ACT Government | Canberra Health Services

Model of Service

Intensive Care Unit

Division of Surgery

June 2023

Contents

Approvals

Position	Name	Signature	Date
Executive Director, Division of Surgery	Lisa Gilmore		

Document version history

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2.0	19 May 2023	Leanne Done, Senior Change Specialist	ICU Operational Readiness User Group (ORUG)	Draft review and feedback
2.2	31 May 2023	Leanne Done, Senior Change Specialist	Lisa Gilmore, Executive Director Surgery	Approval to proceed to consultation

1. Introduction

This Model of Service (MoS) for the Intensive Care Unit (ICU) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location across the continuum of care. A clearly defined and articulated MoS helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

This MoS:

- outlines the principles, benefits and challenges of each ICU Model of Care
- provides the basis for how we deliver evidence-based care.
- contains information of patient/client flows (the areas from where patients enter and exit the service) and service co-ordination.

2. Principle

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words - they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on the promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community.

Our values:

- We are reliable - we always do what we say we'll do.
- We are progressive - we embrace innovation.
- We are respectful - we value everyone.
- We are kind - we make everyone feel welcome and safe.

Our **Strategic Plan** sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our **Partnering with Consumers Framework** provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our

organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

In addition to the organisation values, this Model of Service is founded on the following service principles. They will guide our work and how we deliver services for patients/clients and families accessing care in the Intensive Care Unit.

Our service principles:

Stream Models of Care - The ICU Models of Care are underpinned by delivery streamlined patient pathways that enable seamless, outstanding care to critically ill patients and their families.

Shared Organisational Goals - The organisation has shared goals achieved by a multidisciplinary team approach to holistic patient care including development of shared-care goals with the patient and their carers.

Access to treatment - The ICU operates 24 hours a day, 365 days a year.

Education and Training - The ICU has a strong focus on education, training and research programs through structured positions and portfolios.

Clinical Leadership and Expertise - The ICU Leadership team support clinicians through effective communication, clinical expertise, role modeling and commitment to excellence.

Evidence informed best practice and continuous quality evaluation - Highly specialised medical, nursing and allied health staff work collaboratively with referring clinicians to adopt evidenced based care for each patient. The ICU will use data, evidence, research and consumer feedback to inform best practice and quality evaluation.

3. Description of Service

Canberra Hospital is a Level 6 tertiary referral hospital and has been the major trauma centre for the Australian Capital Territory (ACT) since 2000. Due to its geographical location, the Canberra Hospital ICU is integral in the management of critically ill or injured patients in surrounding areas of New South Wales (NSW).

The ICU is a separate and self-contained area of CHS, dedicated to the management and monitoring of patients with life-threatening illnesses, injuries and complications.

It provides specialised facilities for the support of vital organ function through the skills of medical, nursing, allied health experienced in complex clinical management.

The Canberra Hospital ICU staff provide clinical support services outside of the ICU, through the Medical Emergency Team (MET), Trauma team response and the Tracheostomy Assessment and Consultation Service (TrACS) follow up team.

Canberra Hospital's tertiary intensive care services align with the College of Intensive Care Medicine (CICM), however the ability to support some specialised conditions are limited by the hospital's subspecialty provision. Quaternary Hospitals in NSW provide ACT residents with access to highly specialised interventions and management. These include:

- NSW State-wide Burn Injury Services at Royal North Shore Hospital and Concord Repatriation Hospital
- NSW Spinal Cord Injury Services at Royal North Shore Hospital and Prince of Wales Hospital
- NSW Paediatric Network at Sydney Children's Hospital, Randwick and the Children's Hospital, Westmead
- NSW Extracorporeal membrane oxygenation (ECMO) Retrieval Service at Royal Prince Alfred Hospital and St Vincent's Hospital, Sydney.

In all circumstances, the Canberra Hospital ICU provides initial resuscitation and stabilisation before patients are transferred.

Time Critical Conditions

As the tertiary referral centre for Southern NSW, NSW patients with time critical conditions may be transferred to Canberra Hospital irrespective of ICU capacity. Examples of time critical conditions include, but are not limited to, severe injury, acute gastrointestinal haemorrhage, and neurosurgical emergencies, such as cerebral aneurysm.

Emergency medical and surgical intervention will be provided by appropriate subspeciality clinical teams, and all attempts will be made to accommodate the patient in ICU. In some instances, the patient may require onward transfer to another facility following emergency procedures.

4. Models of Care and Patient Journey

The Intensive Care Unit Models of Care provide a clear understanding of how care is provided across the ICU patient journey.

The decision to admit a patient to ICU is the responsibility of the Referral ICU Specialist or their delegate and is based on both medical suitability and available resources (see Figure 1).

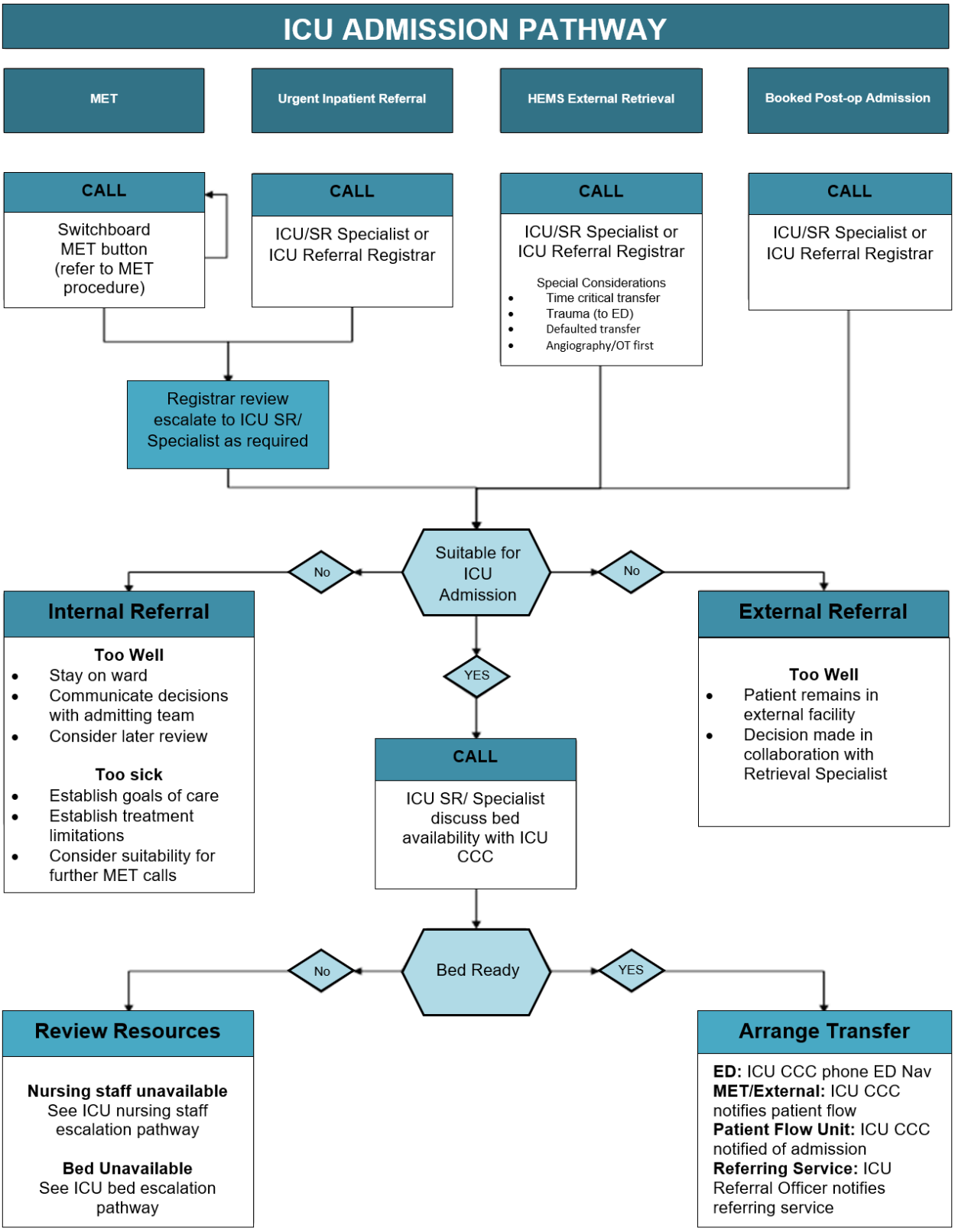
It is the responsibility of the Clinical Care Coordinator (CCC) to inform the Patient Flow Manager of all admissions and their classification. The CCC is the central point of communication for ICU admissions, transfers and discharges from ICU.

The ICU Models of Care are provided in accordance with the Australian College of Critical Care Nurse (ACCCN) Guidelines, the College of Intensive Care Medicine (CICM) Guidelines and the Australian and New Zealand Intensive Care Society (ANZICS).

The Models of Care included in the Intensive Care Unit Model of Service include:

- Intensive Care
- High Dependency
- Paediatrics
- Referral Team

Figure 1. ICU Admission Pathway



4.1 Intensive Care

Model of Care Principles	
Description	Patients admitted for intensive care require high level intervention for multi-organ support for an indefinite period. Patients under this classification have coordinated multidisciplinary care and a minimum of a 1:1 nurse to patient ratio in accordance with the ACCCN and CICM. Intensive care is considered for patients that require: • Invasive ventilation. • Non-invasive ventilation (NIV). • Post-operative Cardiothoracic care. • Complex cardiac and haemodynamic support. • Intra-aortic Balloon Pumps (IABP). • Continuous Renal Replacement Therapy (CRRT). • Invasive neurological monitoring. There are occasionally patients who are extremely complex and are classified as requiring high acuity intensive care. High acuity intensive care patients may require a 2:1 nurse to patient ratio due to multiple organ-supporting treatments (e.g. Extracorporeal Membrane Oxygenation (ECMO), and combined IABP and CRRT).
Principles	• Minimum care provision of 1 nurse to 1 patient in accordance with ACCCN. • Clinical guidelines/protocols to enhance decision making in management of intensive care patients.
Benefits	• Critically unwell and injured patients are cared for by specially trained medical, nursing and allied health staff. • Ability to provide continuous cardiac, neurological and respiratory monitoring and support. • Ability to respond to sudden changes in clinical condition.
Performance Indicators	• Consumer and staff feedback. • Adverse events. • Length of stay.

4.2 High Dependency

Model of Care Principles	
Description	High dependency patients are clinically determined as lower acuity, provided with a level of care intermediate between intensive care and general ward management. Patients under the high dependency classification are cared for using a 1:2 nurse to patient ratio. To assist in determining patients that require 1:2 nursing, the following is considered: • single-organ failure support. • continuous cardiac monitoring and close observation for deterioration. • low dose inotropic support. • non-ventilated tracheostomy tube. • routine post-operative patients requiring close observation.
Principles	• Provision of care is 1 nurse to 2 patients in accordance with ACCCN and CICM guidelines. • Clinical guidelines/protocols to enhance decision making in management of high dependency patients. • Staff are trained and competent to manage high dependency patients. • The bed spaces are equipped to manage high dependency patients. • Ability to isolate in negative and positive pressure. • Ability to care for high dependency bariatric patient with specialised equipment. • Provide communication and supportive service to family, cares and visitors.
Benefits	• High dependency patients are cared for by specially trained medical, nursing and allied health staff. • Ability to respond to sudden changes in clinical condition.
Performance Indicators	• Consumer and staff feedback. • Adverse events. • Length of stay.

4.3 Paediatrics

Model of Care Principles	
Description	Canberra Hospital's ability to support certain specialised paediatric conditions are limited by the hospital's medical subspecialty provision. The ICU's multidisciplinary team partners with families and carers to provide resuscitation and short-term support for children >2 years or >10kg with single organ failure. Complex paediatric patients with multi-organ failure or who are anticipated to require longer periods of ICU support are transferred via retrieval services to quaternary specialist care. Children requiring transfer to a more specialised health care facility will be transferred via the Helicopter Emergency Medical Service (HEMS) or Newborn and Paediatric Emergency Transport Service (NETS). Children <2 years or <10kg with critical illness are cared for in the Neonatal Intensive Care Unit (NICU), located in the Centenary Hospital for Women and Children..
Principles	• Paediatric patients are cared for by specially trained medical, nursing and allied health staff. • Resuscitation and stabilisation until transfer to appropriate quaternary hospital that can provide for their complex needs. • Availability of paediatric-specific equipment • Clinical guidelines/protocols to enhance decision-making in the management of the severely injured or ill child.
Benefits	• Ability to provide continuously haemodynamic, cardiac, neurological and respiratory monitoring and support. • Ability to respond to sudden changes in clinical condition. • Supported admission, discharge.
Performance Indicators	• Consumer and staff feedback. • Adverse events. • Length of stay..

4.3 Referral Team

Model of Care Principles	
Description	The Referral team provides a review and response service for patient deterioration requiring admission to ICU and HDU. The team may be requested to review inpatients for potential admission to ICU or HDU via direct request or in response to a Code Blue/MET. Interhospital referrals for admission are received by the referral team for assessment and acceptance to CHS. Post Code Blue/MET follow up The Medical Referral Team and MET Nurses works collaboratively to provide an outreach service, following up patients post Code Blue or MET in accordance with the Code Blue, sub-plan of the Canberra Hospital Emergency Management Plan.
Principles	• Provide a referral and review process for potential intrahospital and interhospital admissions to the ICU or HDU. • Provide follow for patient post Code Blue/MET. • Admission to ICU and HDU meet admission criteria in accordance with ANZICS.
Benefits	• Clear communication processes for referral and review of patients for admission to ICU or HDU. • Admission to ICU and HDU are appropriate for clinical management.
Performance Indicators	• ICU/HDU admitted referrals. • ICU/HDU non-admitted referrals. • Interhospital admissions.

5. Innovation

CHS continues to expand and enhance services across the ACT. Building 5 provides a platform for innovative expansion of health care at the Canberra Hospital.

5.1 Isolation Pod

An increased prevalence of patient care requiring isolation and lessons learned from the COVID-19 pandemic has highlighted the importance of planned infrastructure and clinical models to provide safe and quality health care in relation to infection prevention and control.

The ICU has a 12-bed negative pressure compartment specifically designed to safely manage infectious patients who require isolation and specialised care.

5.2 Outdoor Terraces

Level 5 has two outdoor terraces to enhance the patient experience and wellbeing when cared for in the ICU. Each terrace can support four intensive care patients in a covered bed bay with access to medical services panels. The northern terrace houses a dedicated staff courtyard which flows from one of two ICU staffrooms. The southern terrace provides a dedicated visitor courtyard that enters from the ICU visitors lounge.

5.3 Clean-up Room

The divisible function of dirty utility and clean-up rooms are an innovation to ICU. Level 5 contains two clean-up rooms for the purpose of cleaning used, ICU-specific items or holding dirty re-usable medical devices prior to transfer to the Sterilising Services Unit (SSU).

The clean-up room is not considered a substitute for SSU.

5.4 Procedure Room

The ICU procedure room provides a controlled environment for planned or emergent, minimally invasive procedures performed under topical, local, regional anaesthesia or sedated ventilated patients.

The procedure room is fully led lined to support c-arm or mobile computerised tomography (CT) scans.

It is to be noted that the procedure room is not a substitute for an operating theatre with strict guidelines for approved clinical procedures.

5.5 Bariatric Room

Bariatric rooms within the ICU are designed to accommodate patients up to 450kg. Bariatric rooms are fitted with equipment weight rated for bariatric patients. This includes overhead lifters and toilets.

Bariatric rooms are weight rated to 250kgs or Super Bariatric rooms are weight rated to 450kgs.

ICU has one super bariatric room, three single bariatric rooms capable of caring for bariatric patients.

5.6 Automatic Dispensing Cabinets

Automatic dispensing cabinets (ADC) allow medications to be stored and dispensed near the point of care. They allow for the controlling and tracking of drug distribution. ICU will be utilising ADCs throughout. This will enable efficiencies in the management of pharmacological agents.

5.7 Gymnasium

Early mobilisation and rehabilitation of critically ill patients has been shown to decrease the incidence of ICU-acquired weakness, reduce delirium, lessen hospital length of stay and reduce mortality.

Access to a gymnasium on level 5 provides a dedicated space for individualised, evidence-based assessment and therapy to suitable patients in collaboration with Physiotherapists, Occupational Therapists and the ICU team.

The Gymnasium will be open for use 7 days a week during business hours (8:00am – 4:30pm) for the provision of therapy under the direct supervision of a Physiotherapist or Occupational Therapist.

6. Interdependencies

Interdependencies describe the internal and external functional relationships with other clinical services that enable the ICU MoS.

It takes a multidisciplinary approach to provide exceptional care to critically ill patients. Open communication and collaboration are key components in achieving high performance to help provide patient focused care and achieve best patient outcomes.

6.1 ICU Research and Data Team

The CHS ICU leads and contributes to high quality patient-centred research which aims to improved patient experience and outcomes. Research areas include clinical trials, observational, interventional, prospective, retrospective, multicentre and single centre studies.

All research activities undertaken in the ICU undergo a rigorous, consultative process by the ICU Research Executive Group (REX) and patient consent is obtained for any study-specific education.

6.2 Medical Emergency Team (MET)

CHS has a dedicated MET that responds to all Code Blue emergencies. The MET provides acute resuscitation for deteriorating patients on general in-patient wards, as well as any member of the public on the Canberra Hospital campus, who unexpectedly experience a medical emergency.

Due to the complex nature of medical emergencies and the interface with other CHS clinical services, the MET service has a dedicated MoS. The MET provide an outreach referral and review service, referred to as MET-Outreach or the Referral Service. This team includes a dedicated medical and nursing team, that includes members from the ICU and ED.

6.3 DonateLife ACT

CHS is committed to providing the community with an exceptional organ and tissue donation service.

The ICU team works closely with dedicated donation nursing coordinators to provide families with the information and support required for them to make an informed, enduring decision regarding organ and tissue donation as part of their loved one's end of life care. DonateLife ACT acts in accordance with relevant legislation and policy requirements for organ and tissue donation.

6.4 Helicopter Emergency Medical Service (HEMS)

HEMS is the NSW/ACT managed aeromedical service with a dedicated helicopter and road retrieval service. HEMS provides specialist medical crew, comprising of highly skilled emergency medicine physicians, intensivists, anaesthetists, and respective specialty senior registrars.

NSW patients requiring ACT intensive care services will be retrieved by HEMS and transferred to the Canberra Hospital ICU either directly, or via other CHS critical care services, such as Operating Theatres, Interventional Laboratories or ED. HEMS also facilitates interhospital transfer to NSW quaternary hospitals for specialised clinical care that exceed CHS subspecialty expertise or clinical treatments available at Canberra Hospital.

6.5 Trauma Service

The Trauma Service is an overarching service with input from sub-specialities specific to patient care requirements. The service endeavours to ensure that all trauma patients are optimally cared for, from pre-hospital care to discharge and beyond. It provides specialised care through the skills of medical, nursing, and allied health experienced in complex clinical management.

6.6 Healthcare Technology Management

As medical technology, equipment and innovations continue to advance, biomedical engineering and technical support is increasingly important for complex care areas such as ICU.

The Healthcare Technology Management (HTM) team provide biomedical engineering, technical support, and expert advice to ICU to ensure safe, quality patient care, by maintaining international best practice. As equipment becomes increasingly technical and complex, there is a growing need for services and equipment to be maintained by the vendors and HTM.

HTM assists with various agreements and contractual arrangements with vendors relating to medical devices, equipment and ICT systems used within ICU.

6.7 Wardspersons

Wardspersons provide 24/7 clinical support by way of manual handling and other patient needs.

Wardspersons respond to “Code Blue’ (medical emergency) and “Code Black’ (personal threat emergency), "Code Grey" (immediate assistance) situations.

Wardspersons also provide internal transport services for the transfer of patients throughout the hospital campus.

6.8 Hospital Assistants

Hospital Assistants provide support in the clinical areas for the cleaning of patient beds, clinical equipment and restocking of clinical supplies.

Hospital Assistance liaise with the cleaning contractors and assist with the cleaning of infectious patient areas.

6.9 Cleaning Contractors

Cleaning contractors provide general cleaning to the treatment spaces and waiting areas. In addition, they provide infectious cleaning as required.

7. Workforce

The ICU workforce is managed in accordance with the:

- Australian and New Zealand Intensive Care Society
- Australian College of Critical Care Nurses standards
- Relevant Enterprise Agreements
- Public Sector Management Act (1994)
- Public Sector Management Standards 2016
- Health Act 1993
- ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework
- ACORN
- Nursing and Midwifery Patient ratios.

Staffing profiles include an indirect and direct staffing model that responds dynamically to changing capacity demand and patient acuity. The ICU workforce is summarised in Table 2.

Table 2: Workforce Categories

Category	Roles
Medical staff	• Clinical Director • Deputy Clinical Director • Consultants • Senior Registrars • Registrars • Senior Resident Medical Officers • Medical Officers • Interns
Nursing	• Assistant Director of Nursing • Nursing Unit Manager • Clinical Nurse Consultants • Clinical Care Coordinators • Clinical Support Nurse • Clinical Development Nurses • Registered Nurses, Level 1 & 2 • Equipment Nurse • Assistants in Nursing
Allied health	• Pharmacists • Physiotherapists • Occupational Therapists • Social Workers • Aboriginal Liaison Officers • Speech Therapists • Dieticians • Mental Health Consultant Liaison • Clerical staff.

Category	Roles
Support areas	• Administration staff • Clinical support through: – Healthcare Technology Management Officers – Central Equipment – Courier Services – Ward Clerks – Wardspersons – Hospital Assistants – Spiritual Support Services – ISS – Capital Linen – Food Services

ICU staff provide safe and high-quality health care for patients by practicing an evidence-based team nursing-based model. The ICU nursing team works in partnership with each other, the multidisciplinary team and patients to ensure individualised patient-centred care.

It should be noted that the number of bedspaces utilised is directly related to the demand and resources available, in providing and maintaining a safe environment.

8. Implementation

The implementation and evaluation of the ICU MoS will be led by the Division of Surgery in conjunction with the ICU Leadership team and supported by the Campus Modernisation team.

The MoS will be implemented through the following strategies:

- Orientation and training programs for new and existing staff to work within the service.
- Ongoing training programs for staff working within the service.
- Processes and documentation used within the service that support the principles of the ICU MoS/C.

9. Performance and Improvement Measures

The ICU MoS will be delivered in accordance with key government strategic performance objectives and priorities. The ICU MoS supports achieving performance indicators against national service/care delivery standards and accreditation.

The objective for all performance improvements is to ensure patients receive quality, safe health care in 'the right care, at the right time, by the right team and in the right place'.

The ICU will evaluate performance and improvement measures against:

- ACEM Guidelines
- ACT Health Strategic Indicators
- ANZICS CORE Database
- Australian Council of Healthcare Standards (ACHS), National Safety and Quality Standards
- CHS, Clinical Governance Structure and Committees
- CHS, Strategic Indicators
- Core Outcome Measurement and Evaluation Tool (COMET)
- Consumer Feedback
- Digital Health Record (DHR)
- National Emergency Access Targets.

ICU will ensure the provision of high-quality service through ongoing feedback from patients, families and carers who use the service, as well as the measure of staff satisfaction and well-being.

Monitoring and evaluation of ICU will occur through a range of mechanisms including:

- CHS's Clinical Governance Structure and Committees
- CHS's Risk Management Processes
- National Safety and Quality Health Service (NSQHS) Standards Committees
- 'Our' Care Committees

Data collected by the CHS Consumer Engagement team via the Australian Hospital Patient Experience Question Set (AHPEQS) has a key role in monitoring and identifying and acting on themes from surveys and other feedback sources.

This process includes seeking input from the CHS Consumer and Carer Sub-Committee, to ensure subsequent quality indicators from the consumers perspective are appropriate and meaningful.

10. Definitions & Terms

Table 3 provides abbreviations and acronyms used in this document.

Table 3. Acronyms

Acronym	Meaning
ACCCN	Australian College of Critical Care Nurses
ACEM	Australasian College for Emergency Medicine
ACHS	Australian Council on Health Care Standards
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
ANZICS	Australia & New Zealand Intensive Care Society
CCC	Clinical Care Coordinators
CHS	Canberra Health Service
COMET	Core Outcome Measurement and Evaluation Tool
CSN	Clinical Support Nurse
CRRS	Capital Region Retrieval Service
CRRT	Continuous Renal Replacement Therapy
CSB	Critical Services Building
DoCRC	Division of Critical Care Research Committee
ECMO	Extra Corporeal Membrane Oxygenation
ED	Emergency Department

Acronym	Meaning
HEMS	Helicopter Emergency Medical Service
IABP	Intra-aortic balloon counter pulsation
ICU	Intensive Care Unit
MET	Medical Emergency Team
MoC	Model of Care
MoS	Model of Service
NETS	Newborn and Paediatric Emergency Transport Service
NICU	Neonatal Intensive Care Unit
NSW	New South Wales
PICU	Paediatric Intensive Care Unit
REX	Research Executive Group
RN	Registered Nurse

Table 4 provides term definitions used in this document.

Table 4. Term Definitions

Term	Definition
Guideline	Intended for CHS staff, guidelines detail the recommended practice to be followed by staff but allow some discretion or autonomy in its implementation or use. Guidelines are written when more than one option is available under a given set of circumstances, and the appropriate action requires a judgement decision. Guidelines may also be used when the supporting evidence for one or other course of action is ambiguous.
Model of Care	Model of Care describes principles for providing the right care, at the right time, by the right person/team and in the right location.

Term	Definition
Model of Service	Model of Service describes an evidence-based framework for service delivery and performance measures.
Next of Kin	Patient nominated next of kin include biological family relations of any degree, but also family of choice who may not be biologically related, carers or loved ones such as friends.
Policy	Intended for CHS staff, policy documents are an overarching, organisational wide directive about how staff are to act in defined circumstances or regarding a particular situation. Policies are documents based on legislation, Standards, regulations and/or ACT Government requirements and compliance is mandatory. A policy is often, but not always, supported by a procedure or guideline.
Procedure	Intended for CHS staff, procedures details specific methods or actions staff must undertake to complete required processes within CHS. Procedures inform staff about how to complete clinical or administrative actions consistently across the organisation. The actions are evidence based and informed by staff who are subject matter experts. Non-compliance with a clinical procedure must be clearly documented in the patient's clinical record.
Quaternary care	The term quaternary care is used as an extension of tertiary care in reference to advanced levels of medicine which are highly specialised and not widely accessed.

Term	Definition
Tertiary care	The term tertiary care refers to services provided by hospitals with specialised equipment and expertise. At this level, hospitals provide services such as intensive care, major trauma management, neurosurgery, cardiothoracic surgery and interventional procedures.

11. References List

11.1 Frameworks & Strategies

- CHS Clinical Governance Framework 2020-2023
- CHS Corporate Plan 2020-2021
- CHS Exceptional Care Framework 2020-2023
- CHS Partnering with Consumer Framework 2020-2023
- CHS Strategic Plan 2020-2023
- CHS Work Health Safety Strategy 2018-2022

11.2 Policies & Procedures

- ACT Health Incident Management
- ACT Health Services Plan 2022-2023
- ACT Health Violence and Aggression by Patients, Consumers or Visitors: Prevention and Management
- ACT Health Work Health and Safety
- ACT Health Incident Management
- ACT Health Language Services (Interpreters, Multilingual Staff and Translated Materials)
- ACT Work Health and Safety Management System
- CHS Clinical Records Management
- CHS Consumer Feedback Management
- CHS Consumer Handouts
- CHS Protective Security – Security Design for Facilities
- CHS Waste Management
- CHS Work Health Safety Management System
- CHS Work Health Safety Policy

11.3 Legislation

- Charter of Health Care Rights
- Dangerous Substances Act 2004
- Human Rights Act 2004
- Work Health and Safety Act 2011
- Workplace Privacy Act 2011

11.4 External Standards & Guidelines

In addition, external organisations may have standards and guidelines that are relevant to the SSD which may include but not be limited to:

- ACT Ambulance Service, Clinical Management Guidelines.
- Australian College of Perioperative Nurses, Standards for Perioperative Nursing in Australian.
- Australian Commission on Safety and Quality in Health Care.
- Australian Health Facilities Guidelines (HFG) 190 Sterile Supply Unit.
- Australian Sterilisation Standards.
- Gastroenterological Society of Australia (GSA) and Gastroenterological Nurses College of Australia (GENCA), Infection Control in Endoscopy.
- National Health and Medical Research Council (NHMRC), Australian Guidelines for the Prevention and Control of Infection in Healthcare 2010.
- National Safety and Quality Health Service (NSQHS) Standards set by the Australian Commission on Safety and Quality in Health Care.
- NSW Health, Critical Care Tertiary Referral Networks (Paediatrics), NSW Policy Directive PD2018_11 Emergency Paediatric Referrals.
- NSW Health, NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD2018_011.
- NSW Institute of Trauma and Injury Management, NSW Inter-hospital Major Trauma Transfer: Interim Guideline, November 2019.
- NSW NETS Clinical Guidelines.
- NSW NETS Operational Guidelines.

12. Model of Service Development

Participant Position
Clinical Director, Intensive Care Unit, Division of Surgery
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Assistant Director of Nursing, Intensive Care Unit, Division of Surgery
Director of Operations, Division of Surgery
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Registered Nurse, Intensive Care Unit, Division of Surgery
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Client Liaison Officer, Campus Modernisation

ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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