Children and Adolescents - Guidelines for Care in Acute Care Settings

Summary  Clinical Practice Guidelines for the care of children and adolescents in NSW Health acute care facilities

Document type  Policy Directive

Document number  PD2010_034

Publication date  02 June 2010

Author branch  Office of Kids and Families

Branch contact  9391 9503

Review date  30 June 2018

Policy manual  Patient Matters

File number  10/1818

Previous reference  N/A

Status  Review

Functional group  Clinical/Patient Services - Baby and Child


Distributed to  Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience  All staff in health settings where services are provided for children and adolescents

Secretary, NSW Health
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
CHILDREN AND ADOLESCENTS – CARE IN ACUTE CARE SETTINGS

PURPOSE

This policy and the attached Guidelines for the Care of Children and Adolescents in Acute Care Settings are aimed at achieving the best possible paediatric care in all parts of the State. Hospitals, in partnership with clinicians, should aim to ensure services are provided at a level equivalent to that described in the Guidelines. Each patient should be individually evaluated and a decision made as to where the child should be hospitalised in order to achieve the best clinical outcome.

MANDATORY REQUIREMENTS

This policy applies to all facilities that provide services for children and adolescents. It requires all Health Services to have local protocols or operating procedures based on the attached guideline in place in all hospitals and facilities where services for children and adolescents are provided.

IMPLEMENTATION

Roles and Responsibilities

Directors of Clinical Governance are required to inform relevant clinical staff in all departments that provide services for children and adolescents of the policy.

Area Health Services are required to engage relevant clinicians and ensure that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.

Health professionals should use the Guidelines to ensure that local communities have access to a range services which are appropriate to their needs. The Guidelines for the Care of Children and Adolescents in Acute Care Settings should be read in conjunction with relevant documents from the Department such as the Guide to the Role Delineation of Health Services NSW Health Department, (2002).

REVISION HISTORY

<table>
<thead>
<tr>
<th>Version</th>
<th>Approved by</th>
<th>Amendment notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2010 (PD2010_034)</td>
<td>Deputy Director-General, Strategic Development</td>
<td>Rescinds 1998 Guidelines for the Hospitalisation of Children</td>
</tr>
<tr>
<td>1998 Guidelines for the Hospitalisation of Children (Not released as a policy)</td>
<td>Director-General</td>
<td>Rescinds 1994 Guidelines for the Hospitalisation of Children</td>
</tr>
<tr>
<td>1994 Guidelines for the Hospitalisation of Children (Not released as a policy)</td>
<td>Director-General</td>
<td>New guideline</td>
</tr>
</tbody>
</table>

ATTACHMENTS

1. Guidelines for the Care of Children and Adolescents in Acute Care Settings
## CONTENTS

1 Introduction 1
   1.1 Issues For Consideration When Caring for Children and Adolescents in NSW Health Facilities 2
   1.2 Definitions of Key Terms 3
2 Aims and Objectives 4
3 Guidelines 4
   3.1 General 4
   3.2 Special Needs of Children and Adolescents in Acute Care Settings 7
   3.3 Children and Adolescents Requiring Surgery 13
   3.4 Mental Health 15
   3.5 Child Health Networks 19
   3.6 Education For Health Professionals 20
   3.7 Evaluation 21
4 Appendices 22
   4.1 Acknowledgments 22
   4.2 Role Delineation Documents 23
   4.3 Resource Documents 31
1. INTRODUCTION


The NSW Department of Health, in collaboration with the Paediatric Inpatient Advisory Working Group, believed it was timely for the Guidelines to be reviewed and revised to incorporate contemporary practice issues for the care of children and adolescents in acute care settings.

The Guidelines are aimed at achieving the best possible paediatric care in all parts of the State. The document should not be seen as a stringent set of rules to be applied without the clinical input and discretion of the managing professionals. Health professionals should use the Guidelines to ensure that local communities have access to a range of services which are appropriate to their needs. Hospitals, in partnership with clinicians, should aim to ensure services are provided at a level of safety equivalent to that described in the Guidelines. Each patient should be individually evaluated and a decision made as to where the child should be hospitalised in order to achieve the best clinical outcome.

The Guidelines for the Care of Children and adolescents in Acute Care Settings should be read in conjunction with relevant documents from the Department such as the Guide to the Role Delineation of Health Services (NSW Health Department, 2002). The paediatric section of the Guide to the Role Delineation of Health Services is included in the list of resource documents provided at Appendix 2. Role delineation allows for flexibility of application in order for Health Service Managers to respond to local health needs. Similarly, the Guidelines are not intended to be followed uncritically and inflexibly by hospital administration and clinicians. Instead, consideration should be given to the distance from a major centre, severity of illness, availability of local expertise and services available through networking and the needs of the child and family. This is of particular relevance in the rural setting.

The definition of a child in this planning document is any person under the age of 16 years, neonates excluded. It is acknowledged that adolescents are defined as those of an age 12-18 years. Discretion should be applied in relation to adolescents older than 16 years. Clinical judgement/previous paediatric admissions should be considered when deciding if the older adolescent is suitable for accommodation in a paediatric unit.

Services should deliver safe and appropriate care, and meet the cognitive needs of the child or adolescent. The Guidelines do not address the special needs of adolescents or services for the newborn. Some resource documents which address these age groups are listed in Appendix 3.
1.1 Issues for Consideration When Caring for Children and Adolescents in NSW Health Facilities

- Children and adolescents account for 23% of presentations to emergency departments and for 14% of admissions to public hospitals in NSW\(^1\).

- In order to best meet the needs of these children and adolescents and their carers, a number of models of care have been developed in NSW health facilities and are supported by the Child Health Networks. Many of these models incorporate significant components of ambulatory care linked with programs such as Hospital in the Home. While these Guidelines focus on meeting the needs of children and adolescents in acute health care settings, planning and service delivery should not be done in isolation of ambulatory care and other service models.

- Technology is increasingly used to support the delivery of health care to children and young people. Telehealth can be a valuable tool in linking local services with more specialised services, to enable safe and effective delivery of services in addition to staff training and support.

- The Child Health Networks have a critical role in facilitating ongoing staff development and education opportunities in order to build local capacity.

- Health care delivery should be multidisciplinary and shared care models developed to address the needs of children and adolescents with chronic and complex health problems.

- Opportunities to engage consumers and carers in service planning and delivery should be explored. Parent and family advisory groups and consumer engagement through Area Health Advisory Councils are two approaches that are in place in NSW. Special needs of groups from other cultures and religions should also be considered.

- Inpatient units for children and adolescents have different requirements from those focussed on the care of adults. There are a range of factors impacting on the physical layout, staffing levels and skills, treatments and length of stay including developmental stage and ability, dependence, supervision, relationships between the patient and staff and the family and staff, child protection issues, education requirements and co-morbidities.

- Health facilities should accommodate children and adolescents in the most appropriate setting. Services with role delineation of Level 3 and above for Paediatric Medicine need to have a designated paediatric ward.

- All staff working with children must engage in staff development activities. These may be undertaken locally or could be linked, through the Child Health Networks, to more

---

\(^1\) Source: HIE (ED_Visit); Date Extracted: 13th July, 2009
specialised facilities. Specific education and training is required to become, and maintain the status of, a competent paediatric nurse.

- All staff working with Aboriginal children must consider their specific needs, consult with experts to seek advice and support and utilise the NSW Health Aboriginal Health Impact Statement and Guidelines to guide policy and service delivery.

1.2 Definition of Key Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>For the purposes of these Guidelines, a child is defined as anyone under the age of 16 years</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Adolescents are defined as those of an age 12-19 years</td>
</tr>
<tr>
<td>Acute care facility</td>
<td>An acute care facility provides immediate care for trauma and injuries, severe or sudden illness, or recovery from surgery. Generally, stays are brief in acute care and patients are sent home, are managed through ambulatory care or are transferred to non-acute facilities.</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>All care, including diagnosis, observation, treatment and rehabilitation that are provided outside the inpatient setting. Ambulatory care services include programs such as Hospital in the Home (HITH) and Paediatric Outreach Services.</td>
</tr>
<tr>
<td>Swing beds</td>
<td>Facilities may consider the use of ‘swing beds’ [beds that can alternate between different types of care] in service considerations and capital redevelopments, particularly to allow for the seasonal variability of paediatric admissions. Swing beds allow the temporary closure of beds during non-peak periods without a reduction in optimum staff/patient ratios. The bed/s are located within the ‘ward or unit’ and are satisfactorily shielded from the general ward area to ensure privacy from other patients. The beds are readily accessible to staff from either the general or paediatric ward area.</td>
</tr>
<tr>
<td>Role delineation</td>
<td>Is a process which determines what support services, staff profile, minimum safety standards and other requirements are provided to ensure that clinical services are provided safely and appropriately supported.</td>
</tr>
<tr>
<td>Child Health Networks</td>
<td>Networked paediatric services which enable high quality clinical care as close as possible to home for all children and adolescents, supported by common care guidelines, with staff training and development.</td>
</tr>
<tr>
<td>Competent Paediatric Nurse</td>
<td>A definition of a Competent Paediatric Nurse, defined by the Australian Confederation of Paediatric and Child Health Nurses, in Competencies for the Specialist Paediatric and Child Health Nurses is available at: <a href="http://www.accypn.org.au/downloads/competencies.pdf">http://www.accypn.org.au/downloads/competencies.pdf</a></td>
</tr>
</tbody>
</table>
2. **AIMS AND OBJECTIVES**

The aims and objectives of the Guidelines are:

2.1 To provide safe, effective and appropriate care for children and adolescents in acute care settings.

2.2 To concentrate those paediatric services requiring special facilities or skills in hospitals which can provide those services more effectively and efficiently, offering a network of support for hospitals in rural and remote areas.

2.3 To recognise the special requirements of children and adolescents in ambulatory services (such as emergency, x-ray and pathology), operating theatres and allied health services.

2.4 To recognise the special psychological needs of children and adolescents in hospital and encourage the carer\(^2\) to participate in the child’s care as appropriate, especially in the provision of emotional support during times of high stress.

3. **GUIDELINES**

3.1 **General**

3.1.1 A child or adolescent should only be hospitalised if clinically appropriate and necessary.

3.1.2 Community-based services, hospital in the home programs and other ambulatory care/outreach services, if available, should be used to assist in the care of children and adolescents at home.

Hospital admission should not be a strategy solely for providing supervised care placements for children and adolescents. Children and adolescents in the predicaments of homelessness or breakdown in care should only be admitted if there are specialist health assessment requirements or therapeutic goals that are best achieved by inpatient care.

3.1.3 The use of single rooms for children and adolescents, especially under the age of five years, should be considered with respect to clinical need, developmental stage and risk management strategies.

3.1.4 In cases of unplanned or emergency admissions to hospitals with paediatric medicine or surgery services delineated at levels 1 – 3, consultation with a specialist paediatrician should occur without delay if there is any degree of concern, especially in a situation where the child is not improving, as per NSW Health Policy ‘Management of Paediatric Inpatient Admission in Designated Level 1 – 3 Paediatric Medicine and

---

\(^2\) A carer refers to a parent, guardian or significant other caregiver.
Paediatric Surgery Services’. For a child whose condition is unstable, this consultation should occur immediately.

This enables a decision to transfer a child to a higher level facility, if clinically appropriate, to be set in place early. This decision will consider the child’s clinical condition, the degree of isolation, the medical and nursing expertise, the hospital’s delineated role and the advice of a specialist paediatrician.

Where children and adolescents require family respite care rather than clinical treatment, collaboration with NGOs, the Department of Ageing, Disability and Home Care or the Department of Community Services in more appropriate arrangements should be pursued.

A hospital admitting children and adolescents must have at least one registered nurse delivering care or directly supervising the nursing care of children and adolescents with skills consistent with the following3:

- is able to assess a child’s normal parameters, recognise the deviations from the normal and act appropriately on the findings.
- demonstrates a broad knowledge of growth and development.
- demonstrates an understanding of the effects of hospitalisation on the child and family.
- communicates effectively and works in partnership with children and adolescents and families.
- demonstrates knowledge of paediatric medical and surgical conditions and their management relevant to their casemix.
- is able to commence and maintain effective Basic Paediatric Resuscitation.
- is able to calculate and administer medications safely to children and adolescents.
- recognises and challenges management that compromises the child’s safety.
- utilises contact with the child and family to promote child health; ie. Immunisation, child safety.
- demonstrates an awareness and acts accordingly to the Children and Young Persons’ (Care and Protection) Act, 1998, NSW.

---

integrates the philosophy of Partnership in Care into their clinical practice.

demonstrates psychological assessment skills to identify children and adolescents at risk of harm.

3.1.5 The duration of a hospital stay, particularly for a young child, should be as brief as possible.

3.1.6 Day surgery and ambulatory clinics can play a valuable role in minimising the period of hospitalisation. Day of Surgery Admission (DoSA) should be the preferred mode of admission for planned surgical procedures, if clinically appropriate. These services should utilise preparatory material to assist the child in preparing for the surgery, such as online software, DVDs etc as per the NSW Health Policy 'Management of Paediatric Inpatient Admission in Designated Level 1 – 3 Paediatric Medicine and Paediatric Surgery Services'.

3.1.7 Availability of a range of primary health care, paediatric ambulatory care and other services, such as Hospital in the Home enables earlier discharge from hospital, as does the involvement of carers.

3.1.8 Adequate, relevant and timely information should be provided by hospital staff to carers and other significant family members.

3.1.9 Appropriate integration and coordination of hospital and community-based services will both improve the care for children and adolescents and decrease the need for hospital admission.

Coordinated case management of children and adolescents with chronic and complex conditions should be aimed at improving the care the child and carer(s) receive and reducing the need for hospitalisation.
3.2 Special Needs of Children and Adolescents in Acute Care Settings

3.2.1 Special needs of children, adolescents and their families, whether in-patients or outpatients, must be addressed to minimise physical and emotional distress. Special needs may include the use of Aboriginal liaison officers, interpreters for children, adolescents and their families from culturally and linguistically diverse backgrounds, addressing the needs of adolescents and children with developmental delay or other special family circumstances.

3.2.2 The special needs of the unaccompanied child should be recognised and provided for, including the provision of an alternative care giver (eg. the Hospital Ward Grandparent Scheme coordinated by the Association for the Wellbeing of Children in Healthcare where available).

3.2.3 The acuity of a sick child will determine the nursing care requirements and the observations required.

3.2.4 Emergency departments and outpatient departments of all hospitals treating children and adolescents:

   a. should ensure that the security and safety needs of children and adolescents are addressed

   b. should minimise waiting time for children and adolescents taking into account the guidelines stated in the National Triage Scale

   c. should ensure that processes for fast-tracking the care of children and adolescents are in place. This will include discussion with a paediatrician or a FACEM.

   d. require appropriate staffing levels for times of peak demand

   e. should ensure the skills and competence of staff who are treating children and adolescents

   f. should ideally have a separate children’s waiting areas with play equipment that can be easily observed from a staff base and at least provide appropriate recreational activities for children and adolescents

   g. must have a separate area equipped with paediatric-sized equipment to conduct procedures such as correct sized oximeter probes, blood pressure cuffs, scales and thermometers

   h. utilise NSW Health Paediatric Clinical Practice guidelines where clinically relevant.
i. should ensure that planning for major events is undertaken and considers the needs of children and adolescents, eg. major sporting events being held

j. should address infection control issues for paediatrics

k. should develop appropriate models of care for addressing the needs of children and adolescents, similar to the Aged care Services in Emergency Teams (ASETS) models.

l. design briefs for new or refurbished Emergency Departments should include the elements described above (3.2.4 f. and j.) with input from appropriately skilled medical and nursing personnel.

3.2.5 Hospitals admitting children and adolescents:

a. must not accommodate children and adolescents with adult patients. This means that adults and children and adolescents are not to be nursed in adjoining beds.

b. must have a child safety and security policy in place. Facilities should utilise the NSW Health policy on ‘Safety and security of children in NSW Acute Health Facilities’

c. should not separate children and adolescents from their carer(s) at the time of admission, especially in the emergency situation, unless clinically indicated or due to child protection/ parental inability to adhere to requests or aggression.

d. respect the privacy and dignity of children and adolescents at all times during their admission which involves the assumption that they do not have to sleep in the same room or ward bay as adult patients, or share bathroom or recreational facilities. Further, adult patients should not have to pass through children and adolescent units to reach their own facilities. Similarly, children and adolescents should not be asked to pass through an adult ward to access facilities. This is intended to protect children and adolescents from unwanted exposure, including casual overlooking or overhearing.

e. must consider the issue of gender specific accommodation. For many children and adolescents, clinical need, age and stage of development will usually take precedence. Many children and adolescents take comfort from sharing with others of their own age and this may outweigh any concerns about mixed gender accommodation.

f. may utilise a multi-purpose ward with the potential of changing function according to needs can be used to accommodate fluctuation in demand for paediatric beds. For example, “swing beds” can be positioned between two units (eg. Paediatric and medical), capable of being transferred from one unit to another and remain fully operational.
The main issue with multi-purpose wards is the provision of appropriately skilled nursing staff. Health services should have polices, guidelines and risk management strategies in place to ensure the safety of children and adolescents when admitted.

g. should allow access for carers at all times if clinically appropriate while the child is receiving care and during procedures while the child is conscious, as agreed between the carer and the health professional.

h. should provide facilities for at least one adult carer to stay at the bedside or in reasonable proximity, e.g., lounge chair, sofa bed or folding bed, and amenities including shower/toilet facilities and access to a kitchenette.

i. should regard the carer as an integral part of the multidisciplinary team and a primary care-giver, though not as a replacement for a health professional.

j. should have a flexible visiting policy with regard to hours and number of visitors, encouraging family members to visit when possible.

k. should aim to allocate consistent nursing services that promote continuity of care and includes shared care with the carer.

l. should have a daily hospital routine flexible enough to allow the child to engage in structured and spontaneous play activities at times as close as possible to their home routines.

m. should enable schooling to be continued using media such as books, the internet, video or appropriately qualified personnel where the child’s condition allows.

Children and adolescents with chronic health conditions should have an integrated approach to the delivery of their education needs in partnership with the NSW Department of Education. Level 4 – 6 facilities for children and adolescents should have generalist teachers available to deliver at least some of the school curriculum where this is achievable in the context of the child or adolescents health care plan.

n. will provide access to interpreters when necessary.

o. should provide access to the appropriate multicultural health worker/Aboriginal health worker when necessary.

p. should have a menu designed with appropriate input from a hospital dietitian taking into account the specific nutritional requirements of sick and growing children and adolescents as well as any ethnic/cultural food preferences/requirements of children and adolescents.
q. should notify and encourage carers to be present when a child is to be transferred between wards or hospitals.

r. should develop pathways to appropriate community and sub-speciality services, and transfer to appropriate local services for ongoing care when clinically indicated.

s. should fully inform carers at discharge about the diagnosis, medication and future management of the child. A summary of the child’s hospitalisation should be provided to the carer(s), general practitioner and/or specialist medical officer.

t. should provide for the special needs of the dying child and his/her family.

u. should have a policy on and guidelines for transition to adult care which:

- requires that, at least by the age of 16, an individual plan to appropriate adult services is prepared. This plan may link to regional/remote services and must include communication pathways

- identifies that from 16 – 18 years is the ’active transition phase’

- recognises the importance of family centred care while assisting the young person to establish independence

- considers the developmental issues of the young person

- describes resources to support the child, family and health professionals with the transition and considers the availability of services especially multidisciplinary services

- describes the methods for clinical handover

- identifies the age range of 18 years or after a child has completed high school as when the transition should be completed

3.2.6 A hospital routinely admitting children and adolescents for elective procedures should, in addition to the above:

a. consider the design of the accommodation for children and adolescents to ensure it meets safety and risk management requirements. This may include having separate accommodation areas for adults and children and adolescents. If a separate area is not available, staff should consider scheduling children and adolescents having elective surgery at a time which is different to procedures being performed on adults.

4 NSW Health: Transition Care - Helping young people move successfully from child to adult health services. Available at: http://www.health.nsw.gov.au/gmct/transition/
b. provide carers and, where appropriate, the child with adequate information about the admission.

c. offer pre-procedure preparation, eg. pre-admission visits, videotape, DVD, or pamphlets providing information about the intended procedures appropriate to the child’s age, development and understanding.

d. have trained salaried play specialists and/or voluntary play specialists and/or appropriate resources.

e. has at least one registered nurse delivering care or directly supervising the nursing care of children and adolescents with skills consistent with a competent paediatric nurse3.

3.2.7 A hospital with an Area role in providing paediatric support to other units should, in addition to the above:

a. have at least one paediatric Clinical Nurse Consultant.

3.2.8 A designated children and adolescents’ area or ward should:

a. address special safety and security aspects for accommodating children and adolescents.

b. be easily observed and supervised at all times (preferably through staff attendance at the child’s bedside or treatment area)

c. have treatment areas that:

- are functionally separate and minimise access to distressing sights and sounds which are not appropriate to their age or stage of development
- include a separate area for conducting painful procedures.

d. provide play facilities in and out of the ward, including outdoor areas.

e. have appropriate decorations, furniture, equipment and ample light.

f. provide communication access for the child if age appropriate eg telephone or computer access.

3.2.9 A designated adolescent area or ward should have:

a. consulting and examination areas which enable privacy and confidentiality.

b. suitable recreation facilities.

c. educational access.

d. skilled nurses with developmental and psychosocial expertise.

e. multidisciplinary team support

f. age appropriate rest and meal times.
3.3 Children and Adolescents Requiring Surgery

3.3.1 Paediatric surgery should be provided by surgeon(s) and anaesthetists with experience and/or qualifications in the relevant fields of paediatric surgery as determined by the hospital’s credentialling process. The surgeon(s) and anaesthetists should be involved in appropriate continuing education activities relevant to their clinical paediatric practice.

3.3.2 Surgery for children under the age of one month should be carried out in a hospital with delineated role of level 5 or above for paediatric surgery and for children over the age of one month but under the age of 12 months should be carried out in a hospital with delineated role of level for paediatric surgery service of 4 or above by medical staff with appropriate paediatric experience and/or qualifications as determined by the hospital’s credentialling process; and at least one registered nurse with skills consistent with a competent paediatric nurse delivering care or directly supervising the nursing care of children.

Hospital staff need to consider, and as appropriate arrange for, the follow-up care required for the child or adolescent to receive after discharge, such as allied health and community nursing, to enable safe discharge home.

3.3.3 The advice of a paediatrician or paediatric surgeon should be readily available. There should be a medical officer available within 10 minutes. For any surgical procedure in this age group, adequate monitoring by both medical and nursing staff is essential to prevent complications of either surgery or anaesthesia intra and post-operatively.

3.3.4 There should be arrangements for separation of adult and child patients both in operating theatres and recovery ward (e.g. through use of screens).

3.3.5 There should be adequate paediatric medical and surgical equipment in the operating room including:

a. appropriate heating facilities in the operating room. An overhead heater and humidicrib for the younger infants

b. a separate instrument tray for children and adolescents (assembled with advice from a surgeon with appropriate experience and/or qualifications in paediatric surgery)

c. mobile x-ray facilities should be available.

d. a defibrillator with adaptors for paediatric use

e. suitable anaesthetic equipment for special paediatric use

f. paediatric resuscitation equipment

g. adequate adaptors for all other surgical and recovery equipment needed to perform paediatric surgery and permit safe recovery

3.3.6 Anaesthesia and related post-operative treatment including pain management should be provided by an anaesthetist with appropriate experience and/or qualifications in paediatric anaesthesia, as determined by the hospital’s credentialling process; unless a life threatening emergency makes this impossible.

3.3.7 Hospitals in which surgery is performed on children and adolescents should have ready access to appropriate radiology and pathology services.

3.3.8 Carers should be able to accompany their child to the operating theatre and have access to the recovery room. In addition, when agreed between anaesthetist and carer, the choice is offered to the carer to be with the child at the induction of the child’s anaesthetic, unless medically not indicated.

3.3.9 All hospitals admitting children and adolescents should provide a comprehensive range of resuscitation equipment and inhalation therapy equipment suitable for children and adolescents. Local policy should be developed regarding the specific equipment and staff training in its use. Guidelines from the Australian and New Zealand College of Anaesthetists can assist with development of local policy.

3.3.10 Paediatric infusion sets with an inline burette must be used for all children requiring intravenous therapy. An infusion pump should be used for all children.

3.3.11 All intravenous fluids should be administered from containers of 500mls or less.

3.3.12 All facilities undertaking surgery should have contingency arrangements for the transfer of a child to a specialised paediatric unit (level 5 or 6) in case of an emergency.

3.3.13 When clinically appropriate children admitted under the care of non paediatric surgeons should be assessed by a paediatrician (to assess for non-surgical-related general paediatric condition/s).
3.4 Mental Health

3.4.1 The great majority of children and young people with mental health problems who receive treatment do so in a community setting. Child and adolescent mental health services (CAMHS) must be strongly integrated across community and hospital settings.

3.4.2 Day programs
Day programs are a means of providing more intensive treatments in a community-based setting.

This level of care can provide a “step-up or step-down” approach between usual community programs and inpatient care or can be a less restrictive option to inpatient care in some circumstances. For some young people, day programs may obviate the need for more restrictive inpatient care. For some, they may afford “step-down” rehabilitation following acute inpatient care.

Like all other CAMHS, day programs need to be family-focussed.

Planning for day programs also requires collaboration with the Department of Education and Training to provide educational and vocational options and access to specialist education expertise.

3.4.3 Inpatient care
It is imperative to provide mental health treatment in the least restrictive setting, close to home wherever possible, with minimal disruption to the patient’s family, community supports, networks and relationships.

While acknowledging the three geographical network arrangements for paediatric services, with their hubs at the three paediatric hospitals (Sydney Children’s, John Hunter Children’s and The Children’s Hospital at Westmead), CAMHS inpatient unit role delineation is a separate process.

3.4.4 Telepsychiatry and outreach
Telepsychiatry can be a useful tool and is encouraged to improve continuity of care across services especially in planning transitions to and from inpatient care and to provide specialist consultation and support.

3.4.5 Consultation-liaison to non-specialist settings
When young people are admitted for mental health assessment and treatment to a setting other than a specialist child and adolescent mental health inpatient unit, there should be liaison with the supporting CAMHS. The clinical arrangements will vary according to local staffing profiles. Where child and adolescent psychiatrists are available in an Area, children or adolescents could be admitted under their care. In many sites, this arrangement is not feasible and it is more appropriate for patients to be admitted under the care of paediatricians or general (adult) psychiatrists with identified CAMHS consultation.
• The “Whatever Info Guide” has been developed for children and adolescents who are experiencing a mental health problem and have been admitted to a paediatric unit or other inpatient setting. It is an interactive guide to support the young person by providing them with important information about the ward, what to expect while they are in hospital, and to assist them in planning for their discharge. The guide has been distributed for use in paediatric, mental health and general inpatient settings around NSW.

In addition to support for children and adolescents whose primary presentations are mental health problems, Areas need to provide other forms of consultation-liaison mental health support for high-risk groups, including advice for those caring for children and adolescents with:

• comorbid mental health and physical health problems;
• comorbid mental health problems and problems related to alcohol and other drugs;
• mental health problems complicating their physical health care;
• chronic or severe physical health problems, especially neurological disorders;
• psychosomatic presentations.

3.4.6 “Specialling” or 1:1 nursing care
The fact that a child requires 1:1 nursing care (sometimes known as “nurse specialling”) for a period is not automatically an indication that the child needs to be transferred to a specialist mental health unit.

In specialist child and adolescent mental health inpatient units, where specialling can lead to an escalation of high-risk behaviour amongst other young patients, the emphasis is on high staffing levels for the whole unit, to minimise escalating risk behaviour and decrease the need for specialling.

Nurses providing specialling should be appropriately qualified.

3.4.7 Non-Mental Health wards in paediatric hospitals
The range of specialist staff available in paediatric hospitals means that these settings are the most appropriate for some children and adolescents with severe and complex problems or physical presentations requiring investigation and/or treatment. This care option complements the more intensive multi-component mental health interventions that can be provided in declared specialist acute child and adolescent mental health units in paediatric and other hospitals.

As an example, The Children’s Hospital at Westmead provides specialist inpatient treatment for a number of young patients with eating disorders in their Adolescent Medical Ward rather than the specialist acute mental health unit on Hall Ward. The service model is an integrated shared care program between Adolescent Medicine and the Department of Psychological Medicine.
3.4.8 **Specialist Acute CAMHS Inpatient Units**

Specialist child and adolescent mental health inpatient services are subspecialty programs, providing more intensive multidisciplinary assessment and treatment. The combinations of effective treatments required in these settings necessitate a higher level of staffing than for adult units, both in absolute numbers and in level of expertise.

Higher staffing levels create flexibility to tailor treatment and observation for patients and allow a mix of children and adolescents with a more diverse range of problems and requirements. This flexibility can minimise the need to transfer some patients to other treatment settings including the potential to decrease some transfers and admissions to adult units.

<table>
<thead>
<tr>
<th>Specialist inpatient units for children and adolescents have different requirements from those focussed on the care of adults. Factors impacting on physical layout, staffing levels and skills, treatment components and length of stay include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility and physicality of patients;</td>
</tr>
<tr>
<td>Peer relationships and group dynamics;</td>
</tr>
<tr>
<td>Developmental stage and ability including cognitive ability;</td>
</tr>
<tr>
<td>Dependence, supervision and staff responsibility;</td>
</tr>
<tr>
<td>Working relationships between the patient and staff and the family and staff;</td>
</tr>
<tr>
<td>Child protection issues and interagency care coordination;</td>
</tr>
<tr>
<td>Sexuality;</td>
</tr>
<tr>
<td>Family relationships, separation and visiting;</td>
</tr>
<tr>
<td>Education requirements;</td>
</tr>
<tr>
<td>Lack of symptom specificity/undifferentiated problems;</td>
</tr>
<tr>
<td>Co-morbidity;</td>
</tr>
<tr>
<td>Availability of post-discharge accommodation, supervision and treatment options.</td>
</tr>
</tbody>
</table>

**All specialist CAMHS inpatient units should be integrated with special education services.**

Inpatients in specialist units require access to a range of therapeutic interventions including group, family and individual assessments and treatment and tailored special education support. Exposure to appropriate expectations, social interactions and care by staff also provides modelling for young people and their families.

CAMHS teams should have the capacity to address co-morbidities and use interventions informed by available evidence. Interventions may include group, individual, family, pharmacological and systems interventions, separately, in combination or in sequence. Provision of the full range of interventions requires multidisciplinary expertise from a range of professions including:

- psychologists;
- nurses from relevant subspecialties;
- social workers;
Guidelines for the Care of Children and Adolescents in Acute Care Settings

- community/cultural mental health workers;
- psychiatrists;
- trainees in these disciplines; and
- access to expertise in occupational therapy, dietetics, physiotherapy, speech therapy, health promotion, drug and alcohol, paediatrics, general practice and other related specialties.

In addition to the above staffing profile, CAMHS inpatient units also require access to expertise from pharmacists, paediatric consultation-liaison and other subspecialties to provide comprehensive assessment and treatment for children and adolescents with more severe and complex problems.

There should be clear arrangements for specialist paediatric consultations, where required.

Conduct disorders, substance misuse and homelessness in childhood and adolescence are not absolute contraindications for inpatient care however the aims of hospitalisation should be clearly defined when admission is being considered. There is little evidence to suggest that treatments delivered during inpatient care are effective for children and adolescents with uncomplicated disruptive behaviour disorders however admission may be required to clarify diagnoses and to treat comorbid problems.

3.4.9 Children’s Units
The separation of children and adolescents receiving mental health inpatient care has been considered. The demand for mental health assessment and/or treatment for younger children (under 12 years) in an inpatient setting is less than for adolescents. The number of beds required statewide for this age-group is relatively small, however these children are likely to have more severe and complex problems and high needs.

For most children under 12 who require individual admission, care in a paediatric ward is indicated, with access to mental health consultation-liaison support to the treating paediatric team. The few who require more specialised inpatient mental health care than that available on a paediatric ward are likely to be best treated in a combined child and adolescent mental health unit.

Family/carer contact is an especially important requirement for the younger age-group.
3.5 NSW Child Health Networks

3.5.1 Acute care facilities providing services to children and adolescents should have established networks which focus on improving the quality of care to children and adolescents.\(^5\)

3.5.2 The network should promote an integrated model of service delivery through the development of integrated service networks and common protocols.

3.5.3 Networks have been established to support local services through the provision of specialist clinical outreach services, development of shared treatment protocols and guidelines, staff rotation between services, professional training and development opportunities, support in times of peak demand and smoother transfer and referral of patients between services.

3.5.4 Networks should provide a mechanism to ensure the involvement of consumers, local clinicians, nurses, allied health and other children and adolescents’ service providers in service planning.

3.5.5 The networks should also assist in the provision of services across the continuum of care, including developing links between hospitals and must include GPs, private paediatricians and allied health service providers, community health and primary care services, early childhood services and other agencies with a responsibility for children and adolescents’ health and welfare.

3.5.6 The Child Health Networks’ have a pivotal role in developing and piloting innovative models of care to ensure care provided as close to home as possible and/or to avoid admission to hospital at all where clinically safe to do so.

\(^5\) NSW Health, Guidelines for Networking of Paediatric Services in NSW, 2002
3.6 Education For Health Professionals

3.6.1 Those involved in the care of children and adolescents should have special training to recognise and meet the special health, psychological and developmental needs of children and adolescents, and include training on recognition of the sick and deteriorating child.

3.6.2 Policies and procedures should be in writing and easily accessible by staff that are trained in their use.

3.6.3 Hospitals with an Area role in providing paediatric support and networking to other units should provide education and support for clinical activities for other facilities within the network.

3.6.4 Relevant and ongoing staff development programs should be:
   a. child-oriented rather than task-oriented;
   b. promote family-centred care and partnership in care; and
   c. include initiatives to address the needs of carers as they become more involved with the child’s care in hospital.

3.6.5 All staff involved in the care of children should undertake cultural respect training to ensure that mainstream services are accessible and culturally secure and to increase the capacity of mainstream services to engage with Aboriginal children.
3.7 Evaluation

3.7.1 Continuing evaluation by the hospital of policies, programs for and outcomes of the care of children and adolescents is essential. This should:
   a. involve staff at all levels and disciplines,
   b. include the recipients of care, and
   c. involve the community in general.

3.7.2 Elements of the evaluation should address the six dimensions of quality care outlined in the NSW Health document: *A Framework for Managing the Quality of Health Services in NSW*:
   - Safety
   - Consumer participation
   - Effectiveness
   - Access
   - Appropriateness
   - Efficiency.

3.7.3 Evaluation activities may include:
   a. measurement of outcomes of care and service
   b. peer review and morbidity and mortality meetings
   c. patient and carer satisfaction
   d. facilitated incident monitoring
   e. sentinel event management
   f. the effective use of clinical indicators
   g. ad hoc audits/reviews
   h. retrospective chart review.
4. APPENDICES

4.1 Acknowledgments

The NSW Department of Health extends its appreciation to the members of the Paediatric Inpatient Advisory Working Group and the Paediatric Inpatient Advisory Working Group Subcommittee for their input, advice and assistance in production of this document.
4.2 Paediatric Medicine and Paediatric Surgery sections of the Guide to the Role Delineation of Health Services

### 39 PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UPE</td>
</tr>
<tr>
<td>1</td>
<td>An unplanned inpatient paediatric medical service or designated bed. Provides primary and emergency care; and stabilisation for children prior to moving to appropriate higher level of service. Quality assurance activities(^2). Interpreters as per Circular 04/10.</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Designated paediatric inpatient in a general hospital in an outlying and geographically isolated area. May have isolation capacity. Accredited Medical Practitioner(^{11}) on call. Formal consultative links with Paediatrician. Would be used for only minor medical conditions or convalescence following referral from a higher level unit. RNs(^{11}) with skills consistent with a competent Paediatric Nurse(^{11}). Continuing nursing educational programs available. Able to provide accommodation for parents or carers.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>As Level 2, plus designated paediatric ward area with patient amenities. Has isolation capacity in separate rooms. Provides care for common medical conditions. NUM(^{11}) with post basic clinical qualifications or access to CNC(^{11}) within the Area and RNs(^{11}) with skills consistent with a competent Paediatric Nurse(^{11}). Some RNs(^{11}) undertaking relevant postgraduate study. Has 24-hour access to Medical Officer(^{11}) on site or available within 10 minutes. Access to allied health professionals. Formal link to community child and family health service. Formal quality assurance program(^{11}).</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>As Level 3, plus Designated Director of Paediatric Medical Services, plus provides integrated hospital inpatient, non-inpatient family and child health services, and community health services for most paediatric medical conditions. Designated ancillary area. Specialist Paediatrician on call 24 hours. Paediatric support offered to other units within the Area. Designated Medical Officer(^{11}). May have Paediatric Registrar(^{11}), NUM(^{11}) for access to CNC within the Area. Access to Audiology services. Allied health professionals on site.</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>As Level 4, plus Specialised Paediatric Inpatient Unit. May have some paediatric subspecialty skills. Designated adolescent unit. Has Paediatric Registrar(^{11}) on site 24 hours. Active program of undergraduate and postgraduate teaching and research coordinated with a Level 6 service. Access to CNC(^{11}) is available. Monitored allied health professionals on staff, including recreational therapy. School teacher available.</td>
<td>5</td>
</tr>
</tbody>
</table>
### PAEDIATRIC MEDICINE

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>As Level 5, plus most paediatric medical and surgical sub-specialties available. Designated Adolescent Ward. Clinical and diagnostic services provided by appropriately trained Paediatric Specialists. Provides some statewide services. Subspecialty consultant on call 24 hours. Has designated Subspecialty Registrar. Provides 24 hour Child Protection Services with consultant Paediatrician and Social Worker. School service for inpatients provided by Department of Education. Has research and specialist paediatric teaching role.</td>
<td></td>
<td>Path: 6 6 6 6 4 5 2</td>
</tr>
</tbody>
</table>
### 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No planned inpatient paediatric surgical service. Provides primary and emergency care, and stabilisation of children prior to moving to appropriate higher level of service. Quality assurance activities. Interpreters as per Circular 94/10.</td>
</tr>
<tr>
<td>2</td>
<td>Except in emergencies, children under the age of one year should not be admitted. Minor elective and selected moderate surgical procedures on ASA category 1 and 2 children performed by General Surgeons or Accredited Medical Practitioners credentialled in paediatric surgery, and Specialist Anaesthetists or Medical Practitioners credentialled in anaesthesia with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process involving the relevant College. Appropriately trained, anaesthetic and resuscitation equipment available. Has 24 hour access to Medical Officers on site or available within 30 minutes. RNs with skills consistent with a competent Paediatric Nurse caring for the child. Continuing nursing educational programs available specific to the needs of the service. Formal consultative links with Paediatricians and Paediatric Surgeons. Amenities for parents or carers. Operating suite and recovery room provide for the special needs of children and carers. Formal quality assurance program.</td>
</tr>
<tr>
<td>3</td>
<td>Except in emergencies, children under the age of one month should not be admitted. Designated children's ward with parent amenities. Moderate and selected major surgical procedures on ASA categories 1 and 2 children performed by Surgeons credentialled in paediatric surgery, and Specialist Anaesthetists with appropriate paediatric anaesthetic experience and/or qualifications as determined by the credentialling process. Medical Officer on site 24 hours. Consultation available from specialist paediatrician. Facility to isolate in single room. Has NUMs and RNs with skills consistent with a competent Paediatric Nurse. Some RNs undertaking minimum pre-service studies. Has access to allied health professionals. May have a role in providing paediatric support to other units within the Area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Path</td>
</tr>
<tr>
<td>Pread</td>
</tr>
<tr>
<td>Pread</td>
</tr>
<tr>
<td>ICU</td>
</tr>
<tr>
<td>A stable care unit</td>
</tr>
<tr>
<td>Operating theatre</td>
</tr>
</tbody>
</table>

Issue date: June 2010
### 40 PAEDIATRIC SURGERY

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Minimum Level Of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>As Level 4 plus specialised paediatric inpatient unit with nominated Director of Paediatric Surgical Services. Provides most major diagnostic and treatment procedures on ASA categories 1 to 6 children excluding complex major6 paediatric surgery on rare complex congenital malformations (frequency of less than one in 2,600 births). Specialist Surgeons (paediatric), General Surgeons, paediatric in-patient, and Specialist Anaesthetists (paediatric) on call 24 hours. Participate in undergraduate and postgraduate teaching. Paediatric support offered to other units within the Area. Training positions for Paediatric Nurses. Paediatric Registrars on call 24 hours. Surgical Registrars on call 24 hours. Access to CNS staff is desirable. May have teaching and research role. Fostered allied health professionals, including recreational therapists and educational services.</td>
<td>Path</td>
</tr>
<tr>
<td>6</td>
<td>As Level 5 plus has subspecialty units in most areas of Paediatric Surgery (eg. may have paediatric neurosurgery, cardiac surgery). Provides a statewide service. Active program of undergraduate and postgraduate teaching, research and development. Paediatricians and Specialist Surgeons (paediatric) with subspecialty interest on call 24 hours. Designated Paediatric Surgical Registrars in subspecialty units. Has research and specialist paediatrics teaching role.</td>
<td>Path</td>
</tr>
</tbody>
</table>

1. See "Indicative List of Paediatric Surgical Procedures" in Appendix III
2. See "Indicative List of Anaesthetic Risk - Children" in Appendix II
3. See "Medical and Nursing Staff Definitions" in Appendix I
4. See "Glossary" in Appendix V
5. See "Other" index in Appendix V

---

PD2010_034  Issue date: June 2010  Page 26 of 32
PART 4
APPENDIX I
MEDICAL AND NURSING STAFF DEFINITIONS

MEDICAL OFFICER
Medical officers are registered medical practitioners employed/contracted by hospitals. They are usually responsible to the medical superintendent, 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 senior medical officer, a full-time or part-time resident medical officer, a general practitioner, etc.

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 training 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.

ACCREDITED MEDICAL PRACTITIONER
Is a general practitioner appointed in a hospital and to whom specific clinical privileges have been granted (e.g., in surgery, anaesthetics, obstetrics, endoscopy, etc.). Following review of his/her training and continuing skills, by the hospital's credential committee. The committee will have given regard to medical practitioners documented post-graduate training and the volume, and type of past and recent clinical practice considered to be essential for the maintenance of skills in requested privileges. In the case of infrequently performed procedures, skills maintenance should be through exchange release programs at base hospitals or level 4, 5, or 6 of appropriate service. In addition there should be a demonstrated level of special skills, a commitment to continuing education, and a continual assessment of the ready availability of specialist medical practitioners in the sphere of practice in which privileges are requested.

SPECIALIST ANAESTHETIST
Is a medical practitioner whose training has been acknowledged by the award of Fellowship in the Australian and New Zealand College of Anaesthetists (ANZCA) or one who holds an equivalent postgraduate qualification accepted by the College.

ACCREDITED SPECIALIST ANAESTHETIST
Is a specialist anaesthetist as defined and who, as a result of additional training and acquisition of skills, has been granted additional clinical privileges by hospital's credential committee beyond the usually accepted parameters of specialist anaesthetic practice.

GENERAL PHYSICIAN
Is a registered medical practitioner whose training has been acknowledged by the award of the accolade of Fellowship in the Royal Australasian College of Physicians or one who holds an equivalent postgraduate qualification accepted by the College.

SPECIALIST GENERAL PHYSICIAN WITH SUB SPECIALTY INTEREST
Is a specialist general physician as defined who, as a result of further training and acquisition of skills, has been granted privileges by the hospital's credential committee in areas of medical practice usually considered to be sub-specialties outside the accepted field of general medicine.
MEDICAL AND NURSING STAFF DEFINITIONS

ENROLLED NURSE means a person enrolled by the New South Wales Nurses' Registration Board.

REGISTERED NURSE means a person registered by the New South Wales Nurses' Registration Board.

AN EXPERIENCED REGISTERED NURSE is a registered nurse with at least two years' post basic registration experience including one year's 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 inservice course specific to the needs of the service.

NURSING 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. Preferably will have completed in service management course as minimum. May be attaining a management qualification.

CLINICAL NURSE SPECIALIST

In hospitals of 250 A.D.A. and above and in country base hospitals the definition of a clinical nurse specialist is:

A registered nurse with a minimum of two years post basic registration experience including one year experience in the relevant specialist field together with an approved formal post basic qualification in that field,

or

A minimum of four years post basic registration experience including three years experience in the relevant specialist field.

In other hospitals the definition is:

A registered nurse with a minimum of two years post basic experience including one year experience in the relevant specialist field together with an approved formal post basic qualification in that field.

CLINICAL NURSE CONSULTANT is a position approved by the Department of Health and must be filled by a registered nurse who has had at least five years post basic registration experience and who has in addition approved post basic qualifications relevant to the field in which such appointment is made, or such other qualifications or experience deemed appropriate by the Department.
Continued

MEDICAL AND NURSING STAFF DEFINITIONS

A COMPETENT PAEDIATRIC NURSE:

- is able to assess a child's normal parameters, recognise the deviations from the normal and act appropriately on the findings.
- demonstrates a broad knowledge of growth and development.
- demonstrates an understanding of the effects of hospitalisation on the child and family.
- communicates effectively and works in partnership with children and families.
- demonstrates knowledge of medical and surgical conditions and their management relevant to their casemix.
- is able to commence and maintain effective Basic Paediatric Resuscitation.
- is able to calculate and administer medications safely.
- recognises and challenges management that compromises the child's safety.
- utilises contact with the child and family to promote child health, i.e. immunisation, child safety.
- demonstrates an awareness and acts accordingly to the Children's (Care and Protection) Act 1987, NSW.
- integrates the philosophy of Partnership in Care into their clinical practice.

Adopted by the Australian Confederation of Paediatric & Child Health Nurses (NSW Branch) Executive Committee, 7 November 1994 and revised February 1998.
Levels of Risk – Children  
The ASA Physical Status Classification

<table>
<thead>
<tr>
<th>ASA</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA 1</td>
<td>Healthy Child</td>
</tr>
<tr>
<td>ASA 2</td>
<td>Child with mild systemic disease – no functional limitation</td>
</tr>
<tr>
<td>ASA 3</td>
<td>Child with severe systemic disease – definite functional limitation</td>
</tr>
<tr>
<td>ASA 4</td>
<td>Child with severe systemic disease – that is a constant threat to life</td>
</tr>
<tr>
<td>ASA 5</td>
<td>Moribund child not expected to survive 24 hours with or without an operation</td>
</tr>
</tbody>
</table>

From the ‘Guide to Role Delineation of Health Services’
4.3  Resource Documents

1. Australian and New Zealand College of Anaesthetists: Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice - 2008
   Available at: http://www.anzca.edu.au/resources/professional-documents/technical/t3.html

   Available at: http://www.anzca.edu.au/resources/professional-documents/technical/t1.html

   Available at: http://www.anzca.edu.au/resources/professional-documents/professional-standards/pdfs/PS29.PDF

4. Australian Confederation of Paediatric and Child Health Nurses, 2006, Competencies for the Specialist Paediatric and Child Health Nurses

5. Guidelines for Networking of Paediatric Services in NSW

6. NHS Scotland, Better Health, Better Care – Hospital Services for Young People in Scotland, 2009
   Available at: http://www.scotland.gov.uk/Publications/2009/05/07130749/10


10. NSW Health, Children and Young People’s Health Priority Taskforce, September 2008, Framework for Policy and Planning of Services for Children and Young People in New South Wales
    Available at: NSW Health, Statewide Services Development Branch
11. NSW Health, NSW Surgical Services Taskforce Paediatric Surgery Sub Group, 2008, *Paediatric Surgery Model for Designated Paediatric Surgical Sites*

12. NSW Health: Transition Care - Helping young people move successfully from child to adult health services


14. RACP Standards for the Care of Children and Adolescents in Health Services
   Available at: http://www.racp.edu.au/index.cfm?objectid=94150BA4-ACD1-3AA9-A6711B196ABAB1A2

15. Resuscitation Council (UK), Suggested Equipment for the management of Paediatric Cardiopulmonary Arrest (0 - 16 years) (excluding resuscitation at birth)
   Available at: http://www.resus.org.uk/pages/PCAequip.htm

   Available at: http://www.unhchr.ch/html/menu3/b/k2crc.htm