.1 Palliative care guidelines

- Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptom relief.
- Patients referred to the Emergency Department (ED) by a clinician for palliative care should have a care type of Palliative Care assigned from the ED time of admission.

6.4 Maintenance care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.
Following assessment or treatment, the patient does not require further complex assessment or stabilisation. Patients with a care type of 'maintenance care' often require care over an indefinite period.

6.4.1 Maintenance care guidelines

- Care provided to a patient, who would normally not require hospital treatment and would be more appropriately treated in another setting, which is unavailable in the short term, or where there are factors in the home environment making it inappropriate to discharge the patient in the short term. For example:
    - A patient requires home modifications in order to be safely discharged home. The modifications are not yet complete and therefore, although ready for discharge the patient cannot safely return home.
    - A patient requires nursing home placement and although ready for discharge a place is not yet available. The patient has a current acute care certificate.
- Nursing Home Type patients for whom there is no acute care certificate.
- Patients in receipt of care where the primary reason for admission is respite.

6.5 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the patient is separated.

6.5.1 Newborn care guidelines

- Patients who turn 10 days of age and require clinical care must continue in the newborn episode of care (that is "5 – Newborn") until separated. A type change to care type "1 – Acute" must not be performed.
- Patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- Patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type.
- Patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type.
- Within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- A newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status, see Appendix 2 for details
- Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such
- This care type can only ever be allocated at the time of admission. As a result, there can never be a care type change to 'Newborn'.

6.6 Other care

Other admitted patient care is care that does not meet the definitions above.

6.6.1 Other care guidelines

- This care type is included for completeness only; it is not applicable to admitted patients in NSW.
- The purpose of care type of 'Other' is to collect non-admitted activity reported via a patient administration system (PAS). This activity may include community residential care, and residential aged care covered by Commonwealth Block funding.
- Activity collected using this care type is excluded from any reporting of admitted patient care in NSW. This activity is used in cost allocation of residential services in the DNR (District and Network Return)

6.7 Geriatric Evaluation and Management (GEM)

Geriatric Evaluation and Management care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems. Geriatric Evaluation and Management is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability

6.7.1 Geriatric Evaluation and Management guidelines

- When an acute patient is waiting for GEM, but GEM care has not yet commenced, a care type change to GEM cannot occur. The patient must remain in an acute care type until GEM care begins. In some instances a care type change to maintenance may be warranted.
- If GEM is occurring on an acute ward, the GEM care type should be used, as the care type is independent of patient location.
- The period of recovery at the end of an acute episode prior to separation (for example the final 1-2 days after a joint replacement), is not necessarily a separate episode and should not trigger a care type change to GEM. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of 'GEM' (as stated above) is met, the care type remains acute.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- Patients who receive acute same day intervention(s) during the course of a GEM episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the GEM episode of care.

6.8 Psycho-geriatric

Psycho-geriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and / or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related brain impairment or a physical condition.

Psycho-geriatric care is always:

- Delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.
- Psycho-geriatric care is not applicable if the primary focus of care is acute symptom control.

6.9 Organ procurement – posthumous

Posthumous organ procurement is the procurement of human organ or tissue for the purpose of transplantation from a donor who has been declared brain dead.

6.9.1 Organ procurement care type guidelines

- Once clinical staff confirm and document brain death of the patient, a care type change to "Organ procurement – posthumous" must be performed. Date and time of the type change should be recorded as the date and time of documented death, not the date and time the organ or tissue harvest has been completed.
- The posthumous organ procurement care type is to be used for all posthumous organ procurement, irrespective of whether the deceased patient is kept in ICU for the preservation of organs that require oxygen (e.g., heart or lungs, etc.), or whether the deceased patient is transferred to the morgue to await the removal of other tissue (such as corneas, etc.).
- Patients in an Emergency Department (ED) who die in the ED or are dead on arrival do not meet the criteria for admission. However, such patients whose organs are to be procured are to be registered on PAS and be assigned an 'Organ procurement – posthumous' care type.
- All 'Organ procurement – posthumous' care type episodes are in scope of reporting to the Admitted Patient Data Collection, though the posthumous organ procurement component of the admitted patient stay may be excluded from the calculation of specific KPIs and other activity measures
- Diagnoses and procedures undertaken during this activity, including mechanical ventilation and organ procurement should be recorded in accordance with the relevant ICD-10-AM / ACHI Australian Coding Standards.

For more detail refer to the Admitted Patient Data Collection Intranet site.

6.10 Hospital boarder

A hospital boarder is a person who is receiving food and / or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and / or care. Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age nine days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified. Unqualified newborn days (and separations consisting entirely of unqualified newborn days) are not to be counted for all other purposes, and they are ineligible for health insurance benefit purposes.

6.11 Mental health care

Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and / or psychosocial, environmental and physical functioning related to a patient's mental disorder.

Mental health care:

- Is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health
- Is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan and
- May include significant psychosocial components, including family and carer support.

6.11.1 Mental health care guidelines

- This care type is to be initially used for patients treated within a specialised mental health inpatient unit only. Other factors such as diagnosis, DRG assignment or treating specialist (where the patient is not in a specialised mental health unit are not to be used as criteria in assigning this care type.
- This care type is to be introduced across all LHDs and SHNs by 30 June 2017. For the 2016/17 reporting year, it will be used at a point as negotiated by the LHD or SHN and the NSW Ministry of Health during the 2016/17 reporting year.
- Assignment of this care type occurs when a patient is admitted or transferred into a specialised mental health unit. Movements into or out of a specialised mental health unit from other inpatient units, where it reflects a change in the primary clinical purpose or treatment goal of the inpatient episode, will trigger a type change, **with the following exceptions**:
    - Patients within non-mental health units who are transferred into ECT suites for regular ECT and then returned to the non-mental health unit following the ECT procedure are not to be type changed to the mental health care type for the provision of the ECT.
    - Patients within specialised mental health units who are transferred for regular procedures like chemotherapy or renal dialysis, or who go to an operating theatre, and who are returned to the specialised mental health unit following the procedure are not to be type changed from the mental health care type for the provision of the procedure.
- At the point of introduction by the LHD, all existing patients within specialised mental health units are to be type changed to this care type. The date for the type change can be either:
    - The date of the introduction of the care type by the LHD, or
    - The date when the patient was admitted or transferred into the specialist mental health unit. Under this criterion, long standing patients who were in the mental health unit prior to 1 July 2016 are to be backdated to 1 July 2016 only.
    - Note that the decision of which date to use is to be made by the LHD / SHN, and must be applied consistently across the entire LHD / SHN, and not on a facility by facility basis.
- Movements between acute mental health units and non-acute mental health units (rehabilitation or extended care mental health units) do not trigger type changes. They are all to be categorised within this single care type.

7 PROCEDURE FOR ASSIGNING CARE TYPES

7.1 Care type assignment upon admission

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. For example if a patient is primarily receiving acute care and an in-reach rehabilitation team is also involved with the patient, the care type will be acute. When the focus of care provided to the patient shifts to functional improvement, the care type should be changed to rehabilitation at the point this shift in focus occurs.

The care type is assigned by the clinician responsible for the management of the care, based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for the management of the care.

For the mental health care type, the clinical judgement as to the primary purpose of the care forms part of the clinician's decision to admit a patient into the specialised mental health inpatient unit.

At the time of sub-acute care type assignment, a multidisciplinary management plan may not be in place but the intention to prepare one should be known by the clinician assigning the care type.

The clinician determining the appropriate care type to be assigned must ensure that clear documentation of the care type is recorded in the medical record. The clinician determining the appropriate care type to be assigned (or other authorised clinician) must ensure that the ward clerk (or staff member responsible for updating the Patient Administration System (PAS)) is informed of the care type decision.

The ward clerk (or staff member responsible for updating PAS) ensures the correct care type is assigned within the PAS.

7.2 Care type change during the admission event

During an admission or stay the primary clinical purpose or treatment goal of care may change. When this occurs, the care type also changes. It is essential that any change in care type is supported by documentation reflecting the change in purpose and goal of care.
Responsibility for the decision to change care type ultimately rests with the senior medical officer but may be delegated to other senior members of the clinical team. The process of care type change generally occurs as follows:

- Clinical staff assesses the patient, their clinical status and treatment needs and then determine the clinical purpose and goals of treatment. If the current care type accurately reflects the treatment goals and focus of care, no further action is required.
- If the current care type for the episode no longer reflects the clinical purpose and goals of treatment and the care provided fits the definition of another care type, then a care type change is warranted.
- The new care type is determined by the clinician who is taking over responsibility for the management of the care of the patient at the time of transfer. (Note, in some circumstances the patient may continue to be under the management of the same clinician).
- Two methods of initiating and informing the change to be made on the PAS are suggested, either:
    - On a form, or
    - In the healthcare record as a handwritten entry / label / stamp.

  Local processes will determine which method is most suitable. Regardless of the method used, the medical officer must ensure that clear documentation of the care type is recorded in the medical record.
  Documentation must include the following information:
    - When a separate form rather than a notation or sticker in the record is used, the MRN and patient name must be noted on the form
    - Date Effective: indicate the actual date the care type change is effective
    - Time Effective: indicate the actual time the care type change is effective
    - Indicate the new care type
    - If there is an AMO change, document the new AMO and their specialty.
- The receiving or primary clinician must authorise the care type change by signing the documentation.
- The receiving or primary clinician must ensure that the ward clerk (or staff member responsible for updating PAS) is informed that the care type change has occurred.

- The ward clerk (or staff member responsible for updating the PAS), updates the care type in PAS, along with any other relevant information that may have changed such as ward or AMO. It is important that the date of change recorded in PAS matches the actual date and time of the care type change.

7.2.1 Additional guidelines for care type change during admission

- A care type change or admission under a sub-acute or non-acute care type may trigger collection of the AN-SNAP data variables.
- Where AN-SNAP data is collected, care must be taken to ensure reconciliation of care type and care type change dates between SYNAPTIX and the PAS.
- The clinician responsible for the management of care may not necessarily be located in the same facility as the patient. This may be the case when a 'hub and spoke' model of care is in place. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.
- A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and / or carers.
- It is highly unlikely that, for care type changes involving sub-acute care types, more than one change in care type will take place within a 24 hour period. Changes involving sub-acute care types are unlikely to occur on the date of formal separation.
- Patients who receive acute same day intervention(s) during the course of a sub-acute or non-acute episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the sub-acute or non-acute episode of care.
- Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.
- All care type changes must be updated on the PAS at the time of (or as close to) the care type change.
- An Acute Care Certificate should not influence the classification of a patient to a particular care type. Patients may have an Acute Care Certificate and be classified as other than "1 – Acute".
- The completion of an Aged Care Client Record (ACCR) form should not influence the classification of a patient. For example patients may not have an ACCR form completed but the episode can still be care type 'Maintenance'
- Regular training sessions for ward and clinical staff should be conducted to ensure that reviewing patient care types becomes part of daily ward routine.

7.3 Retrospective care type changes not identified during the admission event

The care type should not be retrospectively changed unless it is:

- For the correction of a data recording error, or
- The reason for change is clearly documented in the patient's medical record and it has been approved by the hospital's director of clinical services or delegated officer, or
- As a result of the introduction of a new care type which can apply retrospectively.

It is the responsibility of the staff member identifying the retrospective care type change to ensure that the care type change details have been updated in the patient administration system and to notify staff responsible for patient movement reconciliation processes.

Appendix 1 contains a number of care type change scenarios.

8 REFERENCES AND RELATED POLICIES

- Inter-Government and Funding Strategies Branch (2008), *PD2008_063 Episode Funding Policy 2008/2009 – NSW*, NSW Health
- Admitted Patient Data Dictionary (2009), *Service Category*, NSW Health
- Casemix Policy Unit (2005), NSW SNAP Data Collection: Data Dictionary v 3.0, NSW Health
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- National care type definitions: http://meteor.aihw.gov.au/content/index.phtml/itemId/491557

9 LIST OF ATTACHMENTS

1. Appendix 1: Care type change scenarios

2. Appendix 2: Definitions of terms

Appendix 1: Care Type Change Scenarios

Temporary Care Type Escalation

(a) Overnight

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, he falls out of bed and sustains a fractured neck of femur. The patient is transferred to Orthopaedic surgery for surgical management of the fracture. He remains in the Orthopaedics unit for two days and is transferred back to Rehabilitation on 13/01/11. The patient is discharged from hospital on 30/01/11.*

The care type should be updated on the PAS to reflect the change in the primary clinical purpose of care provided to the patient from rehabilitation to acute care.

The care type was changed in this scenario because the patient had a clear change in primary clinical purpose or treatment goal.

Episode Date Range	Care Type
01/01/11 – 10/01/11	Rehabilitation
10/01/11 – 13/01/11	Acute
13/01/11 – 30/01/11	Rehabilitation

(b) Same Day

***Example**: A patient is admitted to Rehabilitation on 01/01/11 for management of a brain injury. On 10/01/11, the patient is admitted to Neurosurgery for a burr hole procedure, and is transferred back to Rehabilitation on the same day. The patient is discharged on 30/01/11.* The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/01/11 – 30/01/11	Rehabilitation

(c) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 01/02/12. In order to better manage her pain, the patient is taken to theatres for insertion of an intrathecal catheter on 10/02/12. The patient is transferred back to palliative care on the same day. The patient dies on 03/03/12.*

The care type is not changed, however the procedure is coded at the conclusion of the episode.

Episode Date Range	Care Type
01/02/12 – 03/03/12	Palliative Care

(d) Surgical Interventions for a Palliative Care Patient

***Example**: A patient commences palliative care on 10/04/12. During the course of the palliative episode exacerbation of acute renal failure necessitated immediate transfer to the surgical ward. To provide acute care for the management of the renal failure ureteral stenting is performed on 10/05/12 with the patient remaining in acute post surgical care overnight. As the need for acute management subsides the patient is transferred back to the palliative care unit on 11/05/12 for ongoing palliative care management. The patient is discharged on 03/06/12.*

In this example, the care type is changed as the focus of care in the surgical ward was to deal with the management of an acute condition.

Episode Date Range	Care Type
10/04/12 – 10/05/12	Palliative Care
10/05/12 – 11/05/12	Acute care
11/05/12 – 03/06/12	Palliative Care

9.1 Change in Intensity of Care

(a) Post-surgical allied health intervention

***Example**: A 70 year-old female patient is admitted to the acute cardiothoracic surgery inpatient unit on 01/01/11 for Coronary Artery Bypass Graft. Following surgery, the patient goes to HDU for five days for monitoring due to her rapid atrial fibrillation and hypertension. The patient then returns to the cardiothoracic surgery ward for ongoing management, concurrently she receives physiotherapy in preparation for discharge, due to post-acute de-conditioning. The patient is discharged on 07/01/11.*

The provision of physiotherapy does not on its own meet the definition of Rehabilitation. Therefore, the patient remains in the Acute care type as there has not been a clear documented change in the primary clinical purpose or treatment goal.

The care type was not changed in this scenario because the primary clinical purpose tor treatment goal of the episode did not change.

Episode Date Range	Care Type
01/01/11 – 07/01/11	Acute

9.2 Care Type Change due to Change in Focus of Care

(a) GEM

***Example**: An 80 year-old female patient is admitted to Neurosurgery on 01/01/11 for management of a cerebral aneurysm. Following surgery, the patient experiences left-sided weakness and moderate cognitive difficulties. The patient is referred for an Aged Care consult on 05/01/11. The Aged Care consult is completed on 06/01/11. The patient is accepted for Aged Care, however no beds are*

currently available and no intervention to facilitate functional improvement is provided. On 10/01/11 an Aged Care bed becomes available and the patient is transferred. Whilst in the Aged Care Unit, the patient receives interventions to increase her functional independence, ongoing monitoring of her medical condition and assistance to find supported accommodation. These interventions constitute a change of focus of care to GEM. The patient is discharged from Aged Care on 30/01/11.

The care type was changed in this scenario on 10/01/11 because this is when GEM care commenced. Although the patient was identified as an appropriate GEM candidate on the 06/01/11 the care received did not change until the 10/01/11.The patient should remain as an acute patient for the period of time during which they are waiting

Episode Date Range	Care Type
01/01/11 – 10/01/11	Acute
10/01/11 – 30/01/11	Geriatric Evaluation and Management (GEM)

(b) Maintenance

Example*: A 95 year-old female patient is admitted via ED on 26/02/11 for treatment of fractured vertebrae. The patient is transferred to the Aged Care ward on 28/02/11. The patient has a history of falls, lower limb weakness, hypertension and diabetes. During the admission, the patient receives a bone scan, CT scan head and pelvis, and lower limb Doppler ultrasound. During this period of evaluation the patient concurrently receives multidisciplinary interventions aimed at improving her functional status and preparing her for discharge. On 14/03/11 the team determine that the patient will not benefit from Rehabilitation, is unable to return home and will require placement. Interventions are provided to maintain the patient's current functional status whist placement is organised. The patient is discharged to a nursing home on 21/03/11.*

The maintenance care type was used in this example as the patient was no longer receiving acute interventions and was awaiting placement.

Episode Date Range	Care Type
26/02/11 – 14/03/11	Acute
14/03/11 – 21/03/11	Maintenance

(c) Rural patient

Example*: A 75 year-old patient is admitted by their GP to a small rural hospital on 1/9/12 with severe influenza. The patient has co-morbidities of diabetes and cardiovascular disease. The patient receives acute interventions to manage their illness. As they recover, it is evident that they are significantly de-conditioned and are unable to be discharged at their current functional level. The nursing staff request a consult by a visiting Physiotherapist and Occupational Therapist. The allied health staff complete their assessments on 18/9/12, including a formal functional assessment. In conjunction with the patient's GP, a clinician with extensive experience caring for older people with functional impairments, the therapists prescribe a rehabilitation plan that will be carried out jointly by the nursing staff and the therapists on the days that they attend the hospital. This rehabilitation plan includes treatment goals. Regular review of the plan and the patient's functional status is carried out. The patient is discharged home on 5/10/12*

Episode Date Range	Care Type
01/09/12 – 18/09/12	Acute
18/09/12 – 05/10/12	Rehabilitation

Mental Health

(a) Patients treated only within one or more specialised mental health unit(s) for the entire stay

Example*: A patient is transferred from the ED to an associated PECC unit on 01/07/2016. On 03/07/2016, the patient is transferred to an acute mental health specialist unit. They remain there until 17/07/2016 when they are transferred to a mental health rehabilitation unit. They remain there until their discharge on 31/08/2016.*

All care delivered within specialised mental health units, regardless of the intended clinical focus of the unit, is to be categorised under one care type, and thus treated as a single admission.

Episode Date Range	Care Type
01/07/16 – 31/08/16	Mental Health

(b) Patients treated across a number of units, including a specialised mental health unit

Example 1*: A patient is admitted on 21/07/2016 to an orthopaedic unit for a planned total hip replacement. After surgery on 22/07/2016, the patient returns to the orthopaedic unit. On 30/07/2016, the patient's co-morbid schizophrenia deteriorates and a decision is made to transfer the patient to the acute mental health unit. The patient remains there until 16/08/2016 when they develop pneumonia. The patient is transferred to a respiratory unit to manage the pneumonia. They remain there until 27/09/2016 when they are discharged.*

Any ongoing or continuous care that is delivered within a specialised mental health unit triggers a type change if they are transferred from another inpatient unit. Likewise, if the patient is transferred from a specialised mental health unit to another unit for ongoing or continuous care, this will also trigger a type change.

Episode Date Range	Care Type
21/07/16 – 30/07/16	Acute
30/07/16 – 16/08/16	Mental Health
16/08/16 – 27/09/16	Acute

Example 2*: A patient is admitted to a specialist acute mental health inpatient unit on 01/08/2016. On 29/09/2016, the patient is treated for their planned cataract surgery. The patient is transferred to the ophthalmology unit after the surgery, where they remain until the 30/09/2016. They are then transferred back to the mental health rehabilitation unit and remain there until their discharge on 22/03/2017.*

Any ongoing or continuous care that is delivered outside a specialised mental health unit triggers a type change if they are transferred from a specialised mental health unit and they are not returned directly back to the specialised mental health unit following treatment.

Episode Date Range	Care Type
01/08/16 – 29/09/16	Mental Health
29/09/16 – 30/09/16	Acute
30/09/16 – 22/03/17	Mental Health

(c) Patients treated for ongoing chronic conditions whilst admitted within a specialised mental health unit

Example*: A patient is admitted on 31/07/2016 to an acute mental health inpatient unit, and they are discharged on 17/11/2016. During the period of treatment within the specialised mental health unit, they receive twice weekly dialysis, for which the patient is moved to the renal dialysis unit to receive the treatment, following which they are returned to the specialised mental health unit.*

Any non-mental health procedure that is provided to a patient who is currently in a specialised mental health unit will not trigger a type change if the patient is returned directly to the specialised mental health unit after the procedure is complete.

Episode Date Range	Care Type
31/07/16 – 17/11/16	Mental Health

(d) Patients with mental health conditions but not treated within a specialised mental health unit

Example 1*: A patient is admitted on 03/08/2016 for a delivery of a newborn. On 07/08/2016, she develops post-natal depression for which she is treated in the maternity ward by a specialist mental health team via consultation liaison. She is discharged on 15/08/2016.*

Any mental health care that is not delivered within a specialised mental health unit, regardless of the diagnosis or the treating specialty, is not to be categorised under the mental health care type.

Episode Date Range	Care Type
03/08/16 – 15/08/16	Acute

Example 2*: A patient is admitted on 05/10/2016 for treatment of a perforated gastric ulcer, and is discharged on 01/11/2016. During the admission, the patient continues to receive weekly ECT treatment, which is conducted in the ECT suite. After each ECT procedure is completed, the patient is returned to the gastroenterology unit.*

Any care that does not result in a continuous period of treatment in a specialised mental health unit is not to be type changed and categorised under the mental health care type. This includes where a patient is receiving individual courses of treatment in a specialised mental health treatment facility that sees them return directly to the non-mental health inpatient unit once the treatment or procedure is completed.

Episode Date Range	Care Type
05/10/16 – 01/11/16	Acute

(e) Existing patients treated within a specialised mental health unit

Example*: A patient is admitted to a specialist acute mental health unit on 12/02/2016. On 16/03/2016, the patient is transferred to a specialist rehabilitation mental health unit. On 15/06/16 the patient is transferred to a respiratory unit for treatment of the patient's acute exacerbation of their COPD. They return to the specialist mental health rehabilitation unit on 19/07/16. On 15/08/2016, the facility introduces the mental health care type, and decides to backdate the care type introduction to the beginning of the financial year. The patient is discharged from the facility on 12/12/2016.*

For 2016/17, the assignment of the mental health care type for existing patients can be dated to either the date the care type is introduced, or if the LHD wishes to backdate the introduction of the care type, the date is to be either the date the patient was last transferred into the specialist mental health unit, or to the 1st of July 2016 if the continuous period in the specialist mental health unit began before 01/07/2016.

Episode Date Range	Care Type
12/02/16 – 16/03/16	Acute
16/03/16 – 15/06/16	Rehabilitation
15/06/16 – 19/07/16	Acute
19/07/16 – 12/12/16	Mental Health

Same Day Acute Procedures in Sub Acute Care

(a) Dialysis

Example*: A rehabilitation patient (from 01/03/11 to 13/03/11) receives haemodialysis twice a week. They receive haemodialysis and return to the rehabilitation ward on the same day.*

Although dialysis is a high cost and high volume service, national care type definitions state that same day acute interventions or procedures provided to an admitted patient in a sub or non-acute care type do not warrant a change in care type. The provision of dialysis should be captured as a procedure code during coding.

Episode Date Range	Care Type
01/03/11 – 13/03/11	Rehabilitation

(b) Chemotherapy/radiotherapy during a Palliative Care Episode

Example*: A Palliative Care patient (from 01/03/11 to 10/03/11) receives radiotherapy to assist with symptom management.*

There is no care type change in this scenario as the provision of radiotherapy or chemotherapy for symptom management meets the definition of palliative care and does not constitute a change in the focus of care.

Episode Date Range	Care Type
01/03/11 – 31/03/11	Palliative Care

(c) Non Weight Bearing Scenarios

Example 1*: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically stable, their wound is healing well and they do not require any ongoing acute interventions. The patient is referred to the rehabilitation service on 10/08/12, where the patient is assessed. The rehab team determine that the patient would benefit from interventions to increase their independence in sliding transfers, wheelchair mobility and self care. The patient participates in a modified rehabilitation programme until they are cleared for weight bearing by the orthopaedic surgeon. Once able to resume weight bearing the patient receives ongoing rehab for a further 3 weeks. They are discharged home on 17/10/12.

Episode Date Range	Care Type
31/07/12 – 10/08/12	Acute Care
10/08/12 – 17/10/12	Rehabilitation

Example 2*: A patient is admitted to hospital following a fall on 31/07/12 and has hip surgery on 01/08/12. After the surgery, the patient is transferred to the orthopaedic ward. The patient experiences post-surgical complications and on 05/08/12 the orthopaedic surgeon advises that the patient is to be non-weight bearing for a period of 6 weeks.*

The patient is medically unstable, experiencing intermittent chest pain and issues related to wound healing. They receive ongoing monitoring and care related to these medical issues. The patient is referred to the rehab service for assessment. The rehab team determine that the patient is not currently suitable for a rehabilitation program. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are appropriate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 14/09/12	Acute Care
14/09/12 – 07/10/12	Rehabilitation

Example 3*: A patient is admitted to hospital following a fall on 31/7/2012 and has hip surgery on 1/8/2012. After the surgery the patient is transferred to the orthopaedic ward. The patient experiences post surgical complications and on 5/8/2012 the orthopaedic surgeon advises that the patient is to be non weight bearing for a period of 6 weeks.*

The patient is medically stable. The patient is referred to the rehab service for assessment. On 06/08/12 the rehab team determine that the patient is not currently suitable for a rehab program. The patient is unable to be discharged home due to access and safety issues. The patient is transferred to a medical ward and receives ongoing minimal nursing care and occasional physiotherapy to maintain current physical status. On 12/09/12 the orthopaedic surgeon reviews the patient and clears them for weight bearing. The rehab team reviews the patient on 13/09/12 and determines that they are now an appropriate candidate for rehab. The patient commences rehab on 14/09/12. They are discharged home on 17/10/12.

Episode Date Range	Care type
31/07/12 – 06/08/12	Acute Care
06/08/12 – 14/09/12	Maintenance
14/09/12 – 17/10/12	Rehabilitation

Appendix 2: Definitions of Terms

Acute Care Certificate	After 35 days of hospitalisation, private and DVA patients in need of ongoing acute or sub-acute care must have an Acute Care Certificate completed by the registered doctor caring for them. The Acute Care Certificate is valid for a period of up to 30 days, after which a new certificate will need to be issued if the patient is still undergoing acute / subacute care in hospital. If an Acute Care Certificate cannot be issued by the treating doctor, a type change to Maintenance Care is required. The financial class must be reclassified to nursing home type and the appropriate charges to the patient must be organised. Note: For policy details regarding Acute Care Certificates see the *Public Fees Procedures Manual for Public Health Organisations* (Sections 2.56 to 2.67, as amended from time to time) and Policy Directive PD2016_011 *Nursing Home Type Patients and the National Acute Care Certificate*
AMO	Attending Medical Officer: the medical officer / senior clinician (a visiting medical practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted. May also be referred to as *Admitting Medical Officer*.
Other Authorised Clinician	Clinical staff authorised by the AMO to be responsible for care type changes e.g. Registrar, Resident Medical Officer, Junior Medical Officer, Nursing Unit Manager or senior nursing staff.
APDC	Admitted Patient Data Collection: the framework for mandatory data reporting for all admitted patients within New South Wales.
Clinical Coding	Clinical Coding involves abstracting disease and procedure information from the medical record and then assigning codes using the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI). The process of Clinical Coding is performed by Clinical Coders.
Clinician	Medical, nursing and allied health staff involved in patient care

AR-DRGs	Australian Refined-Diagnosis Related Groups are the classification tool allocated to acute inpatients. DRGs are used to fund inpatient episodes of care for acute care.
Episode of Care	The period of admitted patient care between a formal or statistical admission and a formal or statistical discharge, characterised by one care type. (Refer *National Health Data Dictionary*)
Nursing Home Type Patient (NHTP)	A nursing home type patient is a patient who has been in one or more approved hospitals (public or private) for a continuous period of more than 35 days, without a break of seven days, and who is not deemed to be receiving acute care. After 35 days, the patient will be reclassified as a NHTP unless an Acute Care Certificate is issued by a medical practitioner to certify that the patient requires acute care. An Acute Care Certificate may be reissued every 30 days thereafter, for as long as the patient requires acute care. In the event of readmission to a hospital within 7 days (or transfer between hospital), the previous related inpatient periods will be regarded as contributing towards the period of 35 days hospitalisation. The periods of leave themselves are not counted towards the 35 day qualifying period. Hence, a patient who has been in hospital for 20 days and then leaves the hospital for 3 days, will start at day 21 when returning to hospital. However, where a patient is discharged and a period of more than 7 days elapses before readmission, the previous stay in hospital will not be counted. The date of discharge is not to be counted as one of the 7 days; seven days commences from the day after discharge or on leave. The nursing home type patient arrangement does not apply to Third Party, Workers' Compensation and other compensable patients, or patients who are ineligible under Medicare. For compensable patients, Acute Care Certificates should be issued where appropriate in case the patient's compensation claim is rejected.
PAS	Patient Administration System
Care Type (Previously known as 'service category')	Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care), as represented by a code. The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care. Reference:http://meteor.aihw.gov.au/content/index.phtml/itemId/491557
Care Type Change	An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient
AN-SNAP	Australian National Sub-Acute and Non-Acute Patient Classification: the framework for mandatory data reporting for all sub-acute and non-acute episodes within New South Wales designated services.
Stay	The period of admitted patient care between a formal admission and a formal discharge which comprises one or more episodes of care. Refer also 'Care Type Change'
Type Change	See 'Care Type Change'. This terminology is interchangeable with the term Care Type Change.

Newborn Qualification Status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is 'qualified' if the infant meets at least one of the following criteria: • Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, or • Is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, or • Is admitted to, or remains in hospital without its mother. A newborn patient day is 'unqualified' if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day. Reference: http://meteor.aihw.gov.au/content/index.phtml/itemId/327254

NSW PATIENT SAFETY AND CLINICAL QUALITY PROGRAM (PD2005_608)

New South Wales is recognised nationally and internationally, as a leader in improving the quality and safety of clinical services provided to patients.

The NSW Patient Safety and Clinical Quality Program provides the framework for significant improvements to clinical quality in our public health system. Success depends on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

In a system as large and complex as the NSW public health system, it is unrealistic to expect that no mistakes will occur, and our aim is to develop a system that continually strives for ongoing improvement - where lessons are learnt from mistakes and are communicated to other health services.

The Government has invested $55 million in improving frontline clinical care through the NSW Patient Safety and Clinical Quality Program. The Program is ambitious and sets the agenda for one of Australia's most comprehensive clinical quality programs, ensuring patient safety and excellence in healthcare is the top priority for the NSW health system.

The key components of the program are:
- Systematic management of incidents and risks
- A new Incident Information Management System
- Clinical Governance Units in each Area Health Service
- A Quality Assessment Program for all public health organisations
- The establishment of the Clinical Excellence Commission.

These initiatives are designed to support clinicians and managers with improving quality and safety for patients and will focus on promoting and providing the delivery of the best care in health services. Key to the success of the program is the active involvement of doctors, nurses, allied health professionals, health managers and our community.

With this level of commitment, the result will be a more consistent approach to high quality patient care and people in NSW will continue to enjoy access to one of the best health systems in the world.

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Diagram 1:
NSW Patient Safety and Clinical Quality Program flowchart

1. Introduction

There is a growing body of international and Australian knowledge that has contributed to the evolving concept of quality improvement in healthcare.

Borrowing from other high-risk industries where safety is paramount, the health industry is developing techniques to better identify risks, investigate and analyse incidents and to improve practice. These techniques allow health services to manage known risks actively and to develop systems to identify new or emerging risks.

In healthcare, as in any industry, sometimes things go wrong. Equipment can fail, systems can prove inadequate and errors of judgment are made. In relatively few cases, serious incidents occur that might have been prevented and some of these result in serious harm to patients. The majority of these incidents are not the result of a single action by an individual but, more commonly, are generated by a chain of events.

Preventing error depends on identifying the deficiencies in the sequence of events and fixing any identified problems. It is crucial to capture all the relevant information about an incident, investigate all known causes and to take decisive action to protect patients from a recurrence of that kind of event.

The aim of the NSW Patient Safety and Clinical Quality Program is that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system. This shift in thinking about how we deal with error, combined with the rollout of a new system for electronic reporting of incidents, will lead to an increasing number of events being reported. Somewhat paradoxically, a rising number of events reported will be one measure of success for the program.

This first year of the program lays the groundwork for what is potentially one of the greatest ever systemic improvements to clinical quality in our public health system. Future success will depend on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

Everyone working in the health system is encouraged to contribute their knowledge of how and when mistakes are made in this constructive spirit, free of anxiety that the response will be unnecessarily punitive. The lessons from each localised incident can then be used to inform safety improvements in every health facility throughout NSW.

2. Key Components

The NSW Patient Safety and Clinical Quality Program has five key components:

1. The systematic management of incidents and risks both locally and statewide to identify remedial action and systemic reforms.
2. The Incident Information Management System (IIMS) to facilitate the timely notification of incidents, track the investigation and analysis of health care incidents, enable the reporting about incidents, particularly the provision of trended information by incident type, and to understand the lessons learned.
3. The establishment of Clinical Governance Units (CGU) in each Area Health Service (AHS) to implement the NSW Patient Safety and Clinical Quality Program.

4. The development of a Quality Systems Assessment (QSA) Program for all public health organisations undertaken by an external agency, to determine whether the above components are in place and working well. The focus of the assessments is on AHS patient safety and clinical quality systems.
5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and to advise the Minister for Health on where systemic improvements can be made.

3. Guiding Principles

The NSW Patient Safety and Clinical Quality Program is underpinned by guiding principles:

1. **Openness about failures** - errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why.
2. **Emphasis on learning** - the system is oriented towards learning from its mistakes and extensively employs improvement methods for this.
3. **Obligation to act** - the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit.
4. **Accountability** - the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions.
5. **Just culture** - individuals are treated fairly and are not blamed for the failures of the system.
6. **Appropriate prioritisation of action** - action to address problems is prioritised according to the available resources and directed to those areas where the greatest improvements are possible.
7. **Teamwork** - teamwork is recognised as the best defence against system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

4. Patient Expectations

As a patient admitted to a hospital or requiring treatment from a health service what might you reasonably expect?

1. Appropriate treatment for my condition when I need it.
2. The best possible care at all times, based on the latest evidence.
3. To be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals who are providing care to me.
4. To be looked after by clinicians who have the necessary clinical skills for the work that they do.
5. Those who provide care to me are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work.
6. Systems are designed to prevent inadvertent or accidental harm to me while in hospital.
7. If I have concerns, I will be able to talk to someone immediately and have my concerns addressed to my satisfaction.
8. If something goes wrong with my care, that there is a system in place to openly report, investigate and fix the underlying problems so that others are not harmed. In addition, I will be told openly and honestly what went wrong and receive an apology.
9. Reassurance that there is an external body evaluating the safety of care in hospitals and working to improve quality and safety in the NSW health system.

Patient expectations have been incorporated into standards and performance measures developed to monitor the effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program.

5. Roles and Responsibilities

NSW Department of Health

The NSW Department of Health is established under section 6 of the *Health Administration Act 1982* and supports the Minister in performing his statutory functions including responsibility for patient safety and clinical quality in the NSW health system. The Quality and Safety Branch is responsible for the development of the essential components of the NSW Patient Safety and Clinical Quality Program with lead responsibility for:

- Setting standards for Area Health Service Quality Systems
- Developing policies on quality and safety that need statewide implementation
- Developing and reporting on system wide quality indicators
- Monitoring and analysing serious clinical incidents, and taking appropriate action such as advice and warnings to the health system
- Overseeing statewide clinical governance issues
- Overseeing consistent implementation of the NSW Patient Safety and Clinical Quality Program.

Area Health Services

Area Health Services (AHS) and all Public Health Organisations (PHO) are responsible for the quality and safety of the services provided by their facilities, staff and contractors. With the recent implementation of the health reforms, clinical governance has been embedded in the new AHS through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) directly reporting to the Chief Executive (CE). These Units are responsible for the rollout of the NSW Patient Safety and Clinical Quality Program within their AHS.

Clinical Governance Units

The Clinical Governance Units (CGU) have the roles of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the program by ensuring it is uniformly implemented across the state and for overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation systems.

The Clinical Excellence Commission

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the *Health Services Act* by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program, and builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. The core mission of the CEC is to identify issues of a systemic nature that affect patient safety and clinical quality in the NSW health system and to develop and advise on implementation strategies to address these issues. Part of the role of the CEC is to acquire and share information about how well the NSW health system is performing and to use this information to improve the performance of the system.

The CEC has a statewide research oversight, monitoring, education and advisory role. It is not directly responsible for the implementation of the NSW Patient Safety and Clinical Quality Program.

6. Policy and standards

The NSW Patient Safety and Clinical Quality Program lists standards that Area Health Services are required to comply with. This builds upon existing frameworks, programs and initiatives currently well established in all Area Health Services. The Program is based on standards against which a health service's quality system will be assessed.

These standards are derived from existing Departmental policies and guidelines that are familiar to health service staff, administrators and clinicians.

Governance responsibility for identifying patient safety risks and undertaking remedial action is vested in Area Health Services and public health organisations and it is their responsibility to undertake activity to address the standards mandated by the Department.

Standards

Standard 1
Health services have systems in place to monitor and review patient safety.

Standard 2
Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Standard 3
An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Standard 4
Complaints management systems are in place and complaint information is used to improve patient care.

Standard 5
Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Standard 6
Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Standard 7
Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

STANDARD 1

Health services have systems in place to monitor and review patient safety.

Components

Committee Structure

The Area Heath Service has clearly articulated its commitment to quality improvement and patient safety and has an effective committee structure that oversees quality improvement and patient safety.

Clinical Governance Unit

The Area Health Service has established a Clinical Governance Unit responsible for managing patient safety and clinical quality and has developed an operational plan consistent with Departmental directives. NSW Clinical Governance Directions Statement, issued 2005.

Establishing Clinical Indicators and Performance Information

The Area Heath Service monitors and analyses performance information on quality and patient safety using performance measures and clinical indicators included in strategic planning and business documents.

Monitoring and Reporting Performance Information

The Area Heath Service monitors, analyses and compares performance information on quality and patient safety reported to Area executive and Advisory Council and strives to compete with the best performing facilities. PD2014_004 Incident Management Policy.

Using Performance Information to Improve Patient Care

Performance information is used by Area executive to evaluate and improve safety and patient care and to develop strategies to reduce clinical and patient safety risks. PD2014_004 Incident Management Policy.

Public Awareness of Quality and Safety

The Area Health Service publicly reports information on patient safety activities and outcomes.

Patient Safety Performance

Health services perform to desired levels against targets for patient safety and performance is improving.

STANDARD 2

Health services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Components

Minimum Requirements

The Area Health Services develop, implement and review patient safety policies and protocols for incident management, complaint management, complaints or concerns about clinicians, new interventions and correct patient/site/procedure.

Implementation

Systems are in place to effectively disseminate, implement, review and update new policies and procedures on patient safety to health facilities in the Area, including Departmental directives and safety alerts. NSW Clinical Governance Directions Statement, 2005.

Detailed Policy Review - New Interventions

The Area policy on new interventions is consistent with Departmental guidelines and risk assessments are undertaken before new procedures are introduced. An implementation plan is prepared for each new procedure introduced by the Area.

Detailed policy review - correct patient/site/procedure (Note: does not apply to the Ambulance Service)

Health Services have developed an implementation plan to ensure all procedural teams comply with PD2014_036 Clinical Procedure Safety.

Policy Directives and Related Documents

PD2006_007 - Complaint or Concern about a Clinician - Principles for Action
PD2006_073 - Complaint Management Policy
GL2006_002 - Complaint or Concern about a Clinician - Management Guidelines
GL2006_023 - Complaint Management Guidelines
PD2014_004 - Incident Management Policy
PD2014_036 – Clinical Procedure Safety.

STANDARD 3

An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Components

Notifying and Assessing Incidents

The Area Health Service supports a culture that facilitates incident reporting, the use of systems to notify and record incidents using the Severity Assessment Code (SAC) matrix to identify matters requiring investigation, and ensures incident reports are forwarded to relevant authorities within the required timeframe.

Investigating Incidents

High-risk incidents are investigated in accordance with Departmental guidelines by a multidisciplinary team nominated by the Area executive in a timely manner to analyse the incident, and to recommend key actions to minimise the risk of recurrence.

Implementing Recommendations

Recommendations arising from investigations are implemented in health facilities to improve patient safety. Incident data is monitored and analysed to detect trends and determine whether system-wide improvements are needed. Feedback on the outcome of investigations is provided to the Root Cause Analysis (RCA) team and the person who reported the incident (where identified) and feedback is provided to staff on policy and procedural changes.

Incidents Involving the Death of a Patient

Systems are in place to monitor deaths and determine whether changes in practice are needed to improve patient care. PD2014_004 Incident Management Policy.

STANDARD 4

Complaints management systems are in place and complaint information is used to improve patient care.

Components

Complaint Monitoring and Review

Responsibility for the timely management of complaints and feedback on the outcome of investigations to complainants is assigned appropriately and systems are in place to record, monitor and review complaints.

Systems Improvement

Complaint data are monitored, analysed to identify trends and to determine whether system-wide improvement is needed to prevent recurrence. Processes are in place to address the systems issues identified by complaints, to implement recommendations by health facilities and to ensure complaints information is reported to Departmental and other relevant authorities.

Management of Complaints or Concerns About Individuals

Complaints or concerns against individuals are dealt with according to Departmental policy and within relevant timeframes. PD2006_073 Complaint Management Policy and GL2006_023 Complaint Management Guidelines. PD2006_007 - Complaint or Concern about a Clinician - Principles for Action. GL2006_002 - Complaint or Concern about a Clinician - Management Guidelines

STANDARD 5

Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Components

Health services have developed an appropriate system of chart review.

Systems Improvement

The results and recommendations of chart reviews and investigations are reported to management/ Area executive and staff, and the recommendations are implemented to effect system improvement.

STANDARD 6

Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Components

Performance Review Process

Health services have developed an appropriate system of performance review and meetings where clinical management issues are adequately discussed and improvement action identified and documented.

PD2012_028 - Recruitment & Selection of Staff of the NSW Health Service.
PD2015_023 - Appointment of Visiting Practitioners in the NSW Public Health System
PD2005_497 - Visiting practitioners and staff specialists Delineation of clinical privileges
PD2011_010 - Visiting Medical Officer (VMO) Performance Review Arrangements.

Systems/Performance Improvement

Performance review reports are forwarded to an appropriate delegate within the Area for action, matters requiring further review are investigated, and feedback is provided to staff on any policy and procedural changes to effect system improvement.

STANDARD 7

Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

Components

Topic Selection

Health services have developed a program of clinical practice audits that targets major care processes or practices considered to be high risk.

Review Process

People with relevant skills and knowledge conduct the audits. Audits are conducted in an efficient and effective manner against pre-determined components or performance standards.

Systems Improvement

The audits identify clinical management issues that need to be addressed to improve patient safety and quality care. Audit results are reported to management/Area executive and feedback is provided to staff on policy and procedural changes and ongoing monitoring of the effectiveness of systems changes is in place.

7. Clinical Governance Units[18]

The developing focus on the integrity and accountability of health systems through clinical governance is integral to improving the performance of health systems and the enhancement of clinical care through analysis and feedback. The concept of clinical governance integrates clinical decision-making within an organisational framework and requires clinicians and administrators to take joint responsibility for the quality of clinical care delivered by the organisation.

With the recent implementation of the health reforms, clinical governance has been embedded in the new Area Health Services (AHS) through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) as a direct report to the Chief Executive (CE).

Core Functions

The primary focus of the CGU can be summarised as the risk management of patient safety and clinical quality through implementation of the NSW Patient Safety and Clinical Quality Program. The Program will be implemented in collaboration with the Clinical Excellence Commission (CEC), the Department and the CGU.

The CGU will build upon existing incident reporting and investigation systems enhanced through the implementation of the Incident Information Management System (IIMS). Functions that will guide the role of the CGU in 2004/05 are:

1. Structural establishment
2. Incident management
3. IIMS implementation
4. Complaints management
5. Death review
6. Continuous Quality Improvement (CQI) support
7. Communication training
8. Policy development
9. Clinician performance review
10. Reporting
11. External reports.

[18] Draft NSW Clinical Governance Units Implementation Framework, 2004

Other Functions

- Management of individual performance issues. The establishment of clinician performance review is a key part of the NSW Patient Safety and Clinical Quality Program. The role of the CGU will be to determine an appropriate performance management framework for the health service, in collaboration with the CEC, and be a source of advice and expertise regarding due process for those line managers.

- Complaints management. The CGU will ensure a single point of access for staff and the public to register complaints and to take responsibility for the management of serious complaints. The CGU will lead the process of complaints management but should not take over this function on behalf of the health service.

- Integrated risk management. Clinical risk management is an integrated responsibility for clinical operations and for the CGU. The CGU will advise and support clinical operations in the recognition and management of clinical risk. It is not intended that the CGU assume global risk management responsibility for the health service.

8. Incident Management

A quality improvement framework requires routine examination of all incidents that cause patient harm. Most adverse events are not caused by a single, individual action. They usually result from a chain of events where inadequate safeguards and other systemic vulnerabilities erode patient safety. Preventing incidents depends on identifying the deficiencies that allowed the event to occur and fixing those problems.

In the past, information about adverse events was generally derived from single studies and often specific only to a hospital or clinician. Through the NSW Patient Safety and Clinical Quality Program, Area Health Services are now well placed to systematically collect incident information to effect system-wide improvement.

In NSW, all incidents that result in detriment to a patient are 'reportable' - they must be reported to management and, depending on their severity, the AHS and the NSW Department of Health for analysis and remedial action.

The NSW Patient Safety and Clinical Quality Program aims to develop a culture where health care incidents are identified, reported, investigated, analysed and acted upon. The lessons learned locally will be disseminated statewide through a knowledge management strategy.

The Program is supported by an information system, the Incident Information Management System (IIMS), that assists heath care workers to achieve this.

The Incident Information Management System (IIMS)

The Incident Information Management System is an electronic system activated in all AHS in December 2004 to:

- Record all healthcare incidents, both adverse events and incidents that did not result in adverse events, but might have, in four categories:
  1. Clinical
  2. Complaints
  3. Property security and hazards
  4. Staff, visitors and contractors

- Assist managers to deal with incidents in their areas
- Record the results of reviews and investigations of incidents
- Provide reports on all incidents recorded in the system.

There are 100,000 potential users of the IIMS system that includes all NSW health system employees and contractors. A comprehensive training and education program has been developed using 'e-learning modules', a CD-ROM, DVD and video to ensure all potential users have consistent training in the use of the IIMS.

Full deployment was completed in May 2005 across the whole of NSW.

9. Clinical Excellence Commission[19]

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the *Health Services Act* and launched by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program and builds on the foundation work of the Institute of Clinical Excellence established in 2001. The NSW Department of Health, public health organisations, the Health Care Complaints Commission (HCCC) and professional registration boards are the other principal organisations with major roles in this program.

The CEC will work effectively in partnership with these organisations to:

- Promote and support improvement in clinical quality and safety in public and private health services
- Monitor clinical quality and safety processes and performance of public health organisations and to report on these to the Minister
- Identify, develop and disseminate information about safe practices in health care on a state wide basis, including (but not limited to) developing, providing and promoting training and education programs, and identifying priorities for and promoting the conduct of research about better practices in health care
- Consult broadly with health professionals and members of the community in performing its functions
- Provide advice to the Minister for Health and Director-General of Health on issues arising out of its functions.

Patient Safety Risk Identification

A major role of the CEC will be to analyse information from a range of relevant sources regarding adverse events, to identify trends, causes and preventative strategies and to work with Public Health Organisations (PHO) to facilitate ongoing improvements in the health care system. The CEC will analyse information provided by the Department and PHO. This may include information from the following sources to identify systemic issues that need to be addressed:

- Root Cause Analyses (RCAs)
- Incident Information Management System (IIMS)
- Coroners' findings and recommendations
- Special Committees' and expert committees' reports
- Treasury Managed Fund and medical defence organisations
- Quality System Assessments (QSA)
- Information from the Health Care Complaints Commission
- Literature reviews, research and other sources as appropriate
- Special reviews.

[19] NSW Clinical Excellence Commission Directions Statement, 2004.

10. Quality System Assessments

The effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program will be routinely monitored through an external review process, the Quality System Assessments (QSA) conducted by the Clinical Excellence Commission (CEC).

The QSA is an annual review of Area Health Services (AHS) to identify, analyse and advise on issues of a systemic nature that affect patient safety and clinical quality in the NSW health system. The CEC will assess AHS and PHO to identify if there has been effective implementation of the Program.

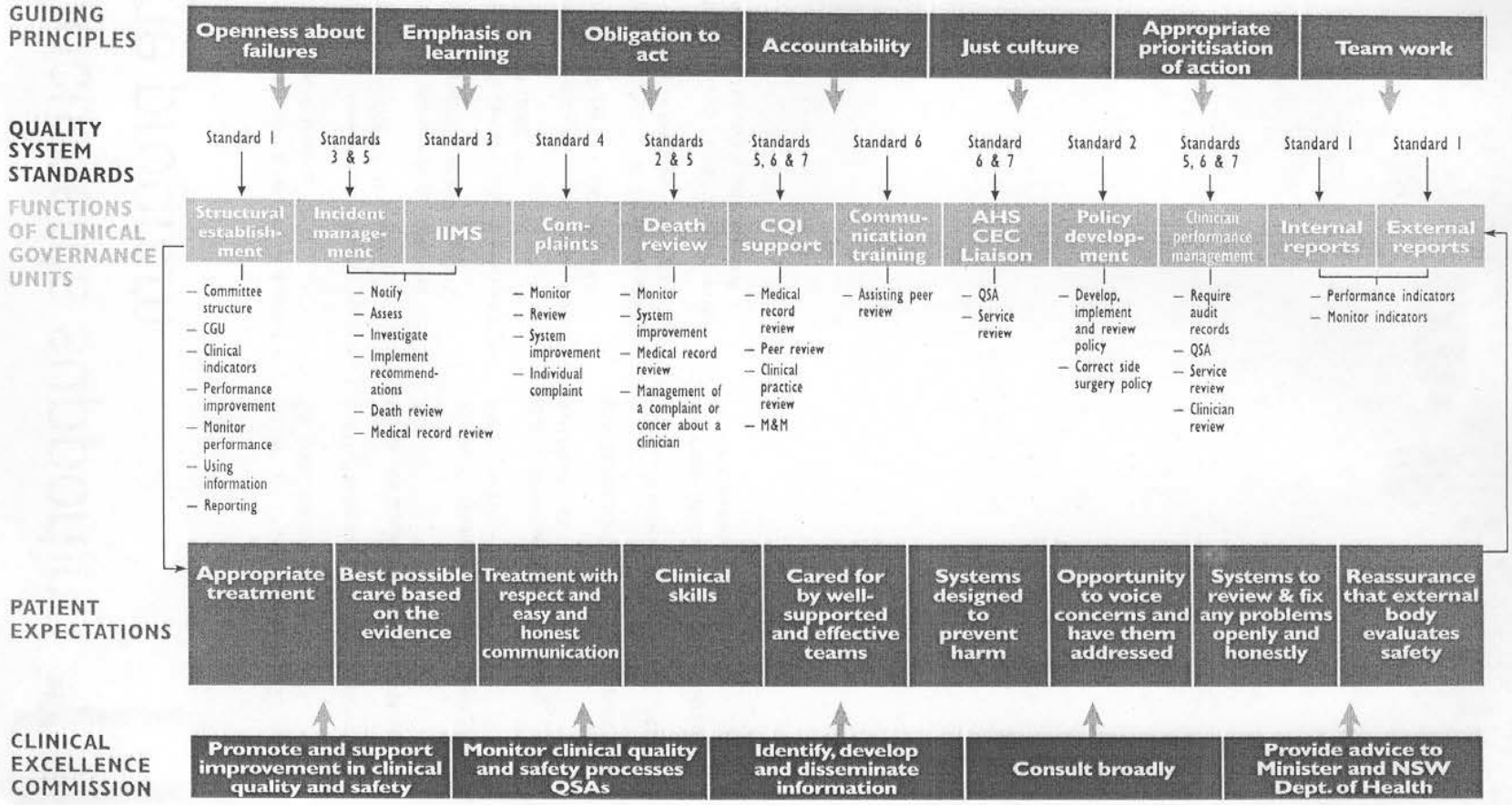
Specifically, the QSA will review patient safety arrangements in AHS focusing on compliance with the standards and policy requirements developed by the Department. The key areas for review are:

- Quality and safety reporting structures
- Safety polices and procedures
- Incident management
- Complaint management
- Medical record reviews
- Audits of clinical practices.

The CEC will provide the QSA Report to the Chief Executive of the AHS and Public Health Organisation, and a copy to the Department of Health. The AHS and PHO will notify the Department of the actions taken to address safety and quality issues contained within the report, and work with the Department to ensure appropriate implementation. It is acknowledged that from time to time significant issues may be identified from a Quality Systems Assessment.

The Department will support AHS and PHO to address risks identified by the CEC, or through its own sources of information and advice. The Areas can also approach the CEC for advice and assistance in improving quality systems.

Patient Safety and Clinical Quality Program



Documents Supporting the Program

PD2015_023 Appointment of Visiting Practitioners in the NSW Public Health System

PD2005_497 Visiting practitioners and staff specialists Delineation of clinical privileges.

PD2006_007 Complaint or Concern about a Clinician - Principles for Action

PD2006_073 Complaint Management Policy.

GL2006_002 Complaint or Concern about a Clinician - Management Guidelines

GL2006_023 Complaint Management Guidelines.

PD2014_004 Incident Management Policy.

PD2014_036 Clinical Procedure Safety.

PD2011_010 Visiting Medical Officer (VMO) Performance Review Arrangements.

PD2012_028 Recruitment & Selection of Staff of the NSW Health Service.

NSW Clinical Governance Directions Statement, 2005.

NSW Patient Safety and Clinical Quality Program Implementation Plan, 2005.

Definition of Terms

Adverse Event

Any event or circumstance leading to avoidable patient harm which results in admission to hospital, prolonged hospital stay, significant disability at discharge or death.

Area Health Advisory Councils (AHAC)

A clinical and community advisory body established in Area Health Services following the health reforms to give clinicians including doctors, nurses and allied health professionals, health consumers and local communities a stronger voice in health decision-making.

Area Health Services (AHS)

Area Health Services provide the operational framework for the provision of Public Health Services in NSW. They are constituted under the *Health Services Act 1997* and are principally concerned with the provision of health services to residents within the geographic area covered by the Area Health Service.

Clinical Excellence Commission (CEC)

A statutory health corporation established under the *Health Services Act* to promote and support improvement in clinical quality and safety in NSW health services.

Incident Information Management System (IIMS)

A state-wide electronic reporting and incident management system designed to underpin the NSW Safety Improvement Program.

Incident[20]

An unplanned event resulting in, or having the potential for, injury, damage or other loss.

Public Health Organisation (PHO)

Means an area health service, a statutory health corporation or an affiliated health organisation in respect of its recognised establishments and recognised services, as defined in section 7 of the *Health Services Act*, and in addition, for the purposes of this document, includes the Ambulance Service of NSW.

Quality System Assessment (QSA)

Criteria for the collection and analysis of information on the quality and safety of health services designed to test the effectiveness of the systems in place to monitor and improve quality and patient safety.

Severity Assessment Code (SAC)

A risk matrix used to stratify the consequence and likelihood of an incident to generate a numerical rating from 1 to 4. SAC 1 events always require investigation and notification to the Area Health Service Executive and the NSW Department of Health. SAC 2 events require notification to the Area Executive and local assessment as to the level of investigation required. Incidents rated 3 or 4 will be managed locally by the Area Health Service.

[20] NSW Health First Report on incident management in the NSW public health system 2003-2004.

KIDNEY HEALTH CHECK: PROMOTING THE EARLY DETECTION AND MANAGEMENT OF CHRONIC KIDNEY DISEASE (PD2010_023)

PURPOSE

This policy directive promotes the early detection and management of chronic kidney disease. It aims to optimise existing contacts with at risk patients in hospital settings in order to prevent progression to end stage kidney disease. The screening tool described is the *Kidney Health Check*. If disease is detected, a primary care referral will be made, highlighting the importance of treating the condition in order to encourage remission and regression of the disease.

MANDATORY REQUIREMENTS

Area Health Services are to develop and implement a framework to screen for chronic kidney disease which consists of three steps:

1. **Identification of High Risk Patients** - risk factors are listed in section 2 step 1 of the attached Kidney Health Check procedures;
2. **Kidney Health Check** - assessment of urinalysis, blood pressure and an estimated measure of glomerular filtration rate (section 2 step 2); and
3. **Follow Up** - a referral is to be made to the patient's General Practitioner or Nurse Practitioner if any one of these tests yields abnormal results (section 3).

IMPLEMENTATION

Chief Executives of Area Health Services are responsible for implementing this Policy Directive and must ensure:

- Local policies and procedures are developed for clinical care establishing standards of practice;
- Staff education and training programs are in place to support the implementation of the Kidney Health Check; and
- An evaluation framework is in place to assess that the Kidney Health Check has been implemented and that the target group has been identified, screened using the Kidney Health Check, and followed up appropriately.

The Clinical Excellence Commission will conduct a longer term evaluation of the Policy Directive at a state level.

BACKGROUND

Chronic kidney disease (CKD) is defined as the occurrence of kidney damage or decreased kidney function (decreased glomerular filtration rate) for a period of three or more months[1].

CKD is responsible for a substantial burden of illness and premature death with:

- 1 in 3 Australians at risk of developing the disease[2];
- 1 in 7 Australians over the age of 25 years having at least one clinical indicator of existing CKD[2];
- the disease being the 7th leading cause of death[2];

- CKD being a preventable and treatable condition. Once the disease is diagnosed and treatment implemented, the progression to end-stage renal failure can be reduced by up to 50%[3]; and
- proteinuria, which is a clinical marker for CKD, also indicative of an increased risk of cardiovascular disease[4].

Early detection of CKD is the key to both the prevention and the slowing of the progression of the disease.

The purpose of this policy directive is to provide a framework to identify those who have or are at high-risk of developing CKD and for the implementation of timely treatment in order to prevent the progression to end-stage kidney disease. In turn, this will raise awareness of CKD for staff and the public and reduce the burden of disease associated with kidney disease in the NSW population. It will be the responsibility of each Area Health Service to develop and implement a framework for the program.

Area Health Services should have in place systems to screen patients in high-risk categories as identified by Kidney Health Australia by conducting the **Kidney Health Check**. This system of screening should, in the first instance, be implemented within all high-risk inpatient units in hospital settings.

The application of this policy to a broader range of clinical settings should be considered subject to evaluation within the hospital setting.

CHRONIC KIDNEY DISEASE SCREENING

The following process is summarised as a simple algorithm in Appendix 1.

Step 1 - Identification of high-risk patients

Patients who have not previously been diagnosed with chronic kidney disease should undergo the Kidney Health Check if they have one or more of the following features:

- cardiovascular disease;
- diabetes;
- Aboriginal and Torres Strait Islander peoples;
- tobacco smokers.
- obesity;
- hypertension;
- aged over 50 years; and
- a family history of kidney disease;

Step 2 - Kidney Health Check

Area Health Services will implement the Kidney Health Check in high-risk inpatient groups such as cardiology, cardiovascular, general medicine, endocrine, stroke, rehabilitation, geriatric medicine and maternity units, and include patients undergoing cardiac surgery and vascular surgery. Over time, it would be expected that the practice is expanded to other areas of the health service including high-risk outpatient clinics and Emergency Departments.

Patients identified as being at high risk for CKD should undergo the Kidney Health Check, as described below. All three tests, that is, assessment of urinalysis, blood pressure and an estimated measure of glomerular filtration rate must be conducted to constitute a Kidney Health Check.

- **Urinalysis ("Dip Stick")**

Proteinuria has been demonstrated to be an independent risk factor for progression of renal disease. Microalbuminuria is a predictor of progressive renal disease in diabetes.

Patient without diabetes	Test for protein	Abnormal > 30mg/dL
Patient with diabetes	Test for albumin	Abnormal > 3mg/dL (albumin specific dipstick)[5]

- **Blood pressure assessment**

Hypertension can contribute to the development of CKD.

Abnormal result	>140/>90 mmHg[6]

- **Estimated Glomerular Filtration Rate (eGFR)**

The eGFR is considered to be an accurate measure of kidney function, although the test is not always accurate in all circumstances (for example, in patients who are obese, elderly or for Aboriginal or Torres Strait Islander peoples).

Abnormal result	< 60 mL/min/1.73m^2

Clinicians should be mindful that proteinuria and haematuria may be clinical indications of a more rapidly deteriorating patient requiring immediate referral to a renal physician.

Step 3 - Follow Up

Should any of these results be abnormal, this suggests the possibility of CKD. A referral for ongoing assessment must be made, highlighting that re-testing is required to confirm a diagnosis.

The Kidney Health Check should be conducted no more frequently than twelve monthly in the absence of abnormal results.

IMPLEMENTATION

Area Health Services should implement the introduction of the Kidney Health Check and appropriate follow up arrangements in accordance with local policies and practices. Efforts to encourage compliance with recommended follow up arrangements should reflect the level of risk associated with non-compliance. This should include, but not be limited to:

- informing the patient of the need for follow up with their GP and/or Nurse Practitioner;
- referral to their GP and/or Nurse Practitioner for follow up; and
- provision of appropriate documentation for their GP and/or Nurse Practitioner and *written information* for the patient.

Sample letters for both the patient and the patient's GP and/or Nurse Practitioner are contained in Appendix 2 and 3.

It is anticipated that Area Health Services will develop an education program to support clinical staff to implement the Kidney Health Check. This could include an education program through Nurse Educators and Clinical Nurse Educators (so that education can be provided to staff of inpatient wards), through the established training/education sessions for junior medical staff and registrars, and through nurse practitioners in transitional positions.

Area Health Services must implement an evaluation framework to assess that the Kidney Health Check has been implemented and patient care improved. The Clinical Excellence Commission will be undertaking a longer term evaluation of the outcome of the Policy Directive at a state level.

REFERENCES

1 Levey AS, Coresh J, Balk E, et al. National Kidney Foundation Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. *Annals of Internal Medicine.* 2003; 139:137-149.

2 *National Chronic Kidney Disease Strategy.* Kidney Health Australia. Melbourne, 2006.

3 Hoy WE, Wang Z, Baker PR & Kelly AM. Reduction in natural death and renal failure from a systematic screening and treatment program in an Australian Aboriginal community. *Kidney International Suppl*. 2003; 83:S66–73.

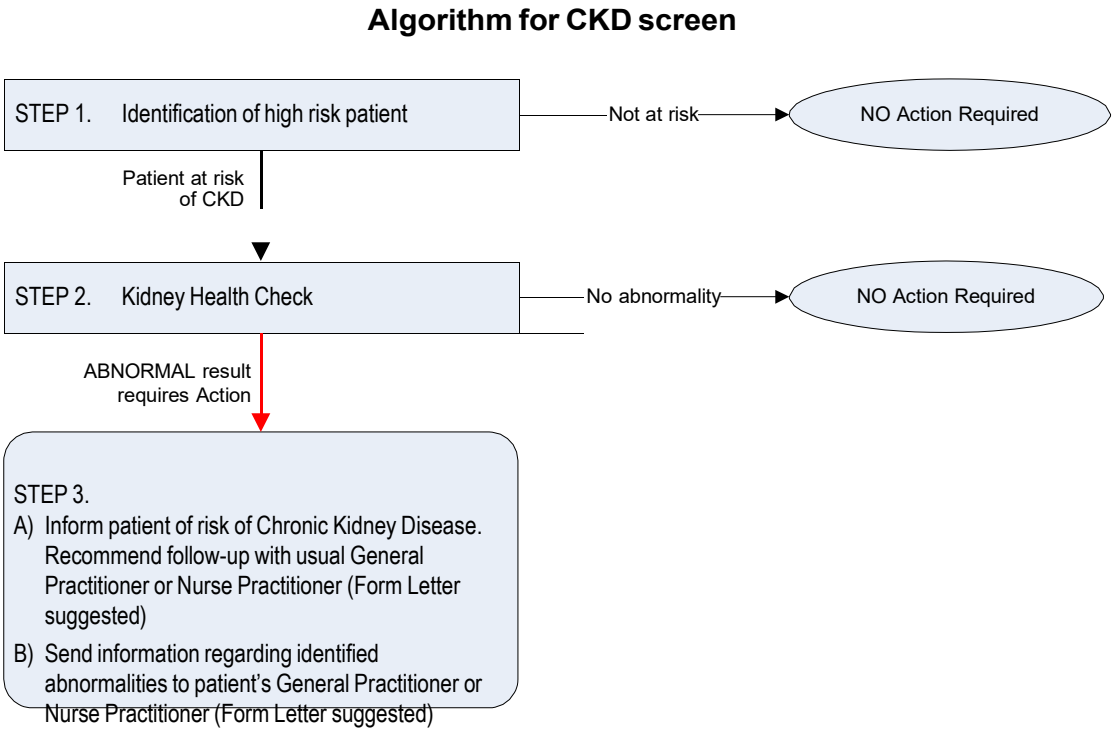
4 Perkovic V, Verdon C, Ninomiya T, Barzi F, Cass A, et al. The relationship between proteinuria and coronary risk: A systematic review and meta-analysis. *PLoS Med*. 2008; 5(10): e207. doi:10.1371/journal.pmed.0050207

5 *Testing for Proteinuria.* The CARI Guidelines – Caring for Australians with Renal Impairment. Published October 2004.

6 National Heart Foundation of Australia (National Blood Pressure and Vascular Disease Advisory Committee). *Guide to Management of Hypertension 2008: Assessing and managing raised blood pressure.* Updated August 2009.
http://www.heartfoundation.org.au/Professional_Information/Clinical_Practice/Hypertension/Pages/default.aspx

7 *Chronic Kidney Disease (CKD) Management in General Practice.* Kidney Health Australia. Melbourne, 2007.

APPENDIX 1: Algorithm for CKD screen



STEP 1:	**STEP 2:**
High risk patients have 1 or more of the following risk factors: 1. Cardiovascular Disease 2. Diabetes 3. Aboriginal and Torres Strait Islander peoples 4. Tobacco Smokers 5. Obesity 6. Hypertension 7. Age over 50 years 8. Family history of Kidney Disease	**Kidney Health Check comprises:** I. Dipstick analysis for protein. II. > 30 mg/dL is abnormal III. Check Blood pressure. IV. >140/>90 mmHg is abnormal V. Check eGFR (estimated from serum creatinine). < 60 mL/min/1.73m^2 is abnormal

APPENDIX 2: Sample Letter Patients

Letter Head

APPENDIX 2: SAMPLE LETTER PATIENTS (Copy to GP or Nurse Practitioner)

[Name]
[Address]
[Suburb] [State] [Post Code]

Dear [Name]

During your hospital stay, routine screening showed that you may be at risk of developing early kidney disease. It is important that you are seen by your GP or nurse practitioner within 3 months so that a few simple tests can be redone to confirm if the condition is ongoing.

Chronic kidney disease often has no symptoms so regular screening of high-risk individuals is recommended. You may be at risk if you have one or more of the following features:

- a previous stroke
- heart disease
- high blood pressure
- a family history of kidney disease
- diabetes
- are of Aboriginal and Torres Strait Islander descent
- aged over 50 years
- obesity
- tobacco smokers.

The good news is that if kidney disease is found early, changes can be made to your lifestyle and/or medications can be prescribed to slow or stop the progression of the disease. If the condition is left untreated, the final outcome may be heart disease and/or end-stage kidney failure and premature death.

A letter has also been sent to your GP or Nurse Practitioner recommending that you are re-tested in 3 months and then annually. The testing, known as a Kidney Health Check, involves:

1. testing a urine sample for protein
2. taking your blood pressure to assess if it is within normal limits
3. taking a sample of blood to assess overall kidney function.

If you would like more information, please contact:

Name and position _____
Phone number _____

Please make an appointment with your GP or Nurse Practitioner 3 months after coming home from hospital for further testing.

Yours sincerely

[Name]

APPENDIX 3: Sample Letter to GP or Nurse Practitioner

APPENDIX 3: SAMPLE LETTER TO GP or NURSE PRACTITIONER

Letter Head

[Name]
[Address]
[Suburb] [State] [Post Code]

Dear [Name]

Re: (Insert patient identification sticker)

During (patient's name) recent hospital stay, he/she was screened for kidney disease. Clinical signs of the disease have been detected but diagnosis of the condition cannot be made until it is confirmed by further testing. *If you have already tested for chronic kidney disease within the last 12 months, then please disregard this letter.*

As you are aware, chronic kidney disease often has no symptoms. Regular screening of high-risk individuals through the ***Kidney Health Check*** is therefore recommended. Your patient was considered at-risk as they have one or more of the following features:

- cardiovascular disease
- hypertension
- family history of kidney disease
- Aboriginal and/or Torres Strait Islander origin
- diabetes
- aged over 50 years
- obesity
- tobacco smokers

A letter has been sent to your patient explaining that if chronic kidney disease is left untreated, the final outcome may be end-stage kidney failure whereby individuals require renal dialysis or a kidney transplant to avoid premature death.

What you need to do

Please repeat the ***Kidney Health Check*** within three months of your patient being discharged from hospital. This involves:

Procedure		Abnormal Results
STEP 1	Dipstick analysis for protein	Greater than 30 mg/dL
STEP 2	Check blood pressure	Greater than 140/90
STEP 3	Check eGFR (estimated from serum creatinine)	Less than 60mL/min

Kidney Health Australia's booklet on Chronic Kidney Disease (CKD) Management in General Practice (2007) contains information on screening and treatment protocols, and indications for referral to a Nephrologist. This can be accessed via the Kidney Health Australia website at http:// www.kidney.org.au/HealthProfessionals/PublicationsforHealthProfessionals/tabid/635/Default.aspx

If you would like more information on the contents of this letter, please contact (Name and position) on (contact phone number).

Yours sincerely

[Name]

END-OF-LIFE CARE AND DECISION-MAKING (GL2021_004)

GL2021_004 rescinds GL2005_057

GUIDELINE SUMMARY

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

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

KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

USE OF THE GUIDELINE

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

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

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

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

The End of Life Care and Decision Making guidelines can be viewed at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_004

336(08/04/21)

RESPONDING TO THE NEEDS OF PEOPLE WITH DISABILITY DURING HOSPITALISATION (PD2017_001)

PD2017_001 rescinds PD2008_010

PURPOSE

This Policy Directive has been updated and replaces PD2008_010 *Disability – People with a Disability: Responding to Needs During Hospitalisation.*

This policy describes the responsibilities of all staff working in hospitals caring for people with disability. The scope of the policy includes: pre-admission planning, admission to hospital, care planning during the hospital stay and planning for the transfer of the patient back to the community; planned and emergency admissions; and in-hospital patient care settings (including Hospital in the Home), hospital emergency departments, and hospital outpatient departments.

MANDATORY REQUIREMENTS

This Policy Directive applies to all NSW Health services, which are required to have local policies, protocols and procedures in place based on the attached Procedures in all hospitals that provide admitted patient services to people with disability.

This policy requires NSW Health organisations and staff to provide services to people with disability that are:

- Inclusive
- Person-centred
- Accessible.

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Health service staff must:

- Make reasonable adjustments according to needs of the individual
- Communicate with and provide information to the person with disability in a way they understand
- Involve the person with disability, and where appropriate, consult their carer, family, guardian and / or disability support staff as outlined in the attached policy directive
- Implement this policy in conjunction with other NSW Health policies relevant to admission to, treatment in, and transfer out of hospital as referenced in this policy.

IMPLEMENTATION

The following NSW Health organisations have responsibilities in relation to this policy:

- Local Health Districts (LHDs)
- Statutory health corporations – network governed (Specialty Health Networks)
- Statutory health corporations – chief executive governed
- Statutory health corporations – board governed
- Affiliated Health Organisations
- Statewide health services.

These organisations and their staff will:

- Treat people with disability, their carers and families equitably, with respect and use a person-centred approach in line with the guiding principles outlined in the attached Procedures
- Aim to keep people with disability healthy and out of hospital
- Allocate responsibility for implementing this policy in hospital facilities to an executive role
- Review their systems for meeting needs of people with disability in line with this Policy Directive, including but not limited to use of the Implementation Checklist in Appendix 3
- Use existing patient safety and quality monitoring processes to identify and address issues in the quality of health care provided to patients with disability and associated outcomes
- Monitor length of stay and unplanned hospital re-admission rate for people with disability and develop mechanisms to determine if there is a difference in outcomes for people with disability when compared to the general population
- Use this policy in the development of LHD / SHN local policies, protocols and procedures related to improving health care provided to people with disability when they are hospitalised (from admission to transfer to care).

Under this Policy Directive the NSW Ministry of Health will:

- Monitor and provide guidance and policy support to relevant health organisations to implement this policy
- Promote awareness of this policy across the NSW Health system
- Encourage LHDs, SHNs and other relevant health organisations to involve people with disability in the development of local policies, protocols and procedures
- Encourage LHDs, SHNs and other relevant health organisations to adopt the principles outlined in this policy.

1. BACKGROUND TO THIS DOCUMENT

This Policy Directive is an update of and replaces PD2008_010 Disability – People with a Disability: Responding to Needs during Hospitalisation.

The purpose of this policy is to improve the experience of people with disability accessing the State Health system, providing a safe and responsive stay during hospitalisation. This policy sets out the requirements of effective communication with the person with disability and where relevant their carer, family, guardian and disability support staff. It also sets out requirements to make reasonable adjustment during the patient journey to ensure people with disability access equitable, effective and safe health care.

Disability for the purpose of this policy is defined as "a long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person's full and effective participation in the community on an equal basis with others."[1] Disability itself is not an illness but people with disability may have long-term illnesses, chronic diseases, or co-morbidities that require ongoing attention and management.

People with disability have the right to the highest attainable standard of health. This is achieved through being able to access health services on an equitable basis, receive care that meets individual assessed health needs and through appropriate supports that ensure that high quality health care services are received prior to, during, and after hospitalisation; that barriers are not created due to a person's disability.

The NSW Disability Inclusion Act (2014) commits the NSW Government to making communities more inclusive and accessible for people with disability. This will be achieved by, among other things, promoting the independence of people with disability and enabling choice and control.

This policy, in alignment with the Act, requires staff to provide services that are inclusive, person-centred and accessible.

2. KEY PRINCIPLES

2.1 Inclusion

The NSW Government is committed to supporting the fundamental right of people with disability to "have the same right to choose the way to live their lives, to access the same opportunities and enjoy the benefits of living and working in our society", and that the state and community have a responsibility to facilitate the exercise of those rights.[2]

For more information on how NSW Health is working to improve access and inclusion for people with disability see the *NSW Health Disability Inclusion Action Plan (DIAP) 2016-2019.*

2.2 Person-centred services

A person-centred approach places the person at the centre of decision making, and works with the carer, family, guardian, natural networks of support, and service providers as partners.

For the person to be at the centre of care he or she needs to be well informed about the hospital experience and involved at the centre of decision-making through all the stages of: planning for admission, during hospital stay, and transfer back to the community.

The treating practitioner is responsible for determining the capacity of the person with disability to participate in developing person-centred care plans, or what type of assistance the person needs to support their participation.

[1] NSW Disability Inclusion Act 2014 No 41
http://www.legislation.nsw.gov.au/maintop/view/inforce/act+41+2014+cd+0+N
[2] p.5, NSW Disability Inclusion Action Planning Guidelines 2015,
http://www.facs.nsw.gov.au/__data/assets/file/0004/322366/NSW-DIAP-Guidelines.PDF

2.3 Accessibility

Accessibility includes access to the full range of hospital services and hospital amenities, and information about hospital services including complaints mechanisms. NSW Health organisations should ensure that facilities, services and information are accessible to both the person with disability and those who support them.

Ways to improve access to facilities include:

- Ensuring there is adequate space for wheelchairs and other equipment, and assistance animals
- Ensuring staff are aware that assistance animals are allowed in hospital buildings, including awareness of the Guideline on GL2012_007 - *Animal Visits and Interventions in Public and Private Health Services in NSW*
- Ensuring call systems, diagnostic equipment, toileting facilities, emergency / evacuation procedures and examination tables are fully accessible
- Having an alternative call system in place for patients who are unable to reach or use the call bell
- Providing any information available to patients, and their families, in an accessible format, for example signage, labels, directions and instructions.

Accessibility of information for patients

Health professionals have an obligation to ensure that information is provided to patients in a way that they can understand. This obligation could include the provision of communication aids, including interpreters or translators.

Information should be given in advance of admission to hospital, where possible, to the person, and to their carer and / or their support network as this will enable them to explain the information and prepare the person prior to the hospital stay.

Written information can be made more accessible when it is supported by verbal information given in an explanation. During hospitalisation, from pre-admission to transfer out of hospital, appropriately trained staff should take the time to go through written material with the person with disability, then check whether the person has understood the information, and answer any questions they may have.

2.4 Communication

The most significant factor associated with both a positive and a negative patient experience is the existence and degree of effective communication between health staff and the patient.

It is important there is effective communication between health staff, the person with disability and where relevant their carer, family, guardian and / or disability support staff to understand the person's health and support needs, to understand expectations and feelings, and respective roles and responsibilities.

People with significant and permanent disability living in both residential care and the community are a particularly vulnerable population. Many people often require assistance with activities of daily living, including communication. It is important that the communication support required is identified, documented and used.

All communication should always be addressed in the first instance to the person with disability in matters including treatment, comfort, services, supports, amenities and needs relating to their disability. Health professionals should consult the person with disability for advice on the most effective method of communication.

If the person is unable to advise hospital staff of the most effective method of communication, health professionals should then consult the carer, family, guardian and / or disability support staff for information about what is 'usual behaviour', how the person communicates and whether they use any particular Augmentative and Alternate Communication (AAC) methods.

Information on the person's communication needs and preferences must be documented in communication profiles in care plans, records and the Transfer of Care Referral form. Documentation should include any communication aids used by the patient, interpreting gestures, signs and behaviours which they may use to convey their needs and responses.

Ways to improve communication:

- Recognise that some patients may be unfamiliar with healthcare information and address each person's level of understanding
- Identify methods a person may use to communicate such as signs and gestures and use these methods when communicating with them such as pointing to objects
- Always speak directly to the person and not through the interpreter or the person's carer, family member or companion
- Allow sufficient time and be patient when communicating
- Listen attentively when talking with a person who has difficulty speaking and let them finish
- Keep sentences short, be specific and talk about one step at a time
- If you are not understood, repeat or rephrase the information, reduce the amount of information, use visual supports, or seek help from someone who knows the person well
- Confirm that the person (or carer / family member / disability support staff) has understood all the information provided, encourage questions
- If you do not understand the person, do not pretend to understand, clarify and confirm what the person is saying, ask the person to say it in a different way, ask the person to show you what they mean, check if the person's non-verbal communication supports what they are saying[3]
- People with a cognitive and / or psychiatric disability may require key information to be communicated more than once - using reminders and reassurance can improve communication.

Additional training may be required for health care workers to optimise their ability to effectively communicate with people with disability.

Health professionals may need to access information from other parties to assist in providing appropriate care to a person with disability. The person with disability should be actively involved as much as possible in providing information to health professionals, being informed about their care in hospital, and making decisions about their care.

Health Care Interpreting and Translating Services

The Policy Directive, PD2006_053 - I*nterpreters - Standard Procedures for Working with Health Care Interpreters* is a mandatory policy. This Policy Directive requires the use of professional health care interpreters (Australian Sign Language (Auslan) and / or spoken languages) to facilitate communication between staff and people who are not fluent in English, or people who are deaf.

- Health care interpreters are professionally accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) or similar accreditation agencies
- Staff are not to be used as interpreters unless they are NAATI accredited at least at paraprofessional level
- NAATI accredited interpreters (AUSLAN and spoken languages) must be booked, as necessary and as requested, to communicate with people with disability and/or their carer and family
- Services are available 24 hours per day, 7 days per week. The service is available either face-to-face, by telephone or via videoconference if available.
- Interpreters are also available to provide 'sight translation' of documents such as consent documents. Sight translations should always occur in the presence of health service providers so questions can be addressed

[3] Complex communication needs. Department of Communities (Disability Services), QLD. 2011
https://www.qld.gov.au/disability/documents/community/complex-communication-needs.pdf

- Subject to the requirements of the NSW Health Privacy Manual for Health Information carer, family, guardian, advocates, and / or disability support staff may be consulted using an interpreter for information that may affect the care or treatment of the person with disability
- It should not be assumed that because a person has good spoken language they have equal understanding of written language
- It should not be assumed a person whose first language is Auslan has English literacy skills.

2.5 Reasonable adjustment

In order for health care services to be accessible and safe for people with disability, adjustments need to be made. Making reasonable adjustments means doing things differently to ensure people are not disadvantaged or harmed.

In practice reasonable adjustment means "removing barriers people with disabilities experience in accessing services. This includes changing the ways services are delivered, ensuring that protocols and procedures work equally well for people with disabilities, and ensuring that staff are equipped with the necessary training and resources to deliver effective, timely and quality healthcare to people with disabilities".

In the context of anti-discrimination legislation, a person-centred approach to individualised-planning, the requirements of the *Disability Inclusion Act 2014*, and the National Disability Insurance Scheme (NDIS) there is growing expectation and increasing demand for accommodating the needs of people with disability through mainstream services.

The *Disability Discrimination Act 1992*[4] (Cth) (the Act) recognises the rights of people with disability to equality before the law and makes discrimination based on disability unlawful. The Act defines both direct and indirect disability[5] discrimination. A failure to make reasonable adjustments[6] is an explicit feature of the definitions of direct and indirect discrimination.[7]

Local Health Districts (LHDs) / Specialist Health Networks (SHNs) must make reasonable adjustments to respond to the needs of people with disability during hospitalisation. Health staff should consult with the patient and where relevant their carer, family member, guardian and / or disability support staff and acknowledge and act on the advice provided.

Examples of reasonable adjustment include:

- Adjusting communication methods by taking into account the patient's communication needs
- Addressing the patient's ability to cope with different environments, changes in routines, unfamiliar procedures and unfamiliar staff
- Addressing the patient's need to change the ways in which care or treatment is provided
- Allowing extra time to provide the support that is required
- Including and supporting the patient's carer, family member, guardian or disability support staff as expert care partners
- Providing patient information in alternate formats such as 'easy read' documents.

LHDs / SHNs must consider:

- The barriers a person with disability may experience within their hospital's facilities, processes and systems
- The individual person's specific needs
- Supports the NDIS can or is providing for the patient and how they complement Health interventions.

[4] https://www.comlaw.gov.au/Details/C2015C00252/Html/Text#_Toc422301339
[5] Sections 5 and 6 https://www.comlaw.gov.au/Details/C2015C00252/Html/Text#_Toc422301340
[6] Definition of reasonable adjustment is defined in section 4(1); definition is copied in the Glossary.
[7] See section 5(2) direct discrimination and section 6(2) indirect discrimination.

3. THE PATIENT JOURNEY

Hospital can be a daunting experience for patients, in particular for people with disability due to unfamiliar environments, routines and care arrangements.

A hospital stay can have a significant negative or destabilising effect on people with disability as well as their carer, family, guardian and support networks. It can result in a loss of living skills, depression, and poor adjustment to school, employment and relationships. Some children, young people and adults with disability spend significant amounts of time in hospital.

For people with physical disability, hospitalisation can result in deterioration in their general physical and mental condition such as: loss of joint range, muscle strength and tone, functional independence, and ability in activities of daily living. Similarly, the patient's previous confidence in mobility may deteriorate unless this is noted on admission and reinforced daily within the limits of the patient's presenting diagnosis or condition. The patient's confidence in their ability to perform all functional tasks within the limits of their disability may also deteriorate unless health professionals continue to encourage maintenance of, or improvement on pre-hospitalisation independence.

Where appropriate, Hospital in the Home (HITH) should be considered for people with disability to enable them to receive the hospital care they need in their home environment allowing for the maintenance of routines and care arrangements.

Where hospitalisation is needed, it is important that people with disability receive flexible service delivery, where the health service adapts to meet their particular needs. Ensuring the patient is at the centre of their care, involved in pre-admission planning and supported with information will lead to a good hospital experience for people with disability.

While communication, consultation, consent and planning are essential elements of a good hospital experience for all people, these elements can be particularly important for people with disability.

3.1 Privacy

The collection, use, exchange, or disclosure personal information about the patient must be undertaken in accordance with the *NSW Health Privacy Manual for Health Information* (the Manual) which can be found at: http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx

The NSW Privacy Commission has issued a Direction for permitting an exception to the Health Privacy Principles to enable the exchange of health information to assist in the transition of funded individuals to the NDIS.[8]

The link to the Direction is
http://www.ipc.nsw.gov.au/sites/default/files/file_manager/NDIS_s62_HRIPA_Direction_Approved_by_Min_of_Health.pdf

The direction will enable Family and Community Services (FACS) (and other NSW public sector agencies including Health and Education) to collect, use and disclose personal health information about individuals and their carers, who receive disability supports funded by FACS, Health, NSW public sector agencies or an allied agency for the purposes of transitioning funded individuals to the NDIS.

The National Disability Insurance Authority (NDIA) will use this information to contact those individuals and commence their entry into the NDIS.

Guidance should be sought from LHD / SHN Privacy Contact Officers in relation to any external requests to release patient information under the Direction:
http://www.health.nsw.gov.au/patients/privacy/Pages/privacy-contact.aspx

Resource: Privacy Information Leaflet for Patients
http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-appendix-5.pdf

[8] This Direction has effect until 28/10/2017

3.2 Consent

The NSW Health Policy Directive PD 2005_406 - *Consent to Medical Treatment – Patient Information* sets the legal requirements for obtaining a valid consent from patients and advising patients of material risks associated with any proposed medical or dental treatment.

The policy also outlines how the law is to be applied when obtaining consent from a person who lacks capacity, is a minor, or is a patient who is being treated under the *Mental Health Act*. The Consent Policy can be found at: http://www0.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf

Treating practitioners should assume that an adult patient has capacity to consent unless there is evidence to contradict this assumption. The patient must have capacity to give consent to medical or dental treatment. A person has decision making capacity if they can:

- Understand the facts and choices involved
- Weigh up the consequences, and
- Communicate their decision.

For information on obtaining consent for people who lack capacity see Appendix 2.

3.3 People with disability and their support networks

People with disability may have a range of support needs and may access these supports from a range of sources, and have multiple parties involved in providing care or support to have those needs met.

It is important that health professionals find out if the person with disability has a support network and whether the person will need the support network's involvement during their hospital stay.

Developing a plan for disability support while in hospital should be part of pre-admission planning.

Health staff should communicate with the carer, family, guardian, and / or disability support staff, about ways to provide safe and personalised care for people whose disability could result in significant risk of harm to themselves, the carer or hospital staff e.g. due to fear, anxiety, absconding, challenging behaviours, difficulties with communication.

With the consent of the person with disability, health professionals should ensure that appropriate information is effectively communicated to the relevant members of the person's support network, in both the admission and the transfer of care planning stages.

Refer to section 4.2 Protocols between key agencies on LHD / SHN responsibility for negotiating and establishing frameworks and protocols with local disability support service providers for the provision of disability support services to the person with disability while they are in hospital.

Carers, family members, and disability support staff may assist with basic needs at the request of the person with disability and in consultation with health professionals, but are not obliged to assist with individual or medical care needs.

Carers

A carer[9] provides ongoing, unpaid[10] support to a family member, neighbour, or friend who needs help because of disability, chronic, terminal or mental illness or frail ageing.

The patient, their carers, hospital staff and the health care system all benefit from involving carers as a partner in the health care team. The work carers do is essential to the wellbeing of the person with disability and it is essential that they are listened to and consulted with through all stages of a person's hospitalisation.

The level of carer involvement may vary. Regardless of whether the carer chooses to remain with the person, or not, carers should be consulted at all stages of the patient's hospitalisation.

[9] As defined in the NSW Carers (Recognition) Act 2010, refer to the Glossary for definition.
[10] Carers may receive the Carer Payment or Carer Allowance
http://www.humanservices.gov.au/customer/services/centrelink/carer-allowance

LHDs / SHNs should develop local policies which outline the level of support that is available for the carer while the person with disability is in hospital e.g. bedside accommodation for the carer or family are providing support to the patient.

When a person the disability has a paid carer or disability support worker, due consideration will need to be paid to their status on the wards as an employee of the person with disability. Please refer to section 4.2 for more specific advice.

3.4 Care coordination

Care coordination and transfer of care arrangements for people with disability should be made in accordance with NSW Health Policy Directive PD2011_015 - *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*[11] [12], which sets out five stages of care coordination:

1. Pre Admission / Admission
2. Multidisciplinary Team Meetings
3. Estimated Date of Discharge (EDD)
4. Referrals and Liaison for patient transfer of care
5. Transfer of care out of the hospital.

LHDs / SHNs are responsible for establishing mechanisms to ensure that the essential stages of care coordination are undertaken in each facility and are sustained as part of normal care coordination and transfer of care planning.

Preparing for planned admission

Health services should ensure that as part of their pre-admission screening process, people with disability are offered pre-admission meetings for all planned episodes of hospitalisation. A relatively simple procedure can become unnecessarily complicated if there is insufficient pre-admission planning to ensure optimal supports are in place for the person with disability.

If the person requires multiple tests and / or procedures, consideration should be given to scheduling these in a way to maximise outcomes for the person during their admission to hospital.

Close liaison with the person's General Practitioner (GP) or other community based health professionals will support safe, quality, smooth admission into hospital and subsequent transfer back to the community.

Hospital staff should inform and involve the person's carer, family, guardian and / or disability support staff in planning for the admission as appropriate and with the agreement of the patient.

Should there be an expectation that during the patient's admission their accommodation needs will change, discussing these with the patient and their carer or family as early as possible will facilitate a smoother discharge.

Information about the facility's Patient Representative and consumer feedback mechanisms as well as the Inquiry Service of the Health Care Complaints Commission should be provided as part of pre-admission planning.

[11] http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_015.html

[12] Care Coordination. The following links to three documents that were developed to support staff with implementation of the Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*: http://www.health.nsw.gov.au/pfs/Pages/carecoordination.aspx . The three documents are:

1. Care Coordination Policy Directive Reference Manual
2. Care Coordination Policy Directive Staff Booklet
3. Planning your hospital stay patient brochure

Pre-admission meeting

A pre-admission meeting should be arranged with the person, and when relevant, involve the carer, family, guardian, disability support staff and relevant hospital staff. Reference should be made to GL2013_001 section 4.3.1, Pre admission meeting (pp.10-11), of the *NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline: Supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital*, NSW Health.[13]

Staff should be aware that additional time may be needed to develop a pre-admission plan with people who use augmentative and alternative communication methods.

Hospital staff should ensure that information about the hospital admission, hospital routines, and procedures are communicated to the person in the person's preferred communication style.

Transfer of Care Risk Assessment Tool

The person conducting the Transfer of Care Risk Assessment (TCRA) is responsible for communicating any identified risk to the relevant members of the multidisciplinary team. When a transfer of care risk is identified it must be documented and managed.[14]

A TCRA should be conducted at pre-admission and patients with an identified risk should be referred early to the appropriate community teams so planning for transfer back to the community can begin. Completion and actioning of the TCRA within the first contact with the patient, or within 24 hours will expedite this process.

Planned day-only admission

Transfer of care planning must also occur for patients having day-only procedures. Hospital facilities may nominate their own processes to ensure the Transfer of Care Risk Assessment is completed. Ideally this should occur prior to the day of the patient's procedure.

Pre-admission plan

The following issues may need to be addressed in order to complete a pre-admission plan for a person with disability:

- Disclosure of information and the inclusion of others from the person's support networks in the pre-admission and discharge planning process in line with the *NSW Health Privacy Manual for Health Information*
- Identification of whether the person is a participant of the NDISor in the process of making an application to the Scheme
- Procedures for determining informed consent
- Information regarding medical history, social and functional skills
- Clarification of the role of parties involved in care of a person with disability during the hospital stay, including the role of hospital staff, carer / family and disability support staff
- Key community resource contacts, where community or disability service agencies are involved or may be available
- Transportation and mobility requirements
- Physical support needs including appropriate lifting and positioning
- Nutrition and diet requirements; eating and drinking techniques
- Hygiene assistance needs
- The person's specific communication requirements. Hospital staff responsible for planning the admission should ensure that if required a person with disability can bring to hospital their communication resources or equipment such as augmentative communication devices, mobility or functional aids

[13] http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_001.pdf
[14] p. 1, Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*, http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_015.pdf

- Management strategies for difficult or challenging behaviours. Consider involving Dementia Specialists e.g. Clinical Nurse Consultant Aged Care in a suitable management plan
- Consideration of usual care and activity routines to ensure that any medical intervention causes the minimal amount of disruption, confusion and stress to them
- Specific information on equipment that patients must bring to the hospital e.g. for pressure care, respiratory support, should also be discussed. Consider involving Occupational Therapy and Physiotherapy in discussions regarding required equipment
- Hospital staff should ensure that space is provided for comfortable operation and safe storage of equipment, and that the equipment is readily available for use
- Patients who use an assistance animal, such as a guide dog, should not be separated unnecessarily from the animal, and space and care for the animal should be planned and made available
- Conflict resolution mechanisms
- Hospital complaints mechanisms and processes.

Planning for an extended hospital stay may need to include strategies to assist the person to maintain their skills and capacities such as:

- Hospital day passes to access day program and community services can assist in sustaining pre-hospital functional capacity
- Patients, their carer and family, where the patient is an NDIS participant, should be consulted to acquire details of any education, home or day programs that they receive funding for and how those may be accessed.
- Where the patient is not an NDIS participant, they should be consulted to determine whether they are involved in any Information Linkages and Capacity Building (ILC), state / Commonwealth provided education, respite or day supports and how these are accessed
- Where the patient is a long stay resident, the NDIA will need to be informed that the Hospital will temporarily assume the status as the clients' place of residence and that all correspondence should be sent there
- Patients with intellectual disability who underutilise their skills will risk losing those skills. In extended admissions, where possible, hospitals should seek input from their current disability supports and education services for their day-to-day care.
- Where practicable, enable children to continue their school education activities and have access to play therapy.

Engage with the National Disability Insurance Agency (NDIA)

When the person with disability has identified themselves as a participant of the NDIS, identify on what basis their plan is being managed:

- Self-managed – the person with disability will be able to discuss their plan components and, as the coordinator of supports, work with hospital staff to incorporate discharge and ongoing service needs into their budget

- Plan Management Provider – appropriate client consent needs to be gathered and contact made with the plan management provider to ascertain the types of disability supports the client is funded by the NDIS for and discuss their future discharge needs.

Where the person with disability is <u>not an NDIS participant,</u> consideration should be given at the pre-admission stage as to whether they may be eligible for the NDIS. If the person with disability is understood to satisfy the access requirements then they should be supported with an application to the NDIA as early as possible. However this should not delay the planned hospitalisation unnecessarily.

3.5 Admission

When a person with disability is admitted to hospital, health staff should ask the patient, what communication needs they have, whether they are in the NDIS, what existing home support networks they have in place and how their supports and care are coordinated at home. It should always be assumed that the patient is capable of providing consent unless there is evidence (legal or other) otherwise. See Appendix 2: Obtaining consent from a person who lacks capacity.

Planned admission

All planned admission patients should have their Transfer of Care Risk Assessment completed at presentation or before admission to hospital, such as at a pre-admission clinic or meeting. Completion of this assessment will allow the identification of transfer of care risks. Necessary referrals should be made before admission, where possible, and confirmed during the acute phase of care.

Emergency or direct admission

An emergency admission for a person with disability may result in a lack of optimal supports being readily available because of the absence of pre-admission planning.

Non-planned admissions through the Emergency Department or through direct admission should have a Transfer of Care Risk Assessment completed on the inpatient ward within the first 24 hours of admission.[15] This will ensure that all risks to the safety and wellbeing of the person while in hospital are identified, and appropriate arrangements made for the availability of supports needed by the person while they are in hospital. The risks identified and arrangements made should be documented in care plans, records and Transfer of Care Risk Assessment. This should be done as soon as practical either prior to transfer to the ward or once the person is settled in the ward.

People with disability admitted through the Emergency Department should be asked whether they are a NDIS participant. Refer to discussion under *Engage with the National Disability Insurance Agency* above for reasons and suggested action.

Where the patient has a known intellectual disability, the presence of a known person may reduce stress, reduce the risk of escalating challenging behaviours and improve overall health and safety outcomes for the health service and the person with disability alike.

Emergency admission to hospital from an Ageing, Disability and Home Care (ADHC) operated or funded supported accommodation

Reference should be made to *NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital*[16] NSW Health GL2013_001 (pages 9-10), which sets out what the disability support staff member who accompanies the person to hospital will do at presentation to the Emergency Department.

Emergency admission from non-government supported accommodation facilities and contracted accommodation providers under the NDIS.

LHDs / SHNs should consult with clients and their local non-government (NGO) supported accommodation providers, for example assisted boarding houses, to develop frameworks and protocols to establish arrangements for patients to be admitted through the Emergency Department from those facilities. Reference should be made to the Joint Guidelines for examples of issues for which there should be agreed frameworks and protocols between the LHD / SHN and the NGO. Refer to section 4.1 on NGO's.

[15] p.2, Policy Directive PD2011_015 *Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals*, http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_015.pdf
[16] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html

3.6 During the hospital stay

All staff providing care must ensure that they are familiar with the specific care and communication needs of the person with disability throughout the duration of their hospitalisation.

Staff will need to recognise the individual needs that some patients with complex impairments may have and make additional time is available for discussion and treatment.

Staff and other resources may need to be available to enable patients to access usual care in activities such as eating, drinking, toileting and personal hygiene. Some patients with disability may also require frequent checks on their safety.

In some cases, simple techniques can be used to enable patients to access usual care – for example, letting a patient who is blind know that their meal has arrived, where it is, and where different parts of the meal are on a plate, acknowledging the patient when entering or leaving the room; obtaining the visual attention of a person who is deaf or hard of hearing prior to addressing or approaching them.

Additional staffing resources may be required to meet these needs. Refer to section 2.5 Reasonable adjustment.

Multidisciplinary Team meeting

Refer to Policy Directive PD2011_015 - *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* for policy requirements on:

- Conducting multi-disciplinary team meetings
- Estimated Date of Discharge (EDD).

Referrals and Liaison

In consultation with the patient, their carer, family, guardian and/or disability support staff, it is important to agree what services are required after transfer from hospital following an acute episode of care. Where the supports are not chronic or disease focused, the patient may be able to acquire supports through NDIS funding.

Each hospital is required to develop a referral structure to enable staff to easily contact relevant chronic condition or disease service providers. When the patient is in the NDIS, they will need to provide details of their current relevant service providers as well as their plan management provider and be ready to contact the NDIA about their plan.

Involvement of NDIA planners, during discharge planning by multidisciplinary teams, should be considered to ensure that health related components are represented in NDIS applicant's plans and that a proper discharge timetable can be constructed.

Details for referrals should be recorded in one place in the patient's medical record and on any relevant individual referrals, for example to the patient's General Practitioner (GP) and other community based services. [17]

Where a patient has given permission for Health staff to contact their community service provider, Community based staff who will be involved in providing out of hospital care and support should be encouraged to visit the patient while they are in hospital to assess their ongoing needs at home and discuss the patient's needs with the Multidisciplinary Team.

Examples of out of hospital programs or services (non-NDIS) that may support transfer of patients from hospital, or patients in the community, are:

- Community Packages (ComPacks)
- Hospital outpatient department services
- Community nursing
- General Practitioners.

[17] p.5, Op.cit.

3.7 Transfer of care out of hospital

Clear communication between the patient, carer, family, guardian, hospital staff, community-based services and the person with disability's support network is vital to an effective transfer of care process.

Special information that should be noted and will assist in the completion of the Transfer of Care Risk Assessment and Transfer of Care Readiness Checklist, and identification of the Estimated Date of Transfer includes:

- Whether the person has capacity to consent to medical treatment, and, if not, what arrangements have been made for someone to make decisions on behalf of the person
- Clarification of the patients' NDIS status and of the role of people already involved in providing supports and their contact details
- Mobility and transport requirements.

Information provided to patients, and where appropriate, to carers, family, and disability support staff who will be involved in their ongoing care should be in plain English and explained to the patient and those who will be involved in their care.

The transfer of care process for the person with disability must include:

- Determination of the suitability of existing home support systems or the patient's NDIS plan components (if an NDIS client), when completing a Transfer of Care Risk Assessment. This should involve consultation with the patient, and, where appropriate, their carer, family, guardian, their advocate, and provider of supports to establish the level of care and support needs required. Environmental adjustments should be made as needed
- Referral to out of hospital, community-based health services, or specialist services as required by the patient:
    - Arrange appointments for post hospital services as required, examples:
        - Follow up appointments with medical specialists related to acute episode of care, and if needed, referrals for management of chronic conditions or disease
        - Allied Health services
        - Hospital outpatient department.
    - Refer the patient, if needed, to post hospital home visits by nursing services. For surgical admissions, post-surgery links with community health services (e.g. community nursing services). Referrals are to be made before transfer of care and service/s negotiated, including consideration if the patient's care needs can be met on a short or long-term basis
    - Provide information about the appointments and arrangements to the patient and where appropriate to their carer and or family. If the person's home is in supported accommodation this information should be provided to the disability support staff that provide support to the person
- Medication education / medical reconciliation: if the Multidisciplinary Team identifies the patient has a medication risk (as per Transfer of Care Risk Assessment) the patient should be prioritised for the pharmacist's review over non-urgent cases
- Provide information and relevant education and training to the patient, and, where appropriate, their carer, family, guardian, and disability support staff. The information should include: post-hospital care and support the person needs, including: changes to or new medication/s or treatments reflecting any changes in care required as a result of the hospitalisation or treatment provided
- Explain the transfer of care plan to the patient, and where appropriate, to their carer, family, guardian, and disability support staff

- In the case of a patient living in supported accommodation, the transfer of care plan needs to be developed in collaboration with the patient, and where appropriate their carer, family, guardian, and disability service provider/ staff in a case conference
- Notify, advise and confirm transfer date and time with carer, family, guardian and disability support staff.

It may not be feasible for the patient to return to their previous accommodation on leaving hospital, including people who were admitted from supported accommodation. For example, if a clinical event has changed their ongoing care needs the patient's support arrangements may need to be altered. Early identification of the person's care needs after the hospital stay and timely referrals to establish appropriate arrangements may minimise delay in transfer of care out of hospital. The person, their carer, family, and guardian should be involved in these discussions and supported while arrangements are made for alternative residential accommodation.

Progressively from June 2016 where a person with disability requires functional supports to be put in place in order to be safely transferred back to the community and they are not an NDIS participant, consideration should be given to an application being made to the NDIA. This should be done as soon as practical, ideally as a part of pre-admission planning or shortly after admission, in order for the NDIA to make a decision about eligibility and for an appropriate plan to be put in place.

Transfer of care referral (known as transfer of care summary or discharge summary)

The patient's General Practitioner (GP) or Aboriginal Community Controlled Health Service (ACCHS), and community nurse (where required) should receive a written transfer of care referral when the patient is transferred out of hospital or within 48 hours of the transfer.

The transfer of care referral should include:

- A summary of the person's clinical episode of care
- A list of medications with information about changes to medications
- Follow up advice for the GP or ACCHS
- Details of community services involved or residential care arrangements
- Information on the person's communication needs and preferences. Documentation should include: communication aids used by the patient, interpreting gestures, signs and behaviours which people may use to convey their needs and responses.

The transfer of care plan should be explained to the patient, and where appropriate, to their carer, family, guardian, and disability support staff.

In short stay services such as emergency departments, day only or planned day only services, a short stay referral summary may be utilised instead of a full transfer of care referral summary; as clinically appropriate.

4. IMPLEMENTATION AND MONITORING

4.1 Local working relationships

LHDs / SHNs should establish effective working relationships with local community based health and disability service providers to improve transfer of care for people with disability between public health facilities and community based service providers.

Examples of types of organisations include:

- National Disability Insurance Agency (NDIA)
- Plan Management Providers funded by the NDIA
- Community based medical practitioners, includes specialists and General Practitioners

- Community based allied health services (private; non-government)
- Disability service providers
- Community organisations
- Supported accommodation providers
- Aged care providers
- Aboriginal Medical Service (AMS)
- Aboriginal Community Controlled Health Service (ACCHS).

LHDs / SHNs should work collaboratively with community based service providers to establish effective referral pathways to ensure coordination of care around the needs of the person with disability.

Stakeholders

The phased implementation of the NDIS across NSW from July 2016 is likely to increase the number and diversity of non-government disability support services.

LHDs / SHNs should ensure that organisations representing people with disability, such as disability advocacy and carers organisations are consulted in implementing changes to health service systems to interface with the new disability service system that will result from the reforms.

4.2 Protocols between key agencies

LHDs / SHNs should develop and establish agreements and protocols with local disability support providers to apply in situations where disability support staff or disability support nurses provide disability supports in the hospital or acute care setting.

Section 2.5 Reasonable adjustment is relevant to this section.

Ageing, Disability and Home Care (ADHC) operated and funded accommodation support services

The NSW Health and Ageing, Disability and Home Care (ADHC) Joint Guideline: Supporting Residents of ADHC Operated and Funded Accommodation Support Services Who Present to a NSW Public Hospital, NSW Health GL2013_001 [18] (Joint Guideline) aims to ensure staff in hospitals and disability accommodation services operated and funded by ADHC are aware of their respective roles and responsibilities for people with disability before, during and after transfer of care from hospital.

Reference should be made to the Joint Guideline in situations when a person with disability is admitted to hospital from an ADHC operated or funded facility, for guidance on:

- Roles and responsibilities of staff in hospitals, and disability accommodation support services before, during and after transfer of care from hospital
- Identifying areas of risk that could compromise a person with disability's capacity to achieve the best health outcome and their safety and/ or dignity during their hospital stay
- Agreeing on what additional supports will be required to reduce identified risks
- Negotiating responsibility and resources for the provision of agreed additional support.

Non-government supported accommodation

People with disability living in non-government organisation (NGO) supported accommodation may receive support from disability support staff, which includes any of the following: residential care workers, assistants, physiotherapists, occupational therapists, speech pathologists, psychologists, social workers, nurses, case managers, and other support staff who are involved in the care or support of the person at the time of hospitalisation. Residential care workers are most likely support providers.

LHDs / SHNs should develop frameworks and protocols with NGO service providers in their district for the provision of supports and care to people with disability before, during and after transfer of care from

[18] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html The Joint Guideline was endorsed by ADHC and NSW Health, and was developed in consultation with key stakeholders across health and disability sectors. The Joint Guidelines notes some Local Health Districts and ADHC Regions have developed local protocols which provide the framework for effective support of ADHC clients during a hospital stay, and the Guideline aimed to facilitate a higher level of compliance with NSW Health and ADHC policies.

hospital for people who live in supported accommodation settings.

In some instances, disability support staff may assist with basic needs, but this should happen within the context of a protocol or agreement between the disability support provider and the hospital, with the respective roles clarified at pre-admission planning.

It is important at pre-admission that the expectations, roles and responsibilities of disability support staff are clarified within the context of a protocol or agreement between the disability agency and the LHDs / SHNs including who pays while disability support staff are providing support in hospitals.

The frameworks between the LHDs / SHNs and NGO service providers should address effective partnerships and provide a structure for protocols between local hospitals and the local community and/or disability services. Local protocols should:

- Address roles and responsibilities of disability support staff in the hospital or acute care setting including, work health and safety arrangements, workers compensation, professional indemnity, and public liability insurance
- Address what the disability support staff will do when accompanying a person to the Emergency Department. Refer to section 3.4.2 Admission
- Include a decision making escalation process for issues that cannot be negotiated at the level of Nurse Unit Manager with their counter-part representing the NGO service provider
- Include general principles and procedures to ensure that transfer of care between the hospital, community and disability services is articulated and coordinated clearly around the needs of people with disability. Section 3.4.3 on Transfer of care out of hospital is relevant here.

LHDs / SHNs may wish to use the Joint Guidelines as a reference for the range or types of issues that need to be jointly agreed across stages in the patient's journey.

4.3 Existing resources

In addition to patient safety and quality monitoring systems, a range of resources are available to support staff to meet the needs of people with disability during hospitalisation.

- Aboriginal Hospital Liaison Officers are an important resource for patients who identify as Aboriginal
- LHD / SHN Carer Support Services are available to provide staff with development and training, information, resources and advice on support for carers.[19]
- Courses and programs are offered by Health Education and Training Institute and Intellectual Disability Mental Health e-learning [20]
- The NSW Health and Ageing, Disability and Home Care Joint Guideline supporting residents of ADHC operated and funded accommodation supported services who present to a NSW Public Hospital, NSW Health GL2013_001[21]
- TOP 5 Model is a simple process that encourages health professionals to engage with carers to gain valuable non-clinical information to help personalise care[22]
- Health Care Interpreting and Translating Services – Patients, carers, and family who do not speak English as a first language or who are deaf have a right to free confidential and professional interpreters when they use public health services. Policy Directive 2006_053 - I*nterpreters – Standard Procedures for Working with Health Care Interpreters* is mandatory.[23] Information about the five Health Care Interpreter Services in NSW – three metropolitan and two rural, and three

[19] Information on:
  - NSW Health support for carers can be found here: http://www.health.nsw.gov.au/carers/Pages/default.aspx
  - Local Health District Carer Support Services can be found here: http://www.health.nsw.gov.au/carers/Pages/resources.aspx

[20] http://www.heti.nsw.gov.au/heti-online-modules/
[21] http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_001.html
[22] http://www.cec.health.nsw.gov.au/programs/partnering-with-patients/top5
[23] http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_053.html

Translation Services can be found on the Health Care Interpreting and Translating Services website. [24]

- Agency for Clinical Innovation (ACI) has developed resources that "relate to the care and health of people with intellectual disability across all ages, including acquired brain injuries by enhancing the capacity of primary and secondary health services." The link to these resources is: http://www.aci.health.nsw.gov.au/networks/intellectual-disability/resources [25]
- *NSW Health Carers (Recognition) Act and Carers Strategy Implementation Plan 2013-2016*[26]
- *NSW Carers 3 2014-2019*[27]; factsheet[28] on NSW Health website has actions that Health staff can undertake to reflect the strategy.

4.4 In-service, education and training

It is important that hospital staff are familiar with developments including contemporary practice in the support of people with disability in the community.

Training must include information about appropriate communication with people from culturally and linguistically diverse backgrounds (including people who are deaf) and people from an Aboriginal and / or Torres Strait Islander background.

LHDs / SHNs should support health staff to access to education and training on:

- Values and attitudes towards people with disability, their families and carer
- Skill development (e.g. communication and disability etiquette)
- Best practice in health provision for people with disability.

Organisations representing people with disability should also be consulted in the development of disability awareness training for staff.

4.5 Monitoring

An Implementation Checklist (Appendix 3) has been developed for use by LHDs / SHNs to assess their compliance with this policy directive. LHDs / SHNs can also use the checklist to monitor their implementation of the policy by undertaking assessments in different time periods or at stages of an implementation plan.

Safety and quality systems

In most LHDs / SHNs there are existing patient safety and quality monitoring processes that can be used to identify issues in the quality of health care provided to patients with disability and associated outcomes. These include:

- Incident Information Management System (IIMS)
- Complaints mechanisms
- Consumer, carer and patient satisfaction surveys and interviews
- Accreditation processes
- Periodic health record audits
- Length of stay reporting
- Monitoring of hospital readmissions.

Performance indicators, outcomes measures and patient experience

LHDs / SHNs should develop mechanisms to determine if there is a difference in outcomes for people with disability when compared to the general population. This information should be disaggregated by

[24] http://www.health.nsw.gov.au/multicultural/Pages/Health-Care-Interpreting-and-Translating-Services.aspx
[25] The ACI Intellectual Disability Network works to improve the care and health of people with intellectual disability across all ages by providing clinical leadership, research and education to enhance the capacity of primary and secondary health services. Information about the network including on becoming a member can be found here: http://www.aci.health.nsw.gov.au/networks/intellectual-disability/about
[26] http://www.health.nsw.gov.au/carers/pages/default.aspx
[27] https://www.adhc.nsw.gov.au/__data/assets/file/0017/300077/NSW_Carers_Strategy_2014-19.pdf
[28] http://www.health.nsw.gov.au/carers/Documents/carers-strat-fact-sheet-final.pdf

age, gender, type of disability, place of residence and cultural background. [29] See Appendix 1 for examples of performance indicators and outcome measures.

The type of assessment described above could be undertaken in targeted projects or reviews of specific areas or service types of interest.

Systematic monitoring of people with disability's access to health services, and comparing their outcomes against those of the general population requires data items to identify people with disability in data collection systems.

NSW Health is committed to enhancing services and building greater accountability by improving data collection and reporting on disability inclusion in Strategy 8 of the *Disability Inclusion Action Plan 2016-2019* (DIAP):

- Action 8.1 The DIAP Governance Group to work closely with relevant partners to consider appropriate systems to identify people with disability to improve equity in access and measure health outcomes compared to the general population.

The NSW Ministry of Health will monitor changes in the sensitivity and adaptability of LHDs / SHNs staff to the needs of people with disability during hospitalisation through an annual report which will be prepared by the Bureau of Health Information and made publically available:

- Action 8.2 Produce a disability focused report on an annual basis of patient perspectives on the care people with disability receive through NSW Health.

APPENDIX 1: POTENTIAL PERFORMANCE INDICATORS AND OUTCOMES MEASURES

The following are examples of performance indicators and outcomes measures that LHDs / SHNs may use to assess whether there is a difference in outcomes for people with disability when compared to the general population. Refer to *section 4.5 Monitoring*.

- Access by people with disability to health services (including hospitals) — how many seen; in what services; for what reasons
- Adherence to adjustments to meet the needs of people with disability — including audits of identified support needs/adjustments required and the adjustments made (and type of adjustment)
- Rates and trends over time for emergency department presentations, including:
  - Pathways to and from emergency department
  - Rates of ambulatory care sensitive presentations to emergency department for people with disability, disaggregated by disability type.
- Rates and trends over time for admitted patient data for people with disability, disaggregated by disability type and admission facility, including
  - Admission pathways
  - Diagnoses
  - Potentially avoidable admissions
  - Length of stay
  - Separation mode
  - 30-day readmission rates.
- Rates and trends over time for ambulatory care for people with disability, disaggregated by disability type and ambulatory care setting.
- Error rates for people with and without disability, disaggregated by disability type.
- Use of restraints (with examination of the identified support needs and the support provided)
- Inclusion in chronic disease management and other out-of-hospital programs.
- Inclusion in preventative health programs.

[29] United Nations *Convention on the Rights of Persons with Disabilities*, Article 31 – Statistics and data collection http://www.un.org/disabilities/convention/conventionfull.shtml

APPENDIX 2: OBTAINING CONSENT FROM A PERSON WHO LACKS CAPACITY

If a health care practitioner has doubts or concerns about whether their patient has capacity to make a particular decision, then a capacity assessment may be needed.

Capacity is specific to the particular decision that needs to be made. In some circumstances, the law sets out what tests must be met for capacity to make the decision, for example in relation to medical treatment. The NSW Capacity Toolkit produced by the NSW Department Justice aims to assist people in correctly identifying whether an individual has the capacity to make their own decisions. It provides information generally about capacity, capacity assessments and the various legal tests of capacity in NSW although it does not specifically address the assessment of capacity in regard to consent to medical treatment. For further information refer:
http://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609.pdf

Where a patient lacks capacity to consent – substitute decision makers

In circumstances where a patient lacks capacity to consent to medical or dental treatment, there are legislative and policy frameworks to assist health professionals identify a person who can make decisions on behalf of that patient.

The Responsible Person

The *Guardianship Act 1987* requires the health care practitioner to seek consent from the patient's 'Person Responsible' if the patient is not capable of consenting to their own treatment.

A Person Responsible may not necessarily be the patient's next of kin or carer. Section 33A(4) of the *Guardianship Act 1987* sets out a hierarchy of people who can be the Person Responsible.

NSW Civil and Administrative Tribunal (NCAT) Guardian Division Fact Sheet Person Responsible (April 2016) http://www.ncat.nsw.gov.au/Documents/gd_factsheet_person_responsible.pdf

Enduring Guardian

An adult can appoint an Enduring Guardian to make personal and lifestyle decisions on their behalf if they lose capacity to make such decisions. If a person appoints an Enduring Guardian with authority to make medical treatment decisions then they will be their Person Responsible.

In addition to the usual authority of a Person Responsible, an Enduring Guardian may also have the authority to make decisions about a range of personal/lifestyle areas on behalf of the appointee, not just medical treatment decisions. Find out more about how to appoint an Enduring Guardian at
http://planningaheadtools.com.au/appoint-an-enduring-guardian/

For more information see the Guardianship Division of the NSW Civil and Administrative Tribunal at
http://www.ncat.nsw.gov.au/Pages/guardianship/guardianship.aspx

Mental Health Act 2007

Under the Mental Health Act 2007, a patient who is either mentally ill or mentally disordered will be admitted or treated in a declared mental health facility as a voluntary or detained patient (including assessable patients, involuntary patients, correctional patients and forensic patients). This status determines how decisions should be made about their mental and physical health treatments and who has the legal authority to make them.

The *Mental Health Act* establishes obligations for health care practitioners to inform carers of patients being treated under the *Mental Health Act* depending on the category of patient and the medical treatment involved.

The two types of carers are designated carers and principal care providers.

A *designated carer* of a person (the patient) is defined in the Act to be:

(a) the guardian of the patient; or
(b) the parent of a patient who is a child (subject to any nomination by a patient referred to in paragraph (c)); or
(c) if the patient is over the age of 14 years and is not a person under guardianship, a person nominated by the patient as a designated carer under the Act under a nomination that is in force; or
(d) if the patient is not a patient referred to in paragraph (a) or (b) or there is no nomination in force as referred to in paragraph (c);
  a. the spouse of the patient, if any, if the relationship between the patient and the spouse is close and continuing; or
  b. any individual who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a commercial basis); or
  c. a close friend or relative of the patient.

A person may nominate up to two persons to be their designated carers.

A *principal care provider* of a person is defined in the Act to be the individual who is primarily responsible for providing support or care to the person (other than wholly or substantially on a commercial basis).

A principal care provider may also be the designated carer of a person.

Voluntary patients without capacity under the Mental Health Act

If a voluntary patient lacks capacity to consent (due to mental illness or otherwise) and requires medical treatment, the substitute decision making provisions of the *Guardianship Act* will generally apply (see above).

Refer to NSW Health Policy Directive PD2005_406 - *Consent to Medical Treatment – Patient Information.*

Assessable patients, involuntary patients, correctional patients and forensic patients

The *Mental Health Act* provides for a substitute decision to be made for detained patients without capacity. The decision maker may vary according to the category of patient and the type of medical treatment required as well as the urgency of the need for such treatment. These decision makers include:

- The Secretary of NSW Health
- Senior Officers within NSW Health who have been designated as authorised medical officers by the Secretary of NSW Health
- The Mental Health Review Tribunal.

Refer to:

- The NSW Health Policy Directive *Consent to Medical Treatment – Patient Information,* PD2005_406

The Mental Health Review Tribunal: http://www.mhrt.nsw.gov.au/the-tribunal/

To download **APPENDIX 3: IMPLEMENTATION CHECKLIST** And

APPENDIX 4: GLOSSARY please refer to the following link:

Responding to Needs of People with Disability during Hospitalisation PD2017_001.pdf

NSW DRUG AND ALCOHOL CLINICAL SUPERVISION GUIDELINES (GL2006_009)

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1. Executive summary

This document provides comprehensive guidance in relation to the implementation of clinical supervision programs within NSW Drug and Alcohol (D&A) services. In summary, the key messages contained within the Guidelines are:

- *Participation in clinical supervision is expected* of all staff in D&A services who provide direct services to clients, including medical and nursing staff, psychologists, social workers, D&A workers and D&A counsellors.
- It is advisable for D&A services to clearly articulate their requirements, arrangements and expectations in relation to clinical supervision in policies and procedures and to make staff aware of these.
- Managers and clinical leaders can play an important role in *engendering a culture of support and acceptance* for clinical supervision within the organisation.
- The *purpose of clinical supervision* is to provide a tool for workforce development, a mechanism for quality assurance and clinical safety, and a means of providing professional support and debriefing to staff.
- Clinical supervision sessions involve the *review and discussion of a worker's clinical practice* with a clinical supervisor. The content of such discussions remains confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a worker or client.
- *Clinical supervision is not line management* and the two processes ought to remain separate. It is generally inadvisable for line managers to act as clinical supervisors for their direct reports. However it should be noted that this might not apply in medical settings where traditionally the Clinical Medical Director provides both clinical supervision and line management to junior medical colleagues.
- Supervisors, supervisees and managers all have *specific roles and responsibilities* within the clinical supervision process, and all parties need to be clear about these. Ideally, roles and responsibilities will be articulated in contractual arrangements or service agreements.
- Organisations can elect to utilise clinical supervisors who are either internal *(employed by the organisation) or external*. Both models are in operation and have merit.
- Clinical supervision can be offered as either *individual (one supervisor with one worker)* or group (one supervisor to a small number of staff). Both models are in operation and have merit, although there are particular issues that need to be taken into account in group supervision models.

- Supervisors need to be *trained in clinical supervision*, ensure that they operate within relevant ethical and professional codes of conduct, and provide supervision in line with the requirements of the service. Ideally, they will also access supervision for their clinical supervision practice.
- Clinical supervisors should be appointed through *appropriate recruitment and selection* processes and there are generally agreed criteria applicable to the selection of appropriate supervisors.
- Effective clinical supervision relies on the development of a strong *alliance between supervisors and supervisees*, and ideally there should be a degree of choice for workers in selection of a supervisor.
- Clinical supervision *programs need to remain flexible* to ensure that they meet the needs of workers at all stages of their development and career path.
- It is important for policies and procedures to spell out the appropriate mechanisms whereby staff, managers and supervisors can *address any concerns they have about clinical supervision.*
- Organisations need to ensure they put in place *appropriate infrastructure* to support, coordinate and manage clinical supervision programs.
- *Monitoring and evaluation* of clinical supervision programs is considered important to ensure that they are meeting objectives, to identify the benefits, determine effectiveness and levels of staff satisfaction, and to report on uptake and compliance across the organisation. Any such mechanisms should ensure that the content of clinical supervision sessions remains appropriately confidential.

All of the above issues are discussed comprehensively within the Guidelines.

2. Introduction and background

These Guidelines have been developed for the NSW Health Drug and Alcohol sector. This section outlines the impetus for and process of their development, their intended application and the policy context within which they operate.

2.1 Impetus for the guidelines

A number of key factors created the impetus for the NSW Drug and Alcohol Council to commission the development of NSW D&A Clinical Supervision Guidelines. Considerations were:

- A growing recognition of the value and importance of clinical supervision, and a desire to provide support to its broader implementation.
- Some concerns that the extent to which workers in D&A services were able to access clinical supervision was somewhat ad-hoc across the state.
- The need for a greater level of understanding about the purpose and benefits of clinical supervision.
- A desire to develop greater consistency in the implementation of clinical supervision programs within D&A services.

2.2 Policy context

The broad policy context within which the Guidelines sit is twofold. Firstly the NSW D&A Policy context, which is outlined in the NSW Drug Treatment Services Plan 2000-2005 and which states that:

> *Clinical treatment should reflect good practice identified in the current research literature and documented in clinical outcome studies. Programs need to be flexible, individualised and based on the best available evidence of effectiveness'.*[27]

[24] NSW Health Drug Treatment Services Plan 2000-2005.

Clinical supervision provides one mechanism whereby services can facilitate 'good practice' on the part of individual clinicians, because through supervision, clinical practice is subject to a process of professional enquiry that aims to ensure that services to clients remain within treatment modalities that are known to be the most effective.

The second important policy context is that of clinical governance, which places responsibility for the quality of care jointly on organisations and individuals. Clinical governance is defined as:

> *The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*[28]

Ensuring the ongoing clinical competence of individual clinicians is a cornerstone of clinical governance, and this is formalised in NSW Health's Framework for Managing the Quality of Health Services in NSW and the supporting document The Clinician's Toolkit, which identifies the need for transparent and accountable processes to be in place, including clinical supervision for all clinicians. Clinical supervision is one of a number of activities that are designed to manage, enhance and monitor the delivery of clinical services, and active participation in clinical supervision is one way in which clinicians can exercise their individual responsibilities for clinical governance.[29]

In addition to the broad policy context described above, the majority of NSW Health D&A services already provide a level of clinical supervision for staff, and this is generally governed by local policies and procedures. As its name suggests, this document provides guidance, is not a policy, and is not intended to replace or take precedence over local policies and procedures, but rather to further inform local policies, and provide a framework for good practice that D&A services can refer to.

2.3 Intended application

The Guidelines are generic and intended to be applicable across disciplines to all workers in D&A services who have responsibility for the provision of direct services to clients, either individually or in groups. This includes medical staff, nursing staff, psychologists and social workers, as well as positions that are classified more generally as either D&A worker, or counsellor. At the outset, some comments related to scope and limitations of their application are warranted:

- The Guidelines are unlikely to be entirely appropriate for Aboriginal and Torres Strait Islander workers in D&A services. The scope of their development did not allow for extensive consultation and consideration of issues related to Indigenous staff; however, the indications are that Aboriginal and Torres Strait Islander workers may well have a particular need for clinical supervision given the complexities of their role, and because the potential for personal impact is greater, due to their dual responsibilities to organisation and community. Whilst these Guidelines provide a basis for good practice, they would require further review and adjustment to be appropriate. Any such review should occur in collaboration, for example with the NSW Health Aboriginal Workforce Development Branch.

- As indicated above, the Guidelines are intended to apply to medical staff working within D&A services. However, it is acknowledged that health services have historically experienced a level of difficulty in engaging all medical staff in the full range of quality assurance mechanisms expected of them. It is therefore worth noting at the outset that it is the intention that the Guidelines apply to medical staff and to stress the importance of services developing agreed pathways for clinical supervision for this key professional group.

[25] NHS 1998, The new NHS: Modern and Dependable, quoted in NSW Health's The Clinicians Toolkit for Improving Patient Care, 2001.

[29] Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. Butterworth and Woods, The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.

- There are specific requirements for clinical supervision associated with some professions, for example the requirements for psychologists seeking registration. These Guidelines are not intended to replace any such requirements, which clearly need to be adhered to as required, and negotiated on a case-by-case basis between workers and services.

- The Guidelines are applicable to staff employed within D&A services, and are not intended to apply to students on placement who are not employees. Whilst students may well have clinical and/or other supervision requirements associated with their placement, these are not referred to in this document.

- The intent of the Guidelines is to allow for flexibility. They are not prescriptive, but rather make suggestions about what constitutes good practice. Whilst the evidence related to clinical supervision is somewhat limited, there are themes in the literature about what is commonly considered to be sound or best practice, much of which is already reflected in some D&A clinical supervision programs. There is no single recommended model of clinical supervision, and there is a need for services to have flexibility to implement programs and processes appropriate to the local context, and within the available resources. The Guidelines are intended to provide a framework for, and support to local operations, and to encourage a degree of consistency across the state. In addition, the recent amalgamation of Area Health Services (AHSs) will potentially require the review of two existing approaches to clinical supervision and agreement about one Area-wide approach. It is anticipated that this document may assist with any such deliberations.

2.4 Development process

In June 2005 the CDA contracted an external consultant (Jacq Hackett Consulting) to develop the Guidelines and established an Advisory Group to provide oversight to the process. Membership of the Advisory Group is at Appendix 1. During the same timeframe, a related consultancy was commissioned for the development and delivery of Clinical Supervision Training for senior clinicians within NSW Health Drug and Alcohol Services. This project was undertaken by Access Macquarie Ltd, and work undertaken through this project also informed the development of the Guidelines.

Key steps in the development process were as follows:

- A review of current processes and policies for clinical supervision within D&A Services across the state.
- Broad consultation with stakeholders from AHSs[30] including D&A Directors, Service Managers, clinicians, D&A workers, MERIT staff and internal and external providers of clinical supervision. In addition interviews were undertaken with staff from Justice Health, Odyssey House, NADA (Network of Alcohol and Drug Agencies), the CDA, the Centre for Aboriginal Health, Aboriginal Workforce Development Branch, NCETA (National Centre for Education and Training on Addiction), Relationships Australia and with the co-chairs of the D&A Nursing Advisory Committee and the D&A Allied Health Workers Advisory Committee.
- Review of findings from work undertaken by Access Macquarie Ltd as part of their training needs analysis, including an email survey of NSW D&A workers and a series of consultations with Aboriginal and Torres Strait Islander D&A workers.
- A desktop review of relevant documentation and literature.

[30] Site visits were held in SSWAHS (Croydon), H&NEAHS (Tamworth and Newcastle sites) and SWAHS (Parramatta, Penrith and Blue Mountains), GWAHS (Dubbo), NCAHS (Lismore, and telephone consultations in Coffs Harbour).

- The development of a Discussion Paper that was distributed to all D&A Directors for comment and feedback.
- The development of Draft Guidelines, taking account of feedback from the Discussion Paper, also distributed to D&A Directors for comment and feedback.
- The development of Final Guidelines incorporating feedback on the Draft.
- Close collaboration and consultation with the Advisory Group at all key stages of the project.

3. Definition and purpose of Clinical Supervision

This section provides a working definition of clinical supervision as it applies throughout these Guidelines. It also outlines the common benefits of clinical supervision from the perspective of organisations and staff.

3.1 What is Clinical Supervision?

Agreeing a definition is never easy, and indeed the literature offers an extensive range of definitions for the term clinical supervision. In addition, the views of workers in the field about the meaning of clinical supervision are somewhat variable. However, there are some common themes, and three key purposes for clinical supervision emerge, it is a:

- **Tool for workforce development** - that is, through discussion of research findings and reflection on current practices, it provides an opportunity for the development of the worker's professional identity, skills and knowledge, and awareness of the impact of personal attitudes and issues on clients
- **Mechanism for quality assurance and clinical safety** - that is, it is part of a suite of activities designed to ensure that services to clients are appropriate, safe and effective, and to identify and address any concerns or breaches in a constructive manner, in an appropriately formal, but confidential setting.
- **Means of providing professional support and debriefing** - workers reportedly benefit from a formal forum where they can debrief aspects of their work and gain support to manage any personal impact. This can become even more necessary in the Drug and Alcohol field where the work can be particularly complex and demanding.

There is no single definition of clinical supervision that is more correct than any other, and D&A service policies already include definitions that are considered appropriate for the local context. Nonetheless it is important to include a definition in these Guidelines in order to engender a shared sense of meaning.

For the purposes of these Guidelines, clinical supervision is defined as:

> *A formal and ongoing arrangement between one worker and a (generally) more experienced practitioner whereby the clinical practice of the worker is reviewed and discussed in confidence for the purposes of:*
> - *Further developing the worker's professional identity and clinical practice skills and knowledge.*
> - *Ensuring workers are operating within relevant clinical, organisational, ethical and professional boundaries.*
> - *Monitoring and supporting the worker's wellbeing and coping capacity in relation to their work.*

3.2 Benefits of Clinical Supervision

As discussed earlier, the evidence based knowledge about the benefits of clinical supervision is somewhat limited, and comprehensive, reliable evaluation studies have yet to be undertaken in the field. Notwithstanding these limitations, the available evidence does suggest that clinical supervision:

- Is commonly valued by managers and practitioners.
- Can facilitate the acquisition of complex clinical skills.
- Is associated with higher levels of job satisfaction or morale, where it is perceived to be of high quality.
- Can support staff retention.

There is a wealth of anecdotal knowledge and theorising in the literature and resources pertaining to clinical supervision, and findings from these, and from the consultations held within NSW commonly suggest that the following benefits are likely:

For the organisation/service:

- It contributes to workforce development.
- It contributes to quality assurance and to maintaining clinical safety.
- It provides a mechanism for ensuring that professional boundaries and codes of ethics are being complied with in the delivery of services to clients.
- It ensures that individual workers are operating within agreed treatment modalities.
- It provides a level of assurance that new or inexperienced workers are receiving appropriate support, learning and guidance in developing their role.
- It provides a level of assurance that more experienced staff are being exposed to new ideas, reflecting on their current practices, and where appropriate, are being challenged and stretched in relation to their clinical practice.

For workers receiving clinical supervision:

- It provides a mechanism for support and debrief, and for managing workplace stress.
- It provides an opportunity for coaching and professional guidance, for enhancing skills, identifying new ways of working with clients, and identifying areas of further skill development.
- It provides a confidential mechanism through which they can reflect on and raise issues related to their practice.
- It can validate their work clinical skills and contribute to increasing confidence in their work with clients.
- It can prevent workers operating outside appropriate boundaries with clients.
- It can contribute to increased job satisfaction, reduced stress and prevention of burnout.

4. Key elements of Clinical Supervision

This section helps further clarify what we mean by clinical supervision by outlining its common characteristics, the key parties involved and the common structure and processes utilised in its implementation.

4.1 Common characteristics of Clinical Supervision

As outlined earlier, clinical supervision sits within an overall *framework of clinical governance* and as such, is one of a number of mechanisms that are put in place to facilitate clinical safety, and which workers are expected to participate in. Other examples include clinical case review meetings, clinical audits, mandatory training and critical incident debriefings. Whilst clinical supervision is not commonly mandated within NSW Health services[31], there is nonetheless an expectation that it will be organised and supported by management and that workers will participate.

Clinical supervision is a *formal organisational arrangement*, commonly governed by policies and/or procedures that set out its purpose, the administrative arrangements, and the expectations and responsibilities of the key parties. Whilst the content of clinical supervision sessions remains largely confidential, and can be tailored to the needs of individual workers, it is not a private arrangement. Rather, it is conducted as part and parcel of workplace activities, and in line with the needs and requirements of the organisation. As such, clinical supervision must reflect the goals of the organisation and support the agreed/endorsed organisational approaches and therapeutic modalities.

Clinical supervision sessions are formalised, have an agreed purpose, work towards outcomes and entail an element of rigour. It is expected that all three primary purposes of clinical supervision are addressed, namely issues relevant to clinical safety, skill and knowledge development, and support and debrief.

There are three parties involved in clinical supervision arrangements – the supervisee (worker), the supervisor and the organisation (manager). Whilst only the worker and supervisor actually participate in clinical supervision sessions, the organisation has a clear role in organising, managing and supporting the clinical supervision program. More information about the roles and responsibilities of the three parties can be found in section 5.

Clinical supervision is appropriate regardless of a staff member's level of experience or their professional background. All staff can benefit from clinical supervision and it is appropriate for services to expect participation from all workers that fall within the parameters of their local policy.

Clinical supervision needs to be flexible to ensure it meets the needs of workers at all stages of their development. The supervision requirements of a novice worker are likely to be very different from that of a highly experienced worker, and this requires flexibility within the clinical supervision program to ensure workers at all levels of experience benefit.

The primary focus is the clinical practice of the worker. Whilst discussion of clients and their case management is an integral part of the supervision process, this is principally for the purpose of providing a tool for reviewing and discussing the clinical practice of the supervisee. The focus remains on developing the worker's conceptualisations, skills and knowledge, rather than on providing indirect treatment of the client.

Effective clinical supervision relies on the development of a strong alliance between supervisors and supervisees. A successful alliance will involve the development of a bond between the two parties, the establishment of clear goals for the clinical supervision process, and an agreed set of tasks to achieve the goals.

[31] A small number of D&A service policies do state that participation in clinical supervision is mandatory for workers.

Ideally, there will be an element of choice on the part of the supervisee in selecting an appropriate supervisor. Clearly, achieving a 'match' between supervisee and supervisor is an important factor in ensuring a strong supervisory alliance, and having the flexibility for some negotiation on the part of the supervisee is likely to assist in achieving this. Notwithstanding this ideal, it is acknowledged that this may not always be possible, and there is a need for services to remain pragmatic in relation to this issue.

The content of clinical supervision is confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a client. The intent is to allow for frank and open discussion about clinical practice, in a safe environment. Further discussion of confidentiality is discussed in section 6.

Clinical supervision is not line management and the two processes should remain separate. Whilst managers certainly have responsibilities in the clinical supervision program (see section 5.3), the purpose of clinical supervision is distinctly separate from that of line management supervision. Overall clinical accountability for services to clients is an organisational and line management responsibility, whereas clinical supervisors are responsible for addressing only those matters raised within clinical supervision sessions, and only within the agreed parameters outlined in the clinical supervision policy.

It is strongly recommended that line managers do not also provide clinical supervision to staff that report directly to them. Whilst it is acknowledged that there are exceptional circumstances where this cannot be avoided, it should be considered a last resort, and will require careful attention to clear boundaries to ensure an appropriate separation of the two roles, and a high degree of trust and mutual respect between the two parties.

4.2 Structure of Clinical Supervision sessions

What is outlined here are the common structures and processes involved in clinical supervision. These are not set in concrete, are offered as a guide, and there is scope for D&A services to have some flexibility around local arrangements.

Clinical supervision is organised as individual sessions or appointments, commonly of one hour's duration and held monthly. They involve a worker (or group of workers) and a supervisor working together in private and without interruption.

For novice workers or those with limited experience, a high degree of structure is common and the role of the supervisor tends to be somewhat directive, involving a high degree of guidance and modelling. For highly experienced workers, clinical supervision sessions are likely to have less need of such structure, and there is scope for more supervisee-led discussion and identification of relevant issues.

In newly establishing clinical supervision arrangements there is commonly a process at the outset whereby the goals of the supervisee are agreed, the boundaries of confidentiality are made clear, and there is discussion and agreement about how the two parties will work together. Commonly, such agreements are formalised in a written contract or agreement, and an example of a supervisor/ supervisee agreement can be found at Appendix 3.

Clinical supervision sessions utilise a range of processes to achieve their agreed purpose. As outlined earlier, the focus of sessions is always on the role and clinical practice of the supervisee, and it is the responsibility of the supervisor to ensure that sessions are appropriately structured to engage the supervisee in discussion, reflection and appropriate disclosure. The most common method of generating discussion and identifying the pertinent issues is through *case presentation or review*, in which a worker presents a case they are currently working on, commonly utilising an agreed presentation format, and requiring a degree of preparation on the part of the supervisee prior to the clinical supervision session. Less common, but important processes used in clinical supervision sessions are direct supervisor observation of a worker with a client, video or audio recording of a client intervention, and review of case notes and documentation.

Regardless of what method is used, it is the intention of clinical supervision sessions to generate discussion and reflection on a broad range of issues directly related to clinical practice, including but not limited to:

- The methods and modalities of clinical practice.
- Concerns the worker has in relation to any aspect of a case or client.
- Difficulties or lack of progress with a client.
- Awareness of the potential impact of the worker's personal values on their clinical practice.
- Identifying any negative impact on the worker from a case they are managing.
- Issues related to establishing and maintaining appropriate boundaries with clients.
- Ethical and professional practice, and compliance with codes of conduct.
- Professional identity and role development.
- Skill and knowledge development.
- Issues related to workload management, team functioning and career development.

5. Roles and responsibilities

This section provides guidance about the roles and responsibilities of the three key parties involved in clinical supervision - supervisors, supervisees and managers. It also outlines the responsibilities of all three in upholding the ethical and professional codes of conduct that are applicable in the clinical supervision process.

5.1 Supervisors

The common responsibilities of supervisors are to:

- Ensure they are clear about the organisational goals, the supported treatment modalities of the D&A Service, and any relevant codes of conduct or ethical standards applicable to those they are supervising. Ensure that their supervision practice is in line with all of the above.
- Ensure that supervisees are clear at the outset about the purpose of supervision, what is expected of them, the role of the supervisor, the parameters of confidentiality, and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process.
- Work with supervisees to agree on goals for supervision sessions, and put in place processes for regular review of progress.
- Enter into any required formal contractual arrangements in relation to the provision of clinical supervision services, including with the organisation and with individual supervisees. Examples of contracts between services and supervisors can be found at Appendices 4 and 5.
- Facilitate a safe and trusting environment for clinical supervision sessions.

- Ensure that clinical supervision sessions have structure, and work toward achievements in all three of the purpose areas identified earlier. This will require the initiation of processes whereby the supervisee can review and reflect on their clinical practice, identify areas of concern, explore new ways of working, identify development needs, and debrief issues of concern.
- Validate good practice and provide constructive feedback where appropriate.
- Challenge practice that is inappropriate, or which does not fit with the agreed treatment modalities of the Service, and facilitate the development of sound clinical skills and ethical practice.
- Work within the agreed boundaries of confidentiality and take responsibility for reporting any serious issues to line managers, and for informing supervisees when such a circumstance arises.
- Share their own knowledge, experience and skills with supervisees.
- Take responsibility for ensuring they provide clinical supervision only within the limits of their expertise.
- Participate in any agreed monitoring or reporting mechanisms related to the provision of clinical supervision.
- Contribute to evaluation of clinical supervision programs as required by the D&A service.
- For externally contracted supervisors, where general concerns arise in relation their clinical supervision (that is, not concerns related to individual supervisees) take steps to address these issues with the appropriate manager, not with supervisees. Examples of such concerns include issues related to the agreed clinical modalities or work practices of the service, or the contractual arrangements. In the event that an external supervisor considers their own professional views are inconsistent with those of the organisation, or in the event of any conflict of interest, take appropriate steps to terminate the contract.

5.2 Supervisees

In reality, workers have a range of different values and attitudes towards the idea of clinical supervision, along the spectrum from positive to negative, often related to their professional background, or their previous experience of clinical supervision. This inevitably results in some workers being willing, responsive participants, and others being reluctant or even resistant. Notwithstanding this, participation in clinical supervision is expected of all workers in D&A services and they also have responsibilities related to this.

The common responsibilities of supervisees include:

- Negotiate arrangements for clinical supervision, in line with organisational polices or procedures, and with line management approval.
- Ensure regular attendance as agreed with the organisation, and in line with local policies.
- Work with the supervisor to agree the goals of clinical supervision, and agree ways of working together.
- Undertake an appropriate level of preparation for clinical supervision sessions, for example preparation of case review material and completion of any agreed homework.
- Actively participate in all sessions.
- Take action in relation to any development needs identified through clinical supervision.
- Maintain any records related to clinical supervision sessions as set out in local policies or procedures.
- Resolve any difficulties or concerns with supervision through appropriate processes, for example in the first instance by discussing the matter with the supervisor, and if the matter remains unresolved, taking it up with the line manager and/or appropriate others within the service. In circumstances in which concerns have not been resolved through these processes, workers should refer to the applicable grievance or complaints procedure.

Contribute to evaluation of clinical supervision programs as required by the D&A service. For group supervision, comply with the parameters of confidentiality that are agreed by the group.

5.3 Managers

Because clinical supervision is a formal organisational arrangement, managers play a key role in its implementation. The common responsibilities of managers include:

- Ensure staff are aware of the D&A service's policy and procedures related to clinical supervision, and the expectations of their participation.
- Ensure that all relevant staff can access clinical supervision. This includes making any changes in the workplace required to enable staff to attend, for example rostering arrangements, making transport available, establishing group supervision arrangements, making meeting rooms available etc.
- Where an external supervision model is in operation, recruit and arrange contracts with appropriate clinical supervisors and ensure attention to key issues such as insurance requirements and criminal record checks. Where internal supervision models operate, ensure compliance with any formal agreements.
- Ensure clinical supervisors are appropriately briefed. This will be particularly important for external supervisors to ensure they are oriented to the requirements of the D&A service, including the supported treatment modalities and any relevant codes of ethics or conduct. It may also be helpful for supervisors to be informed about any related policies and procedures, for example in relation to managing suicide risk, violent or intoxicated clients, guidelines for home visiting etc. Managers need to also keep supervisors informed of any changes in policies or treatment practices in a timely manner.
- Where an internal supervision model is in operation, ensure that staff are made aware of the processes for engaging a supervisor and undertake any necessary approval processes as prescribed in local policies/procedures.
- Take reasonable steps to ensure that workers have an element of choice in selection of a clinical supervisor.
- Comply with any organisational reporting requirements in relation to clinical supervision, for example reporting attendance numbers and frequency, and associated costs and resources.
- Participate in and/or take responsibility for regular review and evaluation of clinical supervision programs.
- Take reasonable steps to resolve any concerns raised by supervisees in relation to their clinical supervision.

5.4 Ethical guidelines and codes of conduct

Managers, supervisees and supervisors all need to be aware of their common responsibilities in ensuring compliance with relevant codes of conduct, ethics and professional practice. Clinical supervision is one mechanism through which breaches of such codes can be identified, and concerns about inappropriate practice can be identified and addressed early, potentially preventing future breaches. (For example addressing the early signs of inappropriate boundaries with clients). What constitutes appropriate and sound clinical practice is outlined within a number of key documents, some of which apply to all workers, and some of which apply to workers within specific professions.

All workers must comply with the following:

- Mandatory reporting requirements under the *Children and Young Persons Care and Protection Act*, which requires them to report suspicion that a child is at risk of harm, as defined in the Act and which is clearly outlined in the NSW Health Frontline Procedures for the Protection of Children and Young People.
- The legal obligations outlined within the NSW Policy for Identifying and Responding to Domestic Violence; and which outline the obligations of AHSs to ensure appropriate response to individuals at risk of, or having experienced domestic violence across health settings.
- Their local Area Health Service Code of Conduct. Whilst there may be some variations in such Codes of Conduct, commonly they provide guidance about appropriate conduct in relation to conflicts of interest, the acceptance of gifts or benefits, bribery and corrupt conduct, the development of inappropriate personal relationships with clients (including social, sexual or financial relationships), acting with honesty and integrity, harassment and bullying and professional standards of behaviour.

Supervisors need to be familiar with all of the above documents and have a sound understanding of compliance as it relates directly to the provision of services within the D&A setting. Managers need to ensure that supervisors are provided with copies of all relevant documents.

In addition to the above requirements, there are also specific professional and ethical codes that apply to some individual professions, and supervisors also need to be aware of which of these additional codes apply to their supervisees. In summary, these codes are:

- The NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, and the Australian Nursing Federation).
- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Further information related to ethical and professional codes of conduct, including web references to access the complete documents as listed above can be found at Appendix 2.

Supervisors also need to ensure that their own clinical supervision practices remain within ethical and professional parameters, and to ensure they take appropriate steps to protect themselves, the supervisee and the organisation, for example by ensuring that:

- Their clinical supervision practice remains within their level of competence and capabilities.
- They are appropriately trained to provide supervision.
- They operate with clear contractual arrangements in relation to their role and responsibilities with the organisation, and in relation to their work with supervisees.
- They operate within the agreed parameters of confidentiality.
- They do not develop inappropriate boundaries or relationships with supervisees.

6. Confidentiality

Issues related to the confidentiality of clinical supervision can be somewhat contentious. On the one hand there is a need to ensure the confidentiality of individual sessions in order to provide a safe and constructive learning environment, and to encourage a sufficient level of disclosure. On the other, given the role of clinical supervision as a mechanism for clinical quality and safety, there is a need to ensure that any sufficiently serious issues related to clinical practice are dealt with appropriately and transparently. To balance these two legitimate concerns, the parameters of confidentiality need to be clear, documented, and communicated to all participating parties.

These Guidelines propose that to ensure an appropriate measure of accountability for clinical supervision, confidentiality is ensured except in circumstances where there is:

- A breach of the code of conduct of the organisation.
- A breach of professional code of ethics.
- A breach of duty of care.
- Serious concern about the safety of the worker or a client.
- Issues identified that are subject to mandatory reporting requirements.

Adherence to these parameters requires that supervisors are sufficiently clear about the particular role of the worker, and are cognisant of the relevant codes of ethics, professional conduct, duty of care and mandatory reporting requirements.

In any of the circumstances outlined above, it is the responsibility of the clinical supervisor to inform the worker of their concerns and of the need to inform the line manager. Clinical supervisors need to take such concerns to managers as soon as is practical once they are identified.

7. Operational approaches to Clinical Supervision

This section of the Guidelines provides information about internal and external supervision approaches to clinical supervision, and about individual and group supervision approaches. All these approaches are appropriate and have merit, and D&A services commonly have to make decisions about which models to implement. The following information is intended to be of assistance to services in their decision-making, and to facilitate sound practice, whichever approach is in place.

7.1 Internal Clinical Supervision

In this approach to clinical supervision, supervisors are employees of the organisation, and take on clinical supervision as an adjunct to their primary role. This model is commonly selected by services because:

- The majority of resources required to provide clinical supervision can be found internally within the organisation, and therefore do not incur additional costs.
- It utilises and values existing expertise and experience.
- It can provide an opportunity for some staff to extend their role, skills and experience through taking on a clinical supervision role.
- There can be benefits where internal clinical supervisors have a greater understanding about the needs of the organisation, for example, the agreed treatment modalities, the working environment, and the specific complexities of the client group.
- It is often perceived to be more straightforward to organise and administer.

There are many different operational models of internal clinical supervision in place in D&A services, reportedly with varying degrees of success. Ideally, internal models of clinical supervision will take account of the following factors, which are considered to represent good or sound practice, and which will likely assist in ensuring the effectiveness of the clinical supervision program.[32]

Appropriate and transparent processes for recruitment and selection of clinical supervisors. Whilst more comprehensive guidance can be found in relation to this in section 8.2, it is important to stress that the need for such processes is a critical, yet sometimes overlooked factor in the implementation of programs that utilise internal supervisors. Whereas formal processes for recruitment and selection of external supervisions is common, they tend to be less rigorous for internal supervisors, and yet are equally important.

The provision of training for selected supervisors in the clinical supervision role. Ideally, the training will be conducted by an external individual or organisation with relevant expertise, with sufficient briefing about the particular organisational issues/requirements.

The use of contracts or service agreements to govern the clinical supervision work of staff that clearly outlines the expectations and parameters of the role. Again, this can tend to be overlooked when utilising internal clinical supervisors, when in fact, there is potentially a heightened need for transparency about the role, function and expectations.

The establishment of a pool of clinical supervisors from which workers can choose. Offering an element of choice on the part of the worker in selecting a clinical supervisor is always ideal; however, where internal clinical supervisors are utilised this becomes somewhat of an imperative. Internal supervisors inevitably have less objectivity than external supervisors, and the reality of organisations is that there is generally history and baggage between some staff. The literature confirms the importance of 'match' between supervisor and supervisee if the process is to be effective, and when using internal arrangements, choice is particularly important.

The establishment of protocols for reaching agreement between a worker and a clinical supervisor to work together. Workers require more than a list of names if they are to make an informed choice in relation to selecting a clinical supervisor. Clinical supervisors need to feel confident that they can work effectively with their supervisee, and also have an element of choice and decision-making. Suggested protocols include:

- Ready availability of relevant written information about the clinical supervisors in the organisational pool. For example information about their background, qualifications and experience, their particular strengths and areas of interest, and information about their preferred counselling or treatment modalities.
- A meeting to undertake a process of 'mutual interview' between worker and clinical supervisor to assess expectations and 'fit', prior to committing to any ongoing arrangements.
- Early review of the appropriateness of the arrangement and an understanding of 'no blame' or recourse if there is agreement to terminate.

The need to ensure that the supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

[32] Some of the factors outlined are also applicable for external supervision models, and whilst efforts are made to minimise repetition in these Guidelines, some repetition is unavoidable.

The establishment of mechanisms for accountability for internal clinical supervisors to ensure that their supervision practice remains sound over the longer term, and in line with the requirements of the organisation. Whilst section 8 provides further guidance about organisational issues, what is being stressed here is the need for mandatory participation on the part of internal clinical supervisors in a range of activities designed to bring a level of accountability to the clinical supervision program. For example participation in supervision of their clinical supervision work, preferably from an external practitioner, attendance at clinical supervision network meetings, participation in ongoing training and development opportunities.

The use of formal written agreements between internal supervisors and supervisees, for example to agree the goals of supervision, the frequency and duration, the agreed processes and ways of working together. This is considered particularly important for novice or inexperienced workers and supervisors.

Flexibility to ensure that highly experienced senior staff have access to appropriate clinical supervision, which may mean offering exemption from the internal model. It is well acknowledged in the literature that accessing appropriate clinical supervision is generally more difficult for those staff with extensive experience, or who are considered to be the most senior staff within a service. Ideally, clinical supervision is provided by a more senior practitioner, and this may only be possible by going externally. Alternatively, peer supervision may be an appropriate option, and this may also require flexibility for this to be sought externally.

7.2 External Clinical Supervision

In this approach supervisors are external to the organisation and are contracted to provide an agreed level of clinical supervision services. Commonly in D&A services external clinical supervisors are registered clinical psychologists, and are paid on an hourly basis in line with the standard professional rate. This model is commonly selected by services because:

- It provides an opportunity to recruit from a broader field and potentially a greater capacity to be selective.
- External people can bring external ideas, views and perspectives, which are potentially helpful to the organisation.
- Contractual arrangements are required, and so there is generally a greater acceptance that the role, responsibilities, reporting requirements and circumstances under which the services will be terminated can be clearly stipulated (than with internal arrangements).
- External supervisors are more likely to bring a lack of bias or subjectivity, which is beneficial to the supervision process.
- There is potential for a more open and honest supervisory process than with some internal arrangements because staff are more confident about the confidential nature of the relationship and do not have to interact with the supervisor in other settings.
- Internal staff time, training and support is not required (for supervisors).

Ideally, external models of clinical supervision will take account of the following factors:

Appropriate and transparent processes for recruitment and selection of clinical supervisors. (See section 8.2.) In addition, recruitment processes will need to ensure that a criminal record check is undertaken.

The need to ensure that external clinical supervisors are fully cognisant of relevant organisational issues, for example:

- The goals, priorities and agreed treatment modalities.
- Organisational structure.
- The role and responsibilities of staff they will be supervising.
- Intake and assessment procedures.
- Weekly operational structure.

The need to ensure that external supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

Appropriate briefing and orientation of external supervisors by managers, and regular monitoring and review of services provided.

The selection of supervisors whose professional values are sufficiently congruent with those required by the organisation. In particular it will be important to select supervisors who are able to support harm minimisation approaches common to the provision of treatment services within the NSW Health D&A environment.

Contractual arrangements are put in place that clearly specify all aspects of the clinical supervision arrangement, for example the responsibilities of the clinical supervisor, requirements for any documentation related to clinical supervision sessions, payment, term of the contract, reporting requirements.

7.3 Individual and Group Supervision

Another key consideration for D&A services is whether to provide group or individual supervision. Both are common and have merit. As it implies, individual clinical supervision is a one-to-one process between a clinical supervisor and an individual worker. In group supervision a number of workers get together with one clinical supervisor. Many D&A services opt for a group supervision approach primarily because of its cost effectiveness, however there are other benefits, including:

- It can be a less threatening approach for some people compared to individual clinical supervision.
- It can contribute to team building and cohesiveness.
- It can draw on the expertise and knowledge of other group members, which can be extremely valuable.

Not surprisingly, individual clinical supervision tends to be the more straightforward approach, and does have some advantages over group supervision, for example:

- It involves building one trusting relationship.
- Confidentiality can be more easily guaranteed.
- Workers tend to have a greater level of self-disclosure that can lead to increased insight.
- There is more time available to focus on each individual worker.

The supervisory role is more easily managed with one supervisee.

There is a greater capacity to find a good match between supervisor and supervisee.

Notwithstanding the above, group supervision is a common approach within D&A services currently, and because it can be less straightforward, and there are additional factors that need to be considered, this section provides some guidance in relation to this.

Group clinical supervision (as defined within these Guidelines) involves a clinical supervisor. This may seem an obvious point to make, however, peer supervision in groups does occur in health settings, and these Guidelines seek to draw a distinction between that and the approach intended here, where there is a designated role of supervisor, with responsibilities as outlined earlier in section 5.1.

If group supervision is to be effective, clinical supervisors must have skills and experience in facilitating groups. Generally, clinical supervision training does not include training in group work, and such expertise is usually developed over time through hands on experience working with groups. In selecting supervisors for group supervision, group work skills and experience need to be added to the essential selection criteria.

As a general rule, small is better in terms of numbers. Given the purpose of clinical supervision (to develop skills and knowledge, provide professional support and facilitate sound clinical practice) it is clear that there are limitations to how effective a group setting can be in achieving this if the numbers are high. As a general rule, three or four is considered ideal.

It will be helpful to have more than one clinical supervisor operating group supervision within the organisation, thereby allowing workers some element of choice. The importance of match has been referred to previously, and the issue of choice is obviously more difficult to achieve with group supervision; however, limited choice is preferable to none.

It is important to pay attention to the membership mix when establishing group supervision arrangements. The sessions need to offer all members an opportunity for learning and growth, and provide a safe and trusting environment in which disclosure and honesty are the norm. To achieve this, it is important that some planning takes place at the outset, rather than having groups either selected at random or completely self selected. Useful considerations are having workers who are at a similar level of experience and skill, similar professional backgrounds, and avoiding situations in which there are power differentials between members, for example by including a worker and their team leader in the same group. Inevitably in organisations there are also situations where negative history between workers make it inappropriate to have them join the same group, and this may require some sensitive management.

Discipline specific and multidisciplinary groups can both be effective. There are mixed views in the field about this issue, and a tendency for some workers to believe that they should only be in groups with others from the same profession. However, there is no evidence to support this approach exclusively and both models are in use and can work well.

There are some inevitable limitations to group approaches to clinical supervision compared with individual supervision. They are outlined below not to promote one approach in favour of another, but rather to provide useful additional information for consideration in implementation. Common limitations are:

- Some people are not sufficiently comfortable in a group setting to openly discuss and explore issues related to their work practices, or to debrief difficult issues. Where this is the case, those workers can tend to be low contributors, or can be so uncomfortable as to have a generally negative experience of clinical supervision (which essentially renders it ineffective).
- It can be more difficult to address issues or problems related to team functioning, which is a legitimate issue that clinical supervision can be helpful in addressing. Without skilled facilitation there can be a tendency for sessions to become simply a forum for complaints.

- There are limitations in the extent to which workers are likely to disclose in relation to certain issues because they are with colleagues. In reality, group sessions cannot offer the same level of confidentiality as individual sessions, and this will impact on the extent to which workers are prepared to disclose. In turn, this can limit the depth of insight and learning that can occur as a result.
- Where primarily group supervision is offered, it may be helpful for services to have the flexibility or discretion to offer individual supervision sessions to staff on an as needs basis, for example for a limited number of sessions if things have been particularly difficult or stressful for a worker, if a worker is just so uncomfortable with group settings that it is simply not helpful to require them to attend, or for very senior workers, for whom it would be difficult to have their needs met in a group with less experienced workers.

8. Organisational considerations

8.1 Developing a supportive environment

It is important for services to consider what strategies might be needed to engender a culture of support for clinical supervision. Commonly in D&A services the values of workers in relation to the concept of clinical supervision are variable, as is their degree of support for it. In addition, workers have varied experiences of clinical supervision, often related to their professional background. For example:

- Psychologists and social workers have generally participated in clinical supervision from the outset of their training and tend to value it highly.
- There is less consistency in the understanding and experiences of nurses in relation to clinical supervision, and their training has often included a quite different type of supervision focused on competency development. Where nurses have not accessed clinical supervision (as defined in these Guidelines) they can be wary or suspicious of it.
- Workers who do not have tertiary or formal qualifications can have limited understanding of, or experience in, clinical supervision and can also be wary or suspicious.
- There are wide variations in the extent to which medical staff have participated in clinical supervision, and historically there can be a measure of resistance from some individual clinicians to participation in such activities.
- Across all professional groups there are workers who believe that they do not need clinical supervision, usually because they consider themselves to be sufficiently experienced. There are also workers who do not want to participate due to a fear of having to change, or of being exposed as inadequate.

The comments above are clearly generalised, and are not intended to reflect negatively on any professional group or individual. Rather they are highlighted because in being aware of such differences, D&A services can consider how they might best work with these factors in building a climate of support for their clinical supervision program, increase staffs' understanding about its purpose and benefits, and increase compliance in line with the service's expectations of staff participation.

How clinical supervision is marketed or introduced to staff can be critical to the success of its uptake. Line managers and clinical leaders can play an important role in building support, and it is likely that where people in such positions present a positive and encouraging attitude, this will have a constructive effect. Conversely in organisations where managers and clinical leaders are not supportive, and make their views known either overtly or covertly, this can have a negative impact on the climate of support for and participation in clinical supervision.

In particular it is considered important for managers and clinical leaders to:

- Provide staff with clear information about what supervision is and take the necessary time to introduce the concept, and allow for discussion of their queries, concerns or issues.
- Be clear about what clinical supervision isn't; make sure that staff understand that it is not a line management function, that it is not an opportunity simply to find fault with their work, and that it is not simply a mechanism for debriefing.
- Make sure that staff are provided with clear information about the boundaries of confidentiality that apply to supervision sessions.
- Highlight the benefits of supervision for staff, rather than simply focusing on its role in clinical quality. Staff should be made aware that it is a process put in place for their benefit and gain, for example to ensure they have an appropriate level of professional support for their work and to assist them in developing their clinical skills and expanding their experiences.
- Actively demonstrate their support for clinical supervision, for example by participating in their own clinical supervision, and through enabling staff to participate by arranging rostering to accommodate it, and assisting in their selection of clinical supervisors.

8.2 Recruitment and selection of supervisors

The success of clinical supervision is heavily dependent on having competent, appropriate and effective supervisors, and ensuring there are appropriate recruitment and selection processes in place for both internal and external supervisors is a key organisational consideration. There is a high level of constancy in the literature about appropriate criteria for the selection of supervisors. These are outlined below and are recommended as a basis for selection processes within D&A services. Clinical supervisors will ideally have:

- Relevant formal qualifications.
- Extensive clinical experience, specifically a breadth of counselling and/or therapy experience, particularly with complex clients and behavioural therapies. In general it is considered ideal for the supervisor to have more experience than the supervisee, although this is obviously not possible for some very senior staff, for whom peer supervision is appropriate.
- A clear understanding of the role and function of clinical supervision.
- A demonstrated history of continued professional development and supervision of their own clinical supervision practices.
- A demonstrated interest in and ability to enhance the skills and abilities of others, particularly to provide constructive feedback and to ensure a safe environment for disclosure and challenge.
- Held in high respect within their field or specialty.
- An understanding of and respect for the particular role of the supervisee.
- If providing group supervision, supervisors need demonstrated facilitation, group work and mediation skills.
- The ability to remain impartial and balanced in their views.
- An empathetic and non-judgemental approach.
- An intellectual interest in their professional arena.
- If providing supervision to Aboriginal and Torres Strait Islander workers, they must have demonstrated cultural awareness, and previous experience working with Aboriginal and Torres Strait Islander workers.

Selection processes for supervisors should be similar to those in place for recruitment to other positions, and in line with the organisation's recruitment policy, for example the development of a duty statement outlining the role and responsibilities, submission of formal, written applications, the convening of a selection panel to make decisions, and the requirement for referee checks. Where external clinical supervisors are contracted, they should also undergo a criminal record check.

8.3 The importance of policy, procedures and record keeping

Ideally, clinical supervision within D&A services should be governed by a written policy, and currently this is common practice. Staff and supervisors should be made aware of the policy and any accompanying procedures. In addition, a degree of record-keeping and documentation is recommended, some of which can be kept confidential.

Records which are not considered confidential, and which are commonly provided to managers include summary information from supervisors about numbers of attendees, session times and general, de-identified reports summarising the conduct of clinical supervision over a period of time.

A level of confidential record keeping is also expected in most D&A services, and recommended in the literature, for example records kept by both supervisors and supervisees relating to the goals and expectations, plans for achieving agreed goals, summaries of what has been undertaken in individual clinical supervision sessions, and reports arising from regular review about goals and achievements. (Examples at Appendices 6 and 7). All such records would remain confidential except in the circumstances outlined in section 6, in which case they may be required for the purposes of any investigation arising from breaches of code of conduct or clinical safety, or in the event of any other formal investigation related to a worker.

Whilst there is room for flexibility in terms of record keeping, local policies need to make clear their expectations and requirements.

8.4 Infrastructure and support for Clinical Supervision

Clinical supervision programs, like any other initiative, require a degree of organisational support and infrastructure if they are to be effective and efficient. Most D&A services have a policy that provides some governance and this is considered essential. However, there are additional factors to consider, outlined below:

- The need to locate responsibility for clinical supervision within an appropriate organisational portfolio. Given its stated purpose, the two obvious fits are workforce development and clinical quality, and ensuring that some overarching responsibility and leadership is provided through one of these portfolios is recommended.
- Consideration of a staff member with designated responsibility for coordinating the clinical supervision program. The roles of the key parties (managers, supervisors and supervisees) have been outlined earlier; however, there is also merit in the organisation designating responsibility for overall coordination and management of the clinical supervision program. This is not to suggest that a full-time position is required, but rather that a staff member with an appropriate related role (for example Coordinator of Quality, Workforce Development Manager) could also take on responsibility for clinical supervision.
- Establishing a clinical supervision advisory committee (or similar) with appropriate membership and specific terms of reference to oversight the policy and its implementation.
- Where an internal supervision model is used, establishing a network of supervisors, with a designated coordinator. The aims of the network could include ongoing training and development, support and debriefing.
- Embedding the organisational requirements about clinical supervision in relevant job descriptions. This is applicable to staff who are expected to access supervision, and to staff who provide internal clinical supervision.

8.5 Resourcing Clinical Supervision

Like any other activity or program, clinical supervision requires human and financial resourcing. Contributing resourcing factors include the time and effort required to provide appropriate infrastructure and coordination functions, to provide training, support and external clinical supervision for internal supervisors, staff time to participate, costs associated with travel to attend, and payment for the use of external supervisors. If the implementation of clinical supervision programs is to be an expectation across the board in D&A services then Directors and managers will need to take account of this in budget and business planning. It is beyond the scope of these Guidelines to suggest or recommend any strategies related to budget, suffice to highlight that it is an important organisational consideration.

8.6 Monitoring and evaluation

There has historically been a level of tension between the principle of confidentiality that applies to clinical supervision and the desire for organisations to have in place an appropriate level of monitoring and accountability for clinical supervision processes. The important distinction to highlight here is between performance management issues related to *individuals*, which need to be identified and addressed through other mechanisms, and mechanisms for quality assurance in relation to the overall clinical supervision *program*, which are appropriate and necessary.

Unless there are breaches of relevant codes of conduct, concerns for client or worker safety or breaches of duty of care (as outlined in section 6) the content of individual supervision sessions remains confidential, and issues related to the supervisee's clinical practice do not enter into the public domain of the organisation. However, the organisation does have a responsibility to have a level of reporting in place in relation to clinical supervision, and to have mechanisms in place to monitor and evaluate its effectiveness. For example it is appropriate for organisations to have information related to:

- The extent of uptake of supervision, specifically, which staff are attending supervision and how often.
- Where internal supervisors are utilised, which staff are active and their clinical supervision caseload.
- The extent of human and financial resources being utilised for the provision of clinical supervision.
- The satisfaction levels of staff in relation to the clinical supervision that is provided.
- Any areas of concern about the current clinical supervision program.
- The effectiveness of individual clinical supervisors.
- The impact and benefits of clinical supervision from the perspectives of staff and managers.
- Where internal supervisors are used, information about their participation in any required or recommended quality assurance processes, for example supervision of supervisors, attendance at supervision network meetings, and participation in ongoing training and development opportunities related to their supervisory role.

Some of the above information can be collected by ensuring a basic level of record keeping and reporting on the part of supervisors and managers, for example in relation to attendance and numbers, and it is suggested that such information be collected and reported as a matter of course. To assess satisfaction, impact and effectiveness, formal evaluation tools will need to be utilised. Some of the key issues to consider in evaluating clinical supervision are:

- The importance of having a degree of independence when seeking staff feedback about clinical supervision processes, for example having someone in a neutral role coordinate the process, analyse and report on results.
- The importance of getting feedback from supervisees and supervisors. Both viewpoints will provide useful information in relation to perceptions of the quality of clinical supervision sessions, satisfaction levels, if and how it has been helpful, the degree of fit between supervisor and supervisee, and ideas about strengthening the current processes.
- The need to ensure that supervisees can provide anonymous feedback, which will be particularly important where supervisors are internal.
- Being able to identify individual supervisors in any evaluation process so that constructive feedback can be provided, areas of development identified, and any serious concerns can be addressed directly with the individual supervisor.
- Ensuring that supervisors and supervisees are informed from the outset of any monitoring or evaluation processes that may be implemented, including the expectations of their participation in formal evaluation.

Some D&A services have agreed proformas for monitoring and evaluation purposes and there are samples at Appendices 8, 9, and 10.

8.7 Managing difficulties

Difficulties can and do arise within clinical supervision programs, and it is wise for local policies to clearly identify the intended processes for dealing with problems or conflict. Examples of issues that can arise are:

- A staff member is not happy with their clinical supervisor.
- There are problems with the mix of membership of a clinical supervision group.
- Managers have concerns about a particular supervisor.
- There are breaches of confidentiality of clinical supervision sessions.
- A staff member consistently doesn't attend their agreed clinical supervision.
- A staff member has been unable to resolve an issue with clinical supervision through their line manager.

Common principles for addressing these or similar issues are for the matter to be raised between the relevant parties in the first instance and attempts made to manage or resolve the issues. Where issues remain, it is generally recommended that they are taken to the line manager, or where appropriate, to a more senior staff member. Whilst this may seem an overly obvious approach, it is considered useful for local clinical supervision policies to highlight some of the common problems that may arise, and outline the expectations of how these will be managed so that all parties have a clear way forward. All AHSs have grievance procedures that should be followed when all other attempts at resolution have been unsuccessful.

A common concern for line managers can be the lack of information flow between clinical supervisors and managers about the performance of individual workers.

As a general rule, and for reasons outlined earlier related to the role, purpose and key characteristics of clinical supervision, it is recommended that services do not blur the boundaries between line management and clinical supervision, for example by managers approaching supervisors with concerns they have, or seeking comments or information about individual workers.

8.8 Issues for rural D&A services

There are particular issues in relation to implementing clinical supervision in rural D&A services. These include:

- Barriers associated with the provision of supervision to remote staff who were often isolated and therefore potentially in greater need of clinical supervision.
- The extent of time and travel required for staff to access face-to-face supervision.
- Difficulties in accessing appropriate supervisors. Internally, there may be insufficient professional distance between supervisees and supervisors. Externally there are often limitations or shortages in the number of private practitioners working in rural communities and there may not be appropriately skilled or senior staff available within the local community.

Rural D&A services need to consider alternative mechanisms to face-to-face clinical supervision such as telephone, email or videoconferencing, all of which have been utilised successfully for clinical supervision purposes. Studies in e-supervision have been undertaken and report both advantages and disadvantages, with the noted advantages being more relaxed communication styles, greater immediacy of responses, and greater mentoring capacity. Some of the noted challenges of electronic supervision are the need for increased time for planning supervisory sessions and the need for frequent and ongoing training for operating the required technology.[33]

Useful resources and additional reading

This document provides guidance for D&A services in relation to the operation and management of clinical supervision programs, drawn from what is commonly considered sound practice in the literature, and within the NSW D&A field. It is not intended to be prescriptive, nor wholly comprehensive, and has been informed by a range of existing resources and previous work by other authors. This section provides a summary of additional sources of clinical supervision information and advice that D&A services will likely find valuable.

9.1 D&A specific resources

Three resources are worthy of particular note.

The first is the recently produced, and very comprehensive *Clinical Supervision Resource Kit for the Alcohol and Other Drugs Field*. Developed by the National Centre for Education and Training on Addiction (NCETA) at Flinders University, this kit is intended to build capacity of the D&A workforce, and includes the following components:

- An *Overview* booklet that provides an overview of all the materials contained in the Resource Kit, as well as a sample one-day training program for clinical supervisors
- A comprehensive *Practical Guide* for the AOD field, which includes a review of the relevant literature and practical recommendations for establishing clinical supervision programs and conducting supervision sessions.
- A *Clinical Supervision Training Demonstration* on DVD which contains a 40 minute scripted demonstration of clinical supervision in four sessions, revealing the key process and content issues.
- A *Training Demonstration Booklet*, which is a supplement to the DVD and provides guidance about the DVD's use for training purposes.

[33] Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, in Journal of Rehabilitation July-Sept 2002.

- A *CD* containing PDF versions of all the materials contained within the kit, as well as a set of 75 PowerPoint training slides.

Further information about the kit can be found at the NCETA website
http://www.nceta.flinders.edu.au/

The second is the *Workforce Development Resource Kit: A Guide to Workforce Development for Alcohol and Other Drugs Agencies*. Produced by the Network of Alcohol and Other Drugs Agencies (NADA) this resource includes useful information about implementing clinical supervision programs in section 4.6, and includes relevant case studies. The Kit can be found on the NADA website
http://www.nada.org.au/projects/workforce-development/

Finally, there is the considerable work that was conducted by *Access Macquarie Ltd* as part of their related project to develop and deliver a training package in clinical supervision for NSW Health D&A services. This work includes:

- The training package *Clinical Supervision Training for D&A Professionals - Participant Handbook*, developed by Daphne Hewson, Access Macquarie Ltd, November 2005, for the CDA, NSW Health.
- *Clinical Supervision training package, Final Report to the CDA*, Daphne Hewson, Access Macquarie Ltd, November 2005. (Including appendices on Aboriginal Consultations, Interviews and the Email Survey.)

9.2 Useful Clinical Supervision references

In addition to the above resources, many other articles and references were reviewed, and the following is a summary of those that were considered particularly helpful or relevant in the development of the Guidelines.

- Butterworth and Woods, Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.
- Kavanagh et al, Achieving effective supervision. Drug and Alcohol Review 2002.
- The Development of models of nursing supervision in the UK, and other documents and information contained on the website of Steve Cottrell and Georgina Smith at http://www.northwestsolutions.co.uk/resources.php
- Chris Shanley, Clinical Supervision – an untapped resource for the alcohol and other drug field, Centre for Education and Information on Drugs and Alcohol, NSW (CEIDA).
- Butterworth et al, First Steps Towards Evaluating Clinical Supervision in Nursing and Health Visiting. Journal of Clinical Nursing Vol 5(2) March 1996.
- Ian Clift and Janet Perks, Clinical Supervision Policy and Framework, The Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, 2004.
- JE Mills, KL Franciss & A Bonner, Mentoring, clinical supervision and preceptoring: Clarifying the conceptual definitions for Australian Rural Nurses. A review of the literature, Rural and Remote Health, the International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 2005.
- Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, Journal of Rehabilitation July-Sept 2002.
- Winstanley J and White E (2002) Clinical Supervision: Models, Measures and Best Practice. Australia and New Zealand College of Mental Health Nurses Inc, Sydney.

Appendix 1 - Membership of the advisory group

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Appendix 2 - Codes of conduct and professional practice

Attention to issues related to codes of conduct and ethical behaviour operate on two separate levels. Firstly there is a need for supervisors to ensure that their own clinical supervision practices are carried out within the parameters of relevant codes of conduct; and secondly there is a need for supervisors to be cognisant of the codes of conduct and ethical practice that apply to the staff they are supervising.

In relation to the first of these, namely the clinical supervision practices of supervisors, the following highlights the key issues that supervisors should be aware of:

- The potential for vicarious liability, whereby a supervisor can be held liable for the conduct of the supervisee, especially if the supervisee is not a fully licensed professional.
- The need to ensure that the limits of the confidentiality of supervision are clearly stated at the outset. Should it become necessary to disclose, only information that is necessary and sufficient to address the pertinent issue should be disclosed.
- Supervisors should not practice outside their area of competence or overextend themselves and they should ensure that supervisees do not practice outside their area of competence or overextend themselves.
- Supervisors have a duty to warn and to protect, and are responsible for ensuring that clients at risk (eg suicide risk) are protected and, when legally warranted, that others are warned if they are at risk from a client.
- Supervisors are responsible for ensuring that they and those they supervise conduct themselves within the ethical guidelines and codes of conduct of their profession, and their employing organisation. Particular attention should be paid to gaining relevant informed consent (eg from clinicians for degree of self-disclosure in supervision; from clients to receiving treatment from and intern/trainee).
- Supervisors are responsible for ensuring that neither they nor those they supervise have dual relationships(eg can't be supervisor and therapist; no sexual relationships between supervisor and counsellors or counsellors and clients, etc). The dual relationship of Line-Manager and Supervisor is not ideal; and if it becomes necessary, extra care should be taken to create safe boundaries between the two roles.
- Supervisors are responsible for ensuring that the supervisee's rights are addressed by providing a clear statement of the requirements of clinical supervision, and specific information about what will be evaluated, through the supervisory process and how.

In addition, the Australian Psychological Society has produced an ethical guidelines paper on clinical supervision. Whilst the paper is only available online to members, most D&A services will have staff who are members and will have access. The paper is entitled Australian Psychological Society Ethical Guidelines: Guidelines on Supervision, July 2003 and can be found at http://www.psychology.org.au/

Supervisors also need to ensure that they are familiar with the relevant ethical guidelines and codes of conduct that apply to staff they are supervising. A number of codes are likely to apply within D&A services as follows:

- Area Health Service Codes of Conduct.
- NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia and the Australian Nursing Federation).

- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Whilst a brief summary of information contained within the above codes is outlined below, it is strongly recommended that supervisors access the relevant codes in full to ensure they are clear about the full extent of ethical and professional parameters that apply.

In circumstances where a supervisor is unclear about the application or interpretation of a particular code, they are encouraged to seek advice from a senior staff member from within the same profession as the supervisee.

D&A Services Codes of Conduct

All Area Health Services have codes of conduct in place for staff and D&A services need to ensure that staff and supervisors are provided with copies of the relevant organisational policy documents. Notwithstanding the need for all parties to have a sound understanding of the particular ethical and professional guidelines, commonly AHS Codes of Conduct refer to the need for staff to comply as follows:

- To be aware of and avoid potential situations of conflict of interest, for example whereby they could be influenced or perceived to be influenced by a personal interest when carrying out their public duty.
- Staff must not accept gifts or benefits from clients which could in any way influence, or appear to influence, their official capacity.
- Staff must not submit or accept bribes or inducements from individuals or organisations.
- The requirement for staff to behave honestly and with integrity in the execution of their duties.
- Staff must not develop inappropriate personal relationships with clients, including social, sexual or financial relationships.
- Staff must not harass, bully or discriminate against others, including colleagues and clients.
- Staff must not use official resources for non-official purposes.
- Staff must not engage in corrupt conduct, as defined in sections 8 and 9 of the *Independent Commission Against Corruption Act (1988)*, including in relation to official misconduct, bribery and blackmail, unauthorised use of confidential information, fraud and theft.

NSW Medical Board Code of Professional Conduct

There are four standards outlined in this code as follows:

Standard 1

You must possess and apply adequate knowledge and skill in the practice of medicine.

Standard 2

You must observe professional and ethical obligations. These include:

- Education, teaching and training responsibilities.
- Providing honest assessment of the performance of colleagues.
- Putting patients first while putting aside your own personal views.
- Maintaining trust with patients through your interaction with patients.
- Arranging appropriate alternative treatment when the doctor/patient relationship deteriorates.
- Disclosure of adverse events to appropriate authorities.
- Responding appropriately to situations in which a complaint is made about your treatment or where treatment is unsuccessful.
- Co-operating fully with the investigating authorities such as the HCCC and the NSW Medical Board in respect of adverse events.
- Dealing appropriately with the next of kin of deceased patients.
- Ensuring your professional position is not abused or compromised through improper financial or personal dealings with patients.
- Ensuring that your own health or that of another practitioner does not put patients at risk.
- Ensuring other practitioners do not place patients at risk through their health, conduct or performance.
- Providing factual information about your services.

Standard 3

You must ensure that you enjoy a good relationship with all colleagues in health care teams:

- Through treating colleagues with respect regardless of your personal views.
- By working constructively with health care teams.
- By ensuring patient treatment is covered during your own absence or unavailability.
- Ensuring that a patient's care is co-ordinated.
- Ensuring appropriate delegation and referral of care of a patient.

Standard 4

You must display probity in your professional practice in respect of:

- Financial and commercial dealings.
- Financial interests in hospitals, nursing homes and other medical organisations.
- Not accepting gifts or other inducements.
- Not entering into financial agreements with patients which may compromise the therapeutic relationship.
- Ensuring that any documents signed by you are not false or misleading.
- Ensuring that research in which you are engaged is conducted ethically and according to protocol and that you report fraud or misconduct in research to the appropriate authority.

The full document can be found at: http://healthcpd.com.au/

Code of Ethics for Nurses in Australia

The Code of Ethics includes the following six key value statements. Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care.

- Nurses accept the rights of individuals to make informed choices in relation to their care.
- Nurses promote and uphold the provision of quality nursing care for all people.
- Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
- Nurses fulfil the accountability and responsibility inherent in their roles.
- Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well-being.

The full document can be found at:
http://anf.org.au/documents/policies/PS_Compulsory_reporting.pdf

Code of Professional Conduct for Nurses in Australia

The purpose of the Code of Professional Conduct for Nurses in Australia is to:

- Set an expected national standard of conduct for the nursing profession.
- Inform the community of the standards for professional conduct of nurses in Australia.
- Provide consumer, regulatory, employing and professional bodies with a basis for decisions regarding standards of professional conduct.

Under the code of professional conduct a nurse must:

- Practise in a safe and competent manner.
- Practise in accordance with the agreed standards of the profession.
- Not bring discredit upon the reputation of the nursing profession.
- Practise in accordance with laws relevant to the nurse's area of practice.
- Respect the dignity, culture, values and beliefs of an individual and any significant other person.
- Support the health, well being and informed decision-making of an individual.
- Promote and preserve the trust that is inherent in the privileged relationship between a nurse and an individual, and respect both the person and property of that individual.
- Treat personal information obtained in a professional capacity as confidential.
- Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services.

The full document can be found at: http://nursesstaging.elcom.com.au/professional-conduct-book/default.aspx

Australian Association of Social Workers Code of Ethics 1999

The purpose of the Code is to:

- Identify the values and principles which underpin ethical social work practice.
- Provide a guide and standard for ethical social work conduct and accountable service.
- Provide a foundation for ethical reflection and decision-making.
- Guide social workers when determining what demands they may legitimately make on their employers, colleagues and the AASW.
- Provide clarification of social workers' actions in the context of industrial or legal disputes.
- Act as a basis for investigation and adjudication of formal complaints about unethical conduct.

The full document can be found at: http://www.aasw.asn.au/document/item/740

NSW Psychologists Registration Board Code of Professional Conduct

The Code of Professional Conduct provides principles and guidelines for observation by registered psychologists in their professional practice, and that guide the interpretations relevant to Part 4 of the *Psychologists Act 2001* related to complaints and disciplinary proceedings). Under the code psychologists will:

- Demonstrate continuing competence in their practice of psychology that includes adequate knowledge, skill, judgment and care.
- Aim to maximise benefit and do no harm in their practice of psychology.
- Respect the dignity and welfare of individuals and groups with whom they have professional contact.
- Act ethically and properly and will promote accuracy, fairness and honesty in their practice of psychology.

The full document can be found at:
http://www.hpca.nsw.gov.au/ArticleDocuments/250/Psychology%20Council%20GIPA%20%20Publication%20Guide%202011.pdf.aspx

The Australian Psychological Society Code of Ethics

The code outlines principles of ethics and professional practice for members of the Society which aim to safeguard the welfare of consumers of psychological services and the integrity of the profession. Its general principles state that:

- Members remain personally responsible for the professional decisions they make.
- Members shall bring and maintain appropriate skills and learning in their areas of professional practice.
- The welfare of clients and the public, and the integrity of the profession shall take precedence over a member's self interest and over the interests of the member's employer and colleagues.

The full document can be found at:
http://www.psychology.org.au/about/ethics/#s1

Australian Counselling Association Code of Conduct

This code is intended to provide standards of professional conduct that can be applied by the ACA and by other bodies that chose to adopt them in Australia. Under the code, members will:

- Offer a non judgmental professional service, free from discrimination, honouring the individuality of the client.
- Establish the helping relationship in order to maintain the integrity and empowerment of the client without offering advice.
- Be committed to ongoing personal and professional development.
- Ensure client understanding of the purpose, process and boundaries of the counseling relationship.
- Offer a promise of confidentiality and explain the limits of duty of care.
- For the purpose of advocacy, receive written permission from the client before divulging any information or contacting other parties.
- Endeavour to make suitable referral where competent service cannot be provided.

- Undertake regular supervision and debriefing to develop skills, monitor performance and sustain professional accountability.
- Be responsive to the needs of peers and provide a supportive environment for their professional development.
- Not act as or practice legal council on behalf of or to a client when practicing as a counsellor or act as an agent for a client.
- Not initiate, develop or pursue a relationship be it sexual or nonsexual with past or current clients, within 2 years of the last counselling session.
- Be responsible for your own updating and continued knowledge of theories, ethics and practices through journals, the association and other relevant bodies.
- Be committed to the above code of ethics and recognise that procedures for withdrawal of membership will be implemented for breaches.

Full document can be found at:
http://www.theaca.net.au/documents/ACA%20Code%20of%20Ethics%20and%20Practice%20Ver%2010.pdf

Appendix 3.
Clinical Supervision contract (example)

This proforma is an example of the kind of contract or agreement used between supervisor and supervisee in relation to the arrangements and processes for clinical supervision sessions. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This agreement covers the clinical supervision arrangements between:

_____

(Supervisee), and

_____

(Supervisor)

Structure of sessions

We agree the structure of clinical supervision sessions will be as follows:

Frequency _____

Duration _____

Time _____

Location _____

Goals of clinical supervision for the agreed contract period:

_____

_____

_____

_____

_____

Agreed strategies and methods of achieving these goals:

_____

_____

_____

_____

_____

Agreed records to be kept in relation to clinical supervision:

_____

_____

_____

_____

_____

We have read the D&A Service Clinical Supervision Policy and agree to operate in compliance with it.

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

Appendix 4. External Clinical Supervisor contract 1 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

Parties to the contract

This contract is between:

_____

(D&A Service), and

_____

(external Clinical Supervisor)

The agreed terms of the contract are:

Commencing date _____/_____/_____

Completion date _____/_____/_____

Renewal of Contract is subject to performance review and availability of funds.

Services and remuneration

The number of hours per month will be approximately

_____ Variations to be approved by Area Manager, Drug & Alcohol, as required.

Remuneration will be at Australian Psychological Society (APS) current standard rate currently _____ per hour plus GST.

Clinical supervision services will be provided in accordance with the D&A Service Clinical Supervision Policy and as per the attached schedule.

Insurance

The Provider shall insure themselves and keep himself/herself insured during the period of the Contract with an insurance office approved by the Health Service to the full extent against his liability to his/her employees employed in the performance of the Contract, under the laws relating to Workers' Compensation. The Contractor shall also on demand produce to the Health Service evidence of renewal of such insurance.

The Provider shall also insure themselves and keep himself/herself insured during the period of the Contract for public liability and Professional Indemnity insurance in the amounts as follows:

$_____ Public liability insurance

$_____ Professional indemnity insurance

The Provider will supply the following information in relation to insurance:

- Name of insurance companies with whom cover is affected.
- Policy number of the Policies.
- The expiry date or currency of the policies.

Termination of Contract

The Contract shall be terminated:

a. Upon the expiry of the period for which it was made or on such earlier date and may be agreed between the Clinical Supervisor and the Health Service.

b. By one months' notice in writing given by either the Clinical Supervisor or the Health Service.

c. If the Clinical Supervisor ceases to be registered as a Psychologist in NSW.

d. If the Clinical Supervisor becomes permanently mentally or physically incapable of rendering services under the contract.

e. If the Clinical Supervisor commits serious and/or willful misconduct; or

f. If the Clinical Supervisor appointment is terminated by operation of any Act or Regulation.

On the termination of a Contract, any amount due and payable to the Clinical Supervisor pursuant to the Contract shall be paid at the time of such termination or as soon thereafter as reasonably practicable.

Dispute Resolution Procedure

In the event that the Clinical Supervisor or Health Service is dissatisfied with any aspect of the operation of the Contract, the Clinical Supervisor or Health Service may give the other party notice in writing, identifying the matter or matters the subject of dispute. As soon as practicable after the giving of notice, Health Service staff and the Clinical Supervisor, who may be accompanied by an observer of his/her choice, shall meet to discuss the dispute and attempt to resolve it by a mutually agreed method.

Appendix 5. External Clinical Supervisor contract 2 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This contract is for a period of _____ months,

starting _____/_____/_____

Payment for clinical supervision services provided will be

$_____ per hour.

Supervision sessions contracted will be _____ hours per month.

As part of my role as an external supervisor, I agree to:

- Provide supervision, which is consistent with the services' aims and objectives.
- Consult with supervisee(s) in order to prepare a supervision contract. The supervision contract includes negotiated goals for a specified supervision period, strategies and methods to be used for achieving those goals, an outline of the structure and process of supervision, and a review date.
- Consent to annual internal staff satisfaction surveys.
- Maintain an accurate log of supervision sessions in accordance with plans agreed to with supervisees, which include the date and duration of each session. This is submitted annually to the line manager.
- Provide documentation on past professional experience and professional qualifications to the service manager.
- Continue my own professional development and supervision.
- Provide the Director of Drug and Alcohol Services (or delegate) with access to the supervision log when requested.
- Address any difficulties arising from the supervision relationship in accordance with the supervision guidelines within Drug and Alcohol Services.
- Ensure appropriate client and supervisee confidentiality
- Inform management and appropriate professional bodies where there is serious concerns about the client/patient health and safety due to the health status of the supervisee or non-adherence to professional codes of ethics and the Service's code of conduct
- Undergo a criminal record check.

I have read and understand the terms of this contract and the supervision guidelines for the Drug and Alcohol Service.

Signed _____

Date _____/_____/_____

Date for Review _____/_____/_____

Appendix 6. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by individual **supervisees** following each clinical supervision session.

Date _____/_____/_____

Name of Supervisor_____

Name of Supervisee _____

What was the contract for the session?

Key issues identified during the session?

Action taken:

What was learnt?

What will I do differently in the future?

Further agreements:

Comments:

Appendix 7. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by **supervisors** following each clinical supervision session.

Date _____/_____/_____

Supervisor _____

Supervisee _____

What was the contract for the session?

_____

_____

_____

_____

_____

_____

Key issues identified during the session:

_____

_____

_____

_____

_____

_____

Action taken:

_____

_____

_____

_____

_____

_____

What will be done differently and by whom?

_____

_____

_____

_____

_____

_____

Checklist:

- ☐ Issues identified
- ☐ Ethical practice/compliance with codes of conduct
- ☐ Increased learning
- ☐ Objectives met

Notes and evaluation:

_____

_____

_____

_____

_____

_____

Plans for next supervision session:

_____

_____

_____

_____

_____

Appendix 8.
Annual evaluation form (example)

The following is an example of an annual evaluation form used by an external clinical supervisor to gather information from supervisees. **End of year clinical supervision evaluation.**

The following questionnaire has been designed to evaluate the clinical supervision sessions you have been receiving over the past year.

All responses are ANONYMOUS. Feel free to add any additional comments. Your responses will be provided to the Manager of your service for consideration for future clinical supervision in 2005.

How helpful has been clinical supervision been?

0 1 2 3 4 5 6 7 8 9 10

Not helpful at all Very helpful

What have been the most helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

What have been the least helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

How has clinical supervision influenced your work with drug and alcohol clients?

_____

_____

_____

_____

_____

_____

Has clinical supervision improved your understanding in working with drug and alcohol clients?

Great deal A little Not at all

Has clinical supervision improved the way you work therapeutically with drug and alcohol clients?

Great deal A little Not at all

Tick the areas you think your knowledge and skills have improved in:

- ☐ Assessment
- ☐ Understanding the clients concerns
- ☐ Interviewing skills
- ☐ Dual diagnosis
- ☐ Intervention skills
- ☐ Problem solving
- ☐ Team issues
- ☐ Other areas *(please state)* _____

_____

Appendix 8: Annual evaluation form (example)

What recommendations do you have to improve clinical supervision in the future?

_____

_____

_____

_____

_____

_____

Other comments:

_____

_____

_____

_____

_____

_____

Many thanks for completing this form.

Acknowledgement for this evaluation format to Christine Senediak

Appendix 9. Annual report from Clinical Supervisors (example)

The following is an example of an annual report provided by clinical supervisors to service managers. Note whilst there is no detailed information about the content of clinical supervision sessions, there is summary information related to compliance with the policy, and ethical practice.

CONFIDENTIAL

Annual Report

_____

(Supervisee's name)

has attended clinical supervision sessions with me

_____

(Supervisor's name)

on _____ occasions from

_____/_____/_____to_____/_____/_____.

Both supervisor and supervisee have signed records of these sessions.

The general goals of supervision as detailed in the Clinical Supervision Policy and the specific goals of the contracts agreed to during the period under review are designed to promote best practice. In my opinion, the supervisee is working towards these supervision goals.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

From discussion during supervision it would appear that the supervisee is performing according to the service Code of Conduct and in line with appropriate Professional Codes of Ethics for the discipline.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

cc Manager

Appendix 10. Clinical Supervision evaluation format (example)

The following supervision questionnaire was developed by Ladany, Hill and Nutt (1966) as measure of supervisee perceptions of the quality and outcomes of supervision. The score is the sum of the items.

1. How would you rate the quality of the supervision you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of supervision you wanted?

1	2	3	4
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has this supervision fit your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of supervision, would you recommend this supervisor to him or her?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of supervision you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the supervision you received helped you to deal more effectively in your role as a counselor or therapist?

4	3	2	1
Yes definitely	Yes generally	No not really	No definitely

7. In an overall, general sense, how satisfied are you with the supervision you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek supervision again, would you come back to this supervisor?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

MANAGING WITHDRAWAL FROM ALCOHOL AND OTHER DRUGS (IB2022_041)

IB2022_041 replaces GL2008_011

Purpose

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

Key information

Clinical guidance for managing withdrawal from alcohol and other drugs

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

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

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

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

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

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

PREVENTION OF VENOUS THROMBOEMBOLISM (PD2019_057)

PD2019_057 rescinds PD2014_032.

PURPOSE

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

MANDATORY REQUIREMENTS

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

IMPLEMENTATION

Clinical Excellence Commission

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

Chief Executives of Local Health Districts and Specialty Health Networks

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

Director of Clinical Governance

- Ensure that a local monitoring and evaluation program is in place that includes regular review of VTE prevention indicators, assess the effectiveness of VTE prevention strategies and assist with identifying areas that require focused attention.
- Regularly report on VTE prevention indicators to local quality committees, the Clinical Excellence Commission and other relevant State committees.

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

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

Attending Medical Officer (or Delegate)

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

Prevention of Venous Thromboembolism Procedures

1 BACKGROUND

1.1 About this document

Venous thromboembolism (VTE) is a significant preventable adverse event for hospitalised patients. The incidence of developing a VTE has been shown to be 100 times greater among hospitalised patients than those in community[1]. Serious adverse outcomes resulting from VTE may occur, including an increased risk of recurrent thrombosis, morbidity from post-thrombotic syndrome or death.

Effective prevention of VTE is achieved through assessment of risk factors and the provision of appropriate prophylaxis.

This Procedure describes the system processes required to be embedded into standard workflow and clinical practice, to reduce a patient's risk of developing VTE.
These include:

- Identifying patients who should be assessed for VTE risk
- Assessing VTE risk
- Prescribing appropriate prophylaxis
- Reassessing VTE risk during care
- Engaging the patient
- Monitoring performance and practice, to assess compliance and to facilitate continuous improvement.

This Policy requires:

- All public health organisations (PHOs) to have a strategy to embed systems to support clinicians assess and manage VTE risk in patients.

  The Prevention of Venous Thromboembolism Framework (Appendix 4.1) provides a summary of the required actions for NSW public hospitals and health services.

- Attending Medical Officers and their medical teams to review all adult patients that require assessment for risk of VTE and, based on that assessment in correlation with evidence-based guidelines, prescribe prophylaxis accordingly.

  Assessment outcome must be noted in the patient health care record or other approved form, and the rationale behind decision to prescribe or withhold prophylaxis should also be noted.

- Nursing staff/ midwives, pharmacists and other relevant allied health staff to be aware of VTE risk and assist in ensuring the processes for prevention are implemented.

To support the implementation of this Policy, the Clinical Excellence Commission (CEC) has developed tools to support clinicians to undertake VTE risk assessments. NSW VTE risk assessment tools and other resources can be found on the CEC website http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention).

The use of these VTE risk assessment tools is NOT mandatory. Where not used, a similar tool meeting the requirements set out in this Procedure document must be implemented.

The CEC will continue to work with PHOs to facilitate VTE prevention strategies across NSW public hospitals.

1.2 Related Documents

This Policy is to be read in conjunction with the following NSW Health Policies:

- High-Risk Medicines Management
- Clinical Handover
- Incident Management

1.3 Key definitions

Anticoagulant	Any agent used to prevent the formation of blood clots. These include oral agents, such as warfarin, dabigatran, rivaroxaban and apixaban, and others which are injected into the vein or under the skin, such as unfractionated heparin and low molecular weight heparin e.g. enoxaparin sodium.
Attending Medical Officer (AMO)	The Attending Medical Officer (AMO) is the senior medical practitioner who has primary responsibility for the patient during admission. This AMO is a consultant who may be a visiting medical officer or a staff specialist. The AMO may lead a team that includes related medical officers and this team plays a critical role in the assessment and prevention of VTE.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	The Australian Commission on Safety and Quality in Health Care is a government agency that leads and coordinates national improvements in safety and quality in health care across Australia.
Deep Vein Thrombosis (DVT)	A blood clot that occurs in the "deep veins" in the legs, thighs or pelvis. - ***Asymptomatic deep vein thrombosis*** is defined as painless DVT detected only by ultrasound, or ascending venography and is often confined to the distal veins. - ***Symptomatic deep vein thrombosis*** results from occlusion of a major leg vein and results in leg pain or swelling. It requires specific investigation and treatment which in hospitalised patients may delay discharge, or require readmission to hospital.
Family of Measures	There are three types of measures. **Outcome measures:** - Refer to the 'voice of the customer or user' - Define how the system is performing - Broadly speaking describe what the result is. **Process measures:** - Refer to the 'voice of the workings of the system' - Serve to answer process questions i.e. are the parts and/or steps in the system performing as planned? **Balancing measures:** - Reflect on what happened to the system as we improved the outcome and process measures (e.g. unanticipated consequences, other factors influencing outcome).
Health Information Exchange (HIE)	HIE data is coded data based on the medical record. The quality of this information depends on the quality of the medical records, currency and accuracy of coding.

Mechanical Prophylaxis	VTE prophylaxis in the form of a Graduated Compression Stocking, anti-embolic stocking, Intermittent Pneumatic Compression or Foot Impulse Device.
Must	Indicates a mandatory action requiring compliance.
Postpartum Period	Period beginning immediately after the birth of a child and extending for about six weeks.
PowerPlan	An electronic order set listing pharmacological and mechanical options based on protocols, grouped for faster electronic order entry.
Prescriber	A health professional legally entitled to prescribe medicines according to prevailing *NSW Poisons and Therapeutic Goods Act 1966* and Regulations.
Pulmonary embolism (PE)	A blood clot that breaks off from the deep veins and travels around the circulation to block the pulmonary arteries (arteries in the lung). Most deaths arising from deep vein thrombosis are caused by pulmonary emboli. *(Plural = pulmonary emboli)*
Public Health Organisation (PHO)	Under the *Health Services Act 1997 (NSW)*, a local health district, statutory health corporation or affiliated health organisation in respect of its recognised establishments and recognised services.
Quality Audit Reporting System (QARS)	The QARS has been developed by the CEC to provide local health districts (LHDs) and speciality networks (SNs), and their facilities with a tool to conduct quality audits to provide evidence for the accreditation process, evaluate performance and initiate relevant action plans. The QARS allows evaluation at LHD, facility or ward levels. Benchmarking against the NSW average and peer groups is also available.
Quality Improvement Data System (QIDS)	The QIDS is a system that takes data and presents in charts for quality improvement. It was designed for unit level managers and clinicians to have easy access to information to improve their services.
Should	Indicates a recommended action that is best followed unless there are sound reasons for taking a different course of action.
Significantly Reduced Mobility Relative to Normal State	Refers to patients who are bedbound, or likely to spend a substantial proportion of the day in bed or in a chair due to the clinical condition for which they are being treated, or unable to walk unaided due to injury such as severe lower leg injury (e.g. fracture, dislocation, complete tendon rupture), requiring rigid immobilisation, or non-weight bearing status. The change in mobility should be assessed in relation to the patient's normal state of functioning.
Transfer of Care	Transfer of care involves transferring professional responsibility and accountability for the care of a patient to another person or professional or a combination of professionals. It includes discharge from an acute inpatient setting to the community setting, subacute care or non-acute care. It can also include transfer between hospitals, or transfer between attending teams and/or units within a hospital..
Thromboprophylaxis	Measures taken to assist in reduction of the risk of thrombosis.
Venous thromboembolism (VTE)	The blocking of a blood vessel by a blood clot. Includes both deep vein thrombosis and pulmonary embolism.

VTE Risk Outcome	The decision reached after a risk assessment is carried out to evaluate the likelihood of a patient developing a VTE due to existing risk factors. The patients risk outcome can fall under one of three categories. **Lower Risk:** Patient has a lower risk of developing a VTE and requires no active treatment. **Moderate Risk:** Patient is at risk of developing a VTE and requires treatment with pharmacological prophylaxis (where no contraindications exist) and mechanical prophylaxis should be used where pharmacological therapy is contraindicated. **Higher Risk:** Patient is at a relatively higher risk of developing a VTE and requires combination treatment (where no contraindications exist) with both pharmacological AND mechanical prophylaxis.

2 VENOUS THROMBOEMBOLISM PREVENTION

2.1 Identifying Patients for Assessment

All PHOs must have systems in place to support clinicians to assess and manage VTE risk in patients. The following patient groups must be identified and undergo a VTE risk assessment.

2.1.1 Patients in the Emergency Department

Adult patients (>16 years) to be discharged home from an Emergency Department who, as a result of their acute illness or injury (including interventions such as leg casts/braces), have significantly reduced mobility relative to normal state. They should undergo VTE risk assessment and be prescribed appropriate prophylaxis by an Emergency Department clinician prior to leaving the Emergency Department.

All other patients to be discharged home from an Emergency Department do not need to be assessed for VTE risk.

PHOs need to have systems in place that ensure adult patients being admitted to an inpatient ward or unit from an Emergency Department undergo a VTE risk assessment and be prescribed appropriate prophylaxis within 24 hours of presentation.

2.1.2 Admitted Patients

All adult patients (>16 years) admitted to a NSW public hospital or health service should undergo a VTE risk assessment within 24 hours of admission and, if appropriate, be prescribed prophylaxis.

This includes patients admitted to an inpatient ward (medical or surgical), or a unit such as a mental health unit or sub-acute facility (such as rehabilitation or palliative care).

Although, VTE prevention processes within the mental health setting are currently not as robust as in the general population, there is growing evidence to suggest that atypical antipsychotics (particularly clozapine) increase VTE risk. Additionally, reduced mobility is a strong risk factor for VTE and should be considered in the context of mental health patients, particularly in catatonia, neuroleptic malignant syndrome, over-sedation, use of physical restraints, severe depression, bed rest in anorexia nervosa and other acute states of reduced activity.

It should also be noted that while palliative care patients are required to undergo VTE risk assessment, patients in the terminal stage of life may not require VTE prophylaxis and therefore may not need to undergo assessment. This decision should be aligned with the goals of care, which are to be considered in consultation with the patient and their family and/or carers.

2.1.3 Pregnant and Postpartum Women

All pregnant and postpartum women should undergo VTE risk assessment:

- During the first comprehensive antenatal assessment
- Within 24 hours of admission into a non-obstetric setting for a non-pregnancy related complaint
- Within 24 hours of admission into an obstetric setting for a pregnancy or non-pregnancy related complaint
- During postpartum care, within 2 hours of birth (vaginal or caesarean section)

2.1.4 Planned Admission and Day Surgery

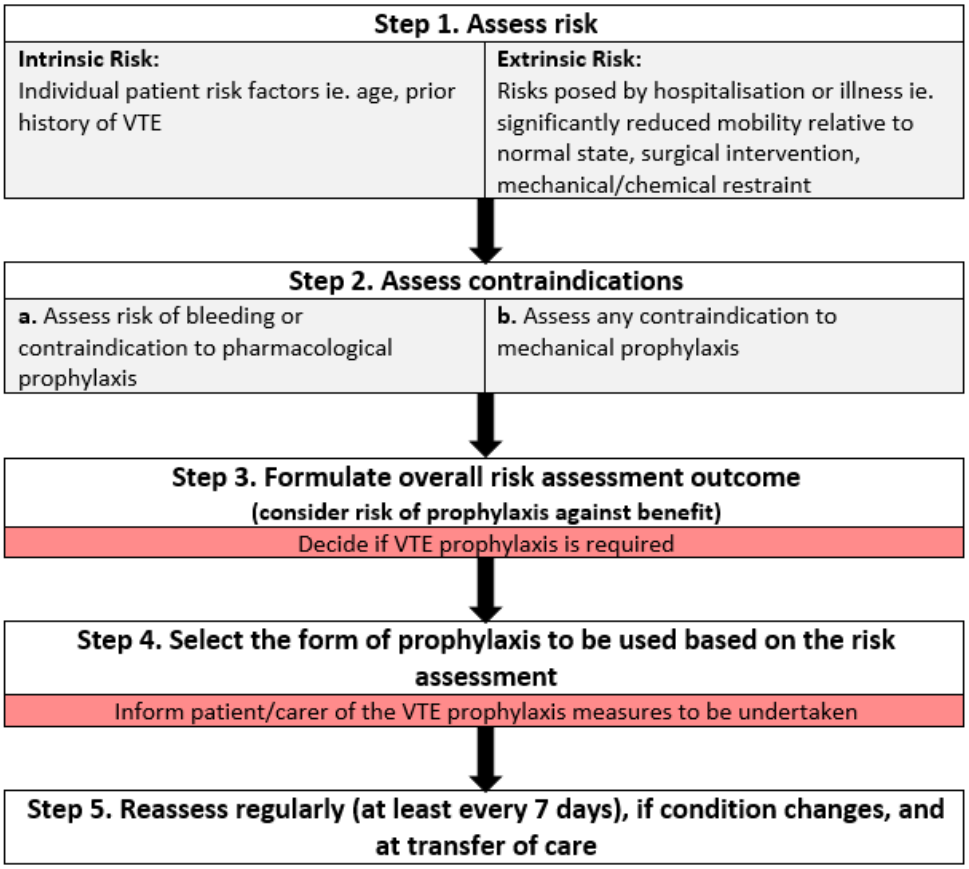
Patients undergoing planned surgical and invasive interventions and/or imaging guided invasive interventions are required to be assessed by a medical officer to determine the risks and benefits of stopping pre-existing, established anticoagulation or anti-platelet therapy before discontinuing these therapies.

- Prophylaxis should be considered for day surgery patients based on evidence in situations of significantly reduced mobility relative to normal state, prolonged and/or general anaesthesia and for patients demonstrating one or more other risk factors.

Day surgery or procedure patients who receive only local anaesthesia without any reduction in mobility relative to normal state, do not require routine VTE assessment, unless otherwise clinically appropriate.

2.2 Risk Assessment

Systems introduced by PHOs should support clinicians to complete a VTE risk assessment for the identified target patient groups. Standardised, approved risk assessment tools are to be made available to all clinical staff.The risk assessment tool must ensure the following steps are undertaken during the assessment.



2.2.1 Assessing VTE Risk in Admitted Patients

Systems introduced by PHOs should are to support Attending Medical Officers (and delegates) to complete a VTE risk assessment for all adult patients admitted to NSW public hospitals within 24 hours.

A **NSW Adult Venous Thromboembolism Risk Assessment Tool** has been developed for use in admitted patients and to support implementation. See the CEC website for a copy of the tool (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/risk-assessment).

2.2.2 Assessing VTE Risk in Pregnant and Postpartum Women

Systems introduced by PHOs should support midwives and medical officers to complete a VTE risk assessment. Where a midwife completes the assessment, systems need to ensure that the outcome of the assessment is referred to the attending medical officer (or delegate).
Any standard risk assessment tool used within the PHO must identify all pregnant and postpartum women to be at risk of VTE. These women should then be referred to an obstetrics consultant/team for risk assessment and decision to commence pharmacological and/or mechanical prophylaxis.
A pregnant woman admitted into a non-obstetric setting for a non-pregnancy related complaint can initially be assessed using a standard risk assessment tool given it complies with the requirements highlighted above.
A dedicated obstetric VTE risk assessment tool should be used to assess pregnant and postpartum women in an obstetrics setting. It should identify risk factors, contraindications and evidence-based treatment options that are unique to this target group.
A **NSW Maternity Venous Thromboembolism Risk Assessment Tool** has been developed to support implementation. See the CEC website for a copy of the tool (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/maternity).

2.2.3 Documenting VTE Risk

Systems introduced by PHOs should support clinicians to document:

- That a risk assessment has been completed
- The outcome of the risk assessment.

When in use, clinicians are to document once a risk assessment has been completed on the dedicated VTE section of the acute National Inpatient Medication Chart (NIMC) (not included on the long-stay version).
Additional areas for documentation may include:

- Electronic medical record
- The patients' health care record
- Approved risk assessment tools
- Maternal antenatal hand-held record
- Other locally approved forms, such as patient care plans.

2.2.4 Additional Prevention Strategies

Irrespective of a patient's VTE risk outcome, the following prevention strategies should be considered and promoted.

- Patients remain adequately hydrated (unless contraindicated due to their clinical condition e.g. fluid restriction due to chronic heart failure) and must be encouraged to mobilise as soon as possible and to continue being mobile post discharge.[2]
- A plan for early mobilisation should be developed by a multidisciplinary team with the patient and their family/ carer.

2.3 Prescribing and Administration of Appropriate Prophylaxis

If pharmacological and/or mechanical prophylaxis is required and appropriate, prophylaxis should be prescribed and administered as early as possible during the patient's admission or as scheduled after the commencement of care and risk assessment is carried out.
The choice of pharmacological and mechanical prophylaxis must be informed by evidence. PHOs should ensure that systems are in place to provide clinicians with access to evidenced-based guidelines, a clinical specialty protocol, as well as reference to drugs available on the hospital formulary. Pharmacological prophylaxis in this setting is in the form of an anticoagulant, and should be managed in accordance with the *NSW Health High-Risk Medicines Management* Policy Directive.
The standardised risk assessment tool made available should provide clinical decision support for Attending Medical Officers or other authorised prescribers such as Nurse Practitioners, when prescribing prophylaxis.
This procedure should be read in conjunction with clinical guidelines on VTE Prophylaxis. These include (but not limited to):

- Venous Thromboembolism Prevention Clinical Care Standard, Australian Commission on Safety and Quality in Health Care, Oct 2018 https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/
- Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism VTE: Reducing the Risk for Patients in Hospital, NICE guideline [NG89], Mar 2018
- VTE Prophylaxis, BMJ Best Practice, July 2018
- Antithrombotic Therapy and Prevention of Thrombosis, 9th ed (2012): American College of Chest Physicians (ACCP) Evidence-Based Clinical Practice Guidelines
- Prevention and Treatment of VTE, International Consensus Statement, International Angiology, April 2013

2.3.1 Documentation of Prophylaxis

- Where electronic prescribing systems are in use, Attending Medical Officers or other authorised prescribers such as Nurse Practitioners should prescribe pharmacological and/ or mechanical prophylaxis as per local protocol. Where available, prescribing via a VTE PowerPlan (or similar) is encouraged and to be promoted.
    - The regular NIMC (acute), contains a dedicated VTE section. Where this chart is used, the Attending Medical Officer (or delegate) or other authorised prescribers such as Nurse Practitioners, must prescribe pharmacological and/ or mechanical prophylaxis within the dedicated section. Prescribing outside of this section may lead to duplication of orders and risk of patient harm.

  Where other versions of the NIMC without this section are in use, such as the long-stay chart, prescribing should be completed within the normal sections.

  Checks associated with mechanical prophylaxis must also be documented at least twice daily by nursing staff/midwives. Checks should be documented on the NIMC (acute) or in an electronic medical record, where mechanical prophylaxis has been prescribed.
- For pregnant women, prescribed prophylaxis is also to be noted on the Antenatal hand held record, and electronic antenatal record where in use.

2.3.2 Contraindications and other considerations with Prophylaxis

- The risk of bleeding is a significant complication of pharmacological prophylaxis, particularly in surgical patients. The decision to commence pharmacological prophylaxis should be made after considering the benefits of treatment i.e. reducing VTE risk, against the risk associated with treatment (bleeding and other contraindications).

To support clinicians select the most appropriate prophylaxis for their patients, the standardised risk assessment tool should promote consideration of absolute or relative contraindications to pharmacological prophylaxis before a patient is prescribed therapy.
Where an absolute contraindication exists (e.g. bleeding disorders, active bleeding), the use of pharmacological prophylaxis should be avoided due to life-threatening risk, while relative contraindications require caution to be exercised and the benefits of therapy to be weighed against the risk.
Where pharmacological prophylaxis is contraindicated, mechanical prophylaxis remains an option and should be considered, as indicated, until the patient is mobile.

- Prescribers should refer to the current product information to select a safe dose for individual patients. Some agents are contraindicated or may require a reduction of dose i.e. in elderly patients or those with renal impairment.

  Prescribers should take care to select the dose recommended for prophylaxis and not the dose recommended for therapeutic anticoagulation.
- In certain clinical scenarios where there is limited evidence and guidance available, careful consideration of individual patient risks and specialist advice may be required. This includes the following scenarios:
  - Peri-operative and peri-procedural management with anticoagulants
  - Cessation of oestrogen-containing oral contraceptives or hormone replacement therapy, if clinically appropriate.
  - Selecting an appropriate dose for extremes of total body weight <50kg or >120kg or body mass index ≥35kg/m^2).
- **Anaesthesia and VTE**

  It is recommended that clinicians follow the advice provided in Section 5.9 of the Acute pain management: scientific evidence guidelines produced by the Australian and New Zealand College of Anaesthetists and Faculty of Pain Management (2015)[3]

  For a practical guide on how to appropriately manage pregnant women receiving pharmacological prophylaxis requiring anaesthesia, clinicians may refer to the published consensus statement by the Society for Obstetric Anaesthesia and Perinatology (SOAP)[4]

2.4 Partnering with Patients

Systems introduced by PHOs should support clinicians to partner with patients and their carers in managing their risks and to have an active role in preventing VTE. Systems are in place for clinicians to provide patients information about VTE to enable shared-decision making regarding their VTE prevention plan.

Patients, carers and their families should be informed about:

- What a VTE is
- Signs and symptoms of VTE
- Risk factors specific to the patient's condition
- Effective interventions to reduce the risk of VTE developing
- Any pharmacological and/or mechanical prophylaxis they are receiving
- VTE prevention discharge plans (where required).

Written information should accompany any counselling points. Patient information highlighting the risk of developing a VTE in hospital should be available, and patient leaflets summarising key points should be provided. Resources are available at:

- CEC VTE Prevention website contains information for adult admitted patients http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention and for women who are pregnant or postpartum http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/maternity
- ACQSHC website https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/Information about the pharmacological agent used must also be provided. For example, Consumer Medicines Information (CMI) is available at https://www.ebs.tga.gov.au/.

2.4.1 Documenting Patient Information

When a treatment decision has been made, clinicians should document that the patient has received an explanation of risks and benefits of prophylaxis, including the provision of additional information regarding VTE prevention. This should be recorded within the patients' health care record and/ or other approved form or tool.

2.5 Reassessing VTE Risk

Systems are in place for clinicians to undertake a reassessment of patient's VTE and bleeding risks:

- Regularly as clinically appropriate, as a minimum every 7 days
- When clinical condition changes (e.g. unplanned surgery, changes in mobility)
- At transfer of care.[2]
- Pregnant and Postpartum Women with a protracted antenatal admission should be reassessed every 7 days, as a minimum

Reassessment is required to:

- ensure that appropriate methods of VTE prophylaxis are used
- ensure that VTE prophylaxis is being used correctly
- identify adverse events resulting from VTE prophylaxis or its absence.

2.5.1 Reassessing Risk at Discharge and Continuity of Care

Systems should enable clinicians to reassess patients identified at risk at the point of discharge. Consideration should be made regarding the need for extended prophylaxis.

Attending Medical Officers are to ensure the development of a prospective action plan for patients requiring continuation of pharmacological and/ or mechanical prophylaxis on transfer home or to another care level. The plan is to be communicated in a timely manner to the patient's primary healthcare provider and explained to the patient/carer/family. This is particularly important when patients are transferred into community or residential aged care.

Clinicians must comply with key principles for transition of care and clinical handover with special regard to VTE prophylaxis treatment. This should occur at all transition points including transfer home or to another care service. Key principles are outlined in the *Venous Thromboembolism Prevention Clinical Care Standard* and the *NSW Health Clinical Handover* Policy Directive.

On transfer to home or another care service, a patient's supply of prophylactic medication should be arranged to enable uninterrupted treatment. Referral to another care model should be arranged including assurance of follow-up and continuity of supply as needed. Patients should be informed of the reason for ongoing treatment and the anticipated timeframe for discontinuation of the treatment. Patients must receive education on the administration of treatment as needed and be encouraged to mobilise (unless instructions for mobility restriction are in place).

2.6 Monitoring Performance and Practice

PHOs must ensure they have in place a monitoring and evaluation program that includes regular review of VTE prevention indicators to monitor performance, assess the effectiveness of VTE prevention strategies and assist with identifying areas that may require focused attention.

PHOs are required to regularly report on VTE prevention indicators to local governing quality committees and other relevant State committees.

As a minimum, the following indicators are required to be included in the monitoring and evaluation framework:

Indicator	Type of Measure	Suggested Data Sources
1. Rate of Hospital Acquired VTE events where prophylaxis was not prescribed appropriate to the level of risk in accordance with guidelines or local protocols. Numerator = Hospital-acquired VTE events where appropriate prophylaxis was not prescribed Denominator = All hospital-acquired VTE events	Outcome	• Clinical Audit • Non-Fatal VTE Incident Tool • Incident Investigations i.e. RCAs
2. Hospital Acquired VTE (rate per 1000 separations).	Outcome	• HIE • QIDS
3.1. Rate of documented VTE risk assessment completion within 24 hours for all adult inpatient admissions.	Process	• Clinical Audit (QARS question ID 7110)
3.2. Rate of documented VTE risk assessment completion on the first comprehensive antenatal assessment (for Maternity patients)	Process	• Clinical Audit (QARS) • eMaternity
3.3. Rate of documented VTE risk assessment completion during postpartum care, within 2 hours of birth (vaginal or caesarean section) (for Maternity patients).	Process	• Clinical Audit (QARS) • eMaternity
3.4. Rate of documented VTE risk assessment completion for adult patients discharged from ED with isolated lower limb injury requiring temporary lower limb mobilisation (for ED patients).	Process	• Clinical Audit (QARS)
4. Rate of VTE prophylaxis appropriate to the level of risk in accordance with Guidelines or local protocols.	Process	• Clinical Audit (QARS question ID 7115)

2.6.1 Clinical Audit

Regular clinical auditing is required to capture the necessary data to inform PHOs on VTE prevention indicators i.e. process measures relating to compliance with risk assessment completion and the prescription of appropriate prophylaxis.

For the purpose of monitoring performance for assurance, PHOs must review VTE indicator data from regular clinical auditing. As a guide, clinical audit should occur at least annually if the system is considered to be in a reliable state and more frequently i.e. quarterly to biannually where compliance is considered unreliable.

As well as providing assurance for local VTE prevention performance, data collection by clinical auditing and feedback play an important role in driving improvement.

Measurement for improvement generally require smaller sample sizes and short timeframes for data collection, to allow it to be repeated frequently for trending changes over time.

A simple VTE Prevention questionnaire is available within Quality Audit Reporting System (QARS) to assist PHOs to conduct clinical audit to capture data on VTE process measures and assessing compliance with the Prevention of Venous Thromboembolism Policy Directive. The questionnaire can be modified by adding or removing questions to suit local needs. However, the following questions must be included in any locally adapted QARS questionnaires:

- Rate of documented VTE risk assessment completion within 24 hours for all adult inpatient admissions. (question ID 7110)
- Rate of VTE prophylaxis appropriate to the level of risk in accordance with Guidelines or local protocols. (question ID 7115).

See the CEC website for further information: (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention/monitoring-practice)

The following audit tools and metrics are also available to assist with review of clinical processes and outcome. These include:

- The National Quality Use of Medicines indicators (accessible from NSW TAG website: http://www.nswtag.org.au/qum-indicators/)
- The NIMC (acute) VTE Prophylaxis Section Audit and Reporting Tool (accessible from ACSQHC website: https://www.safetyandquality.gov.au/our-work/medication-safety/vteprophylaxis/)
- VTE event rates using ACSQHC's hospital acquired complication (HAC) specifications or CEC defined ICD10 VTE codes (accessible from the VTE dashboard on QIDS)
- National Surgical Quality Improvement Program (NSQIP). Hospitals participating in the Agency for Clinical Innovation's NSQIP Collaborative may have access to data presenting performance against VTE metrics relating to preventable surgical complications.

2.6.2 Incident Reporting

All patients who present on admission with a VTE resulting from a previous hospitalisation (within 90 days of discharge) or who develop a VTE during hospitalisation must have the incident documented in the patient's health care record and recorded into the incident monitoring system.

Any significant unexpected change in a patient's condition relating to VTE prophylaxis including embolism and bleeding, must be considered an adverse event and be recorded in the incident monitoring system with the appropriate level of investigation initiated as per the requirements outlined in the *NSW Health Incident Management* Policy Directive.

2.6.3 Feedback to Clinical Staff

The PHO's VTE prevention monitoring and evaluation program must include a system of communicating VTE indicator data to clinicians in a timely manner to enable practice and quality improvement.

VTE incidents are to be reviewed with other clinical indicators and to be included as part of the existing hospital morbidity and mortality review process. Apart from PHO's Safety and Quality Committees, Morbidity and Mortality meetings should be considered as a forum to present data on VTE indicators.

2.6.4 Staff Education

Clinical staff should be provided with education on VTE prevention strategies.

Training resources can be found at:

- The CEC website http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/vte-prevention
- 'Electronic Venous Thromboembolism (VTE) Risk Assessment Tool for Adult Inpatients' My Health Learning (Course Code: 212082420)

- ACSQHCHC website: NIMC (acute) VTE Prophylaxis section: https://www.safetyandquality.gov.au/our-work/medication-safety/vteprophylaxis/
- ACSQHC website: Hospital Acquired Complication (HAC) clinician fact sheet - Venous thromboembolism: https://www.safetyandquality.gov.au/publications/hacs-information-kit-fact-sheet-venous-thromboembolism/
- ACQSHC website for the Venous Thromboembolism Prevention Clinical Care Standard and implementation resources (including clinician fact sheet): https://www.safetyandquality.gov.au/our-work/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard/

3 REFERENCES

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4. Leffert L, Butwick A, Carvalho B, Arendt K, Bates SM, Friedman A, et al. The Society for Obstetric Anesthesia and Perinatology Consensus Statement on the Anesthetic Management of Pregnant and Postpartum Women Receiving Thromboprophylaxis or Higher Dose Anticoagulants. *Anesthesia and analgesia* 2018;126(3):928-44.

4 APPENDIX

4.1 Prevention of Venous Thromboembolism Framework

FRAMEWORK FOR THE PREVENTION OF VENOUS THROMBOEMBOLISM

This Framework has been developed to guide LHDs and facilities in the implementation of the *Prevention of Venous Thromboembolism Policy Directive*

To Prevent VTE	What this means for Patients	Actions Required by NSW Hospitals and Health Services
Identify Patients	• Patients with a potential to be at risk of VTE are identified	1.1 All patients admitted to a ward or unit will undergo VTE risk assessment 1.2 All patients discharged from Emergency Departments with significantly reduced mobility relative to normal state will undergo VTE risk assessment 1.3 All pregnant and postpartum women will undergo appropriate VTE risk assessment during the first comprehensive antenatal assessment, any antenatal admission (including for non-pregnancy related complaints) and during postpartum care, within 2 hours of birth (vaginal or caesarean section)
Assess and Document VTE Risk	• VTE assessment is promptly completed • Risk vs. benefit of treatment is considered • The outcome of the assessment is clearly documented and easily accessible by health care providers	2.1 VTE risk assessments are completed within 24 hours of patient admission 2.2 A standardised, approved risk assessment tool should be made available to all clinical staff 2.3 The risk assessment tool enables clinicians to weigh the risk of clotting against the risk of bleeding 2.4 Outcome of the risk assessment is clearly documented in an approved record such as (i) Electronic medical record (ii) National Inpatient Medication Chart (NIMC) (iii) Patient health care record (iii) Approved risk assessment tool (iv) Maternal antenatal hand-held record (v) Other locally approved form
Prescribe Appropriate Prophylaxis	• Treatment is based on the best clinical knowledge and evidence • Prescribed therapy is clearly documented and easily accessible by health care providers	3.1 Clinical decision support is available for all clinicians, and encourages review of risk vs. benefit of prophylactic treatment 3.2 Clinical decision support is based on evidence-based guidelines 3.3 Access to a range of antithrombotic agents is available on the formulary 3.4 Where the regular NIMC is used, prescribing of both pharmacological and mechanical prophylaxis is completed in the dedicated VTE section
Engage the Patient	• Decisions actively involve patient/carers • Patients/carers are aware of the risks and symptoms of VTE	4.1 Patients/carers are informed of VTE risks and treatment options 4.2 Patients/carers are involved in treatment plans 4.3 A standardised patient information leaflet is available for clinicians to provide to patients
Reassess	• Patients are regularly assessed for VTE throughout admission • Prevention of VTE continues after discharge if required	5.1 VTE risk is reassessed regularly (at least every 7 days) OR as clinical condition changes 5.2 Pregnant and postpartum women with a protracted admission should be reassessed every 7 days as a minimum 5.3 Clinicians are prompted at discharge to assess the need of prolonged prophylaxis
Monitor Practice	• Hospitals monitor performance and strive to improve processes • Health professionals are updated and aware of requirements	6.1 Rates of risk assessment completion are audited periodically (at least annually, or more frequently if compliance is poor) 6.2 Rate of provision of appropriate prophylaxis are audited periodically 6.3 Results of audit and review are reported back to clinicians to drive change 6.4 Clinicians are educated on the need for VTE prevention measures

NSW GOVERNMENT | CLINICAL EXCELLENCE COMMISSION

TERM CHANGEOVER – ENSURING AN EFFECTIVE HANDOVER OF PATIENT CARE (GL2008_015)

Guidelines to ensure that patient care and patient flow are maintained by clinical teams during end of term changeover for junior medical staff and registrars.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2008/GL2008_015.html

USING RESUSCITATION PLANS IN END OF LIFE DECISIONS (PD2014_030)

PD2014_030 rescinds GL2008_018.

PURPOSE

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

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

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

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

MANDATORY REQUIREMENTS

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

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

All Public Health Organisations must:

- Adopt the state Resuscitation Plans (adult and paediatric). T hese should replace similar existing LHD forms (e.g. No CPR Orders, Not for Resuscitation Orders).
- Incorporate evaluation of whether Resuscitation Plans were completed into death audit protocols.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor who is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

IMPLEMENTATION

Roles and Responsibilities

NSW Ministry of Health

- Significant developments regarding end of life planning and care are underway in NSW Health that impact use of Resuscitation Plans. These include death audit standards, development of clinical triggers for end of life planning and targeted education for health professionals. However, as these broader implementation measures are still under development, this Policy Directive has been confined in scope to principles and standards related to usage of the Resuscitation Plan.
- Provide current policy to support use of Resuscitation Plans. A guideline will be developed in 18 months addressing how Resuscitation Plans integrate with other state level projects and programs. The Ministry will also evaluate the Resuscitation Plan forms in two years to assess whether they are meeting clinical need given rapid changes in End of Life care in NSW.
- Establish an end of life education strategy in partnership with the pillar agencies, that includes best practice approaches to training health professionals in having end of life conversations (relevant to Resuscitation Plans).
- Develop an appropriate service measure for Resuscitation Plans in readiness for the 2015/16 Service Level Agreements.

LHD and Specialty Network Chief Executives

- Identify an appropriate Executive Sponsor for this policy.
- Provide an appropriate governance mechanism to oversee implementation planning related to Resuscitation Plans consistent with *Advance Planning for Quality Care at End of Life: Action Plan 2013-2018.*
- Establish means of identifying the Person Responsible as a routine part of procedures for all admissions.
- Integrate Resuscitation Plans into the electronic Medical Record.
- Include assessment of whether Resuscitation Plans have been completed prior to in-hospital deaths as part of death audit standards.

Ambulance Service NSW

- Incorporate Resuscitation Plans into relevant protocols.

1. BACKGROUND

1.1 Purpose

This policy directive supersedes GL2008_018 Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

Development of standardised adult and paediatric Resuscitation Plans and implementation policy is required by the *NSW Health Advance Planning for Quality Care at End of Life: Action Plan 2013-2018* (Action 2.1 and 2.2).

Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

Key terms used in this document are defined in the Glossary.

1.2 Mandatory Requirements

All Public Health Organisations must adopt the NSW Health Resuscitation Plans (adult and paediatric). Resuscitation Plans are intended for use in all NSW Public Health Organisations, including acute facilities, sub-acute facilities, ambulatory and community settings, and NSW Ambulance for patients 29 days and older.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor that is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

1.3 Legal and legislative framework

The Resuscitation Plan – state forms included in this Policy Directive are legally enforceable medical orders and must be followed by staff.

Interdisciplinary disputes should be managed in accordance with GL2005_057 End-of- Life Care and Decision-Making - Guidelines.

The existing legal framework in NSW supports end of life decisions, including Resuscitation Plans and permits:

- Refusal of any and all life-sustaining treatments by a person with decision making capacity at the end of life.
- Advance refusal for a time of future incapacity.
- Decisions made by a doctor, in consultation with and preferably agreement of the Person Responsible, where a person has no decision-making capacity to withhold or withdraw life-sustaining measures so as to focus primarily on palliative care. (*Advance Planning for Quality Care at End of Life: Action Plan 2013-2018*).

A Resuscitation Plan must be made:

- With reference to pre-planning by patients (such as Advance Care Plans or Directives).
- In consultation with the patient/Person Responsible.
- Taking into account the current clinical status, prognosis, wishes of the patient, and goals of care.

In NSW, common law governs many aspects of end of life decision-making, including use of Advance Care Directives and these must be adhered to when valid. In NSW an Advance Care Directive must be adhered to provided that it is made voluntarily by a capable adult; was made without undue influence; and it is clear and unambiguous in applying to the circumstances at hand.

The NSW *Guardianship Act 1987* governs the legal standards for substitute decision-making i.e. regarding roles and responsibilities of the Person Responsible.

See also web-resource *End of life decisions, the law and clinical practice: legal considerations for health care practitioners in NSW* (2014).

2. WHEN RESUSCITATION PLANS SHOULD BE CONSIDERED

Planning care for patients who are approaching end of life will generally include a shift in the focus of care away from aggressive medical intervention and towards a palliative approach; opting out of Rapid Response Systems; initiating palliative care; and/or making arrangements to facilitate dying in place of choice. Making a Resuscitation Plan is one important step in this process of planning. (See Figure 1)

Improved end of life care will be achieved, in part, if conversations between doctors, patients and families about changing goals of care and appropriate use of life-sustaining measures as end of life approaches are undertaken earlier than currently occurs.

Patients and their families should be genuinely reassured that quality, individualised care consistent with the ongoing goals of treatment will continue to be provided to the patient, regardless of whether or not resuscitation is appropriate.

Decisions to withhold CPR and other resuscitation measures seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life. At some point in the course of life-limiting illness, a shift in the focus of care away from aggressive intervention and towards a palliative approach is often the agreed outcome.

2.1 Triggers for discussing a Resuscitation Plan

Resuscitation Planning is one component of Advance Care Planning and End of Life care (see Figure 1).

Discussing a Resuscitation Plan should be undertaken:

- If the patient's recovery is uncertain.
- If the treating clinician asks him or herself, 'Would I be surprised if this patient were to die in 6-12 months?' (so-called 'surprise question') and the answer is 'No'.
- If a patient clinically deteriorates requiring activation of a Rapid Response System, or is anticipated to do so.
- If the patient's condition is considered high risk, for example recurrent admission to hospital with severe chronic illness; a diagnosis of metastatic cancer; steady deterioration of a chronic respiratory, cardiac, liver or neurological illness; and other progressive advanced life limiting illnesses e.g. severe end stage dementia or frailty.

2.2 Rationale for withholding resuscitation

In general, the rationales for not instituting CPR are:

2.2.1 Where there is a clearly stated, adequately informed and properly documented or verbally expressed refusal by a person with decision-making capacity.

- Such a person has a lawful right to refuse any medical interventions, including resuscitation and other emergency interventions, even where that refusal will predictably result in death. This decision legally takes precedence over the contrary wishes of family or treating doctors; or

2.2.2 Where the person has no capacity to make this decision, there is an adequately informed and properly documented decision to withhold resuscitation by the Attending Medical Officer in consultation with the Person Responsible.

- This should be based on any known previous refusal of resuscitation or, in the absence of such refusal, a decision that resuscitation would not be in the patient's best interests. The Attending Medical Officer must also document a reason for overriding a documented decision such as an Advance Care Directive, for example that it does not adequately apply to the clinical situation at hand; or

2.2.3 Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.

- Given that judgments about the benefits or otherwise of a therapy ultimately reflect the values, beliefs and hopes/goals of the patient, any decision to withhold resuscitation on clinical grounds alone must be carefully considered, properly justified and documented .
- Focussing on patient comfort also entails withholding life-sustaining measures sometimes considered to be of negligible benefit (for example, where the ability to restore spontaneous rhythm or circulation with CPR is highly unlikely).
- A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit, but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit.

2.3 Disagreement about end of life decisions

- Planning end-of-life care is an iterative or cyclic process based on assessment, disclosure, discussion and consensus building with the patient and/or their family and the treatment team. Disagreement within families of patients without decision-making capacity, or between families and the health care team about whether resuscitation is appropriate can generate significant impediments to good patient care planning.
- Use a Resuscitation Plan to record agreement. Efforts to reach consensus and/or resolve disagreement within a family or between the family and the treating team about appropriate use of life-sustaining measures should precede this.
- Where a patient, family or Person Responsible requests a second medical opinion as to the predicted outcome with, or without resuscitation, such requests should always be respected and facilitated.
- These scenarios should be managed sensitively and according to options outlined in GL2005_057 Guidelines for end of life care and decision-making. See also NSW Health Conflict Resolution in End of Life Settings Project Report. http://www.health.nsw.gov.au/patients/acp/Pages/conflict-resolution.aspx

3. USE OF THE RESUSCITATION PLAN FORMS

The following section addresses the technical requirements, rationales and related clinical process when completing Resuscitation Plans. These are presented so as to complement the structure of the Resuscitation Plans and the clinical process they are used in.

3.1 Is there evidence of any prior planning?

- Check if the patient has previously prepared an Advance Care Plan (ACP) or Advance Care Directive (ACD). The ACD/ACP reflects the patient's preferences/wishes, often including those relevant to resuscitation. An ACP often becomes a synopsis of previous discussions which will be useful in completing the 'goals of care' section. Where one exists, this must inform decisions recorded in the Resuscitation Plan. This 'translation' or bridging step is critical if patients' prior wishes are to effectively determine how health professionals practically respond to clinical deterioration, most importantly as death approaches.
- If the ACD/ACP is ambiguous or it is unclear if it applies to the situation at hand, conversation should be revisited with the patient and/or Person Responsible, as appropriate.
- Identify the patient's Person Responsible irrespective of whether the patient now has decision capacity. An informed Person Responsible is important to support decision-making where the patient does not have capacity at many times throughout illness, including but not limited to end of life.

3.2 Capacity and participation

- Doctors prescribing medical orders, including 'Resuscitation Plans', hold responsibility for reaching those decisions, in consultation with patients.
- Where the patient does not have decision-making capacity, a consensus building approach to end-of-life decision-making that considers the patient's best interests as paramount is recommended. The patient, Person Responsible and/or family should be informed about the nature of CPR; the likely effects of resuscitation, including CPR, in this particular circumstance; and its possible adverse outcomes e.g. broken ribs; and the consequences of not instituting CPR. These should be discussed in the context of broader goals of care applicable at that time. As part of such discussions it may be helpful to seek advice from other health professionals who may have been involved in the care of the patient and had conversations about end of life care, such as the patient's General Practitioner. The Attending Medical Officer should recommend a course of action when discussing resuscitation in the context of goals of care with the patient, Person Responsible or family.

3.2.1 Where the patient wishes to discuss resuscitation

- Where the patient has decision capacity and is willing to discuss resuscitation and treatment goals, they should be asked who (if anyone) they would like to be involved in discussions.
- Patients and families from culturally and linguistically diverse groups may have preferences for different decision-making styles, other than involving solely the patient and their doctor. These should be explored and cultural differences respected. For Aboriginal patients, the involvement of an Aboriginal Liaison Officer, where available, is advised.

3.2.2 Where the patient does not wish to discuss resuscitation

- Discussion about diagnosis, prognosis and preferences for care should be encouraged, but not forced. A patient's desire not to discuss resuscitation, or the possibility of his or her own death, should always be respected and emotional support provided, for example through social work or chaplaincy as appropriate.
- In situations where the patient does not want to discuss or decide on resuscitation, the health care professional should establish whether the patient would prefer to have others make resuscitation planning decisions on their behalf.

3.2.3 Where the patient does not have decision-making capacity

- Where decision-making capacity is impaired, reasonable efforts should be considered to maximise his or her capacity to participate in decisions regarding resuscitation.
- If there is any doubt that the patient has sufficient decision-making capacity, their decision-making capacity should be assessed and documented in the patient's records. See *Capacity Toolkit*: http://www.diversityservices.lawlink.nsw.gov.au/agdbasev7wr/divserv/documents/pdf/capacity_toolkit0609.pdf

- Where the patient lacks decision-making capacity, the Attending Medical Officer or their delegate should identify the Enduring Guardian (or other category of Person Responsible). Enduring Guardians can refuse life sustaining measures if they have been expressly given such a power in their appointment.

3.2.4 Where the person's wishes regarding resuscitation are unknown

- Cardiorespiratory arrest may occur before there has been sufficient time to hold discussions regarding resuscitation. Health professionals still need to decide about use of resuscitation without knowing the person's wishes in some circumstances. This is addressed in PD2005_406 *Consent to Medical Treatment - Patient Information* in providing medical treatment in emergency situations.
- Not having a Resuscitation Plan does not necessarily mean that resuscitation is a default action that *must* be applied in all situations. Clinical judgement should be used where resuscitation is manifestly inappropriate and/or the patient is deceased.

3.2.5 Withholding resuscitation without explicit discussion

Where there is time to plan end of life care and to make decisions regarding resuscitation, then the discussion should be had. There are some exceptions to the general requirement to discuss a Resuscitation Plan with the patient, or Person Responsible, or family:

- The patient (Person Responsible/enduring guardian/or family) does not wish to discuss resuscitation. Decisions may then be undertaken by the Attending Medical Officer.
- The patient is aware they are dying and has already expressed a desire for palliative care.
- The health care facility does not provide resuscitation as a matter of course, consistent with the values and practices relevant to their patient population, such as hospices, and this has been made clear to the patient and their family when the facility assumes care; or
- The patient has had a prior therapeutic relationship with a doctor other than the Attending Medical Officer and prior discussion has made the patient's views regarding resuscitation apparent.

3.3 Clinical interventions and monitoring

- Vital sign monitoring should be (re)considered if the patient is in their last days and this should be consistent with monitoring frequency prescribed on the Standard Adult General Observation chart, or equivalent standard observation chart.
- Implantable devices such as defibrillators or pacemakers may need to be deactivated in patients at end of life.
- Nurses may call for medical review of unrelieved symptoms associated with dying, even where activating an urgent Clinical Review call has been considered unnecessary. A plan for monitoring and managing symptoms associated with dying should be put in place if this is the case.

3.4 Referral/Transfer

- 'Referral to palliative care' means referral for specialist palliative care review.
- 'Referral home' may be applicable in some scenarios where discharge to supported care may be feasible and appropriate.
- Careful consideration should be given to the need for, and appropriateness of transfer of an individual with a 'Resuscitation Plan' in place where there is possible need for resuscitation en route, for example if the individual is pre-terminal.
- NSW Health Resuscitation Plans are valid for use by NSW Ambulance staff in all situations involving patient contact.

- A hard copy of the Resuscitation Plan should accompany the patient on inter-facility transfer.
- Where a patient is transferred to a non-NSW Health facility, the receiving medical practitioner should be encouraged to review the Resuscitation Plan's contents and consider whether they authorise a consistent Plan (according to that facility's documentation protocol). Immediate repeat conversation with the patient or family about the decision to use a local Resuscitation Plan is not necessarily required.

3.5 Authorising and Signing the Resuscitation Plan

- Every patient who is admitted to a public hospital is admitted under the bed care of a doctor (Attending Medical Officer) who has medico-legal responsibility for that patient. As part of the AMO's responsibility, it is incumbent that they or their delegate clarify with others including the health practitioners who may have known that patient for many years (such as the patient's General Practitioner), about the patient's background, ongoing management and resuscitation or advance care plans.
- Discussion with the patient/Person Responsible about resuscitation should generally be undertaken by the most experienced clinician.
- Neither the patient, nor their Person Responsible, is required to sign the Resuscitation Plan.
- The 'delegated signatory Medical Officer' e.g. registrar who is not the Attending Medical Officer may undertake the conversation with the patient/Person Responsible and complete and sign the Resuscitation Plan. However, this must be authorised by the responsible Attending Medical Officer at the earliest opportunity.
- Delegation to a junior medical officer should only occur with adequate training, supervision and support. If a junior medical officer is required to discuss and document a Resuscitation Plan (e.g. out of hours) this must be discussed with the Attending Medical Officer at the earliest opportunity.
- Both sides of the form must be completed and signed.
- Consistent with PD2005_406, other health care professionals (including nurses) cannot be delegated the task of informing patients or obtaining consent for resuscitation planning. When requested by a patient, they are permitted to provide information and should document this in the medical record.
- A copy of the form may be provided to the patient or Person Responsible.

3.6 Reviewing the Resuscitation Plan

- A fixed frequency for review is not appropriate for all scenarios. Generally, a Resuscitation Plan needs to be clarified from one acute admission to the next where a change in prognosis is likely.
- A Resuscitation Plan may be valid for up to 3 months for frequent and routine 'admissions' e.g. renal dialysis.
- A Resuscitation Plan should be reviewed prior to elective minor procedures.
- A Resuscitation Plan may be compatible with palliative surgical procedures, and potentially time and goal limited ICU support in some cases.
- Where surgery is planned for someone with a Resuscitation Plan, this should be reviewed in consultation with the patient, Person Responsible, anaesthetist and surgeon as to whether it is appropriate to suspend it during the intra- or post-operative period. This decision should be clearly documented in the medical record.

3.7 Revoking or amending the Resuscitation Plan

- The procedure for revoking the Resuscitation Plan is to rule a diagonal line through both sides, then print and sign your name and date on the line.
- For significant amendments (for example, a change to the CPR order), the Resuscitation Plan must be revoked and a new Plan completed.

- For less significant amendments (for example, a change to the intervention section), the Resuscitation Plan can be amended and initialled. This should be documented in the medical record. It should be noted that this option may not exist if the form is included in an Electronic Medical Record. If this is the case, the Resuscitation Plan must be revoked and reissued – documentation in the medical notes alone is not sufficient.

3.8 Storage of Resuscitation Plans

- The current Resuscitation Plan must be made readily accessible to attending health professionals. It is preferable that multiple copies are not made because of the potential for confusion.
- It is recommended that the current hard copy should be kept at the front of the patient's health record. Details of the Resuscitation Plan should be included in handover between shifts.
- Resuscitation Plans must be integrated into electronic health record systems in appropriate forms e.g. alerts/orders;
- Resuscitation Plans should be incorporated into hospital discharge summaries, where possible

4. USE OF RESUSCITATION PLANS IN CHILDREN

- The general principles and process guiding the completion of a Resuscitation Plan are the same for children as for adults, with a focus on communication and exploration of goals of care with the person/s responsible, and where appropriate, the child.
- The Paediatric Resuscitation Plan is not intended for use in Neonates (patients under 29 days), although it may be used to guide discussions.
- The Paediatric Resuscitation Plan should be used for patients older than 29 days and up to and including the age of 17 years. The Adult Plan should be used for patients aged 18 years and over.
- Decisions to withhold resuscitation may also be required where a child is in care of the state. The Minister for Family and Community Services is required by the *Children and Young Person's Care and Protection Act* to be responsible for this kind of medical decision. It is the Minister's delegate (the Director-General, NSW Family and Community Services) who authorises a Resuscitation Plan where the Attending Medical Officer considers resuscitation limitation appropriate.
- Refer to PD2005_406 Consent to Medical Treatment - Patient Information for information regarding the potentially complex consent issues for children (persons aged under 16 years) and young people (persons aged 16 or 17).

5. GLOSSARY

Attending Medical Officer
The Attending Medical Officer (AMO) is the senior medical practitioner who has primary responsibility for the patient during admission. This medical officer is a consultant who may be a visiting medical officer or a staff specialist. The AMO may lead a team that includes related medical staff. This team plays a critical role in the clinical review of the patient.

Advance Care Directive
An Advance Care Directive is a type of advance planning tool that can only be completed by a person with decision capacity. These were formerly known, in particular in the US, as "living wills". They should inform a Resuscitation Plan.

Advance Care Plan
An Advance Care Plan is the outcome of an Advance Care Planning process. Like an Advance Care Directive, an Advance Care Plan also records preferences about health and personal care and treatment goals. However, it may be completed by discussion or in writing and it may be made by, with, or for the individual. It should inform a Resuscitation Plan.

Capacity
In broad terms, when a person has capacity to make a particular decision they can:
- Understand the facts and the choices involved
- Weigh up the consequences
- Communicate the decision.

Clinical review
This is a patient review undertaken within 30 minutes by the attending medical team. Depending on local protocol, the review may be undertaken by a medical officer on call or an appropriately experienced Registered Nurse/Midwife, preferably First Line Emergency Care accredited or with post graduate qualifications in emergency/critical care nursing or other relevant qualifications.

Enduring Guardian
An Enduring Guardian is someone appointed by a person to make personal (including medical) or lifestyle decisions on their behalf when they are not capable of doing so for themselves. Enduring Guardians and those appointed by the Guardianship Tribunal may make end of life decisions on the person's behalf. The appointment of an Enduring Guardian comes into effect when the appointing individual loses capacity to make personal or lifestyle decisions. People can choose which decisions (called functions) they want their Enduring Guardian to make. These functions are governed by the *NSW Guardianship Act 1987*

Goals of care
The general goal of medical treatment is the health and wellbeing of the patient. The specific goal of medical treatment may, in the circumstances, be cure of an illness, relief of the symptoms of an illness, stabilisation of the patient in a satisfactory condition, improvement in the way the patient dies, etc.

Person Responsible
The *NSW Guardianship Act 1987* establishes who can give valid consent for medical treatment to an incompetent patient aged 16 years and over. The Act establishes a hierarchy for determination of who is the Person Responsible as follows:
- The patient's lawfully appointed guardian (including an Enduring Guardian) but only if the order or instrument appointing the guardian extends to medical treatment.
- If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship.
- If there is no such person, a person who has the care of the patient (otherwise than for fee and reward).
- If there is no such person, a close friend or relative.

Currently in NSW a Person Responsible who has not been appointed as Enduring Guardian or by the Tribunal does not have the same decision authority in end of life decisions. Guardians (including Enduring Guardians) can consent to treatment being withheld or withdrawn if they have been expressly given such a power in their appointment.

Rapid response
This refers to an immediate review undertaken by an individual or multidisciplinary team of healthcare professionals who have been trained and assessed to hold an advanced level of competence in resuscitation and stabilisation of patients. A Rapid Response call must be made if a patient's observations fall into the 'Red Zone' of NSW Health Standard Observation Charts.

Resuscitation
Resuscitation encompasses a spectrum of emergency interventions such as supplemental oxygen, intravenous fluids and non-invasive ventilation. It is not limited to cardiopulmonary resuscitation.

Resuscitation Plan
A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and document other time critical clinical decisions related to end of life. These were formerly called No CPR Orders. A Resuscitation Plan is made:

- With reference to pre-planning by patients (such as Advance Care Plans or directives)
- In consultation with patients/families
- Taking account of the current clinical status, as well as the wishes and goals of the patient.

Standard observation charts
Observation Charts approved for use by NSW Health System e.g. the Standard Adult General Observation (SAGO) Chart, Standard Paediatric Observation Chart (SPOC), Standard Maternity Observation Chart (SMOC), Adult and Paediatric Emergency Department Observation Charts.

Attachment 1: Resuscitation Plan – Adult (SMR020.056)

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESUSCITATION PLAN - ADULT

For patients aged 18 years and over

Refer to PD2014_030

SMR020056

Patient Name: ..... (PRINT)

This Plan was discussed with and authorised by the Attending Medical Officer

.....(PRINT NAME) on ...../...../..... (DATE).

Diagnoses .....

.....

Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient or Person Responsible's* choice.

Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes ☐ No ☐ N/A ☐

The **Goals of Care** negotiated through conversations with the doctor/patient/family/Person Responsible* are:

.....

.....

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

- **Respiratory Support:**

Pharyngeal suction	Yes ☐	No ☐			
Supplemental oxygen	Yes ☐	No ☐	Bag & mask ventilation	Yes ☐	No ☐
Non-invasive ventilation	Yes ☐	No ☐	Intubation	Yes ☐	No ☐

- Referral to ICU Yes ☐ No ☐
- Are other non-urgent interventions appropriate? Yes ☐ No ☐

(e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required: _____

_____

_____

Clinical Review Call are to be activated Yes ☐ No ☐

YELLOW ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Rapid Response Call are to be activated Yes ☐ No ☐

RED ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated.

- Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes ☐ No ☐

In the event of cardiopulmonary arrest:

CPR ☐ **No CPR** ☐

(see rationale overleaf)

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print & sign your name & date on the line.

NO WRITING

Page 1 of 2

SMR020.056

RESUSCITATION PLAN - ADULT

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SAMPLE - DO NOT PRINT

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESUSCITATION PLAN - ADULT

For patients aged 18 years and over

Refer to PD2014_030

Capacity and Participation:

Good practice involves consulting with the family. The patient and/or Person Responsible* have been advised they can revisit these decisions at any time.

This Plan was discussed with the patient and/or Person Responsible* (circle which one applies)

on...../...../..... (date).

- **An interpreter (if required) was present.** Yes ☐ No ☐ N/A ☐

If no to any of the above, or the patient and/or Person Responsible* has not been involved in discussions, record details in the patient's health care record.

Name of the Person Responsible* .....(PRINT)

Relationship to patient..... Phone number/s .....

*The *NSW Guardianship Act* establishes the Person Responsible who can give valid consent for medical treatment to an incompetent patient aged 16 years and over according to this hierarchy as:

1. The patient's lawfully appointed guardian (including an enduring guardian) but only if the order or instrument appointing the guardian extends to medical treatment.
2. If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship.
3. If there is no such person, a person who has the care of the patient (other than for fee and reward).
4. If there is no such person, a close friend or relative.

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

Referral/Transfer/eMR Alert: (tick as appropriate)

- Referral to Palliative Care Specialist/Team/Facility ☐
- Transfer to other facility (specify) ..... ☐
- Transfer home (if patient/family choice) ☐
- Has the eMR clinical alert 'Check Resuscitation Plan' been activated? ☐

This Resuscitation Plan remains valid:

- Until a change in prognosis warrants medical review ☐
- Until the patient and/or Person Responsible* request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. dialysis) ☐
- Until review date at ...../...../..... and/or time at..... ☐

Delegated signatory Medical Officer (must have discussed this decision with the AMO)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

Page 2 of 2

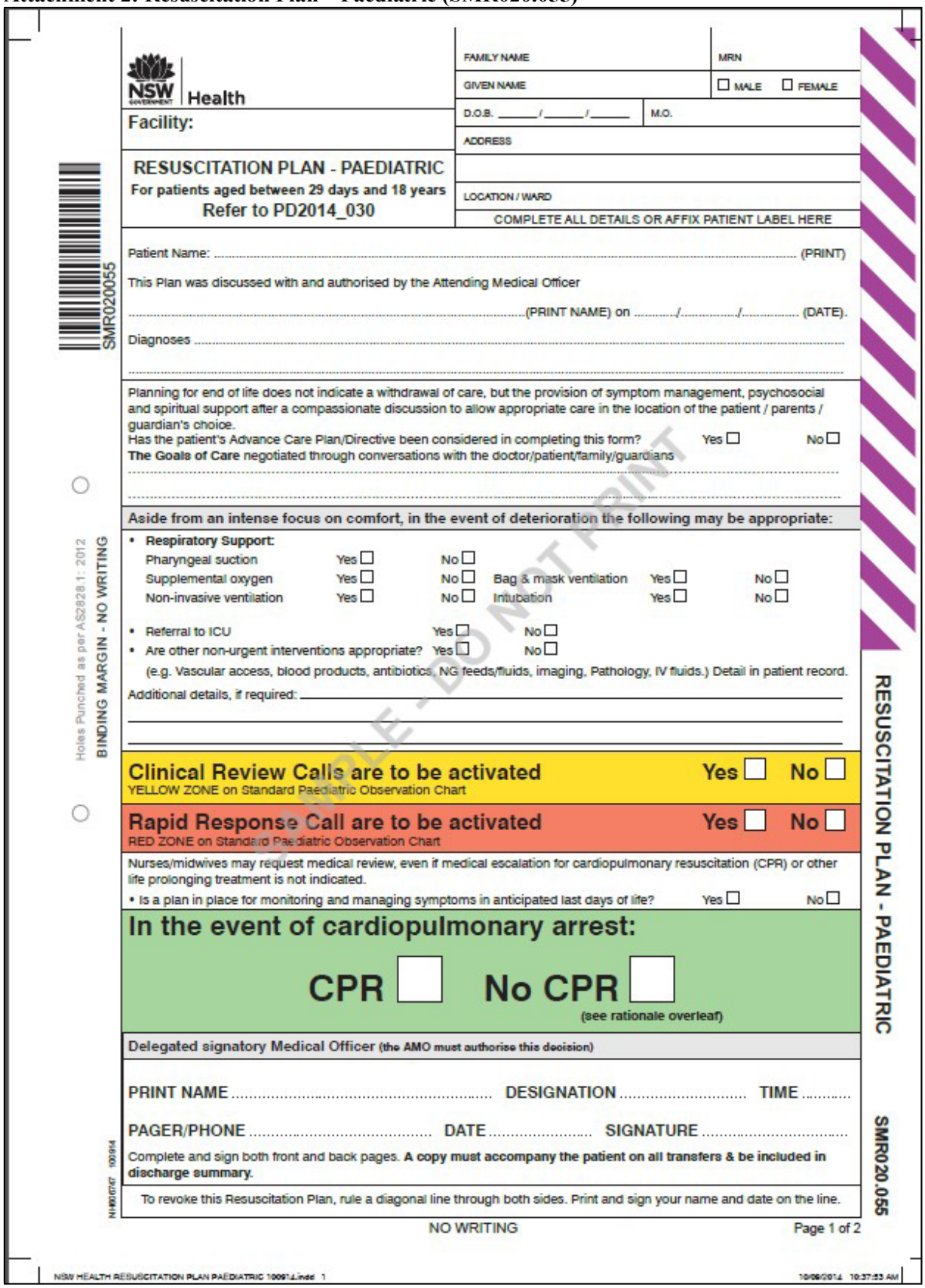
NO WRITING

SAMPLE - DO NOT PRINT

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR020056

Attachment 2: Resuscitation Plan – Paediatric (SMR020.055)



NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020055

RESUSCITATION PLAN - PAEDIATRIC

For patients aged between 29 days and 18 years

Refer to PD2014_030

Patient Name: ..... (PRINT)

This Plan was discussed with and authorised by the Attending Medical Officer

.....(PRINT NAME) on ...../...../..... (DATE).

Diagnoses .....

.....

Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient / parents / guardian's choice.

Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes ☐ No ☐

The Goals of Care negotiated through conversations with the doctor/patient/family/guardians

.....

.....

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

- **Respiratory Support:**
  - Pharyngeal suction Yes ☐ No ☐
  - Supplemental oxygen Yes ☐ No ☐ Bag & mask ventilation Yes ☐ No ☐
  - Non-invasive ventilation Yes ☐ No ☐ Intubation Yes ☐ No ☐
- Referral to ICU Yes ☐ No ☐
- Are other non-urgent interventions appropriate? Yes ☐ No ☐

(e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required: _____

_____

_____

Clinical Review Calls are to be activated Yes ☐ No ☐

YELLOW ZONE on Standard Paediatric Observation Chart

Rapid Response Call are to be activated Yes ☐ No ☐

RED ZONE on Standard Paediatric Observation Chart

Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated.

- Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes ☐ No ☐

In the event of cardiopulmonary arrest:

CPR ☐ **No CPR** ☐

(see rationale overleaf)

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME ..... DESIGNATION ..... TIME .....

PAGER/PHONE ..... DATE ..... SIGNATURE .....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

NO WRITING

Page 1 of 2

RESUSCITATION PLAN - PAEDIATRIC SMR020.055

NSW HEALTH RESUSCITATION PLAN PAEDIATRIC 10091.indd 1 10/09/2014 10:37:53 AM

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

RESUSCITATION PLAN - PAEDIATRIC

For patients aged between 29 days and 18 years

Refer to PD2014_030

Capacity and Participation:

Use this Resuscitation Plan for minors aged from 29 days up to and including 17 years. For 18 years and above use the Adult Resuscitation Plan.

Good practice involves consulting with the family. The patient / parents / guardian have been advised they can revisit these decisions at any time.

This Plan was discussed with the patient / parents / guardians (circle which one/s apply)

on...../...../..... (date). Include the family in discussions where possible.

- **An interpreter (if required) was present.** Yes ☐ No ☐ N/A ☐

If no to any of the above, or the patient / parents / guardian have not been involved in discussions, record details in the patient's health care record.

Name of the parents / guardians / family members.....(PRINT)

Relationship to patient..... Phone number/s .....

When a child is under the parental responsibility of the Minister, only the Director General of FaCS has the delegated authority to authorise a Resuscitation Plan. Phone the Child Protection Line: 133 627 available 24/7.

Rationale for withholding CPR:

- Following consensus with the patient / parents / guardians, resuscitation is inappropriate. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

Referral/Transfer/eMR Alert: (tick as appropriate)

- Referral to Palliative Care Specialist/Team/Facility ☐
- Transfer to other facility (specify) ..... ☐
- Transfer home (if patient/family choice) ☐
- Has the eMR clinical alert 'Check Resuscitation Plan' been activated ☐

This Resuscitation Plan remains valid:

- Until a change in prognosis warrants medical review. ☐
- Until the patient / parents / guardians request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. regular immunoglobulin infusions) ☐
- Until review date at ...../...../..... and/or time at..... ☐

Delegated signatory Medical Officer (the AMO must authorise this decision)

PRINT NAME..... DESIGNATION..... TIME.....

PAGER/PHONE..... DATE..... SIGNATURE.....

Complete and sign both front and back pages. **A copy must accompany the patient on all transfers & be included in discharge summary.**

To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.

Page 2 of 2

NO WRITING

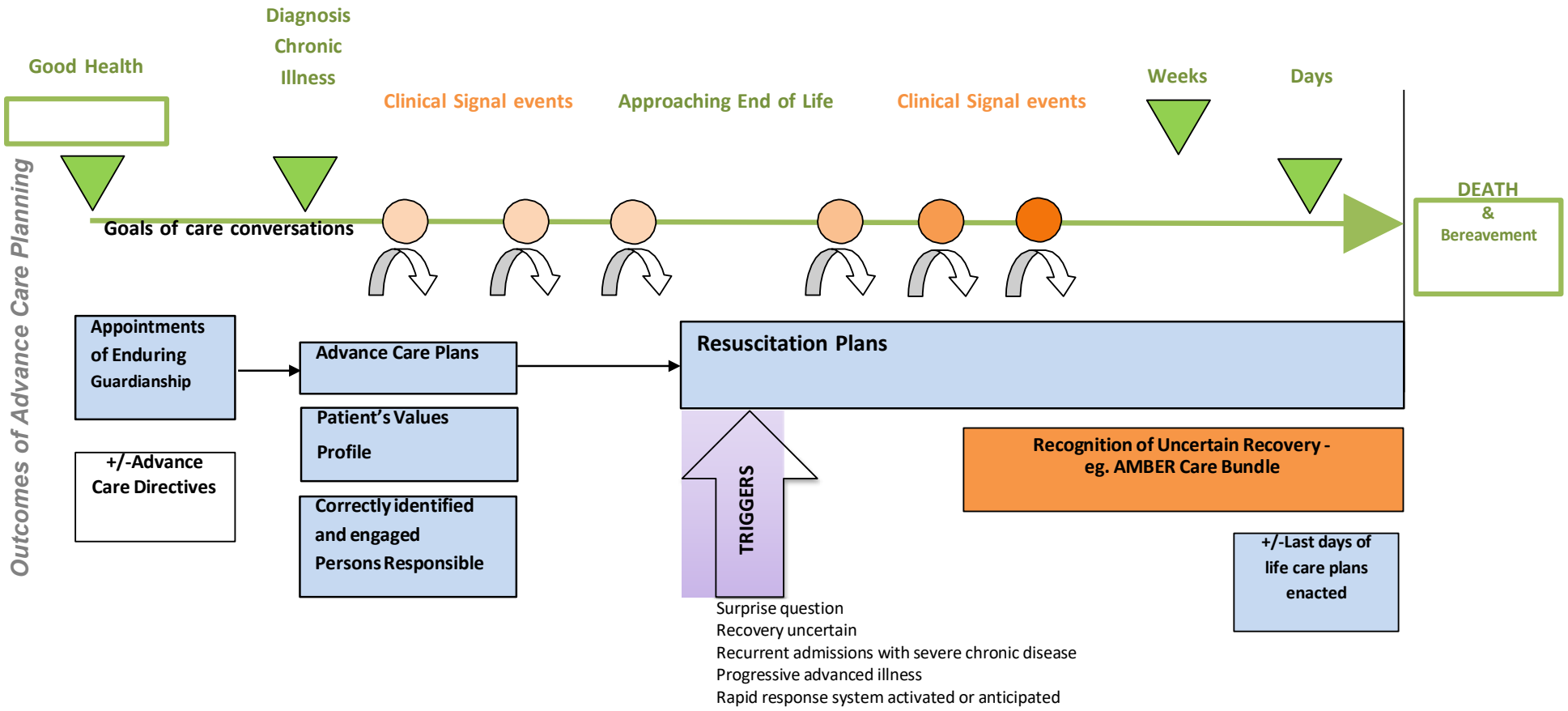
SAMPLE - DO NOT PRINT

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR020055

Attachment 3: Figure 1: ***Resuscitation Plans in the context of Advance Care Planning and End of Life***



INSERTION AND MANAGEMENT OF NASOGASTRIC AND OROGASTRIC TUBES IN ADULTS (GL2023_001)

GL2023_001 replaced PD2009_019

GUIDELINE SUMMARY

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

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

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

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

GUIDELINE SUMMARY

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

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

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

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

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

Before an inserted tube can be used for any enteric intake (feeding formula, medication or fluids), confirmation of correct tube placement must be actioned and documented.

Confirmation of tube placement can be done radiologically (via chest x-ray), or via pH testing of aspirates. Radiological confirmation also requires that the chest x-ray is reported by a radiologist, or reviewed by an experienced medical officer, who can exclude insertion complications and can confirm the anatomical position of the tip of the tube below the diaphragm and in the stomach.

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

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

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

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

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

The entire Insertion and Management of Nasogastric and Orogastric Tubes in Adults guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2023_001

HEALTHCARE RIGHTS (IB2023_032)

IB2023_032 replaced PD2011_022

PURPOSE

This Information Bulletin advises NSW Health has adopted the *Australian Charter of Healthcare Rights* (second edition) and the *Charter on the Rights of Children and Young People in Healthcare Services in Australia* (collectively referred to as the Charters)

The Charters reflect NSW Health focus on elevating the human experience and the responsibility of health service staff to ensure that consumers or someone they care for are aware of their healthcare rights.

KEY INFORMATION

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

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

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

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

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

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

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

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

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

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

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

A frequently asked questions document is available.

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

CLINICAL HANDOVER (PD2019_020)

PD2019_020 rescinds PD2009_060

PURPOSE

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

MANDATORY REQUIREMENTS

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

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

IMPLEMENTATION

Clinical Excellence Commission

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

eHealth and local Information and Communication Technology

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

Chief Executive of Local Health Districts/ Specialty Health Networks

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

Directors of Clinical Governance

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

Hospital, facility, clinical stream and unit managers

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

Clinical staff

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

Clinical Handover: Procedures.

BACKGROUND

About this document

Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient/s to another person or professional group on a temporary or permanent basis.
Clinical handover does not just happen at the change of shift. It happens within and between teams constantly and is considered a time of risk for patients, where gaps in information transfer can impact patient safety. Examples include:

- Escalation of the deteriorating patient
- Patient transfers:
    - to another unit/clinic or facility
    - for a test, procedure or appointment
    - to, from and within Community settings, including Residential Aged Care
    - involving other teams (e.g. Ambulance, patient transport)
- Shift to shift change over
- Multidisciplinary team handover

Key definitions

Patient/family/carer	Includes guardian or those nominated to advocate on the patients behalf
Journey board	Indicates a board or portal that provides information about patients which directly relates to care coordination
Briefing	A tool, which can be used before or after clinical handover, for teams to summarise the key concerns, anticipate changes and to assign accountability
Huddle	A tool which, when used in this context serves the same function as a briefing and can be scheduled before or after clinical handover

KEY PRINCIPLES FOR SAFE AND EFFECTIVE CLINICAL HANDOVER

The seven (7) key principles provide a framework to guide the structure and process for safe clinical handover.

Patient/Family/Carer involvement

- Emphasise a culture where patients and their family/ carer are partners in care.
- Support patients and their family/ carer to be involved in clinical handover, in line with the wishes of the patient (e.g. patient/ family/ carer is given the opportunity to lead their clinical handover where appropriate).
- Establish the patient's care goals, preferences and needs regarding their admission/presentation/illness.

- Ensure there is a system for the early identification of Aboriginal and Torres Strait Islander patients and a process in place for including the Aboriginal Liaison Support Officer or Aboriginal Health Worker (where appropriate).
- Identify individual patient needs for example, Culturally and Linguistically Diverse (CALD) patients or those with communication challenges such as hearing or vision impairment.

Leadership

- Nominate a leader at each clinical handover.

Handover participants

- Handover is attended by relevant members of the multidisciplinary team who:
  - When handing over, arrive prepared with current information and knowledge of the patient's clinical situation.
  - Are provided the opportunity to ask questions and to seek clarity.

Handover time

- Schedule an agreed time and duration for clinical handover to occur.
- Ensure the clinical handover process remains interruption free (with the exception of emergencies).
- Have in place strategies to reinforce punctuality.
- Provide sufficient time for family/carer involvement by notifying them of clinical handover times.

Handover place

- Set an agreed location for clinical handover aiming for minimal interruption.
- Ensure access to all clinical results and healthcare records.
- Occurs in the patient's presence where possible.

  Face-to-face handover is preferred, although it is recognised that many handovers involve telephone or telehealth communication, especially in community or clinic settings. Any written information is to be supplementary only, that is, it must not replace verbal handover. Voice recorded handover is never permitted. When handover occurs and the patient is not present, processes must ensure that the patient/family/carer is aware of who will be taking over their care.

Handover process

Include tools such as electronic clinical communication tools, flow charts and scripts to help keep clinical handover relevant, succinct and consistent. A documented and approved approach must include:

1. A 'journey board' meeting, huddle or briefing is held prior to or after bedside handover
2. Introduction of team members and their roles and the patient/ family/ carer
3. Confirmation of the patient's identity using at least three (3) approved patient identifiers

- Summary of relevant clinical history and current clinical situation, including infectious status, diet/fluid/supervision requirements, invasive or implanted devices and medications

4. Review of the most recent recorded set of observations noting any trends, recent clinical review and/or rapid response calls and resultant management plans

5. Assessment of recent test results which require follow-up, for example, scans, x-rays and blood tests
6. Identification of timeframes and requirements for transition of care/discharge
7. Cross-check information in the patient's health care record/s including medications and observations to support the handover communication
8. Respond to patient/family/carer concerns
9. Acceptance of responsibility for the care of the patient by the clinician receiving handover.

Documentation

- Document findings and include changes in clinical condition and feedback from patient/ family/ carer regarding ongoing care requirements; update management/care plans.

  Cross-check documentation has occurred in the electronic medical record and on paper when using hybrid systems.

EVALUATION

All Public Health Organisations must collect and monitor data to evaluate the implementation of clinical handover based on the key principles. The results of data analysis will be provided to clinical units, facility, Local Health District/ Specialty Network quality and safety committees in a timely manner.

Scheduled reviews of clinical handover audit results and incidents should form the basis of the organisation's evaluation plan. Although not exhaustive, examples of supplementary data, to complement the scheduled audits, are outlined below.

Data source	What to look for
Incident Management data/Root Cause Analysis review/other case review protocols	- Readmissions due to gaps in handover of care - Medication incidents due to gaps in communication - Number of complaints/compliments about clinical handover - Number of RCAs where clinical handover was identified as a contributing factor
HIE data	- Readmissions where patients were not able to be cared for at home or care was impacted by ineffective clinical handover
Mortality and Morbidity meetings/mortality review	- Readmissions that were due to inability to be cared for at home, according to patient/family/carer wishes, during the last days of life, where clinical handover was identified as a contributing factor
Patient Experience Survey	- Review the results in relation to how patients/family/carer perceive the communication between themselves and the multi-disciplinary team (MDT) and between members of the MDT

APPENDIX 1: OBSERVATION AUDIT

- Observational clinical handover audits must occur annually, as a minimum, or more frequently as clinical incidents relating to clinical handover are identified, and based on audit outcomes.
- Audits must be completed at the point-of-care, in real time, and be undertaken by a clinician with a good understanding of the clinical handover policy.
- The following audit/criteria has been developed in line with the key principles of the policy
- It can be adapted to reflect care settings and patient cohorts.

Select type (including format) of clinical handover being observed

☐	Shift-to-shift in a hospital setting (record start times in the spaces below)
☐	Intra-facility - the handover of care from one area to another within a facility
☐	Other (please specify) (for example; telephone, telehealth)

For shift-to-shift clinical handover

Record *planned* start time of clinical handover __:__

Record *actual* start time of clinical handover __:__

Multidisciplinary team members in attendance

☐	Nursing/Midwifery Staff	☐	Medical staff
☐	Nursing Unit Manager/Midwifery Unit Manager/Nurse/Midwife in Charge	☐	Allied Health Staff
☐	Management/Executive	☐	Non-clinical staff
☐	Other (provide details)		

Preparation

	Yes	No	N/A
There is a nominated leader	☐	☐	■
A briefing or huddle is held prior to or after bedside handover	☐	☐	☐
Patients/family/carer from CALD background or with communication challenges (such as hearing or vision impairment) are identified and information needs met	☐	☐	☐
Aboriginal Liaison Support Officer or Aboriginal Health Worker services involved for patients who identify as Aboriginal and Torres Strait Islander. Document here if the service is not available. _____	☐	☐	☐

12. MEDICAL CARE 12.275

Handover – Key Principles

	Yes	No	N/A
Patient present at the handover (if No or N/A, state reason in space below)	☐	☐	☐
At the commencement of clinical handover the patient/family/carer is introduced to staff taking over their care	☐	☐	☐
The patient/family/carer is invited to be involved in clinical handover (eg, asked to repeat back or contribute to relevant information)	☐	☐	☐
The patient is given the opportunity to lead their clinical handover, where appropriate	☐	☐	☐
At least three (3) approved patient identifiers are used to confirm the patient's identity (e.g. patient name, MRN, DOB)	☐	☐	☐
Involve Patient/family/carer in the patient identification process	☐	☐	☐
Allergies are noted and confirmed with the patient/family/carer	☐	☐	☐
An approved, documented, standardised tool is used to guide clinical handover	☐	☐	☐
Relevant clinical history is provided, such as: infectious status, invasive or implanted devices, medications, most recent observations and test results	☐	☐	☐
A summary of the clinical assessment including care needs (e.g. cultural, linguistic, diet/fluid/supervision requirement) and risks (e.g. falls, pressure injury, vulnerability, sexual safety) is provided	☐	☐	☐
The patient's risk factors for suicide attempts are included where applicable	☐	☐	☐
The patient's risk factors for violence are included where applicable	☐	☐	☐
At conclusion of clinical handover the patient/family/carer is provided the opportunity to ask questions	☐	☐	☐

Process

Indicate if there were any interruptions during the clinical handover (tick all that apply)

☐	None
☐	Patient's hygiene needs
☐	Procedures and/or observations
☐	Staff member/s moves away to discuss other patients' issues
☐	Ward rounds/other clinical staff review of the patient
☐	Other (please provide details)
Details:	

Record actual finish time of clinical handover __:__

	Yes	No
Handover occurred within the agreed time-frame	☐	☐
Health care record reflects that clinical handover and transfer of responsibility/accountability of care has occurred with all findings and changes in the patient's clinical condition documented	☐	☐

NSW PALLIATIVE CARE STRATEGIC FRAMEWORK (PD2010_003)

PURPOSE

The *NSW Palliative Care Strategic Framework* builds on and replaces the *NSW Palliative Care Framework (*2001*)*.

The *Strategic Framework* is aligned with the goals of the *National Palliative Care Strategy.* The *Strategic Framework* sets out five priority areas for strengthening palliative care services in NSW.

The Statewide Centre for Improvement of Palliative Care (SCIP) has been established to provide leadership for palliative care service planning and to support the implementation of the *Strategic Framework*. This work will be aided by the Palliative Care Service Development Officer Network (SDO). A Service Development Officer position has been established in each AHS. These positions were approved in 2006 with recurrent funding.

MANDATORY REQUIREMENTS

The *Strategic Framework* sets out the priority areas for strengthening palliative care services in NSW. The values and operating statements articulate the way forward, and are supported by five planning priorities.
Priority 1: Improving NSW palliative care service planning & delivery
Priority 2: Implementing the Standards for Providing Quality Palliative Care for all Australians
Priority 3: Improving the palliative care workforce capacity
Priority 4: Improving palliative care data
Priority 5: Strengthening evidence based practice

Area Health Services are required to develop *Palliative Care Service Plans*, with support and guidance from SCIP. Each Area *Palliative Care Service Plan* should reflect the priorities of the *NSW Palliative Care Strategic Framework*. Areas must lodge their plans with SCIP, which will review them as necessary in partnership with the Department of Health to ensure they align with the *Strategic Framework*.

SCIP will also take a lead role in developing the *NSW Palliative Care Service Development Plan* and work in partnership with the Children's Hospital at Westmead on the *NSW Paediatric Palliative Care Service Development Plan*. The *NSW Palliative Care Service Development Plan* for paediatric and non paediatric patients will also be used to align *Area Health Service Palliative Care Service Plans*.

IMPLEMENTATION

The *Strategic Framework* will be implemented through the *NSW Palliative Care Service Development Plan* and the *NSW Paediatric Palliative Care Service Development Plan*. Strategies from these plans will be incorporated into *NSW Area Health Service Palliative Care Service Plan*s. Implementation at an AHS level is being supported by the Palliative Care Service Development Officer Network.

The Palliative Care Advisory Group (PCAG) will provide advice during the implementation process, and the *Palliative Care Strategic Framework* will be reviewed in 2013.

The document is available at http://www.health.nsw.gov.au/policies/pd/2010/PD2010_003.html

SAME GENDER ACCOMMODATION (PD2022_042)

PD2022_042 rescinds PD2015_018 .

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

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

Admission to hospital must not be delayed when same gender accommodation is not available. Staff must make it clear to patients and carers that mixed gender accommodation is not normal practice.
Mixed gender accommodation in critical care and short stay units may take priority over gender specific accommodation.

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

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

1. BACKGROUND

Patients who are staying overnight in hospitals must not have to sleep in the same room, ward or bay as a different gender to their own, use mixed bathroom facilities or pass through different gender wards to reach their own facilities, except in exceptional clinical circumstances. These only apply in Critical Care and Short Stay Units.

1.1 About this document

The aim of this document is to provide direction to NSW Health organisations and staff on the importance of providing same gender accommodation in hospitals. This is so that patients and carers experience healthcare in environments that are safe, comfortable, and culturally appropriate.

1.2 Key definitions

Aboriginal patients	The word Aboriginal is used in this document in line with the NSW Health Guideline *Communicating Positively: A Guide to Appropriate Aboriginal Terminology* [2]. The word Indigenous is used in this document only when referring to a Commonwealth document.
Exceptional clinical circumstances	Providing specialised or urgent care takes priority over ensuring gender specific accommodation. This is applies in Critical care and Short Stay Units.
Children and Adolescents	A person under the age of 16 years. The borderline between childhood and adulthood is not distinct: clinical need and stage of development will need to be considered.
Critical care units	Intensive Care Units (ICUs), Coronary Care Units (CCUs), Emergency Departments (EDs), Recovery Units
Short stay units	Emergency Department Short Stay Units (EDSSUs) and inpatient Short Stay Units
Sexual characteristics	Physical parts of the body that are related to body development/regulation and reproductive systems. Primary sex characteristics are gonads, chromosomes, genitals and hormones.
Gender	One's sense of whether they are a man, woman, non-binary, agender, genderqueer, genderfluid, or a combination of one or more of these definitions.
Intersex people	People who are born with anatomical, chromosomal and hormonal characteristics that are different from medical and conventional understandings of female and male bodies.
Cisgender/Cis	A term used to describe people who identify their gender as the same as what was presumed for them at birth (male or female).
Transgender and gender diverse	These are inclusive umbrella terms that describe people whose gender is different to what was presumed for them at birth. Transgender people may position 'being trans' as a history or experience, rather than an identity, and consider their gender identity as simply being female, male or a non-binary identity.
Non-binary	An umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender.
Patient flow systems framework	A whole of health approach to managing patient flow and improving patient experience. The framework is used in conjunction with the NSW Health Patient Flow Portal. For more information please access the NSW Health website http://www.health.nsw.gov.au/pfs/Pages/default.aspx or contact the MoH Patient Flow Portal team at MOH-patientflow@health.nsw.gov.au.

Note: Some definitions for terminology covering sexual characteristics and gender have been sourced from Child Family Community Australia and TransHub. Further information and definitions can be found at these websites.

2. SAME GENDER ACCOMMODATION

2.1 Same gender accommodation cannot be provided in the short term

When same gender accommodation is not immediately available, every reasonable effort must be made to ensure transfer to a same gender room or bay occurs as soon as possible and within 24 hours.

When not in same gender accommodation, NSW Health staff must ensure patients' privacy is maintained in sleeping areas and bathroom facilities. Patients and carers must also remain informed about what is being done to address the situation and when same gender accommodation will be provided.

2.2 Mixed gender accommodation

There are exceptional clinical circumstances, such as highly specialised or urgent care and managing clinical circumstances such as infectious diseases, which may take priority over gender specific accommodation. In Critical Care Units mixed gender rooms or ward bays may be considered clinically appropriate.

In Short Stay Units same gender rooms or ward bays may be sometimes unachievable due to the specialised and rapid care received in these units.

Decisions are to be made on the needs of each individual patient and their clinical needs must take priority. Decisions are to be re-evaluated as the patient's condition improves and must not be based on the constraints of the environment or staff convenience.

2.3 Same gender bathrooms

Every effort must be made to provide patients with access to a same gender bathroom. Patients must not have to walk through a different gender area to reach their own bathroom.

If same gender bathrooms cannot be provided, patients and carers must be told what is being done to address the situation and the bathroom options available. Staff must make it clear that NSW Health considers mixed bathroom facilities to be the exception and not normal practice. When mixed bathroom facilities are unavoidable, each patient must have their privacy and dignity constantly maintained.

2.4 Nightingale wards

Nightingale wards are long rectangular wards with a row of beds on each side. Every effort must be made to separating genders on these wards, using fitted partitions or bedside curtains as a minimum. This is intended to maintain patient privacy and dignity, as well as protect patients from exposure, including casual overlooking or overhearing.

2.5 Child and adolescent units

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.

Adult patients must not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents are not to 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.

Where possible adolescent patient preference must 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).

2.6 Aboriginal patients

An important factor to achieve a culturally safe experience for Aboriginal patients in hospital is through providing same gender accommodation where possible. Mixed gender accommodation is considered culturally inappropriate for many of communities.

Providing same gender accommodation will minimise Aboriginal patients discharging against medical advice.

It is also recommended that Aboriginal patients and their families be provided access to an Aboriginal Health Worker and a designated waiting room or other culturally safe space as part of this process. Ongoing professional development for hospital staff to further support Aboriginal patients to feel culturally safe is strongly supported.

Local processes to develop same gender accommodation for Aboriginal patients need to be implemented in all hospitals for patients identifying as Aboriginal.

The Australian Commission on Safety and Quality in Health Care's report *Vital signs 2015: The State of Safety and Quality in Australian Health Care* outlines that episodes of incomplete care may be an indication of 'how safe, welcome and understood an Indigenous person feels and an indirect indicator of the extent to which services respond to an Indigenous patient's needs'.

The Bureau of Health Information (2016) 'Patient Perspectives – Hospital care for Aboriginal people' found that there were 'gaps' in experiences of care between Aboriginal and non-Aboriginal patients. It also found that there were differences in Aboriginal patients' experiences of care across the state.

2.7 Transgender and gender diverse patients

Transgender and gender diverse patients are people whose gender does not match their assigned sexual characteristics at birth. For staff to deliver effective care to transgender and gender diverse patients it is important that staff are well informed about the diversity of genders, bodies and sexualities.

All staff must be educated and trained on these areas so that they are capable and confident in working with the diversity of patients they meet.

When caring for patients, it may not always be appropriate or necessary to ask a person's gender. When a patient does share their gender, this must be respected, even if this conflicts with staff perceptions or what has been recorded in legal documents.

Staff are to make accommodation arrangements led by the needs of each patient. Given some transgender and gender diverse people have experienced stigma, discrimination and trauma in health settings, all staff should be guided by insights and advice that patient's chose to share, and by checking on their sense of safety and comfort.

2.8 Intersex patients

NSW Health staff are to understand who intersex people are and have an awareness of their health needs, experiences with health care, and potential sensitivities in health settings.

Intersex people are born with anatomical, chromosomal and hormonal characteristics that are different from medical and conventional understandings of female and male bodies. Intersex people therefore may have been assigned a gender at birth which is incorrect.

It is important to acknowledge that many people with intersex variations have undergone medical interventions associated with their intersex variation/s. In some cases, these interventions are undertaken in adulthood, while in other cases they are undertaken in infancy or childhood.

When providing care to intersex patients and placing them in a gendered space, ask the patient if they feel comfortable with that placement and work with them to meet their needs, sense of safety and comfort.

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RECOGNITION AND MANAGEMENT OF PATIENTS WHO ARE DETERIORATING
(PD2020_018)

PD2020_018 rescinds PD2020_010

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

All NSW public health organisations are to:

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

Recognition and Management of Patients who are Deteriorating: Procedures

1. BACKGROUND

Failure to recognise and appropriately manage patient physiological and mental state deterioration is a contributing factor in many adverse events in hospitals and health care organisations around the world.[1-6] Evidence derived from clinical incident reporting in NSW has demonstrated the same problem exists in NSW health services.[3]

Between the Flags was developed by the Clinical Excellence Commission in collaboration with clinical experts. It is based on research into patient clinical deterioration initiated in NSW and published in the international literature.[3, 6] Between the Flags provides the foundation for the NSW Deteriorating Patient Safety Net System, which is strengthened by the integration of other programs and frameworks, such as:

- Sepsis Kills
- End of Life
- Patient, carer and family escalation, known as R.E.A.C.H, and
- Take 2, Think, Do framework for diagnostic error.

The Deteriorating Patient Safety Net System has five components:

1. **Governance**: structures and processes to support implementation, management and quality improvement at Local Health District (LHD)/Specialty Health Network (SHN), facility, clinical service and clinical unit level
2. **Standard Clinical Tools:** including observation charts with standard calling criteria for clinical review and rapid response, and approved local clinical management guidelines/pathways that outline the Clinical Emergency Response System (CERS) response and support documentation
3. **Clinical Emergency Response System (CERS)**: a local system for the escalation of care that is used by staff, patients, carers and families
4. **Education:** tiered education for clinicians to develop and reinforce clinical and non-technical skills in recognising and responding to patients who are deteriorating
5. **Evaluation:** evaluation strategy that includes a family of measures (outcome, process and balancing measures) for monitoring the performance and improving the effectiveness of the Deteriorating Patient Safety Net System.

The Deteriorating Patient Safety Net System addresses criteria within the Australian Commission on Safety and Quality in Health Care's Recognising and Responding to Acute Deterioration Standard.

BTF addresses the Australian Commission on Safety and Quality in Health Care National Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care.[8-9]

1.1 Roles and responsibilities

Clinical Excellence Commission

- Identify and advise the NSW Ministry of Health and public health organisations (PHOs) on available strategies, standards and tools to support continued improvement of the NSW Health Deteriorating Patient Safety Net System.
- Support clinicians and relevant Executives/Directors of Clinical Governance (DCGs) to implement, monitor and improve the Deteriorating Patient Safety Net System across NSW.
- Monitor and evaluate the implementation of local Deteriorating Patient Safety Net Systems and provide advice to PHOs to make changes, as required.

Health Education and Training Institute

- Work in collaboration with the CEC on the development of education program content.
- State wide education and training and management of the learning pathways for the Deteriorating Patient Program.
- Provide advice on educational standards and governance of content in the state wide learning management system.

Local Health Districts & Specialty Health Networks

- Assign responsibility, personnel and appropriate resources to implement all the requirements of this Policy.
- Ensure the requirements of this Policy are effectively implemented, including system governance, standard clinical tools, CERS, education and evaluation.
- Work with NSW Ambulance in the development, implementation and monitoring of local CERS where the provision of CERS Assist is required.

HealthShare NSW

- Incorporate the core principles of Deteriorating Patient Safety Net System and clinical handover into non-emergency transport clinical practice, where appropriate.
- Support PHOs with the implementation of the Deteriorating Patient Safety Net System/s, where required.

NSW Ambulance

- Incorporate the core principles of the Deteriorating Patient Safety Net System and clinical handover into Ambulance clinical practice, where appropriate.
- Support PHOs with the implementation of the Deteriorating Patient Safety Net System, including the provision of CERS Assist, where required.

eHealth NSW

- Ensure that the design and build of electronic medical record functionality and clinical decision support tools align with the standards and principles outlined in this document.
- Ensure that relevant electronic medical record functionality and clinical decision support tools are maintained and continuously improved where required.
- Support PHOs, as required, to implement applicable electronic medical record functionality and clinical decision support tools that align with the standards and principles outlined in this document.

KEY TERMS

Acute alterations to calling criteria	Alterations made to calling criteria for a condition where the patient's observations will fall outside the standard parameters for a defined period of time, while treatment is taking effect. Acute alterations to calling criteria are set for a defined period of time (not longer than 12 hours), after which they revert back to standard calling criteria. Patients with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with the patient's treatment plan.
Additional criteria	Signs or symptoms of deterioration depicted on the standard observation chart that a patient may exhibit outside of, or in addition to, the standard calling criteria for vital sign observations.
Agreed signs of deterioration	Signs or symptoms of deterioration that a patient may exhibit outside of, or in addition to, the standard calling criteria and additional criteria that are agreed following engagement of the patient, carer and family, and tailored to the patient's specific circumstances.
Altered calling criteria	Changes made to the standard calling criteria by the AMO/delegated clinician responsible, to take account of a patient's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.

A-G systematic Assessment	A structured approach to physical assessment that considers a patient's **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure, **F**luids, **G**lucose.
Attending Medical Officer (AMO) / Delegated clinician responsible	Senior medical practitioner who has primary or delegated responsibility and accountability for a patient on a temporary or permanent basis. For an inpatient, this is the named Attending Medical Officer (AMO) or another consultant, staff specialist or visiting medical officer with delegated responsibility. As defined in local guidelines and following a risk assessment, the delegated clinician responsible may also be a senior clinician such as a nurse practitioner. In the non-hospital/residential setting this may be the patient's general practitioner.
Balancing measure/s	A unit of data that measures whether changes to one part of a system have an impact on another part of the system and the size of the effect.
Behaviour change	Changes to the way a patient interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.
Blue zone	A coloured zone on the standard clinical tools that requires an increase in the frequency of observation. Staff are to consider calling for an early clinical review.
Clinical Emergency Response System (CERS)	A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).
CERS Assist	A NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating patient (red zone observations or additional criteria) in a public health care facility.
Chronic alteration to calling criteria	Alterations to calling criteria where a patient has a chronic (lasting >3 months) health condition which causes their normal observations to fall outside standard parameters. Chronic alterations are set for the duration of the patient's episode of care and are reviewed during routine medical review and assessment of the patient.
Clinical Review	A review of a deteriorating patient undertaken within 30 minutes by the clinical team responsible for the patient's care, or designated responder/s, as per the local CERS protocol.
Clinical team responsible for the patient's care	The clinicians, led by the AMO/delegated clinician responsible, who are involved in, and responsible for, the care of the patient on a temporary or permanent basis. In most cases this is the medical team unless otherwise specified.
Clinical service	A health professional or group of professionals who work in co-operation and share common facilities or resources to provide services to patients for the assessment, diagnosis and treatment of a specific set of health-related problems/conditions in a facility or in the community.
Clinical unit	A subset of a facility or service with a special clinical function.

Clinician/s	Medical, nursing, midwifery and allied health professionals who provide direct patient care.
Deterioration in mental state	A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.(7)
Deteriorating Patient Safety Net System	The NSW Health Deteriorating Patient Safety Net System refers collectively to the various individual programs and frameworks implemented by NSW Health facilities/clinical services or clinical units to support the recognition and appropriate management of patients who deteriorate.
End of life	Refers to the timeframe an individual is clearly approaching the end of their life and is living with and/or impaired by a life-limiting illness. This includes the patient's last weeks or days of life, when deterioration is irreversible and when a patient is likely to die in the next 12 months(10).
Facility	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
Family of measures	A collection of outcome, process and balancing measures that monitor many facets of the system and provides a framework to understand the impact of changes.
Individualised monitoring and assessment plan	A plan for assessing and monitoring the patient's clinical situation that considers their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological and behavioural observations to be monitored and the frequency of monitoring(7, 8).
ISBAR	An acronym for Introduction, Situation, Background, Assessment, Recommendation, a structured communication tool.
Last days of life	Refers to the last 24-72 hours of life when treatment to cure or control the person's disease has stopped and the focus is on physical and emotional comfort and social and spiritual support.
New onset confusion	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days)(11).
Outcome measure/s	A unit of data that measures whether changes to the system have an impact on the intended recipient and the size of the effect.
Palliative care	An approach that aims to prevent and relieve suffering and improve the quality of life of patients and their families who are facing the problems associated with life-threatening illness through early identification and assessment and treatment of pain and other physical, psychosocial and spiritual issues(10).
Process measure/s	A unit of data that measures whether the system is performing as it is intended to and that activities are occurring as planned, and the extent to which that is happening.
Public health organisation (PHO)	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.

Rapid response	An urgent review of a deteriorating patient by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
R.E.A.C.H	An acronym for Recognise, Engage, Act, Call, Help is on its way. R.E.A.C.H is a CEC program for patients, carers and families to directly escalate concerns about deterioration through the local CERS.
Red zone	Coloured zone on the standard clinical tools that represent warning signs of deterioration for which a rapid response call (as defined by the local CERS protocol) is required.
Resuscitation Plans	A medically authorised order to use or withhold resuscitation measures (formerly called 'No CPR Orders'). Resuscitation Plans can also be used to document other time-critical clinical decisions related to end of life. A Resuscitation Plan is made: • With reference to pre-planning by patients (such as Advance Care Directives or plans) • In consultation with patients, carers and families • Taking account of the patient's current clinical status, as well as their wishes and goals of care. Resuscitation Plans are intended for use for patients 29 days and older in all NSW PHOs, including acute facilities; sub-acute facilities; ambulatory and community settings; and by NSW Ambulance (12).
Special Care Nursery	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation(13,18).
Standard calling criteria	Signs and symptoms that a patient is deteriorating and may require review of their monitoring plan or escalation of care through the Clinical Emergency Response System to appropriately manage the deterioration. Standard calling criteria are depicted on standard observation charts as blue, yellow and red zones.
Standard clinical tools	A tool or resource that supports clinicians to recognise when a patient is deteriorating and outlines the appropriate response, such as the sepsis pathways; electronic fetal heart rate monitoring algorithm and labels; Comfort Observation and Symptom Assessment chart; and Resuscitation Plan, as well as the NSW Health standard observation charts.
Standard observation chart	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings.
Track and trigger tool	A tool, such as the standard observation chart, that records vital sign observations and allows them to be tracked over time to support identification of a change in the patient's condition that requires a review and/or change in management or frequency of observation.
Transfer of care	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Also known as clinical handover.
Yellow zone	Coloured zone on the standard observation charts and standard clinical tools that represent warning signs of deterioration for which a clinical review or other CERS call may be required.

3 GOVERNANCE

Public health organisations (PHOs) need to have a clearly defined governance system in place at LHD/SHN level and facility/clinical service/clinical unit level to oversee the management and continuous improvement of the local Deteriorating Patient Safety Net System.

At the LHD/SHN level, the governance system needs to:

- Provide leadership to support the management and continuous improvement of the Deteriorating Patient Safety Net System locally
- Establish and articulate clear objectives and expectations for the Deteriorating Patient Safety Net System that align with the standards and principles outlined in this policy
- Provide a framework, endorsed by the Director of Clinical Governance or other responsible senior executive, for determining exemptions for specialty clinical units where patients are appropriately monitored and care is escalated as required, such as intensive care units, coronary care units and operating theatres, from using the NSW Health Standard Observation Charts
- Delegate clear roles, responsibilities and accountabilities to personnel at facility/clinical service/clinical unit level to lead, manage and continuously improve the Deteriorating Patient Safety Net System
- Determine the education and training requirements for all staff involved in the management and continuous improvement of the Deteriorating Patient Safety Net System at a facility/clinical service/clinical unit level, including those with delegated roles, responsibilities and accountabilities for managing the system
- Review regular reports and monitor performance of the Deteriorating Patient Safety Net System across facilities, clinical services and clinical units
- Communicate with stakeholders, including patients, carers, families, clinicians and the Clinical Excellence Commission, to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System.

At the facility/clinical service or clinical unit level, the governance system needs to support the following functions:

- Facilitate collaboration between patients, carers and families, clinicians and managers to design, implement, monitor and continuously improve the Deteriorating Patient Safety Net System consistent with the objectives and expectations of the LHD/SHN, including a local CERS protocol that meets the requirements outlined in this Policy
- Support the development of organisational policies and procedures relevant to the Deteriorating Patient Safety Net System that reflect the role, capacity and capability of the facility/clinical service or clinical unit in hospital and non-hospital settings
- Delegate clear roles, responsibilities and accountabilities to appropriately skilled and trained personnel for managing and improving the local Deteriorating Patient Safety Net System
- Ensure clinicians with delegated roles, responsibilities and accountabilities under the local Deteriorating Patient Safety Net System are oriented to the system and demonstrate a clear understanding of their roles, responsibilities and accountabilities, including contracted staff, locums and clinicians on rotating rosters
- Provide opportunities for clinicians to complete the required education and training relevant to their delegated role in the local Deteriorating Patient Safety Net System and maintain records of completion
- Ensure that clinicians with delegated responsibilities under the local Deteriorating Patient Safety Net System are appropriately credentialed

- Support use of appropriate standard clinical tools/approved local clinical management guidelines or pathways as part of the local Deteriorating Patient Safety Net System, including approved NSW Health standard observation charts unless exempt
- Ensure that adequate resources (personnel and equipment), are allocated, available and fit-for-purpose to support the delivery of high-quality care as part of the Deteriorating Patient Safety Net System
- Collect and report data and information on the performance and effectiveness of the Deteriorating Patient Safety Net system to the LHD/SHN, relevant local committees, clinicians, patients, carers and families to facilitate quality improvement
- Monitor variation in practice against expected outcomes and provide feedback to clinicians on variation in practice and health outcomes to inform improvements in the Deteriorating Patient Safety Net System
- Regularly test the local Deteriorating Patient Safety Net System and/or processes through mock drills or simulated exercises where these events are infrequent or when there are significant changes to the context of service delivery.

Clinicians using, and/or with delegated roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System are to:

- Actively take part in the design, implementation, monitoring and improvement of the local Deteriorating Patient Safety Net System
- Understand and perform their delegated roles and responsibilities, as per their local Deteriorating Patient Safety Net System
- Participate in education and training related to the Deteriorating Patient Safety Net System, including education and training that focuses on culturally appropriate engagement of patients, carers and families and shared decision making
- Review their clinical practice and performance of their roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System and use the information to implement improvements to the system and changes to practice.

The allocation of roles, responsibilities and accountabilities under the Deteriorating Patient Safety Net System will vary depending on the health services' local context, availability of resources and models of care. Some examples of the key roles, responsibilities and accountabilities that might be allocated to personnel as part of a local Deteriorating Patient Safety Net System are outlined in Appendix 10.1.

4 ASSESSMENT OF DETERIORATION

4.1 Assessment

Assessment of a patient needs to, at a minimum, include a systematic A-G assessment and be documented in the patient's health care record, as per the requirements outlined in NSW Health Policy Health Care Records – Documentation and Management (PD2012_069). To establish the patient's baseline and agree on other patient-specific signs of deterioration initially, assessment needs to:

- Include a comprehensive systematic physical and mental state assessment
- Consider any pre-morbid conditions and where accessible, medical or clinical history documented in health care records
- Engage patients, carers, families and where appropriate, the patient's general practitioner, case manager or other clinicians familiar with their care.

Ongoing assessment is to involve the patient, their carer/s and family in monitoring changes in their physical and mental state and vital sign observations, as well as interpretation of clinical information and trends.

The frequency of assessment is to be increased above the minimum requirements outlined in Table 2 when:

- The patient's vital sign observations fall within a coloured zone on a standard observation chart
- Assessment identifies other signs and symptoms of deterioration
- A CERS call has been made.

Assessment is to be respectful of, and sensitive to, the cultural and religious needs of the patient, including their personal preferences, cultural values, language and kinship systems. Patients and carers are also to be given information and education of the importance of communicating concerns around signs of deterioration.

4.2 Standard clinical tools

Standard clinical tools support clinicians to assess patients, recognise when they may be deteriorating and outline the appropriate escalation of care.

The standard observation charts approved by the NSW Ministry of Health are standardised clinical tools designed using human factors principles. The charts incorporate colour-coded calling criteria and a 'track and trigger' format to alert clinicians to patients who are deteriorating, by graphically 'tracking' their vital sign observations over time and 'triggering' an appropriate escalation of care based on the coloured calling criteria. The charts also include a list of additional colour-coded escalation criteria that include other standard signs and symptoms of deterioration.

All NSW Health services are to use the approved standard observation charts as part of their Deteriorating Patient Safety Net System, unless they have an exemption issued by their LHD/SHN to use alternative charts. Specialty clinical units where patients are appropriately monitored and care is escalated as required, such as intensive care units, coronary care units and operating theatres, may be exempt from using the standard observation charts, as per section 3.

Where facilities or clinical services use electronic versions of the standard observation charts, processes must be in place to ensure documentation of vital sign observations can continue to be completed during system outages.

The standard observation charts have three colour-coded zones:

Blue zone: (where applicable) represents criteria for which increasing the frequency of observations and/or increased vigilance is required

Yellow zone: represents early warning signs of deterioration and the criteria for which a clinical review (or other CERS) call may be required

Red zone: represents late warning signs of deterioration and criteria for which a rapid response call is required.

Appendix 10.2 provides further details of required actions when each zone is triggered.

Other standard clinical tools, such as the sepsis pathways, electronic fetal heart rate monitoring algorithm and labels, Comfort Observation and Symptom Assessment Chart, and Resuscitation Plan, have been designed to align with the colour-coded calling criteria used on the standard observation charts. The coloured zones on the standard clinical tools outline the appropriate response and these are to be incorporated as part of the local CERS.

Local clinical management guidelines or clinical pathways may be developed for specialty areas or groups of patients with clinical indications for more or less frequent monitoring. Local clinical management guidelines and clinical pathways need to outline the criteria for escalation of care (coloured zones); be approved using the local governance system; and incorporated into the local CERS.

4.3 Minimum requirements for vital sign monitoring

The minimum set of vital signs and frequency of observations for different patient groups are outlined in Table 2 below.

In addition to the minimum requirements, a full set of vital sign observations must be taken and documented in the patient's health care record:

- At the time of admission or initial assessment (this excludes the brief clinical assessment conducted as part of the triage process on arrival to the Emergency Department)
- Within one (1) hour prior to discharge from a facility, clinical service or clinical unit.
- Prior to and following transfer of care between a facility, clinical service or clinical unit.
- A medical officer may only prescribe the frequency of vital sign observations below the minimum requirements following an assessment of the patient and with authorisation from the AMO/delegated clinician responsible for the patient's care.
- Where a medical officer is not available onsite, a registered nurse/midwife or allied health professional may vary the frequency of observations below the minimum frequency outlined in Table 2, with authorisation from the AMO/ delegated clinician responsible for the patient. This must be arranged via phone order and follow agreed local procedures.

Table 2: Minimum number and frequency for vital sign observations

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Adult inpatients	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Including pregnant women greater than twenty (20) weeks gestation and less than six (6) week post-partum admitted for a condition unrelated to pregnancy who are monitored on the Standard Maternity Observation Chart (SMOC).
Mental health acute and subacute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then daily thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Mental state assessment of patients within a mental health inpatient unit are to be completed in line with Engagement and Observation in Mental Health Inpatient Units PD2017_025.
Mental health non-acute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then monthly thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Patients with active comorbid physical health conditions or aged 65 years and over are to have observations no less than weekly and are to have a comprehensive systematic physical assessment completed at least monthly.

Hospital in the Home	At least once during each consultation/visit (17)	To be determined locally based on the models of care and assessment of risk	
Special Care Nursery	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*, pain score	
Newborn	**Before leaving the birthing environment** One (1) full set of vital signs observations and a newborn risk assessment completed If perinatal risk factors are identified and/or observations within the blue, yellow or red zone and/or additional criteria present, further observations must be recorded on a Standard Newborn Observation Chart (SNOC) six (6) times per day at four (4) hourly intervals.	Respiratory rate, oxygen saturations, heart rate and temperature	Newborns with low or no identifiable risk factors are to be monitored/assessed in-line with local protocols.
Paediatric inpatients	**Six (6) times per day at four (4) hourly intervals**	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Baseline blood pressure (BP) is required within 24 hours of admission. Additional BPs are to be taken as clinically indicated (PD2010_32)
Maternity/ antenatal inpatient	**Four (4) times per day at six (6) hourly intervals.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*. For fetal heart rate monitoring requirements refer to Maternity – Fetal heart rate monitoring GL2018_025	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Maternity/ postnatal inpatient with no identified risk factors	**Before leaving the birth environment** **One (1) full set of vital signs observations and a maternity risk assessment completed.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	If a woman has observations in a coloured zone or identified risk factors, vital sign observations are to be performed four times per day at six hourly intervals. Women receiving midwifery care in the home are to be monitored according to local protocol, refer to section 4.6.

Maternity/postnatal inpatient with risk factors	**Four (4) times per day at six (6) hourly intervals.**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Inpatient sub-acute/ long stay/ rehabilitation	**Twice a day at a maximum interval of 12 hours apart**	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops an acute medical/ physiological problem the required frequency of observations reverts to a minimum of four (4) times per day at six (6) hourly intervals
Inpatient palliative care	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops acute medical/physiological problems are managed in line with their goals of care and Resuscitation Plan
Residents in long term care facilities, such as a multipurpose service (MPS)	At least once per month	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	The frequency of observations may change depending on the resident's condition and will be determined locally by the AMO/delegated clinician responsible for the resident's care. Additional vital signs may be determined as clinically appropriate for the patient cohort cared for in these settings, such as weight, and monitored on a regular basis.

* Includes an assessment of the patient's behaviour in the context of their developmental age and/or baseline assessment, noting changes in their cognitive function, activity/tone, perception, or emotional state such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.

4.4 Individualised monitoring and assessment plans

It is recommended that patients with clinical needs which differ from approved clinical management guidelines have an individualised monitoring and assessment plan in place.

An individualised monitoring and assessment plan takes into account the patient's clinical situation, including their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological/mental state observations to be monitored, and the frequency of monitoring.

Individualised monitoring and assessment plans, along with the rationale for the plan, are to be documented in the patient's health care record.

Patients, carers and families need to be engaged in the development of an individualised monitoring and assessment plan to ensure that it meets the patient's needs.

An AMO/delegated clinician responsible must authorise any individualised monitoring and assessment plan which varies the vital signs or other observations to be monitored below the minimum requirements outlined in section 4.3, Table 2. This includes when the delegated clinician responsible is a senior medical officer not employed or contracted by the PHO, such as the patient's treating general practitioner.

If a patient with an individualised monitoring and assessment plan has observations within the blue, yellow or red zone, care must be escalated according to the appropriate zone response unless an alternative response is stipulated in their Resuscitation Plan.

Following the initiation of a CERS call, the individualised monitoring and assessment plan need to be reviewed and the frequency of observations increased.

4.5 Alterations to calling criteria

Standard calling criteria (blue, yellow or red zone parameters) may be altered and/or other agreed signs of deterioration identified, based on assessment of the patient's condition and with input from patients, carers and families.

A medical officer may alter the standard calling criteria following assessment of the patient and engagement of patients, carers and families, and **in consultation with the AMO/delegated clinician responsible.**

If the AMO/delegated clinician responsible is not available onsite, a registered nurse/midwife or allied health professional responsible for vital sign observation monitoring may alter calling criteria when prescribed by the AMO/delegated clinician responsible and following assessment of the patient. This process needs to be outlined in the local CERS protocol, along with defined processes for altering calling criteria, as listed in section 5, below.

The local CERS protocol also needs to define processes for altering calling criteria, including:

- Documentation of the rationale for the new calling criteria in the patient's health care record
- Authorisation of the alterations by the AMO/delegated clinician responsible, including when the delegated clinician responsible is a senior medical officer not employed or contracted by the PHO, such as the patient's treating general practitioner
- The minimum timeframe for review of the altered calling criteria.
- Altered calling criteria are to only be used:
- To align the calling criteria with the patient's baseline vital sign observation parameters when they are above or below the standard calling criteria. Establishment of the patient's baseline is to be done in consultation with the patient, carers and/or family and based on assessment of the patient
- If the course of the patient's disease or condition, or recovery from a particular intervention, is expected to be above or below the standard calling criteria
- If the proposed changes to the standard calling criteria will improve detection of patient deterioration.

A 'chronic' alteration may be set to align the calling criteria with the patient's baseline vital sign observation parameters. A chronic alteration may be set for the duration of the patient's episode of care and needs to be formally reviewed by the clinical team responsible for the patient's care during routine assessments. A chronic alteration may be set for patients treated in non-hospital or residential care settings, however time limits for the duration of the alteration must be set at the time the alteration is ordered and documented in the patient's medical record.

An 'acute' alteration may be set to align the calling criteria with the expected progression of a patient's disease or condition. Acute alterations are set for a defined period of time, not longer than 8 hours, before reverting back to the standard calling criteria on the appropriate standard observation chart. Acute alterations are not intended to be used for patients who are cared for in a non-hospital or residential care setting.

Special treatment plans, such as a Resuscitation Plan, which may also alter the response to the red and yellow zone triggers, are to be documented in the patient's health care record.

4.6 Vital sign monitoring for patients in non-hospital/residential care settings

It is expected that patients who are receiving care outside of a hospital or in a residential care setting (such as outpatient clinics, community and primary health care services, midwifery care provided in the home or Hospital in the Home services) are monitored for signs of deterioration and that protocols are in place to escalate care as required.

For patients in these settings, monitoring of vital signs and other observations will depend on the:

- Patient's clinical needs, risks and proposed treatment
- Environment in which care is being delivered
- Scope of practice of the clinician providing care
- Resources available to monitor and document vital signs and other observations
- Capacity of the service to escalate care when required.

Non-hospital and/or residential care settings need to develop local protocols that establish clear expectations for monitoring physiological or mental state deterioration, including the vital signs and other observations that will be monitored, how frequently they will be monitored and the criteria for escalation of care (coloured zones).

Non-hospital and/or residential care facilities may implement a local clinical management guideline or pathway for cohorts of patients who are frequently cared for or based on the model of care that is provided. The minimum expectations for monitoring signs of deterioration need to consider clinical risks and be approved by the local governance system or relevant committee.

Non-hospital and/or residential care settings may also consider using individualised monitoring and assessment plans for each patient. Where individualised monitoring and assessment plans are used in non-hospital/residential care settings, the requirements outlined in section 4.4 apply.

4.7 Palliative care and last days of life

Patients admitted under palliative care services are to have an individualised monitoring and assessment plan and Resuscitation Plan that aligns with their goals of care. When it is identified that a patient under the care of any clinical service/clinical unit is dying or in their last days of life, the use of standard observation charts is not appropriate. The patient's individual monitoring and assessment plan and Resuscitation Plan are to be reviewed in consultation with the patient, carers and family to ensure comfort is observed and, where required, concerns escalated via the local CERS.

Clinicians are to refer to the CEC Last Days of Life Toolkit for appropriate resources to:

- Ensure comfort is observed in patients whose death is expected, such as the Comfort Observation and Symptom Assessment Chart; and
- Facilitate the accelerated transfer for the patient who wishes to die at home.

5 CLINICAL EMERGENCY RESPONSE SYSTEMS

A Clinical Emergency Response System (CERS) is a formalised system for obtaining prompt assistance from appropriately skilled and knowledgeable clinicians when a patient has signs and symptoms of physiological or mental state deterioration.

As the signs and symptoms of deterioration in mental state are often indicative of a physiological/organic condition and not necessarily a sign of an acute mental health condition, the CERS response to these are to be same as for physiological deterioration. Organic causes of deterioration are to be considered prior to accessing specialty expertise from a mental health service.

The CERS needs to:

- Operate 24 hours per day, 7 days per week
- Have the capacity to manage multiple calls at any given time;
- Have contingency plans to account for known or unexpected absences of key personnel;
- Be known and understood by all clinicians.
- Be able to be activated by staff, patients, carers or families.

NSW Health organisations are to develop and implement a local CERS across their organisation which includes:

- Procedures to enable patients, carers and families to directly escalate care within 30 minutes to a clinician who is not routinely involved in the patient's care. These procedures must clearly identify how patients, carers and families may initiate the escalation and what the expected response is. Refer to the CEC's R.E.A.C.H program[22]
- Procedures to systematically and proactively identify patients at increased risk of deterioration, with appropriate mitigation strategies
- Protocols that outline the actions to be taken to escalate care when a patient's observations breach a blue, yellow or red zone, including who will respond and how they are to be contacted
- Procedures to review the provisional diagnosis and/or differential diagnosis by a second clinician following a CERS call, or when deterioration has not been reversed
- Protocols for accessing secure clinical units or clinical services not physically co-located with an acute service that is responsible for responding to a CERS call within agreed timeframes
- Procedures for accessing specialty expertise in alignment with the facility, clinical service or clinical unit's service capability framework or referral network
- Protocols for intra- and inter-facility escalation that clearly identify who to refer to, how to contact them and how the transfer is to be conducted, consistent with the principles outlined in section 5.4
- Defined skills, education and training requirements for clinicians with assigned responsibilities as designated responders that align with the Deteriorating Patient Education Strategy
- Defined roles and responsibilities for team leaders and members of the rapid response team (RRT)
- An agreed set of minimum core emergency equipment and medication consistent with best practice guidelines that is readily available throughout the facility, clinical service or clinical unit in accordance with the organisation-wide risk assessment, and approved by the governance system or relevant committee
- Procedures for orientation and training of staff on how to access and use equipment for advanced resuscitation, including specialist equipment for paediatric, neonatal and maternity patients
- A structured clinical handover tool, such as ISBAR, to communicate critical information, outcomes, alerts and risks during the escalation of care between the clinicians involved
- Requirements for documenting a CERS call, including the outcome of the call, the subsequent medical management and monitoring plan, and a provisional and/or differential diagnosis in the patient's health care record
- Prompt communication with the patient, carers and families about the response to and outcome of any CERS calls.

For facilities, clinical services or clinical units that have a formal arrangement with the NSW Ambulance or who use 'CERS Assist' as part of their escalation framework, the point at which escalation to NSW Ambulance is required must be outlined in the relevant protocols and procedures.

5.1 CERS in specialty areas

Specialty areas with the internal resources to manage clinical emergencies may use a graded and tailored response protocol for patient deterioration that uses a combination of internal specialty expertise and external support to escalate care. Areas that may require a graded and tailored response protocol include emergency departments; maternity wards; neonatal intensive care or special care nurseries; and post-anaesthetic care units (recovery units).

Where a facility, clinical service or clinical unit requires a graded and tailored response protocol, the organisation wide CERS must identify and include these specialty area protocols. A specialty area's response protocol needs to:

1. Identify the area to which the protocol applies
2. Outline the types of deterioration that can be managed without external support and the point at which external support needs to be called
3. Define the roles and responsibilities of both internal and external designated responders in managing, and reversing, patient deterioration
4. Specify the minimum core emergency equipment and medication consistent with best practice guidelines that is to be readily available and the location of these (in accordance with the organisation-wide risk assessment), and approved by the governance system or relevant committee
5. Define the skills, education and training requirements for clinicians with assigned responsibility as a designated responder for that specialty area that align with the Deteriorating Patient Education Strategy
6. Include a structured clinical handover tool, such as ISBAR, to communicate critical information, outcomes, alerts and risks during the escalation of care between the clinicians involved.

5.2 Clinical review process

Prompt and effective clinical review is essential in managing patients who are deteriorating and is to be undertaken (or supervised) by experienced staff.

If a patient's observations enter the yellow zone (based on vital sign observations and/or additional criteria), the yellow zone response instructions on the appropriate standard observation chart, standard clinical tool or approved local clinical management guideline/pathway are to be followed. Unless specified otherwise, the decision to call a clinical review (or other CERS call) is to be made in consultation with the nurse/midwife-in-charge or relevant clinical supervisor. The decision to escalate (or not) is to be documented in the patient's health care record.

For patients in hospital settings, a clinical review is to be undertaken by the clinical team responsible for the patient's care (or another designated responder) within 30 minutes.

Depending on the local CERS protocol, the clinical review may be undertaken by a medical officer on call or an appropriately experienced registered nurse/midwife (RN/RM), preferably First Line Emergency Care Course (FLECC) accredited, or post graduate qualifications in emergency/critical care nursing, or credentialed in the procedures of the relevant specialty.

For patients in non-hospital or residential care settings, initiation of a clinical review must follow local procedure. The timeframe for review, the clinician most appropriate to undertake the review and other related responses need to be locally determined in line with the implemented model of care and based on clinical risks associated with the delivery of care. In these settings, the decision to initiate a clinical review also needs to be made in consultation with a clinical supervisor and documented in the patient's health care record.

5.3 Rapid response process

If a patient's observations enter the red zone (based on vital sign observations and/or additional criteria), the red zone response instructions on the appropriate standard observation chart, standard clinical tool or approved clinical management guideline are to be followed, and a rapid response is to be activated as per the local CERS protocol.

For patients in hospital settings, the nurse/midwife-in-charge or equivalent relevant clinical supervisor must be informed that a rapid response call has been made, and the instructions outlined on the appropriate standard observation chart, standard clinical tool and/or approved local clinical management guideline/pathway need to be followed.

Where a rapid response is called for a patient who is on an end-of-life pathway, and the appropriate level of escalation is unclear, the AMO/delegated clinician responsible is to be called, as well as the patient's carer and/or family.

The RRT members or designated responder/s must urgently attend a rapid response call, assess the patient, treat the underlying cause of deterioration and/or provide interventions to resuscitate the patient.

In small or rural health services, the designated responder may be an appropriately experienced registered nurse/midwife (RN/RM), preferably First Line Emergency Care Course (FLECC) accredited or with post graduate qualifications in emergency/critical care nursing, or credentialed in the procedures of the relevant specialty, or a paramedic who attends as a result of a CERS Assist call.

When responding to the deterioration of a maternity, paediatric or neonatal patient, at least one member of the RRT or designated responder needs to be credentialed in the advanced resuscitation techniques and procedures of that specialty.

A facility, clinical unit or clinical service may implement a graded rapid response process based on the:

- Severity of the patient's condition and the reason for the call. For example, patients with an immediately life threatening condition, such as cardio-respiratory arrest, airway obstruction, stridor, or are unresponsive, are prioritised to a rapid response team, and patients with red zone observations or additional criteria that are not immediately life threatening are attended by a senior registrar or equivalent in the first instance
- Skills required to support a tailored response to a specialty area. For example, a maternity emergency managed by obstetric and midwifery staff who require additional airway support for immediate management and ICU support post-intervention.

This graded response needs to be risk assessed and approved by the relevant local committee/senior management, and clearly defined in the local CERS protocol.

For patients in non-hospital or residential care settings, the initiation of a rapid response must be in accordance with the local procedure. The actions to be taken when a red zone response is triggered need to be locally determined in line with the implemented model of care and based on the clinical risks associated with the delivery of care. In most cases, this will usually mean calling triple zero (000) for NSW Ambulance.

5.4 Patient transfer processes

5.4.1 Intra-hospital transfer processes

Patients with observations in the red or yellow zone can **only** be transferred between clinical units when:

1. The transferring responsible clinician approves the transfer
2. There is an individualised monitoring and assessment plan in place, which may include altered calling criteria
3. The receiving clinical team responsible for the patient's care is advised of the individualised monitoring and assessment plan
4. They have appropriate clinical support during transportation.

5.4.2 Inter-facility transfer processes

For patients requiring transfer for specialist care, the processes for requesting and arranging transfers are outlined in the following documents:

PD2011_031 – *Inter-facility Transfer Process for Adults Requiring Specialist Care*

PD2018_011 – *Critical Care Tertiary Referral Networks & Transfer of Care (ADULTS)*

PD2019_024 – *Adult Mental Health Intensive Care Networks*

PD2019_020 – *Clinical Handover*

PD2019_053 – *Tiered Networking Arrangements for Perinatal Care in NSW*

GL2017_010 - *NSW Paediatric Service Capability Framework*

PD2010_030 – *Critical Care Tertiary Referral Networks (Paediatrics)*

PD2010_031 – *Children and Adolescents Inter-facility Transfers*

GL2016_018 – *NSW Maternity and Neonatal Service Capability Framework*

PD2018_002 – *Service Specifications for Transport Providers, Patient Transport Service*

5.4.3 Transferring patients from non-hospital/residential care settings

Patients in non-hospital or residential care settings who require escalation of care will usually be referred to their general practitioner or an acute health care facility; this may involve transfer via ambulance or other patient transport service.

Staff in non-hospital or residential care settings are to refer to and follow their locally determined procedure for escalating care. Staff must support the transfer process by communicating relevant clinical information to the receiving health care professional or facility through written documentation provided to the patient, carer or family, documenting notes in the patient's health care record or verbally during clinical handover.

This does not include patients who are cared for in the community as an admitted patient of a Hospital in the Home (HITH) service. HITH patients who deteriorate are to be managed as per the requirements outlined in GL2018_020 Adult and Paediatric Hospital in the Home.

6 EDUCATION

This section is to be read in conjunction with the CEC Deteriorating Patient Education Strategy which outlines the minimum training requirements for clinicians who provide direct patient care.

All facilities/clinical services/clinical units are to have a documented local education program that:

- Incorporates patients, carers and families in the co-design and delivery of locally provided deteriorating patient education and training
- Ensures all staff are aware of and know how to activate the local CERS, including contracted staff, locums and clinicians on rotating rosters
- Describes the skills, knowledge, education and training requirements for all clinicians to understand how to engage and partner with patients, carers and families in the recognition and management of deteriorating patients, including cultural awareness and cultural competency training
- Identifies appropriate education and training programs for clinicians to complete that align with the Deteriorating Patient Education Strategy
- Describes the minimum skills, knowledge, education and training requirements on the recognition and management of the deteriorating patient for all clinicians providing direct patient care, including completion of basic life support training

- Describes the skills, experience, education, training and credentialing requirements for clinicians who are members of the RRT or are designated responders, including advanced life support training
- Details the resources allocated to support clinicians to complete the required education and training, including protected time off
- Identifies specialty units that require clinicians to respond to and manage clinical emergencies within their own clinical service/clinical unit, and describe the skills, experience, education and training and credentialing requirements for these clinicians, including team training and the non-technical skills component of the BTF Tier Three Framework
- Outlines the system for ensuring regular educational updates are provided for existing clinicians, and the orientation and training of new clinicians on the recognition and management of the deteriorating patient
- Incorporates the components of the BTF education into other educational activities/opportunities, including: signs of physiological and mental state deterioration; systematic A-G assessment, synthesising assessment findings and observations to guide clinical decision making; expected trajectory of illness; appropriate escalation of care and the appropriate management of the deteriorating patient; structured communication, handover and team work
- Outlines processes to reinforce structured communication techniques and systematic patient assessment in daily clinical practice
- Identifies appropriate performance measures for monitoring satisfactory completion of required education and training
- Describes the roles and responsibilities for the governance of the local education program, including responsibility for developing, implementing and monitoring the program.

7 EVALUATION

All PHOs need to have a measurement strategy in place to monitor the performance and effectiveness of local Deteriorating Patient Safety Net Systems. The measurement strategy is to outline a selection of outcome, process and balancing measures, including the collection and reporting of mandatory quality improvement measures:

- Rapid response call rate per 1,000 acute separations
- Cardio-respiratory arrest rate per 1,000 acute separations.

Advice on collection and reporting of mandatory quality improvement measures, including definitions and methods for collection, is provided by the NSW Ministry of Health as part of the LHD/SHN service agreements. Mandatory quality improvement measures are available on the CEC Quality Improvement Data System (QIDS).

The outcome, process and balancing measures selected as part of the PHO's measurement strategy are to facilitate continuous quality improvement of local Deteriorating Patient Safety Net Systems. Details on developing a measurement strategy are provided in the Deteriorating Patient Measurement Strategy Guide.

A list of example measures that could be used as part of a measurement strategy are provided below. However, these are not exhaustive and facilities/clinical services/clinical units are to select the most meaningful measures for their context.

Outcome measures:

- In-hospital mortality rates
- Percentage of patients surveyed who report a positive experience

Process measures:

- Rates/count/number of clinical review (yellow zone) calls
- Rates/count/number of rapid response (red zone) calls
- Rates/count/number for patient, carer and family (REACH) escalation calls
- Percentage of patients, carers and family members surveyed that know how to raise their concerns and if required make a patient, carer and family escalation (REACH) call
- Percentage of patients with a full set of observations completed at the required minimum frequency
- Percentage of patients with a full set of observations completed at initial assessment and prior to departure from a facility, clinical service or clinical unit
- Percentage of patients that have an increase in their observation frequency following triggering of a coloured zone and/or a CERS call
- Percentage of red zone triggers escalated to a rapid response call
- Percentage of yellow zone triggers escalated to a clinical review (or other CERS) call
- Percentage of patients with a Resuscitation Plan
- Percentage of patients transferred to a higher level of care following a CERS call
- Percentage of patients with alterations to calling criteria
- Percentage of clinical staff that provide direct patient care who have completed their Deteriorating Patient mandatory training

Balancing measure:

- In-hospital length of stay
- ICU length of stay
- ICU admission rates/occupancy rates
- Re-presentation rates.
- When selecting measures to form their measurement strategy, PHOs are to:
- Consider the care provided by the facility, clinical service or clinical unit, the usual patient cohort/s and the patients goals of care
- Ensure measures align with the aims and objectives of the system and any changes/improvements made to it
- Engage with patients, carers and families to consider what factors are meaningful to measure from a patient's perspective.

Performance reports are to be communicated to the LHD/SHN; clinicians and managers; patients, carers and families; and other key stakeholders and include an analysis of the data identifying improvement opportunities and the impact of any improvements implemented by the facility, clinical service or clinical unit/s.

8 REFERENCES

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9 RELATED DOCUMENTS

National

Australian Commission on Safety and Quality in Health Care

National Safety and Quality Health Service (NSQHS) Standards (second edition)

National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration (second edition)

Recognising and Responding to Deterioration in Mental State: A Scoping Review

National Consensus Statement: essential elements for safe high quality end of life care

National Consensus Statement: Essential elements for safe high quality paediatric end-of-life care

Delirium Clinical Care Standard

NSQHS Standards User guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium

NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health

NSQHS Standards User Guide for Health Service Providing Care for People with Mental Health Issues

NSQHS Standards User Guide for Measuring and Evaluating Partnering with Consumers

NSQHS Standards (second edition) User Guide for Governing Bodies

NSW Health

Clinical Excellence Commission – Between the Flags Project: The Way Forward

Clinical Excellence Commission – R.E.A.C.H Toolkit

PD2012_069 Health Care Records – Documentation and Management

GL2016_018 NSW Maternity and Neonatal Service Capability Framework

GL2018_025 Maternity Fetal Heart Monitoring

GL2018_016 Maternity – Resuscitation of the Newborn Infant

GL2017_018 Maternity - Prevention, Detection, Escalation and Management of Postpartum Haemorrhage (PPH)

IB2008_002 Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training

PD2019_053 Tiered Networking Arrangements for Perinatal Care in NSW

PD2017_025 Engagement and Observation in Mental Health Inpatient Units

PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services

PD2015_004 Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint

GL2017_010 NSW Paediatric Service Capability Framework

PD2010_034 Children and Adolescents: Guidelines for Care in Acute Care Settings

PD2010_032 Children and Adolescents – Admission to Services Designated Level 1-3 Paediatric Medicine and Surgery

PD2010_031 Children and Adolescents – Inter-Facility Transfers

GL2014_007 NSW Rural Paediatric Emergency Clinical Guidelines Second Edition

PD2010_030 Critical Care Tertiary Networks (Paediatrics)

PD2011_038 Children and Infants – Recognition of a Sick Baby or Child in the Emergency Department

PD2018_011 Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS)

PD2011_031 Inter-Facility Transfer Process for Adults Requiring Specialist Care

GL2020_004 Rural Adult Emergency Clinical Guidelines

PD2014_030 Using Resuscitation Plans in End of Life Decisions

GL2005_057 End-of-Life Care and Decision-Making

GL2005_056 Advance Care Directives (NSW) – Using

GL2018_020 Adult and Paediatric Hospital in the Home Guideline

PD2018_002 Service Specifications for Transport Providers, Patient Transport Service

PD2019_020 Clinical Handover

IB2018_048 2018-19 KPI and Improvement Measure Data Supplement

GL2018_025 Maternity – Fetal Heart Rate Monitoring

PD2018_010 Emergency Department Patients Awaiting Care

PD2014_025 Departure of Emergency Department Patients

10 APPENDICES

10.1 Example roles and responsibilities for the Deteriorating Patient Safety Net System

AMO/delegated clinician responsible (i.e. consultant / staff specialist / VMO) are to:

- Provide leadership to the clinical team responsible for the patient's care, to ensure they respond as per the local CERS
- Support processes for, and awareness of, patient, carer and family escalation
- Ensure every patient, taking their diagnosis and proposed treatment into account, has an individualised assessment and monitoring plan specifying the vital sign observations and other relevant observations to be recorded and the frequency of these
- Involve patients, families and carers in the development and review of documented individualised assessment and monitoring plans, medical management plans and resuscitation plans, to ensure they align with the patient's goals of care
- Ensure any alterations to calling criteria are reviewed for appropriateness, formally authorised, and documented in the patient's health record
- Ensure that a medical management plan (including the monitoring plan) is reviewed and documented for all patients following a CERS call (clinical review or rapid response).

Members of the clinical team responsible for the patient's care are to:

- Inform patients, carers and families of processes available to escalate their concerns about deterioration
- Involve patients, carers and families in the establishment of baseline observation parameters for patients to inform individualised assessment and monitoring plans and potential alterations to calling criteria
- Involve patients, carers and families in the establishment of their communication preferences and needs
- In consultation with the AMO/delegated clinician responsible, document a clear individualised assessment and monitoring plan that specifies the vital signs and other relevant observations to be recorded and the frequency of the observations
- Identifies patients at increased risk of deterioration and deploys strategies to mitigate the risks
- Discuss with, and seek authorisation from, the AMO/delegated clinician responsible for any alterations to calling criteria and document the rationale for these alterations in the patient's health care record
- Review and confirm the provisional diagnosis and/or proposed differential diagnosis and medical management plan, including an individualised assessment and monitoring plan, for all patients following a clinical review or other CERS call, and communicate critical
- information about a patient's care to the AMO/delegated clinician responsible and other clinicians, as appropriate
- Communicate critical information, outcomes, alerts and risks to patients, carers and families following a clinical review and/or rapid response in a timely manner
- Escalate care as per the local CERS.

Nursing/Midwifery Unit Manager/supervisor or delegate (i.e. nurse/midwife-in-charge) is to:

- Support processes for, and awareness of patient, family and carer escalation
- Provide leadership in monitoring compliance with the minimum requirements of the Deteriorating Patient Safety Net System, such as completion of vital sign observations at the required frequency
- Determine the need for a clinical review for patients whose vital sign observations are in the yellow zone, when additional yellow zone criteria is present or when clinicians, patients, carers or family are concerned about a patient's deterioration, and call for a clinical review or other CERS call as required
- Continue to escalate care as per the local CERS in the event that a clinical review is not attended by the clinical team responsible for the patient's care, or designated responder, within 30 minutes
- Work in partnership with, and communicate critical information to, the RRT during a rapid response call
- Support staff to complete relevant deteriorating patient education programs, including the allocation of protected time to attend required training
- Identify opportunities to reinforce structured communication techniques and systematic patient assessment as covered in the BTF education program during routine clinical practice
- Provide feedback to the local Deteriorating Patient governing committee(s) regarding implementation of the five elements of the Deteriorating Patient Safety Net System.

Nursing/midwifery/allied health staff (within the related scope of practice) are to:

- Be aware of, and know how to activate, the local CERS
- Inform patients, carers and families about how to escalate their concerns about deterioration
- Conduct a systematic patient assessment, including documenting a full set of vital signs observations on an approved standard observation chart, at the frequency specified in their individual monitoring plan. In the absence of an individual monitoring plan, refer to the appropriate approved local clinical management guideline/pathway, or the minimum requirements outlined in Table 2 of this policy.
- When a coloured zone is triggered, follow the relevant coloured zone response instructions on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Increase the frequency of observations and initiate appropriate clinical care when a patient's systematic assessment triggers a blue zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Promptly notify the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge when a patient's systematic assessment triggers a yellow zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Initiate a rapid response call and notify the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge when a patient's systematic assessment triggers a red zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, or serious concern exists about a patient's deterioration
- Document actions taken in relation to recognition, and management of deterioration in the patient's health care record
- Work in partnership with, and communicate critical information to, the RRT during a rapid response call
- Communicate critical information, outcomes, alerts and risks of any clinical review or rapid response calls to the Nursing/Midwifery Unit Manager or delegated nurse/midwife-in-charge, and the clinical team responsible for the patient's care, if/when they are not involved in the process.

Rapid response teams are to:

- Ensure patients are attended to urgently when required as part of the local CERS
- Work in partnership with, and communicate critical information to the clinical team responsible for the patient's care during a rapid response call
- Ensure all rapid response calls are documented in the patient's health care record and outcomes are handed over to the clinician and the clinical team responsible for the patient's care
- Communicate critical information, outcomes, alerts and risks to patients, carers and families following a rapid response in a timely manner
- Have a process to challenge or confirm the provisional diagnosis and/or proposed differential diagnosis, medical management and monitoring plan for all patients following a rapid response.

10.2 Response instructions on the standard observations charts for hospital settings

10.2.1 Blue zone response

If a patient has any observations which breach the blue zone on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, clinicians are to:

- Initiate appropriate clinical care
- Increase the frequency of observations, as indicated by the patient's condition.

If a clinician is worried or unsure whether to initiate a CERS call, consult with the nurse- /midwife-in-charge or relevant clinical supervisor to decide whether a CERS call is to be made, considering the following:

- What is usual for the patient and are there documented alterations to calling criteria?
- Does the abnormal observation reflect deterioration in the patient?
- Is there an adverse trend in observations?

10.2.2 Yellow zone response

If a patient has any observations or additional criteria which breach the yellow zone observations or additional criteria on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, clinicians are to:

- Initiate appropriate clinical care
- Repeat and increase the frequency of vital sign observations, as indicated by the patient's condition
- Consult promptly with the nurse /midwife-in-charge or relevant clinical supervisor to decide whether a clinical review (or other CERS) call is to be made.

Together with the nurse/midwife-in-charge or relevant clinical supervisor, consider the following:

- What is usual for the patient and are there documented alterations to calling criteria?
- Does the trend in observations suggest deterioration?
- Is there more than one yellow zone observation or additional criterion?
- Are you concerned about your patient?

If a clinical review is called:

- Reassess the patient and escalate according to the local CERS if the call is not attended within 30 minutes or there is increasing concern

- Document a systematic A-G assessment, reason for escalation, treatment and outcome in the patient's health care record
- Inform the AMO/delegated clinician responsible that a call was made as soon as it is practicable.

Where required, outcomes of the clinical review are to be documented into any relevant NSW Health, LHD/SHN or local database for capturing key performance indicators.

A structured communication tool, such as ISBAR, is to be used when providing clinical handover to the AMO/delegated clinician responsible and/or the designated responder(s).

The patient, carer and family are to be informed that a clinical review was activated and the outcome of this review.

10.2.3 Red zone response

If a patient has any red zone observations or additional criteria on a standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, a rapid response call needs to be made. In addition, the clinicians are to:

- Initiate appropriate clinical care
- Inform the nurse/midwife-in-charge or relevant clinical supervisor that a rapid response call has been initiated
- Repeat and increase the frequency of vital sign observations, as indicated by the patient's condition
- Document a systematic A-G assessment, reason for escalation, treatment and outcome in the patient's health care record
- Inform the AMO/delegated clinician responsible that a call was made as soon as it is practicable.

Members of the RRT or designated responder(s) are to attend urgently (as per the local CERS protocol) to assess the patient; treat the underlying cause of deterioration and/or provide interventions to resuscitate the patient.

The RRT leader is responsible for ensuring the outcome of the rapid response and the resultant medical management plan is entered into the patient's health care record.

Where required, outcomes of the rapid response call are also to be entered into any relevant NSW Health, LHD/SHN or local database for capturing key performance indicators.

A structured communication tool, such as ISBAR, is to be used when providing clinical handover to the AMO/delegated clinician responsible and/or the designated responder(s).

The patient, carer and family are to be informed that a rapid response was activated and the outcome of this response.

INTER-FACILITY TRANSFER PROCESS FOR ADULTS REQUIRING SPECIALIST CARE (PD2011_031)

PURPOSE

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital's ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location.

MANDATORY REQUIREMENTS

Access to urgent specialist care and inpatient specialist care should be coordinated by a senior clinician and the Patient Flow Units within the nominated tertiary referral centre where clinical referral pathways do not exist.

Each Local Health District (LHD) must have a process in place by June 2011, outlining policy and operational guidelines on inter-LHD transfer for patients requiring access to specialist care.

IMPLEMENTATION

Roles and Responsibilities

Chief Executive (CE) LHD

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.
- Align inter-LHD networks for patient transfers within the existing critical care services adult tertiary referral networks, and clearly identify designated tertiary facilities according to the specialist services provided.
- Meet the needs of patients within the LHD, including the provision of clinical advice and access to appropriate treatment prior to transfer and on return to local LHD facility.
- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.

- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

PURPOSE

About this document

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital's ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location.

This policy does not override:

1. Current referral networks established within the adult, paediatric or perinatal critical care referral network policy directives:
   - *PD2010_021 Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*
   - *PD2010_030 Critical Care Tertiary Referral Networks (Paediatrics)*
   - *PD2010_031 Children and Adolescents - Inter Facility Transfers*
   - *PD2010_069 Critical Care Tertiary Referral Networks (Perinatal)*

2. Current established intra- and inter-Local Health District (LHD) referral pathways which have been established and enable timely access to specialist care. However, where referral pathways do not exist or delays in the transfer of care are experienced, this policy designates a nominated referral pathway to an appropriate facility to manage timely access to specialist care

3. Existing memorandums of understanding governing the transfer of mental health patients between facilities and LHDs.

The following table provides a summary of the referral process, contact pathways and responsibilities for staff when coordinating a patient transfer. Of note is the differentiation between PD2010_021 and PD2011_031.

Clinical Condition	Urgency of Transfer	Refer To	First Phone Call To	Responsibility for Bed Finding and Clinical Advice	Responsibility for Initiating Transport
Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD2010_021	Patient has a time-urgent clinical condition needing transfer in the shortest time possible. Patient's condition is not time-urgent	Linked Tertiary Hospital Linked Tertiary Hospital	AMRS 1800 650 004 Linked Tertiary Hospital via documented LHD referral pathway	Patient is automatically transported to the linked Tertiary Referral Hospital. Linked Tertiary Hospital using Critical Care Resource System Patient Flow Unit AMRS if problems	AMRS 1800 650 004 Referring clinician contacts AMRS
Inter-facility Transfer Process for Adult Patients Requiring Specialist Care **PD2011_031**	Patient requires transfer for urgent specialist care (within 24hrs) Inpatient requiring specialist care (within 24-72hrs)	Linked LHD or Tertiary Hospital Linked LHD or Tertiary Hospital	Receiving specialty clinician via documented LHD referral pathways Receiving specialty clinician via documented LHD referral pathways	Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found. Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.	Patient Flow Unit Patient Flow Unit

Key definitions

In this document the term:

- **Must** - indicates a mandatory action that must be complied with
- **Should** - indicates a recommended action that should be followed unless there are sound clinical reasons for taking a different course of action
- **Urgent specialist care (<24hrs)** - indicates where patients require specialist intervention to prevent or manage further deterioration within a short time frame (immediate to within 24 hours).
- **Inpatient specialist care (24-72hrs)** - indicates where patients require specialist investigations or management of care not available at originating site (requires transfer within 24 to 72hrs).
- **Patient Flow Units** - represents dedicated patient flow units for the LHD or a facility or the person(s) responsible for patient flow depending on the resources within a given facility. This includes facility Bed Managers and After Hours Nurse Managers.
- **Senior Clinician** - A senior medical officer such as a Consultant, (Staff Specialist or VMO) or Senior Registrar

KEY PRINCIPLES

Each LHD must have a clear and readily available policy incorporating the following principles:

- **Good Communication and clinical handover** - between referring and receiving Senior Clinicians that involves the Patient Flow Units, resulting in the coordination of timely and safe patient transfer for ongoing care within medically agreed timeframes.

- **Patient Flow Responsibility** - all facilities have personnel tasked with coordinating patient flow, available 24/7 at all sites (e.g. Patient Flow Manager, After Hours Nurse Manager, Bed Manager).
- **Inter LHD Transfers** - where clinically appropriate patient transfers to occur within the LHD.
- **Existing Clinical Referral Networks** - where existing historical clinical referral networks are working well, these should be continued to facilitate timely access to specialist care. As part of the development of the new LHD Health Care Plans, formalised clinical networks will be determined.
- **Nominated Referral Centres** - accessing the nominated tertiary referral centre where existing clinical referral networks don't exist or where time is delaying the patient's access to ongoing specialist care as per Appendix 2.
- **Direct to inpatient bed** - the patient should be admitted directly to an inpatient bed and avoid the Emergency Department (ED) where possible unless deterioration in the patient's condition requires assessment in the ED.
- **Return Transfers -** on completion of specialist care patients are returned to the originating or other clinically appropriate facility within 24hrs or one working day.
- **Timely Escalation** - immediate escalation is to occur with the appropriate service managers for decision making, when an issue regarding patient transfer arises which will impact on the patient accessing safe and timely care within the medically agreed timeframe.

IMPLEMENTATION

Roles and responsibilities

Chief Executive (CE) LHD:

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD:

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.
- Align inter-LHD networks for patient transfers within the existing critical care services adult tertiary referral networks, and clearly identify designated tertiary facilities according to the specialist services provided.
- Meet the needs of patients within the LHD, including the provision of clinical advice and access to appropriate treatment prior to transfer and on return to local LHD facility.
- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.
- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

ACCESSING THE LEVEL OF CARE REQUIRED

LHDs are required to establish a single telephone contact number within 6 months of implementation. The purpose of this contact number is to provide all clinicians with clinical support and advice on clinical care and access to appropriate care and clinical referral pathways.

Patients who require transfer for specialist treatment fall broadly into two categories:
1. Those who require urgent specialist care (<24hrs) not available at the originating site
2. Those who require inpatient specialist care (24-72 hrs) not available at the originating site

The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the senior clinician at the referring site and a senior clinician from the specialist service at the receiving facility.

Patients and their representatives must be kept informed of any decisions to transfer a patient between facilities.

Delays in transfer of urgent patients must be minimised. If a bed is not available at the receiving hospital within a clinically relevant time or there is a disagreement regarding transfer, LHD policy must provide clear and immediate escalation pathways in advance of the transfer. This should not delay the transfer.

Escalation pathways should involve senior clinicians, facility and LHD executive and Patient Flow Units.

Should the senior clinician at the nominated *receiving* facility not support the patient transfer, they then have a clinical and professional responsibility to assist with patient placement to an appropriate alternative location for treatment and care.

Ongoing delays must be escalated to executive staff of the referring hospital. Communication amongst each facility executive may be required to assist with escalation processes. Such events should be routinely subject to audit and review.

Paramount to all communication between clinicians is the provision of adequate clinical information regarding the patient, sufficient to enable clinicians to make clinical decisions on the most appropriate care for the patient.

It is imperative that facility and LHD Patient Flow Units are involved in the discussions coordinating the patient transfer, and that the Bed Board Tool within the Patient Flow Portal is used to log transfer requests and facilitates good communication. This will allow for streamlined coordination of inter-hospital transfers.

LHDs must ensure a transfer checklist is in place. The use of an inter-facility transfer checklist will assist in standardising practice and ensuring an adequate level of information is provided, assisting clinical handover of the patient. (See Appendix 1 for an example of an inter-hospital transfer checklist.)

For urgent specialist care (<24hrs)

Transfer of patients for urgent specialist care must occur within 24 hours. The transfer of these patients requires a coordinated approach between the referring and accepting senior clinician (or their representative) and the receiving and sending Patient Flow Units. **Direct transfer to an appropriate inpatient bed should be the first preference**.

Prior to transfer, the referring senior clinician must:

1. Determine transfer urgency in consultation with the receiving senior clinician (the Patient Flow Unit at the facility should be working with the Clinicians to identify a transfer timeframe that best meets the patient's needs.
2. Contact the person responsible for allocating beds at the receiving hospital. (Bed Manager, After Hours Nurse Manager, Patient Flow Unit)
3. Ensure the transfer is made in a timeframe that is appropriate to the patient's clinical condition and provide an accurate estimated time of arrival.
4. Determine the appropriate form of clinical transportation and level of supervision for the patient in consultation with the receiving senior clinician
5. Provide copies of appropriate documentation with the patient which must include the patient's clinical notes, medication chart, current investigation results and referring and receiving doctor contact details.

A patient who is at risk of deterioration should be considered for early transfer to a facility where their care could be managed more effectively. At any time should the patient's condition deteriorate and become critical, PD2010_021 *Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* should be utilised to ensure the patient has access to the appropriate level of care required in a timely manner.

Patients should be transferred directly to their allocated inpatient bed or a clinically appropriate area on arrival to the receiving facility (irrespective of time of day). It is the responsibility of the accepting team to conduct a timely review. If a patient's condition has deteriorated en route to the receiving facility, assessment may be required in the Emergency Department. The Emergency Department senior clinician should be notified, if this is required, and provided with a clinical handover prior to arrival at the receiving facility.

For Inpatient specialist care (24-72 hrs)

Transfer of inpatients for specialist care should occur within business hours wherever possible. The transfer process must be coordinated between the referring senior clinician, the accepting senior clinician and the Patient Flow Unit, and include agreement on timelines around the transfer.

In hours

Patients who are being transferred from a hospital ward/unit for the purpose of ongoing specialist care do not generally require clinical assessment or treatment by Emergency Department staff at the receiving facility unless the patient has deteriorated en route. Their admission should be managed by inpatient specialist teams in appropriate inpatient/ward areas. This assessment should be carried out in a similar timeframe to transfers from the emergency department.

Out of hours

Outside business hours, and where specialist inpatient teams are not available within a reasonable time frame, local policy should clearly state arrangements regarding:

1. The specific location within the facility where the patient will be transferred for specialist assessment and management
2. The process for conducting the initial assessment and management.

Patient safety should guide the decision on where the patient is most appropriately placed.

For return transfer of care post specialist assessment review or intervention

All patients that require specialist care must be transferred with the understanding that when the specialty services are no longer required, care of the patient will be transferred back to the originating hospital, or a hospital with an equivalent level of care capability close to the patient's geographical home location.

This ensures that specialist services are available for others in need and that care is delivered to the patient in the most appropriate setting. The treating specialist team is responsible for initiating return transfers of care and should liaise with the admitting team at the receiving facility to negotiate the plan for transfer. The Patient Flow Unit must be included in the discussions and transfer information including contact details of individuals logged in the Bed Board application within the Patient Flow Portal.

LHD policy must clearly outline the return referral process. The policy must reinforce that:

1. The specialist hospital must notify the receiving hospital that the patient is ready for return transfer and provide a clinical handover informing them of the patient's clinical condition and management
2. Relevant details must be entered onto NSW Bed Board via the Patient Flow Portal
3. The receiving hospital should give the returning patient priority in bed allocation and avoid return transfer through the emergency department
4. The planned inter-facility return transfer should occur within 24 hours or 1 working day of notification
5. Transfers to rural areas must consider the availability of a medical officer to admit the patient back into a facility and relevant clinical health support when coordinating the patient transfer.
6. Escalation pathways should be in place to address transfer delays outlining the person(s) responsible for managing the escalation and action to be taken.

GOVERNANCE

The Chief Executive (CE) of the receiving LHD is responsible for ensuring coordination of inter-facility transfers for patients requiring access to specialist care.

If a situation arises where issues are encountered in coordinating appropriate care for patients requiring specialist care or return transfer patients, these issues are to be escalated via the hospital's and LHDs organisational management structure. In the event that a resolution cannot be reached the issues are then to be escalated to a position delegated by the CE LHD of no less than tier 2 level. The CE LHD or delegate is required to ensure a process is in place to:

I. Activate the nominated tertiary referral hospital pathway
II. Implement return patient transfer pathway

Resolutions of issues are to be managed at the CE LHD to CE LHD level to ensure policy compliance results in patient accessing safe and timely specialist care.

THE TRANSFER NETWORK

Due to the variety of indications for transfer for specialist review, specific clinical conditions cannot be described here. Transfer of patients may need to occur within LHD (intra-LHD transfer) and between LHDs (inter-LHD transfer). LHD Policy should reflect the need for intra-LHD and inter-LHD transfer of patient to access specialist care. Operational guidelines should include clear processes that link the transfer to an accepting clinician, Patient Flow Manager and transport at the same time.

In line with the PD2010_021 *Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* the CE LHD or delegate is responsible for ensuring the appropriate referral arrangements are in place for all non-critical patients requiring referral for specialist care. Formalised specialist clinical referral networks and referral processes must be in place to guide and assist clinicians to ensure appropriate and timely patient referrals.

Where cross-jurisdictional border arrangements are in place i.e. Victorian, Queensland, Australian Capital Territory and South Australian borders, this policy supports existing arrangements. However where delays occur in accessing timely care for patients, transfer to the nominated referral hospital must be considered. These clinical referral networks are as per, PD2010_021 NSW Critical Care Tertiary Referral Networks & Transfer of Care (Adults), which defines the links between LHDs, and tertiary referral hospitals for specialist clinical care. (Appendix 2)

Justice Health does not have acute health care facilities, but seeks acute services from LHDs where necessary, generally through emergency departments. Liaison with Justice Health is critical prior to transfer of care back to Justice Health, to ensure ongoing care needs are met.

Intra LHD transfers

LHDs are responsible for developing intra LHD links to assist clinicians in transferring patients that require specialist care.

LHD policy must clearly identify

- The process for coordinating the transfer (which includes the Patient Flow Units)
- The facilities responsible for accepting particular patient cohorts by speciality need.

Inter LHD transfers

If intra LHD specialist services are not available it will be necessary to escalate the transfer to a facility in another LHD.

Local policy should indicate who is responsible for coordinating inter LHD transfer and reflect the following steps.

1. Unless an alternative clinically appropriate transfer is agreed, inter LHD transfers should follow the nominated clinical referral networks used for critically ill or injured patients to tertiary referral centres
2. If the nominated tertiary referral hospital has issues accepting the patient, and the patient has an urgent condition, transfer must not be delayed: LHD escalation pathways must be activated to ensure the patient has timely access to specialist care.
3. If a patient can receive equivalent and effective specialised care in a less acute facility within the tertiary referral LHD, the tertiary referral centre will arrange treatment in that facility.
4. Any patient transfer should take into account the receiving hospital's distance from the patient's home and the impact this may have on the patient's relatives and carer(s).
5. The final decision must be made by the receiving senior clinician in consultation with the referring senior clinician and the Patient Flow Units.
6. If an alternative provider cannot be found within an appropriate time frame, the nominated tertiary hospital must accept the patient.

FEEDBACK

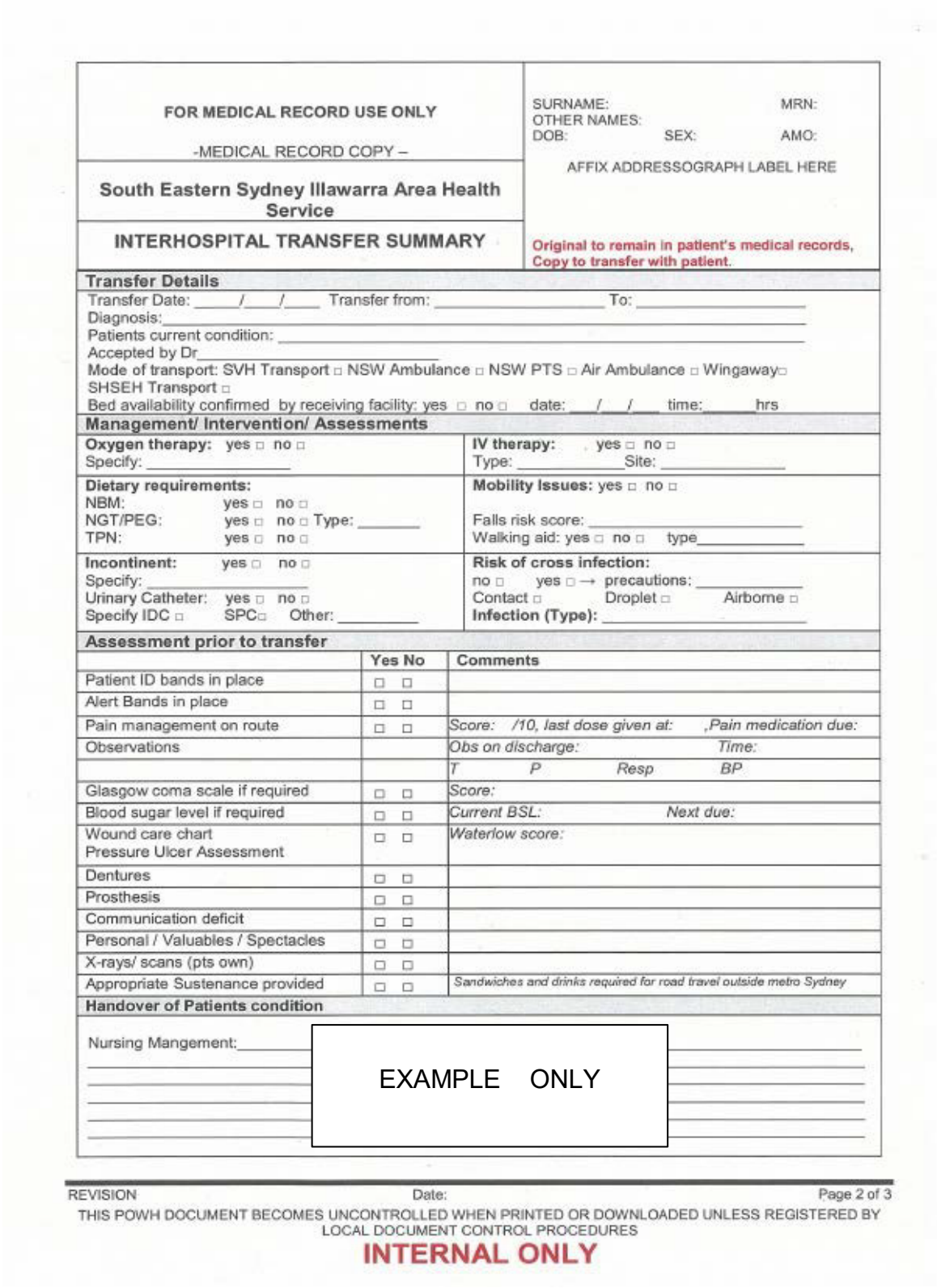
LHDs should incorporate feedback loops into inter-facility transfer procedures. This should manifest in a monthly or more frequent teleconference or face to face meetings with the LHD's Patient Flow Managers.

There must also be a well documented and immediate escalation process if issues arise at any stage, whether it is in forward or return transfers.

A post implementation checklist (Appendix 7.3) is to be completed at 3 and 6 months after Policy Directive implementation and be forwarded to the Director, Health Services Performance Improvement Branch.

ATTACHMENTS

Appendix 1 EXAMPLE of an Inter-hospital Transfer Checklist



FOR MEDICAL RECORD USE ONLY

-MEDICAL RECORD COPY –

SURNAME: MRN:
OTHER NAMES:
DOB: SEX: AMO:

AFFIX ADDRESSOGRAPH LABEL HERE

South Eastern Sydney Illawarra Area Health Service

INTERHOSPITAL TRANSFER SUMMARY

Original to remain in patient's medical records, Copy to transfer with patient.

Transfer Details

Transfer Date: ____/____/____ Transfer from: _____ To: _____
Diagnosis: _____
Patients current condition: _____
Accepted by Dr _____
Mode of transport: SVH Transport □ NSW Ambulance □ NSW PTS □ Air Ambulance □ Wingaway□
SHSEH Transport □
Bed availability confirmed by receiving facility: yes □ no □ date: ___/___/___ time: _____hrs

Management/ Intervention/ Assessments

Oxygen therapy: yes □ no □ Specify: _____	**IV therapy:** yes □ no □ Type: _____ Site: _____
Dietary requirements: NBM: yes □ no □ NGT/PEG: yes □ no □ Type: _____ TPN: yes □ no □	**Mobility Issues:** yes □ no □ Falls risk score: _____ Walking aid: yes □ no □ type_____
Incontinent: yes □ no □ Specify: _____ Urinary Catheter: yes □ no □ Specify IDC □ SPC□ Other: _____	**Risk of cross infection:** no □ yes □ → precautions: _____ Contact □ Droplet □ Airborne □ **Infection (Type):** _____

Assessment prior to transfer

	Yes No	Comments
Patient ID bands in place	□ □	
Alert Bands in place	□ □	
Pain management on route	□ □	*Score: /10, last dose given at: ,Pain medication due:*
Observations		*Obs on discharge: Time:*
		T P Resp BP
Glasgow coma scale if required	□ □	*Score:*
Blood sugar level if required	□ □	*Current BSL: Next due:*
Wound care chart Pressure Ulcer Assessment	□ □	*Waterlow score:*
Dentures	□ □	
Prosthesis	□ □	
Communication deficit	□ □	
Personal / Valuables / Spectacles	□ □	
X-rays/ scans (pts own)	□ □	
Appropriate Sustenance provided	□ □	*Sandwiches and drinks required for road travel outside metro Sydney*

Handover of Patients condition

Nursing Mangement: _____

EXAMPLE ONLY

REVISION Date: Page 2 of 3

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INTERNAL ONLY

Appendix 2 HD and Nominated Tertiary Referral Centres for Urgent and Non Urgent Specialist Care

Metropolitan NSW LHDs

LHD	Central Coast	Illawarra Shoalhaven	Nepean Blue Mountains
Nominated Tertiary Referral Centre	Royal North Shore	St George	Nepean
Hospital	Gosford Long Jetty Woy Woy Wyong	Bulli Coledale David Berry Kiama Milton Ulladulla Port Kembla Shellharbour Shoalhaven Wollongong	Blue Mountains Hawkesbury Lithgow Portland Springwood
LHD	**Northern Sydney**	**South Eastern Sydney**	**South Western Sydney**
Nominated Tertiary Referral Centre	Royal North Shore	Prince of Wales St George Royal Hospital for Women	Liverpool
Hospital	Greenwich Hornsby Macquarie Manly Mona Vale Neringah Royal Rehabilitation Ryde	Calvary Healthcare Gower Wilson (Lord Howe Island) Sutherland Sydney & Eye Hospital War Memorial	Bankstown Lidcombe Braeside Bowral Camden Campbelltown Fairfield
LHD	**Sydney**	**Western Sydney**	
Nominated Tertiary Referral Centre	RPAH/Concord	Westmead	
Hospital	Balmain Canterbury	Auburn Blacktown Mount Druitt St Josephs	

Rural LHDs

LHD	Hunter New England	Mid North Coast	Murrumbidgee
Nominated Tertiary Referral Centre	John Hunter	John Hunter	Prince of Wales St George St Vincent's
Hospital	Armidale Barraba Belmont Bingara Boggabri Bulahdelah Cessnock Denman Guyra Inverell Kurri Kurri Maitland Manilla Merriwa Moree Murrurundi/Wilson Muswellbrook Narrabri Tomaree Community (Nelson Bay) Calvary Newcastle Mater Quirindi Scone Singleton Tamworth Warialda Wee Waa Werris Creek Wingham	Bellingen Coffs Harbour Dorrigo Kempsey Macksville Port Macquarie Wauchope	Albury[42] Balranald Barham Koondrook Batlow Berrigan Boorowa Deniliquin Coolamon Cootamundra Finley Griffith Gundagai Hay Henty Hillston Holbrook Jerilderie Junee Leeton Lockhart Murrumburrah-Harden Narrandera Temora Tocumwal Tumbarumba Tumut Urana Wagga Wagga West Wyalong Young

[42] Albury is networked with clinical services in Victoria however referral to a NSW facility may be required due to clinical need.

LHD	Northern[43]	Southern[44]	Western	Far West
Nominated Tertiary Referral Centre	John Hunter	The Canberra/Prince of Wales*	Royal Prince Alfred	Royal Prince Alfred
Hospital	Ballina Bonalbo Byron Casino Coraki Grafton Kyogle Lismore Maclean Mullumbimby Murwillumbah Nimbin Tweed Urbenville	Bateman's Bay Bega Bombala Braidwood Cooma Crookwell* Delegate Goulburn* Moruya Pambula Queanbeyan Yass	Baradine Bathurst Blayney Bourke Brewarrina Canowindra Cobar Collarenebri Cudal Dubbo Dunedoo Eugowra Forbes Gilgandra Gulgong Lake Cargelligo Lightning Ridge Molong Mudgee Narromine Nyngan Oberon Orange Tottenham Trangie Trundle Tullamore Wellington	Broken Hill[45] Ivanhoe Menindee Tibooburra Wilcannia

Sydney Children's Hospital Network
Randwick Westmead *(State-wide referral role)*

[43] Northern LHD maintains a clinical referral with Queensland
[44] Murrumbidgee, Southern maintains a clinical referral network between The Canberra Hospital and the following hospitals: Bateman's Bay, Batlow, Bega, Bombala, Boorowa, Braidwood, Cooma, Delegate, Moruya, Pambula, Queanbeyan, Tumut, Yass and Young.
[45] Broken Hill maintains clinical referral networks with South Australia

Post Implementation Checklist

Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
4. Evidence of documented clinical referal pathways established across and between the Local Health Network	❑	❑	❑
	Notes:		
5. Establishment of a single point of telephone contact providing support to clinicians with issues relating to access of appropriate care and clinical referral pathways	❑	❑	❑
	Notes:		
6. Single LHD arbitrator designated for the resolution of escalated patient inter-facilty transfer issues	❑	❑	❑
	Notes:		
7. Number of patients requiring arbitration at tier 2 level to successfully occasion an inter-facility transfer to a higher level care facility	❑	❑	❑
	Notes:		
8. Number of patients breaching >24hr for a return transfer time at 3 and 6 months	❑	❑	❑
	Notes:		

PATHWAY FOR ACUTE CORONARY SYNDROME ASSESSMENT (PACSA)
(IB2023_009)

IB2023_009 replaced GL2019_014

PURPOSE

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

KEY INFORMATION

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

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

The PACSA consists of four documents:

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

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

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

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

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

ABORIGINAL EAR HEALTH PROGRAM GUIDELINES (GL2011_013)

PURPOSE

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

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

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

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

To download or view the Guidelines go to
http://www.health.nsw.gov.au/policies/gl/2011/GL2011_013.html

NUTRITION CARE (PD2017_041)
PD2017_041 rescinds PD2011_078

PURPOSE

Local Health Districts, Specialty Health Networks and other NSW public health organisations have a responsibility to provide nutrition care for all their admitted patients.[30] This Policy directive sets out the NSW Health framework for a strategic and coordinated approach to nutrition care for admitted patients, including weight and height/length assessment, from admission to transfer of care.

MANDATORY REQUIREMENTS

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

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

IMPLEMENTATION

Chief Executives are responsible for:

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

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

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

The Agency for Clinical Innovation is responsible for:

- Providing support to NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations for the implementation of the Nutrition Care Policy.
- Monitoring and evaluating implementation of the Policy within NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations in collaboration with the NSW Ministry of Health and key stakeholders.

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

- Reporting on the implementation and evaluation of the Policy to the NSW Ministry of Health Nutrition and Food Committee. This includes recommendations for amendments to the Policy and other relevant documents such as nutrition standards and diet specifications.

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

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

Health Education and Training Institute

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

NUTRITION CARE PROCEDURES

1 BACKGROUND

1.1 Food and nutrition in health

Good nutrition is vital for everyone, particularly for those who are frail, ill or suffering from injury. The provision of good nutrition care is an integral aspect of health care and is associated with better patient outcomes.[31] Hospital patients rely on the hospital to provide foods which are nourishing and acceptable to the patient in terms of their developmental, cultural and psychosocial needs. To achieve the best outcomes for the patient other issues such as patient access to foods and the provision of assistance with eating need to be addressed.

Food is not only essential for physical health, childhood growth and development, mental health and general well-being but also essential to an individual's sense of self. Food has strong psychological connotations associated with nurturing. In the hospital environment, meal times provide a welcomed routine to the day. Eating may be one of few opportunities many patients have to regain independence, make choices and ultimately take control over an aspect of their care, providing a positive milestone on the road to recovery.[32] Familiar foods are also important and can provide comfort and security in unfamiliar situations.

All hospital food services have a duty of care to meet the nutrition requirements and the developmental, cultural and psychosocial needs of each patient. All staff can contribute to making the mealtime environment pleasant and can assist patients in accessing and enjoying their meals.

Assessment of a person's nutritional status is important for identifying their nutritional risk during admission, as well as for promoting longer-term health and wellbeing. Along with nutrition screening, weight and height/length assessment is an important component of identifying patients who may benefit from additional nutrition care.

1.2 Malnutrition in hospital

The term malnutrition can be used to describe any nutritional imbalance and includes over and under-nutrition. However, for the purpose of this Policy, malnutrition refers solely to **protein-energy under-nutrition.**

[31] Correia et. al., 2014

[32] Segaran, 2006

A primary concern for acute, chronic, and transitional care settings is the recognition and treatment of malnutrition.[33] Malnutrition may be present in a person who is a normal weight, overweight or obese, not just those who are underweight. Many patients are malnourished on admission to care, or are at nutritional risk. If not addressed, the nutritional status of patients may worsen during the course of admission. This may result from impaired intake, impaired digestion and/or absorption, poor food choices, poor eating behaviours, altered metabolic states and unusual nutrient requirements. Early identification, documentation and management of malnutrition is critical.

1.3 Overweight and obesity in hospital

The prevalence of overweight and obesity among Australians has been steadily increasing over many years and health problems related to excess weight impose substantial economic burdens on individuals, families and communities.[34]

Long-term management is required for people who are overweight or obese. Interventions need to be individualised and supported by self-management principles and regular review by a healthcare professional.

The hospital setting provides an opportunity to identify people who are affected by overweight and obesity, and to initiate appropriate care including nutrition advice, weight management strategies or pathways where appropriate.

However, people who are overweight or obese and develop a severe acute illness or experience a major traumatic event are at risk of malnutrition and frequently need and benefit from intensive nutrition intervention.[35]

1.4 Consequences of poor nutrition

Unless systematic efforts are made to identify and manage patients at nutritional risk, the above conditions may go undetected and unmanaged during the person's admission and on transfer of care. If untreated, they can cause a wide range of adverse outcomes for the person and the health system. These include:

For the individual:

- Delayed wound healing
- Increased risk of falls and pressure injuries
- Muscle wasting and weakness
- Increased prevalence of both adverse drug reactions and drug interactions
- Infection
- Dehydration
- Impaired mobility
- Diarrhoea, constipation
- Impaired metabolic profiles
- Apathy and depression.

Consequences for paediatric inpatients can also include:

- Faltering growth and poor weight gain

[33] White et. al., 2012

[34] National Health and Medical Research Council, 2013

[35] White et. al., 2012

- Excess weight gain for length or height
- Impaired neurodevelopment
- Delayed achievement in developmental milestones. This may include some or all of the following aspects of development: physical (fine & gross motor skills), emotional, cognitive, social, language, and cultural.

For the health system:

- Increased lengths of stay
- Increased rates of readmission
- Increased costs
- Greater antibiotic use
- Increased complications
- Increased clinical intervention
- Increased staff time per patient

1.5 Key definitions

The following terms apply in this document

Malnutrition	Malnutrition due to starvation, disease or ageing can be defined as "a state resulting from lack of uptake or intake of nutrition leading to altered body composition (decreased fat free mass) and body cell mass leading to diminished physical and mental function and impaired clinical outcome from disease"[36]
Must	Indicates a mandatory action
Nutrition Care	A coordinated multidisciplinary approach to the provision of nutrition that adapts to the consumer/patient's individual needs and preferences throughout the healthcare journey. It encompasses interventions, monitoring, and evaluation designed to facilitate appropriate nutrient intake based upon the integration of information from the nutrition assessment. This includes access to safe, acceptable and appropriate food services, nutrition supplements and/or enteral and parenteral nutrition.[6,37]
Nutrition Screening	'A process of identifying patients with characteristics commonly associated with nutrition problems who may require comprehensive nutrition assessment and may benefit from nutrition intervention.'[38]
Nutrition Assessment	'A comprehensive approach to gathering pertinent data in order to define nutritional status and identify nutrition-related problems. The assessment often includes patient history, medical diagnosis and treatment plan, nutrition and medication histories, nutrition-related physical examination including anthropometry, nutritional biochemistry, psychological, social, and environmental aspects' [10]
Nutrition Support	The provision of nutrients to make up the shortfall between the patient's nutrient requirements and their oral intake. Supplementary nutrition can be given in the form of additional foods and/or fluids, enteral feeds or parenteral nutrition (PN).

[36] Sobotka 2012 and Cederholm et. al, 2015
[37] American Dietetic Association, 1994
[38] Watterson et. al, 2009

Overweight and Obesity	Abnormal or excessive fat accumulation that may impair health.[39] For adults, the World Health Organization (WHO) defines overweight and obesity as follows: • overweight is a Body Mass Index (BMI) greater than or equal to 25kg/m^2; and • obesity is a BMI greater than or equal to 30kg/m^2. For children (2-18 years), the Centre for Disease Control (CDC) and Prevention BMI for age charts (2000)[40] are used: • above a healthy weight (overweight) is BMI for age: 85th centile to below 95th centile • well above a healthy weight (obesity) is BMI for age: 95th centile and above. For children under 2 years, monitor for evidence of excess weight gain using WHO Child Growth Charts.[41] For example, where the percentile documented on the weight-for-age chart is higher than the percentile documented for the length-for-age chart, and especially if the difference is increasing.
Should	Indicates a recommended action that is to be followed unless there are sound reasons for taking a different course of action.
Underweight	For adults, the World Health Organization (WHO) defines below a healthy weight (underweight) as: • a Body Mass Index (BMI) less than 18.5kg/m^2 For children (2-18 years), the Centre for Disease Control (CDC) and Prevention BMI for age charts (2000)[42] are used: • below a healthy weight (underweight) is defined as a BMI for age below the 5th centile For children under 2 years, monitor for evidence of inadequate weight gain or poor growth using WHO Child Growth Charts.[43]
Weight and height/length assessment	The process of 1. Measuring and documenting a person's height (or length in children under 2 years) and weight, 2. Using the measurements to calculate a BMI, and 3. Using the appropriate BMI for age chart (in children) and BMI cut-off values (in adults) to inform clinical decision making and care.

1.6 Related NSW health policies and guidelines

PD2010_049	Multipurpose Services - Policy and Operational Guidelines
PD2011_015	Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
PD2012_042	Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients
PD2012_069	Health Care Records – Documentation and Management
PD2014_004	Incident Management Policy

[39] World Health Organization, 2016
[40] National Center for Health Statistics, 2000
[41] World Health Organisation, 2006
[42] National Center for Health Statistics, 2000
[43] World Health Organisation, 2006

PD2017_001	Responding to the needs of people with disability during Hospitalisation
PD2017_033	Physical Health Care within Mental Health Services
GL2005_057	End-of-Life Care and Decision-Making – Guidelines
GL2017_012	Healthy Food and Drink in NSW Health facilities for Staff and Visitors Framework
GL2017_019	Physical Health Care of Mental Health Consumers
GL2017_021	Growth Assessment in Children and Weight Status Assessment in Adults
IB2012_024	Metabolic Monitoring Clinical Documentation Module
IB2013_039	Foodborne Listeriosis Control in Health Care Institutions

Agency for Clinical Innovation

- Nutrition Standards and Diet Specifications available at http://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-standards-diets
- ChOICES: The Patient Menu Selection process available at: https://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-policy
- Palliative and End of Life Care – A Blueprint for Improvement available at: https://www.aci.health.nsw.gov.au/palliative-care-blueprint

1.7 Other related sites

- NSW Department of Primary Industries Food Authority http://www.foodauthority.nsw.gov.au/industry
- Australian Commission on Safety and Quality in Health Care http://www.safetyandquality.gov.au/
  - This policy aligns with the National Safety and Quality Healthcare Standards
- The Healthy kids website www.healthykids.nsw.gov.au
  - general information on healthy eating and physical activity information for children and parents
- Healthy kids for professionals website https://pro.healthykids.nsw.gov.au/
  - for NSW health professionals, focusing on lifestyle management in children.
- The Go4Fun program www.go4fun.com.au
  - a free, community-based referral program for children who are above a healthy weight, and their families
- The Get Healthy Service www.gethealthynsw.com.au
  - a free, phone-based lifestyle coaching service for NSW residents 16 years and older.

2 GOVERNANCE

A strategic and coordinated approach is required by Local Health Districts, Specialty Health Networks and other NSW public health organisations to ensure a high standard of nutrition care is provided to patients.

Governance structures should include consumer, clinical and corporate representation. Each Local Health District and Specialty Health Network should have a governance structure for food and nutrition that includes representatives from the following groups:

- Senior management
- Medical staff
- Nursing/midwifery
- Consumers and their carers
- Nutrition and Dietetics
- Food services
- Other allied health staff (e.g. speech pathology, occupational therapy) as required
- Other disciplines should be consulted as needed.

The role of local governance structures should include the following activities:

- Implementation of this Policy
- Operational policy/procedure development, endorsement and review
- Effective communication of policies and procedures to staff
- Ensuring nutrition care is considered in the planning and development of new services
- Monitoring implementation of agreed standards and related procedures
- Monitoring performance against agreed standards
- Review, management and reporting of nutrition care incidents
- Evaluation of nutrition care which includes the consideration of feedback received from consumers, staff and key stakeholders
- Providing feedback to staff and consumers about performance against the Policy.

A governance group at each health facility should be considered.

3 WEIGHT AND HEIGHT/LENGTH ASSESSMENT

Assessing weight and height/length is the first step in identifying and developing a care plan for patients according to their current weight status and clinical condition.

Weight and height/length assessment requires measurement of the patient's actual (not estimated) weight and height/length.

All patients under the age of 18 years **must** have their weight and height/length measured and documented within 24 hours of admission and weight should continue to be measured and documented at least weekly in the acute setting and at least monthly in long stay facilities. Head circumference should also be measured and documented from birth to at least two years of age on admission.

All patients 18 years and older should have their weight and height measured and documented within 24 hours of admission and weight should continue to be measured and documented at least weekly in the acute setting and at least monthly in long stay facilities (e.g. multipurpose services, rehabilitation centres, mental health facilities).

Measurement of weight and height/length, and assessment of weight status, is to be performed and documented according to the NSW Health Guideline: Growth Assessment in Children and Weight Status Assessment in Adults.

There may be a small number of patient populations where measuring weight and height/length is not clinically appropriate and this decision will need to be made at a specific service-level.

4 NUTRITION SCREENING

Nutrition screening is key to early identification of patients with nutritional problems which may go unrecognised and therefore remain untreated.

There are many factors that may prevent a patient from eating and/or drinking adequately and safely. These include, but are not limited to, physical difficulties, medical conditions, behavioural difficulties, age, stage of development, cognitive impairment, and changes to sense of taste as a result of treatment/illness or loss of appetite.

Nutrition screening is a rapid, simple and general procedure used by nursing, medical or other clinical staff to detect patients at risk of malnutrition. It is applicable in the hospital, outpatient, community and ambulatory care settings as well as long stay facilities such as multipurpose services and residential aged care.

NSW Local Health Districts, Specialty Health Networks and other NSW public health organisations **must** have in place a system for nutrition screening using a validated tool. The choice of tool and subsequent action pathway is dependent on the patient population and the staff resources available. Ideally the tool should be quick simple, accurate and reliable.

Examples include but are not limited to: the Malnutrition Screening Tool (MST), the Mini Nutrition Assessment (MNA), the Malnutrition Universal Screening Tool (MUST) and the Paediatric Nutrition Screening Tool (PNST).

Nutrition screening should occur:

- within 24 hours of admission and then weekly during the patient's episode of care
- at least monthly in long stay facilities (e.g. multipurpose services, some rehabilitation centres, some mental health facilities)
- if the patient's clinical condition changes.

Patients whose score is 'at risk' on a validated screening tool or whose clinical condition is such that their treating team identifies them as at nutritional risk should be referred to a dietitian for a full nutrition assessment and nutrition support as appropriate.

There may be a small number of patient populations where nutrition screening is not clinically appropriate and this decision will need to be made at a specific service-level. For example people with eating disorders and people receiving palliative care.

5 NUTRITION ASSESSMENT

Patients should have a full nutrition assessment if they have been identified as at risk by nutrition screening. Nutrition assessment determines an individual's nutritional status and helps identify appropriate nutrition interventions. Early detection of malnutrition and implementation of appropriate nutrition support reduces the risk of patients' nutrition status deteriorating during an episode of care.

Local Health Districts, Specialty Health Networks and Public Health Organisations **must** have in place a system for nutrition assessment for the diagnosis of malnutrition. The nutrition assessment **must** be undertaken by a dietitian and an appropriate validated tool **must** be used to support the diagnosis of malnutrition.
Examples of validated assessment tools include but are not limited to the Subjective Global Assessment (SGA) Tool, Subjective Global Nutrition Assessment in Children (SGNA) Full Mini Nutritional Assessment (Full-MNA) and Patient Generated Subjective Global Assessment (PG-SGA).

Patients requiring nutrition assessment should be seen by a dietitian within two working days of referral.

If there is no dietitian available, a protocol that outlines the management of the patient until a nutrition assessment can be completed **must** be in place and communicated to staff. Strategies such as telehealth could be considered for facilities where access to a dietitian on-site is limited.

Nutrition assessment should be discussed with the treating doctor and multidisciplinary team and **must** be documented in the patient's medical record.

6 NUTRITION CARE PLANNING

Individuals identified as malnourished or at nutritional risk **must** have an appropriate nutrition care plan developed by a dietitian and documented in the patient's medical record.

The patient's overall nutrition care plan **must** be documented and incorporate the recommendations made by the multidisciplinary team involved in the patient's care. This would include, but is not limited to, recommendations made by Dietitians, Speech Pathologists, Occupational Therapists, Nurses/Midwives and the medical team.

This nutrition care plan should contain clearly documented nutrition interventions to attain identified goals of treatment. Good patient care may require help with feeding, recording of food and fluid intake, modified menus, additional dietetic advice and oral nutrition supplements and/or oral, enteral or parenteral nutrition support. Patients, carers and/or relatives should have input into the nutrition care plan and communicate any issues with these plans with a member of the multidisciplinary care team. Referral to the appropriate clinician(s) should follow where required.

Nutrition care plans should be:

- reviewed regularly and documented to reflect changes
- monitored to ensure goals are met with further action taken as necessary
- communicated appropriately to the patient and care givers.

Changes in a patient's clinical condition that may impact on their nutrition should be monitored and appropriate action taken. Action may include re-screening, re-assessment and changes to care plans.

6.1 Transfer of care

Patients who require ongoing nutrition care on transfer of care **must** have a clear nutrition care plan documented. The plan should be communicated to the patient and/or carer as well as to any receiving facility and the patient's general practitioner and other members of the community-based health care team. On transfer, the care plan should include information about:

- weight status
- nutrition status
- special dietary requirements
- key messages for achieving and maintaining a healthy weight, where required
- provision/purchase and preparation of specialised nutrition support products and relevant equipment where required
- arrangements for referral and follow-up.

Arrangements should be in place for continuing care. This could include but is not limited to, primary care, community-based care, private practitioners or an outpatient service.

If the patient has an ongoing need for specialised nutrition support items the patient should have access to, or be provided with, an adequate supply of these items while waiting for their own supply where required (e.g. enteral formula or equipment, thickened fluids, thickener).

7 PLANNING AND DELIVERY OF FOOD AND FLUIDS

Patients are more likely to eat a meal and receive the appropriate balance of nutrients it provides when the meal and presentation is pleasing and appetising. Meals should be delivered to the wards or respective dining areas and served promptly to maintain the nutrition content, temperature and quality.

Effective multidisciplinary communication is vital for the efficient provision of food in hospital and to ensure that patients' nutrition requirements are met while minimising waste.

Patients/carers should be provided on admission with information about meal services and the importance of nutrition in an easy-to-read format.

7.1 Menus

The menu **must** meet the nutrition requirements of patients in accordance with the Nutrition Standards and Diet Specifications available at http://www.aci.health.nsw.gov.au/resources/nutrition/nutrition-food-in-hospitals/nutrition-standards-diets

Patients should be:

- given the opportunity of selecting food and fluids from the menu
- assisted with menu selection, as required, by an appropriate member of staff. This will range from staff with general knowledge of the menu and available food items to those with the skills and knowledge to guide a patient/carer to choose from the menu according to the patient's therapeutic diet order and/or the dietitian's nutrition care plan.
- able to make their menu selections no more than one day ahead of the day of service. This has been shown to enhance oral intake.

Relatives/carers can provide assistance to patients who are unable to make their own menu selections, by either making menu choices on the patient's behalf or informing staff of the patient's food preferences.

7.2 Provision of food and fluids

The diet ordering and the meal delivery systems should be efficient, timely and safe. The diet ordered for the patient should be explained to the patient and/or carers.

The number of meal occasions (mealtimes) should meet the needs of the local population and be spread out to cover most of the hours spent awake. Food should be available for patients who are admitted out of normal hours, or who are not present at ward mealtimes.

All food provided by the facility or service must comply with relevant legislative standards, including those pertaining to food safety. Systems must be in place to cater for patients at risk of sentinel events including those with dysphagia, allergies and those who are severely immunocompromised.

Where clinically possible, patients' nutrition requirements should be provided by food in accordance with endorsed nutrition standards. Appropriate access to fluids, particularly drinking water, must be provided for all patients, as clinically appropriate. Oral supplements should not substitute for, or be relied upon, to enhance the provision of food and fluid unless there are clear clinical indicators.

The following patients should be considered for oral, enteral or parenteral nutrition support:

- patients who cannot consume adequate nutrition orally to meet their nutrition requirements, including those patients on texture-modified diets,
- patients with inadequate intestinal function
- patients who are designated as 'Nil-By-Mouth' for more than three days.

Strategies **must** be in place to minimise fasting including clear guidelines outlining the specific minimum and maximum fasting times required for procedures (including when fasting is not required).

Specific nutrition concerns related to end-of-life issues should be considered according to GL2005_057 End-of-Life Care and Decision-Making – Guidelines.

8 THE MEALTIME ENVIRONMENT

Hospital routines, clinical procedures and ward rounds can disrupt mealtimes and significantly reduce patients' nutrition intake. A relaxed and pleasant mealtime environment enhances patients' enjoyment of their meals and can influence the amount of food and fluids they consume.

All staff should focus on creating a mealtime environment conducive to eating and providing feeding assistance where required during mealtimes. This includes:

- minimising interruptions to the patients' meal times such as ward/medication rounds, teaching and diagnostic procedures
- preparing patients for eating prior to the meal delivery (e.g. appropriate seating, positioning, toileting, hand washing, accessing dentures and or glasses and clearing of over-bed trolleys)
- providing patients who are able the opportunity to sit out of bed to eat their meals
- ensuring patients are able to access their food and open packaging.

For some patient groups access to a dining room for meal times may be appropriate e.g. mental health facilities and multipurpose services.

9 PROVISION OF ASSISTANCE TO EAT AND DRINK

Many patients require some form of assistance or supervision with eating and drinking. This ranges from assistance with opening packages, meal supervision to fully assisted feeding. If assistance with eating and drinking is not provided when required, patients' nutritional status may be compromised.

Independence with eating and drinking should be promoted in a safe and supportive way.

Patients should be:

- treated with respect and dignity at all times when being prepared for and receiving food and fluids
- given adequate time (at least thirty minutes) to consume their meal before the tray is collected
- provided with appropriate modifications to their meal to assist them with accessing and/or eating the meal
- provided with equipment/utensils to meet their individual needs including adaptive aids, cutlery and drinking devices.

Carers, relatives and volunteers can be involved in assisting patients to eat if deemed safe by the clinical staff and if any necessary training has been provided.

Paediatric patients (particularly the very young) require direct supervision during meal times, monitoring total intake and safe consumption. This may be provided by a parent/carer.

Wards and dining areas should be adequately staffed at mealtimes and the importance of providing timely and individualised assistance with eating and drinking should be recognised in work allocations.

A system for the development and assessment of new food products, packaging, dinnerware and cutlery for ease of accessibility and useability by patients should be in place. Such a system **must** include consultation with appropriate stakeholders (e.g. consumers).

10 STAFF EDUCATION AND TRAINING

Training and education programs enhance an understanding of the link between good nutrition care, identifying those at risk of poor nutrition, preventing malnutrition and delivering better patient outcomes.

All staff involved in nutrition care should:

- understand their role and responsibilities, and receive appropriate education and training on the key aspects of nutrition care relevant to their patient demographic, the diets available and the purpose of these diets if responsible for ordering diets
- be aware of the role of food and nutrition supporting a patient to achieve optimal nutrition, prevent malnutrition, and maximise patients' clinical outcomes and quality of life
- be aware that patients who are overweight or obese may also be malnourished
- be aware of their role in measuring and monitoring patients' weight and acting on identified risks.

Education programs on weight status assessment, nutrition care and malnutrition should be provided annually and additionally as required. Training could be provided locally or via Health Education and Training Institute.

11 EVALUATION

NSW Local Health Districts, Speciality Health Networks and other NSW public health organisations **must** have a system to evaluate the nutrition care provided. The system **must** include monitoring and reporting of the following:

- audit of weight and height/length documentation
- audit of nutrition screening and nutrition assessment
- patient experience and satisfaction with food and nutrition care
- regular feedback to staff and consumers on compliance with the Policy.

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ATTACHMENT 1: NUTRITION CARE POLICY SELF-ASSESSMENT CHECKLIST

Element	Examples of evidence	Available Resources	COMPLIANCE			Actions required	Assigned to	Target Completion date
			Not compliant	In progress	Compliant			
The LHD/SHN/Organisation has an effective nutrition care governance structure that has clinical, consumer and corporate representation in place that is appropriate for each facility.	- Terms of Reference - Minutes and Action plans - Communication to staff and consumers about the governance structure. - Clear protocols for nutrition care including weight and height/length measurement and documentation	- Templates for Terms of Reference and Agenda's: ACI Nutrition and Mental health toolkit - Engaging consumers and carers: ACI Nutrition and Mental health toolkit - Growth assessment in children and weight status assessment in adults						
There is a system in place to ensure patients undergo nutrition screening within 24 hours of admission to care and weekly using a validated nutrition screening tool (or monthly for long stay facilities e.g. multipurpose services, some rehabilitation centres, some mental health facilities).*	- Appropriate screening tool(s) are in use and supported by clear protocols. - Monitoring and evaluation plan - Audit results and action plans	- NSW Health Adult Admission form - Evidence based practice guidelines						

Appropriate equipment (such as scales, height/length measures and specialised feeding equipment) is functional, well positioned and available in clinical areas.*	- List of available equipment - Equipment audits, reports and action plans - Evidence of routine calibration							
Patients have their weight and height/length measured and documented within 24 hours of admission to care and then - weight measured weekly in the acute setting.* - weight measured monthly in long stay facilities (e.g. multipurpose services, some rehabilitation centres, some mental health facilities)	- Audits, reports and action plans - Local policy or protocol	- Adult and Paediatric Admission forms - Physical Health Care of Mental Health Consumers (GL2009_007) - NSW Health Metabolic monitoring module - Evidence based practice guidelines - Age appropriate growth charts for boys and girls						
There is a system in place to ensure patients at nutritional risk are referred to a dietitian for a full nutrition assessment. The nutrition assessment occurs within two working days of referral to the dietitian.*	- Clear referral pathways and protocols - Appropriate nutrition assessment tool(s) are in use and supported by clear protocols. - Documentation audit results, reports and action plans	- Evidence based practice guidelines						

The menu provided to patients meets the needs of the local population	The menu development and review process has considered: o Average length of stay o The demographic and cultural profile of consumers o Feedback from stakeholders including consumers (via surveys, focus groups, participation in processes etc.)	- ACI Nutrition Standards - ACI Nutrition Standards Menu review tool - ACI Nutrition Care and Food Service Data Checklist: ACI Nutrition and Mental health toolkit						
There are systems in place to ensure patients have the opportunity to select their own meals where appropriate	- Clear protocols in place - Information is provided to patients/carers about the food service - Audits, reports and action plans	- ACI ChOICES: The Patient menu selection process - ACI Food and Nutrition brochure						
Patients who need assistance with eating and drinking are identified and the level of care they need is provided.*	- Systems in place and supported by clear protocols - Audits, reports and action plans - Feeding assistance program in place	- ACI Dementia and Delirium Care Volunteer implementation and training resource - NSW Health Admitted Patient survey results (Bureau of Health Information)						
Nutrition care requirements are included in care plans, and appropriately communicated on transfer of care	- Systems in place and supported by clear protocols - Audits, reports and action plans							
There is a system in place to identify and train relevant staff in nutrition care.	- Clear protocol in place - Training program available - Training audits, reports and action plans	- HETI eLearning module: Nutrition screening for malnutrition - Weight4Kids online modules						

Nutrition care is evaluated by a range of stakeholders and the process includes: • Patient experience and satisfaction with food and nutrition care. • Multidisciplinary incident review and management	- Surveys, audits, focus groups - Meal time observations - Reports and action plans - Incident investigation or analysis	- NSW Health Admitted Patient survey results (Bureau of Health Information) - HealthShare Food Service patient satisfaction survey results - Data from Incident Management Systems						
Routine feedback is provided to staff and consumers on compliance with the Nutrition Care Policy	- Local intranet and / or internet page - Evaluation results are shared with consumers and staff and used to improve services (e.g. via newsletters, meetings, intranet sites, publications, information for consumers/ carers)							

*This element requires regular audit as part of evaluation.

NSW ABORIGINAL HEALTH PLAN 2013-2023 (PD2012_066)

PURPOSE

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

Over the next ten years the Plan provides unique opportunities for NSW Health to re-examine the best ways of working together and redesigning health services to achieve health equity.

The Plan has been developed to help guide how health systems are planned, delivered, and monitored over the next decade in relation to Aboriginal health. The success of these reforms will be dependent upon working in partnership and utilising the expertise of Aboriginal people in shared leadership arrangements and innovative collaborations.

MANDATORY REQUIREMENTS

Compliance with this policy is mandatory for all staff of Local Health Districts, Specialist Health Networks, Pillars and other NSW health related statutory authorities.

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

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

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

IMPLEMENTATION

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

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

Local Health Districts, Specialist Health Networks and the Pillars will be required to implement and report on achievements over the life of the Plan.

The Plan's strategic directions will be implemented through NSW Health funding and performance management structures. Inclusion of key performance indicators in LHD and SHN Service Agreements and Service Compacts will provide a mechanism to ensure engagement and support of the Plan by NSW Health service providers.

All Service Agreements will explicitly require services to provide a proportion of interventions for Aboriginal people.

The health of the Aboriginal people of NSW: Report of the Chief Health Officer, 2012 has been released in conjunction with the Plan. This report will be used as a baseline of the health status of Aboriginal people and health system performance. It will be reproduced every three years to identify where improvements have been made. Also, annual progress meetings will be held with the Aboriginal Community Controlled Health Services sector and NSW Health to showcase the progress made against the strategic directions and actions contained in this Plan.

To download the document please go to http://www.health.nsw.gov.au/policies/pd/2012/PD2012_066.html

NSW HEALTH & AGEING AND DISABILITY AND HOME CARE (ADHC) JOINT GUIDELINE (GL2013_001)

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

PURPOSE

The aims of the Guideline are:

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

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

KEY PRINCIPLES

The following general principles underpin the Guideline:

- Person Centred Approach
  An approach that places the person at the centre of decision making and treats natural networks of support and service providers as partners. A philosophical background based on the value of human rights, independence, choice and inclusion.
- Patient Centred Approach
  An approach that is geared towards using resources to develop a culture where the patient is both the heart of the system and the driver behind every decision.
- Communication
  Good communication between the person, their family/guardian, hospital staff and the disability support staff and sharing information about the persons health and disability support needs makes a positive difference to a person's health outcomes

- Sharing Information
  Key information that hospital staff need to know about the person and their support needs should be provided in a universally consistent format and travel with the person around the hospital for ease of access.
- Sharing Expertise
  Sharing expertise to ensure that people with disability achieve the best health care outcome is central to this Guideline.
- Capacity to consent
  It is the responsibility of the treating practitioner to determine if the person is able to give consent for medical or dental treatment. Disability Support Staff cannot provide consent for medical treatment under any circumstances.

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

USE OF THE GUIDELINE

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

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

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

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

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

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

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

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

To download the Guidelines please go to http://www.health.nsw.gov.au/policies/gl/2013/GL2013_001.html

SNAKEBITE AND SPIDERBITE CLINICAL MANAGEMENT GUIDELINES 2013 – THIRD EDITION (GL2014_005)

PURPOSE

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

KEY PRINCIPLES

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

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

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

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

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

USE OF THE GUIDELINE

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

To download the Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2014/GL2014_005.html

INSERTION AND MANAGEMENT OF URETHRAL CATHETERS FOR ADULT PATIENTS (GL2021_015)

GL2021_015 rescinded GL2015_016

GUIDELINE SUMMARY

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

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

KEY PRINCIPLES

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

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

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

USE OF THE GUIDELINE

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

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

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

The Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_015

339(31/08/21)

COMPACKS PROGRAM GUIDELINES (GL2016_023)

PURPOSE

The ComPacks Program Guideline is a resource for frontline Local Health District staff and ComPacks Service Provider staff to facilitate the implementation of the Program.

KEY PRINCIPLES

ComPacks was developed specifically for people in NSW Public hospitals who need immediate support to return home safely using a combination of community case management and non-clinical community services. A ComPacks package may include assistance with personal care, domestic assistance, transport and social support, and is available for up to six weeks from the time of discharge from hospital.

The ComPacks Program Guidelines outline the key components of the ComPacks program, including eligibility, referrals, services, assessment, stakeholder responsibilities and coordination and performance management.

USE OF THE GUIDELINE

In 2010 a resource tool kit was implemented for the ComPacks Program. The ComPacks Program Guidelines is an extension of this toolkit and is designed as a resource for frontline Health staff, Local Health District Relationship Managers, ComPacks Service Provider Case Managers and Relationship Managers. It was developed in consultation with representatives from these groups.

The Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2016_023

315(26/09/16)

CARDIAC MONITORING OF ADULT CARDIAC PATIENTS IN NSW PUBLIC HOSPITALS (IB2022_027)

IB2022_027 replaced GL2016_019

PURPOSE

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

KEY INFORMATION

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

The revised document provides further clarification on:

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

NSW CLINICAL SERVICE FRAMEWORK FOR CHRONIC HEART FAILURE (GL2017_006)

PURPOSE

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

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

KEY PRINCIPLES

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

USE OF THE GUIDELINE

Chief Executives

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

Directors of Clinical Governance and Patient Flow Managers

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

Nurse Unit Managers

- Should support their staff to implement the Framework

Nursing Staff

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

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

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

The NSW Clinical Service Framework for Chronic Heart Failure Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_006

GROWTH ASSESSMENT IN CHILDREN AND WEIGHT STATUS ASSESSMENT IN ADULTS (GL2017_021)

PURPOSE

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

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

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

The Growth Assessment in Children and Weight Status Assessment in Adults Guideline is available at
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=gl2017_021

YOUTH HEALTH AND WELLBEING ASSESSMENT GUIDELINE (GL2018_003)

PURPOSE

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

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

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

KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

USE OF THE GUIDELINE

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

This document outlines the -

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

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

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

The Youth Health and Wellbeing Assessment: Guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_003

325(01/02/18)

ESTABLISHING A SUBCUTANEOUS IMMUNOGLOBULIN (SCIG) HOSPITAL PROGRAM (GL2020_024)

GUIDELINE SUMMARY

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

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

333(27/11/20)

KEY PRINCIPLES

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

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

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

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

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

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

BloodSTAR must be used by treating clinicians to obtain authorisation for patients to receive government-funded subcutaneous immunoglobulin. Before entering patient details into BloodSTAR the treating clinician must obtain the patient's consent to do so.

In addition, patient consent is required before the patient is treated with SCIg. BloodNet must be used to order SCIg, to replenish SCIg imprest, to receipt the product and to record SCIg dispensing episodes.

There is no prescriptive dispensing arrangement for SCIg but the product must be dispensed by a pharmacist and recorded by them in iPharmacy. The dispensing arrangement that a facility proposes to adopt must be endorsed by the District Drug and Therapeutics Committee and the Blood Management Committee (or their equivalents) and approved by the District Director of Pharmacy (or equivalent).

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

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

Establishing a SCIg hospital program guideline is available at https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2020_024

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL'S NATIONAL GUIDELINES FOR DRINKING ALCOHOL (IB2021_001)

PURPOSE

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

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

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

KEY INFORMATION

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

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

Main changes to the revised guidelines are:

Guideline 1: Adults

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

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

Guideline 2: Children and people under 18 years of age

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

Guideline 3: Women who are pregnant or breastfeeding

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

CLINICAL PRINCIPLES FOR END OF LIFE AND PALLIATIVE CARE (GL2021_016)

GUIDELINE SUMMARY

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

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

KEY PRINCIPLES

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

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

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

USE OF THE GUIDELINE

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

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

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

Districts and Networks are to use this Guideline to:

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

The Guideline is available at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_016

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339(06/09/21)

DOMESTIC VIOLENCE ROUTINE SCREENING (PD2023_009)

POLICY STATEMENT

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

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

SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

347(03/04/23)

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

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

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

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

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

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

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

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

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

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

The full Domestic Violence Routine Screening policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_009