

Clinical Guideline



Health
Hunter New England
Local Health District

Inter- Facility Transfers of HNE Health Paediatric Patients

Document Registration Number: HNELHD CG 13_20

Sites where Clinical Guideline applies	All HNE Health facilities providing services to infants, children and young people.
This Clinical Guideline applies to:	
1. Adults	No
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
Target audience	All HNE Health medical and nursing staff who provide services to infants, children and young people.
Description	
Keywords	Inter-facility, transfer, transport paediatric
Replaces Existing Guideline?	Yes
Registration Numbers of Superseded Documents	HNEH CPG 09_07 from 25 November 2009
Related Legislation, Australian Standards, NSW Ministry of Health Policy or Guideline, NSQHS Standard/EQuIP Criterion and/or other, HNE Health Documents, Professional Guidelines, Codes of Practice or Ethics:	
<ul style="list-style-type: none"> • NSW Health (2011) PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals. • NSW Health (2010) PD2010_031 Children and Adolescents – Inter-Facility Transfers • NSW Health (2006) PD2006_068 Transport for Health • NSW Health (2005) PD2005_157 Emergency Paediatric Referrals Policy • NSW Health (2011) PD2011_038 Emergency Departments Recognition of a Sick Baby or Child • HNEH Policy (2008) Security of Children Admitted to HNE Health Facilities. HNEH 08/04. • HNEH (2008) Security of Children Admitted to HNE Health Facilities. HNEH 08/04: PCP 1. • Patient Flow Unit. Business Rules. (Updated January 2010) Patient Flow Unit, Health Transport Unit. 2007 • NSW Health PD2009_060 Clinical Handover – Standard Key Principles 	
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Note: Over time links in this document may cease working. Where this occurs please source the document in the PPG Directory at: <http://ppg.hne.health.nsw.gov.au/>

GUIDELINE SUMMARY

This document establishes best practice for HNE Health. While not requiring mandatory compliance, staff must have sound reasons for not implementing standards or practices set out within the guideline, or for measuring consistent variance in practice.

Introduction:

This guideline addresses the recommendations for paediatric transport. This guideline is not for use for transfer of newborn patients, all of whom are referred via NETS. The role of the Patient Flow Unit (PFU) and Newborn & paediatric Emergency Transport Service (NETS) will be addressed.

Situation – Risk Statement:

Category: Clinical Care & Patient Safety: Non-compliance to this guideline may result in infants, children and adolescents receiving care that is not 'in the right place at the right time' and undergoing inappropriate transportation between HNE LDH facilities that is not cost effective, timely and optimal for best patient outcomes.

Background

HNE Health consists of a large geographical area of 130, 000 square kilometres. This area includes a diverse rural hospital network, which provides acute care to infants, children and adolescents.

The requirement to transfer paediatric patients between hospitals is a necessary and frequent occurrence to promote care that is "in the right place and at the right time". In accordance with the aim of HNE Health of providing appropriate paediatric care as close to home as possible, it is expected that the demand for 2 – way transfer of paediatric patients will increase.

Assessment

The facilitation of optimal care at every stage of the referral process, so that any paediatric patient, whose care is more suitably provided at another hospital, is transferred appropriately. This includes appropriate involvement of senior clinicians in the referring and destination hospital, optimal use of local resources, effective communication between patient transport systems/services and transfer by the most appropriate means to the most appropriate institution in a timely manner.

Recommendation

When a child requires care beyond the capacity of the attending hospital, consultation must occur between the referring and accepting clinician.

The method of transport used when transferring children should be integral to any treatment discussion.

Inter-Facility Transfers of HNE Health Paediatric Patients HNELHD CG 13_20

All non-emergency transfers into or out of facilities in Geater Newcastle, Lower Hunter Cluster, Hunter Valley Cluster and Mid North Coast are arranged by PFU during operational hours.

Phone: 1800 660 361.

PFU Hours 0630 hours - 2200 hours

0800 hours – 1600 hours weekends and public holidays

Outside these hours as outlined below:

All emergency retrievals are organised through NETS 1300 362 500. NETS Coordinates neonatal and paediatric retrieval using NETS-Hunter team, the Hunter Retrieval Service and regional services such as Tamworth Retrieval Sevices.

GLOSSARY

Acronym or Term	Definition
Inter District Hospital Transfer	Transfer of paediatric patient to a hospital in another Local Health District or interstate.
Intra District Hospital Transfer	Transfer of a paediatric patient to another hospital in the same Local Health District.
Back transfer	The transfer of a paediatric patient following presentation or treatment at another hospital within or outside the District for the purpose of continuing care closer to home.
Referring hospital	Hospital identifying the need for and initiating the transfer.
Destination hospital	Hospital to which the paediatric patient is being transferred, for treatment, ongoing care or investigations.
Unstable child	A paediatric patient with a clinical condition that may require interventions during transport, where vital signs are unstable, where the airway is compromised or where there is potential for deterioration of condition during transport.
NETS is the Newborn & paediatric Emergency Transport Service	Retrieval service which manages transfer requests for all infants, children and adolescents, whose clinical condition is critical, serious, unstable; at risk of deterioration or requires intensive care. NETS has a single number service 1300 362 500 for emergency calls inter and intra District referrals.
Patient Flow Unit (PFU)	Is responsible for the referral/co-ordination of inter-facility transfers into and out of the John Hunter Hospital (JHH), Maitland, Manning, Calvary Mater and Belmont Hospitals, across HNE Health of paediatric patients who are stable enough not to require a retrieval team. It liaises with the Health Transport Unit (HTU) once confirmation of need to transfer is secured and the patient has been accepted for ongoing care.
HNE Health Transport Unit (HTU)	Is a single point of telephone contact for all non-emergency health related transport in the HNE Health. Staff should dial 1800 660 361 and select from the options available to speak with an operator.

GUIDELINE

Emergency/urgent transfers for critically ill newborns and children are organised through NETS. For all other transfer when it has been identified the child requires care beyond the capacity of the referring hospital, the most Senior Attending Medical Officer or Nursing staff member, Registrar or Senior Emergency Department Medical Officer at the Rural/Referral or Tertiary Hospital should contact the Consultant Paediatrician or ED Consultant on-call to discuss the need for transfer. This will be done through Patient Flow Unit (PFU) when open for Greater Newcastle, Lower Hunter Cluster, Lower Mid North Coast & Hunter Valley Cluster.

This process should not delay appropriate clinical action or retrieval activation.

1. Responsibilities Referring and Destination Hospitals

It is the responsibility of the most senior Medical Officer to assess, and when necessary, initiate the transfer of an infant, child or young person to a facility offering a different level of care. When the child requires care at a higher level, the Senior Medical Officer should consult with the specialist Admitting Medical Officer, Paediatrician or Emergency Department physician regarding assessment and management, including the most appropriate mode of transport, of the patient before their care can be taken over by the destination hospital.

The decision to transfer the child to higher-level hospitals will be dependent on the condition of the child and the local circumstances. If there is no Medical Officer, the Senior Nurse will make the call. In most instances the Admitting Medical Officer and Emergency Department physician at the nearest Rural Referral or Tertiary Hospital will be contacted.

In Greater Newcastle, Hunter Valley Cluster, Lower Hunter Cluster and Lower Mid North Coast the phone call will be made through Patient Flow Unit, who will arrange a conference call with the Medical Officers at the destination hospital. This should include both the doctor at the ED and the doctor at the accepting unit, i.e. ICU or ward (refer to page 6 point 5 for circumstances when PFU service not available).

If the patient is being transferred by NETS then the call would be made directly to NETS. If the patient is being transferred by the Hunter Retrieval Service then NETS will call them into the conference call and coordinate this.

If PFU is not involved the following applies.

1.1. The Referring Medical Officer should:

- Identify the most appropriate destination hospital and level of care required.
- Consult with relevant clinicians and make arrangements for the availability of a bed if the patient is not critical.
- If the patient requires retrieval call NETS first. NETS will provide advice, include relevant clinicians from a higher level hospital, arrange a retrieval team and vehicle, identify any accepting destination hospital.
- Agree on transfer arrangements and ascertain the expected time of arrival.
- Identifying the most appropriate mode of transport (i.e. ground or air), taking into account availability, weather etc.
- Discuss with the parent/carer/patient as appropriate.
- Ensure the accepting unit has full details of the child's/infant's medical condition and requirements.
- Ensure the child's/infant's condition has been assessed to be stable prior to transfer. It is good practice to review the patient's condition just before transfer.

1.2. Referring Nursing staff should:

- Discuss the transfer arrangements with destination hospital's nursing staff in the ED or accepting ward, where required.
- Identify appropriate level of escort required to accompany the patient, if necessary
- If using Health Transport, complete a Request for Health Transport Booking Form and fax to the relevant Health Transport Unit (HTU)
- For a planned transfer, book an ambulance through the Ambulance Service of NSW, 24 hours ahead (before 5pm) of required time, to avoid significant costs to the referring hospital.

- Obtain a time for transfer.
- Identify appropriate nursing staff required to accompany the patient, if necessary
- Ensure a full explanation is given to parent/carer and patient, if appropriate
- Ensure all relevant documentation accompanies child.

1.3. **Destination Medical Officer** should:

- Provide advice and assistance to the referring Medical Officer and other relevant clinicians to ensure that the inter-hospital transfer is appropriate.
- Provide continuing support to the referring hospital until the transfer occurs
- Ensure there is an onsite plan of clinical management until the transfer occurs.
- If there is a more appropriate destination hospital, offer to cross-refer.
- When a transfer has occurred to a higher level facility, feedback must be made to the referring facility, within 24 hours.

2. Feedback to referring facility

- 2.1. The referring hospital should always be provided with feedback on the child's condition. The senior clinician who has received and managed the child should ensure the referring doctor is contacted to provide feedback within 24 hours. The referring doctor's name will be noted on the transfer documents.
- 2.2. Clinicians at the destination hospital must confirm the identification of any health professional requesting information about the child's condition, by obtaining the enquirer's details and phoning them back through the facility switchboard.
- 2.3. Clinicians at the referring hospital should not be told to ask the parents for information.

3. Parents

When a decision is made to transfer the child to a facility providing a different level of care, the Medical Officer or Senior Nurse are to inform the parents or carers of the decision and, where possible provided with advice on:

- The reason for transfer and the anticipated time of transfer.
- Mode of transport, approximate travel time and estimated time of arrival at the destination hospital.
- Any treatment that may be required during transport.
- Escort if required or allowed.

Written information, including directions to the accepting hospital, and contact details for key staff at the hospital should also be provided to the parents or carers. This information can be obtained from HNE Health website, services and facilities index. http://intranet.hne.health.nsw.gov.au/services_and_facilities

4. Transport mode where PFU not involved.

Inter-hospital transfer should be considered as Emergency or Non-Emergency. The prioritisation for transport should be given to those requests with the effect of preventing further development of a medical condition, or, decreasing the chance of an existing health condition becoming more severe.

Non-emergency inter-facility transport services are health-related transport services for transporting admitted and/or non-admitted patients between health facilities. Transport for Health establishes a policy framework to improve patient access to NSW health services

Non-emergency inter-facility patient transport services are able to transport inpatients between health facilities. Transport for Health is able to assist transporting disadvantaged people living in the community to travel to health services.

The timing and method of transport should be discussed between senior clinicians at the referring and accepting hospitals and in emergency situations NETS, taking into account:

- urgency of transfer

- the clinical needs of the child or infant
- the distance to the accepting hospital and urgency to definitive treatment
- potential for deterioration in clinical condition during transport
- distance to the destination, and time required for a clinician escort to complete a return trip
- availability of transport
- travel conditions – weather, road etc
- cost

When the decision has been made to use NETS details of the transport and internal communication with various teams within the destination hospital will be decided by NETS in consultation with the destination hospital: allowing the staff at the referring hospital to return quickly to the care of their patient. There will be only one call required by the referring hospital.

TRANSPORT DECISIONS

1. *The Recognition of the Sick Baby or Child.*

The Clinical Practice Guideline *NSW PD 2011_038: Emergency Departments Recognition of a Sick Baby or Child* provides cues for triaging staff to assist in the allocation of appropriate triage level according to the Australian Triage Scale (ATS - ACEM 2002). The triaging of children should be done in consultation with parents, 'as parents know their child'.

All health facilities in HNE Health should display prominently in the Emergency Department the Recognition of the Sick Baby or Child chart that is relevant to their area, to assist in the care and management of children attending the ED

2. *Immediately Life Threatening, Limb Threatening or Urgent - NETS*

The Newborn & paediatric Emergency Transport Service (NETS), should be called on the statewide hotline for all infants' children/adolescents who are:

- Condition critical / serious / unstable
- Risk of deterioration
- Requires intensive care

- 2.1. The referring hospital calls NETS to get advice, discuss an appropriate destination, establish the best mode of transport and identify a retrieval team to do the retrieval. A retrieval team will be tasked as follows; Hunter NETS (neonatal), Hunter Retrieval Service or Tamworth Retrieval teams or a NETS – NSW team from Sydney
- 2.2. When the paediatric patient's condition requires a medical escort, the most senior attending medical or nursing staff member must contact NETS to discuss the case and negotiate the transfer.
- 2.3. NETS is available 24hrs/day, 7 days per week to discuss patient issues: **1300 36 2500**.
- 2.4. NETS acts as a 'clinical gateway' into the tertiary paediatric system as well as providing critical care transport services.
- 2.5. NETS may recommend a plan of care to be implemented in the interim until the retrieval team arrives. The Admitting Medical Officer, Registrar or Senior Medical Officer's will document and implement this plan of care, in discussion with the specialist at the referring hospital. This plan should include appropriate monitoring and surveillance of the patient. The patient's immediate treatment requirements are the highest priority.
- 2.6. Electronic monitoring appropriate to the patient's clinical condition should be in place.
- 2.7. The MO should communicate with the nursing staff about the planned retrieval and its timing. The decision to transfer and the expected delay until time of transfer will have impact on nursing staff requirements for the shift[s] involved.
- 2.8. If at any time clinical circumstances change after the initial call, the MO should notify the Specialist & NETS Coordination to review the transfer plan and/or discuss any appropriate changes in treatment prior to the retrieval team's arrival.

- 2.9. Callbacks to NETS can be on the NETS 'warmline' 1300 36 2499. This includes both deterioration and improvement. Such calls are normally 'conferenced' with the destination hospital clinician and the NETS team so that all stakeholders are informed. It can facilitate a change in estimated time of arrival if the child is deteriorating, or a reallocation of resources if the child's condition improve.
- 2.10. The MO should complete a comprehensive and concise written medical report at handover to accompany the infant/child.
- 2.11. All investigative results should be forwarded in a timely fashion to the accepting hospital.
- 2.12. Ensure that the retrieval team is provided with all relevant patient history and clinical data. This information will be conveyed to the destination hospital.
- 2.13. If all test results are available at the time of transfer, they should be forwarded to the destination hospital as soon as possible.
- 2.14. The MO/Senior Nurse will verbally handover to the team on their arrival.
- 2.15. NETS will coordinate the communication by the retrieval team with the destination hospital clinician via conference call.

3. Transfer for Non-Urgent Cases

When used, the Patient Flow Unit (PFU) will ensure the nearest appropriate specialty service is contacted. A three way conference call is then facilitated where clinical details are obtained to guide the level of escort and transport service (ASNSW or HTU vehicles) required. The Flow Manager will ensure all parties have agreed to the plan of management and timeframe for transfer based on clinical need. The Patient Flow Unit will then ensure facility bed managers are aware of need to create capacity and forward the transport booking request through to the HTU who is responsible for lodging the request with:

- Ambulance Service of NSW
- NSW Air Ambulance
- Internal HTU fleet

The JHCH neonatal ICU uses NETS for all transfers including non-urgent or back transfers

4. After-hours Transport Bookings

For ambulance, these are usually of a retrieval nature and are made direct to that service.

It is important to limit the potential increase in ambulance costs, and improved utilization of our existing non-emergency HTU vehicles also protecting the Ambulance Service's ability to respond to 000 calls.

If patients who are referred to PFU are considered 'Unstable patients' for existing Health Transport Unit vehicles, the PFU may suggest retrieval via NETS.

Ambulance Service NSW may be utilised in this instance if the child is not suitable for retrieval, as Health Transport Unit staff are not authorized to use flashing lights, sirens or speed in the transfer should deterioration occur.

5. Ambulance Service NSW

Categories of children/adolescents to be transported include those who:

- Does not have a defined diagnosis and/or clinical condition is unstable.
- Require airway management or supplemental oxygen.
- Require continuous monitoring eg cardiac monitoring or SpO2 monitoring
- Require inotropic support.
- Require a stretcher.
- Are suspected of being at risk ie Non-accidental injury.

6. Fixed Wing (Air) Transport

Patient meets Ambulance criteria

- Travel time must exceed 2.5hrs by road
- NSW Air Ambulance requires all bookings by 1500 the day prior to transport.
- If the patient requires same day service and/or service not available from NSW Ambulance, a secondary provider can be utilized.
- While the trip may be faster by air, the time taken to get an aircraft to the site must be considered.
- JHCH neonatal ICU arranges return transfers by fixed wing via NETS.

7. Patient Transport Service

Categories of children/adolescents to be transported will include those:

- Stable paediatric patients, with or without intravenous access, including Insulin infusion and epidural infusion.
- With oxygen therapy.
- With a Patient Controlled Analgesia (PCA) unit.
- With a past history of seizure activity may be transported, **only** if they are not seizing at the time of transport, and are deemed stable for transport with the Patient Transport Service by the registrar or consultant.
- Patients with a hip spica plaster once a modified wheelchair has been manufactured. Until then, NSW Ambulance will transport the children in consultation with the PFU.

General Considerations:

- All children will be restrained in the transport vehicle using appropriately fitted approved child safety restraints (eg. baby capsule, child seat, harness/seatbelt). See Appendix 4)
- Parents/care givers are encouraged to accompany their child during transport, however, safety aspects will need to be considered. Such considerations may include child protection issues. The decision not to allow parents/care givers to accompany their child will be at the discretion of the escort nurse, ambulance officer, and / or medical officer.
- Nurses who escort paediatric patients with Patient Transport will be the only medically trained personnel on the trip and must travel in the back with the patient in full view at all times
- The transport vehicle has a mobile phone, power, oxygen and suction supplied, but all other paediatric supplies, pumps, monitors or emergency equipment must be taken by the nurse. (See appendix 4 Information For The Nurse Escort)
- In accordance with the Service Level Agreement between Ambulance Service of NSW and HNE Health, the Ambulance Service of NSW should arrange the transport needs of all nurse/medical escorts back to their point of departure in a timely manner.
- All nursing staff and drivers assisting with the transport of paediatric patients must complete annual accreditation of Paediatric Basic Life Support/CPR.
- Neonatal patients are accompanied by neonatal nurses from NICU.

8. Private Vehicle

'The decision to allow private transport (car or taxi) for an inter-hospital transport is the responsibility of the Emergency Clinician at the destination hospital in consultation with the Senior Medical Officer of the transferring hospital and the patient's parent. The transporting parent should consent to this transport method. The Medical Officer should document that the issue has been discussed with the parent and they have agreed to transport the child.' PD2010-031.

Both clinicians must agree that private transport is appropriate for the child.

Categories of paediatric patients able to be privately transported include children who:

- Are independent and mobile, according to their level of development
- *Children with a SINGLE fracture or suspected fracture with the following:*
 - Single fracture which has been stabilized with approved splinting
 - Potential for neurovascular disruption is low
 - Child can safely sit in a car with an approved seatbelt fastened, complying to road regulations.
 - Pain is well controlled, pain score assessed as mild immediately prior to transfer. If analgesia has been administered to relieve pain then the child must be observed for 1 hour post analgesic administration in the Emergency Department prior to transfer and the pain score at the time of transfer is assessed as mild (pain score less than 4) .
 - The journey must not be more than 2 hours and no further analgesia is required during the journey.
- Condition is considered mild / minor issue
- Pain score (other than for a suspected or known single fracture) prior to administering analgesia is assessed as mild (e.g. pain score less than 4).
- Parents able and agree to provide safe transportation e.g. vehicle has age appropriate safety equipment, road conditions not hazardous for traffic.
- Child protection concerns have not been identified by nursing and medical staff.
- Do not require
 - oxygen,
 - suctioning,
 - ongoing intravenous medications, fluids, or nebulised therapy,
 - any type of emergency procedure.
- Have not received paediatric life support measures or sedative medications
- Clinical condition is not at risk of deterioration requiring urgent medical care.

PFU is required to question the use of private car to ensure those responsible for the transfer are aware of all the risks of the transport environment when making this decision.

Infants and children can only be transported in vehicles that have age appropriate safety equipment installed (child restraints). For information about current legislative requirements regarding safety of children in cars go to:

<http://www.racv.com.au/wps/wcm/connect/internet/primary/road+safety/child+safety/child+restraints/the+law+and+standards+on+child+restraints/>

Prior to private transportation the transporting parent/guardian should have access to:

- Contact details of the accepting health facility and staff
- Directions or maps to the health facility
- Transfer documents and relevant investigations
- Local car parking facilities
- Appropriate car child safe equipment e.g. age appropriate car seat. (See appendix 4)
- A functioning telephone - in the event of an acute deterioration in the child's/infant's condition.

9. Back Transfer

Planning for back-transfer of children and infants begins with discharge planning which commences at time of admission to the higher-level facility.

As with all inter-hospital transfers of paediatric patients, necessary documentation of the patient's history, treatment and management plan should be forwarded to the local hospital. Parents/carers should be appropriately prepared, supported and provided with necessary information.

In Greater Newcastle, Lower Hunter Sector, Hunter Valley Cluster and Lower Mid North Coast Hospitals, back transfer will be organised through Patient Flow Unit. Neonatal back-transfers are arranged via NETS.

IMPLEMENTATION PLAN

In addition to inclusion on the HNE Health Intranet and Kaleidoscope websites, to achieve maximum awareness of this revised guideline, it is intended that relevant senior managers and general managers will be advised of its existence via direct email. Targeted distribution to identified stakeholders will also occur. Information about the revised guideline will also be promoted through The Latest, articles in HNE Health Matters as well as Kaleidoscope (Child Health newsletter), and staff forums and education days.

EVALUATION PLAN

IIMs reports for paediatric inpatients will be monitored for any increase or decrease in incident activity at facilities, by Children Young People & Families Clinical Network who will report to Area Executive Team.

CONSULTATION WITH KEY STAKEHOLDERS

1. Paediatric CPG ED Committee. Co-chaired by Dr Keith Howard and Dr Mark Lee
2. Ms Jenny Carter Nurse Manger PFU
3. Emergency Clinical Stream, chaired by Dr Cameron Dart
4. Children Young People & Families Clinical Network, contact Mr Matthew Frith
5. NETS, contact Dr Andrew Berry
6. Paul Craven Neonatologist, JHCH

APPENDICES

1. Paediatric Feedback Form
2. Safety restraint weight recommendations
3. Information for the escort nurse
4. Patient transport matrix

REFERENCES

- NSW Health. *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*. PD2011_015
- NSW Health. PD2011_031 *Inter-facility Transfer Process for Adults Requiring Specialist Care*.
- NSW Health. PD2010_034 *Children and Adolescents – Guidelines for Care in Acute Care Settings*.
- NSW Health. *Emergency Paediatric Referrals - Policy* PD2005_157.
- NSW Health. *Management of Paediatric Inpatient Admission in Designated Level 1-3 Paediatric Medicine and Paediatric Surgical Facilities*. PD2010_032.
- NSW Health. *Children and Adolescents – Inter Facility Transfers*. PD2010_031.
- NSW Health. *Safety and Security of Children in NSW Acute Care Health Facilities*. PD2010_033.
- HAHS Critical Care and Trauma Committee (May 1999), *HAHS Inter-Hospital Transport Guidelines*.
- SW Health (2002) *Guide to the role delineation of Health Services Third Edition*
- NSW Health (2002) *Guidelines for the Networking of Paediatric Services in NSW*
- Child Health Network for the Greater Toronto Area (2003) *Paediatric Transfer Protocols Acute Transfers and Retro-transfers*
- Children's Hospital at Westmead (2004) *Practice Guidelines: Transporting Infants and Children*
- Children's Hospital at Westmead (2004) *Policy and Procedure: Urgent (Emergency) Admissions*
- CREST (2006) *Protocol for the Inter hospital transfer of Patients and their Records*

- Hertfordshire Partnership NHS Trust (2005) *Acute children's Services Policy for the transfer of children and young people inter and intra hospital*
- Hornsby Ku-ring-gai Health Service (2005) *Transfers of Paediatric Patients to Hornsby Ku-ring-gai Hospital*
- Sydney West Area Health Service (2004) *Emergency transfer of Infants and Children from emergency Department of Children's Ward or Post Natal Ward*
- Sydney West area Health Service (2004) *Inter-Hospital Transfer of a Paediatric Patient*
- *The Australian Triage Scale*, Australasian College of emergency Medicine 2000.
- Western Child Health Network (2008 draft). *Inter-hospital Facility Transfer Guide*

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.

HUNTER NEW ENGLAND AREA HEALTH SERVICE

PLEASE USE GUMMED LABEL IF AVAILABLE

UNIT NUMBER

Facility: _____

**PAEDIATRIC TRANSFER
FEEDBACK FORM**

Ward _____

HOSPITAL/WARD: _____

SURNAME		UNIT NUMBER
OTHER NAMES		
ADDRESS		
DATE OF BIRTH	M.O.	

This form has been designed to satisfy the following outcomes;

1. Provide timely, concise feedback to the referring hospital on the child's condition
2. Provide a brief description of the child's current management plan to the referring clinician

It is therefore essential that this clinical information be transferred to the referring facility as soon as possible (within 24 hours of transfer). Therefore Faxing would be the most convenient method to do this. However Faxing of this form must be in accordance with the NSW Privacy Manual (section 9.2.3.2) which requires certain responsibilities be taken by the person sending the fax to ensure that it reached the correct destination.

Referring Hospital _____ Fax Number: _____

Referred to accepting hospital by _____

Dear _____

Re: Patient _____

Family GP _____

Reason for transfer _____

Outcome _____

Comment _____

Signature _____ Designation _____

Print Name _____ Date _____

Date Faxed On: _____

Staff use only: when complete, please retain the original in the patient's medical record.

The information contained in this fax message is intended for the named addressee only.

If you are not the intended recipient you must not copy, distribute, take any action reliant on, or disclose any details of the information in this fax to any other person or organisation. If you have received this fax in error please notify us immediately.

BINDING MARGIN - DO NOT WRITE

HNEMR20 - July 2009

HNEMR20

PAEDIATRIC TRANSFER
FEEDBACK FORM

Paediatrics

Appendix Two

Safety Restraint Weight Recommendation: For information about current legislative requirements regarding safety of children in cars go to:

<http://www.racv.com.au/wps/wcm/connect/internet/primary/road+safety/child+safety/child+restraints/the+law+and+standards+on+child+restraints/>

Infant restraints for babies



For babies up to 9kg, 70cm long and from birth to 6 months, an infant restraint should be used.

An infant restraint must be correctly installed in the vehicle and adjusted properly to fit your baby. If it is not, the restraint may not offer full protection in the event of a crash.

Child seats for young children



For young children 8 - 18kgs and from 6 - 9 months to approximately 5 years old, a child seat should be used.

To use a child seat, the child must be able to sit and easily hold their head upright.

A child has outgrown their child seat when their shoulders no longer fit comfortably within the child seat or when their eye-level is higher than the back of the top of the child seat.

Booster seats for older children

For children 14 - 26kgs and until they are large enough to be safely secured by an adult seatbelt, a booster seat should be used.

Children should travel in a booster seat that is secured by an adult seatbelt, never a lap belt only. A booster seat should be used until the child's shoulders no longer comfortably fit within the booster seat or when their eye-level is higher than the back of the top of the booster seat.

Appendix Three

Information for the Escort Nurse

- Ensure the “*Transfer of Care*” or “*Nursing Discharge*” form is complete.
- Collect the Transport Pack if available or any equipment required for the journey.
- Add patient specific requirements to the kit as needed.
- Identify the equipment needed to complete the transport safely e.g. IV pump, feeding pump, oximeter, nebulizer mask, bunny rugs / small blanket, and P.P.E. (personal protective equipment).
- Obtain the medications and feeds that may be required en-route or in case of emergency. e.g. infants and diabetics
- Make copies of the medication charts, fluid balance, last days’ reports, observation charts and the Admission front sheet with emergency contact details.
- Obtain the “*Summary of Hospital Care*” or “*Discharge Summary*” as provided by the attending Doctor.
- Compile the paperwork in a plastic sleeve and attach a pen and all relevant observation charts on the front.

BE AWARE THAT:

- Feeding pumps will malfunction if the fluid level in the drip compartment over / under-fills or if vibrations / movement interrupt the pump’s ability to count the drops. A spare giving set should be taken along.
- Infants and young children may have the seat belt or harness in a position which pushes on a gastrostomy button if insitu. Care must be taken to protect the gastrostomy site.
- A form of neck support (e.g. a rolled up nappy) may also be required for infants and young children if they are travelling in a car seat.
- A car seat is available but is not suitable for use on the transport trolley so you must specify the anticipated requirements.
- If the transport trolley is required, a baby / child harness is available as a restraint.
- The escort nurse is required to wear a seatbelt at all times. If the patient needs attention that requires the nurse to unbuckle the seatbelt, the vehicle must be pulled over and parked.

DURING TRANSPORT:

- Monitor and record observations as deemed necessary. Some children may need to be transported with oximetry in progress for ongoing observation.
- Allow the patient to rest as able.
- Request the driver to stop the vehicle if the patient requires care resulting in the need to remove the nurse’s or child’s seatbelt / restraint.

ON ARRIVAL:

- Ensure that the patient is clean and comfortable.
- Escort the patient by staying positioned near their head to allow for good observation.
- Ensure that the patient, all paperwork, medications and patient belongings are handed over to the accepting staff with an up to date summary of care needs.
- If the parent/ carer is accompanying the child, introduce him/her to the accepting staff.
- Ensure that the patient is safe in their new area before leaving. e.g. transferred to new bed with cot sides or bed side rails up and an alert buzzer available.
- Collect any equipment from your hospital for return.

ON RETURN TO YOUR HOSPITAL:

- Document the transfer in the medical record.
- Restock and clean the transport pack.
- If the return is beyond the hours of the nurse’s shift, notify the NUM.
- Report any adverse events / near misses / incidents which occurred during the transport process on IIMs, to the PFU and your NUM.

Paediatric Transport Matrix

CPG Recognition of the sick baby and child, may assist in the decision making process
CLINICIAN TO CLINICAN CONSULTATION MUST OCCUR BEFORE TRANSFER

CATEGORY	ESCORT	CHILD	TRANSPORT & DESTINATION
A RETRIEVAL	Critical Care Expertise	Condition critical / serious / unstable <ul style="list-style-type: none"> Requires intensive care Requires airway management Requires inotropic support Requires continuous monitoring e.g. cardiac monitoring or SpO2 	Mandatory discussion with appropriate retrieval services: NETS 1300 36 2500 Transport Modality: Road/Helicopter/Fixed Wing Transport team; NETS, Hunter Retrieval Service, Tamworth Retrieval Service
B URGENT	Critical Care Nurse and ASNSW Level 4- 5, with paediatric ALS	Condition serious / stable <ul style="list-style-type: none"> Major oxygen dependence Severe tachypnoea Risk of deterioration enroute Any drug infusion that requires medication alteration enroute Any history of apnoeas requiring stimulation/ airway support/ resuscitation in last 24 hours 	Mandatory discussion with appropriate retrieval services: NETS
C INTRA TRANSPORT CARE	RN or EEN with current paediatric experience	Care required enroute and condition stable <ul style="list-style-type: none"> Ongoing intravenous therapy, intravenous medication administration or nebulised therapy Oxygen therapy Patient Controlled Analgesia (PCA). Suctioning 	Mandatory discussion with appropriate MO HNE Patient Flow Unit, 1800 660 361 Weekdays 0630-2200hrs, Weekends 0800-1600hrs Ambulance /Internal Transport Transport modality: Ambulance, Road/Fixed Wing
D NON COMPLEX INTRA TRANSPORT CARE	EN or AIN escort if within their scope of practise	No care required enroute and condition stable <ul style="list-style-type: none"> No IV therapy but may have cannula / PICC in situ (capped) Suspected of being at risk i.e. Non-accidental injury	Mandatory discussion with appropriate MO HNE Patient Flow Unit, 1800 660 361 Weekdays 0630-2200hrs, Weekends 0800-1600hrs Ambulance /Internal Transport Transport modality: Ambulance, Road/Fixed Wing
E ROUTINE NO INTRA TRANSPORT CARE	No Health Escort Private transport provided by Parent or Carer, following consultation	Condition is considered mild / minor <ul style="list-style-type: none"> Independence or mobility unchanged. Pain score, prior to receiving simple analgesia, is assessed as mild (i.e. pain score less than 4). Stabilized single fracture (see page 9) Parents able to and agree to provide safe transportation No child protection concerns have been identified. Does not require oxygen, suctioning or ongoing intravenous fluids, medications, or nebulized therapy. Has not received paediatric life support or sedative medications Clinical condition is not at risk of requiring urgent medical care. 	Mandatory discussion with appropriate medical officer at destination facility HNE Patient Flow Unit 1800 660 361 Weekdays 0630-2200hrs Weekends 0800-1600hrs Transport modality: Road/Fixed Wing Private transport / Hire Car, Taxi
Fixed Wing or Air Transport <ul style="list-style-type: none"> Travel time must exceed 2.5hrs by road NSW Air Ambulance requires all bookings by 1500 the day prior to transport. If the patient requires same day service and/or service not available from Ambulance Service of NSW a secondary provider can be utilized. While the trip may be faster by air, the time taken to obtain an aircraft and travel to and from airports must be considered 		These guidelines must be used in conjunction with the <u>Inter-facility Transfer of HNE Paediatric Patients</u> These conditions are examples only and should not replace the judgment of attending clinicians or advice from the attending hospital	