SYDNEY ADVENTIST HOSPITAL
SAN DAY SURGERY HORNSBY

# Policies and Protocols for Doctors

**August 2024**

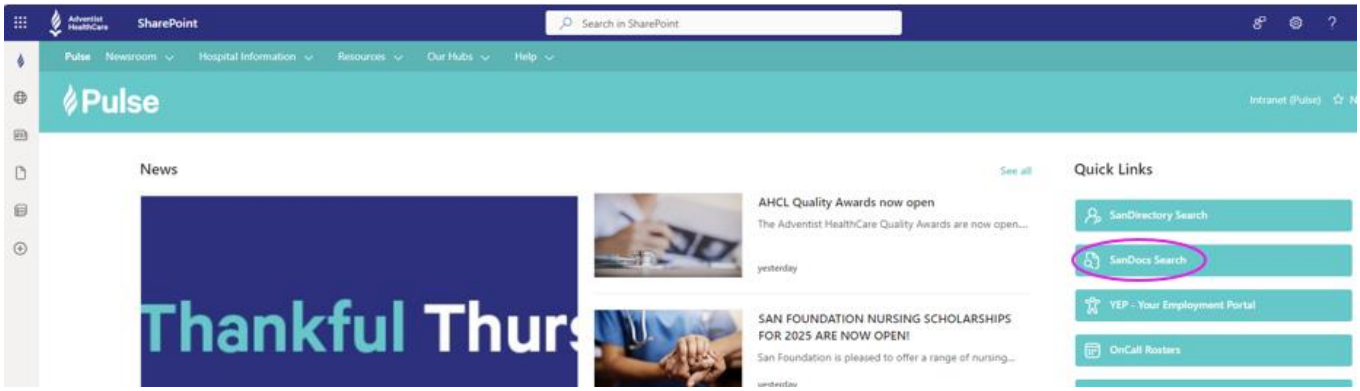
Adventist HealthCare

# CONTENTS

This guide gives an overview of Policies and Procedures relevant to doctors at Adventist Health Care Limited (AHCL) facilities. **Note that this document is indicative only and does not replace those policies**. Doctors are expected to be aware of and read the relevant policies and By-Laws, copies of which are easily available online in *SanDocs* on *Pulse*, the SAH intranet, or by request from Medical Services (Ph: 9480 9400 or E: medadmin@sah.org.au)

For additional information about hospital services and contact details, please consult the "**Quick Reference Guide for Doctors**" (available online as above or from Medical Services).

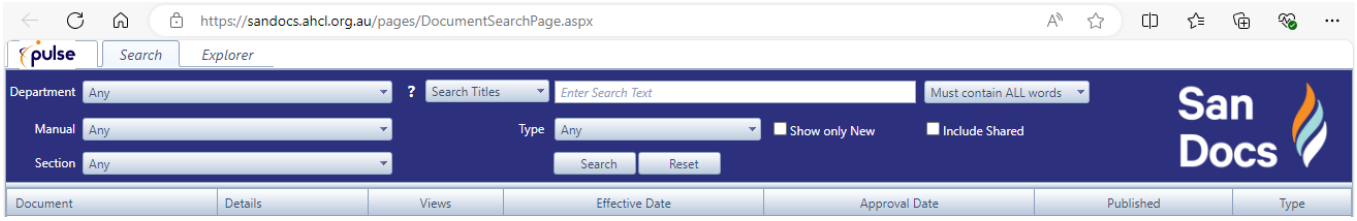
# AHCL AND HOSPITAL POLICIES




AHCL and Hospital Policies are stored in *SanDocs* on *Pulse*, the SAH intranet. *Pulse* is the default home page when you open the Microsoft Edge browser on any hospital computer, or remote access desktop on a personal device. *Pulse* contains general hospital information, staff and department directories, hospital policy documents and other useful resources.

## TO LOCATE HOSPITAL POLICIES ON PULSE, THE SAH INTRANET

From the **Pulse** homepage, click on the *SanDocuments* tab:




Then click on the *Search* tab, enter the Department, topic or other search criteria and click the Search button. You can choose to search titles only or use the drop down menu to select and search document content.

Most policies relevant to doctors will be found in the *Medical Services Manual*, including the *By-Laws* (see screenshot on following page). Ensure that you tick "Include shared" to display all documents in a Manual (some documents are shared with other Departments and Manuals). Other documents can be searched for individually.


Other key policies on *SanDocs* that doctors should be aware of:

**Corporate**

- Code of Professional Conduct
- AHCL Privacy Policy
- Privacy and Confidentiality of Health Records and Information
- Grievance Management Policy
- Management of a Complaint or Concern about a Clinician

**Safety**

- Personal threat plan – Code Black
- Work Health and Safety
- Fire and Evacuation
- Emergency Response

**Clinical**

- Clinical Incident Management Policy
- Clinical deterioration
- Life Support – basic, advanced, adult, paediatric etc
- REACH (escalation plan for potentially deteriorating patient, initiated by patients, families or carers)
- Stroke protocol

## BY-LAWS

Adventist HealthCare Ltd (AHCL) has by-laws which apply to all accredited doctors. The full *By-Laws for Medical Officers and Visiting Health Practitioners* are available on *Pulse* (the SAH intranet), in *SanDocs* (see above for how to access) or on the *Doctors Information* page, or they can be requested from Medical Services. The By-Laws are updated from time to time, and when that happens this will be communicated to doctors. The ***Key Point Summary*** is reproduced below:

**All Accredited Medical Officers (AMOs) and Visiting Health Practitioners (VHPs) are expected to:**

1. Respect and support Adventist HealthCare Limited's (AHCL's) Mission and Values (see By-Laws appendix A);
2. Attain and maintain excellence in all episodes of patient care through individual and collective activity and close cooperation with the hospital's management and staff;
3. Comply with relevant AHCL Policies and Procedures;
4. Treat all staff members with professionalism and respect;
5. Abide by these By-Laws and work within the limits of their accreditation and scope of practice;
6. All accredited and eligible practitioners must have a provider number for SAH and/or SDSH (each location they work at);
7. All accredited and eligible practitioners must have a prescriber number;
8. Comply with the National Safety and Quality Health Service Standards and ACSQHC Clinical Care Standards and reporting requirements (such as Accreditation Outcome Standards) or other legislated requirements [see Standards section of this document];
9. Be aware of the hospital's emergency procedures [see Emergency section of this document];
10. Notify the CEO or delegate in writing if their:
    - professional indemnity insurance lapses;
    - their accreditation is withdrawn or suspended from any hospital or medical institution;
    - any restrictions, notifications or conditions are placed on their registration to practice or their registration is suspended or cancelled;
11. Adhere to responsible billing practices for AHCL patients including obtaining informed financial consent;
12. Comply with reasonable requests to participate in teaching for hospital staff and students;
13. Notify the CEO or delegate and/or the Clinical Governance Department of any potential and actual claims of incidents that occurred or are associated with an Adventist HealthCare facility or service;
14. Avoid providing medical care to their relatives or anyone else with whom they have a close personal relationship, as per Clause 4.15 of Good Medical Practice: A Code of Conduct for Doctors in Australia (Oct, 2020). https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx
15. Abide by departmental obligations for providing after-hours on-call services (see details on on-call expectations below).

In addition to the above, **Admitting Medical Officers** are expected to:

1. Be available for contact at all times regarding inpatients, either in person or by his or her deputy who must also be accredited to use the hospital;
2. Respond to all reasonable requests by hospital staff in a timely manner and attend patients promptly when requested by hospital staff for good clinical reason;
3. Notify Medical Services at SAH or in other facilities the relevant Manager if AMO will be unavailable at any time and nominate a colleague who will care for the patient during AMO's absence or unavailability;
4. At SAH, use the ward Career Medical Officer only for emergency care of patients and not for routine care;
5. Maintain a well-documented healthcare record in accordance with the hospital documentation policy and Schedule 4 of the Health Practitioner Regulation (NSW) Regulation 2016 https://legislation.nsw.gov.au/view/html/inforce/current/sl-2016-0543#sch.4
6. Sign telephone orders for medication or confirm the order via email or fax within 24 hours of being given, as prescribed in Section 58 of the Poisons and Therapeutic Goods Regulation 2008;

7. Provide their patients with a full explanation about the patient's proposed treatment and ensure that the patient or their authorised representative sign an appropriate Consent Form. Obtain full clinical and financial informed consent;
8. Keep the patient or relevant guardian informed of the treatment plan;
9. Keep their patients' length of stay to the minimum required to provide acute care for the presenting problem;
10. At SAH, clear overnight stay patients for discharge by 10am if clinically possible and ensure good clinical handover and completion of the discharge summary has occurred.
11. For surgical and procedural AMOs, uphold expectations of completing minimum monthly sessions (e.g. 2 sessions per month or as per agreed annually between the AMO and AHCL).

On-call expectations:

1. Roster arrangements and scheduling as per department.
2. While on call, rostered AMO must:
    a. Respond to phone or text messages from Emergency Care within 30 minutes of being contacted. If no response within 30 minutes, EC will use all available contact methods and if still unsuccessful, will contact another doctor in that specialty. EC will provide details to Medical Services if no response.
    b. Either accept patient care or admissions when contacted by EC, or personally ensure that an alternative doctor will accept care.
    c. Attend in person, and be available to undertake any required procedural or surgical care at AHCL facilities in an appropriate timeframe to the clinical circumstance.
    d. Make appropriate follow up arrangements
3. All details regarding on-call duties in **By-laws Section 11.17.7.**

## MEDICAL ADVISORY COMMITTEE (MAC) AND DIVISIONS

As per the Private Health Facilities Act 2007 (NSW) and its associated Regulations, the Medical Advisory Committee is responsible for the safety of patients and for clinical governance, including advising on the accreditation / credentialing / clinical responsibilities of practitioners and advising on matters concerning clinical practice and patient care and safety.

### MAC MEMBERSHIP AT SAH

**Chairperson:** Medical Advisory Committee Chairperson (also on SAH Board of Directors)

**Secretary (Non-Voting):** Medical & Clinical Governance Executive

**Recording Secretary (Non-Voting):** Medical Services Coordinator

**Standing members:**

- Deputy MAC Chairperson
- Head of the SAH Clinical School
- Director of Research
- Clinical Director, Division of Surgical Services
- Clinical Director, Division of Medicine
- Clinical Director, Cancer Services
- Deputy Clinical Director, Division of Surgical Services
- Deputy Clinical Director, Division of Medicine

**Invitees (Non-voting):**

- Director of Medical Services
- Others as determined by Agenda and at the call of the Chairperson

**Ex-officio:** The CEO of AHCL

## DIVISIONS AT SAH

The Divisional Committees (Surgical Services, Medicine and Cancer Services) focus on patient safety; quality; a culture of collaboration, teaching and research; implementation of AHCL strategic priorities that affect the Division; and effective clinical performance. Heads of Departments, representing each specialty, attend Divisional meetings.

## MAC MEMBERSHIP AT SDSH

**Chairperson:** elected by the SDSH MAC members and endorsed by AHCL Board of Directors

**Secretary:** SDSH Nurse Unit Manager. Recording Secretary will be appointed as required.

**Representatives from the following specialties** (minimum of 6 and maximum of 10 representatives across Anaesthesia and Surgery):

- Anaesthetics
- Dental / Oral Surgery
- Hand Surgery
- Gynaecology
- Ophthalmology
- Plastic / Cosmetic Surgery

**Permanent Invitees (non-voting)**

- SDSH NUM
- Perioperative Director or delegate
- Director of Medical Services or delegate
- Others as determined by Agenda and at the call of the Chairperson

For further information, see *"By-Laws for Medical Officers and Visiting Health Practitioners"*, "*AHCL SAH Medical Advisory Committee TOR*", "*Division of Surgical Services Committee - TOR*", and "*Division of Medicine Committee*" [Terms of Reference] on *SanDocs*.

All doctors are encouraged to raise issues or ideas with their Head of Department, Divisional Clinical Director or a MAC member. A list of "*Medical Department HOD, Secretaries, Divisions & MAC Representatives"* is available on *Pulse* on the *Doctors Hub* page.

# ACCREDITATION AND CREDENTIALING

Only practitioners who are accredited to AHCL may admit or care for and treat patients at an AHCL facility. Practitioners will be considered for accreditation to one or more AHCL facilities only if they demonstrate that they are the most suitable applicant for the available position and can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character and their ability to work harmoniously with others sufficiently to convince AHCL that all patients treated by them in the hospital will receive quality care and that the hospital and its staff will be able to operate in an effective manner. The Board has complete discretion as to whether to grant accreditation and is not bound to accept any application. (See *By-Laws* for further details)

Appointments and responsibilities are granted for a 1-year probationary period (or until the next annual review cycle) for new appointees, with review by the Medical Advisory Committee, thereafter quinquennial appointments for 5 years.

Credentialing for medical and dental officers considers both:

- **Clinical privileges** (Admitting, On-call, Admitted patient consulting, Operating theatre or procedural suite procedures, Non-admitted patient consulting, Teaching and supervision, Research, Surgical assisting)

- **Scope of practice**
  - **Core scope of practice** which may include sub-specialty scope of practice; and
  - **Specific Credentialing** which requires specific evidence of appropriate skills and experience. Practitioners wishing to be credentialed in a **new interventional procedure** must apply for approval according to the *Policy for the Introduction for a New Interventional Procedure* (see *SanDocs*).

## RESEARCH

Researchers must provide evidence of:

- **Indemnity insurance** which provides coverage for research and / or clinical trials (this may be automatic or may require separate listing – check with your indemnity provider)
- Evidence that you have completed a **course on Good Clinical Practice** within the past three years. We recommend the following course https://globalhealthtrainingcentre.tghn.org/, which meets the minimum criteria, is ICH GCP R6 (latest version) and TransCelerate approved (allows mutual recognition from a number of companies) and is estimated to take 45-60mins to complete online. However, you are welcome to provide evidence from other GCP training programs.

SAH has a Director of Research, Research Advisory Committee, and Research Office:
Ph: 9480 9604, E: research@sah.org.au or www.sah.org.au/research

# COMMUNICATION

- Notify Medical Services (9480 9400 or medadmin@sah.org.au) ASAP of any changes in your:
  - contact details, including email address(es)
  - provider number
  - AHPRA registration status (including a withdrawal or conditional accreditation imposed at another workplace)
- Report any clinical and WHS (Work, Health and Safety) incidents to Medical Services or the Manager or Director of the relevant area (eg, operating theatres, wards, emergency department), and participate in investigation and feedback when requested.
- Read, and respond to if requested, communications from Medical Services and other hospital departments with respect to clinical or operational matters in a timely fashion.

## CLINICAL DOCUMENTATION

Patient records must be clear, legible, concise, contemporaneous, progressive and accurate. They must be sufficient for the present and future care of the patient, including continuity of care, clinical handover, during escalation of care for a deteriorating patient and transfer within healthcare settings. Undocumented or poorly documented patient information can result in misdiagnosis and harm.

**At SAH, the electronic medical record (*SanCare* on the wards and *Metavision* in ICU) is the legal record.** All diagnostic and therapeutic orders must be provided in writing. Remote access to *SanCare* and *Metavision*, and the *SanCare Mobile App*, enable doctors to log on from locations external to the hospital to view patient information and enter orders at any time. Phoned medication orders must be signed on the medication chart within 24 hours.

SAH **electronic Discharge Summaries are required for all patients who stay overnight or longer**, with a few exceptions (see SAH Discharge Summary Policy on *SanDocs* on *Pulse*, the SAH intranet), and are the responsibility of the Admitting Doctor. They should be completed before discharge, particularly for patients being transferred to other facilities. Completing them electronically in SanCare is simple and quick, and copies will be automatically sent to your practice software as well as to the patient's GP. Discharge summaries are a vital part of continuity of care and the single most common negative feedback item we receive from our General Practitioner colleagues in the community.

SAH surgeons are required to complete the **SanCare electronic Procedure Report,** and endoscopists in the Jones Endoscopy and Procedure Centre must document in the **Endobase report writer**.

**Clinical Documentation Guidelines** must be followed to optimise safe and appropriate care, and to enable accurate auditing and health statistics. The *National Safety and Quality Health Service Standards* provide a nationally consistent statement of the level of care consumers can expect from health service organisations – see *Standard 6: Communicating for Safety* https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard

**As a private hospital, detailed clinical documentation is also central to our funding.** Accurate documentation ensures that funding is in keeping with the complexity of the clinical services provided – in most cases only medical practitioners' notes can be used for clinical coding; assumptions about diagnosis or management are not permitted to be made by coders. Therefore, documentation should be as specific and inclusive as possible. Please familiarise yourself with the documentation guidelines, and **respond ASAP should Medical Records request any clarifications for coding**.

**Acute care (3B) certificates** are required to be completed by a doctor for any acute hospital stays over 35 continuous days, and then every 30 days thereafter, to ensure continuing payment by health funds. You will receive an alert in *SanCare* and the *SanCare mobile app*, and may also be contacted by Patient Services when these are due – please complete the form immediately. Instructions for completing these electronically are available on *Pulse* (SAH intranet), on the *Doctors Information* page

**Death Certificates** should be completed by the AMO (or their registrar or intern). If a death occurs after hours, it would be usual for the CMO on duty to complete the online "Assessment of extinction of life", however the formal (paper) death certificate with the cause of death should follow. CMOs can also complete death certificates, but they often lack the background information required for reason of death, in which case they will contact the AMO to complete the certificate. NSW Health mandates that the death certificate must be completed within 24 hours of the patient's death. Where applicable, certification for cremation should be completed at the same time.

## CLINICAL DOCUMENTATION IMPROVEMENT AT SAH

We know that the case mix of patients we see at SAH is more complex than many other private facilities, however our coded data suggests that we see a much less complex group of patients than our peers. This is directly related to the quality of clinical documentation. If the clinical record does not contain the required information, then the coded record will be assigned, incorrectly, a lower acuity DRG. Having accurate data relating to our complexity assists in benchmarking and importantly, facilitates discussions regarding health fund contract negotiations.

**Principal Diagnosis and Additional Diagnoses**
On admission to the hospital the doctor should document:

1. **Reason for Admission**: eg, Increased confusion, fall, likely UTI
2. **Principal Diagnosis**: "The diagnosis established after study, to be chiefly responsible for occasioning an episode of admitted patient care": eg, E coli UTI
3. **Additional Diagnoses**: "conditions that are significant in terms of treatment required, investigations needed, and resources used during the episode of care": eg, Hypoactive delirium, fractured pubic rami, hyponatremia

The reason for any changes in care must be documented, in particular:

- *Commencement, alteration or adjustment of treatment* – what was it due to?
- *Diagnostic procedures* – what was it due to?
- *Increased clinical care* – what was it due to?

**Clinical Coding**
Clinical Coders are governed by coding standards. While certain conditions and their treatment are often assumed by clinicians, conditions can't be coded unless they are specifically documented, along with an associated treatment plan. Clinical Coders are not clinicians, so they are not permitted to code from, for example, a test result or an item number, even though they may know what the results mean.

Below are some **examples of good clinical documentation, where a treatment is related to a condition that meets the coding rules for additional diagnoses**:

- Mr JS: Hb 76, give 2 U PRBC – **due to** acute blood loss anaemia
- Mr WT: pitting oedema lower legs, increase Lasix to 40mg bd IV – **due to** fluid overload
- Mrs BN: K 3.0 give 10 mmol KCL - **due to** hypokalaemia (a coder cannot infer and code hypokalaemia from the test result alone – "hypokalaemia" must be written in the notes)
- Mr CL – admitted with SOB, sats 85%, admitted to ICU for BiPAP – **due to** acute type 1 respiratory failure secondary to acute pulmonary oedema
- Mr MT (Procedure Report) – Procedure details: Laparoscopic appendicectomy and adhesiolysis **due to** a previous procedure (the underlying cause of the adhesions must be specified)

If the cause is not documented, these conditions must be coded at a lower acuity, or with the cause as "unspecified", with resultant lesser DRGs and lower funding.

Other important clinical documentation points:

- **Discharge Summaries** are required to be completed at SAH by the AMO (or their JMO) before discharge for **every** overnight-stay patient. Please ensure the *Reason for Admission* (which may be pre-filled but can be edited), *Principal Diagnosis* and *Additional Diagnoses* are complete and accurate
- **Abbreviations and acronyms** are best avoided, but if used they must be standard, unambiguous and from the approved list.

**Clinical Documentation Specialist at SAH**
The Clinical Documentation Specialist (CDS) and the Case Managers review clinical notes at the point of care, with the goal of creating a culture whereby clinical documentation reflects the clinical truth, ensures that hospital funding reflects patient complexity and the care provided, and enhances the integrity of Australian healthcare data. If documentation is inadequate, the CDS may contact the clinician to amend it. The CDS also provides education throughout the hospital, focused on common poorly documented conditions (identified at audit), and information to new Interns and Registrars at their orientation.

**Medication Charts**

Script legibility is taken very seriously at the Sydney Adventist Hospital.

Please see more information under Medication Safety section of this document.

**For more information on CLINICAL DOCUMENTATION**, please contact Jocelyn Cox, Clinical Documentation Specialist (Mob: 0437717490) or Kerrie Ebbutt, Cardiac Case Manager (Mob: 0437694529), or email queries or suggestions to CDIfeedback@sah.org.au.

## PROTOCOLS

### DOCTORS PROTOCOLS

Doctors' "in-hospital" and "discharge" *Protocols* (routine instructions) for specific conditions or procedures, or pre- and post-op care, are held in *SanCare*, to assist nurses in caring for patients. Stored discharge instructions can be printed and given to patients, or copied into the electronic discharge summary (also given to patients).

Doctors should email their *Protocols* to dr.protocols@sah.org.au for uploading to *SanCare*. Doctors should routinely check on *SanCare* that their protocols remain current, and either submit updates or edit the protocol themselves in SanCare if required. To view *Protocols* in *SanCare*, click on the *Info* icon, or right click on the *Admitting Doctor* column in the patient list screen. Doctors will be contacted to review and re-approve their *Protocols* annually if medications are specified, otherwise every 3 years.

### DEPARTMENT PROTOCOLS

Some wards have standard *Protocols* for drug administration, other patient management activities and discharge instructions. These are also located in SanCare – click on the *Info* icon then select *Department Protocol*.

## SURGICAL BOOKINGS

Surgeons and proceduralists must read the "*Sydney Adventist Hospital Management of Theatre Booking Process",* available online on *SanDocs* (see above for access instructions) in the *Clinical Governance* section, or contact the Theatre Bookings office or the Theatre Manager to request a copy. There is some additional information and contact details in the booklet "Quick Reference Guide for Doctors" (available online on *Pulse* or request from Medical Services)

**At SAH, online bookings are preferred**, via the SAH *Hospital Booking* portal (available on the SanApps menu when you are logged in to the SAH network), although the *Hospital Booking Letter* can currently also be emailed or faxed. All bookings must have signed consent attached or uploaded. The online portal will enable you and your practice staff to view and manage all your bookings and lists in real-time. For an introduction to the online system, and to organise training for your practice staff, contact Allison Penman on 0437353373, Allison.Penman@sah.org.au or the Booking Manager on 0457921385.

**SAH Doctors can view and check their theatre lists** for the next 90 days at any time on the *SanCare mobile app*. Theatre lists can also be viewed on desktop *SanCare* by clicking on the *Reports* icon.

**At SDSH**, the Hospital Booking letter and consent form should be emailed to sandaysurgeryhornsby@sah.org.au as soon as the booking is made.

**Patients must complete their admission and patient history forms** prior to their hospital stay: online is preferred: at https://eadmissions.sah.org.au/ (SAH) or www.sandaysurgery.com.au (SDSH), otherwise on paper and then emailed, posted, or delivered to the front desk.

## THEATRE BOOKINGS CONTACTS

**SAH**

- **Operating Theatres Booking Office:** 9480 4577, hospitalbookings@sah.org.au, fax 1800 009 111
- Operating Theatres Bookings Manager: 0457921385
- **Issues on the day:** NUM 1 – Theatre Floor Supervisor: 0416093765
- **Advanced bookings/ad hoc sessions:** NUM 2 – Theatres: 0438427935 or Operating Theatre Bookings Coordinator 0457921385
- **Permanent allocations:** Operating Theatre Manager: 9480 4599 or 0418638603
- **Ad hoc or permanent session requests can be emailed to** surgicalsessions@sah.org.au
- **Emergency out of hours:** After Hours Manager: 0414879432
- **Director Perioperative**: 9480 4580, 0421312671 or Cathie.Murphy@sah.org.au
- **Endoscopy and Procedure Centre bookings:** 9480 6420 (0700-1500) or 9480 6436 (after-hours) or endoscopy@sah.org.au
- **Endoscopy and Procedure Centre NUM 2:** 0409617257
- **Theatre Reception:** 9480 4560

**SDSH**

- **Hospital Reception:** (8am-5pm, M-F) 9480 6888, Fax: 94808321, E: sandaysurgeryhornsby@sah.org.au
- **Theatre Reception:** 9480 5880/9480 5881
- **Theatre Bookings:** (8am-5pm, M-F) 9480 6888, M: 0408 309970 (NUM), E: sandaysurgeryhornsby@sah.org.au

### SURGEONS WITH REGULAR SESSIONS

Surgeons who have regular allocated sessions will receive a date listing of their sessions every three months for verification. If any sessions are NOT required, you must inform the Theatre Booking Clerk as soon as possible so that the session can be reallocated. **Bookings close at 2pm three business days prior to the session.** Cancellation of sessions is required at least two weeks prior to the session (if submitted later, they will be registered as “invalid cancellations” in utilisation data).

### SURGEONS WITHOUT REGULAR SESSIONS

Surgeons who do not have a regular operating session may book an entire session in advance on the understanding that it will be fully utilised. Bookings for a single operation may also be made, with the remainder of the session being allocated to another surgeon. If additional time is required by any surgeon, every effort will be made to assist.

### ANAESTHETISTS FOR OPEN SESSIONS

If you are using an open session following another surgeon, the services of the anaesthetist attached to the session would normally be used. If no anaesthetist is allocated to the session, it is the surgeon’s responsibility to arrange an anaesthetist from the hospital’s accredited list. A listing of available anaesthetists may be obtained from the Operating Theatres Booking Office. Anaesthetists (and all other SAH accredited doctors) and their contact details can also be found on the *SanCare Mobile App*, in the *Phone Directory* – search by name or specialty.

## EMERGENCY OR ADDITIONAL PROCEDURES

Same day emergency or additional procedures must be booked through the Theatre Floor Supervisor on 0416093765. Late add-ons for the next day must be booked through the NUM 2 Theatres on 0438427935 or Operating Theatre Bookings Coordinator 0457921385. Surgeon, anaesthetist and theatre availability will be discussed, and a suitable timeframe organised.

## PROSTHESES

Any prostheses or specialised sets to be used must be clearly documented on the eHBL or hospital booking letter and, if the instrumentation is not kept at the hospital, it must be ordered by the surgeon's rooms at time of consultation. The prosthetic company usually supplies the equipment at least the day before surgery, so that instruments can be sterilised and prosthetics checked in. Please contact the Theatre Floor Supervisor on 0416093765 if you need clarification on available instrumentation.

## PRE-ADMISSION CLINIC (PAC)

PAC is located within the Surgical Centre on Level 4 of the Clark Tower. Appointments for pre-operative tests +/- consultation with an anaesthetist can be made up to three weeks prior to surgery by phoning 9480 9115 (M-F 0800-1600).

## ADMISSION TIMES

At SAH, most patients are admitted on the day of surgery and are notified the night before by Day Surgery nursing staff. If special work-up is required prior to surgery, arrangements may be made through the Booking Office. Transfers from other facilities should be undertaken on the day prior to any procedure being performed at SAH, as the Ambulance Service is not able to guarantee urgent transport.

At SDSH, all patients are admitted on the day of surgery, and are notified between 3 and 5pm the day before.

## WORKERS COMPENSATION PATIENTS

These must be approved by the insurance company before admission. The doctor must receive approval for themselves and the hospital and send the approval to Hospital Bookings (fax 9480 9935 or email accesscentre@sah.org.au).

## PUBLIC LIABILITY AND THIRD PARTY PATIENTS

These must be cleared by the Patient Services Department before admission (9480 9903 [option 1] or accesscentre@sah.org.au). All anticipated hospital costs must be paid in advance.

## VETERANS' AFFAIRS PATIENTS

The doctor must get approval from the Department of Veterans' Affairs (9213 7419) prior to admission for White Card holders. Gold Card holders do not need approval.

## PATIENTS TRANSFERRED FROM ANOTHER HOSPITAL

The hospital must accept the booking, and a health fund check must be attended to before a patient is transferred from another facility. Contact the Hospital Bookings Office: 9480 9908, email: accesscentre@sah.org.au.

## NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS

See https://www.safetyandquality.gov.au/standards/nsqhs-standards, or PDF booklet at (https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition)

The eight *National Safety and Quality Health Service (NSQHS) Standards* provide a nationally consistent statement about the level of care consumers can expect from health services. Like all other healthcare providers, AHCL undergoes accreditation against these standards. The eight NSQHS Standards are:

1. **Clinical Governance**: clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.
2. **Partnering with Consumers:** systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.
3. **Preventing and Controlling Infection:** systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials (as part of effective antimicrobial stewardship) and promote appropriate and sustainable use of infection prevention and control resources.
4. **Medication Safety:** systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.
5. **Comprehensive Care:** the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.
6. **Communicating for Safety:** systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.
7. **Blood Management**: systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.
8. **Recognising and Responding to Acute Deterioration:** systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

## CLINICAL CARE STANDARDS

A *Clinical Care Standard* is a small number of quality statements that describe the care patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence (eg, Acute coronary syndromes, venous thromboembolism prevention).

AHCL is accredited against these standards, therefore Doctors are expected to work with AHCL to abide by these standards to consistently provide safe and quality care to our patients. Each standard has information sheets for clinicians which could be relevant to your practice. See https://www.safetyandquality.gov.au/standards/clinical-care-standards.

| **Clinical Care Standards** | | |
|---|---|---|
| Acute anaphylaxis | Delirium | Osteoarthritis of the knee |
| Acute coronary syndrome | Heavy menstrual bleeding | Psychotropic Medicines in Cognitive Disability or Impairment |
| Acute Stroke | Hip Fracture Care | Sepsis |
| Antimicrobial Stewardship | Low Back Pain | Stillbirth |
| Cataract | Management of peripheral intravenous catheters | Third and fourth degree perineal tears |
| Colonoscopy | Opioid analgesic stewardship in acute pain | Venous Thromboembolism Prevention |

# AHCL QUALITY AND SAFETY

### MORBIDITY AND MORTALITY MEETINGS

Departments or Clinical Sections are to conduct Morbidity and Mortality (M&M) meetings to review deaths and adverse outcomes **at least six-monthly** – most do so quarterly. Review of professional practice is a valuable and important part of the maintenance and enhancement of a practitioner's clinical and professional skills. Review of practice by professional peers is also a part of the ongoing professional performance management used for regular organisational assessment and reporting. The Chairperson of the Department is to ensure that M&M meetings occur regularly, and the Department is to provide a report of outcomes from the M&M meeting to the Medical Advisory Committee and/or the relevant Division. (See policy on SanDocs.)

Communication about M&M meetings can be emailed to Morbidity.Mortality@sah.org.au.

### BLOOD SAFETY

Sydney Adventist Hospital has policies to ensure safe and appropriate practice in blood sample collection, blood components/blood products and patient blood management (see *Blood Transfusion Manual* on *SanDocs*) which AMOs are expected to review. All patients receiving a blood transfusion must give informed consent and have a valid signed hospital consent form.

*BloodSafe eLearning Australia* (https://bloodsafelearning.org.au/) has many free online courses about blood safety and AHCL recommends you complete those relevant to your practice. ANZCA accredits a number of these courses for CPD points for anaesthetists.

## MEDICATION SAFETY

The prescriber is the most important factor in medication safety. Dispensing and administration will only be good if the prescriber has done their job correctly. A best possible medication history must be documented in the electronic medical record on presentation or as early as possible in the episode of care.

Please ensure:

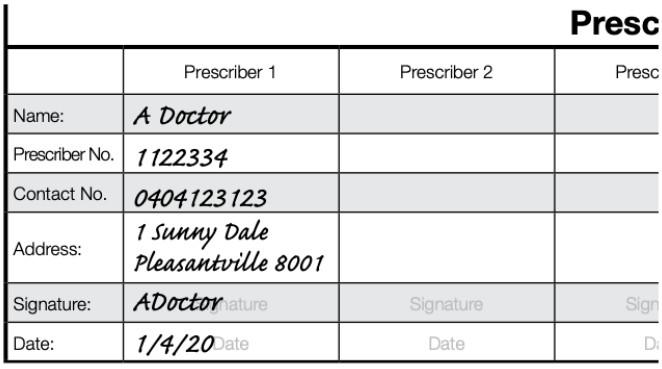
| | |
|---|---|
| **Right Patient** | Ensure medication chart is labelled with correct patient's name. If handwritten label, ensure writing is legible and another identifier (eg, DOB or MRN) is included |
| **Right Drug** | Ensure writing is legible; check for allergies and interactions; write indications on medication chart, especially for antibiotics (check *Therapeutic Guidelines** if necessary); use generic drug names |
| **Right Dose** | Check *Therapeutic Guidelines** for dosage; use only approved abbreviations (eg, write *units*, not "*u*"); be very careful with decimal points, check drug levels as required; ensure writing is legible |
| **Right Time** | Check *Therapeutic Guidelines** for frequency, use only approved abbreviations (eg, write *daily,* not "*OD"* but daily, write the administration times on the medication chart; cross out and initial medication to be ceased; ensure writing is legible |
| **Right Route** | Check *Therapeutic Guidelines** for route, use only approved abbreviations; ensure writing is legible |

**Therapeutic Guidelines* is available on *Pulse* (on the *Doctors Information* page) or in *SanCare* under the Info icon.

### Medication Charts

Prescription legibility is taken very seriously at the Sydney Adventist Hospital. It is legally required for prescriptions on medication charts to be identifiable by the prescriber's name, prescriber number and signature. Prescribers should complete the box on the front page of each medication chart (see below) and ensure their signature and name is printed on all medication orders. If not filled in correctly there will be a delay in medication reaching patients.

Illegible medication orders may also result in medication errors which can have serious adverse outcomes for patients. Please take care to write legibly to avoid errors and delays.



| | Prescriber 1 | Prescriber 2 | Presc |
|---|---|---|---|
| Name: | A Doctor | | |
| Prescriber No. | 1122334 | | |
| Contact No. | 0404123123 | | |
| Address: | 1 Sunny Dale Pleasantville 8001 | | |
| Signature: | ADoctor | Signature | Sign |
| Date: | 1/4/20 | Date | D |

Medication errors or adverse events must be reported on *Riskman* (contact Medical Services for more information). Adverse events may also need to be reported to the Therapeutic Goods Administration (TGA).

## INCIDENT AND FEEDBACK (COMPLIMENTS & COMPLAINTS) REPORTING

Incident and Feedback (Compliments or Complaints) Management is managed through software called Riskman.

**Clinical Incidents or Patient Feedback**

The Clinical Governance Department and/or Medical Services may contact AMOs in the course of incident and/or complaint investigation and response. AMOs are requested to provide a timely response to requests of this nature. While it is not an absolute requirement for AMOs to access Riskman (as the investigative team can provide information to you separately), there is an option for you to gain login access via the SanApps menu on your San desktop.

We encourage doctors to obtain access to Riskman and use it to enter incidents, complaints or compliments. If you require login access to Riskman, or would like to have someone make an entry for you, please contact Medical Services at medadmin@sah.org.au or the Clinical Governance Department at Customerfeedback@sah.org.au.

## CLINICAL GOVERNANCE

The Clinical Governance department is responsible for the coordination and management of the following areas reporting to Medical Services.

1. AHCL accreditation which includes the National Safety Quality Healthcare Service (NSQHS) Standards, Clinical Care Standards, and the National Clinical Trials Governance Framework Accreditation.
2. Infection Prevention and Control processes.
3. Incident reviews and management including submission to the Ministry of Health of any Harm Score 1 or Sentinel events using the Serious Adverse Event Review (SAER) process (which replaces the RCA process, to keep in line with NSW Health).
4. Submission of benchmark data via ACHS Clinical Indicators and Health Roundtable benchmarking.
5. Clinical Auditing to measure compliance to the NSQHS standards and clinical policies.
6. Management and updating of all clinical policies, procedures, and work instructions.
7. In-depth reviews of Hospital Acquired Complications to develop both quality improvement systems and identify data quality improvement opportunities through clinical documentation and coding.
8. Quality Improvement and the management of the annual Thrive quality awards. Submission of clinical data to external entities for compliance measurements e.g., CHASM.

## RISK MANAGEMENT

The Corporate Risk Management team provides advice and reviews matters relating to legal, insurance, claims management (including feedback or incidents which may give rise to a claim), employed doctor insurance, corporate incidents, policy, compliance, and administration of the Riskman Software system.

Enquiries can be emailed to Risk.Management@sah.org.au

**PRIVACY**

The privacy officer oversees privacy governance and incidents. Enquiries can be emailed to privacy@sah.org.au

# INFECTION PREVENTION AND CONTROL

## CONTACTS

**Infection Prevention and Control (IPC) Coordinator:**
Ph: 94879732, M: 0406752685, E: jayne.oconnor@sah.org.au

**Infection Prevention and Control general email: IPC@sah.org.au**

## INFECTION CONTROL ADMISSION POLICY

AHCL has an *Infection Prevention and Control Admission Policy* available in SanDocs on Pulse, the AHCL intranet.

To reduce the risk of infection to other patients, staff and visitors, and to ensure that the appropriate room is allocated for the patient being admitted, as well as appropriate placement on procedure lists is made, the following MUST occur:

- The Infectious Risk section on the Hospital Booking Form MUST be completed.
- The Booking Office is to be advised by the doctor when requesting admission for patients:
  - to be transferred from another hospital (if admission in the other hospital was > 48 hours)
  - who are an overseas patient transfer
  - who have been admitted to a hospital, including SAH, within the last 6 months (if admission was >48 hours)
  - from a nursing home/long-term care facility
  - with a confirmed history of any multi-resistant organism (MRO) eg, MRSA, VRE, , ESBL, MRAb, MRPA, CRE, CPE, CRPA
  - diagnosed or potentially infected with CJD
  - with any other known or suspected infectious condition, including infectious wounds, TB, Varicella, Shingles, Meningococcal disease, COVID-19 or any other transmissible infection.

The Infection Prevention and Control (IPC) Department may also be contacted with any queries about the infectious status of patients regarding their admission.

The Infection Prevention and Control (IPC) Department also oversees the hospital's actions to minimise risks of COVID-19 transmissions. The hospital's COVID-19 policies are available in SanDocs on Pulse, and updates will be shared with AMOs and staff as they arise.

### MULTI-RESISTANT ORGANISMS (MROS)

**MRSA /MSSA Pre-Surgery Screening swabs:** should be performed preferably through the SAH Pre-Admission Clinic. If performed in doctor's rooms, results are to be faxed through to the Infection Prevention and Control Department and / or Booking Office. Surgery should not take place until MRSA/MSSA screening swab results are known. *Required for:* Cardiothoracic Surgery and Orthopaedic Prosthetic Joint Replacement Surgery.

**MRSA/MSSA on-admission screening swabs:** High risk patients are swabbed either prior to or on presentation to SAH (e.g., in Emergency Care). *High-Risk patients* include transfers from nursing homes/long-term care facilities; transfers from other hospitals (if admission in the other hospital was > 48 hours), planned admissions from overseas; re-admission to hospital, including SAH, within 6 months of discharge; chronic wounds and indwelling devices.

If booking a patient for transfer from another hospital, it is preferable for the transferring hospital to perform the MRSA/MSSA screening swabs and fax results through to SAH.

Contact the IPC Department for any queries.

**Patients with confirmed Multi-Resistant Organisms (MROs):** Any history of MROs must be documented on the Booking/Referral Letter. MRO patients' records are flagged with an infectious risk code alert and will be managed using CONTACT Transmission-Based Precautions for the duration of their admission and any subsequent admissions.

**Vancomycin** can only be used as routine antibiotic prophylaxis for previously known or newly positive MRSA patients with documented pathology results or after consultation with an Infectious Diseases Physician.

**MRO status clearance:** Clearance may be considered for those patients who meet the clearance criteria as per the AHCL *Multi-Resistant Organism (MRO) Clearance Policy* available in SanDocs on Pulse. Patients can only be officially cleared of their MRO status by the IPC Department, or the Infectious Diseases Physician. The IPC Department must be contacted to discuss any clearance of a patient's MRO status **prior** to the clearance procedure being commenced.

## INFECTION CONTROL PRECAUTIONS

**Standard Precautions** are the minimum precautions required when providing care to a patient at any time in any health care setting. Standard Precautions include hand hygiene, respiratory hygiene and cough etiquette, personal protective equipment (PPE), aseptic technique, needlestick and sharps injury protection, cleaning and disinfection, waste and linen disposal.

Personal Protective Equipment (PPE) should be worn when anticipated contact is likely with blood, body substances (except sweat), non-intact skin and mucous membranes. Appropriate PPE should be guided by the anticipated amount and type of exposure. PPE includes gloves, impervious/fluid-resistant gowns and aprons, face and eye protection including face shields, surgical masks and particulate filter respirator (N95) masks.

**Transmission Based Precautions** are implemented for any patient with a known or suspected infectious condition. Patients are isolated according to the mode of transmission of the microorganism.

A **Patient Protection Poster,** colour coded according to the mode of transmission (contact, droplet, airborne, enteric), will be displayed on the wall outside the patient's room. Appropriate PPE, cleaning wipes and alcohol-based hand rub (ABHR) will be available on either a trolley or bench (Clark Tower only) or in a yellow PPE holder outside the patient room. An Infectious Risk Code alert appears on all patient lists and in the electronic medical record.

**Neutropenic Precautions** are implemented for any patient with a Neutrophil count <1.0. These patients will have a **Patient Protection Poster**, colour coded for neutropenic, displayed on the wall outside the patient's room. Appropriate PPE, cleaning wipes and alcohol-based hand rub (ABHR) will be available on either a trolley or bench (Clark Tower only) or in a yellow PPE holder outside the patient room. A Neutropenic Risk Code alert appears on all patient lists and in the electronic medical record.

**Staff and Patient/Visitor Information Fact Sheets** about each of the infectious conditions are available for printing on Pulse in the *Infection Prevention and Control Policy and Procedure Manual* on SanDocs.

**COVID-19 policies** are in SanDocs in the *Pandemic Manual (Covid-19),* on Pulse*.* The full *COVID-19 Admission and Treatment Plan* (ATP) is available in SanDocs, This document provides hyperlinks to all components of the COVID-19 pandemic response, guidelines and other references. Please contact Medical Services to receive the link and the password for access outside of Pulse.

Note that external links imbedded in the ATP (e.g., NSW Health resources) will be available on any browser, but links to internal documents (e.g., AHCL policies) will only be available through Pulse if logged on to a hospital-based computer or your AHCL remote access desktop.

## PROCEDURE LIST SCHEDULING OF KNOWN OR SUSPECTED INFECTIOUS PATIENTS

To reduce the risk of infection to other patients, it is AHCL policy to schedule:

- **FIRST** on the list: at risk patients (e.g., immuno-compromised)
- **LAST** on the list: known or suspected infectious patients (e.g., MROs and infectious conditions)

However, if a patient with an MRO or other infectious condition has other needs that require them to be first on the list, e.g., diabetic, this can be arranged following discussion with the IPC Department. Please note: the procedure room will require a terminal clean before any other procedure can follow.

Procedural lists include – Operating Theatres, Cardiac Catheter Lab, Endoscopy, Radiology, Radiation Oncology, Physiotherapy, and any other list that involves multiple patients on the same day.

## ANTIMICROBIAL STEWARDSHIP (AMS)

Antimicrobial Stewardship is one of the Clinical Care Standards which AHCL is accredited against.

The primary goal of antimicrobial stewardship is to optimise clinical outcomes while minimising unintended consequences of antimicrobial use, including toxicity, the selection of pathogenic organisms (such as Clostridium

difficile), and the emergence of resistance. AHCL encourages the regular review of all antibiotic therapy, in particular switching IV antibiotics to oral agents as soon as appropriate for patient care and taking care to adhere to surgical antibiotic prophylaxis standards including selection of appropriate antibiotic and timing of administration and duration.

***Therapeutic Guidelines – Antibiotic*** (reference) can be accessed in SanCare (via the *Info* icon) or on Pulse, on the *Doctors Hub* page.

## HAND HYGIENE

At AHCL, alcohol-based hand rub (ABHR) is available on entry into all patient rooms and inside patient rooms to facilitate easy hand hygiene when hands are not visibly soiled. All non-intact skin such as abrasions, lesions and cuts must be covered with an occlusive dressing.

Hand Hygiene must be performed as per the **'5 Moments of Hand Hygiene'** (see below):


| | | |
|---|---|---|
| 1 | BEFORE PATIENT CONTACT | WHEN? Clean your hands before touching a patient when approaching him or her<br>WHY? To protect the patient against harmful germs carried on your hands |
| 2 | BEFORE AN ASEPTIC TASK | WHEN? Clean your hands immediately before any aseptic task<br>WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body |
| 3 | AFTER BODY FLUID EXPOSURE RISK | WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal)<br>WHY? To protect yourself and the health-care environment from harmful patient germs |
| 4 | AFTER PATIENT CONTACT | WHEN? Clean your hands after touching a patient and his or her immediate surroundings when leaving<br>WHY? To protect yourself and the health-care environment from harmful patient germs |
| 5 | AFTER CONTACT WITH PATIENT SURROUNDINGS | WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient<br>WHY? To protect yourself and the health-care environment from harmful patient germs |

# EMERGENCY PROCEDURES

## EMERGENCY NUMBERS

| | |
|---|---|
| **Cardiac Arrest Stations** | 9999/Press the Cardiac Arrest (Red) Button in patient rooms / at Nurses' Stations |
| **Fire** | 9999 or external 0-000 |
| **Internal Emergency** | 9999 |
| **Hospital Security** | 9988/Pager #33 |

## CLINICAL EMERGENCIES

### CLINICAL DETERIORATION, RESUSCITATION PLAN AND/OR ADVANCE CARE DIRECTIVE

The assessment and management of clinical deterioration is of upmost importance to patient safety.

SAH uses the **"Between the Flags"** system of red (rapid response required) and yellow (clinical review required) colour-coded nursing observation charts and escalation process to ensure that clinical deterioration is well managed. Red zone observations need doctor review urgently. Communication regarding the expected parameters for observations and actions to be taken for clinical deterioration will assist staff to respond appropriately to clinical deterioration.

SAH also uses a new alert system – the **Ainsoff Index** – a score of 0-10 with similarly red (score 8-10) and yellow (score 6-7) colour-coded alerts in *SanCare*. The Ainsoff Index is an advanced deterioration index and early

warning system, using artificial intelligence to interpret trends in vital signs, laboratory values and demographic data in real-time.

**CMOs** (Career Medical Officers) cover the inpatient wards and are available 24 hours a day to respond to medical emergencies and assist with any deteriorating patient, but AMOs have final responsibility. Medical personnel from ICU or Emergency Care also attend cardiac arrest calls.

A **Resuscitation and Treatment Directive, and/or Advance Care Directive** should be discussed with any patient who may not wish full active treatment in response to clinical deterioration. If a directive exists, it must be clearly documented in the *SanCare* electronic medical record, and the signed directives must be added to the patient's medical record.

## REACH

SAH has implemented REACH, a system developed by the NSW Clinical Excellence Commission to help patients, their family and carers escalate their concerns about worrying changes in a patient's condition. They are invited to:

**R – RECOGNISE:** Have you noticed a recent worrying change in you or your loved one's condition or behaviour?

**E – ENGAGE:** We encourage you to always engage (talk) with your nurse first and discuss your concerns with them, your doctor or the nurse manager.

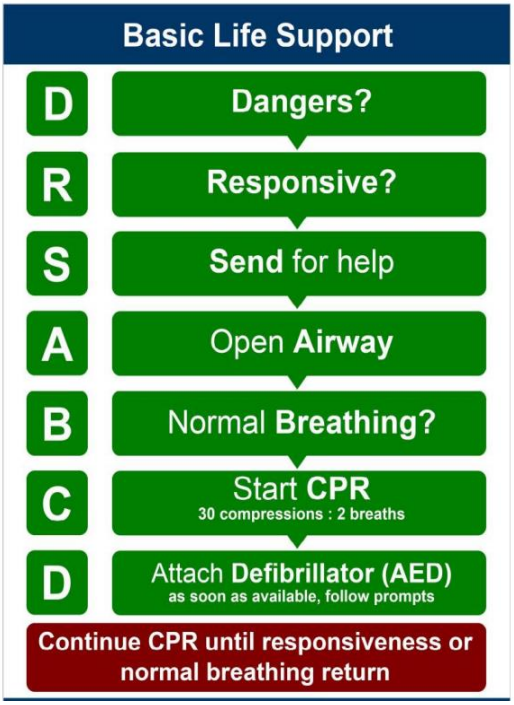
**A – ACT**: If you remain concerned, or if the condition is getting worse, act by asking your nurse to arrange a clinical review for you. This should occur within 30 minutes.

**C – CALL:** If you are still concerned after the clinical review, call REACH by dialling 9999 (or 9480 9999 externally) and ask the operator to arrange a REACH call. Provide your name, room number and building, or ask the nurse to make the call for you. If you are calling on behalf of a patient, also provide your name.

**H – HELP IS ON THE WAY**

The REACH program complements the Between the Flags program via the inclusion of patients, families and carers, thus widening the safety net to manage a patient's physical and mental deterioration more efficiently. Doctors are requested to participate and respond appropriately. For more information, see policy on *SanDocs*

## BASIC LIFE SUPPORT



## AUTOMATED EXTERNAL DEFIBRILLATOR (AED)

An AED must only be used when a patient is unresponsive and not breathing normally. CPR must be continued until the AED is turned on and pads attached. The rescuer should then follow the AED prompts.

**The time to defibrillation is a key factor that influences survival.** For every minute defibrillation is delayed, there is approximately 10% reduction in survival if the victim is in cardiac arrest due to Ventricular Fibrillation (VF). CPR alone will not save a person in VF. Hence a defibrillator should be applied to the person in need as soon as it becomes available so that a shock can be delivered if necessary.

**AEDs can accurately diagnose cardiac rhythms** and separate them into two groups:

- "Shockable" – rhythms responsive to defibrillation, eg ventricular fibrillation
- "Non-shockable" – rhythms unresponsive to defibrillation, eg asystole

In most cases, Basic Life Support will be commenced before starting the Advanced Life Support algorithm. However, if defibrillation is immediately available, then applying an AED or the use of a manual defibrillator by an Advanced Life Support accredited clinician takes precedence.

**Technique:** In general, pads should be placed in an anterior-lateral position as indicated on the outer covering of each pad. For individuals with large breasts it is reasonable to place the left electrode lateral to or underneath the left breast. Prior to placement, excessive hair and or moisture may need to be removed. Pads should be placed 8cm away from implanted medical devices (eg, pacemakers) and medication patches should be removed and the skin wiped before attaching the electrode pad. Alternatively, an anterior-posterior position may be used. The pregnant woman should be positioned on her back with her shoulders flat and sufficient padding under the right buttock to give an obvious pelvic tilt to the left.

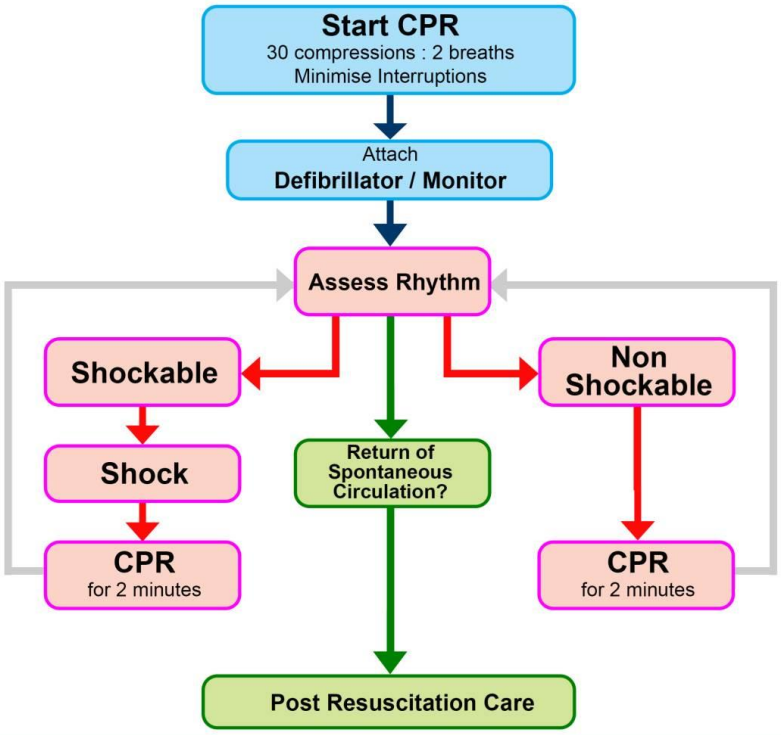
Rescuers should not touch the patient during shock delivery. Prior to pressing the shock button, the rescuer should visually sweep the bed area and ensure the patient is still unresponsive and not breathing normally. The rescuer should state loudly "STAND CLEAR" and press the button while continuing to observe the patient and bed area.

**CPR should be continued until:**

- the patient becomes responsive or begins breathing normally
- an authorised person pronounces life extinct

Rescuers should minimise interruptions to chest compressions and CPR should not be interrupted to check for signs of life. See also: https://resus.org.au/the-arc-guidelines/.

# Advanced Life Support for Adults




**During CPR**
Airway adjuncts (LMA / ETT)
Oxygen
Waveform capnography
IV / IO access
Plan actions before interrupting compressions
(e.g. charge manual defibrillator)

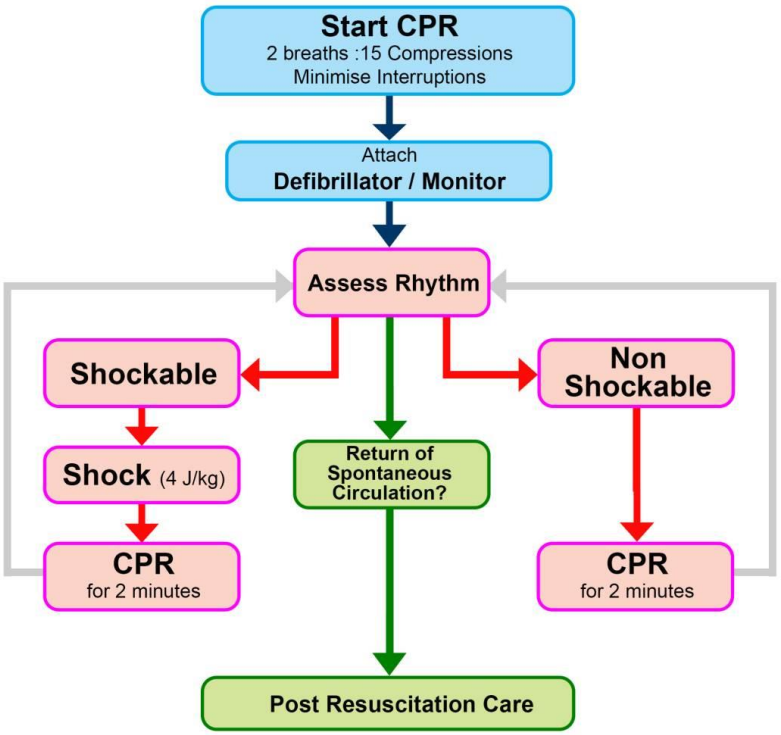
**Drugs**
***Shockable***
* Adrenaline 1 mg after 2nd shock (then every 2nd loop)
* Amiodarone 300mg after 3 shocks

***Non Shockable***
* Adrenaline 1 mg immediately (then every 2nd loop)

**Consider and Correct**
Hypoxia
Hypovolaemia
Hyper / hypokalaemia / metabolic disorders
Hypothermia / hyperthermia
Tension pneumothorax
Tamponade
Toxins
Thrombosis (pulmonary / coronary)

**Post Resuscitation Care**
Re-evaluate ABCDE
12 lead ECG
Treat precipitating causes
Aim for: SpO2 94-98%, normocapnia and normoglycaemia
Targeted temperature management

# Advanced Life Support for Infants and Children




**During CPR**
Airway adjuncts *(LMA / ETT)*
Oxygen
Waveform capnography
IV / IO access
Plan actions before interrupting compressions
*(e.g. charge manual defibrillator to 4 J/kg)*

**Drugs**
**Shockable**
* Adrenaline 10 mcg/kg after 2nd shock *(then every 2nd loop)*
* Amiodarone 5mg/kg after 3 shocks

**Non Shockable**
* Adrenaline 10 mcg/kg immediately *(then every 2nd loop)*

**Consider and Correct**
Hypoxia
Hypovolaemia
Hyper / hypokalaemia / metabolic disorders
Hypothermia / hyperthermia
Tension pneumothorax
Tamponade
Toxins
Thrombosis *(pulmonary / coronary)*

**Post Resuscitation Care**
Re-evaluate ABCDE
12 lead ECG
Treat precipitating causes
Re-evaluate oxygenation and ventilation
Targeted Temperature Management

# WORK HEALTH AND SAFETY (WHS)

## AMO RESPONSIBILITIES

- Take reasonable care of your own health and safety, and the health and safety of others
- Follow health and safety procedures, instructions, and rules
- Use safety equipment and personal protective equipment, and clothing as instructed, and provided
- Leave workplace in a safe condition
- Participate in application health and safety training and discussions
- Report health and safety hazards, injuries and incidents
- Be familiar with emergency procedures
- Should workers be subcontracted by you, provide an adequate induction, site and task specific training, information and supervision to ensure workers are capable of performing their tasks
- Maintain continual and effective communication

## IMMUNISATION

- Maintain immunisation status in line with AHCL's Category A worker requirements and provide evidence of vaccination documentation to the Medical Administration team

## PATIENT HANDLING POLICY

Patient handling equipment is available, and staff are trained to use the equipment to maintain staff and patient safety. Please ensure you are aware of the manual handling requirements.

## WEIGHT RESTRICTIONS

**Patients weighing more than 180kg**, unless having specific bariatric surgery, cannot be safely cared for within SAH.

**Patients weighing more than 140kg** (for routine admission or elective surgery) must be seen in the Pre-Admission Clinic (PAC) prior to admission to ensure that appropriate equipment and accommodation will be available.

**Patients weighing more than 110kg**, whose size, mobility and/or weight restrict the use of standard hospital equipment, must have a Bariatric Patient Manual Handling Plan completed to ensure appropriate equipment and accommodation is available when they are admitted.

## SHARPS INJURIES AND BODY FLUID EXPOSURE

Incidents, injuries or accidents should be reported to Infection Prevention and Control (9480 9732) and to Medical Services (9480 9400) and logged in *Riskman* at the time of the incident during office hours, or to the After-Hours Manager (AHM, 0414879432) after hours. Blood testing and counselling and will be made available.

# FIRE AND EVACUATION

## WHAT DO I DO WHEN I HEAR A FIRE ALARM?

- Remain calm
- Search for the fire (touch back of hand to closed doors first to check for heat)
- Check the detectors to see which one has activated
- If the threat is real, activate the R.A.C.E procedure

## ACTION TO BE TAKEN IN THE EVENT OF A FIRE

**R** **REMOVE** patients/persons from immediate danger if it is safe to do so.

**A** **ALERT** others nearby. Contact switch on 9999 and give your name, what is on fire, and the exact location of the fire OR call the fire brigade on 0-000 OR Activate a Break Glass Alarm.

**C** **CONTROL / CONTAIN** by closing all doors, windows and medical gasses or other products that support fire if safe to do so.

**E** **EXTINGUISH** if it is safe and you feel competent, and then use the appropriate equipment/extinguisher to fight the fire

Do not put yourself and others at risk.

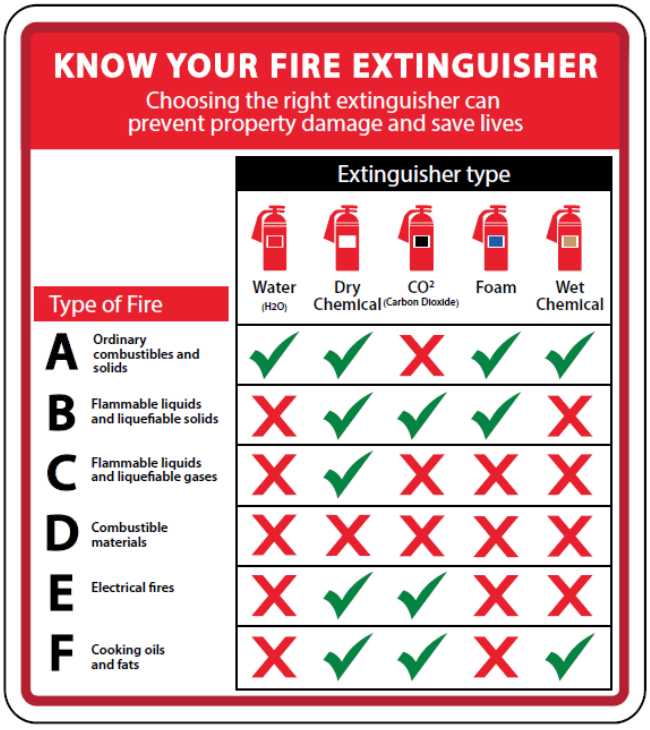
Take direction from the Emergency Coordinator and Area Wardens.

## TYPES OF FIRE

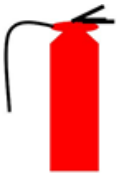
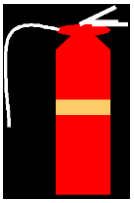
| CLASS | FIRE TYPE | EXAMPLES |
|---|---|---|
| A | **Ordinary combustibles and solids** | wood, paper, fabric, plastics |
| B | **Flammable liquids and liquefiable solids** | petrol, kerosene, lubricating oil, waxes |
| C | **Flammable liquids and liquefiable gases** | natural gas, LPG gas, acetylene |
| D | **Combustible materials** | magnesium |
| E | **Electrical Fires** | machines, computers, photocopiers |
| F | **Fats, cooking oils** | including vegetable and sunflower oils |

## FIRE EXTINGUISHERS – HOW TO USE

1. **PULL** the pin – pull the pin at the top of the extinguisher and break the seal. Do not squeeze the handle when pulling the pin – it won't work. **Test the extinguisher to make sure it is working**. Do not touch the metal parts of the extinguisher – hold the moulded (plastic) parts only
2. **AIM** the nozzle or outlet towards the base of the fire
3. **SQUEEZE** the handles of the extinguisher to operate it
4. **SWEEP** the nozzle from side to side as you approach the fire



## TYPES OF FIRE EXTINGUISHERS: HOSE AND FIRE BLANKET INSTRUCTIONS

| | |
|---|---|
| **Red with black band**<br>  | **C0$^2$ (carbon dioxide)**<br>▪ Use on fire classes: **B, E, F**.<br>For example: small flammable liquid fires, fires involving electricity and cooking and oil fires<br>▪ Smothers the fire by excluding oxygen from the fire<br>Last 8-20 seconds depending on the size of the extinguisher, with a range up to 2 metres |
| **Red**<br>  | **Water ($H_20$)**<br>▪ Use on fire class: **A**<br>▪ Cools the fire only<br>▪ Can be used on fires involving solids<br>▪ Never to be used on electrical fires or fires involving oils or fats<br>A large water extinguisher lasts up to 60 seconds, and has a range of up to 6 to 8 metres |
| **Red with blue band**<br>  | **Foam**<br>▪ Use on fire classes: **A, B**<br>▪ Smothers the fire and has limited cooling effect<br>Examples: paper, wood, cardboard (Class A), petrol, kerosene, lubricating oil and waxes (Class B)<br>Lasts 45 seconds |
| **Red with a tan band**<br>  | **Wet chemical**<br>▪ Use on fire classes: **A, F**<br>▪ Smothers and cools the fire<br>▪ **Kitchen Use Only** - for cooking oil or deep fat fryers<br>▪ Never use on a class E fire (electrical)<br>Lasts 45 seconds |
| **Red with a white band**<br>  | **Dry chemical powder**<br>▪ Used on Fire Classes: **A, B, C, E, F**<br>▪ extinguishes the fire when it spreads and melts over the flames.<br>Lasts about 45 seconds |
|  | **To operate a hose reel:**<br>▪ turn on the main valve<br>▪ release the nozzle<br>▪ activate the reel by turning it on<br>▪ unroll the hose to a safe distance from the fire<br>▪ turn on the nozzle and hold tightly<br>▪ aim the stream at the base of the fire |

| | |
|---|---|
|  | **To access a fire blanket:**<br>▪ Pull the tape at the bottom of the packaging to release the blanket.<br>▪ As you approach the fire, keep the blanket at arm's length from yourself and place it between yourself and the fire.<br>▪ Use the blanket as a shield |

## EVACUATION

### AUTHORITY TO EVACUATE

The decision to evacuate is to be made by the most senior person at the time in consultation with the corresponding external emergency services (eg, Fire Brigade).

### STAGES OF EVACUATION

1. Remove people from the immediate danger area, eg, move people from the room which is affected by fire or from an area that is unsafe.
2. Move people to a safer area, eg, an adjoining compartment protected by fire doors or to a level below the affected floor.
3. Move people to an assembly point – complete evacuation of the building (see assembly areas below)

### PRIORITY OF EVACUATION

Common sense should be used, and always follow your team leader/supervisor's instructions. The priority is to evacuate the people in the most danger first!

If you have to evacuate, do so in this order:

1. **Ambulant patients** (people who can walk without assistance)
2. **Semi-ambulant patients** (people who need assistance to walk). Mobile patients and visitors can assist to evacuate the semi-ambulant patients
3. **Non-ambulant patients** (eg, bed ridden). These patients rely totally on staff and rescuers to remove them from the danger.
4. **Violent, aggressive or resistive people** should be evacuated last as they may put the rescuers at risk.

**Search toilets**, **general areas and store rooms** to ensure no one is left behind **-** *if it is safe to do so***.**

## SAH EVACUATION ASSEMBLY AREAS


## SDSH EVACUATION ASSEMBLY AREAS