Rural Companion Guide to the Role Delineation of Health Services

First Edition 2004

This Guide has been designed to be read in conjunction with the Guide to the Role Delineation of Health Services

Statewide Services Development Branch

NSW HEALTH DEPARTMENT

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INTRODUCTION

The *NSW Health Report* (2002) recommended that a Rural Companion to the *Guide to the Role Delineation of Health Services (the Guide)* document be developed. This paper has been prepared with the assistance of the Advisory Group. This group consisted of Area Health Service staff, clinicians and Department staff.

The *Rural Companion Guide* should assist Rural Area Health Services in the provision of services by encouraging the building of partnerships between facilities and promoting intra and inter Area networking.

It is anticipated that the developed of the *Rural Companion Guide* will assist in improving the certainty around the future roles of hospitals in rural areas.

The *Rural Companion Guide* recognises the workforce and resource differences between rural and metropolitan practice. The *Rural Companion Guide* has been developed to assist in the application of the *Guide* in rural and regional areas.

The *Rural Companion Guide* utilises the role delineation process. Role delineation is a process which determines the level of support services, staff profile, minimum safety standards and other criteria required to ensure that clinical services are provided safely and are appropriately supported. The aim of the *Guide* and the *Rural Companion Guide* is to provide a consistent language that Area, and statewide, health care providers and planners can use when describing health services, and as a tool for planning service and capital developments.

The role level of a services describes the complexity of the clinical activity undertaken by that service, and is chiefly determined by the presence of medical, nursing, allied health and other health care personnel who hold qualifications compatible with the defined level of care. However, these factors need to be supported by similar consideration in related and support services. Adequate formal appointment and credentialing processes are therefore mandatory for all facilities. This document does not represent a description of criteria for credentialing. Information relating to credentialing can be sourced from Circular 95/24- *Guidelines for the Delineation of Clinical Privileges of Medical Staff.*

The *Guide* and the *Rural Companion Guide* do not attempt to describe all the services which are provided by health care facilities, but confine themselves to those which are considered to be the core services for hospitals and community health facilities.

Services not included in the *Guide* and the *Rural Companion Guide* should be covered by appropriate Area policy.

HOW TO USE THIS COMPANION GUIDE

These Guidelines have been prepared to assist health service planners and providers in rural communities to determine the appropriate level of service that can be safely provided at their location.

The *Rural Companion Guide* was developed for use in conjunction with the *Guide*. The *Rural Companion Guide* provides appropriate and acceptable divergences in the definition of services levels, from those in the *Guide*, in the instances where it is acknowledged that health service delivery may be altered without impacting on clinical standards.

The *Rural Companion Guide* includes a definition section that provides information in relation to telehealth, Area-wide Specialist Appointments, and the role of Rural Referral Hospitals and Networking.

The Appendices contained in the *Guide to the Role Delineation of Health Services* should be referred to when using the *Rural Companion Guide.* They are included at the back of this document.

Section A – CLINICAL SUPPORT SERVICES

The *Guide to the Role Delineation* and the *Rural Companion Guide* apply to all public health hospitals and health services. When developing functional and strategic plans, Area Health Services should use these documents to describe the size, service profile and roles of the institutions which form part of the Area network. Each service will then need to be planned and developed at the level necessary to meet the needs of the catchment population for that service as determined in the Area, thus ensuring efficiency in the health system as a whole, while also improving local access.

The *Rural Companion Guide* has been developed in acknowledgement of the difference that exist between urban and rural areas in the provision of health services. The *Rural Companion Guide* should enable a greater level of flexibility to be applied to determine the appropriate level of service in rural facilities. The aim of the *Rural Companion Guide* is to document variances in service provision which are acceptable and appropriate for the provision of health services in a rural area.

The following tables highlight the qualifying descriptions for selected rural services at varying levels of role delineation. It is given that the higher levels of services are able to provide the services described in the lower service definitions. The following qualifying descriptions should be read together with the *Guide to the Role Delineation of Health Services*, third edition, 2002.

1 PATHOLOGY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
3	Pathology service may be networked between facilities, rather than on-site to allow level 3 requirements to be met for hospitals in close proximity (approx 30 minutes). Where available, Point of Care pathology is acceptable for level 3 services.
4	On-call, rather than 24-hour on-site pathology
5	On-call, rather than 24-hour on-site pathology service. Stipulate a 10 minute call back time for urgent pathology.

2 PHARMACY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
2	Patient and staff education may be provided via telehealth.
3	Pharmacist may be employed on a part-time or full-time basis.

3 DIAGNOSTIC IMAGING

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	Licensed Remote X-Ray Operators, able to access Level 3 hospitals, or higher, for radiography support.
2	Radiographer has access to Radiologist support on an "as required" basis. This access may be via telehealth.
3	Ideally should have access to teleradiology at Level 5 sites.
5	Radiology support service on call rather than 24 hour onsite.
6	Radiology support service on call with 10 minute call back.

5 ANAESTHETICS

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
2	Medical Officer on-site during normal working hours and available within 10 minutes after hours.
3	Medical Officer on-site during normal working hours and available within 10 minutes after hours. In general, Registrars will participate in a formal approved training program. Other Medical Officers, with appropriate anaesthetic experience, may also occupy Registrar positions and contribute to on-call roster. Formal networking arrangement with specialist anaesthetic services for support as required.

6 INTENSIVE CARE

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
2	Formal network with Level 5 Referral Hospital. Patients referred for consultation, when deemed appropriate by the attending Medical Officer in the Level 2 unit, to optimise management and minimise transfers. Initial consultation via telephone, or via telehealth, where available. If there is no Level 5 Referral Hospital in the network, default to formal network with Level 4 centre, or Level 6 Tertiary centre.
3	Formal network with Level 5 Referral Hospital, where available. Patients referred for consultation, when deemed appropriate by the attending Medical Officer in the Level 3 unit, to optimise management and minimise transfers. Initial consultation via telephone, or via telehealth, where available. If there is no Level 5 Referral Hospital in the network, default to formal network with Level 4 centre, or Level 6 Tertiary centre. Appropriate access to physiotherapy (generalist). Access to speech pathologist within 48 hours.
4	Medical Director has an Area-wide role. Formal network with Level 5 Referral Hospital where available. Patients referred for consultation when deemed appropriate by the attending specialist in the Level 4 unit, to optimise management and minimise transfers. Initial consultation via telephone, or via telehealth, where available. If there is no Level 5 Referral Hospital in the network, default to formal network with level 4 centre, or Level 6 Tertiary centre.
5	Level 5 Referral Hospital will be the regional hub for designated lower level units. If there is more than one Level 5 Referral hospital in the Area Health Service, each may form a hub for a set of designated smaller units based on local geography and critical mass. Formal networking should be developed between these hospitals to minimise transfers to Tertiary Level 6 centre, when tertiary level care is not required. Each Level 5 unit to have a formal network with a Level 6 Tertiary centre. Patients are referred for consultation, when deemed appropriate by the attending specialist in the Level 5 unit, to optimise management and minimise transfers. Initial consultation may be via telephone, or telehealth, where available. RMO(s) on site, predominantly present in the units and available to the Unit at all times.

7 CORONARY CARE

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
3	NUM may oversee other areas in the facility.
4	Access to allied health professionals, especially Dietician and Social Worker. Designated coronary care area may include a designated critical care area, which incorporated coronary care, intensive care and/or high dependency service.
5	Rostered Cardiologist Director or other specialist Medical Director with qualifications in a critical care specialty appropriate to the nature of the work in the unit (e.g. general medicine, intensive care, emergency medicine), and with substantial training and experience in coronary care.

8 OPERATING SUITES

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
5	As Level 4, plus operating room equipped for major and complex, major diagnostic treatment procedures. May have Specialist Units and teaching role. Staffing on site or available within 20 minutes. Access to CNC is desirable.

9 EMERGENCY MEDICINE

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	RN/GP are able to phone designated Allied Health Professional for advice. Able to refer patient to appropriate Allied Health Professional, either locally or within network.
3	Specialist consultative services may be on-site or as part of a formal network.
4	Access to a retrieval service with participation in a regional retrieval system essential if there is no regional Level 5 service in the Area.
5	Medical Director with substantial training and experience in emergency medicine; qualifications in critical care specialty appropriate to the nature of the work in the department (preferably emergency medicine); and the ability to work within an integrated critical care model. Participation in an Area/Regional retrieval system.

10 GENERAL MEDICINE

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	RN/GP are able to consult Allied Health Professional, as appropriate for advice.
2	Access to Allied Health Professionals via telehealth if required and not available on-site.
3	Other Allied Health Professionals available for consultation either on-site or via telehealth.

Section B – CORE SERVICES

11 CARDIOLOGY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
4	Allied Health Professionals available on-site.
5	On-site local Allied Health Professional with skills in cardiology available.

19 MEDICAL ONCOLOGY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
4	Access to Allied Health Professionals, with Dietician, Physiotherapist and Occupational Therapist on-site.

21 RADIATION ONCOLOGY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
4	Access to Allied Health Professionals, with Dietician, Social Worker, Physiotherapist and Occupational Therapist on-site.

Section B – CORE SERVICES

22 RENAL MEDICINE

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
4	Allied Health Professionals available as required. Access to Dietician and Social Worker.

25 GENERAL SURGERY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
5	A Level 5 Surgery Service requires a Level 5 Operating Suite.

32 OPTHALMOLOGY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
5	Access to Orthoptist, rather than on staff.

37 MATERNITY

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	Where available, access via telehealth with midwives (including those who work in community health).
5	Access to Area CNC and/or CNE, rather than on-site.

38 NEONATAL

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
4	Paediatrician with neonatal experience and paediatric registrar on-call rather than on-site
5	Access to Area CNC and/or CNE, rather than on-site

51 GERIATRICS

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	Does not require any level of ICU support service.
2	Does not require any level of ICU support service.

53 PALLIATIVE CARE

Level	Description *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
3	Access to CNC as required.
4	Access to consultation with Palliative Care Specialist - either intra-Area or inter-Area network.

54 REHABILITATION

Level	Description *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
5	Able to access to CNS and CNC. Networked service to improve bed management between Level 5 services in Area and integrated community based care.

Section B – CORE SERVICES

COMMUNITY BASED HEALTH SERVICES

It is suggested that services that are contained in the Community Based Health Services section of the *Guide to the Role Delineation of Health Services* are planned using a model developed by Mid Western Area Health Service in their document, *Equity of Access for Rural Health Services – Community Based Service Mapping*, 2001.

Service levels are defined by taking into consideration the following information:

- Population base
- Equity of access and distance from other services
- The Department of Health document *Guide to the Role Delineation of Health Services*[1]
- The MWAHS Review of Community Based Services[2]

Service levels were assigned to each community based on their weighted and adjusted populations and distance factors. The following criteria were used:

- Level 1 – weighted and adjusted population of less than 2,000
- Level 2 – weighted and adjusted population of 2,001-7,000
- Level 3 – weighted and adjusted population of 7,001-20,000
- Level 3 – weighted and adjusted population of more than 20,000

The levels are considered to be minimum standards for service delivery and are not intended to restrict service delivery.

[1] NSW Health, 2002, *Guide to the Role Delineation of Health Services*, 3rd edition, State Health Publication No SWS 9901862002
[2] MWAHS 1999, Community Based Service Review

COMMUNITY BASED HEALTH SERVICES continued

Level	**Description** *(These descriptions are to be read in conjunction with the Guide to the Role Delineation of Health Services)*
1	Locally available primary care nursing services that include: domociliary nursing services; child and family health services; and Aboriginal Health Education Officer/Health Worker (AHEO - depending on the Aboriginal population). Access to consultative services including: Area Program Managers; Clinical Nurse Consultants; and Allied Health Advisers. Participation in quality improvement activities. Community development/health improvement activities.
2	A Level 2 Service will meet the requirements for a Level 1 service, and will provide the following additional services (based on need): outreach programs and services; counselling services; physiotherapy; dietetics; speech pathology; occupational therapy; mental health; aged care; dental; alcohol and other drugs; women's health; sexual assault; sexual health; brain injury; child protection; Aboriginal Health; genetic counselling; continence advice; diabetes education; oncology/palliative care; and rehabilitation. Community development programs with formal outcome evaluation. Access to administrative support. Structured Quality Improvement Programs. Should outreach primary care nursing to Level 1 Services as required.
3	A Level 3 Service will meet requirements of a Level 2 Service, and may provide the following locally based programs and additional services, as required: alcohol and drugs; dietetics; physiotherapy; occupational therapy; speech pathology; women's health; sexual assault; and counselling services. Administrative support - staffing dependent upon individual service requirements. Regular visiting services may include: Area program/services such as diabetes education and Aged Care. Level 3 Services will network their services as appropriate to ensure the efficient use of available resources.
4	A Level 4 Service will meet the requirements of a Level 3 Service, and may provide the following designated specialist teams/services in addition: Aged Care Assessment Team (ACAT); Brain Injury Team; Oncology and Palliative Care Service; Sexual Health Service; Diabetes Service; and Genetic Counselling. Provision of outreach services to all other levels, as appropriate. Level 4 Services will network their services to allow the sharing and efficient use of highly specialised services and resources.

CONCLUSION

Rural Companion Guide to the Role Delineation of Health Services has been produced to assist rural Area Health Services with the degree of flexibility required at a functional level when planning rural health services. The *Rural Companion Guide* has been developed to assist in the application of the *Guide to the Role Delineation of Health Services*, in rural and regional areas.

Role delineation provides health service planners with a valuable tool to facilitate the development of facility based and networked services in Areas. The Area should coordinate the process of delineating the health service roles of the facilities and networks which operate in that Area. The *Rural Companion Guide* should be used in conjunction with the *Guide to the Role Delineation of Health Services* in order to ensure a flexible approach in achieving service levels which best meet the needs of the community it serves when planning.

The *Rural Companion Guide* recognizes that differences occur in the way in which services are provided and networked in rural NSW. The *Rural Companion Guide* should assist rural Area Health Services in the provision of services by encouraging the building of partnerships between facilities, and intra and inter Area networking. The *Rural Companion Guide* recognises the workforce and resource differences between rural and metropolitan practice.

The *Rural Companion Guide* includes a section that provides information in relation to the use of telehealth and Area-wide Specialist Appointments to achieve appropriate clinician support for service provision in developed networks based on critical mass rather than location of a facility and the role of rural Hospitals and Networks.

APPENDIX 1

DEFINITIONS

Telehealth

Telehealth has become an important means of networking. In addition, telehealth remains in a state of development as new uses and systems are implemented. Telehealth now assists with activities such as image transfer, radiology and psychiatry. A properly developed Telehealth system within a network may enable a hospital to have a support service where there is equivalent functional access to that service and where patient care is not compromised by that service being off-site.

Telehealth can be applied as a demonstration tool to assist service delivery.

Telehealth is a suitable means for access or liaison with other health professionals.

Area-wide Specialist Appointments

The further development of Area wide and cross-Area appointments is encouraged. Some Areas have already commenced the development of these appointments and other Areas are commencing the process as they develop Area-wide Clinical Departments. The development of Area-wide Clinical Departments enables the appointment of Area Directors in specific specialty services to facilitate the coordination and management of that clinical stream throughout an Area Health Service.

An Area Director will oversee, coordinate and provide a means of communication across the network of facilities providing a specific clinical service. The Area Director should be an experienced clinician. This will improve coordination of services at an Area Health Service level and allow for standardisation of clinical policy, protocols, guidelines and training. The role of the Area Director would be one of coordination, liaison, planning and support, not direct day-to-day management of each site.

Role of Rural Referral Hospitals & Networking

Through formal networking and service arrangements a hospital may be able to effectively operate with its support services off-site.

In rural Area Health Services the role of the Rural Referral Hospital is to function as a hub in the network. They should ensure linkages with other Rural Referral Hospitals in the Area. In addition, they may be linked to Rural Referral Hospitals in other Areas. These facilities should also have a formal network link with a metropolitan Level 6 Hospital. The networked link could provide a number of functions including referral advice, assistance with education and telehealth.

The greatest benefit of networking appears to be gained when the network is formalised and linkages clearly defined. Networking involves linkage of health services across a range of sites and settings to provide an appropriate, effective, comprehensive, and well-coordinated response to health needs. Networking enables staff to work together to ensure a wide range of services is available locally. Networking requires planning and delivery of clinical services across an Area or between Areas, without the impediments of a facility oriented approach. Networking offers opportunities in structure, certainty, growth, development and recognition for rural health services.

Facilities within a network may each provide different services. Collectively, the network ensures that the patients are able to get the care they need, close to where they live.

Networking between facilities across a geographical area can help create sufficient work volume, and therefore attract a full range of staff needed to sustain a safe and high quality clinical service. Networking also provides better opportunities for staff to be exposed to a wider range of clinical experiences and for the development of 'seamless' care through collective planning and common protocols.

It is proposed that the development of these networks will allow:

- Improved access to all levels of community based health services
- The coordination of service provision across levels
- Sharing of resources such as equipment, information, clinical expertise and community education programs
- Clinical support for service providers, reducing profession isolation
- Continuity of client care

APPENDIX II

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

MEDICAL AND NURSING STAFF DEFINITIONS

Accredited Medical Practitioner

Accredited Medical Practitioners are GPs appointed to a hospital and to whom specific clinical privileges have been granted (eg. surgery, anaesthetics, obstetrics, endoscopy, etc.) following review of his/her training and continuing skills, by the Health Service's Credentials Committee.

The Committee will have given regard to Medical Practitioner's documented post-graduate training and (the volume, and type of past and recent) clinical practice history considered to be essential for the maintenance of skills in the requested privileges. In case of infrequently performed procedures, skills maintenance should be through exchange release programs at base hospitals with Level 4, 5, or 6 of appropriate service.

Clinical Nurse Consultant (CNC)

Means a Registered Nurse appointed as such to a position approved by the Area Health Service, who has had at least five years full-time equivalent post registration experience and in addition who has approved post registration nursing qualifications relevant to the field in which he/she is appointed, or such other qualifications or experience deemed appropriate by the Area Health Service.

Clinical Nurse Educator (CNE)

Means a registered and tertiary qualified nurse with at least five years relevant experience who assesses, plans, implements and evaluates nursing education and professional development programs. A Clinical Nurse Educator:

- Plans and develops syllabus structures and course programs for nursing education;
- Plans and participates in clinical education in hospitals, other health care facilities and community settings;
- Designs, implements and evaluates educational programs and curricula for specialised nursing groups;
- Undertakes nursing research; and
- Maintains an information base on educational programs.

Clinical Nurse Specialist (CNS)

The definition of a Clinical Nurse Specialist is:

> A Registered Nurse with relevant post-basic qualifications and twelve months experience working in the clinical area of his/her specified post-basic qualification.

OR

> A minimum of 4 years post-basic registration experience including three years experience in the relevant specialist field and who satisfies the local criteria.

Experienced Registered Nurse of Midwife

Is a Registered Nurse with at least two years post basic registration experience, including one year experience in the relevant clinical field or experience as deemed appropriate by the facility nursing administration. An experienced Registered Nurse may be a Clinical Nurse Specialist. Education for

the purpose of this definition refers to staff development, continuing education or any orientation and in-service course specific to the needs of the service.

Experienced Staff (Mental Health)

Is an "appropriately qualified and experienced mental health professional" as defined in Section 3 of the glossary of the National Standards for Mental Health Services (NSMHS) who has either:

1. Two years of post basic qualification experience, including one year experience in the relevant clinical field; or
2. Experience as deemed appropriate by the Area Mental Health Service.

For this document the NSMHS definition has been adapted to be consistent with that of "An Experienced Registered Nurse or Midwife" (see above). This is based on the understanding that Area Mental Health Services are complying with the NSMHS and thus would not deem a person to have the required qualifications and experience unless they met the NSMHS requirement (below).

The NSMHS definition is:

> "An individual with recognised qualifications and experience which enable them to provide appropriate treatment and support to the consumers and their carers. The degree of formal training and expertise required will be determined by factors such as the degree of specialisation required/ available (eg: staff specialising in child and adolescent mental health), the needs of the defined community (eg: Aboriginal and Torres Strait Islander mental health staff, ethnic health workers) and the type of services being delivered (acute care, residential support, drop-in, rehabilitation)."

It should also be noted that the NSMHS definition also applies explicitly to persons who are not necessarily recognised health professionals, but may have relevant experience.

First Line Emergency Care

A Registered Nurse with recognised education and training, who can demonstrate the ability to initially assess, resuscitate and aim to stabilise the emergency presentation of trauma and acutely ill patients.

General Physician

General Physicians are registered Medical Practitioners whose training has been acknowledged by the award of the Fellowship in the Royal Australasian College of Physicians, or one who holds an equivalent post-graduate qualification accepted by the College.

Medical Officer

Medical Officers are registered Medical Practitioners employed/contracted by health service providers. They are usually responsible to the Director, Medical Services and to the senior clinicians contracted in the service in which they perform their duties. They do not require experience specific to the area of practice and may be a career Medical Officer, a full-time or part-time resident Medical Officer, a GP, etc.

Medical Superintendent

The Medical Superintendent means the Medical Practitioner appointed under section 209 of the Mental Health Act to be responsible for clinical treatment and standards in a gazetted facility.

Nurse Practitioners

Nurse Practitioners are registered nurses working at an advanced practice level. They are authorised by the Nurses Registration Board of New South Wales to use the title 'Nurse Practitioner'.

Authorised Nurse Practitioners may initiate medications, order diagnostic tests and make referrals only when they are operating within approved guidelines.

They will provide expert nursing care in collaboration with other health professionals, who will deliver a new and additional health service to many communities.

Nurse Unit Manager

Means a Registered Nurse in charge of a ward or unit or group of wards or units in a hospital or health service. Responsibilities include:

- Coordination of patient services;
- Unit management; and
- Nursing staff management

Nurses Caring For Sick Children

This statement is directed at any nurse caring for sick children. The minimum standard is related to competence rather than experience. The Nurse:

- Demonstrates a broad knowledge of growth and development.
- Assesses children's normal parameters, recognises the deviations from the normal and acts appropriately on the findings.
- Demonstrates a knowledge of medication, calculates and safely administers medication and other preparations for children.
- Demonstrates an understanding of the effects of hospitalisation on children and families.
- Communicates effectively and works in partnership with children and families.
- Demonstrates knowledge of health problems and their management relevant to their area of childhood clinical practice.
- Commences and maintains effective basic paediatric life support.
- Recognises and challenges clinical management that may compromise children's safety.
- Utilises contact with children and families to promote health.
- Demonstrates an awareness of appropriate Federal and State legislation and policies and acts accordingly.

The Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) accepts and endorses:

1. ACHS Standards "Guidelines for Hospital-Based Child and Adolescent Care (1998)
2. AWCH Health Care Policy relating to children and families (1974)
3. United Nations Convention on the Rights of the Child (1989)

* A child is defined as a person between birth and 18 years of age.

Adopted by the ACPCHN (NSW Branch) Executive Committee, May 1999.

Recognised Intensive Care Specialist

Recognised Intensive Care Specialists have qualifications, training and/or experience that meet the criteria for specialist recognition defined by the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC). The JSAC-IC is a joint committee of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetics and the Royal Australasian College of Physicians.

Registered Nurse

Means a person registered by the New South Wales Nurses' Registration Board.

Registrar

Registrars are experienced Medical Officers appointed to positions in hospitals or community health services. They may participate in a formal training program approved by a learned college and may have prior experience in the relevant specialty area. Medical Officers may occupy Registrar positions in some circumstances provided they are experienced in the relevant specialty area.

In addition, there should be a demonstrated level of special skills, a commitment to continuing education, and a continuing assessment of the ready availability of specialist Medical Practitioners in the sphere of practice in which privileges are requested.

Specialist Anaesthetist

Specialist Anaesthetists are Medical Practitioners whose training has been acknowledged by the award of Fellowship in the Australian and New Zealand College of Anaesthetists (FICANZCA), or one who holds an equivalent post graduate qualification accepted by the faculty.

Specialist General Physician with Subspecialty Interest

This category of specialist General Physician is defined, as a result of further training and acquisition of skills, by the granting of privileges by the Health Service’s Credentials Committee in areas of medical practice usually considered to be sub-specialties outside the accepted field of general medicine.

A Specialist Physician, (eg. cardiology, paediatrics, geriatrics, psychiatry, rheumatology, dermatology, etc). is a physician who has completed a learned College approved training program with the award of a fellowship, and who has successfully undertaken additional approved training programs in the indicated sub-speciality.

Specialist Staff (Mental Health)

Is an "appropriately qualified and experienced mental health professional" as defined in Section 3 of the glossary of the NSMHS who has the specific qualifications and/or training for the field in which they are working, for example child/adolescent versus general adult versus psychogeriatric care, within their basic professional qualification.

Specialist Surgeon

This title includes:

(A) **General Surgeon**

Is a registered Medical Practitioner whose training has been acknowledged by the award of a Fellowship in General Surgery in the Royal Australasian College of Surgeons, or one who holds an equivalent postgraduate qualification accepted by the college; and holds a hospital appointment as a specialist surgeon.

(B) **General Surgeon** (credentialed for a specialist interest in a subspecialty).

Is a General Surgeon as defined, whose training has included areas of surgical practice additional to the current training program in general surgery and who has been granted privileges by the hospital credentials committee to practise in those additional fields.

The current training program in general surgery includes:

- alimentary surgery: (i) Upper gastrointestinal surgery; (ii) Heptobiliary/pancreatic surgery; (iii) colorectal surgery.
- head and neck surgery
- vascular surgery
- endocrine and breast surgery
- endoscopy and other diagnostic procedures

For subspecialty privileges to be granted to a General Surgeon evidence of training in relevant subspecialty of 6-12 months duration in a hospital which has Level 5 or 6 in the subspecialty must be demonstrated.

(C) **Subspecialty Surgeon**: (Subspecialty type eg. urologist, gynaecologist, ophthalmologist, Orthopaedic Surgeon, vascular surgeon, plastic surgeon, etc).

Is a surgeon who has successfully completed a college approved training program with the award of a fellowship in the indicated specialty, or subsequent to the award of a fellowship in general surgery, has undertaken successfully the approved post fellowship training in a surgical subspecialty; or, a surgeon whose training has been accepted by the appropriate college.

APPENDIX III

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

LEVELS OF RISK - ADULTS
CLASSIFICATION OF PHYSICAL STATUS FOR PRE-OPERATION ASSESSMENT

The ASA Physical Status Classification System

GOOD RISK
P1: A normal healthy patient

P2: A patient with a mild systemic disease

MODERATE RISK
P3: A patient with severe systemic disease

BAD RISK
P4: A patient with severe systemic disease that is a constant threat to life

P5: A moribund patient who is not expected to survive without the operation

DESPERATE
P6: A declared brain-dead patient whose organs are being removed for donor purposes

Taken from the American Society of Anaesthesiologists Relative Value Guide 1999.

LEVELS OF RISK - CHILDREN (Ages 0-14 inclusive)
CLASSIFICATION OF PHYSICAL STATUS FOR PRE-OPERATION ASSESSMENT

The ASA Physical Status Classification System

ASA1: Healthy Child

ASA2: Child with mild systemic disease – no functional limitation

ASA3: Child with severe systemic disease- definite functional limitation

ASA4: Child with severe systemic disease- that is a constant threat to life

ASA5: Moribund child not expected to survive 24 hours with or without an operation.

With acknowledgement to the American Society of Anaesthesiologists.

LEVELS OF RISK - OBSTETRICS AND NEONATAL

BROAD RISK CATEGORIES FOR MATERNITY PATIENTS

NORMAL RISK:

This category implies the absence of any risk factors that may lead to pregnancy complications which would require the services of a specialist obstetrician. Most women are in this category and are appropriate for delivery in a unit of any level, and could receive care from practitioners of any description including midwives, GPs or specialists. In general this category implies delivery at full term of a healthy neonate who does not require a paediatrician. These patients may deliver in Level 2 or 3 Maternity Units. In certain circumstances operative delivery by non-specialists may be appropriate eg. the need for caesarean section does not always necessitate a move to moderate risk if appropriately trained proceduralists are available.

MODERATE RISK:

This category implies the presence of fetal or maternal risk factors which may adversely impact on pregnancy outcome. Management by, or least consultation with a specialist obstetrician is mandatory. Delivery will usually be in Maternity Units of at least Level 4. Preterm delivery may be anticipated but this should not be less than 32 weeks. Paediatric involvement is likely and should be available.

HIGH RISK:

Patients in this category have major fetal or maternal risk factors which will always require management by a specialist obstetrician, and frequently management by, or at least consultation with a subspecialist in Maternal-Fetal Medicine. Delivery in a Level 6 Unit will usually be indicated due to the potential need for Neonatal Intensive Care facilities. In some cases delivery in Level 5 Units may be appropriate depending on the availability of appropriate sub-specialties for consultation, and if delivery at greater than 32 weeks is anticipated.

Specific examples of At Risk Pregnancies are given below:

"At Risk" Pregnancies
While obstetric complications may occur in any pregnancy at any time, it is recognised that certain categories of patients or conditions, either solely or in combination, place some women 'at risk'. In these categories, both maternal and perinatal morbidity and mortality are substantially increased. The accompanying list is presented to remind those practising in maternal and neonatal health of these dangers. It is recommended that patients falling into these groups should be assessed carefully and that if more than minor complications exist, consultation with an obstetrician with specialist experience should be considered, with possible referral of the case to a higher level of care.

1. General Factors

- prematurity
- age (early teenage, later reproductive years) especially primigravida
- social economic status
- aboriginality
- parity (primigravida and gravida 4+)
- height (short stature)
- weight (overweight and underweight)
- dietary aberrations
- drug dependence (opiate or other) and abuse of alcohol or tobacco
- mental disturbance/psychoses
- primary infertility

2. Maternal Diseases

- autoimmune disease
- cardiovascular disease including essential hypertension and hypertensive disease of pregnancy, previous thromboses (embolisms)
- diabetes mellitus
- anaemia's (all types)
- chronic renal disease including recurrent urinary infection
- past history of venous thrombosis and/or pulmonary embolism
- epilepsy
- sexually transmitted diseases diagnosed in pregnancy

3. Family History of Genetic Disorder or Birth Defect

- parent heterozygous for haemoglobenopathy or inherited disorders

4. Past Obstetric History

- previous prolonged labour
- previous caesarean section
- previous abortion, including habitual abortion
- previous perinatal mortality or morbidity
- previous premature labour or placental insufficiency
- previous obstetric complications (post partum haemorrhage, retained placenta)

5. Diseases Peculiar to Pregnancy

- preeclampsia
- rhesus and other blood group incompatibility

6. Bleeding in Pregnancy

- threatened abortion
- abruptio placentae
- placenta praevia

7. Obstetric Difficulties Discovered Antenatally

- serious infection (HIV, Hepatitis)
- polyhydramnios and oligohydramnios
- intrauterine growth restriction
- malpresentation, especially breech presentation and transverse lie
- disproportion
- multiple pregnancy
- placental insufficiency and restricted intrauterine growth
- prolonged pregnancy (past 42 weeks)
- premature rupture of membranes
- abnormalities of genital tract
- uterine fibroids

8. Patients Having Inadequate Antenatal Care

- failure to attend for regular antenatal checks
- non-booked cases
- late booked cases

9. Difficulties Discovered During Labour

- failure to progress satisfactorily, including prolonged labour
- fetal distress
- malpresentation

Rural non specialist obstetric practitioners may seek consultant advice either by telephone or referral if necessary when actual or potential problems are recognised which may put the outcome of the pregnancy at risk.

Base hospitals/metropolitan district hospitals must continue to upgrade their level of competence and facilities to perform effectively as Level 5 centres of perinatal expertise and advice, and in some cases they are the Area perinatal centres.

Problems of transport and accommodation for the isolated population coming to Level 4, 5 or 6 maternity units must be discussed and arrangements made by Areas well in advance of the woman requiring transfer. This will help the woman and her family to have a reasonable knowledge of what will be expected. Particular consideration in some Areas needs to be given to air transport facilities.

Lines of communication should be established between the rural Area perinatal centre and a special obstetric unit. (Level 6).

NEONATE:

HIGH RISK FACTORS

- Apgar score 7, or less, at 5 minutes
- Birth weight less than 2000 gm
- Evidence of respiratory distress
- Persistent hypothermia
- Neonatal hypoglycaemia
- Major congenital anomaly

Reference:
Obstetric Services in NSW, Part 2, Country Regions,
Report of the Maternal and Perinatal Committee, 1983, NSW Health Department

APPENDIX IV

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

INDICATIVE LIST OF SURGICAL PROCEDURES

GENERAL SURGERY

MINOR SURGICAL PROCEDURES

Excision of skin lesion
Excision of subcutaneous tumour
Drainage of abscess
Toe-nail surgery

MAJOR SURGICAL PROCEDURES

Thyroidectomy
Vascular graft
Cholecystectomy
Bowel resection
Mastectomy
Exploratory laparotomy

COMMON AND INTERMEDIATE SURGICAL PROCEDURES

Appendicectomy
Varicose vein surgery
Herniorrhaphy
Haemorrhoidectomy
Excision of breast lump

COMPLEX MAJOR SURGICAL PROCEDURES

Abdomino-perineal resection
Anterior resection
Oesophagectomy
Aortic surgery
Pancreatic resection
Neck dissection

Note: The procedures listed are indicative of the complexity of surgical activity in each category.

The actual range of procedures which may be performed by individual practitioners appointed to a general or subspecialty surgical service of a given level will be determined through the credentialing process at which clinical privileges are granted.

Acknowledgment is given to the Royal Australasian College of Surgeons for assistance with the indicative list of surgical procedures.

APPENDIX V

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

INDICATIVE LIST OF PAEDIATRIC SURGICAL PROCEDURES

MINOR SURGICAL PROCEDURES

Suture of laceration
Excision of skin lesion

Drainage of abscess
Circumcision (ie. any operation which in competent hands takes less than half an hour)

MODERATE COMPLEXITY

Pyloromyotomy
Herniotomy after the first year of life
Orchidopexy after the first year of life
Appendicectomy

MAJOR SURGICAL PROCEDURES

Neonatal surgery
Major reconstructive surgery (anorectoplasty, rectosigmoidectomy, etc)
Pyeloplasty
Thoracotomy
Lymphangioma
Ureteric reimplantation
Fundoplication
Splenectomy
Cleft lip/palate surgery
Herniotomy in first year of life
Orchidopexy in the first year of life
Burns grafting
Urethroplasty
Operative reduction of intussusception
Closure of colostomy
Insertion of central line in first two years of life (ie. any procedure which in the hands of competent surgeon takes more than one hour

Note: The procedures listed are indicative of the complexity of surgical activity in each category.

The actual range of procedures which may be performed by individual practitioners appointed to a general or subspecialty surgical service of a given level will be determined through the credentialing process at which clinical privileges are granted.

Acknowledgment is given to the Royal Australasian College of Surgeons (Paediatric Surgeons) for assistance with the indicative list of paediatric surgical procedures. The procedures and their ranking are based on complexity definitions of the Board of Paediatric Surgery of the RACS.

APPENDIX VI

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

TRAUMA SERVICES
RELATED LEVEL SUPPORT AND CORE SERVICES

Trauma Service Designation within Trauma Services Plan	Pathology	Diagnostic Imaging	Nuclear Medicine	Anaesthetics	ICU	Operating Suite	Emergency	General Medicine	Neurology	General Surgery	Cardiothoracic	Neurosurgery	Ophthalmic	Orthopaedics	Plastic	Urology	Vascular	Rehabilitation
Local	Support and core services as delineated for the individual hospital																	
Area	4	4	4	4	4	4	4	4	4	4	*	** 5	4	4	*	4	4	4
Supra-Area	6	6	5	6	6	6	6	5	5	5	5	6	5	5	5	5	5	6

* Access to Level 5 of this service by appropriate interhospital transfer

** Where Level 5 Neurosurgery not appropriate, Level 4 plus access to Level 5 by established interhospital transfer.

PAEDIATRIC TRAUMA SERVICES
RELATED LEVEL SUPPORT AND CORE SERVICES

Trauma Service	Pathology	Diagnostic Imaging	Nuclear Medicine	Anaesthetics	ICU	Operating Suite	Emergency	Burns	Cardiothoracic	Neurosurgery	Orthopaedic	Paediatric Medicine	Paediatric Surgery	Family and Child Health	Rehabilitation
(Local)	As for General Medicine/Surgery appropriate to the Hospital														
Area	4	4	4	4	4	4	4	4	4	4	3	4	4	3	4
Paediatric Referral Centres	5	6	6	6	6	6	6	5	6	6	6	6	6	6	6

* Access to Level 5 of this service by appropriate interhospital transfer

** Where Level 5 Neurosurgery not appropriate, Level 4 plus access to Level 5 by established interhospital transfer.

APPENDIX VII

Taken from the Third Edition of the Guide to the Role Delineation of Health Services

GLOSSARY

ACCESS: The ability to make use of, without difficulty or delay. If referring to an individual, such a person may or may not necessarily be a Full-time employee of the hospital concerned, but formal arrangements regarding this person's service to the hospital have been made.

CONSULTATION AVAILABLE: A formal arrangement has been made with a consultant (eg. an obstetrician), who has agreed to provide advice in person or by telephone under agreed circumstances.

DESIGNATED: Obligation to a defined or specified purpose.

DESIRABLE: Recommended, but not mandatory or obligatory.

FORMAL: To follow established or agreed process.

GAZETTED BEDS (OR GAZETTED HOSPITAL): The physical facilities approved for admission of persons who are informal (voluntary) or involuntary patients under the Mental Health Act.

LINK: To connect with, or be connected with, by formal association.

NETWORKING: Refers to an inter-connected group, eg. of hospitals. This arrangement may be a vertical one, as instanced by reference of patients to a hospital providing overall increased levels of skills or facilities; or horizontally by referral of patients to a hospital of similar level but having greater expertise or facilities in a specific service in patient management. If there is ready access to a support service, and where patient care is not compromised by that service being off campus, a hospital may be credited with itself providing that level of support service for the purposes of role delineation.

CONTINUOUS QUALITY IMPROVEMENT: "Quality Improvement is a planned and systematic approach to monitoring and assessing the care provided, or the service being delivered, that identifies opportunities for improvement and provides a mechanism through which action is taken to make and maintain these improvements"(1).

QUALITY IMPROVEMENT ACTIVITIES: The undertaking of measurement of outcome and other assessments of quality of service. Improvements in practice brought about on the basis of assessment. Local activities should be complemented by participation in a networked cluster of hospitals with similar and higher levels.

FORMAL QUALITY ASSURANCE PROGRAM: The use of explicit criteria, objective measurement of performance, comparisons of results over time, documentation of review procedure and results, and mechanisms for communication of findings and recommendations, and taking corrective action. A Level 3 Service should incorporate services with levels below it in a networked program.

MENTAL HEALTH SERVICE NETWORK: Refers to a group of specialised mental health services linked usually through responsibility for a specific geographical catchment and function to provide integrated and coordinated treatment options for persons with mental disorders. They are mainstreamed within general health services and have well developed relationships with all community groups able to assist people with mental disorders.

PSYCHIATRIC CONSULTATION/LIAISON SERVICES: Psychiatric consultation/liaison services are services which provide psychiatric assessment or advice to general hospital or other patient care facilities either as a direct service and/or as a consultative service to primary care personnel for the management of psychiatric or psychological problems.