

**To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.**

## CHAPTER 6 – EMERGENCY CARE

### TABLE OF CONTENTS

	<b>PD/IB/GL NUMBER</b>
Emergency Department Patients Awaiting Care	<a href="#"><u>PD2018_010</u></a>
Emergency Department - Notification of Specialist or VMO Regarding Patients Admitted Through the ED	<a href="#"><u>GL2011_003</u></a>
Triage in NSW Emergency Departments	<a href="#"><u>PD2013_047</u></a>
Emergency Department – Direct Admission to Inpatient Wards	<a href="#"><u>PD2009_055</u></a>
NSW Rural Adult Emergency Clinical Guidelines	<a href="#"><u>GL2022_004</u></a>
Responding to Sexual Assault (adult and child) Policy and Procedures	<a href="#"><u>PD2020_006</u></a>
Domestic Violence - Identifying and Responding	<a href="#"><u>PD2006_084</u></a>
Domestic Violence – Men’s Behaviour Change Programs	<a href="#"><u>IB2014_003</u></a>
Domestic and Family Violence Migration Regulations: Relevance for Health Workers	<a href="#"><u>IB2018_017</u></a>
New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)	<a href="#"><u>PD2014_012</u></a>
Major Incident Medical Services Supporting Plan	<a href="#"><u>GL2018_017</u></a>
Mass Casualty Triage Pack – SMART Triage Pack	<a href="#"><u>PD2017_037</u></a>
Closed Head Injury in Adults – Initial Management	<a href="#"><u>PD2012_013</u></a>
NSW Paediatric Clinical Care and Inter-Hospital Transfer Arrangements	<a href="#"><u>PD2023_019</u></a>
Departure of Emergency Department Patients	<a href="#"><u>PD2014_025</u></a>
Critical Care Tertiary Referral Networks & Transfer of Care (Adults)	<a href="#"><u>PD2018_011</u></a>
Autonomic Dysreflexia (Revised) – Safety Notice 014/10	<a href="#"><u>SN:014/10</u></a>
Maternity –Resuscitation of the Newborn Infant	<a href="#"><u>GL2018_016</u></a>
Hospital Response To Pandemic Influenza Part 1: Emergency Department Response	<a href="#"><u>PD2007_048</u></a>
Public Health Real-Time Emergency Dept Surveillance System (PHREDSS) Public Health Unit Response	<a href="#"><u>GL2010_009</u></a>
Retrieval Handover (Adults)	<a href="#"><u>PD2012_019</u></a>
Emergency Department Short Stay Units	<a href="#"><u>PD2014_040</u></a>
Emergency Department, Nurse Delegated Emergency Care, Medication Standing Orders	<a href="#"><u>PD2015_024</u></a>
Safe Assessment Rooms	<a href="#"><u>GL2020_001</u></a>
Early Evidence Collection	<a href="#"><u>GL2022_010</u></a>
Managing non-fatal strangulation in the emergency department	<a href="#"><u>IB2023_038</u></a>

**EMERGENCY DEPARTMENT PATIENTS AWAITING CARE (PD2018\_010)**

**PD2018\_010 rescinds PD2010\_075.**

**PURPOSE**

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

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

This Policy does not seek to outline the triage process – please refer to NSW Health policy [PD2013\\_047 Triage of Patients in NSW Emergency Departments](#) for information on triage in NSW.

**MANDATORY REQUIREMENTS**

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

- This Policy applies to all adult and paediatric patients, following triage in the ED waiting for clinical care to commence and/or medical assessment, regardless of their location.
- In addition to the parameters of this Policy; people brought to the ED involuntarily for the purpose of initial health assessment, care and treatment, will be cared for in accordance with the relevant legislative framework for example The Mental Health Act 2007 (NSW) or the Crimes (Administration of Sentences) Act 1999.
- Undifferentiated patients can be at risk of deterioration – for those located in the waiting room, lack of supervision adds to this risk. Ensuring the safety of patients in the waiting room is the responsibility of the senior medical and nursing staff in charge of the shift.
- The ED waiting room should be a pleasant, safe environment where patients, families and carers can be comfortable. When designing or redesigning ED waiting rooms, emphasis should be on ensuring that adequate signage, a culturally appropriate setting and access to toilets and refreshments are accommodated.
- Regular communication with waiting patients is essential, particularly in relation to ED processes and waiting times. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified.
- Patients waiting for clinical care to commence and those accompanying them may become frustrated, particularly in the absence of regular communication. Local practices that focus on taking action to recognise and respond to escalating behaviour are safer, for both patients and staff, than those that rely solely on managing behaviour that has already become aggressive or violent.
- NSW Health has a zero tolerance policy<sup>2</sup> to violence and aggression where, as far as reasonably practicable, action will be taken to prevent and mitigate aggressive behaviour and violence. Appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour, while ensuring clinical services continue to be provided.

298(16/03/18)

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

<sup>2</sup> NSW Health Policy 2015 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach (available at [http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015\\_001](http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015_001) )

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

### **IMPLEMENTATION**

Local Health District Chief Executives are responsible for:

- i. Assigning responsibility, personnel and resources to implement this policy.
- ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for patients awaiting care. This should include nomination of an executive sponsor to support staff responsible for implementation of this policy.
- iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management, and clinical staff.

## **Emergency Department Patients Awaiting Care Procedures**

### **1. BACKGROUND**

#### **1.1 About this document**

This Procedure document supports and further explains the mandatory requirements of the Emergency Department Patients Awaiting Care policy statement through the following components:

- The waiting room environment; including safety.
- Procedure for managing waiting patients; including communication, assessment and escalation of care.
- Guidance on patients who arrive with other services staff such as NSW Police, NSW Ambulance and custodial officers.
- Patients who decide not to wait for treatment.

This procedure applies to all patients, following triage in the emergency department (ED) awaiting clinical care to commence and/or medical assessment, regardless of their location.

**Key definitions**

Key Definitions are only included in this section where there may be multiple uses for terminology used and so detailed here to provide clarification on the use in this document.

<b>Absconding Patient</b>	For the purposes of this document, an absconding patient refers to an involuntary patient detained under the Mental Health Act 2007 or the Mental Health Forensic Provisions Act, who leaves an Emergency Department, without permission, or a voluntary patient who leaves an Emergency Department who is considered at risk.
<b>Did Not Wait</b>	Refers to a patient who decides not to wait for clinical care to commence or medical assessment following triage in the emergency department
<b>Medical assessment</b>	For the purposes of this document, medical assessment also indicates assessment by a Nurse Practitioner
<b>Transfer of Care</b>	Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to an emergency department clinician. Transfer of Care is deemed complete when clinical handover has occurred, the patient has been offloaded from the ambulance stretcher and the care of the paramedics is no longer required.

**2. THE WAITING ROOM ENVIRONMENT****2.1 Waiting room design**

Waiting rooms are areas specifically for patients, families and carers before and after clinical care. Waiting rooms that are not comfortable have been demonstrated to play a key role in patients leaving the ED before treatment<sup>3</sup>. In light of this, specific attention should be given to the design of the waiting room including making modifications and improvements. Waiting areas should not be cluttered with posters and unnecessary signs as this creates confusion for those visiting the ED.

The waiting room should be well lit with access to natural light if possible.

If able to be accommodated; EDs and waiting rooms should be designed with unobstructed views of the entrances and exits. An open plan design allows staff to visually monitor the movements within and outside the waiting room as well as changes in patients' conditions. Similarly waiting room and triage staff should be visible to patients and relatives in the waiting room, which then allows patients to interact with staff when they have concerns and updates. An open visual environment allows staff to quickly assess the waiting area at any given time. Reception and triage areas should have convex mirrors or CCTV in place to ensure reception and triage staff can see all parts of the waiting room.

The use of different coloured seating or different areas of seating as a visual cue indicating where the patient is in the triage process may be used. Chairs should be comfortable, easy to clean and robust. Consideration should be given to multimedia activities that can provide some distraction in the waiting room including the use of televisions and videos. Consideration should also be given to provision of a mobile device charging station.

For further guidance on waiting room design and NSW requirements please see Chapter 15 of [Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#). Additionally, information is available in the [Australasian Health Facility Guidelines – Emergency Unit](#) document.

298(16/03/18)

<sup>3</sup> Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? Emerg Med J 2011, 28: 945-947

### 2.1.1 Wayfinding

Clearly visible wayfinding solutions directing patients, families and carers to the various areas within the ED must be used. Wayfinding plays a major role in the coordination of safety, process and patient flow in the ED<sup>4</sup>.

Wayfinding solutions should be in culturally specific languages of the cultural groups that predominately access the hospital's services. It should include the use of universal pictorial symbols and also consider the use of braille symbols.

### 2.1.2 Access to toilets and refreshments

EDs should make provision for adequate access to toilets and refreshments within or in close proximity to the ED. Facilities for people with a disability, parents with babies and young children should also be factored into the design and location of the toilets and refreshments. Larger EDs should consider access to cafes and vending machines thereby providing 24 hour access to refreshments. Smaller EDs may have access to vending machines or other means of providing refreshments.

The NSW Health Framework '[Healthy food and drink in NSW Health facilities for staff and visitors](#)' provides best practice guidelines to increase the availability of healthy options to make the healthy choice an easy choice for our staff and visitors. It provides guidance on appropriate options in vending machines (e.g. no sugary drinks and including everyday snacks such as dried fruit or lightly salted nuts).

The positioning of both toilets and refreshments is important and the design should not impede the flow and movement within the waiting room.

### 2.1.3 Considerations for Aboriginal patients

[Section 4.1](#) acknowledges the higher rates of Aboriginal patients who choose not to wait for treatment in ED when compared to non-Aboriginal patients. An important contributor to this issue is Aboriginal patients feeling safe to stay and wait. The use of local Aboriginal art in ED waiting rooms can provide links to culture and community; advice should be sought on appropriate art from the local Aboriginal community. If available in the hospital, relatives may access the designated Aboriginal waiting room for families and carers. If no room exists, a culturally appropriate space within the local hospital should be identified.

Patients identifying<sup>5</sup> as Aboriginal people should be provided with information regarding access to Aboriginal Health Workers that may be available. Access to any of these services may include referral pathways for patients that present out of business hours.

### 2.1.4 Cultural and age appropriate considerations

EDs should seek to cater for all community specific needs; this will be based on the demographic of the local population and will include information in languages other than English that relate to the local community's needs.

Ideally there should be a dedicated waiting area for children that is easily observable by staff, and where possible with age appropriate play equipment. Where there is not a separate waiting area, there should be processes in place that, where possible, children can be fast tracked out of the waiting room area. Art that specifically caters to the engagement of children should be considered.

298(16/03/18)

<sup>4</sup> NSW Health publication 2008 Practical steps to improving Emergency Department signage (available at [http://internal.health.nsw.gov.au/pubs/2008/pdf/ed\\_signage.pdf](http://internal.health.nsw.gov.au/pubs/2008/pdf/ed_signage.pdf))

<sup>5</sup> NSW Health policy PD2012\_042 Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012\\_042.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_042.pdf))

**2.2 Waiting room personal safety****2.2.1 Organisational safety factors**

Procedures to identify and manage risks in the clinical environment must be developed and implemented, in consultation with staff and other duty holders. For more information see [NSW Health Protecting People and Property - Policy and Standards for Security Risk Management in NSW Health Agencies](#).

The occurrence of an incident of aggressive behaviour is to be reported and reviewed with the required timeline in accordance with the [PD2014\\_004 Incident Management Policy](#) and local management procedures.

**2.2.2 Environmental safety factors**

Factors for consideration when assessing potential risks in ED waiting rooms include:

- Areas of first contact should be designed to prevent unauthorised entry and provide security and protection for staff members, patients and visitors while still allowing good communication.
- Main public entry access doors must be able to be secured and fitted with Closed Circuit Television (CCTV) cameras and intercom systems for after-hours access and be able to be secured remotely.
- Procedures and physical design/layout must reflect the specific risks identified for that ED environment, ensuring effective and safe access and egress from the ED.
- Consideration should be given to any objects or furniture that may be used to cause injury. Objects like this should be fixed appropriately e.g. television screens and brochure stands.
- Consideration should be given to the installation of physical barriers to aggression such as security screens for triage and clerical staff and must be appropriate to the environment, i.e. provide protection for staff but not reduce the ability for patients or their carers to clearly communicate with staff.
- Triage, reception, and interview rooms must include duress alarms, fixed and/or mobile alarms as appropriate. All staff working in EDs must have and wear a mobile duress alarm.
- Triage, reception and interview rooms must have two doors to allow for appropriate access and exit and where possible have doors that swing outwards.
- Access to clinical areas from the waiting room must be controlled, e.g. doors are secured by swipe card access, with entry by permission of clinicians.

When patients presenting to an ED are considered to be at risk, or who have a particular security need, a risk assessment to identify and address the identified security risks must be undertaken. These patients may include (but are not limited to):

- victims of sexual assault<sup>6</sup>
- victims of domestic violence<sup>7</sup>
- patients affected by the use of drugs or alcohol
- patients with mental illness or mental disorder
- patients in custody
- patients who are confused or cognitively impaired
- patients with developmental disability
- children at risk of harm<sup>8</sup>.

298(16/03/18)

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<sup>6</sup> NSW Health Policy PD 2005\_607 Sexual Assault Services Policy and Procedure Manual (Adults) (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005\\_607.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_607.pdf))

<sup>7</sup> NSW Health Policy PD2006\_084 - Identifying and Responding to Domestic Violence, Section 12.1 Emergency Departments (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2006\\_084.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2006_084.pdf))

**2.2.3 Response to escalation**

Where patients, or their carers/guardians, present a known risk to the health and safety of staff or others, a patient alert (or file flag) should be added to the health care record. Where a patient alert is added there must be an up to date management plan documented in the health care record to ensure those staff managing the presenting individual can do so in a safe and appropriate manner. Information on current individuals with patient alerts must be highlighted during clinical handover.

Staff should use de-escalation techniques to prevent and address escalating behaviour. Where de-escalation is not successful or a staff member continues to feel unsafe, the following actions should occur:

- Use of personal space and environmental awareness to keep safe.
- Calling for back up from colleagues, including from more senior staff.
- Activating duress alarms to alert the duress (code black) response.
- Scanning the environment for dangerous items.
- Identifying exits.
- Activating the process for calling the police where a matter involves a weapon or continues to escalate.

Where a duress alarm is activated summoning the organised response, the duress response team must be multi-disciplinary and led by clinicians with assistance by security staff if necessary. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

**2.2.4 Education and Training**

Staff working in or moving through ED waiting rooms must maintain awareness of personal safety at all times. All staff are responsible for engendering a workplace health and safety culture. Staff working within the ED setting are to be provided with training, consistent with the standards set out in [PD2017\\_043 Violence Prevention and Management Training Framework for NSW Health Organisations](#), to ensure they are equipped to de-escalate or manage violent/aggressive behaviour. This training must include team based training.

**3 CARING FOR WAITING PATIENTS****3.1 Customer Service Approach for frontline ED staff**

Frontline ED staff includes reception, triage, nursing, medical, porters and allied health staff who interact with patients at all stages of their journey. These staff are often the first contact patients and their families/carers will have with the health system and hospital; a specific focus on patient experience, customer service and welcoming, caring communication is an important part of their role.

Education resources such as online learning, videos and locally delivered resources which allow for simulation training should be provided (at state and local level) and will support the maintenance of a high standard of interaction with all patients by staff.

Utilising a customer service approach in ED reception areas will also assist in minimising common issues in ED such as patients who “Did Not Wait” for treatment, escalating behaviour and patient dissatisfaction with their ED experience. Review of these types of incidents in NSW EDs is often traced back to unclear or perceived uncaring interactions with staff at the beginning of the patient’s journey.

Local investment in real time opportunities for patients, families and carers to provide feedback on their ED experience should be considered.

298(16/03/18)

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<sup>8</sup> NSW Health Policy PD2013\_007\_Child Wellbeing and Child Protection Policies and Procedures for NSW Health (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013\\_007.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf))

**3.2 Communication with waiting patients and families/carers**

Patients and families/carers should have access to information outlining the ED process, including information brochures and/or audio visual information. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified<sup>9</sup>.

Patients from culturally and linguistically diverse backgrounds and patients with a disability should be provided with specific information regarding their ED stay including access to Social Workers and interpreters.

Patients and families/carers should be provided with regular, ongoing communication regarding changes to waiting times and their management. In many cultures, family members have a specific role or responsibility to carry out on behalf of the family member in the ED and these needs should be understood and accommodated where possible by ED staff. Patients may be informed of alternatives to ED care for their condition for example, general practitioner and medical centres if clinically appropriate.

Patients must be encouraged to speak with the triage/waiting room nurse prior to leaving the ED prior to medical assessment.

All communication should be documented in the patients' health care record.

**3.3 Assessment of waiting patients following triage**

Clinical care may commence whilst the patient is in the waiting room. Patients may be identified by the triage nurse as appropriate for initiation of care according to locally endorsed and statewide clinical pathways.

Regular reassessment of patients should occur, particularly if they wait longer than the allotted triage category time. This may include regular visual observation and haemodynamic observations where appropriate.

Documentation of the initiation of care and patient assessment must be completed in the patient health care record.

ED processes should facilitate early contact with senior medical and nursing decision makers to ensure that relevant tests are ordered and treatment commenced as soon as possible after arrival.

The waiting room nurse or Clinical Initiatives Nurse (CIN) (where these roles exist) should be responsible for the regular reassessment and initiation of care of waiting room patients. The CIN may function under the direction of the triage nurse or according to local policies. Where there is no CIN or waiting room nurse, local processes must be in place to ensure safety of patients in the waiting room.

High risk patients should be positioned in a highly visual area of the waiting room and moved to an appropriate clinical area as soon as possible. This may include patients at risk of harm to themselves/others or at risk of absconding. Vulnerable patients including children or elderly patients or those unable to self advocate in the waiting environment must to be allocated to an area of the ED where appropriate supervision by ED staff is available.

Staff should be trained on how to identify patients at risk of highly contagious infectious diseases and to quickly isolate patients and/or provide masks and other personal protective equipment to prevent the spread of disease.

298(16/03/18)

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<sup>9</sup> NSW Health Policy PD2017\_001 Responding to Needs of People with Disability During Hospitalisation (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017\\_001.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_001.pdf) )



### **3.4 Escalation of care for waiting patients**

Recognition of a patient's deterioration may occur through patients, families, carers and ED staff who assess the patient following triage.

Deterioration in condition may be recognised through:

- Physiological abnormality including falling or trending 'outside of the flags' on the standard patient observation chart.
- New or progressive clinical symptoms that require more urgent medical review.
- Deterioration in mental state.
- Escalation in behaviour.
- Patient, family or caregiver concern.

Any waiting patient whose condition deteriorates should be managed in accordance with the local clinical emergency response system processes<sup>10</sup> including notification to senior ED clinical staff and documentation in the health care record.

Patients and families/carers should be informed of how to contact a staff member should they feel that the patient's condition is deteriorating whilst waiting for care to commence.

Should a patient or visitor who deteriorates in the waiting room need assistance to a more appropriate location manual handling must be in accordance with Work Health and Safety safe working practices.

### **3.5 Patients arriving with other services staff**

#### **3.5.1 Patients who arrive by ambulance**

The ED is responsible for the overall clinical management of any patient transported by ambulance as soon as the patient enters the department<sup>11</sup>. The following principles apply for these patients:

- Local strategies should be in place to support early offload of ambulances.
- Local systems should be implemented to monitor the number of patients in the ambulance bay to assist in quality care delivery, safety and patient flow.
- Clinical care should commence in accordance with locally endorsed or statewide clinical pathways as appropriate.
- Following triage, patients suitable to be transferred into the waiting room are to be offloaded and appropriate clinical handover undertaken.
- Patients remaining on an ambulance stretcher for longer than 30 minutes or who have escalating care requirements are to be managed according to local clinical emergency response system processes.
- If a delay in Transfer of Care of the patient between paramedics and ED clinicians occurs, a shared care responsibility exists for monitoring and communicating changes in the patient's clinical condition, between Ambulance and ED staff. The triage nurse should inform the Paramedic of an appropriate staff member to contact should the patient deteriorate whilst on the stretcher.

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<sup>10</sup> NSW Health Policy PD2013\_049 Recognition and Management of Patients who are Clinically Deteriorating (available [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013\\_049.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_049.pdf))

<sup>11</sup> ACEM Statement of Responsibility for Care in Emergency Departments (2012) <http://www.acem.org.au/getattachment/1e5b1137-43b5-4304-af42-de4c00884d01/Statement-on-Responsibility-for-Care-in-Emergency.aspx>

- A joint risk assessment should be undertaken by ED clinical staff and paramedics for patients with mental health issues who have been voluntarily brought to the ED but for whom presenting paramedics have safety concerns.
- All care is to be documented in the patient's health care record.

### **3.5.2 Patients who arrive with Police**

For people presenting in Police custody or detained under the Mental Health Act/ Mental Health Forensic Provisions Act, Police are to provide a comprehensive verbal handover to the triage nurse or assessment clinician. The handover discussion should focus on:

- Facilitating the effective and safe management of the person.
- Maintaining the safety of staff, other patients and visitors.
- Include a risk assessment of the likelihood of the person's behaviour escalating to become a safety issue; particularly once any mechanical restraints are removed and/or police withdraw.

These processes will assist with expediting handover of patients to ED staff from Police at the earliest opportunity.

Presenting police are to clearly communicate with clinical staff whether to notify police prior to the person being discharged from the ED. ED staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers.

People brought to the ED under the Mental Health Act by Police are not to be handed over to NSW Health security staff only. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

### **3.5.3 Patients who arrive with custodial officers**

Patients arriving from custody should be assessed and managed in the same manner as other patients. If a private section of the ED is available, they should wait there with custodial officers. ED staff can contact Justice Health & Forensic Mental Health Network (JH&FMHN) clinicians if required, especially for those custodial patients requiring ongoing nursing care on discharge, as many custodial sites do not have 24 hour nursing care. Patients transferred from an adult correctional or juvenile justice centre will have a letter with them titled 'Information for Hospital Staff: Healthcare for People in Custody' including contact phone numbers.

## **4 PATIENTS WHO DECIDE NOT TO WAIT FOR TREATMENT**

The term "did not wait" (DNW) or equivalent is used to describe patients who leave whilst awaiting clinical care or medical assessment to commence. These patients have been triaged and may or may not have had initial nursing assessments and observations as part of the triage process. DNW patients represent an important subset of the ED patient population in relation to quality of care for both access to and the process of ED care delivery<sup>12</sup>.

Signage must be prominently placed in ED waiting areas advising patients to notify the triage staff if they leave the ED whilst awaiting clinical care to commence or medical assessment.

ED clinical staff should discuss the safety implications of leaving without being medically assessed with the patient and family/carers. Communication of safety implications should be in line with guidance in Section [3.1 Communication with waiting patients and families/carers](#). A senior clinician must be notified of any concerns about patient's safety. Documentation of conversations with the patient, family/carers and senior clinician is to be recorded in the patient's health care record. 298(16/03/18)

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<sup>12</sup> EMERGENCY MEDICINE — RESEARCH The Medical Journal of Australia ISSN: 0025-729X 3/17 December 2007 187 11/ 12 626-629 ©The Medical Journal of Australia 2007 [www.mja.com.au](http://www.mja.com.au)

Notification to a senior ED clinician and documentation should also be undertaken if the triage nurse is concerned for patients who choose to leave without notifying staff.

Health practitioners should be mindful of their obligations with regard to Section 27 of the Children and Young Persons (Care and Protection) Act 1998, which requires mandatory reporting by health care workers where there are reasonable grounds to suspect a child is at risk of significant harm.

Health practitioners should also be mindful of whether the Mental Health Act provisions may be applied to the patient. Involuntary patients detained under the Mental Health Act who have absconded are able to be apprehended and returned to the ED in accordance with the Act. Notification of incidents should be as per [PD2014\\_004 Incident Management Policy](#)

#### **4.1 Monitoring of rates of patients who ‘Did not Wait’**

EDs should maintain a local auditing system to monitor trends in rates of DNW. Review of data should also be undertaken by Aboriginal and non-Aboriginal patients as there is significant evidence in the literature of higher rates of DNW among Aboriginal patients presenting to ED<sup>13</sup> <sup>14</sup>. Addressing this issue is in line with the Australian Commission on Safety and Quality in Healthcare’s guidance on [Improving care for Aboriginal and Torres Strait Islander People](#).

Locally designed strategies to manage identified reasons for patients who DNW should be implemented with outcomes reviewed. Consideration may be given to follow up of patients who DNW who are considered to have high risk issues or are from a vulnerable patient group.

### **5 LIST OF RELATED DOCUMENTS**

- PD2012\_022 Maternity - Management of Early Pregnancy Complications (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012\\_022.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_022.pdf) )
- PD2010\_034 Children and Adolescents- Guide for care in Acute care settings (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010\\_033.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_033.pdf) )
- PD2015\_004 Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint (available at [http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015\\_004](http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015_004) )

298(16/03/18)

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<sup>13</sup> Tropea J, Sundararajan V, Gorelik A, Kennedy M, Cameron P, Brand CA. Patients who leave without being seen in emergency departments: an analysis of predictive factors and outcomes, *Acad Emerg Med*. 2012 Apr;19(4):439-47

<sup>14</sup> Wright, L. 2009 “They just don’t like to wait”—A comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment or discharged against medical advice from rural emergency departments: Part 1 AENJ, vol 12 (3) 78-85

**EMERGENCY DEPARTMENT - NOTIFICATION OF SPECIALIST OR VMO REGARDING PATIENTS ADMITTED THROUGH THE ED (GL2011\_003)**

**GL2011\_003 rescinds GL2005\_026.**

**PURPOSE**

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

**KEY PRINCIPLES**

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

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

**USE OF THE GUIDELINE**

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

The Guideline can be downloaded at [http://www.health.nsw.gov.au/policies/gl/2011/GL2011\\_003.html](http://www.health.nsw.gov.au/policies/gl/2011/GL2011_003.html)

119(10/02/11)

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**TRIAGE IN NSW EMERGENCY DEPARTMENTS (PD2013\_047)**

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**PD2013\_047 rescinds PD2008\_009.**

**PURPOSE**

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

This policy does not seek to outline the clinical components of this process; clinical information related to triage is as indicated by the Australasian College for Emergency Medicine's (ACEM) policy<sup>15</sup> and guideline<sup>16</sup> on triage and the College of Emergency Nursing Australasia (CENA) Position Statements on Triage.<sup>17,18</sup>

This policy should be read in conjunction with NSW Health Policy [PD2010\\_075 Emergency Department Patients Awaiting Care](#)

**MANDATORY REQUIREMENTS**

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

196(12/12/13)

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15 ACEM Policy on the Australasian Triage Scale <http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx>

16 ACEM Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments <https://www.acem.org.au/getattachment/d19d5ad3-e1f4-4e4f-bf83-7e09cae27d76/G24-Implementation-of-the-Australasian-Triage-Scale.aspx>

17 CENA Position Statement: Triage Nurse [http://www.cena.org.au/wp-content/uploads/2014/10/CENA\\_Position\\_Statement\\_Triage\\_Nurse.pdf](http://www.cena.org.au/wp-content/uploads/2014/10/CENA_Position_Statement_Triage_Nurse.pdf)

18 CENA Position Statement: Triage and the Australasian Triage Scale [http://www.cena.org.au/wp-content/uploads/2014/10/2012\\_06\\_14\\_CENA\\_-\\_Position\\_Statement\\_Triage.pdf](http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf)

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

## **IMPLEMENTATION**

Local Health District and Specialty Health Networks are responsible for:

- i. Assigning responsibility, personnel and resources to implement this policy.
- ii. Establishing mechanisms to ensure that the essential criteria are applied, achieved and sustained as usual processes for triage; this should include nomination of an executive sponsor.
- iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with responsible executive, Clinical Governance unit, ED senior management, and senior clinical staff.
- iv. Providing opportunity for Registered Nurses to complete local triage education programs; ensure adequate supervision for Registered Nurses learning the triage role and demonstrate local processes for the ongoing evaluation of triage practice.

## **1. BACKGROUND**

### **1.1 About this document**

Triage is an essential function of an Emergency Department (ED) and must be the first interaction a patient has in the ED. This Procedure Document supports and further explains the mandatory requirements of the *Triage in NSW Emergency Departments Policy* through the following components:

- The purpose and role of Triage.
- Use of the Australasian Triage Scale.
- Re-triage of patients with deteriorating conditions.
- Triage location and safety requirements.
- Triage education.
- Triage of Ambulance patients.
- Telephone advice.
- Mass Casualty Disaster and Triage.

### **1.2 Key definitions**

For the purpose of the Policy Statement and this Procedures Document, the following definitions apply:

#### **Acuity:**

Acuity is a synonym for urgency, and they can be used interchangeably. An acuity-based description should answer the question: “This patient should wait for assessment and treatment by a treating clinician no longer than....”.

#### **Australasian Triage Scale (ATS):**

The Australasian Triage Scale (ATS) is a 5-point scale that is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is used to help sort patients by clinical urgency.

**Competency:**

Competency refers to the consistent application of knowledge and skill to the standard of performance required in the workplace. It is also the ability to consistently perform work activities; applying skills and knowledge; to agreed standards over a range of contexts and conditions.<sup>19</sup>

**Complexity:**

Complexity relates to the difficulty of the presenting problem and the resources involved in finding a solution to the problem. A low ATS category with a highly complex problem may consume more resources and workload than a high urgency but low complexity presentation.

**Emergency Triage Education Kit (E TEK):**

The Emergency Triage Education Kit (E TEK) is a teaching resource that aims to provide a consistent approach to the educational preparation of Australian emergency clinicians for the triage role. In particular the E TEK has been designed to promote the correct use of the ATS. The E TEK can be accessed via:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents>

**Re-triage:**

The process of re-triage involves an assessment of the waiting patient who has not been assessed by a clinician responsible for care within the time frame allocated by the initial triage category. The purpose of re-triage is to identify and escalate the care of a patient whose condition is deteriorating, reassign an appropriate triage category and prioritise clinical resources to manage the patient.

**Streaming:**

Streaming is a predetermined method of allocating patients to a particular treatment cohort during the triage process based on specific criteria. Such criteria may include urgency or complexity, age or presenting problem. Streaming may include allocation to a specific area within the ED, a specific set of resources (eg. medical and nursing teams) or to a patient service external to the ED (eg. specialty clinic). The practice of streaming patient presentations from the point of triage into appropriate care areas is shown to result in improvements in waiting times and ED length of stay.

**Transfer of Care:**

Transfer of Care in this policy refers to the NSW Health key performance indicator of the percentage of patients arriving by ambulance whose care is transferred from paramedics to ED staff within 30 minutes of arrival. Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to a hospital clinician.

**Triage:**

Triage is the process of assessment of a patient on arrival to the ED to determine the priority for medical care based on the clinical urgency of the patient's presenting condition. Triage enables prioritisation of limited resources to obtain the maximum clinical utility for all patients presenting to the ED. The triage nurse applies an Australasian Triage Scale category in response to the question: "This patient should wait for assessment and treatment by a treating clinician no longer than....".

### 1.3 Legal and legislative framework

**Duty of Care**

By engaging with a patient as they present to the ED, the Triage Nurse enters into a health professional-patient relationship. The Triage Nurse shares the responsibility of the hospital to ensure that patients who present to the ED are offered an appropriate assessment of their urgency of treatment requirements.

196(12/12/13)

<sup>19</sup> <http://www.hwa.gov.au/sites/uploads/national-competency-report-final-20120410.pdf>

All nurses should have an understanding of basic legal principles, which include consent, the elements of negligence, definition and sources of the standards of care, and how policies and guidelines can influence practice to maximise patient safety. There is an expectation that the Nurse performing the role of triage will have adequate experience, training and supervision to perform the role. The employing institution also has a responsibility to ensure that triage staff are adequately prepared to perform the role.

### **Patients who ‘Did Not Wait’ for treatment following Triage**

Patients may choose to leave the hospital without being seen by the treating clinician in the ED; if the patient is competent, the Triage Nurse cannot prevent them from leaving. However, the Triage Nurse has a responsibility to advise the patient of the consequences of such a decision, and appropriate documentation recording this event should be completed (see ‘Documentation’ section below). Issues must be escalated to the appropriate senior ED clinician in charge of the department as required.

Patients who have a cognitive impairment (e.g. from drug use, alcohol use, a head injury, mental illness, delirium or patients at risk of suicide or with self-harm ideation) are at risk from adverse events in such situations. The Triage Nurse must therefore consider their duty of care in such cases. The Triage Nurse must be aware of and fulfil his or her responsibilities with these patients and abide by any local policies or protocols. For the purposes of triage, a rapid re-triage and/or escalation to senior ED staff may be indicated.

### **Documentation**

Medical records are a method of communication for health care team members and are a contemporaneous record of events. They must be accurate, clear and succinct. It is also expected that the records will be easily accessible and able to be understood<sup>20</sup>.

Minimum information that is required to be recorded for any triage episode include the following:

- Date and time of triage assessment.
- Name of the Triage Nurse.
- Presenting problem.
- Relevant clinical assessment findings and limited relevant history.
- Initial triage category allocated.
- Area the patient is allocated or streamed to within the ED.
- Diagnostic, first aid or treatment initiated at triage.
- Type of visit code.

Any change in the patient’s condition prior to being seen by the treating clinician must be documented clearly. If re-triage is required; documentation should include:

- The time of re-triage.
- Reason for the re-triage.
- Information about escalation of the patient’s change in condition to relevant senior ED staff.

Documentation regarding patients that choose to leave the ED without treatment should detail as much information as is available, including the following:

- Information given to the patient or carer regarding the need to stay for treatment.
- Advice given regarding alternative or ongoing care.

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<sup>20</sup> NSW Health Policy 2012\_069 Health Care Records – Documentation and Management available [http://www.health.nsw.gov.au/policies/pd/2012/PD2012\\_069.html](http://www.health.nsw.gov.au/policies/pd/2012/PD2012_069.html)



- The name and position of the clinician that concerns were escalated to.
- The patient's condition on departure.
- The time that the patient left.
- Any action that was taken subsequent to the patient leaving.
- Any other relevant information.

## **2. COMPONENTS OF THE TRIAGE PROCESS**

### **2.1 The Purpose and role of Triage**

Triage is a critical component in the delivery of emergency care, and is the first point of contact and assessment in the patient's ED journey.<sup>21</sup> The purpose and role of triage is to first identify patients with life-threatening or emergency conditions and initiate appropriate interventions (eg. emergency first aid as per local protocols), then second, allocate the patient to an appropriate area or stream within the ED.

ED and Hospital processes must support the ability of triage to be carried out within five minutes so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED.

Triage is used to determine the patient's clinical urgency; it is not an indicator of complexity of the patient's condition and should not be used as a substitute for this.

Triage involves rapid patient assessment, interpretation of the clinical history and physiological assessment, while objectively discriminating between the ATS categories of urgency. Triage decision-making is inherently complex, made under conditions of uncertainty and with limited or obscure information.

Assessment of clinical urgency is achieved by observation of general appearance, collection of a focused history to identify presenting problem and clinical risk and collections and interpretation of physiological data using a primary survey approach.

It is the responsibility of the Triage Nurse to escalate and engage further assistance from senior ED clinical staff where appropriate.

It is recognised that the triage process relates to managing the queue of patients who present for treatment. Currently this is done consistently by Triage Nurses, however EDs may choose to implement strategies to manage the queue according to local needs (for example, decision making clinicians seeing patients immediately on arrival to the ED).

It is important that the Triage Nurse is competent in identifying and promoting cultural safety for patients that are triaged including access to interpreter services, notification of Aboriginal Liaison Officers where appropriate and is able to access culturally appropriate information regarding triage and the waiting room for patients.

### **Use of the Australasian Triage Scale**

In all NSW EDs, emergency nurses perform the triage role using the ATS. The ATS is a five-point scale used to prioritise patients. An ATS category from one to five is allocated according to the maximum time the Triage Nurse determines the patient can wait for emergency care.

196(12/12/13)

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<sup>21</sup> Hodge, A., et al., *A review of the quality assurance processes for the Australasian Triage Scale (ATS) and implications for future practice.* Australasian Emergency Nursing Journal, 2013. 16(1): p. 21-29.

The Triage Nurse applies an ATS category in response to the question “*this patient should wait for assessment and treatment by a treating clinician no longer than...*”.

ATS Category	Treatment Acuity (maximum waiting time)	Performance Indicator Threshold*
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

\*Performance Indicator Threshold represents the percentage of patients assigned ATS Category 1 through to 5 who commence clinical assessment and treatment within the relevant waiting time from their time of arrival.<sup>22</sup>

### 2.3 Re-triage of patients with deteriorating conditions

It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes, deteriorates or additional relevant information is received prior to being seen by a treating clinician.

Such relevant information may be received via a source such as: interpreters, Drs letter, family members, past medical records etc.

The process of re-triage involves an assessment of the waiting patient who has not been reviewed by a clinician responsible for care. The purpose of re-triage is to acknowledge any change in clinical condition of a patient and assign a relevant triage category. A patient may be assessed as requiring a higher acuity triage category (due to deterioration).

Documentation is to occur detailing the assessment, application of a new triage category, and necessary discussions or escalation of the patient’s condition to a senior ED clinician (Registered Nurse, Medical Officer, Team Leader).

Patients and/or carers should be informed at the time of triage what to do if their condition changes or they become concerned while waiting for care and how the triage system works to prioritise care.

All waiting patients should be regularly assessed by either the Triage Nurse or Clinical Initiatives Nurse (CIN) if available; particularly if the waiting time exceeds the allotted triage category maximum waiting time.

### 2.4 Triage location and safety requirements

The triage environment must provide safety for the public, the Triage Nurse, staff and patients of the ED. The triage environment must take into account the potential risk of aggressive behaviour of patients or their relatives.

<sup>22</sup> ACEM Policy on the Australasian Triage Scale <http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx>

The environment:

- Must be immediately visible and well sign posted.
- Must allow for clear visibility of the waiting room by the Triage Nurse.
- Must have access to an area for patient examination and provision of first aid.
- Must be designed to maximize the safety of the Triage Nurse, staff and patients (eg. duress alarms, egress routes for staff exiting the triage room and access to security personnel).
- Should enable and facilitate patient privacy (a private consultation room is recommended for patient examination).

### 2.5 Triage education

It is recognised that triage should be completed by *specifically trained and experienced RNs*<sup>23</sup> as:

*... clinical decisions made by triage nurses require complex cognitive process. The Triage Nurse must demonstrate the capacity for critical thinking in environments where available data is limited, incomplete or ambiguous.*<sup>24</sup>

The Registered Nurse must demonstrate clinical expertise in emergency nursing prior to commencing triage education and training.

The LHD will determine the baseline level of clinical expertise expected of a prospective Triage Nurse; however, new graduate (transitional) nurses should not be eligible to undertake a triage education program. The following is recommended as baseline clinical expertise:<sup>25</sup>

- One-two years full time ED nursing experience (this does not include the New Graduate year).
- Successful completion of the NSW Health 'Transition to Practice, Emergency Nursing Program' or equivalent transitional program.
- Completion of the Clinical Excellence Commission (CEC)<sup>26</sup>
  - Between the Flags program
  - D.E.T.E.C.T.
  - D.E.T.E.C.T. junior
- Advanced Life Support accreditation
- NSW Health Paediatric Clinical Practice Guidelines e-learning package.<sup>27</sup>

Local decision making should be applied by ED Nursing Managers, Clinical Nurse Consultants and Nurse Educators on readiness of nurses to undertake the triage role where appropriate. Local systems should be in place for Recognition of Prior Learning to ascertain an equivalent level of the development of clinical expertise.

It is the responsibility of the LHD Executive, the Medical Director of the ED (or equivalent), the Nurse Manager of the ED (or equivalent) and LHD Nursing Education service to ensure an adequately resourced, locally relevant, comprehensive triage training and assessment program. It is recommended that the program should encompass the following elements:

- It should be based on the *Emergency Triage Education Kit*<sup>28</sup> (ETEK).
- It should not teach ETEK in isolation, but use it as part of a training and competency based triage program.

196(12/12/13)

<sup>23</sup> [Australasian College for Emergency Medicine \(2006\) Policy on the Australasian Triage Scale](#)

<sup>24</sup> [College of Emergency Nursing Australasia \(2009\) Position Statement Triage Nurse](#)

<sup>25</sup> [Health Policy Priorities Principle Committee \(2011\) Australian Triage Process Review](#)

<sup>26</sup> [Clinical Excellence Commission \(2013\) Between the Flags](#)

<sup>27</sup> [NSW Ministry of Health \(2010\) Paediatric Clinical Practice Guidelines e-learning package](#)

<sup>28</sup> [Australian Department of Health and Aging \(2009\) Emergency Triage Education Training Kit](#)

- It should include information about local procedures, processes and nuances.
- It should provide supernumerary support during practical triage training.
- It should ensure that novice triage nurses have access to senior medical and nursing staff for support as they learn the triage role (either in person or via appropriate telecommunications).

At the completion of a triage training program, the Triage Nurse must be able to demonstrate knowledge and/or competence as follows:<sup>29</sup>

- Recall the science and practice of triage.
- Outline the Australian health care system.
- Describe the role of the Triage Nurse.
- Apply the ATS.
- Relate the legislative requirements and considerations.
- Discuss epidemiology and population health.
- Demonstrate effective communication skills including use of electronic medical record systems where appropriate.
- Application of the primary and secondary surveys.
- Apply and synthesize an assessment and triage decision making process by the following presentation types:
  - Trauma.
  - Medical and surgical emergencies.
  - Older persons emergencies and delirium identification.
  - Paediatric emergencies.
  - Obstetric and gynaecological emergencies.
  - Mental health emergencies and the *Mental Health Act 2007*.
  - Rural and isolated triage practice.
  - Environmental emergencies.
- Discuss quality and safety in health care and apply it to triage decision making.
- Discuss cultural safety issues and ensure cultural competence of triage staff.

It is recognised that in hospitals with ED role delineation level 1 & 2, there may be occasional circumstances when an Enrolled Nurse is the first point of contact for a patient arriving in the ED.

For these contingencies, hospitals must:

1. Have clear processes established in order to rapidly notify a registered nurse of the patient's arrival.
2. Note that Registered Nurses are responsible for formal triaging in all circumstances.
3. Establish training for those Enrolled Nurses likely to encounter these circumstances so that they are equipped to identify high acuity patients.

Ongoing evaluation of performance, updates of clinical practice and professional development must be in place to ensure currency of knowledge and practice for the role of Triage Nurse.

## 2.6 Triage of Ambulance patients

Patients arriving to the ED via ambulance will be assessed and triaged as per normal ED triage procedures.

Some LHDs may have local protocols in place for rapid triage/triage bypass of specific clinical groups (e.g. ST Elevation Myocardial Infarction, Trauma, Sepsis and Stroke). LHDs are required to ensure that all triage staff are aware of local protocol agreements relating to the triage of specific clinical groups within their ED.

196(12/12/13)

<sup>29</sup> Adapted from [College of Emergency Nursing Australasia \(2009\) Position Statement Triage Nurse](#)

Following triage assessment, the Triage Nurse will determine the most appropriate location within the ED to facilitate transfer of care of patients presenting by ambulance and release of paramedics from care of the patient. This will include allocation of patients to defined clinical areas within the ED or transfer to the waiting room where appropriate, particularly low acuity and low complexity patients for whom staying on the ambulance stretcher is not necessary.

To facilitate Transfer of Care, a clinical handover using a structured approach such as 'IMIST AMBO', must occur between the treating Paramedic and accepting ED clinician. Transfer of Care is deemed complete only when this clinical handover has occurred and the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

In the event, that the patient is unable to be offloaded from the ambulance stretcher to an appropriate location within the ED, joint care and monitoring of the patient by ED staff and paramedics will continue until the patient can be offloaded. Transfer of Care should occur as soon as possible.

### **2.7 Telephone advice**

It is not the role or responsibility of the Triage Nurse to provide clinical telephone advice to the public, carers and non-health professionals who may telephone the ED in an attempt to seek emergency and other medical advice.

If the Triage Nurse identifies that a caller is requiring general medical advice they should direct the caller to phone the National Triage Telephone Advice Line (*healthdirect Australia*) on 1800 022 222. If the Triage Nurse identifies that the call may be of an emergency nature, the Triage Nurse should direct the caller to hang up and phone 000 for assistance. If the Triage Nurse identifies that a caller is ringing about a mental health problem, they should direct the caller to phone the NSW Mental Health Line on 1800 011 51.

### **2.8 Mass Casualty Disaster and Triage**

This procedure document outlines the process for ED triage under 'usual' circumstances.

Mass casualty triage, while similar, is distinct from the triage process that has been described in this document. During mass casualty incidents, or 'disasters' the triage process may change. This decision will be made by a hospital disaster controller, or their delegate.<sup>30</sup>

#### **LIST OF RELATED DOCUMENTS**

1. Australasian College for Emergency Medicine policy on the Australasian Triage Scale available: <http://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx>
2. Australasian College for Emergency Medicine guidelines on the implementation of the Australasian Triage Scale in Emergency Departments available: <https://www.acem.org.au/getattachment/d19d5ad3-e1f4-4e4f-bf83-7e09cae27d76/G24-Implementation-of-the-Australasian-Triage-Scale.aspx>
3. College of Emergency Nursing Australasia position statement: Triage Nurse available: [http://www.cena.org.au/wp-content/uploads/2014/10/2012\\_06\\_14\\_CENA\\_-\\_Position\\_Statement\\_Triage.pdf](http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf)
4. College of Emergency Nursing Australasia Position Statement: Triage and the Australasian Triage Scale [http://www.cena.org.au/wp-content/uploads/2014/10/2012\\_06\\_14\\_CENA\\_-\\_Position\\_Statement\\_Triage.pdf](http://www.cena.org.au/wp-content/uploads/2014/10/2012_06_14_CENA_-_Position_Statement_Triage.pdf)

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<sup>30</sup> [http://www.health.nsw.gov.au/policies/gl/2010/GL2010\\_011.html](http://www.health.nsw.gov.au/policies/gl/2010/GL2010_011.html)

5. Australian Triage Process Review report available:  
<http://www.ecinsw.com.au/sites/default/files/field/file/Australian%20Triage%20Process%20Review.pdf>
6. Emergency Triage Education Kit available:  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents>
7. Emergency Department Triage Method available:  
<http://www.ecinsw.com.au/sites/default/files/field/file/Triage%20Method-Oct%202010-2.pdf>
8. NSW Health Emergency Department Models of Care July 2012 available:  
<http://www.health.nsw.gov.au/Performance/Publications/ed-model-of-care-2012.pdf>
9. PD2015\_001: Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach [http://www.health.nsw.gov.au/policies/PD/2015/PD2015\\_001.html](http://www.health.nsw.gov.au/policies/PD/2015/PD2015_001.html)
10. NSW Health Policy PD2007\_036 Infection Control Policy available:  
[http://www.health.nsw.gov.au/policies/pd/2007/PD2007\\_036.html](http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html)

**DIRECT ADMISSION TO INPATIENT WARDS FROM EMERGENCY DEPARTMENT**  
(PD2009\_055)**PURPOSE**

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

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

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

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

**MANDATORY REQUIREMENTS**

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

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

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

**IMPLEMENTATION**

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

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

**KEY COMPONENTS LOCAL PROTOCOL – ADMISSION DECISION FRAMEWORK**

1. A comprehensive list of clinical conditions for which the hospital is able to provide inpatient care and the clinical team/unit that primarily provides inpatient care for each listed clinical condition. This list will be based on the clinical team/unit skill set.

2. The senior medical staff who are appointed and credentialed to accept admissions in each clinical team/unit listed.
3. If a hospital does not have the facilities or skills to admit certain patients, this should also be clearly stated and an appropriate networked hospital identified which will accept such patients.
4. A clearly set out admission process for patients presenting with co-morbidities, undifferentiated illness or conditions involving more than one clinical discipline (eg. the protocol may set out that a joint admission should occur).
5. An agreed mechanism for ongoing review, improvement and further development of the protocol as issues arise (e.g. a periodic standing agenda item for local clinical unit and medical staff council meetings)
6. A clearly defined dispute resolution process for dealing with unforeseen circumstances with these circumstances then informing the ongoing review and improvement process. The dispute resolution process must NOT delay the admission of a patient from the Emergency Department and transfer of care to an inpatient clinical team in accordance with the protocol.
7. A clear written outline of the agreed admission decision process for patients in the Emergency Department requiring admission to the hospital. The process should comply with the following principles.

#### **Emergency Department inpatient admission process principles**

8. Following assessment in the Emergency Department, a senior doctor in the Emergency Department will:
    - a. decide if the patient requires admission;
    - b. determine the condition(s) necessitating admission;
    - c. apply the agreed local protocol to determine the clinical team under whose care the patient will be admitted;
    - d. request the clinical team to accept the admission.
  9. In situations where there is not agreed acceptance of the admission by the inpatient consultant or team, discussion should take place at the most senior clinical level possible, preferably consultant level, based on the agreed local protocol.
  10. If the appropriate admitting team for the patient is unable to be determined by the above steps in the required time frame, then the most senior medical officer who has seen the patient will make the admission decision. In the emergency department the specialist emergency physician would be the most senior medical officer. If an emergency physician is not on duty, another senior medical officer (specialist, registrar or CMO) who has seen the patient will make the decision.
  11. A reasonable time for conclusion of this decision-making process would be no more than 2 hours from the time of the clinical decision that the patient requires admission.
- This process must result in a clear decision to admit the patient under a specific consultant or clinical team. The decision-maker must then notify the admitting team. The admitting team will accept the patient once this decision is made. An inpatient consultant who remains unwilling to accept the patient after all these steps have been followed may elect to see the patient and having done so, take personal responsibility for discussing with, and arranging admission under, another consultant.
  - Occasions requiring the most senior doctor to make a contested decision to admit the patient under a specific consultant or clinical team must be the subject of a subsequent review at the local hospital level to determine whether further refinement of the local protocol is required, as part of the ongoing review, improvement and further development of the local protocol.



**6. EMERGENCY CARE**

**6.24**

- Should the patient subsequently require transfer to another clinical unit after admission from the Emergency Department under the local protocol, the clinical team on call will arrange this. The local protocol should include prior agreement about processes to expedite the transfer of such patients between units where

This checklist can be used to review the implementation of this policy directive.

Assessed by:		Date of Assessment:			
Requirement:	Assessment:				
	Not commenced	In development	Partial compliance	Full compliance	
<b>IMPLEMENTATION REQUIREMENTS</b>					
1. Comprehensive list of clinical conditions and inpatient teams primarily responsible for these conditions by October 31 <sup>st</sup> 2009	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
2. Written Emergency Department admission decision process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
3. Regular review process for the local protocol in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
4. Clearly defined dispute resolution process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable

**NSW RURAL ADULT EMERGENCY CLINICAL GUIDELINES (GL2022\_004)****GL2022\_004 rescinds GL2020\_004****GUIDELINE SUMMARY**

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

**KEY PRINCIPLES**

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

A graduated clinical response is required, dependant on:

- Severity of the presenting emergency condition e.g. the clinical response to patients with mild to moderately severe asthma is different to that of a patient with immediately life-threatening asthma.
- Level of training and expertise of the nursing staff who initiate the management of the patient i.e. Registered Nurses with advanced clinical training will practice more advanced interventions.
- Legal requirements for Nurses who initiate treatment and administer medications based on medication standing orders.
- Need for flexibility to respond to input from senior clinical staff and medical officers to accommodate local circumstances

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

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

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

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

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

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

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

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

**The Guidelines can be downloaded from:**

**[https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022\\_004](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_004)**

## RESPONDING TO SEXUAL ASSAULT (ADULT AND CHILD) POLICY AND PROCEDURES (PD2020\_006)

**PD2020\_006 rescinds PD2005\_614 and PD2005\_607**

### PURPOSE

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

### SUMMARY OF MANDATORY REQUIREMENTS

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

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

### IMPLEMENTATION

Chief Executives are responsible and accountable for:

- establishing mechanisms to ensure the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are applied, achieved and sustained;
- ensuring NSW Health staff understand and are aware of their obligations in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures* and related policies and procedures;
- ensuring resources are available to deliver and meet the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*;

- ensuring that NSW Health staff are trained to operationalise and implement the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures*; and
- ensuring NSW Health staff are advised that compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures* is part of their patient / client care responsibilities.

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

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

NSW Health workers are responsible for:

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

**For the complete *Responding to Sexual Assault (Adult and Child) Policy and Procedures* document go to:**

**[https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020\\_006](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2020_006)**

**DOMESTIC VIOLENCE - IDENTIFYING AND RESPONDING (PD2006\_084)**

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

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

*"Ask about child safety:*

- *Do you have children? (If so) have they been hurt or witnessed violence?*
- *Who is/are your child/ren with now? Where are they?*
- *Are you worried about your child/ren's safety?*

*Health workers must make a report to the Department of Community Services Helpline on 133 627 where he or she has reasonable grounds to suspect a child is at risk of harm."*

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

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

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

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

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

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

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

[http://www.health.nsw.gov.au/publications/Publications/Domestic\\_Violence\\_Screening.pdf](http://www.health.nsw.gov.au/publications/Publications/Domestic_Violence_Screening.pdf)

**DOMESTIC VIOLENCE – MEN’S BEHAVIOUR CHANGE PROGRAMS (IB2014\_003)****PURPOSE**

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

This information should be read in conjunction with the *Policy and Procedures for Identifying and Responding to Domestic Violence* PD2006\_084. Where the information differs, the information in this bulletin applies.

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

**KEY INFORMATION**

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

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

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

**NSW Health responsibilities**

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

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

**The Principles and Minimum Standards**

1. **Principle:** The safety of women and children must be given the highest priority.
  - 1.1. **Standard:** Program providers will develop and operate from written procedures that address risks to women and children.
  - 1.2. **Standard:** Program providers will ensure that current partners of program participants are provided with support prior to and during the program.
  - 1.3. **Standard:** Partner support workers will prepare women for the participation of their partners in the behaviour change group program.
  - 1.4. **Standard:** Partner support workers will complete individual risk assessments and safety plans.
  - 1.5. **Standard:** The contact worker is to disclose to women any new expressed or perceived threat to their safety.

- 1.6. **Standard:** Where women and children express an interest in having ongoing contact from a partner support worker, additional contact will occur for the duration of the program.
- 1.7. **Standard:** Group facilitators and partner support workers will have approach knowledge and training about the impact of domestic and family violence on women and children.
- 1.8. **Standard:** Partner support workers must have relevant knowledge, training and experience to enable them to support and advocate for women and children.
2. **Principle:** Victim safety and offender accountability are best achieved through an integrated, systemic response that ensure that all relevant agencies work together.
  - 2.1. **Standard:** To ensure program transparency, accountability and integration program providers will develop a formal relationship with relevant local agencies.
3. **Principle:** Challenging domestic and family violence requires a sustained commitment to professional and evidence-based practice.
  - 3.1. **Standard:** Group facilitators must have relevant knowledge and training.
  - 3.2. **Standard:** All programs will have a minimum of two group facilitators.
  - 3.3. **Standard:** Group facilitators must undertake supervision.
  - 3.4. **Standard:** Program providers will develop policies to ensure that group facilitators undertake ongoing professional development.
  - 3.5. **Standard:** Behaviour Change Group Programs will have a duration of at least 24 hours over 12 weeks.
  - 3.6. **Standard:** Program providers will complete an operational review of each program focussing on process and content.
  - 3.7. **Standard:** Program providers will evaluate the impact of programs on the behaviour and attitude of group participants.
  - 3.8. **Standard:** Program providers will contribute to an evidence base for behaviour change programs.
4. **Principle:** Perpetrators of domestic and family violence must be held accountable for their behaviour.
  - 4.1. **Standard:** Programs must be grounded in an evidence-based theory of change.
  - 4.2. **Standard:** Program providers will document and implement thorough participant assessment procedures.
  - 4.3. **Standard:** Program provider will have procedures for engaging participants which challenge them to acknowledge their abusive behaviour.
  - 4.4. **Standard:** Program content will include explicit information about the impact of domestic and family violence on women and children and women's disproportionate experience of domestic violence.
  - 4.5. **Standard:** Program content will include information on different forms of domestic and family violence and provide opportunities for participants to come to an understanding about the nature of their offending behaviour.
  - 4.6. **Standard:** Program providers will develop procedures for non-attendance of mandated participants.
  - 4.7. **Standard:** Program providers will have procedures for group facilitators to prevent their implicit or explicit collusion with participants' attitude that support violence against women.
  - 4.8. **Standard:** Program providers will offer appropriate referrals to meet participants' additional needs.
  - 4.9. **Standard:** Program providers must comply with the requirements of a referring agency for a report on the participant's completion of a program.
5. **Principle:** Programs should respond to the diverse needs of the participants and partners.
  - 5.1. **Standard:** Program facilitators must undertake training to ensure culturally competent practice.
  - 5.2. **Standard:** Programs addressing other forms of family violence will be specific to the participant's needs.

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

To view the Minimum Standards for Men's Domestic Violence Behaviour Change Programs on the Attorney General and Justice website go to [http://www.domesticviolence.lawlink.nsw.gov.au/agdbasev7wr/assets/domesticviolence/m42200112/dfv\\_behaviour\\_change\\_program\\_standards\\_april\\_2012.pdf](http://www.domesticviolence.lawlink.nsw.gov.au/agdbasev7wr/assets/domesticviolence/m42200112/dfv_behaviour_change_program_standards_april_2012.pdf)

200(30/01/14)

## DOMESTIC AND FAMILY VIOLENCE MIGRATION REGULATIONS: RELEVANCE FOR HEALTH WORKERS (IB2018\_017)

### PURPOSE

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

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

### KEY INFORMATION

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

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

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

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

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

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

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

298(24/05/18)



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

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

Professional experts within NSW Health should proactively follow up by asking about the safety of the victim - if they are safe to go home, if they need assistance to go home or a safe place as per the NSW Health policy on *Identifying and Responding to Domestic Violence* PD2006\_084.

Professional experts within NSW Health should also identify if children are involved in the violence by asking victims directly. If so, questions should be asked about this - if children have been hurt or witnessed violence, where and who are the children with, and if victims are worried about the children's safety.

Professional experts within NSW Health are also required to follow mandatory reporting protocols if they suspect that a child is at risk of significant harm.

The NSW Mandatory Reporting Guide should be used as part of this assessment and reports to the Child Protection Helpline should be made where indicated.

## REFERENCES

1. NSW Ministry of Health. 2006. *Domestic Violence - Identifying and Responding*. [ONLINE] Available at: [http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2006\\_084](http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2006_084)
2. Australian Department of Home Affairs. 2016. *Statutory Declaration - Form: 1410*. [ONLINE] Available at: <https://www.homeaffairs.gov.au/forms/documents/1410.pdf>
3. Australian Department of Home Affairs. 2016. *Statutory Declaration - Form: 1040*. [ONLINE] Available at: <https://www.homeaffairs.gov.au/forms/documents/1040.pdf>
4. Minister for Immigration and Citizenship. 2012. *Migration Regulations 1994 - Specification of Evidentiary Requirements - IMMI 12/116*. [ONLINE] Available at: <https://www.legislation.gov.au/Details/F2012L022377>
5. Australian Medical Association. 2016. *Supporting Patients Experiencing Family Violence*. [ONLINE] Available at: <https://ama.com.au/article/ama-family-violence-resource>
6. Childstory Reporter. 2016. *Mandatory Reporter Guide*. [ONLINE] Available at: <https://reporter.childstory.nsw.gov.au/s/mrg>

## **NEW SOUTH WALES HEALTH SERVICES FUNCTIONAL AREA SUPPORTING PLAN (NSW HEALTHPLAN) (PD2014\_012)**

### **PURPOSE**

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

### **MANDATORY REQUIREMENTS**

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

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

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

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

The policy directive *Emergency Management Arrangements for NSW Health* PD2012\_067 outlines the mandatory requirements, governance and operational arrangements for the Local Health Districts and the Health Service Functional Area Coordinators.

### **IMPLEMENTATION**

New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) will replace NSW HEALTHPLAN PD2009\_008 (v3.5 December 2009).

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

PD2014\_012 can be downloaded at [http://www.health.nsw.gov.au/policies/pd/2014/PD2014\\_012.html](http://www.health.nsw.gov.au/policies/pd/2014/PD2014_012.html)

**MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (GL2018\_017)**

**GL2018\_017 rescinds GL2010\_011, PD2009\_080 and PD2009\_048**

**PURPOSE**

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

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

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

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

**KEY PRINCIPLES**

The following principles underpin the NSW MEDPLAN:

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

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

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

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

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

**USE OF THE GUIDELINE**

The NSW MEDPLAN:

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

Responsibilities of key parties are detailed in Part Two of the NSW MEDPLAN. Action Cards for specific position holders are listed in Annex Three with specific actions.

Details for the Concept of Operations for LHDs are listed in Annex Four. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

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

**To download the complete Major Incident Medical Services Supporting Plan Guideline please go to:**  
[https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018\\_017](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_017)

**MASS CASUALTY TRIAGE PACK – SMART TRIAGE PACK (PD2017\_037)**

**PD2017\_037 rescinds PD2011\_044**

**PURPOSE**

This policy specifies the use of Mass Casualty Triage Pack - SMART Triage Pack in a mass casualty situation to denote the priority for treatment under the Medical Service Supporting Plan ([GL2010\\_011](#)).

**MANDATORY REQUIREMENTS**

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

In Local Health Districts, the SMART Triage Packs form part of the Health Response Team Medical Equipment list requirement ([PD2009\\_080](#)). NSW Ambulance carries SMART Triage Packs across all ambulance vehicles for use in mass casualty incident.

**IMPLEMENTATION**

This policy replaces PD2011\_044 Mass Casualty Triage Pack – SMART Triage Pack which was implemented across Local Health Districts and Ambulance Services of NSW in 2011.

SMART Triage Packs are included in the HealthShare NSW catalogue.

**Local Health Districts**

Local Health Districts are responsible for:

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

**NSW Ambulance**

NSW Ambulance is responsible for:

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

**NSW Health Emergency Management Unit**

NSW Health Emergency Management Unit is responsible for:

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

## Mass Casualty Triage & SMART Triage Packs - Procedures

### 1. BACKGROUND

#### 1.1 Triage Process

Triage was first introduced in a military context as a system of sorting the casualties for medical treatment in the field. In recent decades, the triage concept has been adopted and implemented in the disaster medical management and emergency departments.

In the context of medical management in a mass casualty situation, the aims of triage are not only to deliver the right patient to the right place for optimal treatment, but also to 'do the greatest good for greatest number' with medical resources which should not be diverted to treating an irrecoverable condition.

#### 1.2 Australian Standard Mass Casualty Triage Tags

In 2010, the SMART Triage Tags were approved as an Australian standard mass casualty triage label by the Council of Ambulance Authorities (CAA) following consultation with jurisdictional Health Departments.

The SMART Triage Tags provide a standard tool for mass casualty triage process in a mass casualty incident. The tags provide a national consistent approach to mass casualty triage across Australia<sup>31</sup>.

The SMART Triage Tags meet world's best practice and have been tested and evaluated for Australian conditions.

### 2. SMART Triage Pack

#### 2.1 Personal SMART Triage Pack

The personal SMART Triage Pack (Red colour for Ambulance Services and Green colour for Health Response Teams) consists of:

- SMART Triage Tags
- Triage Sieve and Casualty Count Chart
- Paediatric SMART Tape
- CBR Tag
- Light stick and pencils



Photo source: SMART TAG™

Health Response Team Kits are to have two (2) SMART Triage Packs per kit.

298(11/10/17)

<sup>31</sup> 1 Aitken, P. & Fitzgerald, G., (2012) Disaster triage: Evidence, consistency and standard practice. Emergency Medicine Australasia 2012 24,222-224.

## 2.2 Commander Triage Pack

The Commander Triage Pack, located in ambulance supervisor vehicles, includes:

- Incident Control Boards – detachable and Velcro to the Commander pack
- Document holders for maps and plans
- SMART Triage Tags
- Dispatch panels for holding the Transport tags
- Internal pockets for additional equipment

## 2.3 SMART Triage Tag

The SMART Triage Tag is a variable triage tag that enables field documentation. The tag is durable, waterproof and can be written on when wet.

Each Mass Triage Tag has an individual barcode and unique identifier number. The unique identifier number shall be recorded in all patient documentation. Each SMART Triage Tag also has a plastic bag with main pocket for Triage Tag and a small front pocket when using a CBR (Chemical, Biological & Radiation) Tag.

**Figure 1:**

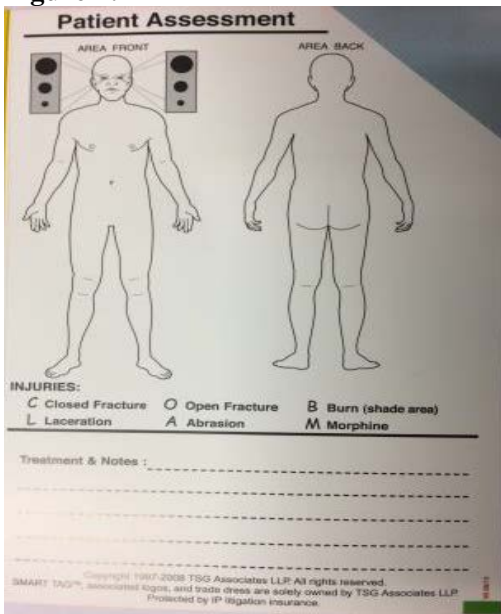


The SMART Triage Tag has a prominent priority numbering and matching colour system on the tag (Figure 1). A separate Black colour triage tag is used for deceased persons (Figure 1).

The blue colour corner (Figure 2) of the SMART Triage Tag is referred to as the Fourth Priority or Expectant. The Expectant priority refers to a patient whose condition is so severe that they cannot survive despite the best available care. The Expectant category will only be used in NSW following a major or catastrophic event where the number and criticality of patient(s) significantly diverts medical resources from the salvageable patient who may then be compromised.

The authorisation to implement this category can only be given by the State Health Services Functional Area Coordinator (HSFAC) following clinical discussions with the Medical Supervisor on site as outlined in NSW Ambulance Major Incident Response Plan (NSW AMPLAN).

Figure 2: Expectant (Blue) category corner



The SMART Tag provides documentation for recording patient changes in condition. The tag can be refolded to display a different priority without losing the important patient information already recorded on the tag.

Time should be recorded on the tag using 24 hour time (00:00-23:59).

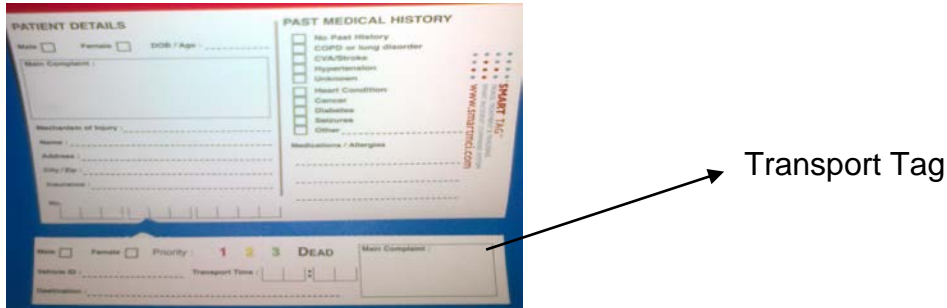
Figure 3:

MED08033 Name : _____ DOB / Age : _____ Address : _____ No. : _____	Eye opening : Spontaneous 4 To voice 3 To pain 2 None 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Verbal response : Oriented 5 Confused 4 Inappropriate words 3 Incomprehensible sounds 2 No response 1	+	+	+	+	+	
	Motor response : Obeys commands 6 Localizes 5 Pain withdraws 4 Pain flexion 3 Pain extension 2 No response 1	+	+	+	+	+	
	Glasgow Coma Scale Total :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Total Glasgow Coma Scale 13 - 15 4 9 - 12 3 6 - 8 2 4 - 5 1 3 0	+	+	+	+	+	
	Respiratory Rate 10 - 29 4 more than 29 3 6 - 9 2 1 - 5 1 0 0	+	+	+	+	+	
	Systolic BP 90 or more 4 76 - 89 3 50 - 75 2 1 - 49 1 0 0	+	+	+	+	+	
	12 = PRIORITY 3 11 = PRIORITY 2 10 or less PRIORITY 1	Total :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Before the patient is transferred to definitive health care facility, the Ambulance Loading Point Officer will complete and remove the transport tag (at the side of the SMART Triage Tag) for records (Figure 4). This documentation enables the tracking and accounting of the casualty's movement and destination.

Figure 4:



The SMART Triage Tag will remain attached to the patient who is then transferred to the definitive care destination.

The card allows further patient information to be recorded as necessary:

Time	Treatment / Intervention	Performed by	BP	Pulse	Resp	Skin	Loc / GCS	SaO <sub>2</sub>

### 2.4 Casualty Count Chart

A double sided card with the casualty count chart (Figure 5) and adult triage sieve process is attached to the SMART Triage Pack with an elastic band. The chart provides a quick reference of the triage sieve process and a casualty count record is a document that can be used by to track the number of casualties and the clinical acuity.

The care is made from the same durable material as the SMART Triage tags.

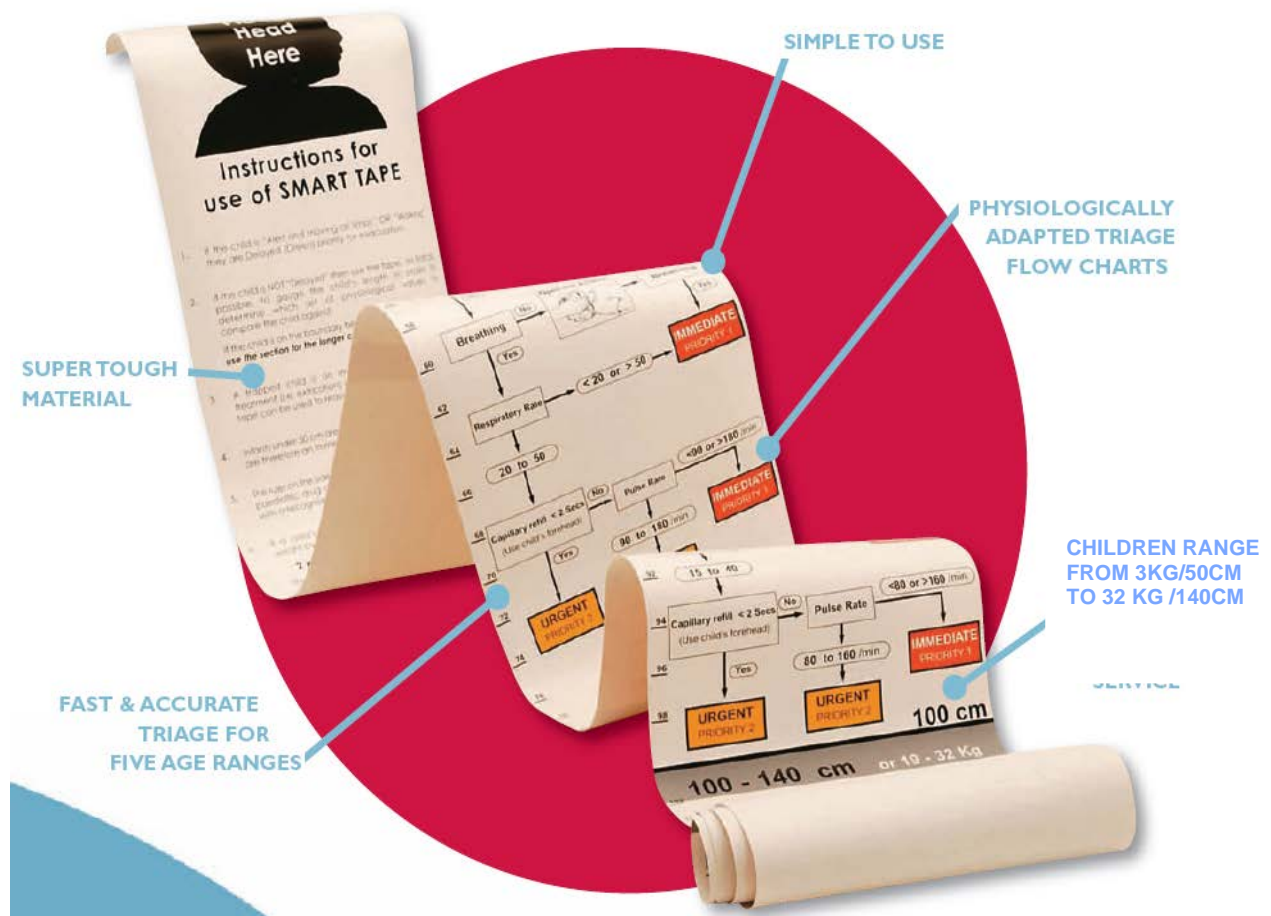
Figure 5:

CASUALTY COUNT									
The Triage Sieve flow chart on the reverse should only be used for adults. For Paediatric Triage (0 to 10 years) use the Smart Tape.									
<i>Cross out the next number in each priority as you label a new casualty</i>									
<b>PRIORITY 1</b>	1	2	3	4	5	6	7	8	
IMMEDIATE	9	10	11	12	13	14	15	16	17
	18	19	20						
<b>PRIORITY 2</b>	1	2	3	4	5	6	7	8	
URGENT	9	10	11	12	13	14	15	16	17
	18	19	20						
<b>PRIORITY 3</b>	1	2	3	4	5	6	7	8	
DELAYED	9	10	11	12	13	14	15	16	17
	18	19	20						
<b>DEAD</b>	1	2	3	4	5	6	7	8	9
	10								

### 2.5 Paediatric SMART Tape

The durable Paediatric SMART Tape is an evidence based system<sup>33 34</sup> and is to be used as a non-biased triage decision for children from 3kg/50cm to 32kg/140cm<sup>35</sup>. The Paediatric SMART Tape allows a triage sieve to be performed on any child less than 32kg. The use of this tool has been incorporated into the existing Health and Ambulance training programs.

If resources or time do not permit, the adult triage sieve can be used for paediatrics, however this may result in the over triage of a paediatric casualty.



### 2.6 CBR Tag<sup>36</sup>

The Chemical Biological and Radiological (CBR) Tag provides a form to record the details for contaminated casualties from an incident involving chemical, biological, radiological or infectious agents. The CBR Tag allows recording of particular agents, decontamination and any use of auto-injectors.

The CBR Tag DOES NOT replace the SMART Triage Tag and does not have the unique identifier barcode and number. The CBR Tag must be used in conjunction with the SMART Triage Tag.

298(11/10/17)

<sup>33</sup> Hodgetts, T., J. Maconochie, C. & Smart, C (1998). Paediatric triage tape. Pre-hospital Immediate Care 2:155-159.

<sup>34</sup> Wallis, LA & Carley, S (2006) Validation of the Paediatric Triage Tape, Emergency Medicine Journal. Jan; 23 (1):47-50.

<sup>35</sup> Sandell, J. M. & Charman, S.C (2009). Can age-based estimates of weight be safely used when resuscitating children? Emergency Medicine Journal 2009;26:43-47.

<sup>36</sup> The term 'WMD' used in the SMART Triage Pack or Education Pack, should be referred as "CBR". "WMD" is a term used in USA but not in Australia. In Australia, the term "CBR" is used instead.

The unique identifier number of the victim’s SMART Triage Tag is required to be documented on the CBR Tag. The completed CBR Tag is to be inserted in the front clear plastic pocket of the SMART Triage Tag.



Photo source: SMART TAG™

**3. Training**

The SMART Triage Pack has been incorporated in the Major Incident Medical Management and Support (MIMMS) course and Ambulance training programs.

An e-learning package has been developed for all staff within NSW Health and NSW Ambulance and is available on My Health Learning. The course code for Mass Casualty Triage Training is 122605241.

NSW Health and NSW Ambulance have trainers that can provide education in th SMART Triage System.

**4. Ordering Requirement and Details**

SMART Triage items can be ordered through the HealthShare NSW catalogue with the following details (as sock items):

HIMF Number	Description
710779	DISASTER TRIAGE TAG, <b>SMART TRIAGE TAG</b>
710789	DISASTER TRIAGE TAG, <b>CBRN/HAZMAT TAG</b>
710787	DISASTER TRIAGE TAG, <b>DECEASED TAG</b> –
710782	DISASTER TRIAGE TAG, SMART CASUALTY CARD, SIEVES (Pack5) – <b>Triage Sieve Algorithm / Casualty Count Card</b>
710783	DISASTER TRIAGE TAG, SMART TAPE, CHILD - <b>Paediatric Triage Tape</b>
710780	DISASTER TRIAGE TAG, RE-SUPPLY FOR SMART TRIAGE KIT - <b>Contents only – no bag</b>
788136	DISASTER PACK, <b>EMPTY</b> , SMART TRIAGE, RED - <b>Empty bag – for re-issue if contaminated</b> *Note: LHDs will need to order replacement green bags directly from Midmed
710790	DISASTER PACK, SMART TRIAGE KIT, RED - <b>Full kit with contents</b> *Note: LHDs will need to order replacement green bags directly from Midmed

\* For Replacement of the Green bags by LHDs, non-stock orders are to be quoted and ordered with the Supplier: MIDMED PTY LTD - 1300 643 633 [www.midmed.com.au](http://www.midmed.com.au)

**CLOSED HEAD INJURY IN ADULTS – INITIAL MANAGEMENT (PD2012\_013)**

**PD2012\_013 rescinds PD2008\_008.**

**PURPOSE**

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

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

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

**MANDATORY REQUIREMENTS**

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

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

**IMPLEMENTATION**

Chief Executives must ensure:

- Local protocols are developed based on the *Initial Management of Closed Head Injury in Adults* clinical practice guideline.
- Local protocols are in place in all hospitals and facilities likely to be required to assess or manage patients with a closed head injury.
- Ensure that all staff treating patients with a head injury are educated in the use of the locally developed protocols.

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

**1. BACKGROUND****1.1 About this document**

The NSW Institute of Trauma and Injury Management (ITIM) has updated the *Initial Management of Closed Head Injury in Adults* clinical practice guideline to reflect the latest evidence based practice for the management of adults with a closed head injury.

The guideline is intended for use by clinicians in all facilities which provide initial care to the mild, moderate and severely head injured patient. The practical evidence based recommendations are regarded as a safe and appropriate approach to the acute management of adults with closed head injury. However, as with any clinical guideline the document should be used as a guide, rather than as a complete authoritative statement of procedures.

Each LHD must have clear and readily available protocols incorporating the following principles.

### **1.2 Key definitions**

**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.

**Mild head injury** – a patient with an initial GCS score of 14-15 on arrival at hospital following acute blunt head trauma with or without a definite history of loss of consciousness or post traumatic amnesia.

**Moderate head injury** – a patient with an initial GCS score of 9-13 on arrival at hospital following acute blunt head trauma.

**Severe head injury** – a patient with an initial GCS score of 3-8 on arrival at hospital following acute blunt head trauma.

**Post traumatic amnesia** – period of time during which a person is unable to lay down new memories following an injury.

**Post concussion syndrome** – a set of symptoms which are commonly experienced following blunt acute head trauma. The symptoms may include headaches; dizziness; fatigue; memory impairment; poor concentration; mood swings; behavioural changes; sleep disturbances and social dysfunction.

## **2. KEY PRINCIPLES**

### **2.1 Mild closed head injury**

Patients with mild closed head injury (initial Glasgow Coma Scale 14-15) should be risk stratified into high and low risk groups based on the presence or absence of specified clinical risk factors.

Patients with a mild head injury should be assessed by a process of structured clinical assessment involving a combination of :

- Initial clinical history and examination.
- Serial clinical observations.
- CT scanning if clinically assessed as being at increased risk of clinically significant lesions requiring acute neurosurgical intervention or prolonged observation in hospital.

Patients with persistent acute clinical symptoms (including post traumatic amnesia, disorientation, confusion, drowsiness, dizziness, nausea, vomiting, headache) at four hours post injury require prolonged clinical observation; and a CT scan should be performed (if not already done) to exclude a structural lesion.

Where CT scanning is unavailable patients with high risk mild head injury will require either admission for prolonged observation or early transfer of CT scanning depending on clinical assessment of risk.

If a patient with mild head injury deteriorates, the priorities are exclusion of other injuries, supportive care of the ABCDEs and early CT scan to identify a neurosurgically significant lesion. If a neurosurgically significant lesion is identified, further management should be discussed with a neurosurgical service.

Mild head injury patients can be safely discharged for home observation after an initial period of in-hospital observation if they meet specified clinical, social and discharge advice criteria.

All patients with mild head injury must be given both verbal and written discharge advice covering signs and symptoms of acute deterioration, when to seek urgent medical attention, lifestyle advice to assist recovery, information about typical post concussion symptoms and reasons for seeking further medical follow up.

## **2.2 Moderate head injury**

Patients who present initially with moderate head injuries should all have an early CT scan and close clinical observation. They should be admitted to hospital for at least 24 hours observation unless they rapidly return to normal, have a normal CT scan and absence of other clinical risk factors.

The majority of patients who suffer moderate head injuries will have some degree of cognitive behavioural social sequelae and should be considered for routine follow up with a brain injury rehabilitation service or a neurologist.

## **2.3 Severe head injury**

Resuscitation with adequate oxygenation and fluid resuscitation and the treatment of other immediately life threatening injuries should be the priority for patients with severe head injury followed by the CT identification of focal intracranial lesions requiring acute neurosurgical intervention. Early intubation to prevent hypoxaemia and facilitate management is recommended.

A neurosurgical service must be consulted about further management of patients with severe head injury as soon as practical after the initial primary survey and resuscitation.

Patients with closed head injury assessed at hospitals without CT scanning facilities should be transferred to the nearest appropriate hospital if there is significant risk of intracranial injury. Transfer of patients to a hospital with CT scanning facilities but without neurosurgical services should be avoided wherever possible.

## **2.4 Analgesia**

Most headaches associated with isolated mild head injury will respond to simple analgesia such as paracetamol. If paracetamol is ineffective as a sole agent then stronger analgesia such as oral opioids or parenteral opioids should not be prescribed to patients with isolated mild head injury unless the need for an initial or repeat CT scan to exclude clinically important intracranial lesions has been considered and a senior clinician has been consulted.

Most moderate head injury patients and nearly all severe head injury patients will require titrated intravenous analgesia and sedation for associated injuries, clinical management or intubation. These patients will all require close clinical observation in a high dependency area following initial clinical assessment and CT scanning.

**2.5 Anti-convulsants**

Post traumatic seizures are a recognised complication of closed head injuries with incidence depending largely on severity of injury. Acute post traumatic seizures occurring in hospital require systematic reassessment of the ABCDEs to exclude systemic causes and termination with benzodiazepines if required. Underlying structural lesions should be excluded with CT scan and then the need for prophylactic anti-convulsants considered.

Prophylactic anti-convulsants are not indicated for patients with uncomplicated mild head injury. Prophylactic anti-convulsants, such as phenytoin, should be considered in patients with complicated mild head injury or moderate to severe head injury who have specific risk factors that put them at increased risk of seizures. Clinical judgement is required and neurosurgical consultation is advisable.

**3. LIST OF ATTACHMENTS**

1. Initial Management of Closed Head Injury in Adults (2nd Ed)  
Available as a single document at:  
[http://www.itim.nsw.gov.au/images/3/3d/Closed\\_Head\\_Injury\\_CPG\\_2nd\\_Ed\\_Full\\_document.pdf](http://www.itim.nsw.gov.au/images/3/3d/Closed_Head_Injury_CPG_2nd_Ed_Full_document.pdf)
2. Initial Management of Closed Head Injury in Adults (2nd Ed) Summary Document  
Available as a single document at:  
[http://www.itim.nsw.gov.au/images/d/d0/Closed\\_Head\\_Injury\\_CPG\\_2nd\\_Ed\\_Summary\\_document.pdf](http://www.itim.nsw.gov.au/images/d/d0/Closed_Head_Injury_CPG_2nd_Ed_Summary_document.pdf)
3. Algorithm: Initial Management of Adult Closed Head Injury  
Available as a single document at:  
[http://www.itim.nsw.gov.au/images/8/83/Closed\\_Head\\_Injury\\_CPG\\_2nd\\_Ed\\_Algorithm\\_1.pdf](http://www.itim.nsw.gov.au/images/8/83/Closed_Head_Injury_CPG_2nd_Ed_Algorithm_1.pdf)
4. Algorithm: Initial Management of Adult Mild Closed Head Injury  
Available as a single document at:  
[http://www.itim.nsw.gov.au/images/7/74/Closed\\_Head\\_Injury\\_CPG\\_2nd\\_Ed\\_Algorithm\\_2.pdf](http://www.itim.nsw.gov.au/images/7/74/Closed_Head_Injury_CPG_2nd_Ed_Algorithm_2.pdf)
5. [Implementation Checklist](#)

## NSW PAEDIATRIC CLINICAL CARE AND INTER-HOSPITAL TRANSFER ARRANGEMENTS (PD2023\_019)

**PD2023\_019 replaced PD2005\_157**

### POLICY STATEMENT

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

### SUMMARY OF POLICY REQUIREMENTS

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

**The NSW Paediatric Clinical Care and Inter-Hospital Transfer Arrangements policy is available at: [https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023\\_019](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_019)**

## DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS (PD2014\_025)

**PD2014\_025 rescinds PD2005\_082.**

### PURPOSE

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

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

For information on patients awaiting care or commencement of clinical treatment please see [PD2013\\_047 ‘Triage of Patients in NSW Emergency Departments’](#) and [PD2010\\_075 ‘Emergency Department Patients Awaiting Care’](#).

### MANDATORY REQUIREMENTS

All NSW Public Health Organisations must:

- Ensure that local processes are in place which comply with this policy and support the four principles of readiness for departure from ED described here.
- Confirm that processes are in place in each ED to ensure that all patients are ready for departure from ED upon completion of the ED phase of their treatment and have been authorised as ready to depart. Readiness for departure from ED encompasses the following four principles:
  - The patient is safe for departure from a clinical and functional perspective.
  - The patient has had appropriate risk assessments undertaken prior to departure.
  - Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
  - Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred. Patients should be given post-discharge care instructions in plain language which is relevant to the individual and provides information that adequately describes follow up treatment. Communication must be undertaken with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED, particularly if there is a requirement for them to provide patient care or a request to follow up outstanding care requirements.
- Ensure all staff are aware of the ‘Departure of Emergency Department Patients’ policy and their responsibilities in relation to managing the departure from ED of patients.
- Ensure that the [Adult and Paediatric ED Observation charts](#) ‘Departure and Discharge from ED’ checklists are utilised to support implementation of this policy as per NSW Health policy [PD2013\\_049 ‘Recognition and Management of Patients who are Clinically Deteriorating’](#). If the ED charts specifically are not used, that alternate local processes must be in place which demonstrate all information on the checklist being collected for patients.
- Ensure that local evaluation of compliance with this policy is undertaken. This should include internal review of incidents related to departure of patients from ED and review of consistency of use of the Adult and Paediatric ED Observation chart ‘Departure and Discharge from ED’ checklists (or equivalent local process).

**IMPLEMENTATION**

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

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

**a. BACKGROUND****1.1 About this document**

For the purpose of this policy, 'Departure from Emergency Department' refers to patients leaving the Emergency Department whether it is to be discharged, admitted or transferred to another facility.

This policy directive and procedure replaces PD2005\_082 '*Discharge Policy for Emergency Department at risk patients*', which was developed in recognition that patients being discharged from Emergency Departments (ED) may be at risk of re-presentation or adverse events. The Special Commission of Inquiry, Acute Care Services in NSW Public Hospitals also recommended in 2008 that a checklist be implemented in NSW EDs to communicate the needs of a patient being admitted to an inpatient unit.

This policy and procedure seeks to encompass both of these elements by detailing a standardised approach for all patients who depart the ED. It describes the principles required to minimise the risk of adverse events for patients who have completed the ED phase of their treatment and have been authorised as ready to depart the ED.

In accordance with NSW Health policy [PD2013 049 '\*Recognition and Management of Patients who are Clinically Deteriorating\*'](#) this policy requires use of the NSW Health Standard Adult and Paediatric ED Observation Charts including the checklist for staff to complete for patients prior to leaving ED. If the charts are not used, alternative local processes must demonstrate that the information contained in the checklists is being collected.

This policy is also consistent with the Australian Charter of Healthcare Rights for patients described in NSW Health Policy [PD2011 022 \*Your Health Rights and Responsibilities\*](#).

## 1.2 Key definitions

<b>At Risk</b>	Refers to a patient who has been assessed as having an identified risk which is recognised to contribute to adverse events or readmissions upon leaving the ED.
<b>Clinical Handover</b>	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.
<b>Emergency Department Departure</b>	(ED Departure) refers to the transfer of responsibility and accountability for a patient's care upon leaving the ED. The patient may be admitted to an inpatient ward, be transferred to another facility or be discharged back to the community and their usual place of residence.
<b>Left at Own Risk</b>	Refers to any person who leaves the ED after treatment has commenced, against advice. The patient's health Care Record will reflect that the patient has been seen by Doctor/Nurse/Nurse Practitioner and will have a diagnosis.
<b>Person Responsible</b>	<p>Refers to someone who has legal authority to make decisions on behalf of someone else who does not have the capacity to consent for themselves.</p> <p>A 'person responsible' is not necessarily the patient's next of kin. A 'person responsible' is either:</p> <ul style="list-style-type: none"> <li>• a <b>guardian</b> (including an enduring guardian) who has the function of consenting to medical, or dental treatment.</li> </ul> <p>or, if there is no guardian:</p> <ul style="list-style-type: none"> <li>• the most recent <b>spouse</b> or <b>de facto spouse</b> with whom the person has a close, continuing relationship. 'de facto spouse' includes same sex partners.</li> </ul> <p>or, if there is no spouse or de facto spouse:</p> <ul style="list-style-type: none"> <li>• an <b>unpaid carer</b> who is now providing support to the person or provided this support before the person entered residential care.</li> </ul> <p>or, if there is no carer:</p> <ul style="list-style-type: none"> <li>• a <b>relative</b> or <b>friend</b> who has a close personal relationship with the person.</li> <li>• The <b>NSW Civil &amp; Administrative Tribunal, Guardianship Division</b></li> </ul> <p><i>Note: The above information has been provided by the NSW Civil &amp; Administrative Tribunal, Guardianship Division</i></p> <p>In accordance with <a href="#">PD2005 406 Consent to Medical Treatment – Patient Information</a>:</p> <ul style="list-style-type: none"> <li>• A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation, procedure or treatment</li> </ul>
<b>Ready for Departure</b>	Refers to a patient who has been authorised by senior ED staff as safe to depart the ED in accordance with the principles of this policy.
<b>Risk Assessment</b>	An activity that identifies risks, estimates their probability and the likely impact of their occurrence particularly in relation to adverse outcomes.

## b. PROCEDURE FOR DETERMINING READINESS FOR DEPARTURE OF EMERGENCY DEPARTMENT PATIENTS

## 2.1 The four principles for determining readiness for departure of Emergency Department patients

Determination of a patient being ready for departure is a multidisciplinary process with ultimate responsibility resting with the senior ED medical officer and nurse in charge of shift of the ED or their delegates. Readiness for departure from ED encompasses the following principles:

1. The patient is safe for departure from a clinical and functional perspective.
2. The patient has had appropriate risk assessments undertaken prior to departure.

3. Identified risks likely to impact on readiness for departure have been mitigated where appropriate and possible.
4. Communication with the patient (including family and carers where appropriate) about ongoing care requirements has occurred; as well as communication with any relevant health professionals who will be involved in the ongoing care of the patient upon leaving the ED.

### **2.2.1 Clinically and functionally safe for departure**

When deeming a patient clinically safe for departure the following aspects must be met:

- The patient will be ‘between the flags’ with respect to recorded observations or there will be documented alterations to calling criteria on the relevant NSW Standard Observation Chart where this is appropriate for the patient. Patients who are leaving the ED for higher level care (e.g. Intensive Care Unit) are often unstable and may not be ‘between the flags’ – this should not delay departure from ED.
- All appropriate diagnostic tests will be completed or there is a documented plan of who is responsible to follow up outstanding tests and results. A management plan is documented including a provisional or definitive diagnosis and this is communicated to relevant health professionals.
- The patient is departing for a location that has a level of supervision or clinical care consistent with their clinical condition and risk assessment.

### **2.1.2 Risk assessment**

There are many health risk assessment tools and guidelines available to clinicians – not all are suitable to be undertaken in the ED. Appropriate risk assessment should be undertaken at the discretion of the treating clinician and according to patient clinical need and local procedures.

In addition to clinical risk identification; mental health, social and cultural aspects that are likely to impact on the patient’s readiness for departure from the ED must be considered.

If a patient is determined to be at risk; documentation and a corresponding risk mitigation process should be enacted.

Possible risks include, but are not limited to:

- Level of supervision required for discharge.
- Availability and accessibility of competent supervision if required.
- Competency to access transport or the provision of own transport.
- Ability to comply with discharge instructions including access to other health providers e.g. GPs and pharmacies.
- Need for specialist care within an inpatient unit or the requirement for inter-hospital transfer.
- Patients with undifferentiated diagnoses.
- Evolving or rapidly progressing disease processes.
- Indication for additional resources including equipment and personnel that is not currently available.
- Unsafe home environment/circumstances e.g. departure of elderly patients to home at night, known domestic violence situations.
- Complex social situation/circumstances where significant allied health intervention is required e.g. [homelessness](#).

### 2.1.3 Risk mitigation

Not all risks can be mitigated in the ED, however every effort should be made to identify and manage potential risks during assessment and treatment in the ED. Referral to appropriate services to manage identified risks should occur as early as possible, this may include Mental Health Services, Aboriginal Liaison Officers or Allied Health services.

Departure from the ED must not take place if significant risk has been identified and these risks cannot be managed after ED Departure, or if the patient requires the supervision of a responsible adult for appropriate ED Departure and this cannot be ensured. A local facility protocol should identify the process to be undertaken in this situation (e.g. transfer to inpatient unit if appropriate).

### 2.1.4 Communication of the Patient's care needs

The communication of information to patients, carers and other health professionals about the ongoing care needs of the patient is essential to ensuring continuity of care.

[PD2009\\_060 'Clinical Handover – Standard Key Principles'](#) clearly states the requirements for the transfer of information, accountability and responsibility for a patient or group of patients between clinicians. The elements relevant to the clinical handover should be addressed as per the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists.

#### **Patients departing the ED for inpatient wards**

Patients departing the ED for inpatient wards should have a clinical handover process completed with the relevant ward staff which details the patient's plan of care and any outstanding tests and actions that require follow up.

Documentation is to be complete as per [PD2012\\_069 Health Care Records - Documentation and Management](#) as well as other relevant information to ensure ongoing care of the patient pending review of the inpatient team (e.g. interim orders for analgesia and other medications charted, progress notes completed).

#### **Patients departing the ED for another facility**

Patients departing ED for another facility must have communication managed as per [PD2011\\_031 'Inter-facility Transfer Process for Adults Requiring Specialist Care'](#) and [PD2010\\_031 'Children and Adolescents – Inter-Facility Transfers'](#)

Communication for the Transfer of Critically ill patients is as per [PD2010\\_021 'Critical Care Tertiary Referral Networks & Transfer of Care \(Adults\)'](#) and [PD2010\\_030 'Critical Care Tertiary Referral Networks \(Paediatrics\)'](#)

#### **Patients departing the ED for home or usual place of residence**

Patients departing the ED for home or their usual place of residence require adequate instruction to ensure the patient (and/or family/carer where appropriate) is aware of ongoing care requirements.

Not every patient requires a formally written discharge letter; however information should be given to the patient which adequately describes follow up treatment. This may be verbal instruction, patient fact sheets with information about their condition or details of who to call or follow up with regarding their treatment and any referrals made to other services.

The method of information given should be at the discretion of the treating clinician and take into account the patient's understanding of information and any cultural, language and social requirements to assist with understanding of information. Documentation in the patient's Health Care Record of the method used is appropriate, e.g. if verbal instruction only is given or a copy of the discharge letter.

Efforts should be made to contact Residential Aged Care Facility staff to notify them of the resident's return to the facility.

#### **Discharge letter**

If further care by another health professional is required, then a discharge letter is appropriate. The letter should include information about the ED treatment, details of test results carried out in the ED or results which require follow up, any changes to medications and any other relevant information required to ensure continuity of the patient's care. A copy of the letter should remain in the patient's Health Care Record.

#### **Authorisation to depart ED**

All patients leaving the ED require authorisation that they are ready to depart the ED. This is the responsibility of senior medical and nursing staff in the ED (or their delegate) and should be indicated on the Adult and Paediatric ED Observation charts 'Departure and Discharge from ED' checklists (or documented as per equivalent local process).

In EDs where there is no senior medical staff on site, delegation of authorisation to depart the ED will be according to locally agreed to and communicated processes.

### **c. PATIENTS WHO 'LEFT AT OWN RISK'**

A competent adult patient has the right to refuse medical treatment for themselves or their children/dependents. A person is incapable of giving consent if they are not "competent". There is no single legal test or definition of competency. However, in order to be competent to consent to or refuse treatment, a patient must be able to comprehend and retain treatment information and consider the information in order to reach a decision.

The [Guardianship Act 1987](#) provides methods for obtaining consent to treat those persons who are incapable of giving consent. A designated Person Responsible may substitute if the patient is unable to give consent.

All reasonable measures must be undertaken to manage the patient who expresses the wish to leave the ED against medical advice.

This includes ensuring the patient:


- Is counselled by appropriate staff against leaving against medical advice. All attempts to convince the patient to stay should be documented in the patient's Health Care Record.
- Has had the potential consequences of leaving the ED explained in plain language which is relevant to the individual (by the senior doctor/nursing staff or their delegate) including the use of interpreters/Aboriginal Liaison Officer if necessary. This must be explicitly documented in the patient's Health Care Record.
- Is competent to make the decision to leave.
- Is given advice on follow up options.
- Is given the option to return.
- Is encouraged to call to inform a friend or relative, or allow the ED staff to do so where appropriate.
- If appropriate has consulted with an Aboriginal Liaison Officer to ensure culturally appropriate treatment options.

Should a patient be found to have left the ED without the knowledge of staff and there are concerns for the patient's or other's safety, actions taken will be in consideration of both the patient's level of competence to make the decision as well as the risk (clinical or otherwise) to the patient/others.

**Section 2.5.2** of [PD2012 060 \*Transfer of Care from Mental Health Inpatient Services\*](#) provides specific detail on Procedures for locating missing patients which can be applied to the ED setting, particularly for patients being detained under the *Mental Health Act 2007*.




Attachment 1: Adult ED Observation Chart 'Departure and Discharge from ED' checklists.

	FAMILY NAME		MRN
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____/____/____	M.O.	
	ADDRESS		
	LOCATION		
<b>ADULT EMERGENCY DEPARTMENT OBSERVATION CHART</b> COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
<b>MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE</b>			
PROVISIONAL DIAGNOSIS:			
Admitting Consultant name: Delegate name (If applicable): Accepted Care of patient Date: Time:		Clinical Plan explained to patient /carer Yes <input type="checkbox"/> Clinical Plan documented in progress notes Yes <input type="checkbox"/> Admission completed by: ED Medical Officer name: ED Medical Officer signature:	
<b>ED to WARD DEPARTURE CHECKLIST</b>			
<b>NURSING</b>		<b>MEDICAL</b>	
Verified that all documentation is complete • Admission/Transfer forms/eMR <input type="checkbox"/> • Medications charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • Analgesia charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • IV Fluids charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • Fluid Balance up to date <input type="checkbox"/> • Progress notes up to date <input type="checkbox"/> • Risk assessments completed <input type="checkbox"/> Diet: Eat & Drink <input type="checkbox"/> Nil By Mouth <input type="checkbox"/> IVT <input type="checkbox"/> NG <input type="checkbox"/> Infection status: Precautions / Isolation required Yes <input type="checkbox"/> Specify: Contact Precautions / Respiratory Patient belongings sent to ward Yes <input type="checkbox"/> N/A <input type="checkbox"/> Medication sent to ward Yes <input type="checkbox"/> N/A <input type="checkbox"/> Ward accepting care: Ward Nurse accepting care: ED Nurse Transferring name: ED Nurse transferring sign:		Medical Handover given Yes <input type="checkbox"/> No <input type="checkbox"/> Outstanding results and actions handed over: 1. 2. 3. 4. 5. Medical Officer Accepting Care name: ED Medical Officer providing handover Name: Sign: Date: Time:	
<b>AUTHORISATION FOR DEPARTURE FROM ED TO WARD</b>			
<b>NURSING</b>		<b>MEDICAL AUTHORIZATION</b>	
Observations within the last hour Yes <input type="checkbox"/> Is the patient 'Between the Flags' Yes <input type="checkbox"/> No <input type="checkbox"/> If not, clinical reason and plan is documented and signed <input type="checkbox"/>		Alterations to calling criteria charted Yes <input type="checkbox"/> No <input type="checkbox"/> Altered frequency for observations charted Yes <input type="checkbox"/> No <input type="checkbox"/>	
Authorised as safe for transfer Yes <input type="checkbox"/> NUM/ Senior ED Nurse name: NUM/Senior ED Nurse sign: Date: Time:		Authorised as safe for transfer Yes <input type="checkbox"/> ED Medical Officer name: ED Medical Officer sign: Date: Time:	
<b>AUTHORISATION FOR DISCHARGE FROM ED TO HOME</b>			
<b>NURSING</b>		<b>ELDERLY:</b>	
Cannula / ID Band removed Yes <input type="checkbox"/> Discharge / Referral Letter Yes <input type="checkbox"/> Discharge Prescription Yes <input type="checkbox"/> Fact Sheet Yes <input type="checkbox"/> Clothes / Belongings Yes <input type="checkbox"/>		Does the patient live alone Yes <input type="checkbox"/> No <input type="checkbox"/> Time of discharge appropriate Yes <input type="checkbox"/> No <input type="checkbox"/> NOK/person responsible aware? Yes <input type="checkbox"/> No <input type="checkbox"/> Nursing Home / Hostel aware? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Authorised as safe for discharge Yes <input type="checkbox"/> NUM/ Senior ED nurse name: NUM/Senior ED nurse sign: Date: Time:		Authorised as safe for discharge Yes <input type="checkbox"/> ED Medical Officer Name: ED Medical Officer Sign: Date: Time:	

ADULT EMERGENCY DEPARTMENT OBSERVATION CHART

SMR040.010

Attachment 2: Paediatric ED Observation Chart 'Departure and Discharge from ED' checklists

	FAMILY NAME		MRN
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____ / ____ / ____		M.O.
	ADDRESS		
	LOCATION		
<b>PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART</b> <b>1 - 4 YEARS</b>			
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
<b>MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE</b>			
<b>PROVISIONAL DIAGNOSIS:</b>			
Admitting Consultant Name: Delegate Name (if applicable): Accepted Care of patient Date: Time:		Clinical Plan explained to patient / carer Yes <input type="checkbox"/> Clinical Plan documented in progress notes Yes <input type="checkbox"/> Admission completed by: ED Medical Officer name: ED Medical Officer signature:	
<b>PAEDIATRIC ED to WARD DEPARTURE CHECKLIST</b>			
<b>NURSING</b>		<b>MEDICAL</b>	
Verified that all documentation is complete • Admission/Transfer forms/eMR Yes <input type="checkbox"/> • Medications charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • Analgesia charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • IV Fluids charted Yes <input type="checkbox"/> N/A <input type="checkbox"/> • Fluid Balance up to date <input type="checkbox"/> • Progress notes up to date <input type="checkbox"/> • Risk assessments completed <input type="checkbox"/> Diet: Eat & Drink <input type="checkbox"/> Nil By Mouth <input type="checkbox"/> IVT <input type="checkbox"/> NG <input type="checkbox"/> Infection status (incl. recent contact): Precautions / Isolation Required Yes <input type="checkbox"/> Specify: Contact Precautions / Respiratory Parents / Guardian aware of transfer Yes <input type="checkbox"/> Patient Belongings sent to ward Yes <input type="checkbox"/> N/A <input type="checkbox"/> Medication sent to ward Yes <input type="checkbox"/> N/A <input type="checkbox"/> Ward accepting care: Ward Nurse Accepting care: ED Nurse Transferring name: ED Nurse transferring sign:		Medical Handover given Yes <input type="checkbox"/> No <input type="checkbox"/> Outstanding results and actions handed over: 1. 2. 3. 4. 5. Medical Officer Accepting Care Name: ED Medical Officer providing Handover Name: Sign: Date: Time:	
<b>AUTHORISATION FOR PAEDIATRIC DEPARTURE FROM ED to WARD</b>			
<b>NURSING</b>			
Observations within the last hour Yes <input type="checkbox"/> Is the patient 'Between the Flags' Yes <input type="checkbox"/> No <input type="checkbox"/> If not, clinical reason and plan is documented and signed <input type="checkbox"/>		Alterations to calling criteria charted Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Altered frequency for observations charted Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Authorised as safe for transfer Yes <input type="checkbox"/> NUM/ Senior ED Nurse name: NUM/Senior ED Nurse sign: Date: Time:		Authorised as safe for transfer Yes <input type="checkbox"/> ED Medical Officer name: ED Medical Officer sign: Date: Time:	
<b>AUTHORISATION FOR PAEDIATRIC DISCHARGE FROM ED to HOME</b>			
<b>NURSING</b>			
Cannula / ID Band removed Yes <input type="checkbox"/> Discharge /Referral Letter Yes <input type="checkbox"/> Clothes / Belongings Yes <input type="checkbox"/> Discharge Prescription / Medications Yes <input type="checkbox"/>		Discharge in care of parents / guardian Yes <input type="checkbox"/> Education / Fact Sheet Yes <input type="checkbox"/>	
Authorised as safe for discharge Yes <input type="checkbox"/> NUM/ Senior ED Nurse Name: NUM/Senior ED Nurse Sign: Date: Time:		Authorised as safe for discharge Yes <input type="checkbox"/> ED Medical Officer Name: ED Medical Officer Sign: Date: Time:	

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART 1 - 4 YEARS

SMR 110.003



**NSW CRITICAL CARE TERTIARY REFERRAL NETWORKS & TRANSFER OF CARE (ADULTS) (PD2018\_011)**

**PD2018\_011 rescinds PD2010\_021.**

**PURPOSE**

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

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

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

**MANDATORY REQUIREMENTS**

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

**IMPLEMENTATION**

Local Health District Chief Executives are responsible for:

- Ensuring implementation of the policy directive and the delegation of a single point of arbitration and decision making to ensure clinically appropriate transfers in appropriate timeframes.
- Meeting the critical care and intensive care needs of that LHD and linked rural LHD, where specified. This includes the provision of clinical advice and ensuring access to appropriate treatment.
- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe. 298(28/03/18)

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

Intensive Care Units are responsible for:

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

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

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

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

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

## **1 Background**

### **1.1 About this document**

This policy directive provides guidance on the appropriate process for referring and transferring critically ill or injured adult patients to a higher level facility for definitive care.

Patients who are critically ill, injured or at risk of critical deterioration need appropriate access to critical care resources. In order to achieve safe, timely and efficient transfer of these patients to a higher level facility a streamlined process must exist. This document aims to support a seamless and integrated network of critical care services to best meet the needs of patients.

State clinical specialty referral networks operate in conjunction with the critical care networks.

These networks assist in ensuring appropriate and timely patient referral and transfer. Once critical care resources are no longer required by the patient a similarly efficient return transfer to the originating hospital is essential.

The Critical Care Resource management System (CCRS) provides information about available adult critical care beds across NSW. CCRS should be used to inform coordination and placement of critically ill patients to the appropriate higher level facility.

The Aeromedical Control Centre (ACC) is responsible for the statewide coordination of adult medical retrieval services for time urgent critically ill or injured patients in collaboration with the Regional Retrieval Services. The ACC is the central point of contact for the medical retrieval of all time urgent critically ill or injured adult patients.

Each Local Health District (LHD) is responsible for ensuring that escalation plans are in place to ensure clinicians can obtain timely clinical advice and/or support to expedite the review, referral and

appropriate placement of critically ill or injured patients. This must include procedures for clinicians to follow for referral of non-time urgent critically ill patients in situations where there are no appropriate beds and negotiation with the receiving hospital is required (Appendix 2).

Implementation of local models, such as the Greater Western Critical Care Advisory Service (CCAS), should be considered to provide critical care specialist advice and support when required.

This policy does not include referral of paediatric, neonatal, obstetric or patients requiring specialist care and does not override referral networks established within the following policy directives:

- Critical Care Tertiary Referral Networks (Paediatrics) PD 2010\_030 1
- Critical Care Tertiary Referral Networks (Perinatal) PD 2010\_069 2
- Inter-facility Transfer Process for Adults Requiring Specialist Care PD2011\_0315

Table 1 provides a summary of the referral process, contact pathways and responsibilities for time urgent and non-time urgent critically ill patients.

**Table 1: Referral Process Summary**

Referral Process Summary					
Clinical Condition	Urgency of Transfer	Contact	Bed finding responsibility	Initiating Transport	Transfer to
Critically ill or injured	<b>Time urgent</b> Fastest response and or transport by appropriate team (often medical retrieval team)	ACC <sup>1</sup>  Advice for stabilisation and transfer	ACC <sup>1</sup>  Patient automatically transported to nearest hospital that can provide definitive care without delay Hospital acceptance or available bed is desirable but not mandatory  NB: Communication <b>must</b> occur with the receiving hospital prior to transfer	ACC <sup>1</sup>	Linked Tertiary Hospital
	<b>Non-time urgent</b> Response and or transport by appropriate team within appropriate timeframe (often medical retrieval team)	Linked Tertiary Hospital for ICU advice	Linked Tertiary Hospital using CCRS <sup>2</sup> /PFP and PFU <sup>3</sup> /hospital bed manager	Referring clinician contact ACC <sup>1</sup>	Linked Tertiary Hospital
Require Specialist Care	Refer to Inter-facility Transfer Process for Adults Requiring Specialist Care PD2011_0315				

1 Aeromedical Control Centre (ACC) 1800 650 004

2 Critical Care Resource management System (CCRS) <http://ccrs.health.nsw.gov.au>

3 Patient Flow Unit (PFU) and Hospital Bed managers cannot refuse transfer of time urgent critically ill patients

**Key definitions**

**Aeromedical Control Centre (ACC):** A NSW Ambulance unit providing clinical support and advice, transport and escort services for critically ill or injured patients requiring medical retrieval.

**Conference call:** “One phone call” referral where possible to connect the referring clinician, medical retrieval consultant and receiving clinician.

**Critical Care Resource management System (CCRS):** provides information about available adult critical care beds across NSW to inform coordination and placement of critically ill patients to the appropriate level of definitive care.

**Critically ill/injured:** A patient whose illness, injuries or physiologic instability constitutes a significant and imminent threat to their life without appropriate resuscitation and support. Patients may be classified as:

- **Time urgent:** Requiring emergency care at the closest appropriate hospital in the shortest time possible to achieve early intervention and stabilisation.
- **Non-time urgent:** Stabilised requiring transfer for a higher level of definitive critical care or clinical specialty, but whose transfer is not time-urgent.

**Patient at risk of critical deterioration:** A patient who has suffered a significant injury or illness who may appear to be stable but whose condition may quickly deteriorate requiring constant monitoring and early transfer for definitive critical care.

**Non-critical patient requiring specialist definitive care:** A patient requiring referral and transfer for specialist care facilitated by the LHD Patient Flow Unit in consultation with the patient’s clinical management team.

**Escalation process:** Defined procedure for escalation 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.

**Major Trauma Service (MTS):** Can provide the full spectrum of care for major and moderately injured trauma patients.

**Neonatal and paediatric Emergency Transport Service (NETS):** A medical retrieval service for babies and children who require intensive care.

**Patient Flow Portal (PFP):** Electronic system which aims to improve patient flow within a ward, hospital or LHD.

**Patient Flow Unit (PFU):** Responsible for managing patient flow within a given facility or LHD. In rural areas this may be a bed or after hours manager.

**Primary Retrieval:** A patient transferred directly from the scene of an incident or medical emergency to hospital.

**Regional Trauma Service (RTS):** Can provide all aspects of care to patients with moderate to minor trauma, and definitive care to a limited number of major trauma patients in collaboration with the MTS

**Secondary Retrieval:** A patient transferred between health facilities.

298(28/03/18)

**2 NSW Critical Care Tertiary Referral Networks (Adults)**

The NSW adult Critical Care Tertiary Referral Networks define the links between LHDs and tertiary referral hospitals. The networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries and cross jurisdictional border arrangements. In

addition, some ICUs may have functional links with a higher level ICU in a networked approach to provide access to senior critical care advice under the Intensive Care Service Model.<sup>3</sup>

It is not the intention of this policy directive to specify each individual hospital's referral pathways. The referral pathways defined within this document are the established links and the **default** patterns to be used when the default adult ICU bed policy is invoked (Section 12).

Operating in conjunction with the critical care referral networks are state clinical specialty referral networks, which are also defined within this Policy Directive. These referral networks and processes are in place to assist clinicians and Patient Flow Units (PFU) to ensure appropriate and timely referrals. These include:

- NSW Burn Injury Service (Adult)
- NSW Acute Spinal Cord Injury Service (Adult)
- NSW Major Trauma Referrals (Adult)
- NSW Rural Cardiac Catheterisation Services (Adult)
- NSW Extra Corporeal Membrane Oxygenation (ECMO) Medical Retrieval

Table 2 outlines the Critical Care Tertiary Referral Networks for critically ill adult patients requiring transfer to a tertiary facility. These are also the default network for private hospitals within LHDs. Due to proximity some LHDs may also have cross jurisdictional border networks with tertiary critical care services in other states and territories, as outlined below.

**Table 2: NSW Adult Critical Care Tertiary Referral Network**

Referring LHD	Receiving Tertiary Hospital
Central Coast	Royal North Shore
Far West	Royal Prince Alfred, South Australia (Adelaide) <sup>1</sup>
Hunter New England	John Hunter
Illawarra Shoalhaven	St George
Mid North Coast	John Hunter, Queensland <sup>3</sup>
Murrumbidgee	ACT <sup>2</sup> (Canberra), Prince of Wales, St George, St Vincent's, Victoria (Mlb) <sup>4</sup>
Nepean Blue Mountains	Nepean
Northern NSW	John Hunter, Queensland <sup>3</sup>
Northern Sydney	Royal North Shore
South Eastern Sydney	Prince of Wales, St George
South Western Sydney	Liverpool
Southern NSW	ACT (Canberra) <sup>2</sup> , Prince of Wales, St George
Sydney	Royal Prince Alfred
Western NSW	Royal Prince Alfred
Western Sydney	Westmead
Due to proximity some LHDs and facilities also maintain clinical referral networks as follows:	
<ul style="list-style-type: none"> <li>• Far West: South Australia<sup>1</sup>.</li> <li>• Murrumbidgee: ACT<sup>2</sup> (Batlow, Boorowa, Murrumbarrah-Harden, Tumut, Young), Victoria<sup>4</sup> (Albury)</li> <li>• Mid North Coast: Queensland<sup>3</sup>.</li> <li>• Northern NSW: Queensland<sup>3</sup> (Tweed)</li> <li>• Southern NSW: ACT<sup>2</sup> (Bateman's Bay, Bombala, Boorowa, Braidwood, Crookwell, Cooma, Delegate, Goulburn, Moruya, Pambula, Queanbeyan South East Regional (Bega) and Yass)</li> </ul>	

### 3 Which Adults May Need Medical Retrieval?

Patients with actual *or potential significant illness or injuries who are at risk of critical deterioration* and **may** require retrieval in the event that the originating hospital is unable to safely continue care include:

**Airway**

- All intubated patients
- Patients potentially requiring airway intervention enroute (threatened airway obstruction, altered or decreasing LOC, head/neck trauma, head/neck / inhalation burns)

**Breathing**

- Significant respiratory distress or compromise after treatment
- RR < 8 or >30, SpO<sub>2</sub> < 90% on 15L oxygen
- PaO<sub>2</sub> <60 or PaCO<sub>2</sub> >60 or pH < 7.2 or BE <-5
- Respiratory dependency on NIV

**Circulation**

- Circulatory shock of any cause
- Heart rate < 40 or > 140 beats per minute with compromise
- SBP ≤ 90mmHg
- Complex or recurrent arrhythmias with compromise (e.g. recurrent VF, sustained VT, CHB)
- Ongoing significant bleeding

**Disability**

- Significant altered LOC - GCS ≤ 13
- Significant head injury
- Severe burns
- Acute spinal cord injuries
- Recurrent or prolonged seizures
- Intracerebral bleeding

**Other**

- Acute life-threatening electrolyte abnormality

**Note:** This list does not necessarily indicate time urgent, but is a list of patients who may need physician-escorted retrieval

### 4 NSW Aeromedical Control Centre (ACC)

The Aeromedical Control Centre (ACC) is a unit of NSW Ambulance which provides statewide 24-hour coordination and support:

- For **time urgent** critically ill or injured patients, the ACC will provide critical care clinical advice from a critical care consultant, location of and referral to an appropriate receiving hospital and mobilise a medical retrieval team (Section 7).
- For non-time urgent critically ill or injured patients, the ACC will organise and mobilise an appropriate clinical team (usually physician escort) (Section 8).
- The ACC will coordinate and mobilise an appropriate medical retrieval team for all medical retrievals (from both public and private facilities, to public facilities).
- Where possible; the ACC will coordinate a one phone call referral via conference call to connect the referring clinician, retrieval consultant and receiving clinician. The
- ACC and regional Ambulance Control Centres monitor all 000 calls for mechanisms and injuries suggestive of severe trauma, and dispatch appropriate retrieval teams (usually Doctor/paramedic) where indicated.
- The medical retrieval team can provide a variety of interventions including; advanced airway management, chest trauma management, advanced vascular access, transfusions, compression of bleeding sites and some time urgent surgical procedures where no viable alternative exists.

298(28/03/18)

The ACC is **not** responsible for coordinating the transfer of non-critically ill patients. These patients must be managed by the LHD as per Section 9.



### 5. Key Elements of the Medical Retrieval System

- The ACC provides statewide coordination of adult medical retrieval services, in collaboration with the regional retrieval services.
- Retrievals may be undertaken by road, fixed wing aircraft or helicopter. Vehicle choice is based on the clinical urgency, transport requirements, optimum transport team, vehicle utilisation and available resources.
- All retrieval services can transport critically ill or injured patients by road ambulance using appropriate advanced medical equipment and clinical staff. An overview of adult retrieval services can be found at Table 3.
- Fixed wing aircraft and helicopters are not capable of safe flight in adverse weather conditions. The ACC uses a protocol to balance clinical priority and aviation risk. Factors such as fatigue, darkness and cold temperatures (fog, icing) increase aviation risk. Therefore, non-urgent transfers are not usually undertaken between midnight and 0700hrs.
- Aviation factors may influence the destination hospital and in some cases alternatives such as long road transfers, with or without an appropriate medical retrieval team, may be necessary.
- Critically ill or injured patients must be transferred to the nearest (in-time) designated appropriate facility (e.g. Major Trauma Service), irrespective of ICU bed status, so that emergency stabilisation and treatment can commence with minimal delay.
- In some cases, the referring clinician, retrieval consultant and receiving clinician may decide to refer a patient to a different hospital which is considered more clinically appropriate for that patient's definitive care.
- Ultimate responsibility for vehicle and team choice rests with the ACC retrieval consultant, with input from relevant stakeholders. Where there is a difference in clinical opinion regarding the appropriateness of the transfer, the final decision will be made by the ACC. This will follow a conference call between the referring clinician, retrieval consultant and receiving clinician, as per retrieval resources (Appendices 5-7).

Overview of adult medical retrieval services							
Aircraft	Location	Uses	Number of aircraft	Patient capacity	Bariatric capacity Max	IABP transfers	ECMO transfers
Fixed Wing	Broken Hill (Royal Flying Doctor Service)	Inter hospital transfer Primary mission Outreach clinic service	1	1-2	230kg	Fixed wing and helicopters are capable of IABP and ECMO transfer  Originate from Sydney and require specialist medical staff and equipment	
	Dubbo (Royal Flying Doctor Service)	Inter hospital transfer	1	1-2			
	Sydney (Bankstown)	Inter hospital transfer	4	1-2			
Helicopter	Sydney (Bankstown)	Primary mission	3	1 critically ill	130kg <sup>1</sup> / 200kg		
	Lismore	Retrieval	1	2 in some cases			
	Tamworth		1				
	Newcastle (JHH)	Search & rescue	1				
	Orange	Water Rescue	1				
	Wollongong		1				
	Canberra		1				

<sup>1</sup> Standard helicopter stretcher capacity is 130kg. Patients exceeding this need a 200kg stretcher and the ACC must be advised of this need in advance. Other requirements outlined in section 6 must also be met.

## 6. Obese Patients

The transfer of critically ill or injured obese patients can be clinically and logistically challenging. Different vehicles and stretchers are used to transport obese patients and limitations in weight capacity need to be considered including:

- The weight the stretcher, loading and securing mechanisms, and vehicle floor can support
- The stretcher width and whether the patient can physically fit and be restrained safely.

The transfer of obese patients by any vehicle is usually much slower than normal transfers. Occasionally the retrieval may occur in two separate stages; with rapid dispatch of clinical retrieval staff to aid in resuscitation the first step, followed by transport to definitive care.

Prior to commencing retrieval of any patient above 110kg, an **accurate** weight and maximum measured width must be determined, as per Bariatric Sizing Chart (Appendix 5). **Hospitals must ensure they can weigh patients**, as an estimate is unacceptable and may result in delays as alternative vehicles, stretchers and restraint systems are sourced.

298(28/03/18)

In addition to the patient's weight and measurement, any logistical issues and resource requirements such as sufficient personnel, equipment and facilities to transport the patient to and into the vehicle must be considered, as per Table 4. Lack of resources may delay or negate the possibility of transfer or necessitate road transfer irrespective of distance.

At the time of retrieval request, the above information must be communicated to the ACC to help determine the most appropriate mode of transport.

The NSW Health Guideline [GL2005\\_070](#) “Occupational Health & Safety Issues Associated with Management of Bariatric (Severely Obese) Patients” 4 should be referred to for the management of obese patients.

**Table 4: Retrieval transport modes and resource considerations**

Vehicle type	Road	Road Multi Purpose Vehicles (MPVs)	Fixed wing	Helicopter
Maximum weight	200kg	Any weight and size	230kg	130kg - normal stretcher 230kg - bariatric stretcher (must be added before leaving base)
Considerations	Patient width	Limited number of vehicles  May not be available in suitable timeframe, depending on patient location	Can road legs to / from airports accommodate patient weight	Onsite concrete helipad  Flat paved pathways into/out of hospital
Resources	Sufficient personnel Equipment and facilities to transport patient to and into vehicle: <ul style="list-style-type: none"> <li>• Manual handling aides</li> <li>• Height adjustable trolley (as per below)</li> </ul>			
Hospital trolley	Minimum safe working load	300kg		
	Height adjustable	660mm to 1020mm above ground level		
	Patient platform length	2 metres- with no raised edging at one end		
	Patient platform width	700mm		
	Patient platform surface	Smooth with raised edges on both sides and one end		
	Patient restraint system	Must have		
Large wheels	Suitable for manoeuvring from hospital to helipad			
Bariatric chart	Complete and return to ACC as soon as possible			
Contact ACC	Provide weight, measurement and logistical considerations as soon as possible to inform transport mode			

<sup>1</sup> Standard helicopter stretcher capacity is 130kg. Patients exceeding this need a 200kg stretcher and the ACC must be advised of this in advance.

### **7. Time Urgent Patients Requiring Critical Care Referral**

The ACC should be the first point of contact for all time-urgent critically ill or injured patient referrals, as per Appendix 1. PFUs should **not** be the first point of contact.

The ACC will provide critical care clinical advice, referral to the appropriate linked tertiary hospital consultant, bed finding and patient transfer for **time urgent** critically ill or injured patients from public and private facilities to public facilities.

Some examples of time-urgent patients include; traumatic head injury requiring urgent craniotomy, exsanguinating multi trauma patient, STEMI with cardiogenic shock, severe burns, acute spinal cord injury with motor sensory level and uncontrolled bleeding with ongoing shock after resuscitation from gastrointestinal or obstetric blood loss.

All time urgent transfers must be discussed with a retrieval consultant, even if the referring clinician believes a medical retrieval will not be the best option for the patient. There are added risks involved with transferring patients between hospitals without appropriately trained staff and properly secured medical equipment. If it is agreed that another option such as road ambulance transfer, with or without nurse or local doctor escort, is best, the retrieval consultant can organise an expedited ambulance response.

The referral process for **time urgent** critically ill or injured patients is:

- Referring clinician to contact ACC and, where possible, a conference call will be established; between the referring clinician, retrieval consultant and receiving clinician at the linked tertiary hospital.
- If a closer hospital can provide the time urgent treatment, the ACC may elect to transport the patient there. In each case the retrieval consultant will notify the receiving clinician.
- Clinical and logistical advice will be provided to the referring clinician to support the stabilisation and resuscitation of the patient.
- The timing of transfer will be triaged and coordinated by the ACC within the context of competing priorities.
- The ACC is responsible for providing timely updates to the referring clinician on dispatch and estimated time of arrival of the medical retrieval team.
- The referring clinician is responsible for ensuring:
  - Specific information regarding the patient’s clinical status, management and any special considerations such as weight or logistical issues are provided to the ACC.
  - Timely updates of any significant changes in the patient’s condition are provided to the ACC.
- The referring and receiving hospitals are responsible for notifying their PFU/hospital bed or after hour’s managers of the impending transfer. However, PFU/ hospital bed or after hours managers **cannot** refuse transfer of time urgent critically ill or injured patients.

The ACC can be contacted on: 1800 650 004.

Retrieval resources including the bariatric sizing chart as per Appendices 5-8.

### 8 Non-Time Urgent Patients Requiring Critical Care Referral

The LHD is responsible for providing 24/7 mechanisms for critical care clinical advice, location of an appropriate receiving hospital and bed (which may be outside the LHD). Established LHD processes are usually via a critical care consultant attached to the linked tertiary hospital or PFU and the Critical Care Resource management System.

The ACC retrieval consultant is available to supplement clinical advice and task an appropriate clinical team to effect the transfer.

Some examples of non-time urgent patients include; ventilated and stable drug overdose, patients ventilated for respiratory failure who do not require an urgent life-saving procedure, stable ventilated multi trauma patients that have been appropriately imaged and do not require urgent surgery or intervention.

The ACC should be contacted as soon as possible and advised of the impending retrieval as outlined in Appendix 1. However, the role of ACC does **not** extend to locating beds or facilitating clinical referral for critically ill or injured patients who are **non-time urgent**. This remains the responsibility of the LHD, regardless of whether the linked tertiary hospital or LHD can provide an appropriate bed themselves.

Communication must occur with the receiving hospital prior to transfer. Once the patient has been accepted at the receiving hospital then ACC should be contacted to undertake the retrieval.

The referral process for **non-time urgent** critically ill or injured patients is:

- Referring clinician to contact their LHD's nominated central point for critical care advice such as the CCAS model with PFU attached medical officer, or linked tertiary referral hospital
- Clinical discussion to occur between referring clinician and LHD central point to determine clinical transfer priority, facilitate conference call with appropriate receiving consultant, facilitate transfer and assist with bed location as required
- Referring clinician/LHD central point to contact ACC to initiate transport and, where possible, a conference call will be established; between the referring clinician, retrieval consultant and receiving clinician
- The timing of transfer will be triaged and coordinated by the ACC and communicated within the context of competing priorities
- The referring clinician/LHD central point is responsible for ensuring communication of all relevant information to the ACC, as per Section 7
- The referring and receiving hospitals are responsible for notifying their PFU/hospital bed or after hour's managers of impending transfers.

### 9 Non-Critical Patients Requiring Referral for Specialist Care (Adults)

The role of ACC does **not** extend to locating beds or facilitating clinical referral for non-critical patients requiring specialist care.

Some examples of these patient types include; physiologically stable STEMI and conscious FAST-positive stroke patients requiring consideration of thrombolysis or neurointervention. All transfers must occur as per "Inter-facility Transfer Process for Adults Requiring Specialist Care" PD2011\_031.

The volume of referrals and multitude of clinical referral networks for non-critical patients necessitates a decentralised model. However, it is recognised that in some cases, unless the referral and transfer is timely, the situation may become critical.

must be in place to ensure patients who require specialist referral are afforded timely access to definitive care.

PFUs/hospital bed or after hours managers support these established networks and facilitate non-critical referrals for patients requiring a higher and/or more specialised level of definitive care. All non-critically ill patients who require time urgent treatment and inter facility referral and transfer for specialist care should be facilitated through the LHD PFU/hospital bed or after hours manager, LHD transport services and if needed NSW Ambulance.

### **10 Critical Care Resource Management System(CCRS)**

Currently the CCRS provides information about available adult critical care beds across NSW. There are plans to include this functionality into the PFP, however until this time CCRS should be used to inform coordination and placement of critically ill patients.

The web based CCRS receives automated data feeds from the Patient Flow Portal (PFP) every fifteen minutes via the LHD Patient Administration Systems (PAS) to inform ICU bed status. Manual updates are also required in real time to ensure that information is accurate and reflective of issues which can affect bed availability, such as staff availability. CCRS can be accessed via <http://ccrs.health.nsw.gov.au>.

The aim of CCRS is to improve access to adult intensive care beds for critically ill patients across NSW. Where appropriate, regional critical care services should be considered as potential sites to refer critically ill patients to improve overall access to intensive care beds. Statewide networking increases the number of patients able to be managed in regional centres and cared for closer to their home and family.

The linked tertiary hospital is responsible for bed finding using CCRS. If the patient has a time urgent critical condition needing transfer in the shortest time possible ACC should be contacted as per Section 7.

Each ICU is responsible for ensuring the information in CCRS is correct and current. Each ICU is required to check and verify the unit bed status at each nursing shift handover.

### **11 Statewide Clinical Specialty Referral Networks**

Operating in conjunction with the adult critical care referral networks are the state adult clinical specialty networks. These networks are designed to achieve appropriate concentration of highly specialised services which can respond to the needs of NSW residents.

These specialty networks are outlined in Sections 11.1-11.6 and include:

- Burns
- Spinal
- Trauma
- Cardiac Catheterisation
- Extra Corporeal Membrane Oxygenation (ECMO)

Note should be taken of the most appropriate referral facility and the ability to take combined injuries such as burns, spinal and trauma if needed.

### 11.1 NSW Severe Burn Injury Service Referral Network (Adult)

The NSW Adult Statewide Severe Burn Injury Service is located at Concord Repatriation General Hospital and Royal North Shore Hospital. Patients may be retrieved to either one of these, except in the following circumstances where patients should be transported directly to Royal North Shore Hospital:

- Adult with burn injury and actual or suspected severe trauma
- Adult with burn injury and acute spinal cord injury
- Adult with burn injury during 2nd and 3rd trimester pregnancy.

Patients with severe burn injury should be referred according to the “NSW Burn Transfer Guidelines NSW Burn Injury Service”<sup>6</sup>, available at: <https://www.aci.health.nsw.gov.au/resources/burn-injury>.

The Severe Burn Injury Service Referral Network defines specialist burn injury services for severe burns and networked LHDs.

**Table 5: NSW State Burn Injury Service Referral Network (Adult)**

NSW Severe Burn Injury Service Referral Network (Adult)	
Referring Local Health District	Receiving Severe Burn Hospital
Australian Capital Territory (ACT) Far West NSW LHD Illawarra Shoalhaven LHD Murrumbidgee LHD Nepean Blue Mountains LHD South Eastern Sydney LHD South Western Sydney LHD Southern NSW LHD Sydney LHD Western NSW LHD Western Sydney LHD	<b>Concord Repatriation General Hospital</b> <ul style="list-style-type: none"> <li>• Burns Registrar/Consultant on-call Ph: (02) 9767 5000 then page</li> <li>• Intensive Care Unit Ph: (02) 9767 6404</li> <li>• Burn Unit/Ambulatory Care Ph: (02) 9767 7775 (b/h) Ph: (02) 9767 7776 (a/h) Fax (02) 9767 5835</li> <li>• Burns CNC Ph: (02) 9767 5000 then page Office (02) 9767 7798</li> </ul>
Central Coast LHD Hunter New England LHD Mid North Coast LHD Northern NSW LHD Northern Sydney LHD	<b>Royal North Shore Hospital</b> <ul style="list-style-type: none"> <li>• Burns Registrar/Consultant on-call Ph: (02) 9926 7111 then page Registrar on call.</li> <li>• Intensive Care Unit Ph: (02) 9463 2600</li> <li>• Burns Unit/Ambulatory Care Ph: (02) 9463 2108 (b/h) Ph: (02) 9463 2111 Fax: 9463 2006</li> <li>• Burns/Plastics CNC Ph: 9926 7111 then page 41731 Office (02) 9463 2102</li> </ul>

Due to proximity some LHD and hospitals may maintain specialty referral networks Interstate; Adult Retrievals: Contact ACC 1800 650 004

### 11.2 NSW State Spinal Cord Injury Referral Network (Adult)

The NSW Adult State Spinal Cord Injury Service (SSCIS) is located at Prince of Wales Hospital and Royal North Shore Hospital. Patients may be retrieved to either one of these, except patients who have combined severe trauma and acute spinal injury should be transported directly to Royal North Shore Hospital, if clinically appropriate

The SSCIS is responsible for the management of patients who have sustained an acute spinal cord injury where there is persistent neurological deficit arising from damage to neural tissue as a result of trauma, or a non-progressive disease process (e.g. transverse myelitis, vascular occlusion, compression by infective process or haemorrhage).

Trauma patients who have sustained a spinal injury with neurological deficit must be transferred to a SSCIS as soon as medically stable. The relevant SSCIS should be notified immediately in all cases where a spinal cord injury has been sustained to facilitate referral and transfer as soon as possible, and to obtain clinical management advice.

This referral process only relates to acute spinal cord injuries with neural loss and those spinal cord injuries as defined by the SSCIS. Patients with vertebral fractures only, are to be referred to a Spinal/Orthopaedic or Neurosurgeon via the existing specialist trauma referral process for each LHD.

The State Spinal Cord Injury Referral Network defines specialist spinal services for acute spinal cord injuries and networked LHDs.

**Table 6: NSW State Spinal Cord Injury Service (SSCIS) Referral Network (Adults)**

NSW State Spinal Cord Injury Service (SSCIS) Referral Network (Adults)	
Referring Local Health District	Receiving Spinal Cord Injury Service
Australian Capital Territory (ACT) Illawarra Shoalhaven Murrumbidgee South Eastern Sydney Southern NSW South Western Sydney Sydney St Vincent's Health Network	<b>Isolated Spinal Cord Injury:</b>  <b>Prince of Wales Hospital PH: (02) 9382 2222</b>  <b>ASK for - On-Call Spinal Surgical Consultant</b>  <b>NB: For referrals with an acute SCI, transfer arrangements within 24 hrs. of injury will be expedited through the POWH policy of non-refusal</b>
Central Coast Far West Hunter New England Mid North Coast Nepean Blue Mountains Northern NSW Northern Sydney Western NSW Western Sydney	<b>Isolated or combined severe trauma and Spinal Cord Injury:</b>  <b>Royal North Shore Hospital PH: (02) 9926 7111</b> (For acute traumatic and non-traumatic SCI) <b>ASK for: On-Call Spinal Surgical Consultant</b> <b>Royal Rehab PH: (02) 9807 1144</b> (For SCI Rehabilitation)

Due to proximity some LHD/ hospitals may maintain specialty referral networks Interstate.; Adult Retrievals: Contact ACC 1800 650 004



### 11.3 NSW Major Trauma Referral Networks (Adult)

The NSW adult trauma services provide expert multidisciplinary care for injured patients. The referral network for NSW trauma patients includes Regional Trauma Services (RTS) and Major Trauma Services (MTS). For patients with time urgent critical injuries, the first call should be to the ACC.

The trauma response begins with early identification of actual or potential severely injured patients by paramedics on scene or by hospital clinical staff. Transfer notification for major trauma patients should occur concurrently with treatment and imaging, and should not be delayed for want of a definitive diagnosis.

When an injured patient is initially managed at a local hospital, the hospital should expedite consultation and transfer to the networked RTS or MTS, as per trauma guidelines<sup>7</sup>.

RTS can provide all aspects of care to moderate - minor trauma patients and definitive care to a limited number of major trauma patients, in consultation with the networked MTS. This may include transfer to a MTS for services not available at the RTS.

The MTS can provide the full spectrum of care to major - moderately injured patients.

Patients with major trauma injury should be referred according to the “NSW Major Trauma Retrieval & Transfers Consensus Guidelines - NSW Institute of Trauma and Injury Management (ITIM)”, available at: <https://www.aci.health.nsw.gov.au/get-involved/institute-of-trauma-and-injury-management/clinical/trauma-guidelines/Guidelines>

All time urgent critically injured trauma patients must be transferred directly to the networked designated trauma service that can provide the required time urgent treatment (usually damage control surgery) prior to subsequent transfer. The ACC or regional retrieval consultant will make this decision in consultation with the referring hospital, retrieval team and receiving hospital.

If clinically appropriate, the following groups of trauma patients should be transferred directly as follows:

- **Isolated injury - acute spinal cord injury or burn injury** - to relevant service (see 11.1-11.2)
- **Combined injury** - acute spinal cord injury or burn injury and severe trauma - to Royal North Shore Hospital

All non-time urgent major trauma patients should be transferred to the nearest appropriate trauma service which may be either an RTS or MTS.

The NSW Trauma Services Referral Network defines specialist trauma services for trauma injuries and networked LHD's.

Table 7: NSW Trauma Services Referral Networks (Adult)

NSW Trauma Services Referral Networks (Adult)		
Referring Local Health District	Regional Trauma Service	Major Trauma Service
Central Coast Northern Sydney	Gosford	Royal North Shore
Far west <sup>4</sup> Nepean Western NSW Western Sydney	Nepean Orange	Westmead
Hunter New England Mid North Coast Northern NSW <sup>1</sup>	Coffs Harbour Lismore <sup>1</sup> Port Macquarie Tamworth Tweed <sup>1</sup>	John Hunter
Illawarra Shoalhaven Murrumbidgee <sup>2&amp;3</sup> South Eastern Southern NSW <sup>3</sup>	Wollongong Wagga	St George  Australian Capital Territory
South Western Sydney	NA	Liverpool
Sydney	NA	Royal Prince Alfred
NA	NA	St Vincent's
Due to proximity the following LHD/ hospitals maintain referral networks as follows: 1. Northern NSW - Queensland. 2. Victoria. 3. The ACT (Canberra) - Batemans Bay, Batlow, Bombala, Boorowa, Braidwood, Cooma, Crookwell, Delegate, Goulburn, Moruya, Pambula, Queanbeyan, South East Regional (Bega), Tumut, Yass and Young. 4. Broken Hill - South Australia.		

Adult Retrievals: Contact ACC 1800 650 004

### 11.4 NSW Rural Cardiac Catheterisation Laboratory Referrals (Adults)

Rural adult cardiac catheterisation services are located at Tamworth, Orange, Wagga Wagga, Port Macquarie, Coffs Harbour and Lismore.

Critically ill patients requiring time urgent inter-hospital transfer from a rural cardiac catheter service to a tertiary hospital for an urgent procedure (usually interventional cardiology or surgery) should be immediately transferred, regardless of bed availability as per Section 7.

The ACC should be contacted to facilitate the transfer. Where an Intra-Aortic Balloon Pump (IABP) device is required for an aeromedical transfer the ACC, must provide their own IABP device (authorized for aeromedical transport) and team (both located in Sydney).

If an IABP is not absolutely required to manage an unstable patient, referring cardiologists should consider whether the presence of the IABP is more important than the necessary delay in transfer time it will incur. The ACC consultant can advise in individual cases what the time differential is likely to be.

The Cardiac Catheterisation Laboratory Referrals (Adults) defines services and networked LHDs.

**Table 8: NSW Cardiac Catheterisation Laboratory Referral Networks**

NSW Cardiac Catheterisation Laboratory Referral Networks	
Referring Local Health District	Receiving Cardiac Catheterisation Service
Far West	South Australia
Hunter New England	John Hunter
Murrumbidgee	St Vincent's
Mid North Coast	Prince of Wales
Northern NSW	Lismore, Queensland
Southern NSW	Australian Capital Territory (ACT)
Western NSW	Royal Prince Alfred

Due to proximity some LHD and hospitals may maintain specialty referral networks interstate.  
Some sites listed may not be operational 24/7. Sites should periodically update local information to include availability  
Retrievals- Adults: Contact ACC 1800 650 004

### 11.5 NSW Extra Corporeal Membrane Oxygenation (ECMO) Medical Retrieval Service

ECMO therapy is used in many tertiary hospital ICUs to temporarily support patients with cardiac and/or respiratory failure. Most commonly this is post cardiothoracic surgery or patients with refractory respiratory failure unresponsive to advanced mechanical ventilation techniques.

Patients who are in smaller hospitals with severe cardiac and/or respiratory failure may also be approaching or beyond the limits of conventional organ support (mechanical ventilation, inotropes etc.). Some of these patients are not safely transportable even by medical retrieval teams.

The NSW ECMO retrieval service enables patients in non-tertiary hospitals to receive this therapy if appropriate and be transported to a tertiary hospital for ongoing care.

ECMO is provided by either Royal Prince Alfred (RPAH) or St Vincent's Hospitals (SVH) via a roster system. The service involves collaboration between the active ECMO/ICU clinicians, medical retrieval services and NSW Ambulance. A combined ECMO and retrieval team is transported to the referring hospital with appropriate equipment to establish the patient on ECMO and transport the patient back to RPAH or SVH by helicopter, fixed wing or road vehicle.

To organise the referral and transfer of a patient requiring rescue ECMO the following steps must occur:

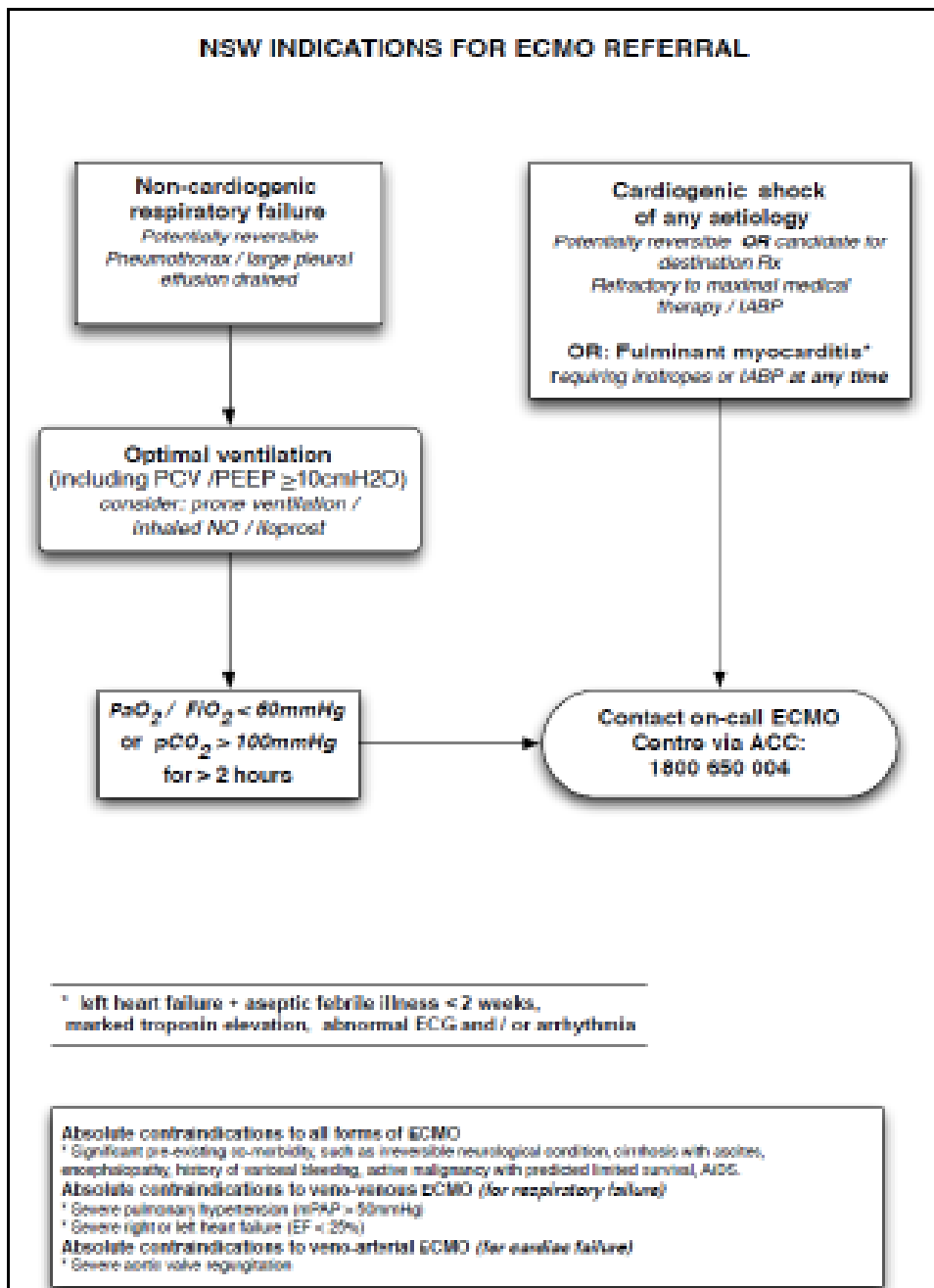
- Early notification of a patient potentially requiring referral for ECMO (Diagram 1)
- Initial contact to be made with ACC who will contact the active ECMO service
- A one phone call referral via conference call is used to connect the referring clinician, medical retrieval consultant and receiving ICU consultant
- The destination hospital will be determined according to the patients underlying condition, required clinical/surgical intervention and access to an available ICU bed.

ECMO Services	
Royal Prince Alfred Hospital	St Vincent's Hospital
PH: (02) 95156111 Ask for: ECMO intensivist on call	PH: (02) 83821111 Ask for: ICU North consultant on duty
The RPA and SVH ECMO roster is available at <a href="https://www.google.com/calendar/embed?src=7p3e1u53fvo59tkmfioK2qad6k%40group.calendar.google.com&amp;ctz=Australia/Sydney">https://www.google.com/calendar/embed?src=7p3e1u53fvo59tkmfioK2qad6k%40group.calendar.google.com&amp;ctz=Australia/Sydney</a> (requires Chrome, not reliable with internet explorer)	

Retrievals- Adults: Contact ACC 1800 650 004

Case selection and treatment protocols used during ECMO are defined by the international Extracorporeal Life Support Organisation (ELSO). Diagram 1 outlines the indications for ECMO therapy and referral based on guidelines developed by ELSO and used internationally.

Diagram 1: NSW Indications for ECMO Referral



Developed based on guidelines developed by EL SO and used internationally

### 11.6 NSW Paediatric, High Risk Obstetric and Perinatal Referrals

All paediatric referrals and transfers must be arranged according to the Critical Care Tertiary Referral Networks (Paediatrics) PD 2010\_030 1 and coordinated via NETS.

All high risk obstetric and perinatal transfers must be arranged according to the Critical Care Tertiary Referral Networks (Perinatal) PD 2010\_0692 and coordinated via the Pregnancy Advice Line (PAL) and NETS on 1300 36 2500.

### 12 NSW Default Adult ICU Bed Policy

Access to emergency care and/or urgent surgical intervention for time urgent critically ill or injured patients must not be delayed due to no-available ICU bed. The ACC should be contacted immediately for such patients.

In time urgent situations, the ACC has the authority to transport the patient directly to the linked tertiary hospital designated by the NSW Adult Critical Care Referral Network regardless of bed state. If there is a closer facility that can provide the time urgent treatment, ACC may elect to transport the patient there.

Each LHD is ultimately responsible for meeting the critical care and intensive care needs (except for super-specialty services) of that LHD and linked rural LHD, where specified. This includes the provision of clinical advice and access to appropriate treatment. In addition, each LHD has a responsibility to ensure that all options for placement of the patient within the LHD have been explored and that all appropriate transfers from ICU to inpatient wards have been made to create capacity.

The LHD Chief Executive (CE) is responsible for; ensuring formalised intra and inter LHD and/or cross jurisdictional referral arrangements exist for critically ill or injured patients needing a higher level of definitive care and for non-critically ill or injured patients requiring referral for specialist care and; that clinical referral and support processes are transparent and effectively communicated to all staff to ensure patients can access definitive care in an appropriate timeframe. The ACC may contact the CE where necessary to resolve inter-LHD and non-urgent transfers.

The NSW default adult ICU bed policy may be invoked, when there are no adult intensive care beds available across NSW for a non-urgent critical patient. This must only occur after thorough assessment of ICU capacity and intra/inter-LHD critical care referral networks to ensure all potential referral options have been exhausted.

If the NSW Default Adult ICU Bed Policy is activated, the tertiary referral hospital designated by the NSW Adult Critical Care Referral Network (will be responsible for providing critical care, irrespective of bed status, to a specified group of referral hospitals. (Table 2 and Appendix 3). This responsibility includes assisting with patient placement to an appropriate alternative location for treatment and care.

The NSW Default Adult ICU Bed Policy is based on a hospital-to-hospital network and does not necessarily follow the normal LHD Critical Care Referral Networks.

In specific cases the referring clinician, retrieval consultant and the receiving clinician may decide to refer a patient to a different hospital which is considered more clinically appropriate for the patient's definitive care.

If the default adult ICU bed policy is invoked, a phone referral via conference call, outlined in Section 4, must still occur and the receiving clinician **must** be notified as soon as possible and prior to patient arrival.

**12.1 Invoking the Default Adult ICU Bed Policy:**

- For time urgent patients, the ACC will contact the linked tertiary hospital, or if appropriate a closer facility, and transport the patient there, regardless of bed state.
- In all other cases, the referring hospital should contact their linked tertiary ICU. If the linked ICU does not have an available bed they are responsible for finding an alternative bed which may be within or outside of the LHD.
- All units to use their escalation policy to review exit blocked beds, liaise with the hospital executive to have them cleared and update CCRS.
- The LHD's tertiary ICU verifies that there are no appropriate available ICU beds either within or outside the LHD, with the assistance of CCRS.
- Where no appropriate available ICU bed can be identified across the system the **designated tertiary ICU** will accept the patient, irrespective of bed status.

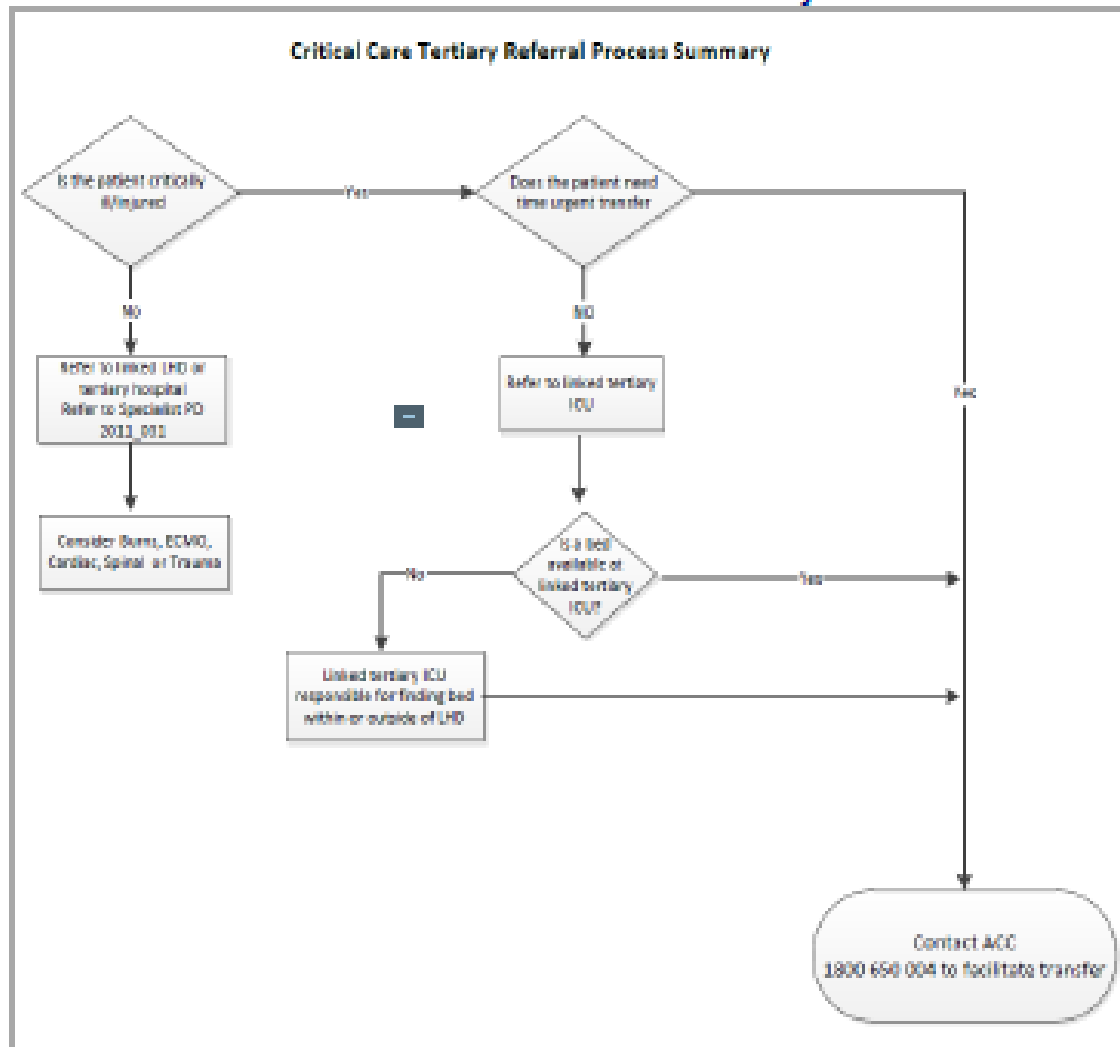
Prior to patient transfer a phone referral via conference call, outlined in Section 4, must occur and the receiving clinician must be notified as soon as possible and prior to patient arrival.

Fundamental to this procedure being activated is the principle that:

**Where a patient requires time urgent critical care, not available at the referring hospital, then the patient must be transferred immediately to the facility designated by the NSW Adult Critical Care Tertiary Referral Network that is able to provide appropriate emergency treatment irrespective of bed status.**

**Aeromedical Control Centre (ACC) 1800 650 004.**

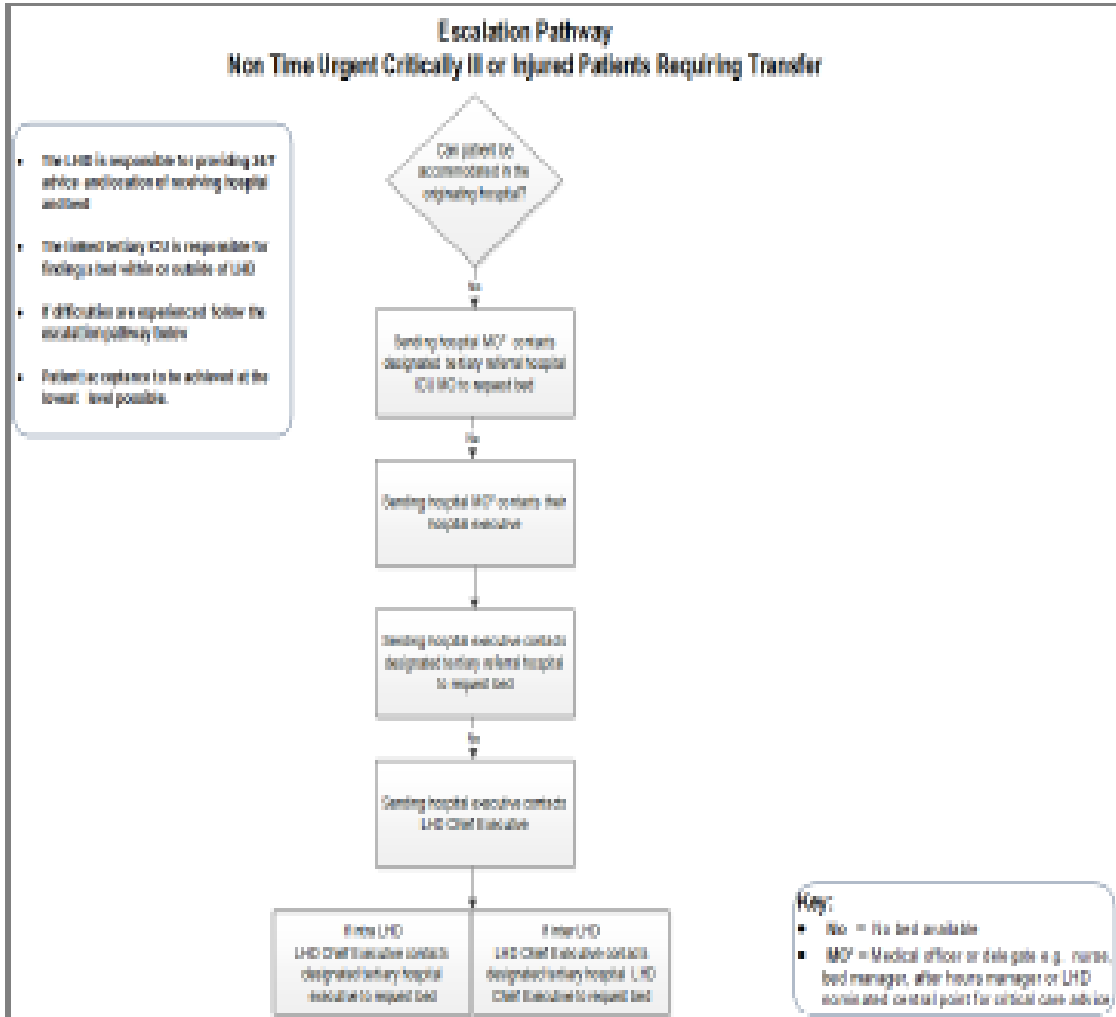
## APPENDIX 1: Critical Care Referral Process- Summary



- Time urgent referral - ACC 1800 650 004.(In emergencies notification can occur prior to full patient assessment and investigation)
- Non-time urgent referral - facilitated via CCRS via <http://ccrs.health.nsw.gov.au>
- Clinical speciality networks:
  - Burns - section 11.1:
    - Concord Hospital (02) 9767 5000
    - Royal North Shore Hospital (02) 9926 7111
  - Spinal - section 11.2
    - Prince of Wales Hospital (02) 9382 2222
    - Royal North Shore Hospital (02) 9926 7111
  - Trauma - section 11.3
  - Cardiac Catheterisation - section 11.4
  - Extra Corporeal Membrane Oxygenation (ECMO) - section 11.5
- Patients above 110kg must have bariatric sizing chart completed and sent to ACC.



**APPENDIX 2: Escalation Pathway - Example**



## APPENDIX 3: Critical Care Referral Networks

LHD	Facilities	Tertiary Hospital
Central Coast	Gooford, Long Jetty, Woy Woy, Wyong	Royal North Shore
Far West <sup>1</sup>	Bainbrake, Broken Hill, Ivanhoe, Merindee, Tibooburn, Wentworth, White Cliffs, Wilcannia	Royal Prince Alfred, South Australia
Hunter New England	Armidale, Barraba, Belmont, Bingara, Boggabri, Bulahdelah, Cessnock, Denman, Dungog, Emmaville/Vegetable Creek, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, John Hunter, Kuri Kuri, Maitland, Manilla, Merriwa, Moree, Murrumbidgee, Muswellbrook, Narrabri, Nelson Bay, Newcastle, Newcastle Mater, Quirindi, Scone, Singleton, Tamworth, Taree/Manning, Tenterfield/Prince Albert, Tingha, Walcha, Warialda, Wee Wee, Werris Creek, Wingham	John Hunter
Illawarra Shoalhaven	Bulli, Coledale, David Berry, Kiama, Milton Ulladulla, Port Kembla, Shellharbour, Shoalhaven, Wollongong	St George
Mid North Coast <sup>2</sup>	Bellingen, Coffs Harbour, Domingo, Kempsey, Macksville, Port Macquarie, Wauchope	John Hunter
Murrumbidgee <sup>3</sup> and 4	Batlow, Tumut	Australian Capital Territory
	Boorowa, Murrumbidgee-Harden, Young	Prince of Wales
	Lake Cargelligo	Royal Prince Alfred
	Barham Koondrook, Benrigan, Corowa, Culcairn, Deniliquin, Finley, Henry, Holbrook, Jerilderie, Tocumwal, Urana	St George
	Coolamon, Cootamundra, Griffith, Gundagai, Hay, Hillston, Junee, Leston, Lockhart, Namandera, Temora, Tumbumba, Wagga Wagga, West Wyalong	St Vincent's
	Albury	Victoria
Nepean Blue Mountains	Blue Mountains, Hawkesbury, Lithgow, Nepean, Portland, Springwood	Nepean
Northern NSW	Bailina, Binalba, Byron, Casino, Conak, Grafton, Kyogle, Lismore, Mackean, Murrumbidgee, Nimbin, Tweed, Urbenville	John Hunter, Queensland
Northern Sydney	Castlebrag (Private), Dalroose (Private), Greenwich, Hornsby, Macquarie, Manly, Mater Macquarie (Private), Mona Vale, Narragah, North Shore (Private) Royal North Shore, Royal Rehabilitation, Ryde, Sydney Adventist (Private)	Royal North Shore
South Eastern Sydney	Cahary Healthcare, Gower Wilson (Lord Howe Island), Prince of Wales, Prince of Wales Private, Royal Hospital for Women, St George, Sutherland, St Vincent's, St Vincent's Private, Sydney & Eye Hospital, War Memorial	Prince of Wales, St George
South Western Sydney	Bankstown, Braeside, Bowral, Camden, Campbelltown, Fairfield, Liverpool	Liverpool
Southern NSW <sup>4</sup>	Batemans Bay, Bega (South East Regional) Bombala, Braidwood, Cooma, Delegate, Moruya, Pambula, Queenbeyan, Yass	Australian Capital Territory
	Cookswell, Goulburn	Prince of Wales
Sydney	Balmain, Canterbury, Concord, Royal Prince Alfred	Royal Prince Alfred
Western NSW	Baradine, Bathurst, Blayney, Bourke, Brewarrina, Canowindra, Cobar, Collarenebri, Condobolin, Coolah, Coonabarabran, Coonambie, Cowra, Cudal, Dubbo, Dunedoo, Eugowra, Forbes, Gilgandra, Goodooga, Grenfell, Gulargambone, Gulugong, Lightning Ridge, Molong, Mudgee, Narramine, Nyngan, Oberon, Orange/Bloomfield, Parkes, Peak Hill, Rylstone, Tottenham, Trangie, Trundle, Tullamore, Walgett, Warren, Wellington	Royal Prince Alfred
Western Sydney	Auburn, Blackdown, Baulkham Hills (Private), Cumberland, Mount Druitt, Westmead, St Josephs, Westmead Private	Westmead
St Vincent's	St Josephs	St Vincent's

Due to proximity some patients may be referred to: South Australia <sup>1</sup>, Queensland <sup>2</sup>, Victoria <sup>3</sup> and Australian Capital Territory <sup>4</sup>  
 Retrieval- Adults: Contact ACC 1800 650 804

## APPENDIX 4: Clinical Referral Networks and Specialty Referral Networks

LHD	Facilities	Receiving Tertiary Hospital				
		Critical Care	Burns	Spinal	Trauma	
					Regional	Major
ACT		NA	CRGH	POW	NA	NA
Central Coast	Gosford, Long Jetty, Woy Woy, Wyong	RNS	RNS	RNS	Gosford	RNS
Far West <sup>1</sup>	Bairnsdale, Broken Hill, Ivanhoe, Merinda, Tibooburn, Wentworth, White Cliffs, Wilcannia	RPA SA- Adelaide	CRGH	RNS	Orange	Wentworth, SA- Adelaide
Hunter New England	Armistide, Baraba, Belmont, Bingera, Boggabri, Bulahdelah, Cassrock, Denman, Dungay, Ennawille/Vegetable Creek, Glen Innes, Gloucester, Gunnedah, Guyra, Inverell, John Hunter, Kurri Kurri, Maitland, Manilla, Merriwa, Morna, Murrumbidgee/Wilson, Murrumbidgee, Narrabri, Nelson Bay, Newcastle Newcastle Mater, Quirindi, Scone, Singleton, Tamworth, Taree/Manning, Ternterford/Prince Albert, Tingha, Walcha, Warialda, Wake Waa, Werris Creek, Wingham	JNH	RNS	RNS	Tamworth	JNH
Illawarra Shoalhaven	Bull, Coledale, David Bery, Kiama, Milton Ulidulla, Fort Kembla, Shellharbour, Shoalhaven, Wollongong	STG	CRGH	POW	Wollongong	STG
Mid North Coast <sup>1</sup>	Bellingen, Coffs Harbour, Dorrigo, Kempsey, Macalville, Fort Macquarie, Wauchope	JNH	RNS	RNS	Coffs Harbour, Fort Macquarie	JNH
Murrumbidgee <sup>1,4</sup>	Balfour, Tumut	ACT	CRGH	POW	Wagga	ACT
	Boorowa, Murrumbidgee-Grange, Young	POW				STG
	Lake Cargilligo	RPA			STG	
	Barham Kosciusko <sup>1</sup> , Berrigan <sup>1</sup> , Corowa <sup>1</sup> , Culcairn <sup>1</sup> , Deniliquin <sup>1</sup> , Finlay <sup>1</sup> , Henty <sup>1</sup> , Holbrook <sup>1</sup> , Jerilderie <sup>1</sup> , Mercy Health Service, Tocumwal, Urana	STG			Wagga, Vic <sup>1</sup>	STG, Vic <sup>1</sup>
	Cootamundra, Griffith, Gundagai, Hay, Hillston, Junee, Leeton, Lockhart, Narrandera, Temora, Tocumwal <sup>1</sup> , Tumbarumba <sup>1</sup> , Wagga Wagga, West Wyalong	DVH				
Albury <sup>1</sup>	Vic <sup>1</sup>	Vic <sup>1</sup>	Vic <sup>1</sup>			
Nepean Blue Mountains	Blue Mountains, Hawkesbury, Lithgow, Nepean, Portland, Springwood	Nepean	CRGH	RNS	Nepean	Wentworth
Northern NSW <sup>1</sup>	Balling, Bonalbo, Byron, Cairns, Conil, Grafton, Kyogle, Lismore, Mackay, Murrumbidgee, Nimbin, Urbinville	JNH, QLD <sup>1</sup>	RNS	RNS	Lismore	QLD
	Tweed <sup>1</sup>	JNH, QLD <sup>1</sup>			Tweed <sup>1</sup>	
Northern Sydney	Cardiac (Private), Dalcos (Private), Frenches Forest, Greenwich, Hornsby, Macquarie, Manly, Mater Misericordiae (Private), Mona Vale, Weragah, North Shore (Private) Royal North Shore, Royal Rehabilitation, Ryde, Sydney Adventist (Private)	RNS	RNS	RNS	NA	RNS
South Eastern Sydney	Calvary Healthcare, Gover Wilson (Lord Howe Island), Prince of Wales, Prince of Wales Private, Royal Hospital for Women, St. George, Sutherland, St Vincents, St Vincents Private, Sydney & Eye Hospital, War Memorial	POW, STG	CRGH	POW	NA	STG
South Western Sydney	Bankstown, Berridge, Berridge, Camden, Campbelltown, Fairfield, Liverpool	Liverpool	CRGH	POW	NA	Liverpool
Southern NSW <sup>1</sup>	Batemans Bay, Bega (South East Regional), Bombala, Brindwood, Cooma, Delegate, Murrumbidgee, Pambula, Queanbeyan, Yass	POW, ACT <sup>1</sup>	CRGH	POW	NA	ACT <sup>1</sup>
	Coolswell, Goulburn	POW, STG				
Sydney	Balmn, Canterbury, Concord, Royal Prince Alfred	RPA	CRGH	POW	NA	RPA
Western NSW	Bareilly, Bathurst, Bayside, Bourke, Brewarrina, Carrowindra, Cobar, Collarenebri, Condonville, Coolah, Coonabarabran, Coonamble, Crows, Cudal, Dubbo, Dumedoo, Eungulla, Forbes, Gilgandra, Goodooga, Grenfell, Gulargambone, Gulargambone, Lightning Ridge, Molong, Mudgee, Narrandera, Nyngan, Oberon, Orange/Bloomfield, Parkes, Peak Hill, Rydstone, Tottenham, Trangie, Thundee, Tulimann, Walgett, Warrumbidgee	RPA	CRGH	RNS	Orange	Wentworth
Western Sydney	Auburn, Blacktown, Bankham Hills (Private), Cumberland, Mount Druitt, Westmead, St Josephs, Westmead Private	Westmead	CRGH	RNS	NA	Westmead
St Vincents	St Josephs	DVH	CRGH	POW	NA	NA

Due to proximity some patients may be referred to: South Australia<sup>1</sup>, Queensland<sup>2</sup>, Victoria<sup>3</sup>, Australian Capital Territory<sup>4</sup>  
 Retrievals- Adults: Contact ACC 1800 650 004

**RT**  
 Due to proximity some patients may be referred to:  
 1. SA  
 2. QLD  
 3. VIC  
 4. ACT  
 ACT- Australian Capital Territory  
 QLD- Queensland  
 NSW- New South Wales  
 POW- Prince of Wales  
 RPA- Royal Prince Alfred  
 RNS- Royal North Shore  
 SA- South Australia  
 STG- St George  
 VIC- Victoria  
 QLD- Queensland

**APPENDIX 5: Bariatric Sizing Chart for Aeromedical Transport**

**NSW Ambulance**

**Aeromedical Control Centre**

**Bariatric Sizing Chart**

For all patients above 110kg

Patient Name..... Booking Reference No.....  
 Requesting Hospital..... Hospital Fax No.....

**INSTRUCTIONS FOR MEASURING PATIENT**

- Take measurements with patient lying on the mattress.
- Measure width of mattress (see diagram)
- Measure from side of patient to edge of mattress at A and B (refer to diagram below).
- Do these measurements at the patient's widest part. (This may be at the shoulders, abdomen or hips)
- Write results in boxes below. We will calculate the patient's width from the measurements you send us.

Width of Mattress	<input style="width: 80%;" type="text"/>	cm	
Measurement A	<input style="width: 80%;" type="text"/>	cm	
Measurement B	<input style="width: 80%;" type="text"/>	cm	
Accurate Patient's Weight	<input style="width: 80%;" type="text"/>	kg	
Patient's Height	<input style="width: 80%;" type="text"/>	cm	

Widest Part (tick  where measurements were taken at) Shoulders  Abdomen  Hips

*Inaccurate measurements may result in significant delay of transport of your patient.*

**When complete please fax to: 02 9553 2270**

Thank you

Version 1 10/09/2014

**APPENDIX 6: Preparation for Retrieval - Making the Call**

PREPARATION FOR ADULT RETRIEVAL – MAKING THE CALL			
A STRUCTURE FOR TELEPHONE HANDOVER. IT IS NOT INTENDED TO REPLACE THE MEDICAL RECORD.			
<b>INTRODUCTION</b>	YOUR NAME, ROLE, FACILITY AND CONTACT NUMBER		
<b>IDENTIFY PATIENT</b>	NAME DOB	AGE MRN	GENDER ADDRESS
<b>SITUATION</b>	MAIN DIAGNOSES / PROBLEM		OTHER DIAGNOSES / PROBLEMS
REASON FOR TRANSFER		PERCEIVED URGENCY	
<b>BACKGROUND</b>	HISTORY OF PRESENTING COMPLAINT		
PAST MEDICAL HISTORY	MEDICATIONS	ALLERGIES	WEIGHT BMI (cm)
ASSESSMENT CONVEY CONCERNS, UNCERTAINTIES AND URGENCY			
LAST OBS:	RR	SpO <sub>2</sub>	FIO <sub>2</sub> HR BP GCS TEMP
<b>DESCRIBE:</b>	<b>ASSESSMENT</b>	<b>→ INTERVENTIONS</b>	<b>→ RESPONSE</b>
<b>AIRWAY</b>	AIRWAY AT RISK?		
<b>BREATHING</b>	RR, SpO <sub>2</sub> , EFFORT, FOCAL FINDINGS, PNO <sub>2</sub> , NR/VENTILATOR SETTINGS		
<b>CIRCULATION</b>	HR/RR, ARRHYTHMIA, VASOACTIVE INFUSIONS		
<b>DISABILITY</b>	GCS, PUPILS, FOCAL FINDINGS, GLUCOSE, SEDATIVE INFUSIONS		
<b>EXPOSURE</b>	OTHER EXAM FINDINGS, TEMPERATURE, SECONDARY SURVEY IN TRAUMA		
<b>FLUID BALANCE</b>	INPUT (TYPE AND VOLUME), URINE OUTPUT, BLOOD LOSS, OTHER LOSSES		
<b>INVESTIGATIONS</b>	BLOODS, ABG, ECG, X-RAYS, ULTRASOUND, CT		
<b>LINES</b>	IV, CVC, ARTERIAL – TYPE AND LOCATION		
<b>MICRO</b>	ANTIBIOTICS, PRECAUTIONS (MRSE, VRE, BLOOD BORNE, RESPIRATORY)		
<b>MENTAL STATE</b>	CONFUSION, AGITATION, HARM TO SELF OR OTHERS, REQUIRES CHEMICAL OR PHYSICAL RESTRAINT		
IS THE PATIENT'S OVERALL CONDITION: IMPROVING? STABLE? DETERIORATING?			
RECOMMENDATIONS FROM RETRIEVAL CONSULTANT			
DESTINATION FACILITY / WARD	DESTINATION CONTACT NUMBER	MODE OF TRANSPORT	RETRIEVAL TEAM ETA
CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN			

## APPENDIX 7: Preparation for Retrieval – Checklist

PREPARATION FOR ADULT RETRIEVAL - CHECKLIST	
<b>DISCUSSED WITH RETRIEVAL CONSULTANT?</b>	ARRANGE RETRIEVAL PRIOR TO COMPLETING CHECKLIST
<b>INTUBATED?</b>	
ETT POSITION CONFIRMED <input type="checkbox"/> CAPNOMETRY <input type="checkbox"/> CRT <input type="checkbox"/> DEPTH AT INCisors ____ CM / cuff pressure 20-30cmH <sub>2</sub> O <input type="checkbox"/>	
MGT/OCT + BAG <input type="checkbox"/>	30 DEG HEAD UP <input type="checkbox"/> CERVICAL COLLAR CONSIDERED <input type="checkbox"/>
SEDATIVE INFUSION <input type="checkbox"/>	ANALGESIC INFUSION <input type="checkbox"/> <a href="#">SEE INFUSION TABLE FOR PREFERRED INFUSIONS</a>
<b>VENTILATION / NIV?</b>	
ADEQUATE VENTILATION? <input type="checkbox"/> CHECK CAPNOMETRY / TIDAL VOLUME / PEAK PRESSURE	
AIR (CONSIDER 3 AT LINE) - SpO <sub>2</sub> CORRELATE PECO <sub>2</sub> WITH EtCO <sub>2</sub>	
NOT FIGHTING VENTILATOR? <input type="checkbox"/>	
TOLERATING NIV WITH NO EXCESSIVE SEAB? <input type="checkbox"/>	
CHEST TUBE(S) REQUIRED? <input type="checkbox"/> POSITION & FUNCTION OK <input type="checkbox"/>	
<b>OPTIMISE HAEMODYNAMICS, ACCESS AND MONITORING</b>	
PATIENT W/- FLUIDS WARMED <input type="checkbox"/> SEPTIC APPROPRIATE ANTIBIOTICS <input type="checkbox"/>	
TRAUMATIC PELVIC BINDER / LIMB SPLINTS <input type="checkbox"/> TRANSDERMIC ACID 4g (IF <3 HOURS) <input type="checkbox"/>	
D X IV CANNULA, SECURED AND FLUSHED, PORTS ACCESSIBLE <input type="checkbox"/> FLUIDS/BLOOD ON PUMP/PTS <input type="checkbox"/>	
ARTERIAL LINE (IF INTUBATED, RESPIRATORY FAILURE OR LABILE BP) <input type="checkbox"/>	
VAGOPRESSOR INFUSION W/- CVC CONSIDERED <input type="checkbox"/> <a href="#">SEE INFUSION TABLE FOR PREFERRED INFUSIONS</a>	
URINARY CATHETER <input type="checkbox"/>	
<b>PACKAGE FOR RETRIEVAL</b>	
SECURE ALL LINES, TUBES AND MONITORING <input type="checkbox"/> EMPTY DRAINAGE BAGS / BLADDER <input type="checkbox"/>	
SPINAL PRECAUTIONS REQUIRED? <input type="checkbox"/> ADEQUATE ANALGESIA <input type="checkbox"/> PROPHYLACTIC ANTIEMETICS <input type="checkbox"/>	
<b>DOCUMENTATION</b>	
PHOTO-COPY/PRINT ALL NOTES AND PLACE IN ENVELOPE <input type="checkbox"/> ECGs <input type="checkbox"/> IMAGING <input type="checkbox"/> PATHOLOGY RESULTS <input type="checkbox"/>	
DOCUMENT NEXT OF KIN AND CONTACT NUMBERS <input type="checkbox"/>	
EXPLAIN RETRIEVAL PROCESS TO PATIENT AND/OR RELATIVES <input type="checkbox"/>	
CLARIFY PATIENT'S WISHES AND LIMITATIONS OF TREATMENT <input type="checkbox"/> LOCAL SPECIALIST AWARE OF TRANSFER <input type="checkbox"/>	
FLAG ANY ISSUES TO THE RETRIEVAL TEAM	
CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN	

**APPENDIX 8: Preparation for Retrieval - Common Infusion Table**


**PREPARATION FOR RETRIEVAL – COMMON INFUSION TABLE**

---

**USE 50ml LUER LOCK SYRINGES WITH MINIMUM VOLUME TUBING**

**ADRENALINE**


1mg



Dilute to 50ml with 5% dextrose

+

60microg/ml



Commence at 1ml/hr, usual rate 1-20ml/hr

---

**DRAW UP INFUSION DRUG**

DRUG	DOSE	DILUTION	CONCENTRATION	TYPICAL RATE
PROPOFOL	500mg	Draw up and diluted in 50ml	10mg/ml	1-20ml/hr
FENTANYL	500micrograms	Dilute to 50ml with 0.9% NaCl	10microg/ml	1-20ml/hr
MIDAZOLAM	50mg	Dilute to 50ml with 0.9% NaCl	1mg/ml	
KETAMINE	400mg	Dilute to 40ml with 0.9% NaCl	10mg/ml	Loading dose 2-5ml, usual rate 1-20ml/hr
MORPHINE	50mg	Dilute to 50ml with 0.9% NaCl	1mg/ml	
MORPHINE 50mg + MIDAZOLAM 50mg		Dilute to 50ml with 0.9% NaCl	1mg+1mg/ml	Loading dose 2-5ml, usual rate 1-5ml/hr
ADRENALINE	1mg	Dilute to 50ml with 0.9% NaCl	60microg/ml	Commence at 1ml/hr, usual rate 1-20ml/hr
NORADRENALINE	1mg	Dilute to 50ml with 0.9% NaCl	60microg/ml	Commence at 1ml/hr, usual rate 1-20ml/hr

---

**PRIME LINES AFTER MIXING**

**IF >15mls/hr REQUIRED, DOUBLE INFUSION CONCENTRATION**

DRUG	DOSE	DILUTION	CONCENTRATION	RATE
ADRENALINE	1mg	Dilute to 50ml with 0.9% NaCl	120microg/ml	
NORADRENALINE	1mg	Dilute to 50ml with 0.9% NaCl	120microg/ml	

---

**CALL RETRIEVAL CONSULTANT IF DETERIORATION / CHANGED PLAN**

**APPENDIX 9: References**

1. NSW Health Policy Directive, Critical Care Tertiary Referral Networks (Paediatrics) (PD 2010\_030), 2010
2. NSW Health Policy Directive, Critical Care Tertiary Referral Networks (Perinatal) (PD 2010\_069), 2010
3. The Agency for Clinical Innovation (ACI), Intensive Care Network, Intensive Care Service Model: NSW Level 4 Adult Intensive Care Units, ACI, 2015
4. NSW Health Guideline, Occupational Health & Safety Issues Associated with the Management of Bariatric Patients (GL2005\_070), 2005  
[http://www.health.nsw.gov.au/policies/gl/2005/GL2005\\_070.html](http://www.health.nsw.gov.au/policies/gl/2005/GL2005_070.html)
5. NSW Health Policy Directive, *Inter-facility Transfer Process for Adults Requiring Specialist Care*, (PD2011\_031), 2011
6. The Agency for Clinical Innovation (ACI), Statewide Burn Injury Service, NSW Burn Transfer Guidelines <https://www.aci.health.nsw.gov.au/resources/burn-injury>
7. The Agency for Clinical Innovation (ACI), NSW Institute of Trauma and Injury Management (ITIM), Trauma Guidelines <https://www.aci.health.nsw.gov.au/get-involved/institute-of-trauma-and-injury-management/clinical/trauma-guidelines/Guidelines>
8. Australian and New Zealand College of Anesthetists (ANZCA) Guidelines for Transport of Critically ill patients PS52 (2015)
9. NSW Health (2008) *Between the Flags Project- The Way Forward (Keeping Patients Safe)*, Clinical Excellence Commission, Sydney, Australia.  
<http://www.cec.health.nsw.gov.au/files/between-the-flags/publications/the-way-forward.pdf>
10. The Agency for Clinical Innovation (ACI), Emergency Care Institute (ECI) preparation for adult retrieval resources <https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/retrieval>



**AUTONOMIC DYSREFLEXIA (REVISED) – SAFETY NOTICE 014/10**

**Safety Notice 014/10 replaces IB2001/1.**

**Background**

Autonomic dysreflexia is a medical emergency that can occur in people with spinal cord injury at or above the sixth thoracic (T6) level. It is a sudden and severe rise in blood pressure resulting from overactivity of an isolated sympathetic nervous system below the lesion, triggered by a nociceptive stimulus that can result in intracranial haemorrhage, fits, arrhythmias, hypertensive encephalopathy and even death. This potentially life-threatening condition requires immediate and decisive action.

Spinal units are very familiar with the diagnosis and treatment of autonomic dysreflexia. However, people with spinal cord injury most often present or are taken by an ambulance to their local healthcare facility. As spinal cord injury is not a common condition local healthcare professionals may have little or no experience in recognising or managing autonomic dysreflexia. This has resulted in preventable adverse outcomes with a minimum of 3-4 critical incidents reported each year in NSW.

**Symptoms and Signs**

The person may present with all or some of the following:

- Pounding headache, which gets worse as the blood pressure rises.
- Flushing or blotching of the skin and/or profuse sweating above Spinal Cord Injury (SCI) lesion level.
- Skin pallor and goose pumps below the SCI lesion level.
- Blurred vision, nasal congestion (stuffiness).
- Chills without fever.
- Shortness of breath, sense of apprehension or anxiety.
- Hypertension - blood pressure is significantly elevated (at least 20-40 mmHg above normal resting systolic level).

Note: It is important to remember that blood pressure for individuals with high paraplegia or tetraplegia may usually be low, around 90-100/60 mmHg lying down and possibly lower whilst sitting. Therefore, patients with spinal cord injury may become symptomatic with blood pressure in the normal range for the general population.

- Bradycardia (as secondary compensatory response to raised blood pressure).

**Common Causes of Autonomic Dysreflexia**

Any irritating stimulus below the level of the spinal cord injury lesion may precipitate autonomic dysreflexia. Causes of irritation include the following:

- Bladder-related: bladder distension, urine infection, calculus, epididymo-orchitis.
- Bowel-related: bowel distension from constipation, inflamed haemorrhoids, chemical irritation from suppositories.
- Skin-related: pressure sore, burn, ingrowing toenail.
- Other: fractured bones, contracting uterus, acute abdominal condition.

**Treatment**

Refer below for the Autonomic Dysreflexia Treatment Algorithm.

### Treatment Alert

**DO NOT** use glyceryl trinitrate if sildenafil (Viagra) or vardenafil (Levitra) has been taken in the previous 24 hours or tadalafil (Cialis) in the previous 4 days. In situations where glyceryl trinitrate is contraindicated, an alternative (short-acting) anti-hypertensive agent, such as captopril should be used. Captopril, administered sublingually<sup>1</sup> as a 25mg tablet, has been shown to effectively lower blood pressure within 15 minutes. Advantages of sublingual administration are that the drug enters the general circulation directly, with therapeutic concentrations and onset of action achieved more rapidly than with oral administration. In addition, the partially dissolved tablet may be spat out if there is a very rapid reduction in blood pressure. A rectal examination or insertion of an indwelling catheter may exacerbate autonomic dysreflexia.

### Suggested Actions

Emergency Departments and the Ambulance Service are often the first point of contact for the person with autonomic dysreflexia. To prevent delayed or missed diagnosis of autonomic dysreflexia, it is recommended that the following steps be followed.

#### Ambulance Officers and Services

- Ambulance triage officers should be familiar with the symptoms and signs of autonomic dysreflexia and be able to alert and dispatch Paramedics to respond quickly to this situation.
- When assessing a person with spinal cord injury at/above the T6 level, a high index of suspicion for autonomic dysreflexia is required. The person should be asked if they have had autonomic dysreflexia before and simple measures to reduce blood pressure should be taken.
- Ring ahead to alert the Emergency Department that a person with suspected autonomic dysreflexia is arriving.
- Ensure the autonomic dysreflexia management algorithm is readily available in ambulances.
- Provide education on autonomic dysreflexia management on a regular basis.
- Have glyceryl trinitrate sublingual (eg: Anginine tablets, Nitrolingual Pumpspray) or transdermal patches available.

#### Emergency Departments

- On arrival at the Emergency Department, the patient should be seen immediately by the triage nurse. Suspected autonomic dysreflexia should be assigned a Category 2.
- Care should be directed by the most senior doctor present in the Emergency Department (ED) with appropriate specialist consultation.
- The cause of autonomic dysreflexia needs to be identified and treated for resolution. If no cause is found and/or autonomic dysreflexia persists, blood pressure must be adequately controlled. Management of hypertensive crisis with intravenous medication may be required to control blood pressure, while contact is being made with a spinal specialist about further management (see below).
- After resolution of an autonomic dysreflexia episode, blood pressure should be monitored for 4 hours. In some severe cases of autonomic dysreflexia, the person should be admitted for observation.
- Ensure the autonomic dysreflexia management algorithm (see below) is easily available in the ED and education on autonomic dysreflexia management is provided.
- For facilities using the EDIS/FirstNet, a clinical alert should be entered onto the system noting that **“the patient is at risk of autonomic dysreflexia please refer to Safety Notice 014/10 - Autonomic Dysreflexia for guidance in the management of this condition”**.

**Staff in general hospitals and wards**

- Any person with spinal cord injury at/above the T6 level should have a “when necessary” order for sublingual glyceryl trinitrate (eg Nitrolingual Pumpspray or Anginine tablet/s) recorded on the drug chart on admission.
- Development of symptoms and signs of autonomic dysreflexia requires immediate attention to assess blood pressure and look for reversible causes. If a reversible cause is not rapidly found, prompt medical review is necessary to further assess possible causes and initiate appropriate treatment.
- The autonomic dysreflexia management algorithm (see below) should be easily accessible.
- For facilities using the electronic medical record a clinical alert should be entered onto the system noting that “the **patient is at risk of autonomic dysreflexia please refer to Safety Notice 014/10 - Autonomic Dysreflexia for guidance in the management of this condition**”.

**Further Advice about Patient Management**

If glyceryl trinitrate or captopril do not lower the blood pressure sufficiently and/or the cause of the autonomic dysreflexia has not been identified, please contact, via the hospital switch board, the on-call Spinal Cord Injury Physician at either Royal North Shore Hospital (02) 9926 7111 or the Prince of Wales Hospital (02) 9382 2222.

**Other Suggested Actions**

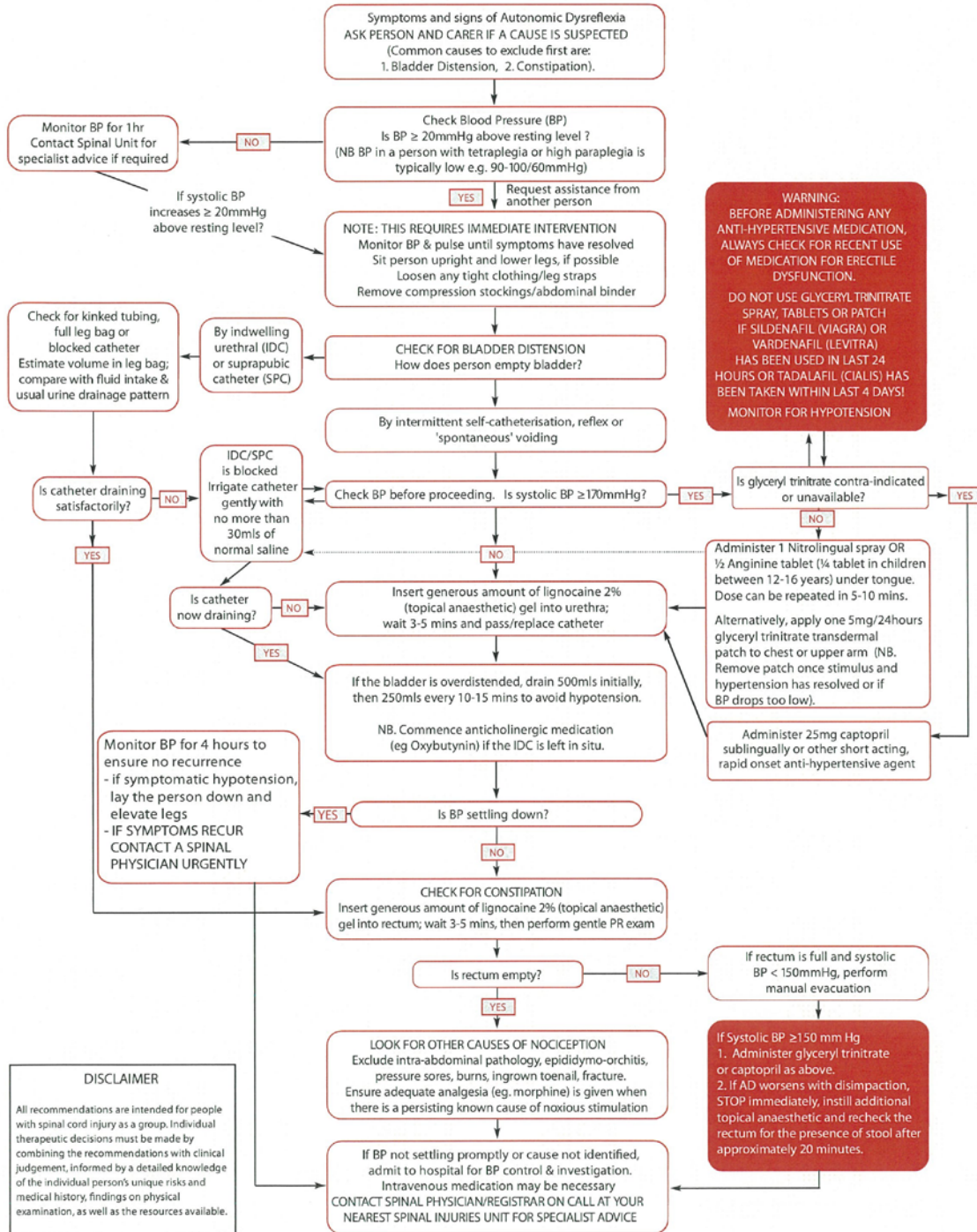
- Consult the patients and carers, determine if they know about this condition as they can often suggest a cause of the symptoms and management strategies.
- Check if patients are carrying an Autonomic Dysreflexia Management Card that can assist to identify the cause of symptoms and provide treatment strategies.
- It is suggested that Autonomic Dysreflexia is noted in the EDIS, NSW Health medical record or Electronic Medical Record Alert and NSW Ambulance Service Alert (Protocol 71 or electronic Mobile Data Terminal) systems.

**Further Information about Autonomic Dysreflexia**

The [NSW State Spinal Cord Injury Service](#) website includes clinical information sheets and practice guides about:

- [Treatment of Autonomic Dysreflexia for Adults and Adolescents](#) with spinal cord injury
- [An Overview of Skin and Pressure Ulcer Management](#)
- Management of the [Neurogenic Bladder](#) in spinal cord injury
- Management of the [Neurogenic Bowel](#) in spinal cord injury

### Treatment Algorithm for Autonomic Dysreflexia (Hypertensive Crisis) In Spinal Cord Injury



**WARNING:**  
BEFORE ADMINISTERING ANY ANTI-HYPERTENSIVE MEDICATION, ALWAYS CHECK FOR RECENT USE OF MEDICATION FOR ERECTILE DYSFUNCTION.  
DO NOT USE GLYCERYL TRINITRATE SPRAY, TABLETS OR PATCH IF SILDENAFIL (VIAGRA) OR VARDENAFIL (LEVITRA) HAS BEEN USED IN LAST 24 HOURS OR TADALAFIL (CIALIS) HAS BEEN TAKEN WITHIN LAST 4 DAYS!  
MONITOR FOR HYPOTENSION

**DISCLAIMER**  
All recommendations are intended for people with spinal cord injury as a group. Individual therapeutic decisions must be made by combining the recommendations with clinical judgement, informed by a detailed knowledge of the individual person's unique risks and medical history, findings on physical examination, as well as the resources available.  
This revised algorithm was re-endorsed for use by the Australian and New Zealand Spinal Cord Society (ANZSCOS) in September 2010.  
This project was funded by the Motor Accidents Authority of NSW.

**MATERNITY – RESUSCITATION OF THE NEWBORN INFANT (GL2018\_016)****GL2018\_016 rescinds PD2008\_027****PURPOSE**

This Guideline aims to optimise, facilitate and standardise newborn resuscitation by endorsing the [Australian and New Zealand Committee on Resuscitation \(ANZCOR\) Guidelines - Section 13: Neonatal Guidelines \(2016- 17\)](#)<sup>1</sup> for use by NSW Health.

**KEY PRINCIPLES**

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

**USE OF THE GUIDELINE**

This Guideline:

- replaces the Policy Directive PD2008\_027 Maternity - Clinical Care and Resuscitation of the Newborn Infant
- endorses ANZCOR Guidelines (2016-2017) Section 13 - Neonatal guidelines 13.1-13.10 and the Newborn Life Support algorithm (Attachment 1)
- outlines local health district responsibilities to develop systems to ensure:
  - clinicians are appropriately targeted to complete mandatory and recommended newborn basic life support education, training and proficiency requirements
  - locally determined clinicians complete newborn advanced life support education, training and proficiency requirements, and are in attendance at the birth of newborn infants who are at higher risk of requiring resuscitation at birth
  - standardised newborn resuscitation equipment is available and operational and clinicians are familiar with the equipment
  - local procedures are in place to review resuscitation interventions and outcomes to monitor patient safety and quality of care and improve training and performance.

**To download the complete Maternity – Resuscitation of the Newborn Infant Guideline please go to: [https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018\\_016](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_016)**

**HOSPITAL RESPONSE TO PANDEMIC INFLUENZA PART 1: EMERGENCY DEPARTMENT RESPONSE (PD2007\_048)****Section 1: Overview****Introduction**

This document describes the response of emergency departments (EDs) and multi purpose services to an influenza pandemic. For simplicity, when the term 'emergency department' is used in this document, it refers to all facilities in NSW with an emergency department, and all multi purpose services.

Due to the wide variability of health care facilities in New South Wales (NSW), a document such as this cannot be entirely prescriptive. Rather, it should be seen as a guide for developing and implementing a local response to pandemic influenza. Strategies will need to be implemented at each facility to ensure they meet the objectives described in this document.

The two main stages of the pandemic response are the containment stage and the 'maintenance of social function' stage.

In the containment stage, the emphasis is on slowing the spread of a pandemic to reduce the burden on the health system and to buy time for the development of a pandemic influenza vaccine. The main strategies in this stage are to:

- prevent people with pandemic influenza entering Australia
- find people with pandemic influenza, isolate them, and treat them with antiviral medication
- trace the contacts of these people, provide them with antiviral prophylaxis, and quarantine them.

A close liaison between clinicians and public health unit (PHU) personnel is vital for containment to be successful.

The 'maintenance of social function' stage will occur when the resources required for containment are exceeded. In this stage, the key role of EDs will be to manage the potentially large number of patients with pandemic influenza who require high level medical care.

A response to an influenza pandemic will require the mobilisation of resources from across the area health services (AHSs), particularly during the later stages. Each AHS will be required to develop plans to operationalise the ED response to an influenza pandemic at all facilities with an ED.

*The Hospital Response to Pandemic Influenza. Part 1: Emergency Department Response* document should be read in conjunction with the *Interim National Pandemic Influenza Clinical Guidelines* and *Interim Infection Control Guidelines for Pandemic Influenza in Healthcare and Community Settings*, which are appendices to the *Australian Health Management Plan for Pandemic Influenza* (AHMPPI) (June 2006).

**Overview of emergency department response to an influenza pandemic**

EDs have a key part to play in the response to an influenza pandemic in NSW, particularly in their role in activating enhanced ED triage and influenza screening stations.

To respond to the changing nature of an influenza pandemic, a graded response to the threat will be required. This response will range from the establishment of enhanced ED triage (when a new influenza strain is reported to be causing clusters of human disease with human-to-human transmission overseas) to the establishment of ED screening stations (when there is a high likelihood that a patient meeting the case definition will present to an ED). Once there are clusters of cases in Australia that exceed (or are expected to exceed) the capacity of EDs such that a broader AHS response is required, stand-alone influenza clinics will be established. The role of stand-alone influenza clinics will be to see suspected pandemic influenza patients who are not in need of high-level ED care. Stand-alone influenza clinics will not provide high-level emergency care; this role will be maintained by the EDs.

The NSW Department of Health (NSW DoH) will request initiation and escalation of response through the AHS chief executives. The NSW DoH will define the level of the operational response required, which will depend upon the epidemiological characteristics of the disease, including the extent of pandemic influenza overseas, transmissibility of the pandemic influenza virus, and the level of morbidity and mortality resulting from the new influenza strain.

Table 1 summarises the levels of response required and the drivers that will determine the need for an increase in the level of response. All NSW public and private hospitals with EDs will be required to initiate the response described in this table. Each facility will need to consider their own circumstances and devise strategies to ensure they meet the response objectives.

**Table 1. Description, drivers for activation, and purpose of emergency department (ED) response to an influenza pandemic**

Response	Description	Drivers for activation	Purpose
<b>Enhanced emergency department (ED) triage initiated</b>	Additional screening conducted at the usual ED triage point, based on an up-to-date case definition.	Declaration of overseas pandemic alert phase 4 <sup>1</sup> (OS phase 4) - clusters with human-to-human transmission overseas - where the clusters are occurring in a relatively isolated region. (If first clusters are in a major centre overseas, a move directly to pandemic influenza screening stations may be required.)	<p><b>Containment stage</b></p> <p>To decrease the rate of transmission of pandemic influenza in the community, general practice surgeries, hospitals and other health care facilities by:</p> <ul style="list-style-type: none"> <li>ensuring rapid identification and isolation of suspected cases</li> <li>allowing diagnosis and treatment of cases with antiviral agents, if indicated</li> <li>providing a linkage with the public health response of contact tracing and provision of anti viral prophylaxis</li> <li>allowing collection of epidemiological and clinical data to inform clinical management and public health decisions.</li> </ul>
<b>ED pandemic influenza screening station established</b>	Pandemic influenza screening station established at the entrance to ED to identify patients who meet the pandemic influenza case definition before they enter the waiting room.	<p>No cases in Australia (Australian pandemic alert phase 0-3) but outbreaks occurring in areas overseas from which it is significantly likely that people will be travelling to Australia.</p> <p>Widespread outbreaks overseas.</p> <p>Significant morbidity and mortality from pandemic influenza overseas.</p> <p>Declaration of Australian pandemic alert phase 4 (i.e., clusters with human-to-human transmission in Australia).</p>	<p><b>Containment stage</b></p> <p>As for enhanced ED triage, and to allow a higher level of vigilance than provided by enhanced ED triage in light of an increased likelihood of pandemic influenza cases being encountered.</p>
<b>Stand-alone influenza clinic<sup>37</sup> established. ED pandemic influenza screening station established/maintained.</b>	<p>A separate influenza clinic facility established to identify and treat those who meet the case definition for pandemic influenza.</p> <p>Note: an influenza screening station at the entrance to ED will still need to be maintained.</p>	<p><b>At containment stage</b></p> <p>ED capacity to isolate and manage suspected cases is exceeded.</p> <p><b>At 'maintenance of social function' stage</b></p> <p>Inability to contain pandemic influenza outbreaks (resulting in declaration of 'maintenance of social function' stage).</p> <p>Declaration of influenza pandemic (Australian phase 6b).</p>	<p><b>Containment stage</b></p> <p>As for enhanced ED triage, and to allow effective management of an increased number of pandemic influenza patients.</p> <p><b>'Maintenance of social function' stage</b></p> <p>To provide standardised assessment, triage, and management of patients with suspected pandemic influenza.</p> <p>To reduce patient presentations to EDs and general practices, thereby allowing those facilities to continue their core business and reduce the risk of transmission within those settings.</p> <p>To collect epidemiological data to monitor progress of the pandemic and inform optimal resource allocation.</p>

<sup>1</sup>This assumes that a pandemic starts overseas. If a pandemic starts in Australia, an elevated level of response will be immediately required.

<sup>2</sup>The governance structure of the stand-alone influenza clinic will need to be determined by the area health service (AHS) and identified in AHS and facility plans.



**Activation of enhanced triage, influenza screening stations and influenza clinics**

The NSW Chief Health Officer (CHO) will notify the AHS chief executives of the change in the pandemic alert level and instruct AHSs to activate one of the ED response strategies listed below. The response will depend on the phase of the pandemic alert, the number and location of people with pandemic influenza, and the epidemiology of the new influenza virus. The three levels of response are:

- enhanced triage within EDs
- separate pandemic influenza screening stations
- stand-alone influenza clinics (note: if a stand-alone influenza clinic is required, screening stations will still need to operate at the entrance to the ED).

Activation of enhanced triage within EDs will be required within 8 hours of notification; activation of ED screening stations will be required within 12 hours, and activation of stand-alone influenza clinics within 48 hours. The NSW DoH will require confirmation by AHS chief executives that activation has occurred.

A pandemic influenza case definition to be used for screening purposes will be provided to all AHSs at, or shortly after, the formal request to activate an ED response. The new case definition, and subsequent case definitions, will be available on the [NSW Health intranet and internet websites](#), and will be found immediately after the Netepi login page. Netepi is a web-based public health data collection and management system.

A detailed breakdown of the ED pandemic influenza response, according to the containment and 'maintenance of social function' stages, is provided in Section 2 of this document.

**Governance structure**

The governance structure for the various response levels will need to be determined by individual AHSs and outlined in the AHS plan.

**Patient disposition**

Following assessment of patients' clinical condition, likelihood of complying with home isolation, and ability to care for themselves, patients will be either admitted to hospital and isolated or discharged for self-care in home isolation. The decision to discharge a potentially infectious patient must be made in consultation with the PHU and relevant specialists. Patients must remain in isolation (in hospital or at home) until an alternative diagnosis is made or the infectious period is over.

If admitted to hospital, the patient may be admitted to either the hospital to which the patient has presented or to another hospital in accordance with AHS plans for suspected and confirmed cases of pandemic influenza. If admitted to hospital, the patient should be cared for in a single room. Patients with confirmed pandemic influenza should also be cared for in a single room; however, if insufficient single rooms are available, patients with confirmed pandemic influenza can be cohorted and isolated in a separate ward or wing of the hospital. The number of staff who come into contact with the patient should be minimised.

The collection of clinical and demographic information required to facilitate contact tracing by the PHU will be an important activity in the ED response. The investigation does not have to be carried out in the ED, but it is important that the patient is kept in isolation at the facility while this investigation is being carried out.

### **Accompanying persons**

It is likely that patients who are suspected of being infected with pandemic influenza will present with accompanying persons. In all but exceptional circumstances (e.g., where the suspected case is a child) accompanying persons who do not meet the case definition should be provided with information about pandemic influenza, have their contact details collected and provided to the PHU, and (upon advice of the PHU) be sent to home quarantine. The PHU will provide advice about the management of accompanying persons.

If the ED clinician decides that it is necessary for an accompanying person to remain with the patient, advice must be sought from the PHU before the accompanying person is allowed into the isolation room with the suspected case.

Management procedures for persons accompanying children presenting to a children's hospital have not yet been finalised. This document will be updated when these procedures are available.

## **Section 2: Response levels**

### **Enhanced emergency department triage**

During the containment stage - when small clusters of human-to-human transmission of the new influenza virus have been reported overseas (WHO Overseas phase 4, Australian phase 0-3) - all facilities with emergency departments (EDs), and multipurpose services, will be required to commence enhanced ED triage with screening for pandemic influenza. Screening is to be performed at the beginning of the ED triage process, and provision must be made for the isolation and management of suspected pandemic influenza patients in single rooms. To ensure the safety of health care workers, screening should be conducted from behind a physical barrier such as a glass screen or by keeping more than a metre away from the patient. If this is not possible, full personal protective equipment (PPE) should be worn.

### **Operating requirements**

Once advised to activate enhanced ED triage screening, a senior medical or nursing staff member, as designated in the AHS pandemic influenza plan, will be required to ensure:

- correct signage is displayed
- an up-to-date version of the case definition is available
- all presentations to ED are screened for pandemic influenza during the triage process
- there is a one-way flow of suspected pandemic influenza patients through the ED
- the availability of at least one single room to be used for isolating a suspected case of pandemic influenza (this room should be selected beforehand and identified in the AHS pandemic influenza plan)
- there is an adequate stock (20-100, depending on the facility size) of P2 masks and other PPE for use by the doctor/nurse(s) assessing and managing the suspected case(s), and that these staff use the PPE appropriately
- PPE stock is replenished as required

- a medical officer (or experienced nurse where no medical officer is normally available) is nominated to assess person(s) meeting the case definition. The staff member should be familiar with the case definition and with protocols for diagnosis, clinical management and infection control
- the PHU is contacted immediately upon identification of a suspected case
- viral swabs (as per testing algorithm) are readily accessible (the designated person should, ideally, be experienced in taking nose and throat swabs for viral testing, given the importance of obtaining a quality specimen for an urgent influenza test)
- surgical masks and hand washing facilities (or alcohol-based gel) are available for use by the suspected pandemic influenza case(s)
- screening staff have access to hand washing facilities and/or alcohol-based gel and wash their hands frequently
- availability of anti-influenza medication for treatment of pandemic influenza patients (this should be detailed in the AHS pandemic influenza plan)
- an appropriate cleaning regime in accordance with infection control guidelines is in place to disinfect areas potentially infected.

### **Operating procedure**

The procedure for enhanced ED triage is described below. A flow diagram summarising the process is shown in Figure 1.

#### **Step 1: Screen**

- At first contact, all patients are to be asked the up-to-date pandemic influenza screening questions.
- If a patient meets the case definition, proceed to Step 2. If a patient does not meet the case definition, the triage process continues as normal.
- Refer to Figure 2 for a more detailed description of the screening process.

Note 1: In facilities where the implementation of enhanced ED triage is not possible (e.g., in facilities that do not have a permanently staffed ED), different strategies will need to be implemented to keep pandemic influenza out of the facility. Strategies may include an early move to setting up a screening station at the entrance to a facility.

Note 2: Once enhanced ED triage is implemented, ambulance officers will screen all patients upon pickup and report identified suspected pandemic influenza cases to facilities prior to arrival. Section 3 of this document provides more information on the role of ambulance officers in response to pandemic influenza.

Note 3: When there is an outbreak or outbreaks of pandemic influenza overseas but not in Australia (WHO Overseas phase 4 or above, Australia phase 0-3) the epidemiological screening questions (on travel history) are to be asked before the clinical questions because they are the more specific discriminators and because they can be asked while keeping a safe distance. Once cases are identified widely in Australia (implying that overseas travel/contact with someone who has travelled overseas to the affected areas ceases to be the discriminating factor) travel history will be removed from the case definition and clinical features will prevail.

**Step 2: Isolate**

- If a patient meets the case definition, treat them as a suspected case of pandemic influenza: provide them with a surgical mask, instruct them to wash their hands, and isolate them immediately in a single room. If a single room is not available, cohort pandemic influenza patients in such a way that risk of transmission is minimised.

Note: If a patient with suspected pandemic influenza has not been triaged immediately on arrival at the ED, the contact details of all the people within the ED waiting room (including other patients and staff) who have been in contact with the suspected case must be recorded in case pandemic influenza is later confirmed and contact tracing is required.

- Clean the triage area as per infection control guidelines.

**Step 3: Assess/manage**

- Continue subsequent assessment and management of the patient with suspected pandemic influenza in a single room. If the patient requires immediate medical intervention, this should be performed in the single room wherever possible.
- Obtain demographic information for the patient.
- Perform a clinical assessment.
- Obtain appropriate specimens for laboratory testing. Details relating to the collection of microbiological specimens can be found in *Pandemic Influenza - Interim Response Protocol for NSW Public Health Units*. For viral specimen collection, one viral swab (not a bacterial swab) from the right nostril, one viral swab from the left nostril and one viral swab from the throat (i.e., three swabs in total) are required.

**Step 4: Notify/consult**

- If the suspected case still fits the case definition, notify the PHU of the suspected case by telephone and provide details of information collected to date. PHU staff are available 24 hours a day in all areas of NSW; contact details are available in the AHS pandemic influenza plan or via the AHS switchboard or the NSW Health intranet contact directory.
- Consult with PHU staff and infectious disease and/or other relevant physicians regarding diagnosis and continued management of the suspected case.
- Obtain advice from the PHU about where specimens should be sent.

**Step 5: Send specimens**

- Following consultation with the public health unit and infectious disease physician, and confirmation that the patient meets the case definition for pandemic influenza, send specimens.
- Specimens are to be labelled 'suspect case of pandemic influenza'.
- The hospital laboratory is responsible for notifying the reference laboratory and ensuring the urgent transport of the specimens to the reference laboratory for specific detection of the pandemic influenza strain. The two reference laboratories in NSW are the Institute for Clinical Pathology and Medical Research (ICPMR) at Westmead, and the South East Illawarra Area Laboratory Service (SEALS) at Prince of Wales Hospital, Randwick.

- Other specimens (including microbiological specimens) should be processed following usual procedures.
- Specimens are to be packaged and transported in accordance with the National Pathology Accreditation Advisory Council's *Requirements for the packaging and transport of pathology specimens and associated materials*. (The National Pathology Accreditation Advisory Council guidelines can be found at <http://www.health.gov.au/internet/publications/publishing.nsf/Content/npaac-pub-transp-path-spec-draft>)

**Step 6: Treat**

- If there is a high index of clinical suspicion for pandemic influenza, assess the patient for contraindication to anti-influenza medication and consider administering the first dose of treatment while awaiting the pathology result (given the importance of administering anti-influenza medication as early as possible after symptom onset), and certainly within 48 hours.
- If reference laboratory confirmation of the diagnosis is likely to take longer than 8 hours, it is recommended that the first dose of anti-influenza medication be administered as soon as possible.

**Step 7: Admit/discharge**

- If the pandemic influenza test is positive or a diagnosis of pandemic influenza cannot be excluded, admit the patient to hospital or, following assessment of the patient's clinical condition and ability to comply, discharge them to home isolation. Discharge of potentially infectious patients *must* be made in consultation with the PHU and relevant specialists.
- If a decision has been made to admit the patient and they do not require further care in the ED, they can be transferred out of the ED and into a single room elsewhere in the facility. Further clinical and public health follow up can occur in that single room.

**Figure 1. Flow diagram for the screening, assessment and management of a suspected pandemic influenza case in the emergency department**

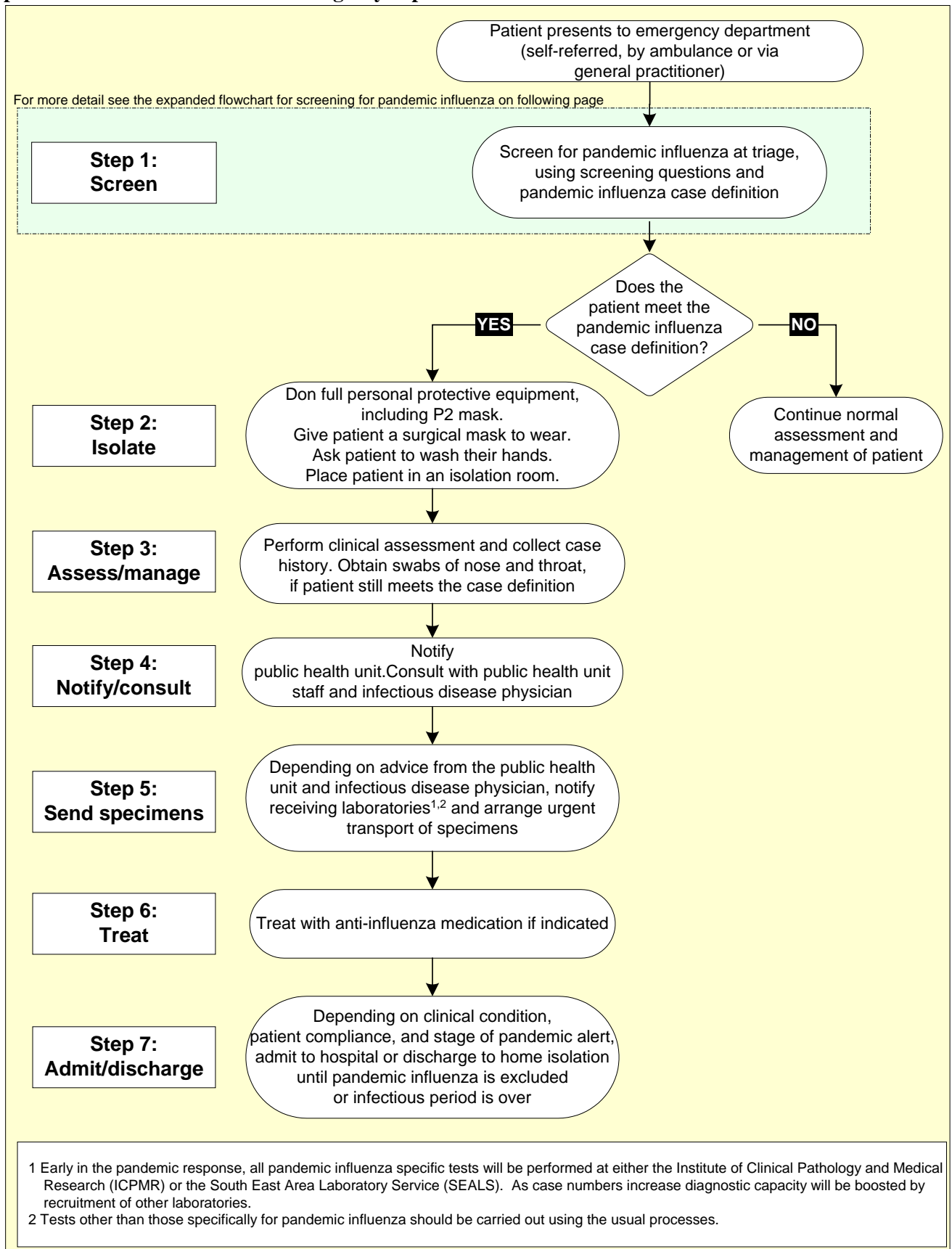
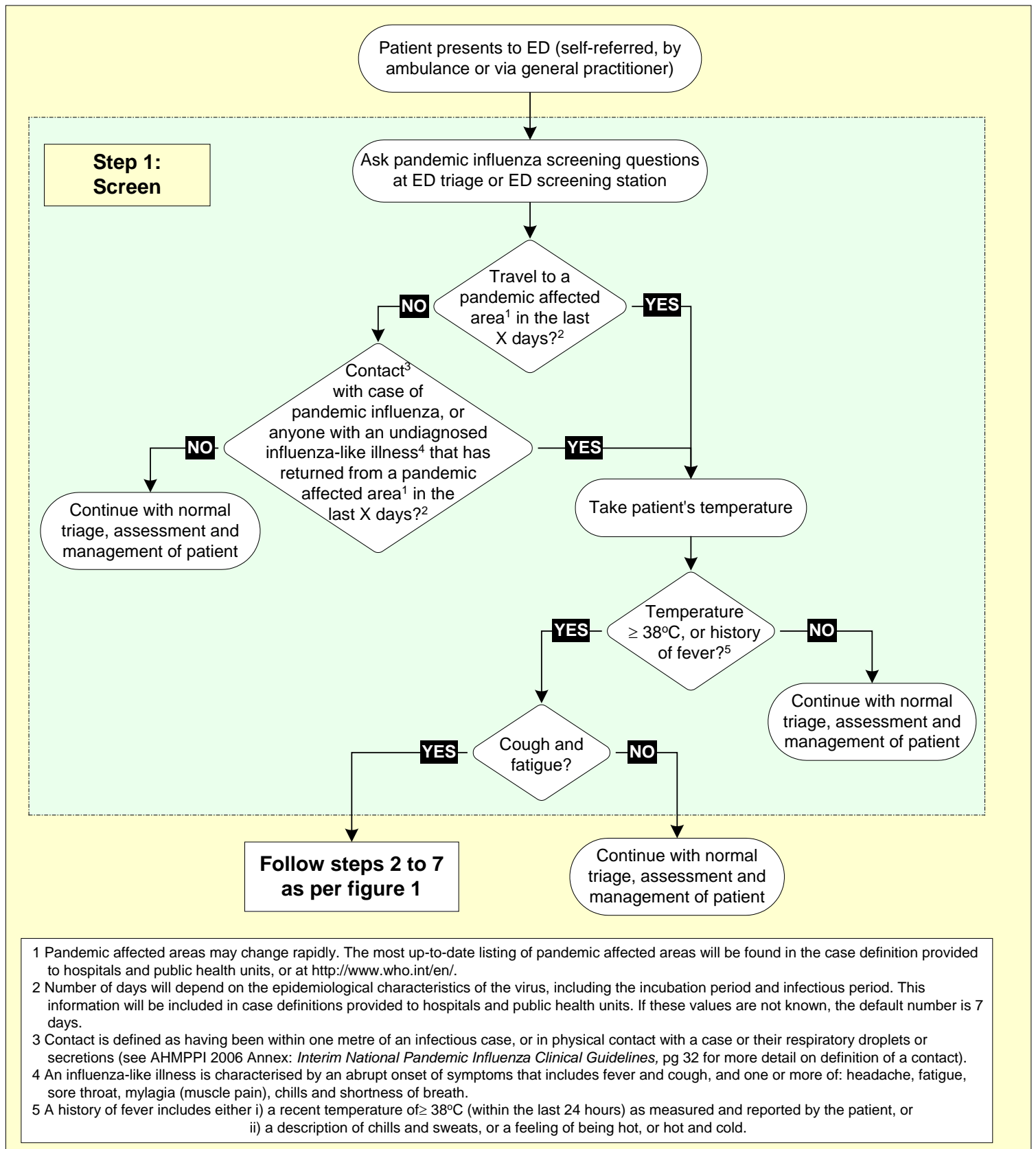


Figure 2. Flow diagram of the screening process for pandemic influenza



### Emergency department screening stations

Screening for influenza using screening stations at the entrance to EDs (or in smaller facilities without permanent EDs, at the entrance to the facility) will commence when the likelihood of patients with pandemic influenza being encountered has increased to a stage that warrants screening of *all* people presenting to an ED *before* they enter the ED waiting room, and *before* they are triaged. This is expected to occur when Australia pandemic alert phase 4 is declared (clusters of cases with the new influenza strain with human-to-human transmission are reported in Australia) or when cases have not yet been reported in Australia but are occurring in major regional transport hubs. Activation of screening stations will be required within 8 hours in metropolitan and base hospitals and within 12 hours in rural hospitals. It is expected that close monitoring of epidemiological data will provide advanced warning that an elevation of response will be required.

It is possible that some parts of the state will establish ED screening stations, while others that are less likely to see patients with suspected pandemic influenza because of their distance from the reported cases of influenza, will continue with an enhanced ED triage response.

The driver for the activation of ED screening stations is principally an assessment that the new influenza virus poses an increased and imminent risk to NSW health facilities. This risk will be assessed based on the epidemiological characteristics of patients identified with the new influenza virus, the number and location of people with confirmed pandemic influenza, and the threat to the local area.

It is acknowledged that a number of very small facilities will not be able to implement screening stations. These facilities will need to be identified in AHS plans and will need to develop strategies locally to meet the objective of keeping pandemic influenza out of their facilities. Strategies may include screening through intercom, facility lock down, or advance screening by telephone.

A cascaded approach to ‘ramping up’ a broader whole-of-facility response to keeping pandemic influenza out of facilities will be implemented according to the level of threat. This will include limiting entry and exit points to facilities; limiting visitor number and times that visitors can enter facilities; postponing elective and non-urgent treatment for persons returning from pandemic influenza-affected areas; and screening staff. A policy designed to keep hospitals safe from the threat of pandemic influenza is being developed.

### Operating requirements

In essence, an ED screening station is similar to the enhanced ED triage response, and the operating requirements are also similar. The significant difference is that with a screening station the screening for pandemic influenza will occur at the entrance to the ED and not at the normal ED triage point. Screening stations will need to operate 24 hours and screen all patients and accompanying persons who present to the ED. The location and management of this screening station will be described in the AHS pandemic influenza plan.

### Operating requirements and procedure

The operating requirements for ED screening stations are similar to those for enhanced triage, described in Section 2.1, except that a screening table, chairs and, if appropriate, shelter will be required.



The operating procedure is also similar, apart from the changes and additions listed below.

**Step 1: Screen**

- All patients and accompanying persons attending the ED must be screened at the influenza screening station located at the entrance to the ED.
- All patients presenting are to be asked screening questions based on an up-to-date pandemic influenza case definition.
- If the patient does not meet the case definition, the patient proceeds to triage as normal.

Note: All staff at pandemic influenza screening stations must wear full PPE while screening and the screening station must be disinfected in accordance with infection control guidelines each time a suspect case is identified.

**Steps 2 to 7**

If the patient meets the case definition, follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure described in Section 2.1.

Refer to Figure 2, above, for a summary of the process of screening for pandemic influenza.

**Stand-alone influenza clinic (during containment stage)**

Stand-alone influenza clinics will commence operation in a location separate from the ED when the number of people with suspected pandemic influenza exceeds the capacity of the ED to isolate and manage them appropriately.

Stand-alone influenza clinics will require activation within 24 hours of notification in metropolitan and base hospitals and within 48 hours in rural and remote hospitals. It is expected that close monitoring of epidemiological data will provide advanced warning of the need to activate stand-alone influenza clinics.

During the containment stage, the key roles of a stand-alone influenza clinic will be to continue the process of containing the spread of pandemic influenza by enabling the rapid identification, isolation, and management of patients with suspected pandemic influenza, and to expedite follow up of their contacts by the PHU. Stand-alone influenza clinics will relieve the patient load on EDs by assessing and managing patients who do not require high-level care in an ED, thus allowing EDs to continue their core role of treating critically ill patients.

Stand-alone influenza clinics will not have the capacity to provide high-level emergency care; EDs will maintain this role. If a patient with suspected pandemic influenza is sick enough to require high-level emergency care, they will need to be transferred to the ED.

Stand-alone influenza clinics will need to be prepared to operate 24 hours per day and have their own dedicated workforce.

Stand-alone influenza clinics will initially be established on hospital campuses. As the number of people affected by pandemic influenza increases, stand-alone influenza clinics may need to be established at other sites.

### Operating requirements

A stand-alone influenza clinic during the containment stage will perform the same function as the enhanced ED triage and screening station, but operate on a larger scale. The driver for establishing a separate influenza clinic is an increase (or anticipated increase) in the numbers of patients that meet the pandemic influenza case definition, or an increase in the numbers of patients presenting at EDs in order to be screened for pandemic influenza.

Note that a screening station will still be required at the entrance to the ED when a stand-alone influenza clinic is in operation. Refer to Figure 3, following, for a summary of screening procedures for pandemic influenza at EDs when stand-alone influenza clinics have been activated. The procedures are described in more detail in the next section.

### Operating procedure

Patients are likely to present at the stand-alone influenza clinic via two mechanisms:

- after being screened and triaged at an ED, or
- having come directly to the influenza clinic (see Figure 3).

The text below describes operating procedures for both the ED pandemic screening station and the stand-alone influenza clinic.

#### (i) Patients presenting to the ED pandemic influenza screening station

##### Step 1: Screen

- All patients and accompanying persons attending the ED must be screened at an influenza screening station located at the entrance to ED.
- All patients and accompanying persons presenting need to be asked screening questions based on an up-to-date case definition for pandemic influenza.
- If the patient does not meet the case definition they should be instructed to proceed through the hospital system as normal.
- Patients that meet the pandemic influenza case definition and are *not* in need of emergency treatment should be provided with a surgical mask and asked to wear it, be asked to wash their hands and then sent to the separate stand-alone influenza clinic for treatment.
- Patients that meet the pandemic influenza case definition and that *are* in need of emergency treatment should be triaged and treated in a single room in the ED.

##### Steps 2 to 7

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure above.

Refer to Figure 2, above, for a description of the process of screening for pandemic influenza.

#### (ii) Patients presenting to the stand-alone influenza clinic after being screened and triaged at an ED

##### Step 1: Identify screened patients

All patients and accompanying persons presenting to the stand-alone clinic after being screened and triaged at an ED need to be identified and placed in a separate queue.

**Steps 2 to 7**

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure above.

**(iii) Patients presenting directly to the stand-alone influenza clinic****Step 1: Screen**

- Patients and accompanying persons presenting directly to the stand-alone influenza clinic need to be screened to ensure that they meet the case definition:
  - If the patient meets the pandemic influenza case definition, they should be triaged and, if *not in need* of high-level emergency treatment, should be assessed and managed in the stand-alone influenza clinic
  - If the patient meets the pandemic influenza case definition, they should be triaged and, if *in need* of high-level emergency treatment, directed to the ED.
- Patients that do not meet the pandemic influenza case definition should be re-directed to the ED, other health care providers (a GP for example) or sent home. Patients that do not meet the influenza case definition should not be treated in an influenza clinic.

**Steps 2 to 7**

Follow **steps 2 to 7** (isolate, assess/manage, notify, send specimens, consult, treat, admit/discharge) as outlined in the enhanced ED triage operating procedure above.

**Stand-alone influenza clinic (during ‘maintenance of social function’ stage)**

The ‘maintenance of social function’ stage of an influenza pandemic will be declared when it is no longer possible to contain the spread of the new influenza virus in the community. Once the ‘maintenance of social function’ stage of the pandemic is declared, the purpose of stand-alone influenza clinics will change significantly, moving from a focus on containment (identification and isolation of patients, and quarantining of contacts) to a focus on maintaining essential health service delivery.

During this stage, stand-alone influenza clinics will operate as influenza triage, assessment, and management facilities for potentially large numbers of sick people. The stand-alone influenza clinic staff will determine whether the patient requires admission to a hospital or staging facility, or whether they can be discharged home with community follow-up as required. Laboratory testing for pandemic influenza will not routinely occur during this stage (unless the patient is hospitalised). Contact tracing will no longer be carried out. Current national policy is that stockpiled anti-influenza medications will be available for pre and post exposure prophylaxis and not for treatment of patients. However, this may change as the size of the stockpile is increased.

**Operating requirements**

The scope and capacity of the ‘maintenance of social function’ stage stand-alone influenza clinics will be determined by a number of factors including the epidemiological characteristics of the virus, the availability of anti-influenza medication for the treatment of cases and the availability of an effective vaccine.

**Operating procedure**

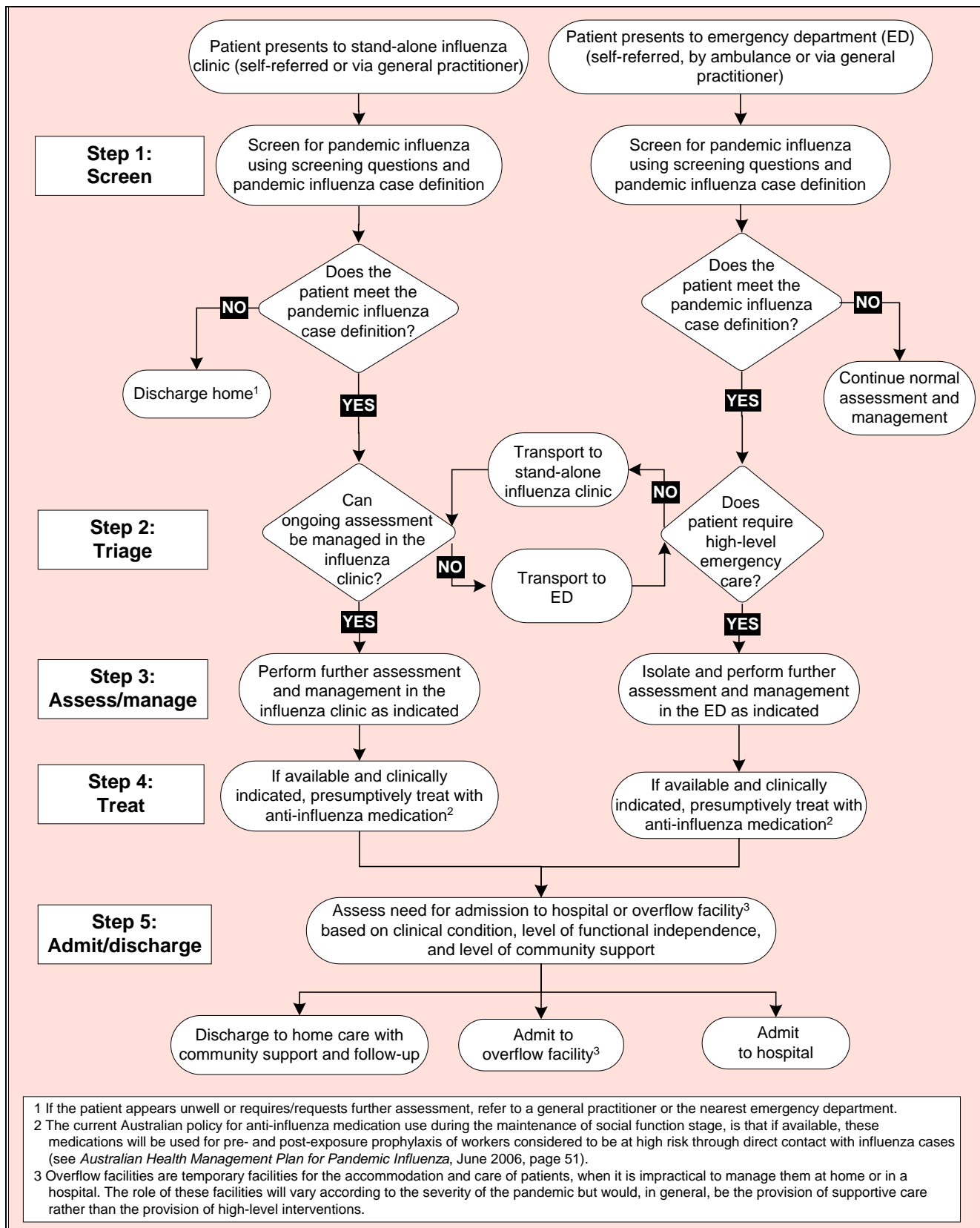
The procedure for operating a stand-alone influenza clinic during the maintenance of social function phase will be significantly different to those for previous response levels.

Staff in a stand-alone influenza clinic will:

- refer patients in need of high-level emergency care to an ED
- manage patients based on a clinical, rather than laboratory, diagnosis of pandemic influenza
- administer anti-influenza medication within 48 hours of symptom onset if medication is still available for treatment of patients, treatment is clinically indicated and there are no contraindications for treatment
- determine whether admission to a hospital, a staging facility, or discharge into home isolation with community follow-up, is required
- if discharging a patient to home care, provide appropriate advice to patient and carer(s) and refer for community follow-up.

A flow diagram summarising case management during the maintenance of social function stage is shown in Figure 3, below.

**Figure 3. Flow diagram for the screening, assessment and management of patients with suspected pandemic influenza during the ‘maintenance of social function’ stage.**



**Role of other health service providers****Role of general practitioners**

The key role of general practitioners (GPs) during an influenza pandemic is to ensure that their usual primary health care services are maintained. If pandemic influenza is suspected in a patient, GPs are encouraged to provide the patient with a surgical mask, refer the patient to an emergency department (ED) or influenza clinic immediately, and notify the ED or influenza clinic that a suspect case has been referred. All suspected pandemic influenza patients should be referred to an ED or influenza clinic as these facilities have the capacity to appropriately assess and manage pandemic patients, access rapid diagnostic tests and anti-influenza medication, and contain further spread of infection.

An exception to this rule will occur in rural and remote areas where GPs may be the only health service provider, or be involved in providing ED response at a local facility. AHSs should plan with GPs as to what the GPs' role will be, and how the GPs' usual primary care role is to be maintained, particularly during the 'maintenance of social function' stage of an influenza pandemic.

The NSW DoH will provide information to all GPs when a change in pandemic alert phase occurs. This information will include advice to refer suspected pandemic influenza patients to EDs and will direct GPs to refer to the NSW DoH website to ensure they are up to date with current case definitions and protocols (e.g., infection control). GPs will also be asked to immediately notify their PHU and ED of any patients with suspected pandemic influenza that they identify and refer.

**Role of Aboriginal Medical Services**

In metropolitan areas, Aboriginal Medical Services (AMSs) will be encouraged to refer patients that meet the pandemic influenza case definition to EDs. In rural areas, a case-by-case assessment to define the role of AMSs will need to be undertaken, taking into account access to ED facilities, the capacity for isolation and management of patients, and the normal role of the AMS.

AHSs will be required to advise AMSs within their boundaries of any change in the pandemic alert phase or pandemic influenza case definition.

**Role of private hospitals that provide emergency department services**

The Hills Private Hospital, Kareena Private Hospital and Sydney Adventist Hospital are the only private hospitals in NSW that have EDs. These hospitals will be required to activate enhanced ED triage and ED screening stations at the same time as public hospitals. AHSs are responsible for notifying private hospitals within their boundaries whenever a change in pandemic alert phase and case definition occurs. The mechanism for notifying private hospitals and the role of private hospital EDs during an influenza pandemic, are to be described in the individual AHS influenza pandemic plans.

**Role of the NSW Ambulance Service**

Once enhanced ED triage is activated, NSW ambulance officers will screen all patients (that are able to be screened) for pandemic influenza on pick-up and, if a case is identified, will (if appropriate) provide the patient with a surgical mask and notify the ED of the suspect case in advance. When ED screening stations are activated, patients that cannot be screened will be presumed to be a suspect case of pandemic influenza, and treated accordingly until proven otherwise. The Ambulance Service of NSW is developing a protocol to guide this process.

The Ambulance Service of NSW is also in the process of developing a protocol defining when ambulances transporting patients who have been identified as suspected pandemic cases should bypass smaller facilities.

The Ambulance Service of NSW will be involved in the transport of suspected and confirmed pandemic influenza patients between facilities. Protocols to cover this are being developed.

#### **Role of pharmacies**

The primary role of pharmacies during all stages of an influenza pandemic is to continue to provide their normal pharmaceutical services. Pharmacies in rural and remote areas in particular should plan for the need to continue to provide essential medicines during an influenza pandemic.

The NSW DoH will notify NSW pharmacies of a change in pandemic alert phase and the pandemic influenza case definition via the Pharmacy Guild. Pharmacies will be encouraged to refer patients that meet the case definition to the nearest public hospital ED.

**PUBLIC HEALTH REAL-TIME EMERGENCY DEPARTMENT SURVEILLANCE SYSTEM (PHREDSS) – PUBLIC HEALTH UNIT RESPONSE GUIDELINES (GL2010\_009)****PURPOSE**

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

**KEY PRINCIPLES**

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

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

**USE OF THE GUIDELINE**

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

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

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

PHREDSS provides daily monitoring of ED visits presenting with various health problems. Using the information transferred to the Department's PHREDSS database, computer programs automatically prepare statistical reports that highlight unusual trends in a range of acute health problems. Situation reports arising from the system are sent by PHREDSS personnel using electronic mail to relevant Departmental and Area Health Service public health authorities for consideration.



**Surveillance Objectives**

- To provide early warning of increases in disease activity in the population that may not be evident through other routine surveillance.
- To provide situational awareness and supplement other information on trends in acute disease and injury in the NSW population.
- To monitor syndrome epidemiology to assist the development and monitoring of prevention strategies for the causes of these syndromes.

**Response options for the PHU receiving the situation report:**

The level of response should be graded according to the apparent size of the increase, severity of illness being caused, opportunity for intervention and local knowledge. The NSW Department of Health may direct or provide guidance for a coordinated response.

**Assessment** should:

- Consider other available information such as notifiable disease reports, the presence of demographic changes through mass gatherings or similar events.
- Include case characteristics, such as: number of people affected, seasonality, age, sex, place of residence and severity of illness (as measured by increases in triage urgency or the proportion of patients being admitted for further treatment or being admitted to a critical care illness). Further information relating to a situation report can be obtained from the PHREDSS team or directly from the PHREDSS reports or other PHREDSS query tools (see next page).

**Responses** may include:

- For sharp increases in the number of ED visits apparently caused by infections or toxins, contacting the relevant ED director, (and other relevant personnel who managed the cases) to determine the likely cause of the increase and unless there is a good alternative explanation, encourage testing for likely causal agents on patients presenting over the next few days with similar syndromes.
- consultation with the relevant policy branch of NSW Health for advice.
- for diseases, including seasonal disease, where alerts to other clinicians or the public are considered likely to assist in prevention of further cases, the issuing of alerts through fax streams or the media.

**Heightened surveillance**

Options are available for heightened surveillance for planned events, such as mass gatherings, or emergencies. For planned events, several weeks notice is required. Options include: increased frequency of data updates; regular line listings of available data; reduced level at which increased activity is signalled, or creation of additional syndromes. For regular events, comparison with equivalent event days rather than the same weekday may be possible.

PHREDSS uses statistical methods to signal unusual occurrences in daily or weekly counts of ED visits categorised into a range of related diagnosis groupings. Each signal is assessed by the PHREDSS team before further reporting. Data available at 12 midnight on the previous day are included in the analysis. Total counts of ambulance arrivals, critical care ward admissions and ED deaths are monitored as well as diagnoses to identify large increases in severe illness. Reports are checked in the morning and afternoon on weekdays and mornings only on weekends and public holidays.

PHREDSS personnel evaluate each signal before issuing a “situation report”, as follows:

- Has there been a recent increase in ED visits?
- Is the increase expected at this time of year (a seasonal increase)?
- How big is the increase compared with both recent and seasonal activity?
- Has the epidemiology of the syndrome changed (such as the age or sex distribution)?
- Has the severity or urgency of the visits increased (based on admission status or triage category)?
- How long has the increase been sustained?
- Is the diagnosis grouping inherently severe, such as meningitis/encephalitis, critical care admissions and ED deaths?
- Is the phenomenon of known interest to our stakeholders? E.g.: influenza-like-illness; gastrointestinal illness; annual childhood asthma epidemics; and drug or alcohol misuse.

The PHREDSS team issues a situation report if the answers to these questions justify informing relevant health stakeholders. The reports generally provide an overview summary along with a description of how the recent epidemiology compares with usual epidemiology. The epidemiological factors include age, sex, mode of arrival at ED, triage urgency, departure status from ED, locality of patient residence.

PHUs can view the PHREDSS reports directly. Various tools to assist with line listing review and statistical analysis (NetEpi Analysis) and ‘keyword searches’ to identify patient visits meeting certain presentation criteria are available from the home page of the PHREDSS reports. Available fields for each ED visit include: medical record number (for some hospitals); date and time of arrival; mode of arrival; presenting problem and triage nurse assessment; triage urgency category; mode of separation; and ED diagnosis. Patient names, addresses and dates of birth are not recorded.

The PHREDSS reports home page is available from the **Biosurveillance** link at:

[hoist.health.nsw.gov.au](http://hoist.health.nsw.gov.au) (NB: this is on the intranet, not the internet).

A username and password are required, which can be obtained by completing the one-page form available at:

[hoist.health.nsw.gov.au/Acumen\\_biosurveillance\\_confidentiality\\_agreement.pdf](http://hoist.health.nsw.gov.au/Acumen_biosurveillance_confidentiality_agreement.pdf)

and returning by facsimile to HOIST Support on: (02) 9391 9232.

For further information about PHREDSS please send an email to: [phredss@doh.health.nsw.gov.au](mailto:phredss@doh.health.nsw.gov.au)

**RETRIEVAL HANDOVER (ADULTS) (PD2012\_019)****PURPOSE**

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

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

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

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

This Policy complements [Clinical Handover – Standard Key Principles \(PD2009\\_060\)](#) which mandates the implementation of standard principles for all types of clinical handover.

**MANDATORY REQUIREMENTS**

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

**IMPLEMENTATION**

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

## Attachment 1: Retrieval Handover (Adults)

**RETRIEVAL HANDOVER PROCEDURE**

***The retrieval team is responsible for directing the coordinated handover and transfer of care.***

This is a vulnerable time for the patient.

**HANDOVER**

- The handover should be between the most senior Hospital clinician caring for the patient and the Retrieval clinician.
- The handover should take place at a predictable time – an estimated time of arrival for the Retrieval team should be provided, with the expectation that the relevant team is **assembled at the agreed time**.
- The handover should occur **before the transfer of management** begins (unless urgent resuscitation is required). This ensures all staff listen to the handover and then focus on the systematic transfer of patient care.

**HANDOVER PROCESS****1. At handover the following information is exchanged:**

- Presenting problem and relevant past history
- Initial and current management (including monitoring, infusions, ventilation)
- Response to management and current condition (including current vital signs)
- Significant results - verbally, plus paper/electronic copy
- A list of issues that need addressing within the next 60 minutes.

**2. Transfer to stretcher/bed**

The hospital is responsible for ensuring that sufficient staff and equipment are available. The retrieval team is responsible for coordinating the move, as they are familiar with the retrieval equipment.

**3. Transfer Monitors**

Monitoring should be transferred between the hospital monitors and retrieval bridge monitors one at a time. There should be no disruption to the continuity of monitoring.

**4. Transfer Therapies**

Therapies should be transferred one at a time, at the direction of the Retrieval team.

**Ventilation:**

- Hospital bed to retrieval stretcher = transfer ventilation last
- Retrieval stretcher to hospital bed = transfer ventilation first; note when transferring from retrieval to hospital equipment, the retrieval team will prescribe initial ventilation parameters.

**Drug infusions:**

- One drug at a time, like-to-like, ensure no dead space
- Retrieval team will determine initial concentration and rate

**Specific therapies:** i.e. intercostal drainage systems, EVDs, Sengstaken Blakemore tubes, IV fluids.

**Routine therapies:** i.e. nasogastric tubes, urinary catheters etc.

Full transfer of care is not complete until all monitoring and therapies are safely established and this is verbally confirmed by the team who are taking over the patient.

**EMERGENCY DEPARTMENT SHORT STAY UNITS (PD2014\_040)****PURPOSE**

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

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

**MANDATORY REQUIREMENTS**

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

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

In some facilities, it may be appropriate for clinically stable ED patients being transferred to another facility, after confirmation of timely availability of a bed at the accepting facility has occurred, to be admitted to EDSSU pending transport to the accepting facility.

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

- Regular monitoring of EDSSUs is important to ensure efficient and appropriate use of EDSSU beds. An admission rate (from EDSSU into the hospital) of 10%-15% is considered acceptable.
  - Regular review of incidents should be undertaken as per the EDs procedure for compliance with [PD2014 004 Incident Management Policy](#) and be included in ED Morbidity and Mortality meetings.
  - Two specific measures for patients admitted to EDSSU (Bed Type 59) which are monitored on a statewide level are:
    1. Length of Stay in the EDSSU, reported as:
      - Percentage of all patients admitted to EDSSU with a LOS (in the EDSSU) less than or equal to 24 hours (calculated in minutes), and
      - Percentage of all patients admitted to the EDSSU with a length of stay less than 4 hours (calculated in minutes).
    2. Destination on departure from the EDSSU
      - Percentage of all patients admitted to EDSSU who were either:
        - Discharged home
        - Transferred to another admitted patient setting in the same service
        - Discharged to another health service.
- Local teams should review adherence to these monitoring measures.

## **IMPLEMENTATION**

Local Health District Chief Executives are responsible for:

- i. Assigning responsibility, personnel and resources to implement this policy.
- ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for admission of patients to EDSSU. This should include nomination of an executive sponsor.
- iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance unit, ED senior management, and clinical staff.

## **1. BACKGROUND**

### **1.1 About this document**

This Procedure document supports and further explains the mandatory requirements of the Emergency Department Short Stay Unit (EDSSU) Policy through the following components:

- Background and use of EDSSU in NSW
- Clinical governance of EDSSU
- EDSSU admission and discharge criteria
- EDSSU design considerations
- Admitted patients in EDSSU
- Paediatric patients in adult EDSSU
- EDSSU staffing
- EDSSU monitoring measures.

### **1.2 Key definitions**

- EDSSU – (also previously known as ‘Emergency Medical Units’ ‘EMU’ and ‘ESSU’) are Inpatient Units, managed by Emergency Department (ED) staff, designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department.
- Bed type 59 - is a bed, staffed 24 hours a day that is designated for the accommodation of patients requiring emergency medical care who would otherwise have remained in the general Emergency Department. Beds in this category may be used for a mix of both day stay and overnight patients, but must be staffed for overnight patient care.

## **2. PROCEDURE FOR USE OF EDSSU**

### **2.1 Background**

Short stay medicine in Emergency Departments (EDs) offers intensive short-term assessment, observation or therapy, in a ‘ward-like’ environment, to optimise the early treatment and discharge of selected ED patients. The model is an alternative to extended stays in hospital EDs and/or the use of multi-day inpatient beds for short-term care.

The aim of the EDSSU is to improve care of patients requiring short term inpatient clinical management. EDSSUs have been shown to reduce inpatient ward length of stay for appropriately selected patients who would otherwise have been admitted to a ward bed, and improve care of those who may have stayed within the ED for prolonged periods. EDSSUs improve the flow of patients through the ED, thereby improving access to care for new emergency patients.

EDSSUs are designated for patients who are to be discharged within 24 hours. This includes stable patients who require observation and/or further investigation to ascertain the seriousness of their condition (e.g. minor head injury, chest pain, infections) or a short course of treatment for conditions that may be rapidly resolved (e.g. asthma, allergic reactions, snake bite and renal colic). Patients are admitted and managed under the care of local Specialist Emergency Physicians (EPs).

EDSSUs also provide a location for ED patients who may require allied health and social support intervention, such as physiotherapy, occupational therapy or social welfare services prior to discharge.

### **2.2 Clinical governance of EDSSU**

Governance of the clinical and operational management of the EDSSU is the responsibility of the ED Director and Nurse Manager/Nursing Unit Manager.

Patients accepted for admission to EDSSU must be authorised by the duty Specialist Emergency Physician or delegate (e.g. emergency registrar overnight) following direct consultation.

Clinical governance includes:

- Review of the EDSSU admission policy and procedures for common Diagnostic Related Group admission categories.
- Medical governance to ensure that all practices in patient care delivery are consistent with high quality evidence based practice, and local LHD, state or national guidelines.
- Governance of patient care, safety and quality, incident reporting and management within an ED quality framework.
- Ensuring that peer review of clinicians involved in the care of patients in the EDSSU occurs and that supervision practices are adequate.

### 2.3 EDSSU admission and discharge criteria

EDs should devise local guidelines regarding the inclusion or exclusion of patients into EDSSU based on local availability of resources and practices which may/may not preclude the management within 24 hours. Some principles which may be used for development of local inclusion and exclusion criteria are as follows.

#### 2.3.1 Patient Inclusion Criteria

##### Anticipated LOS < 24 hours

- EDSSU should target patients with a range of low to moderate risk symptom complexes who, with optimal diagnostic support and clinical management, can be discharged within a 4-24 hour period.
- There should be a focused goal for the period of observation.
- Patients should be clinically stable.

#### 2.3.2 Patient Exclusion Criteria

##### Anticipated LOS >24 hours

The criteria for patient exclusion from an EDSSU will vary between institutions but should be consistent with the following principles:

- It is anticipated that the duration of treatment will be more than 24 hours.
- The patient is admitted under the care of an inpatient team. (local procedures for Hospital in the Home patients returning to hospital for review should be established.)
- The patient has been transferred to the hospital for admission under care of an inpatient team.

##### Clinical exclusion criteria

- The EDSSU cannot provide a suitable level of care or the patient has complex care needs which are unable to be met in the EDSSU.
- Psychotic/violent/disruptive patients/patients at risk of absconding, including patients detained under the [Mental Health Act 2007](#) may often be unsuitable to be cared for in EDSSU unless appropriate resources are available to manage them in the EDSSU environment. Forward planning of resource requirements for this group of patients must be undertaken and not addressed on an ad-hoc basis.
- The patient is clinically unstable. No patients with 'red zone' vital signs according to the [Standard Observation Charts](#) and Between the Flags process should be admitted to EDSSU unless there are documented alterations to the calling criteria.
- The patient has no clear diagnosis or provisional diagnosis.

#### 2.3.3 Admission and Discharge procedures

##### Procedure for admitting a patient to EDSSU

- Discuss with the Specialist Emergency Physician or their delegate on duty for EDSSU.
- Complete an EDSSU admission which must include the applicable medical history, examination findings, provisional and differential diagnoses, a management plan and any outstanding results to be followed up.
- Complete a diagnosis in eMR.
- Complete a clinical hand over of the patient to EDSSU staff including outstanding results or reviews required, and subsequent management plan.



**While in EDSSU**

- Any patient in EDSSU must be included in clinical handover rounds.
- Minimum 4th hourly observations should be performed or as determined by Specialist Emergency Physician.
- The Specialist Emergency Physician must be informed about any deterioration in an EDSSU patient and normal escalation processes utilised across the ED/EDSSU should be followed.

**On discharge from EDSSU**

- Discharge of patients from the ED SSU will be to home or usual residence, inpatient unit (including Hospital in the Home) or another hospital.
- Discharge process should adhere to [PD2014 025 Departure of ED Patients](#) and follow the four principles of departure outlined in the policy.
- A discharge summary must be completed for all patients leaving EDSSU.

**2.4 EDSSU design considerations**

EDSSUs must be designed in a way that allows the unit to be physically separate but in close proximity to the ED. EDSSUs are designated inpatient care areas and as such, the physical design should reflect this. Design should be in line with the [Australasian Health Facility Guidelines – Emergency Unit](#).

The Australasian College for Emergency Medicine [Emergency Department Design Guidelines](#) recommend *a minimum of 8 beds with the capability to monitor each bed to the same level as an acute cubicle*. Beds are to be static in number and are separate to the ED bed base. Decisions regarding final numbers of EDSSU beds/clinical spaces will be determined locally.

It is recognised that some EDSSUs may utilise a process where one clinical bed space may accommodate several recliner chairs for patients staying short periods in the EDSSU. This process should not be used for overnight patients and must ensure appropriate staffing and other resources are maintained.

A dedicated nursing station and adequate desk space for both medical and nursing staff is required. The EDSSU is to have its own patient toilet and shower facilities.

Additionally, the following criteria should be considered in EDSSU design:

- Should have a single room(s) with en suite for the management of short term infectious patients (e.g. gastroenteritis).
- Designs may allow for infection control cohort of patients (or as part of a disaster management response).
- ‘Lounge area’ where patients can be treated that do not require a bed.
- Beverage Bay facilities.
- Storage facilities as well as clean and dirty utility located in the unit (or in close proximity) to maximise productivity and efficiency.

**2.5 Admitted patients in EDSSU**

An admission rate (from EDSSU into the hospital) of 10%-15% is considered acceptable, as it provides a balance of appropriate patient selection, cost effective resource utilisation, and optimisation of quality of patient care.<sup>38</sup> Admission may be required due to a change in the patient’s clinical condition or the subsequent requirement for specialised care and investigations outside of the remit of EDSSU.

229(20/11/14)

Patients must be referred, accepted and transferred from the EDSSU to another appropriate inpatient ward within the 24 hours of arrival to the EDSSU. Direct consultation between the Specialist Emergency Physician and the in-patient consultant (or their delegates) should facilitate clinical handover of the patient as well as the use of NSW Health Policy [PD2009\\_055 “Emergency Department- Direct Admission to Inpatient Wards”](#)

Movement of patients out of EDSSU to a hospital inpatient bed should be a priority to ensure continued flow of appropriate ED patients into EDSSU. Effective communication with the Hospital Bed Manager and After Hours Nursing Manager is essential.

Once transfer of care has taken place, all aspects of clinical care for those patients who are admitted under inpatient teams; but are still in the physical bed space of the EDSSU are the responsibility of the admitting team’s Medical Officers. This includes liaising with family members and carers, reviewing medications, clinical reviews and appropriate discharge planning. Deterioration of these patients whilst they remain in the EDSSU should follow usual local escalation process with the patient being managed jointly by the inpatient team and EDSSU staff.

The EDSSU should not be used to board those patients who are known or expected to be admitted to an in-patient ward from the ED whilst waiting for that bed to become available. Patients who are admitted to inpatient wards via EDSSU are known to have longer total lengths of stay in hospital and utilise more resources than patients admitted directly to the hospital inpatient wards from the ED<sup>39</sup>

## 2.6 Paediatric patients in adult EDSSU

Children requiring short stay admission should be accommodated in paediatric specific units. NSW Health Policy states that “*children admitted to NSW Health acute facilities are not to be accommodated with adult patients*” [PD2010\\_033 Children and Adolescents - Safety and Security in NSW Acute Health Facilities](#).

If no other option exists, any admission of paediatric patients to adult EDSSU is under the strict guidance of PD2010\_033 to ensure they are accommodated in *designated paediatric safe beds*. These admissions should occur in consultation with the on call Paediatrician or delegate, or according to local procedures and care must be provided in accordance with the requirements of [PD2010\\_034 Children and Adolescents - Guidelines for Care in Acute Care Settings](#).

The definition of a child in this document is any person under the age of 16 years, neonates excluded. It is acknowledged that adolescents are defined as those of an age 12-18 years.

Documented local processes may vary between units and are dependent on appropriate resources being provided, however the following principles should provide guidance.

No paediatric patient will be admitted to an EDSSU where the child is:

- Clinically unstable
- Has no definitive diagnosis
- Has no clear signs of clinical improvement following initial treatment
- Is subject to any suspicion of child protection issues
- Has any significant co-morbidity
- Has known acute mental health issues.

<sup>39</sup> Arendts, G. Mackenzie, J. & Lee, J.. Discharge planning and patient satisfaction in an emergency short-stay unit. *Emerg. Med. Aust.* 2006; 18: 7-14.

## **2.7 EDSSU staffing**

Staffing must be commensurate with achieving the EDSSU key functions of: close observation, specialist assessment and diagnosis, short-term high-level care and management of patient conditions<sup>40</sup>.

### **2.7.1 Medical Staffing**

- A Specialist Emergency Physician will be designated and identified on the senior staff roster as EDSSU admitting officer at all times.
- Medical staffing of the EDSSU must ensure senior medical input is available and occurs for every patient.
- Medical staffing must be sufficient to meet the objectives of the EDSSU in providing quality timely care.
- Where junior medical staff are rostered to the EDSSU, the roster profile will be structured to allow direct supervision, on a case by case basis, for every patient by a more senior medical officer (at least registrar level).
- Medical staff in a supervisory role in the EDSSU must be specifically trained and credentialed in emergency medicine.

### **2.7.2 Nursing Staffing**

- Staffing must meet the needs of the patient groups streamed to the EDSSU, and ensure reasonable nurse workloads are maintained.<sup>41</sup>
- A senior nurse in the EDSSU will be allocated per shift that will have first-line management responsibility for the running of the unit, and, working closely with the EDSSU Specialist Emergency Physician/or their delegate, to proactively ‘pull’ appropriate patients from ED into EDSSU.<sup>3</sup>
- At least 1 nurse per shift should be allocated to the EDSSU that has skills in Emergency nursing<sup>42 43</sup> to ensure a range of patient conditions can be managed in the EDSSU.

### **2.7.3 Allied Health in EDSSU**

The EDSSU should have dedicated allied health professionals with appropriate skills and knowledge to provide early intervention, discharge planning and prevent non-medical admission of patients.

Allied health services should be delivered as part of a multidisciplinary team, with staffing levels and skill mix varying in response to the clinical needs of the facility. For an EDSSU, it may be necessary for allied health professionals to work extended hours, on weekends or on-call.

## **2.8 EDSSU monitoring measures**

The ongoing performance of the EDSSUs should be evaluated against the principles and intent of this policy. Data and other monitoring information should be used to drive improvements in service delivery, safety and quality in the EDSSU.

Services should establish mechanisms to ensure that their performance against relevant monitoring measures is regularly reviewed and where issues are identified that there are processes in place to facilitate appropriate action. Monitoring and review should address both the specifically identified state level indicators as well as other locally meaningful measures. 229(20/11/14)

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<sup>40</sup> 2012 NSW Health. Emergency department models of care: Emergency Care Institute ([available](#))

<sup>41</sup> 2011 NSW Health. 2011. Public health system nurses' and midwives' (state) award. ([available](#))

<sup>42</sup> 2013 College of Emergency Nursing Australasia, Standards for the Emergency Nursing Specialist ([available](#))

<sup>43</sup> 2011 NSW Health Transition to Specialty Practice Emergency Nursing Program ([available](#))

Core monitoring measures of for EDSSUs (Bed Type 59) at a state level will include:

- Length of Stay in the EDSSU, reported as:
  - Percentage of all patients admitted to EDSSU with a LOS (in the EDSSU) less than or equal to 24 hours (calculated in minutes) and
  - Percentage of all patients admitted to the EDSSU with a length of stay less than 4 hours (calculated in minutes).
  
- Destination on departure from the EDSSU
  - Percentage of all patients admitted to EDSSU who were either:
    - Discharged home
    - Transferred to another admitted patient setting in the same service
    - Discharged to another health Service

These measures will be calculated by the MoH using existing admitted patient data routinely submitted to the State centralised data warehouse. EDSSU patients should be included in local hospital Morbidity and Mortality meetings.

As well as the core state level indicators, services may wish to investigate the use of other locally meaningful measures, for example:

- Volume of patients admitted and discharged in ED – before and after establishment of the short stay unit.
- Volume of patients admitted from ED to other inpatient locations with LOS less than 24hrs.
- Unplanned representations to ED within 48 hours for patients discharged from an EDSSU.
- NSW Patient Survey Program information.

**EMERGENCY DEPARTMENT, NURSE DELEGATED EMERGENCY CARE, MEDICATION STANDING ORDERS (PD2015\_024)****PURPOSE**

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

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

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

**MANDATORY REQUIREMENTS**

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

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

**IMPLEMENTATION**

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

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

**LEGAL INSTRUMENT**

**POISONS AND THERAPEUTIC GOODS ACT 1966**

**Authorisation to Supply Poisons and Restricted Substances**

PUSUANT to clauses 170 and 171 of the Poisons and Therapeutic Goods Regulation 2008, I, Dr Kerry Chant, Chief Health Officer, a duly appointed delegate of the Secretary of the Ministry of Health, do hereby grant AUTHORITY to registered nurses hereby specified as a class of persons, to supply those poisons and restricted substances listed in the Schedule hereunder either singly or in combination, pursuant to clauses 17 and 53 of that Regulation and subject to the following conditions:

- (1) The registered nurse is employed in a public health organisation within the meaning of the Health Services Act 1997.
- (2) The supply of the poisons or restricted substances is in accordance with the NSW Health Policy Directive PD2015\_024, Standing Orders for the Supply or Administration of Medication under the NDEC Model.

SCHEDULE

cephalexin  
chloramphenicol  
ibuprofen  
paracetamol

Dated: Sydney, 20 July 2015



Dr KERRY CHANT  
Chief Health Officer  
Ministry of Health, New South Wales

## **1 BACKGROUND**

### **1.1 About this document**

The Standing Order authorises an appropriately trained and credentialed Registered Nurse to administer and/or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the Nurse Delegated Emergency Care (NDEC) patient care model. The Standing Orders describe procedures for ordering, storing, administering, and supplying (for take-home use) the specified medication. Any medication Standing Order must be used in conjunction with the applicable NDEC Nursing Management Guideline. The NDEC state-wide Guidelines and Standing Orders are for the management of patients presenting to Emergency Departments (EDs) with the following conditions:

- Minor burns
- Earache
- Eye problems
- Foreign body - minor
- Mild/minor head injury
- Insect bites and stings
- Soft tissue limb injuries
- Stings from marine creatures
- Pain
- Rash
- Respiratory type illness
- Tick bite
- Urinary symptoms
- Vomiting and Diarrhoea.

The state-wide medication Standing Orders form part of a comprehensive suite of patient care resources and, together with the Education and Accreditation Framework and implementation support materials and structures, comprise the Nurse Delegated Emergency Care model.

The NDEC patient care resources include a set of procedures known as Nursing Management Guidelines (NMGs) which can be found online: <http://www.ecinsw.com.au/node/282>. The NMGs direct all clinical care provided through the NDEC patient care model and these Standing Orders are only applicable in accordance with the appropriate NDEC NMG.

The Medication Standing Orders in this document include links to the relevant NMG, describing the types of clinical conditions for which they may be used.

### 1.2 Key definitions

Treatment	An intervention (including medication) to treat an individual case of disease or medical condition.
Supply/ Administration	To provide to or for a specific patient and is consistent with the definition of supply in section 4 of <i>the Poisons and Therapeutic Goods Act 1966</i> . This includes medication selection, recording, labelling, handover to patient/carer, verbal counselling and provision of information sheets and/or Consumer Medicines Information. In this document: a) To 'administer' means the supervised administration of a medication in a health facility. b) To 'supply' means the provision of a medication for take-home use.
Registered Nurse	A nurse or midwife who (i) is on the register of the Nursing and Midwifery Board of Australia, (ii) has completed a 3-year nursing degree from a higher education institution or equivalent from a recognised hospital-based program, and (iii) fulfils all of the ongoing requirements of the Nursing and Midwifery Board of Australia's registration standards.
General Practitioner (GP)	Refers in this document to a GP who has a Visiting Medical Officer (VMO) appointment at a health facility, usually in a rural or remote area, and is a Medical Officer for that site.
Local Facilitator	A key role within the local NDEC governance framework which is usually a senior nurse at a site or LHD level. The role is responsible for ensuring that implementation sites meet the requirements of the NDEC Education and Accreditation Framework.

### 1.3 Legal and legislative framework

Clauses 170 and 171 of the Poisons and Therapeutic Goods Regulation 2008 allow the Secretary of Health to authorise (for the purposes of the Act) a particular person (by means of an instrument in writing given to the person) or a specified class of persons (by means of an instrument published in a manner approved by the Secretary) to supply Schedule 4 medications (restricted substances) under clause 53 of the Regulation and Schedule 2 and Schedule 3 medications under clause 17 of the Regulation. The authorisation applies only to the listed medications for the Standing Orders included in this policy.

### 1.4 Nurse Delegated Emergency Care

The Nurse Delegated Emergency Care (NDEC) patient care model has been developed to support rural and remote facilities provide care for patients presenting to Emergency Departments with low-risk, low-acuity conditions. Under NDEC the care of these patients is managed entirely by an appropriately trained and credentialed Registered Nurse (RN), under the explicit delegation of the site Medical Officer/s. To be credentialed to practice NDEC, RNs must fulfil the requirements of the NDEC Education and Accreditation Framework, including satisfactory completion of the education modules, and competency assessment.

#### Rationale for development of the NDEC Model

NDEC has been developed to improve the care of patients presenting to Emergency Departments with minor illnesses/injuries, and to support the rural clinical workforce in small Emergency Departments. The Model defines the components of safe and quality care for selected low-acuity conditions, and outlines education, credentialing and quality assurance processes so that an episode of care may be delivered entirely by an NDEC credentialed nurse. A robust clinical framework supports care provision when the patient presents, even when no medical officer is available at the site, under a delegated care model.

Key features of NDEC include:

- Assessment of the patient against strict inclusion and exclusion criteria.
- If inclusion criteria are not met, a medical review/phone consult must be sought.



- If the patient is suitable for management under the NDEC model, the RN manages the episode of care using specified:
  - Nurse Management Guidelines
  - Medication Standing Orders
  - Patient Factsheets.
- Nurses may provide interventions to manage symptom relief. The patient will then be discharged with specific follow up instructions in accordance with [PD2014\\_025](#) Departure of Emergency Department Patients.
- The patient is asked to attend follow up with the local GP at their rooms or the ED. The patient will receive a follow up phone call from an NDEC RN within 24 hours of Emergency Department visit to check that symptoms have improved.
- The NDEC model may operate in a facility 24/7, or as an after-hours model, or when no GP is available.
- If at any stage the patient's condition deteriorates and they are deemed no longer suitable for NDEC, the RN is required to revert to "usual care" and contact a the medical officer for further review.
- RNs can opt out of the model if they are concerned about a patient's condition.

### **1.5 Implementation Requirements**

Key prerequisites for the implementation of the NDEC include:

- Express support of care delegation and co-operation in implementing the model from the site General Practitioner(s), Health Service Manager/Nurse Unit Manager and Local Health District Executive is required.
- Submission of NDEC Site Nomination Form to the Agency for Clinical Innovation Emergency Care Institute NSW (ECI). Endorsement by the NDEC Steering Committee is required for sites to work with the ECI to support implementation.
- Pre-implementation education needs assessment.
- Pre-implementation "Snapshot" audit of Emergency Department (ED) presentations pertinent to NDEC.
- Pre-implementation staff survey.
- Pre-implementation patient survey.
- Pre-implementation audit covering existing clinical practice standards related to:
  - Patient assessment
  - Patient symptom management
  - Disposition practices
  - Documentation; and
  - Nursing staff competency and confidence with core nursing skills required for NDEC implementation.
- Establishment of a local governance structure.
- RN training and credentialing in the NDEC Model of Care (MoC) nursing skills.
- Review and local endorsement of Nurse Management Guidelines (NMG).
- Endorsement of Standing Orders by Local Health District (LHD) Drug and Therapeutic Committee.
- Adaption of the paper based NDEC documentation to FirstNet electronic medical record (eMR) if applicable/
- Authorisation and communication of the NDEC "go-live" decision.

### **1.6 Credentialing of Registered Nurses for NDEC**

Operating the NDEC model is within the scope of practice of a Registered Nurse. To be credentialed to practice NDEC, RNs must fulfil the requirements of the NDEC Education and Accreditation Framework, including satisfactory completion of the education and competency assessment. Qualification or endorsement as an Advanced Practice Nurse or Nurse Practitioner is not required.

Credentialing requires NDEC RNs to demonstrate ongoing evidence of recency of practice using NDEC, and ongoing safe use of NDEC through clinical practice audits.

In addition to specific training requirements, the following mandatory education must be completed:

- Emergency Triage Education Kit program (or equivalent).
- NSW Ministry of Health Acute Paediatric Clinical Practice Guidelines on-line.
- Between the Flags, D.E.T.E.C.T. & D.E.T.E.C.T Jnr.
- NDEC mapped core skills review.

Further information can be found in the NDEC Education and Accreditation Framework:

<http://www.ecinsw.com.au/sites/default/files/field/file/NDEC%20RN%20Education%20and%20Accreditation%20Framework.PDF>

### **1.7 Review Process**

The ECI will conduct regular reviews of the NDEC clinical practice materials through its Clinical Advisory Committee, and NDEC Steering Committee, in line with its standard review schedule for clinical tools. Implementation sites can initiate review or revision of NDEC materials through ECI clinical governance processes. NDEC Patient Care Resources have been reviewed by the:

- ECI Executive Committee.
- NDEC Steering Committee.
- CEC Medication Safety Expert Advisory Committee.
- LHD Drug and Therapeutics Committees.

The ECI will provide NDEC sites with appropriate resources and education as reviews and updates occur. Individual sites will be responsible for updating local resources and completing reviews of local Standing Orders in accordance with [PD2013 043 Medication Handling in NSW Public Health Facilities](#).

## **2 IMPLEMENTATION OF STATEWIDE STANDING ORDERS FOR NURSE DELEGATED EMERGENCY CARE**

When a state-wide Standing Order is applied, Public Health Organisation Executives are to ensure:

- A Registered Nurse operating under this standing order is aware of their responsibility to:
  - Comply with the requirements of the NDEC Education and Accreditation Framework.
  - Determine whether the patient meets the criteria for the standing order.
  - Recognise patients who do not meet inclusion criteria for NDEC and refer them to a medical officer for clinical care.
  - Determine any known allergies, hypersensitivity to the medication or contra-indications to treatment, and where these are identified, contact the medical officer to discuss appropriate management.

- Explain the medication and its purpose to the patient (or guardian).
  - Obtain patient/guardian consent for treatment as appropriate.
  - Document all assessments and details relating to the supply of medication as detailed below.
  - Attend yearly training in cardio-pulmonary resuscitation, including review of the protocol for the administration of adrenaline.
- 
- Medications are supplied by the Pharmacy Department to the Emergency Department pre-labelled in accordance with [PD2013\\_043](#) Medication Handling in NSW Public Health Facilities.
  - All medication that is supplied for dosing at a later time is pre-prepared and labelled by a pharmacist, or, in circumstances where pre-prepared packs are not available, is labelled by the clinician supplying the medication to the patient. Labelling must include the name(s), strength(s), and active ingredient(s) of the medication and the directions for use, including duration of use, ancillary labels and other required information. The patient's name and date of supply must be hand-written on the label by the nurse at the time of supply. Any pre-prepared label must be initialled by the nurse supplying the medication to the patient. Additional information that must also be supplied includes the relevant medication factsheet.
  - A Medical Officer is able to be contacted to provide advice to the Registered Nurse who is providing medication under the standing order.
  - A Medical Officer will review, sign and date records within 24 hours to confirm that medications were administered or supplied in accordance with the standing order.
  - All records relating to the administration of medication are retained in accordance with the State Records Authority General Retention and Disposal Authority for Public Health Services: Patient/Client Records (GDA 17).
  - Where possible, medications are stored as Imprest stock Schedule 2, 3 and 4 (but not Schedule 4D) in ED or ED after-hours store – see sections 6.3.3 and 6.8 of [PD2013\\_043](#).

### **3 MEDICATIONS FOR THE MANAGEMENT OF SYMPTOMS ASSOCIATED WITH MINOR INJURIES/ILLNESSES DEFINED IN THE NURSE DELEGATED EMERGENCY CARE PATIENT CARE MODEL**

#### **3.1 Purpose**

This standing order authorises a registered nurse, who has demonstrated compliance with requirements set out in Section 2, to administer and/or supply specified medications for the purpose of treatment of defined low-risk conditions specified under the Nurse Delegated Emergency Care patient care model. It also sets out procedures for ordering, storing, administering and supplying the medications.

If the Registered Nurse applying the standing order has any concerns regarding patient safety for provision of the medication (e.g. people with significant chronic illness or immunosuppression), the nurse should arrange for the responsible Medical Officer, whether in the hospital or on call, to assess the patient so appropriate administration of medication can occur as soon as possible. Where no medical officer is on call, the usual procedure designated by the hospital executive for obtaining medical officer advice will apply.

**3.2 Scope**

The following Standing Orders are to be used within the framework of the Nurse Delegated Emergency Care (NDEC) patient care model. These Standing Orders are not approved for use outside of the NDEC model of care, even if such use may be covered by other NSW Ministry of Health or LHD specific policy or protocol.

**These Standing Orders are not intended to replace clinical judgement and expertise.**

**3.3 Additional points to be noted for all standing orders:**

- Note on drug Trade Names: where applicable, every attempt has been made to list Australian available unique trade names that do not articulate the primary medication within the trade name (e.g. Heron Paracetamol is not listed). To confirm specific constituent components, consult medication packaging, product information such as MIMS Online® or pharmacological resource such as the Australian Medicines Handbook (<https://amhonline.amh.net.au.acs.hcn.com.au>).
- Note on listed Indications: The listed indications are for the NDEC context only. No attempt has been made to present a full scope of indications for each drug. For full medication information, consult an appropriate pharmacological resource like MIMS Online®.
- Note on listed Contraindications: Any RED FLAG listed within a specific Nursing Management Guideline is a contraindication for medication administration under NDEC. In addition, for the purpose of nurse administration of medication within NDEC, relative contraindications are treated as absolute contraindications; and a medical review will be required prior to medication administration.
- Note on listed Side Effects: The management of side effects from administration of any medications under the following Standing Orders should occur as per usual practice. For severe reactions, including anaphylaxis, care should be in accordance with NSW Rural Adult or Paediatric Emergency Clinical Guidelines. Should a patient develop any concerning side effects, a medical officer should be contacted.

## 3.3 Standing Order for supply of Amethocaine Hydrochloride eye drops

<b>TITLE</b>	Standing order for Amethocaine Hydrochloride eye drops
<b>Trade Name(s)</b>	Minims Amethocaine Eye Drops
<b>Presentation</b> <sup>1</sup>	Clear, colourless sterile eye drops 0.5% (5mg/mL), or 1% (10mg/mL) Single patient, single use
<b>Indication</b>	Production of local anaesthesia in the eye. Reduces pain to facilitate adequate eye exam.
<b>Contraindications</b> <sup>1</sup>	Current use of sulphur based antibiotics (sulphonamides)
<b>Precautions</b> <sup>1</sup>	Instruct patient not to rub or touch the affected eye while anaesthesia persists. Should be used with caution in children, as this group is more susceptible to drug effects.
<b>Dose</b>	1 drop into affected eye/s, repeated every 5 minutes if necessary. Up to 3 drops may be used for foreign body removal.
<b>Dose frequency</b> <sup>1</sup>	Single dose
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> Ensure contact lenses are removed Instil dose into affected eye/s (see Emergency Eye Manual pg. 26 for eye drop instructions) <a href="http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0013/155011/eye_manual.pdf">http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0013/155011/eye_manual.pdf</a> Instruct patient not to rub or touch the affected eye while anaesthesia persists
<b>Storage</b>	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>On instillation an initial burning sensation may be experienced. This may last for up to 30 seconds.</li> <li>Blurred vision, lacrimation (watery eyes)</li> <li>Persistent use may result in corneal damage</li> </ul> <u>Never give patient anaesthetic drops to take home</u>
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Eye Problems <a href="http://www.ecinsw.com.au/node/270">http://www.ecinsw.com.au/node/270</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

**Local Standing Order Authorisation:**

<b>Date approved by XXX LHD Drugs and Therapeutics Committee:</b>	<b>Medical Officer Name:</b>
<b>Review Date:</b>	<b>Signature:</b>

<sup>1</sup> The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

## 3.4 Standing Order for supply of Cephalexin

<b>TITLE</b>	Standing order for Cephalexin
<b>Trade Name(s)</b>	Cefalexin, Cephatrust, Cilex, Ialex, Ibilex, Keflex, Rancef
<b>Presentation</b> <sup>1</sup>	Tablet/capsules containing 250mg; 500mg Oral suspension for reconstitution 125mg/5mL; 250mg/5mL
<b>Indication</b>	Antibiotic treatment for suspected UTI by clinical history <u>and</u> positive U/A (positive leukocytes and/or nitrites)
<b>Contraindications</b> <sup>1</sup>	Known allergy to cephalosporin group of antibiotics or previous history of a major allergy to penicillins
<b>Precautions</b> <sup>1</sup>	Nil specific
<b>Dose and frequency</b> <sup>1</sup>	<b>Adults</b> 500mg first dose only* <b>or</b> 500mg every 12 hours for 5 days* <b>Children &gt; 12 years</b> 12.5mg/kg up to 500mg first dose only* <b>or</b> 12.5mg/kg up to 500mg every 6 hours for 5 days* <b>*Refer to local facility NDEC guidelines regarding administration of first dose versus dispensing a full course of antibiotic via this Standing Order.</b>
<b>Administration and Supply</b> <sup>1</sup>	<b>May be administered in hospital and full course of medication may be supplied via pre-labelled stock for use outside the hospital.</b> Oral tablet/capsule Oral suspension – consult product information for reconstitution instructions. Store in fridge once reconstituted (discard unused portion after 14 days).
<b>Storage</b>	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	Gastrointestinal symptoms Hypersensitivity reactions
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of the full course in the “once only” section of the medication chart. The record of administration and supply must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Urinary Symptoms <a href="http://www.ecinsw.com.au/node/278">http://www.ecinsw.com.au/node/278</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

**Local Standing Order Authorisation:**

<b>Date approved by XXX LHD Drugs and Therapeutics Committee:</b>	<b>Medical Officer Name:</b>
<b>Review Date:</b>	<b>Signature:</b>

<sup>1</sup> The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

## 3.5 Standing Order for supply of Chloramphenicol eye drops

<b>TITLE</b>	Standing order for Chloramphenicol eye drops Minims Chloramphenicol 0.5% Eye Drops
<b>Trade Name(s)</b>	Chloromycetin Eye Drops; Chlorsig Eye drops; Minims Chloramphenicol 0.5% Eye Drops
<b>Presentation</b> <sup>1</sup>	Clear to slightly hazy, colourless, sterile eye drops 0.5% (5mg/mL).
<b>Indication</b>	Prophylactic antibiotic coverage against bacterial infection in superficial ocular injuries including corneal foreign body and “welder’s flash” burn
<b>Contraindications</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>• Known allergy to chloramphenicol</li> <li>• Restriction of eye movement/abnormal pupils cloudy cornea</li> <li>• Chronic eye disease (e.g. glaucoma)</li> <li>• Recent (within 6 months) eye surgery, including laser surgery</li> </ul>
<b>Precautions</b> <sup>1</sup>	Patients should be instructed to cease using contact lenses during treatment and seek GP or optometrist advice prior to recommencing use.
<b>Dose</b> <sup>1</sup>	1 drop into affected eye/s
<b>Dose frequency</b> <sup>1</sup>	Every 2–4 hours for 2 days; then 1 drop 4 times daily for 5 days
<b>Administration and Supply</b> <sup>1</sup>	<p><b>May be administered in hospital and full course of medication may be supplied via pre-labelled stock for use outside the hospital.</b> Single patient use (discard after 1 month of opening)</p> <p>Ensure contact lenses are removed</p> <p>Instil dose into affected eye/s</p> <p>(see Emergency Eye Manual pg. 26 for eye drop instructions)</p> <p><a href="http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0013/155011/eye_manual.pdf">http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0013/155011/eye_manual.pdf</a></p>
<b>Storage</b>	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013_043</a> .
<b>Adverse effects</b> <sup>1</sup>	Local ocular irritation; burning or itching. Allergic type reactions. Unpleasant taste. Blurred vision.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of the full course in the “once only” section of the medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Eye Problems <a href="http://www.ecinsw.com.au/node/270">http://www.ecinsw.com.au/node/270</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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**3.6 Standing Order for supply of Fluorescein eye drops**

<b>TITLE</b>	Standing order for Fluorescein eye drops
<b>Trade Name(s)</b>	Minims Fluorescein Eye Drops
<b>Presentation</b> <sup>1</sup>	Sterile ophthalmic solution 2% (20mg/mL) or 1% (10mg/mL). Single patient, single use.
<b>Indication</b>	Diagnostic aid during eye exams.
<b>Contraindications</b> <sup>1</sup>	Nil recorded
<b>Precautions</b> <sup>1</sup>	Ensure single use/single patient regime maintained; significant risk of iatrogenic ocular infection if solution reused. Advise patient to avoid rubbing eyes and avoid expose to dust. Advise patient may temporarily stain skin, urine, tears, nasal secretions yellow; may permanently stain soft contact lenses and clothing.
<b>Dose</b> <sup>1</sup>	Use sufficient solution to apply stain to damaged area – generally 1-2 drops in each eye. Excess can be washed away with sterile saline solution.
<b>Dose frequency</b> <sup>1</sup>	Single dose
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> <ul style="list-style-type: none"> <li>• Ensure contact lens are removed</li> <li>• Instil solution into affected eye/s</li> <li>• (see Emergency Eye Manual pg. 26 for eye drop instructions <a href="http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0013/155011/eye_manual.pdf">http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0013/155011/eye_manual.pdf</a>)</li> <li>• Use cobalt blue light source for assessment</li> <li>• Stain does not show up on a normal cornea. Corneal abrasions or ulcers are stained a bright green. Foreign bodies are surrounded by a green ring. Conjunctival abrasions are also stained.</li> </ul>
<b>Storage</b>	Refrigerate and store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	May cause blurred vision – caution driving.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Eye Problems <a href="http://www.ecinsw.com.au/node/270">http://www.ecinsw.com.au/node/270</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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## 3.7 Standing Order for supply of Ibuprofen

<b>TITLE</b>	Standing order for Ibuprofen
<b>Trade Name(s)</b>	Advil, Brufen, Bugesic, Dimetapp, Heron Blue, Nurofen, Panafen, ProVen, Rafen
<b>Presentation<sup>1</sup></b>	<p><u>Tablets/capsules</u> containing 200mg <u>Suspension</u></p> <ul style="list-style-type: none"> <li>• 200mg/5mL</li> <li>• 100mg/5mL</li> <li>• 100mg/100mL</li> </ul> <p>(Note: Some ibuprofen preparations contain codeine, phenylephrine or pseudoephedrine combinations – this Standing Order is for ibuprofen <u>only</u>. Other preparation combinations are not covered).</p>
<b>Indication</b>	Analgesia for the treatment of mild to moderate pain (any cause). Corresponding pain score may range from 1 – 6.
<b>Contraindications<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• History of allergy to aspirin or other NSAIDs</li> <li>• Concurrent antiplatelet (including low dose aspirin) or anticoagulant use</li> <li>• History of, or likelihood of, active peptic ulcer disease or GI bleeding</li> <li>• History of, or likelihood of, liver, kidney or cardiovascular disease, including hypertension, heart failure, stroke, myocardial infarct</li> <li>• History of asthma or hypertension</li> <li>• Current or possible pregnancy</li> <li>• Breast feeding mothers</li> <li>• Patients &gt;65yrs with multiple comorbidities and on multiple medications</li> <li>• Dehydration</li> <li>• Concurrent use of diuretics, ACE inhibitors or angiotensin receptor blockers</li> </ul>
<b>Precautions<sup>1</sup></b>	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration
<b>Dose<sup>1</sup></b>	<p><b>Elderly – 200mg per dose</b></p> <p><b>Adults – 200 - 400mg per dose</b></p> <p><b>Children - 10mg / kg up to 400mg per dose</b></p>
<b>Dose frequency<sup>1</sup></b>	<p><b>Adults - 4-6 hourly (maximum 3 doses/24hrs)</b></p> <p><b>Children - 6-8 hourly (maximum 3 doses/24hrs)</b></p>
<b>Administration and Supply<sup>1</sup></b>	<p><b>May be administered in hospital and supplied via pre-labelled stock for use outside the hospital in a take-home pack of no more than 10 tablets. Advise patient to consult a doctor about using for more than 2 days.</b></p> <p>Oral tablet/capsule or suspension syrup</p>
<b>Storage</b>	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Gastrointestinal symptoms</li> <li>• Hypersensitivity reactions</li> <li>• Longer term use may exacerbate cardiac or renal disease</li> </ul>
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record and supply is to be documented by the administering nurse. Document first dose and supply (if applicable) on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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## 3.8 Standing Order for supply of Lignocaine 1%

<b>TITLE</b>	Standing order for Lignocaine 1%
<b>Trade Name(s)</b>	Lignocaine, Xylocaine (Plain)
<b>Presentation</b> <sup>1</sup>	<u>Ampoule</u> containing clear, colourless, sterile liquid. Specific ampoule type depends on manufacturer however, contains either <b>50mg/5mL</b> <b>200mg/20mL</b>
<b>Indication</b>	To facilitate the removal of a crawling insect from the ear canal by <u>gentle</u> aural instillation.
<b>Contraindications</b> <sup>1</sup>	Known perforation, bleeding or obvious trauma to external auditory canal Inability for patient to stay still/immobilised during instillation
<b>Precautions</b> <sup>1</sup>	Nil specific
<b>Dose</b>	Single dose (1% lignocaine) for adults and children > 10kgs. Maximum dose (based on 3mg/kg) • ≥ 10kg 3mL
<b>Dose frequency</b> <sup>1</sup>	Single dose
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> The aim of administration is to cover/drown the insect. <u>Gently</u> instil into the ear to achieve desired outcome. <u>Note</u> if the insect is still alive, it may rapidly crawl out of the auditory canal upon commencement of instillation.
<b>Storage</b>	Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	If instilled in an ear with a perforated membrane, middle ear type symptoms may develop (vertigo etc.)
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Earache <a href="http://www.ecinsw.com.au/node/269">http://www.ecinsw.com.au/node/269</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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## 3.9 Standing Order for supply of Loratadine

<b>TITLE</b>	Standing order for Loratadine
<b>Trade Name(s)</b>	Alledine; Allergyne; Allereze; Claratyne; Lorano; Lorapaed; Lorastyne
<b>Presentation</b> <sup>1</sup>	<b>Tablet</b> containing 10mg <b>Syrup</b> containing 1mg/mL (Note: Some loratadine preparations contain a pseudoephedrine combination – this Standing Order is for loratadine <u>only</u> . Other preparation combinations are not covered.)
<b>Indication</b>	Minor urticarial rashes of probably allergen origin
<b>Contraindications</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>Allergy to sodium benzoate (preservative in syrup form)</li> <li>Severe liver disease</li> </ul>
<b>Precautions</b> <sup>1</sup>	Nil specific
<b>Dose</b> <sup>1</sup>	<p><b>Adults/children aged ≥ 12 years</b></p> <ul style="list-style-type: none"> <li>10mg (1 tablet) orally, daily</li> </ul> <p><b>Children</b></p> <ul style="list-style-type: none"> <li>2 – 12 years <ul style="list-style-type: none"> <li>Body weight &gt; 30kg; 10mg (10mL or 1 tablet) orally, daily</li> <li>Body weight ≤ 30kg; 5mg (5mL) orally, daily</li> </ul> </li> <li>1 – 2 years <ul style="list-style-type: none"> <li>2.5mg (2.5mL) orally, daily</li> </ul> </li> </ul>
<b>Dose frequency</b> <sup>1</sup>	Daily
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> Oral tablet/syrup
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013_043</a> .
<b>Adverse effects</b> <sup>1</sup>	May rarely cause drowsiness, fatigue, headache, nausea, dry mouth especially in the elderly.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Rash <a href="http://www.ecinsw.com.au/node/268">http://www.ecinsw.com.au/node/268</a> NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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**3.10 Standing Order for supply of Metoclopramide**

<b>TITLE</b>	Standing order for Metoclopramide
<b>Trade Name(s)</b>	Maxolon; Pramin
<b>Presentation</b> <sup>1</sup>	<b>Tablets</b> containing 10mg <b>Parenteral solution</b> containing 5mg/mL, 2mL (Note: Some metoclopramide preparations contain a paracetamol combination – this Standing Order is for metoclopramide <u>only</u> . Other preparation combinations are not
<b>Indication</b>	Relief of nausea and/or vomiting
<b>Contraindications</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>• Age &lt; 20 years</li> <li>• Hx epilepsy</li> <li>• Previous reactions to metoclopramide (including dystonic reactions)</li> <li>• Impaired renal or hepatic function</li> </ul>
<b>Precautions</b> <sup>1</sup>	Nil specific
<b>Dose</b> <sup>1</sup>	Adults ≥ 20 years <ul style="list-style-type: none"> <li>• 10mg oral tablet/OR by intramuscular injection</li> </ul> If patient weighs 30-60kg <ul style="list-style-type: none"> <li>• 5mg oral tablet/OR by intramuscular injection</li> </ul>
<b>Dose frequency</b> <sup>1</sup>	Can be given three times a day (every 8 hours)
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> Oral tablet OR by intramuscular injection
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	Dystonic type reactions (involuntary muscle contractions and abnormal postures of the trunk, neck, face, or extremities), akathisia, drowsiness, dizziness, headache.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Vomiting and Diarrhoea <a href="http://www.ecinsw.com.au/node/279">http://www.ecinsw.com.au/node/279</a>

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**3.11 Standing Order for supply of Ondansetron**

<b>TITLE</b>	Standing order for Ondansetron
<b>Trade Name(s)</b>	Ondaz; Zifojim Zofran, Zondan
<b>Presentation<sup>1</sup></b>	<b>Wafer (fast dissolving) or oral tablet</b> containing 4mg or 8mg
<b>Indication</b>	Relief of nausea and/or vomiting
<b>Contraindications<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Concomitant use with apomorphine</li> <li>• Children &lt; 2 years</li> <li>• Cardiac disease, particularly conduction anomalies</li> <li>• Hypokalaemia</li> </ul>
<b>Precautions<sup>1</sup></b>	Nil specific
<b>Dose<sup>1</sup></b>	Adults and children ≥ 2 years <ul style="list-style-type: none"> <li>• 4mg single dose (tablet or wafer)</li> </ul>
<b>Dose frequency<sup>1</sup></b>	Single dose
<b>Administration<sup>1</sup></b>	<b>To be administered in hospital only.</b>  Wafer is placed on top of the tongue where it dissolves within seconds and is swallowed Or Tablet orally
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects<sup>1</sup></b>	Headache, sensation of warmth or flushing, dizziness, hypotension, hiccups, arrhythmias, chest pain, seizures.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Vomiting and Diarrhoea <a href="http://www.ecinsw.com.au/node/279">http://www.ecinsw.com.au/node/279</a>

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**3.12 Standing Order for supply of Oral Rehydration Solution**

<b>TITLE</b>	Standing order for Oral Rehydration Solution
<b>Trade Name(s)</b>	E-Lyte; Gastrolyte; Gold Cross Gluco-lyte; HYDRALyte, O.R.S.; Pedialyte; Repalyte; Restore O.R.S.
<b>Presentation<sup>1</sup></b>	Oral Rehydration Solutions are generally available in 4 forms; <ul style="list-style-type: none"> <li>• Soluble powder</li> <li>• Effervescent dissolvable tablet</li> <li>• Pre-made solution</li> <li>• Ice blocks.</li> </ul> Composition of the available Oral Rehydration Solutions vary. For an overview comparison see NSW Health Infants and Children – Acute Management of Gastroenteritis. <a href="http://www0.health.nsw.gov.au/policies/gl/2014/GL2014_024.html">http://www0.health.nsw.gov.au/policies/gl/2014/GL2014_024.html</a>
<b>Indication</b>	Oral correction of fluid and electrolyte loss in infants, children and adults as a result of vomiting and/or diarrhoea
<b>Contraindications<sup>1</sup></b>	Possible surgical intervention and/or a requirement to remain ‘nil by mouth’
<b>Precautions<sup>1</sup></b>	Strict fluid balance record. Input should exceed output. Further vomiting ≠ failed trial of fluid – worsening dehydration assessment status = failed trial of fluid
<b>Dose<sup>1</sup></b>	0.5mL/kg
<b>Dose frequency<sup>1</sup></b>	Every 5 minutes
<b>Administration<sup>1</sup></b>	<b>To be administered in hospital only.</b> If required, reconstitute specific Oral Rehydration Solution as per manufactures instructions. Instruct patient/carer to administer Oral Rehydration Solution in small, frequent amounts (0.5mL/kg every 5 minutes). Provide patient/carer with appropriate measuring/administration equipment; syringe, measuring cup etc.
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013_043</a> .
<b>Adverse effects<sup>1</sup></b>	No clinically significant side-effects
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Vomiting and Diarrhoea <a href="http://www.ecinsw.com.au/node/279">http://www.ecinsw.com.au/node/279</a>

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## 3.13 Standing Order for supply of Paracetamol

<b>TITLE</b>	Standing order for Paracetamol
<b>Trade Name(s)</b>	APO, Dimetapp, Dymadon, Febridol, Lemsip, Panadol, Panamax, Paralgin (Note: Some paracetamol preparations contain combinations of caffeine, chlorpheniramine, codeine, dextromethorphan, dextropropoxyphene, doxylamine, metoclopramide, orphenadrine, phenylephrine, pseudoephedrine, and/or triprolidine. This Standing Order is for paracetamol <u>only</u> ).
<b>Presentation<sup>1</sup></b>	<u>Tablets/capsules/chewable tablets/soluble tablets or soluble powder</u> : containing 120mg, 250mg, 500mg, 600mg, 1000mg <u>Suspension</u> : <ul style="list-style-type: none"> <li>• 50mg/mL</li> <li>• 100mg/mL</li> <li>• 120mg/5mL</li> <li>• 240mg/5mL</li> </ul> (Note: paracetamol is available as modified/sustained release (665mg) tablets, suppositories and intravenous infusions. This Standing Order is for oral non-modified release preparations <u>only</u> ).
<b>Indication</b>	Analgesia for the treatment of mild to moderate pain (any cause). Corresponding pain score may range from 1 – 6
<b>Contraindications<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Known allergy to paracetamol or specific preparation components</li> <li>• Impaired liver function including current alcohol dependence</li> <li>• Previous dose 15mg/kg (1g adult dose) of paracetamol within 4 hours</li> <li>• Cumulative dose 60mg/kg (4g adult dose) of paracetamol within preceding 24 hours</li> <li>• Avoid soluble preparations (due to high sodium content) in heart failure/hypertension/where low sodium intake is indicated</li> </ul>
<b>Precautions<sup>1</sup></b>	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration
<b>Dose<sup>1</sup></b>	<b><u>Adults and children &gt; 12 years</u></b> <ul style="list-style-type: none"> <li>• 1g</li> </ul> <b><u>Children &gt; 1 month</u></b> <ul style="list-style-type: none"> <li>• 15mg / kg (maximum 1g) (maximum 60mg / kg / 24 hours – not more than 4g per 24 hours)</li> </ul>
<b>Dose frequency<sup>1</sup></b>	<b><u>Adults and children &gt; 12 years</u></b> <ul style="list-style-type: none"> <li>• every 4 – 6 hours (maximum 4g per 24 hours)</li> </ul> <b><u>Children &gt; 3 months</u></b> <ul style="list-style-type: none"> <li>• every 4 – 6 hours (maximum 60mg/kg/24 hours – not more than 4g per 24 hours)</li> </ul>
<b>Administration and Supply<sup>1</sup></b>	<b>May be administered in hospital and supplied via pre-labelled stock for use outside the hospital in a take-home pack of no more than 10 tablets.</b>  Prepare and administer appropriate oral dose based on product concentration, product instructions and intended dose.
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013_043</a> .
<b>Adverse effects<sup>1</sup></b>	Rare – though hypersensitivity/allergic type reactions are possible
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration and supply record is to be documented by the administering nurse. Document first dose and supply of take home pack (if applicable) on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.



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**6. EMERGENCY CARE**

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**6.144**

<b>Related Documents</b>	NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>
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**Local Standing Order Authorisation:**

<b>Date approved by XXX LHD Drugs and Therapeutics Committee:</b>	<b>Medical Officer Name:</b>
<b>Review Date:</b>	<b>Signature:</b>

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<sup>1</sup> The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

**3.14 Standing Order for supply of Paracetamol 500mg/Codeine 8mg**

<b>TITLE</b>	Standing order for Paracetamol 500mg/Codeine 8mg ( <b>adults only</b> )
<b>Trade Name(s)</b>	Codapane, Panamax Co, Panadeine, Panalgesc (Note: Paracetamol/codeine preparations are available in multiple dose ratios. Some preparations also contain combinations of doxylamine. This Standing Order is for paracetamol 500mg/codeine 8mg <u>only</u> .)
<b>Presentation</b> <sup>1</sup>	Tablet/soluble tablet containing 500mg paracetamol/8mg codeine
<b>Indication</b>	Analgesia for the treatment of moderate pain <b>in adults</b> (any cause). Corresponding pain score may range from 4 – 6.
<b>Contraindications</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>• Known allergy to paracetamol, codeine or specific preparation components</li> <li>• Breastfeeding mothers</li> <li>• Impaired liver function including current alcohol dependence</li> <li>• Impaired renal function</li> <li>• Decreased respiratory reserve</li> <li>• Previous paracetamol dose (≥ 1g) within last 4 hours</li> <li>• Cumulative dose of paracetamol ≥ 4g within last 24 hours</li> <li>• Avoid soluble preparations (due to high sodium content) in heart failure/hypertension/where low sodium intake is indicated</li> </ul>
<b>Precautions</b> <sup>1</sup>	Nil specific – assess effectiveness by repeating pain assessment 30 – 60 minutes post administration.
<b>Dose</b> <sup>1</sup>	2 tablets (paracetamol 500mg / codeine 8mg)
<b>Dose frequency</b> <sup>1</sup>	4 – 6 hourly up to 8 tablets (4g paracetamol total) per 24 hours
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b> Tablet or soluble tablet orally
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects</b> <sup>1</sup>	<ul style="list-style-type: none"> <li>• Drowsiness and mental impairment</li> <li>• Gastrointestinal symptoms</li> <li>• Rare – though hypersensitivity/allergic type reactions are possible for both paracetamol and codeine</li> </ul>
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Pain <a href="http://www.ecinsw.com.au/node/275">http://www.ecinsw.com.au/node/275</a>

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**3.15 Standing Order for supply of Sodium Citrotartrate**

<b>TITLE</b>	Standing order for Sodium Citrotartrate ( <b>adults only</b> )
<b>Trade Name(s)</b>	Citralite, Citravescent, Ural
<b>Presentation<sup>1</sup></b>	Powder for reconstitution containing 3.7g or 4g sodium citrotartrate
<b>Indication</b>	Symptom management of dysuria <b>in adult patients only</b>
<b>Contraindications<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Renal failure/renal impairment</li> <li>• Hyponatraemia/heart failure/hypertension / peripheral or pulmonary oedema/ where low sodium intake is indicated</li> <li>• Pregnancy</li> <li>• Breastfeeding mothers</li> </ul>
<b>Precautions<sup>1</sup></b>	Nil specific
<b>Dose<sup>1</sup></b>	1 – 2 reconstituted sachets (3.7 – 8g)
<b>Dose frequency<sup>1</sup></b>	3 – 4 times a day
<b>Administration<sup>1</sup></b>	<b>May be administered in hospital and supplied via pre-labelled stock for use outside the hospital. (Patient information sheet must be included.)</b> Reconstitute powder as directed by product packaging.
<b>Storage</b>	Must be stored out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013 043</a> .
<b>Adverse effects<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Mild laxative effect</li> <li>• Prolonged use may cause systematic alkalosis and/or hyponatraemia</li> </ul>
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart. The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	NDEC Nurse Management Guideline: Urinary Symptoms <a href="http://www.ecinsw.com.au/node/278">http://www.ecinsw.com.au/node/278</a>

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## 3.16 Standing Order for supply of Tetanus Toxoid

<b>TITLE</b>	Standing order for Tetanus Toxoid
<b>Trade Name(s)</b>	<i>Tetanus toxoid is only available in combination with other antigens.</i> Adacel (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine), ADT (Diphtheria toxoid + Tetanus toxoid), Boostrix (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine), Tripacel Injection (Diphtheria toxoid + Tetanus toxoid + Pertussis vaccine)
<b>Presentation</b> <sup>1</sup>	0.5mL in needleless prefilled syringe for injection
<b>Indication</b>	<ul style="list-style-type: none"> <li>• All wounds in patients that have not had a booster in the last 10 years</li> <li>• All wounds <u>other than clean minor cuts</u> in adults who have not received a booster in the last 5 years</li> <li>• All wounds where <u>vaccination history is uncertain</u> or <u>less than 3 doses of tetanus toxoid</u>. <i>Ensure this is noted on discharge paperwork. The patient will require further immunoglobulin as part of routine follow-up.</i> (see table below)</li> </ul>
<b>Contraindications</b> <sup>1</sup>	Previous anaphylaxis following a previous dose of tetanus-containing vaccine or any vaccine. Consider Tetanus Immunoglobulin (TIG) TIG for tetanus prone wounds for persons with history of severe adverse event following tetanus vaccination
<b>Precautions</b> <sup>1</sup>	Observe patient until at least 15 minutes post administration for development of allergic type reactions. Notify medical officer immediately if allergic type symptoms develop.
<b>Dose</b> <sup>1</sup>	0.5mL of a tetanus-containing vaccine in combination with diphtheria toxoid. Refer to medication packaging for specific dosages
<b>Dose frequency</b> <sup>1</sup>	Once only
<b>Administration</b> <sup>1</sup>	<b>To be administered in hospital only.</b>  Shake thoroughly before use. 0.5mL given as a slow intramuscular injection
<b>Storage</b>	Refrigerate, store between +2°C to +8°C and according to <i>The National Vaccine Storage Guidelines Strive for 5 (2013)</i> . Store out of patient and public access, preferably in a locked room or a locked cabinet securely attached to the wall or floor – see <a href="#">PD2013_043</a> .
<b>Adverse effects</b> <sup>1</sup>	Pain, redness and swelling at the injection site are common. Headache, malaise, myalgia and fever are uncommon. Anaphylaxis, urticaria and peripheral neuropathy are rare. Brachial neuritis is very rare.
<b>Nursing Accreditation Requirements</b>	An RN whose competency to practice Nurse Delegated Emergency Care and to comply with this Standing Order has been assessed and approved by a <i>Local Facilitator</i> , in accordance with the NDEC Education and Accreditation Framework.
<b>Documentation</b>	<i>Record specific medication trade name and batch number in notes and in discharge letter (will allow GP to update Patient Healthcare Record)</i> Administration record is to be documented by the administering nurse. Document on the “once only” section of the appropriate medication chart The record of administration must be checked and countersigned by a medical officer within 24 hours of initial administration.
<b>Related Documents</b>	Guide to tetanus prophylaxis in wound management (The Australian Immunisation Handbook, 10 <sup>th</sup> Edition, 2013) (see Table 1 below) NDEC Nurse Management Guideline: Foreign Body <a href="http://www.ecinsw.com.au/node/271">http://www.ecinsw.com.au/node/271</a> NDEC Nurse Management Guideline: Insect Bites and Stings <a href="http://www.ecinsw.com.au/node/272">http://www.ecinsw.com.au/node/272</a> NDEC Nurse Management Guideline: Marine Creatures <a href="http://www.ecinsw.com.au/node/283">http://www.ecinsw.com.au/node/283</a>

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**Table 1: Guide to tetanus prophylaxis in wound management (*Australian Immunisation Handbook*)**

Time since vaccination	Type of wound	Tetanus toxoid vaccine [NB1]	Tetanus immunoglobulin
<i>History of 3 or more doses of tetanus toxoid vaccine</i>			
less than 5 years	all wounds	no	no
5 to 10 years	clean minor wounds	no	no
	all other wounds	yes	no
greater than 10 years	all wounds	yes	no
<i>Uncertain vaccination history or less than 3 doses of tetanus toxoid vaccine</i>			
	clean minor wounds	yes	no
	all other wounds	yes	yes
NB1: Tetanus toxoid is available only in combination with other antigens.			

<sup>1</sup> The drug information provided is to act as a guide only, for further information reference should be made to the full product info available on MIMS or the Australian Medicines Handbook <accessible in NSW Health facilities via CIAP: > If contraindications, precautions or interactions are present refer to MO before administration

## **SAFE ASSESSMENT ROOMS (GL2020\_001)**

### **PURPOSE**

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

### **KEY PRINCIPLES**

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

### **USE OF GUIDELINE**

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

**To download the complete guideline go to:**

[https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020\\_001](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2020_001)

## **EARLY EVIDENCE COLLECTION (GL2022\_010)**

### **GUIDELINE SUMMARY**

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

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

### **KEY PRINCIPLES**

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

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

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

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

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

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

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

**To download the complete guideline go to:**

**[https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022\\_010](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_010)**

## **MANAGING NON-FATAL STRANGULATION IN THE EMERGENCY DEPARTMENT (IB2023\_038)**

### **PURPOSE**

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

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

### **KEY INFORMATION**

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

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

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

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