Local Procedure

John Hunter Children's Hospital
CHILDREN, YOUNG PEOPLE AND FAMILIES

NSW GOVERNMENT Health
Hunter New England Local Health District

PAEDIATRIC BED MANAGEMENT in JHCH

Sites where Local Guideline and Procedure applies	JHCH Ward H1, Ward J1, Ward J2 & NICU.
This Local Guideline and Procedure applies to:	
1. Adults	No
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
Target audience	Management, Nursing and Medical Staff
Description	Provides direction to staff and to ensure that the risks of harm to patients associated with prioritisation of admission to inpatient beds are identified and managed.
National Standards	1, 3 & 9

Hyperlink to Procedure

Keywords	Admission, children, ETP, infection control, JHH, JHCH, transfer, special
Document registration number	
Replaces existing document?	Yes
Registration number and dates of superseded documents	JHCH 3.2, July 2012

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- NSW Health Policy Directive 2017_032 Clinical Procedure Safety
- NSW Health Policy Directive PD 2017_013 Infection Prevention and Control Policy
- NSW Health Policy Directive PD2009_060 Clinical Handover – standard key principles
- NSW Health Policy Directive 2010_030 Critical Care Tertiary Referral Networks (Paediatrics)
- NSW Health Policy Directive 2005_157 Emergency Paediatric Referrals
- NSW Health Policy Directive 2012_011 Waiting Time and Elective Surgery Policy
- HNELHD Policy Compliance Procedure-2017: Security of Children Admitted to HNE Health Facilities
- HNE Health Policy Compliance Procedure PD2009_060: PCP1 Clinical handover - ISBAR
- Local Guideline JHH_JHCH_0014 Admission Criteria: medical HDU
- Local Guideline JHCH 4.3 - Patients Requiring Additional Supervision: Assessing the need for Specialling
- HNELHD Clinical Guideline- HNELHD CG 17_22. Admission to Paediatric Hospital in the Home (HITH) Services

Local Guideline and Procedure note	This document reflects what is currently regarded as safe and appropriate practice. The guideline section does not replace the need for the application of clinical judgment in respect to each individual patient but the procedure/s **require mandatory compliance**. If staff believe that the procedure/s should not apply in a particular clinical situation they must seek advice from their unit manager/delegate and document the variance in the patients health record.
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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/

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RISK STATEMENT

This document provides guidance in ensuring the patient's condition, acuity and clinical needs are considered in determining the most appropriate ward placement within JHCH.

Identified risks are:

- Patient is not cared for in an environment that is suited to their needs.
- Patient is not placed in an environment that will reduce cross infection
- Adverse patient outcomes due to delays in transfer from Emergency Department to an appropriate ward.

These risks are minimised by:

- An appropriate physical environment and paediatric bed as defined by HNELHD Security of Children Admitted to Hunter New England Facilities.
- Defined processes for the safe and appropriate allocation and monitoring of patients.
- There is a defined clear method of communication with the Emergency Department for potential admission of patients to the ward.
- Patients need to be assured they are placed in an appropriate physical environment and paediatric bed.
- Care is delivered by staff who can competently meet their health care and developmental needs.
- The physiological, psychological and developmental needs of the patient are addressed in all aspects of care

Any unplanned event resulting in, or with the potential for, injury, damage or other loss to patients/staff/visitors as a result of this procedure must be reported through the Incident Information Management System and managed in accordance with the Ministry of Health Policy Directive: Incident management policy PD2017_004. This would include unintended injury that results in disability, death or prolonged hospital stay.

Risk Category*:* Clinical Care & Patient Safety

GLOSSARY

Acronym or Term	Definition
CGA	Corrected Gestational Age
COB	Close Observation Bed
ED	Emergency Department
ILI	Influenza Like Illness
J2DS	J2 Day Stay
JHCH	John Hunter Children's Hospital
JHH AHM	John Hunter Hospital After Hours Manager
JHH BM	John Hunter Hospital Bed Manager
NM Acute	Nurse Manger Acute
NUM	Nurse Unit Manager

SPOC	Standard Paediatric Observation Chart

RESPONSIBILITIES:

Hospital / Service Manager Responsibility

Hospital and service managers are responsible for the control and coordination of hospital resources to meet demand for admission and for ensuring that the requirements of this procedure are applied, achieved and sustained.

Line management responsibility

John Hunter Children's Hospital will ensure all relevant stakeholders have access to the Bed Management procedure.

Employee responsibility

Staff must read, understand and comply with the requirements of this local guideline and work cooperatively with other staff and departments to facilitate timely admission, transfer and discharge.

PROCEDURE:

This procedure requires mandatory compliance.

General Comments

It is in the best interests of children and adolescents to be care for in an environment that is suited to their needs. This aim will be facilitated by:

- An appropriate physical environment and paediatric bed as defined by HNELHD Security of Children Admitted to Hunter New England Facilities (see below).
- Access to age appropriate play/activities.
- Staff who can competently meet their health care and developmental needs in a safe environment (NSW Health, 2010).
- Designated paediatric/adolescent beds.
- Appropriate patient placement to reduce cross infection (Any unresolved issues are to be referred to the NM Acute, during hours and after hours, the JHH AHM).
- An environment that effectively manages the vulnerability of children in general and the specific child protection requirements of the individual child or adolescent.
- It is recognised that in an environment of fiscal restraint it is essential to safely maximise the utilisation of inpatient beds and other resources. The following bed management procedure has been developed to support the achievement of these aims.

Paediatric Safe Bed as defined by HNELHD Policy: Security of Children Admitted to HNE Health Facilities.

Children should be readily observed and supervised. This includes play areas and/or paediatric beds. Parents must inform nursing staff if they intend to take their child from the ward/play area.

If a child is to be placed in an adult ward the bed must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.

PRINCIPLES:

- The JHH Bed Manager is responsible for overall co-ordination of all admissions, transfers and discharges. After hours the JHH AHM is the delegated Bed Manager.

- The admission of patients from the Emergency Department will occur following the correct patient flow process as per the Communications, Procedure and Workflow; for admitting children to the John Hunter Children's Hospital

- Paediatric patients will be admitted into clinical units appropriate to their conditions and ages.
    - JHCH teams have responsibility to utilise all inpatient and outpatient resources efficiently and effectively.

    - Admissions for acute/urgent medical care must have priority over an admission for elective care. This includes those patients who have been identified for admission by treating speciality teams.

    - Priority for all admissions to the JHCH will be determined by Medical Officers. If there are any concerns regarding placement of a patient further consultation will occur following the correct patient flow process.

    - Admission should only occur when the patient's condition cannot be investigated and treated appropriately in an Outpatient Department; Same Day Unit; Rapid Review Clinic or Hospital in the Home (HITH).

    - JHCH will participate in ongoing dialogue and cooperation with all departments of the John Hospital Campus.

- Patients will be allocated to beds in accordance with inpatient priorities for allocation.

- Transfer of patients from other hospitals during hours will be in consultation with the Patient Flow Unit and the JHCH NM Acute Service. The transfer will only occur after a Medical Officer has accepted the handover of the patient's care/admission. Then a bed will be allocated.
- Transfer of patients after hours will require a medical triage through the Emergency Department, ensuring patients are within SPOC recommendations and provisions put in place to ensure ward ability to deliver immediate care.
- If a confirmed, booked, patient's bed allocation is withdrawn it is the responsibility of Patient Flow and/or the Admissions Clerk to ensure the patient is informed. Hospital initiated postponements should be managed in accordance with section 5.7 of PD2012_011 Waiting Time and Elective Surgery Policy.
- Discharges / transfers should occur prior to 1100hrs where at all possible.

INPATIENT BED ADMISSION BUSINESS RULES:

- Planned access to inpatient beds will be provided through The Admission Department via the booked admission process. Person Responsible: Admitting Medical Officer.

- Emergency access to beds will be negotiated via the Emergency Department with the NUM of Unit/ /Team Leader and/or NM Acute. Person Responsible: Admitting Medical Officer and JHH BM and/or AHM

- Bed availability is to be monitored by NUM of Unit/Team Leader. Of a weekend it is the responsibility of each wards Team Leader to notify the JHH AHM of bed vacancies via text as soon as a patient has been discharged. Person Responsible: NUM of unit/Team Leader

- If a patient is not deemed appropriate for admission the NUM/Team Leader and/or NM Acute will discuss this with the referring Medical Officer and offer alterative admission options. Person Responsible: NUM of unit/Team Leader and Medical Officer.

- The final decision for admission will rest on the Medical Officer requesting the inpatient bed.

- Inpatient beds will be allocated based on the following Bed Allocation hierarchy i.e. Critically ill inpatients requiring more complex care provision:

    i. ii. Patients in the Emergency Department

    ii. Patients in PICU or HDU awaiting an inpatient bed

    iii. Day of Surgery Admissions (DOS)

    iv. Patients waiting inter-facility transfer into JHCH

    v. Planned booked admissions

    vi. Unplanned admissions via clinics or consultants rooms

    vii. Realignment of “outlier” patients into consultant’s subspecialty areas

Prior to allocating any patient consideration will be given to:

• Level of care requirements
• Subspecialty alignment
• Clinical need requirements

Responsible Person: Bed Manager/JHH AHM (Patient Flow). Any escalation required in hours to JHCH NM Acute Service.

SUBSPECIALTY ALIGNMENT:

The John Hunter Children’s Hospital is divided into units based on age and specialty groups. In order to achieve best patient care, patients should be allocated to unit where both age and specialist healthcare teams are co-located. This is termed Subspecialty alignment.

There will be times when according to clinical criteria it is important regardless of age to locate a patient where specialty nursing care is able to be delivered.

Table 2

Division	**Sub Specialty**	**Ward/Unit**	
Surgery	Critical Care	PICU/ICU	
		NICU - <1 month CGA 1. Surgical problems presenting in the neonatal period 2. Neonatal jaundice, requiring phototherapy 3. Excessive weight loss in the neonatal period	
		0-14	**13 - but not yet 18 yrs**
	General Surgery	J1	J2
	Neurosurgery	J1	J2
	Orthopedics	J1	J2
	Special Surgery	J1	J2
	Trauma	J1	J2
	Oncology	J1	J1
	Gastroenterology (Bed placement H1 or J1)	J1/H1	J2
Oncology/Hematology		J1	J1
Medical	**Sub Specialty**	**Ward/Unit**	
	Critical Care	PICU/ICU	
		NICU - <1 month CGA 2. Neonatal jaundice, requiring phototherapy 3. Excessive weight loss in the neonatal period 4. Respiratory support requirement	
		0-14	**13 - but not yet 18 yrs.**
	General Medicine	H1	J2
	Respiratory	H1	J2
	Immunology	H1	J2
	Neurology	H1	J2
	Gastroenterology (Bed placement H1 or J1)	J1/H1	J2
	Cystic Fibrosis *(Never allocated to J1)*	H1	J2

J2 ADOLESCENT UNIT ADMISSION CRITERIA:

The following criteria apply to patients suitable for admission to J2:

Adolescents with primarily medical and surgical conditions who have turned 13 but not reached their 18th birthday.

Adolescents suitable for the unit will be functioning as a child or adolescent, who is still living at home with a carer, still attending education, and not living an independent adult lifestyle.

- Children and adolescents who are medically unstable admitted for management of a mental health presentation.
- Bed placement for patients with Cystic Fibrosis (CF), must be nursed according to the CF Tier and recommendation by the Team Leader, NUM & Cystic Fibrosis team.
- If J1 is at capacity and a febrile neutropenic Oncology patient requires a bed they could be placed in J2A if a single room was available.
- If a J1 Oncology / Haematology patient requires admission with an infection that will compromise other immune suppressed patients on J1, they can be admitted to Ward J2.
- Surgical patients who have reached their tenth birthday when beds are not available in J1.
- Patients not more than 20 weeks pregnant with an uncomplicated pregnancy.

Close Observation Bed (COB):

The Close Observation Bed (COB) is located in J2A. The COB will provide patient centred care that is responsive to patient needs and care in a comfortable safe environment while minimising risk of harm to the patient. Admission to the COB will be based on the management of a clinical condition and should not replace the need for patient specialling. The COB is not to be used for inappropriate admissions or as an additional bed when there is a high bed demand due to increased bed pressure.
Patients are to remain in sight at all times. If curtains need to be drawn for patient care, a nurse needs to remain with the patient.
Admission to the Close Observation Bed (COB) are the following patient population, in order of priority are: -

- Patients who are at risk of self-harm/injury
- Patients who are currently scheduled under the Mental health Act, and medically unstable
- Patients who are unable to be safely cared for in another ward
- Patients who are considered a flight risk
- Patients who have an acquired head injury unable to be managed on another ward
- Acutely unwell adolescent medical patients requiring close observation
- General admitted adolescent private patient population
- General adolescent patient population

Any patient who requires increased nursing supervision requires an appropriate medical review (medical or psychiatric), risk assessment form completed and safety plan documented in ED prior to transfer/admission to J2A. Refer to guideline: Patients Requiring Additional Supervision: Assessing the need for Specialling.

The following criteria identify patients who are unsuitable for admission to J2**:**

- Until cleared, patients with unstable spinal injuries requiring log rolling by more than 2 staff are not suitable for J2A due to insufficient staffing numbers during a night shift.
- If there is the ability to open additional bed spaces a discussion will need to occur with JHCH Executive and approval given before this occurs. A 3rd staff member will need to be rostered to cover the additional bed occupancy.

Medical admissions with co-morbid mental health problems

- Adolescence with a mental health presentation who are medically unstable and have not reached their 18th birthday and do not meet the criteria for admission to Nexus Refer to Policy Directive PD2011 016: Children and Adolescents with Mental Health Problems Requiring Inpatient Care).
- The treating paediatric team can access mental health consultation-liaison support for these patients (NSW Health, 2010).
- Adolescents who are admitted for management of mental health presentations must be consistent with the Provision of Care Agreement between JHCH and Mental Health Services (See 3.15 Provision of Care Agreement), and should only occupy H1 if J2 is full.
- Prior to admission from ED all mental health patients require an assessment by the Consultation Liaison Psychiatry team.
- For those adolescents who are assessed as still at risk of suicide or self-harm, provision is made for 1:1 specialling. Refer to John Hunter Children's Hospital, Local guideline; JHCH 4.3: Patients Requiring Additional Supervision: Assessing the need for Specialling. Supervision in the ward at the joint recommendation of the psychiatric registrar or consultant and medical consultant. A Mental Health Assessment form must be completed for these patients.

J2 DAY STAY ADMISSION CRITERIA:

- The Paediatric Day Stay routinely operates from 0700 – 1530. These hours have the ability to be flexible according to roster and organisational need. Patients returning from surgery after these hours or experiencing delays in recovery may be transferred to another inpatient unit.

- Suitable patients are paediatric and adolescent day stay patients and Oncology and Haematology patients with prior discussion and organisation with the NUMs of both units.

- Other services offered on J2DS include:
  - Food Challenge clinics run by Allergy and Immunology team
  - Burns review and dressing clinic run by surgical team
  - Infusion lounge

Following discussion with the NM Acute or AHNM and dependent on staff availability, there is the potential to admit patients into J2 Day Stay, from the Emergency Department, during day time hours, while waiting bed allocation within JHCH, or for ongoing treatment and assessment decisions.

J1 ADMISSION CRITERIA:

The following criteria apply to patients suitable for admission to J1:

- Infants and children (up to 14th birthday) with a surgical or orthopaedic condition.

- If any patient with an infection or potentially infectious disease must be admitted to J1, the patient will **no**t be allocated to the same staff member caring for oncology patient(s).

- Patients with MRSA & VRE can be nursed on J1, but will not be allocated to the same staff member caring for oncology patient(s). The staff member can be allocated to a surgical patient(s). These patients can only be nursed in rooms 10, 23 & 24 (100% exhaust) and 22 (standard room) with ensuite facilities.

- Patients with Carbapenem Producing Enterobacteriacae (CPE) or Carbapenem Producing Organism (CPO) should not be nursed on J1 and be transferred to H1 or J2 dependent on age.

- Patients with airborne infections (measles, Chicken Pox or TB) should not be nursed on J1. ILI's should not be nursed on J1. The only exception would be an Oncology patient on treatment as long as they could be nursed separately to other Oncology patients either in rooms 10, 23, 24.

- If J1 is at capacity and a febrile neutropenic Oncology patient requires a bed they could be placed in J2A if a single room was available.
- J1 will manage surgical overflow from J2 Adolescent Unit.

Oncology Direct Ward Admissions:

- Patients currently on active treatment will be advised by the treating team to contact staff for specific medical concerns. On contacting the designated staff they will be advised to either present directly to the Oncology Day unit; Ward J1 or the Emergency Department. There is the ability to make contact with staff 24 hours a day to seek advice and direction on the most appropriate place to present.

Individual bed allocations

- Beds 1, 2. 3. 4. 5 – Positive Pressure – Priority for patients requiring protective Isolation e.g. immunosuppressed

- Bed 10 – Negative Pressure room – Can be used for respiratory, airborne and droplet precautions

- Beds 11. 12. . 23. 24 – 100% exhaust – any patient

-**Bed 22- Standard Contact precautions only**

CHILDREN'S ONCOLOGY AND HAEMATOLOGY DAY UNIT:

The Oncology & Haematology Day Unit is a six bed unit, including an isolation room and a treatment room.

This unit operates as a theatre Monday and Thursday mornings and has the capacity to perform intrathecal chemotherapy; bone marrow aspirates and lumbar punctures for the Oncology/Haematology patient group.

The unit also provides outpatient services for new patients and follow up appointments for both oncology and haematology patients.

Haematology Services

- Blood Transfusions
- Platelet Transfusions
- Factor for Haemophiliac patients
- Intragam infusion and other blood products

Oncology Services

- Chemotherapy
- Oral contrast (prior to MRI)
- Cannula insertion (for nuclear medicine tests)
- Access ports for blood collection
- Central venous line dressings
- Portacath flushing

H1 ADMISSION CRITERIA:

The following criteria apply to patients suitable for admission to H1:

- Infants and children with medical conditions who have not reached their 13th birthday.
- Bed placement for patients with Cystic Fibrosis (CF), must be nursed according to the CF Tier system and recommendation by the Team Leader, NUM & Cystic Fibrosis team.
- (Please note - Children with Cystic Fibrosis who are Berkholderia Cepacia positive will need to be isolated from other patients with cystic Fibrosis or immunosuppression).
- Respiratory infections (ILI), infectious patients

Medical admissions with co-morbid mental health problems

- Children presenting to ED who are medically unstable or with symptoms including injuries, relating to mental health disorders, who have not reached their 13th birthday and do not meet the criteria for admission to Nexus Refer to Policy Directive PD2011_016: Children and Adolescents with Mental Health Problems Requiring Inpatient Care) are to be admitted to the ward under the relevant medical team.
- The treating paediatric team can access mental health consultation-liaison support for these patients (NSW Health, 2010).
- Children and adolescents who are admitted for management of mental health presentations must be consistent with the Provision of Care Agreement between JHCH and Mental Health Services (See 3.15 Provision of Care Agreement), and should only occupy H1 if J2 is full.
- Prior to admission from ED all mental health patients require an assessment by the Consultation Liaison Psychiatry team.
- For those children who are assessed as still at risk of suicide or self-harm, provision is made for 1:1. Refer to John Hunter Children's Hospital, Local guideline; JHCH 4.3: Patients Requiring Additional Supervision: Assessing the need for Specialling. Supervision in the medical ward is at the joint recommendation of the psychiatric registrar or consultant, and medical consultant. A Mental Health Assessment form must be completed for these patients.

Children with infectious illnesses

- Individual bed allocations
- Bed 1 – contact precautions
- Beds 10, 11, 23, 24 - 100% exhaust – any patient.
- Beds 20, 21, 22 – Standard rooms – Avoid using for airborne illnesses unless no other single room available

SINGLE ROOMS:

- Patients may be allocated single room accommodation for a variety of clinical reasons, For example isolation for infections, safety, behavioural or security reasons.
- Patients who require privacy due to the nature of their disease process.
- Private patients who request single (private) room accommodation must be informed on admission that single rooms are prioritised on clinical need and if provided with a single room they may need to be moved if needed for a greater clinical need.
- Palliative Care patients should be accommodated whenever possible in the Nicholas Room

Appendix 1: Single room suitability for infection control precautions.

Ward	Room No.	Bed No.	Type of Air Conditioning	Isolation Suitability	Code	Comment
H1	1314	1	Positive Pressure	Contact	R/A	
	1310	10	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	No ensuite
	1309	11	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)		No ensuite
	1305	20	Standard	Contact Precautions	C	
	1302	21	Standard	Contact Precautions	C	
	1301	22	Standard	Contact Precautions	C	

	1299	23	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)		
	1295	24	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)		
J1	1378	1	Positive Pressure Room	Protective Isolation (neut <.5)	PI	
	1375	2	Positive Pressure Room	Protective Isolation (neut <.5)	PI	
	1372	3	Positive Pressure Room	Protective Isolation (neut <.5)	PI	
	1374	4	Positive Pressure Room	Protective Isolation (neut <.5)	PI	
	1371	5	Positive Pressure Room	Protective Isolation (neut <.5)	PI	
	1370	10	Negative Pressure	Airborne, Droplet, Contact	R/A	
	1369	11	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	Not suitable IPC Pts
	1368	12	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	Not suitable IPC Pts
	1356	22	Standard	Contact Precautions	C	
	1347	23	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	1343	24	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
J2	2901	1	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	2898	2	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	2896	3	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	2892	12	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	Not suitable IPC Pts
	2891	13	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	Not suitable IPC Pts
	2887	22	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	2885	23	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	
	2883	24	100% exhaust	Droplet, Contact, Protective Isolation (neut>0.5)	RD/PCL	

PAEDIATARIC SHORT STAY PROCESS:

JHCH does not currently have a physical short stay unit. The current system is to admit patients who are eligible to allocated beds on H1 ward (under 12years); J1 (under 13 years) or J2 (over 12years).

Admission Criteria

- Treatment required >4 and <8 hours
- General Paediatric patients
- Paediatric sub-specialty patients presenting within business hours (and with whom the Specialty registrar or consultant agrees to the admission and discharge criteria)

Note: infectious status does not render patient ineligible. Admission will be dependent on bed availability.

HOSPITAL IN THE HOME (HITH):

HITH is available for patients who need continuing treatment but are stable and well enough to be treated at home.

HITH provide education; child assessment and observations; intravenous antibiotics; care of intravenous lines and dressings. The HITH team are available to home visit once daily.

The HITH service is available seven days a week from 0800 to 1630. Patients who are eligible to be discharged into HITH must live within a 45 minute drive of the hospital.

THE YOUTH ENGAGEMENT SERVICE (YES):

- The Youth Engagement Service (YES) is a newly established Multi-disciplinary team with JHCH and CAMHS remit. The team can assist in developing management plans for patients with emerging mental health problems and while staff will work closely with the Consultation Liaison Psychiatry team, it is not anticipated that they will replace the consultation liaison psychiatry assessment in ED. The YES team will review patients who are presenting multiple times to ED and are identified as having inadequate plans in place to prevent representation to ED

NICHOLAS TRUST ROOM GUIDELINE: FOR ALL WARDS:

- Patients and families with palliative care needs **will be given first priority access to the Nicholas Room and the Parents' room**). Please inform other families admitted to this room, they may be relocated if a child requiring palliative care is admitted.

- Infectious patients who meet the long stay criteria **are** permitted to use the Nicholas Room and parent facilities.

- Parents are responsible for the safety of children in the Nicholas Room. Children are **not** permitted in the kitchen. All hot liquids must be kept within the parents' kitchen.

- Unless needed to accommodate a palliative care child and family, or an infectious patient, patients will not be asked to move out of the Nicholas Room if other single rooms are available.

- Families of patients with short stay admissions will ***not*** have access to the Parent facilities and shutters will remain locked.

- Families of patients with a hospital admission of 5 days or more can access the Parent facilities and kitchen. Please advise families that they must not share the facilities with other patient families.

ADMISSION TO THE SLEEP UNIT:

- If a child presents to the sleep study unit appearing acutely unwell. First, do a set of observations to assess severity, discuss with parents and then contact the relevant consultant (if available) or on-call respiratory consultant to discuss. Observations in the yellow or red zones will be escalated appropriately.
- The sleep study can be postponed and the child and parent directed to either their local GP or GP access (if after-hours) to receive further assessment and/or treatment.
- If the child is particularly unwell (though not critical) and the consultant believes further assessment and or admission may be necessary, the parent and child should be escorted to the emergency department for triage and assessment.

- If the child appears initially well/stable, but later develops a fever, diarrhoea, vomiting, rash, worsening cough or unexpected respiratory deterioration, then the on-call respiratory consultant and Paediatric Registrar should be contacted for discussion and/or review. If admission is required then the after-hours bed manager should also be contacted to arrange a bed.
- If after assessment by the Paediatric Registrar/JMO and discussion with the on-call respiratory consultant it is decided that the sleep study can continue, then it can proceed as planned.
- If the child is considered too unwell for a 'diagnostic' sleep study, but does not require admission, then the child should be disconnected from the sleep study equipment and the parent advised to take the child to GP Access or their local GP for further review. The study will then be rebooked at a later date when the child is well again.
- If an admission is requested by the on-call consultant, an inpatient bed is available (per bed manager) and a ward medical assessment can be done on the sleep unit within 60min by the Paediatric Registrar or JMO, then the patient can be admitted directly to the designated ward from the sleep unit.
- If there are no inpatient beds or a review is not possible within the time frame then the child will be escorted to emergency department for assessment. If time permits, emergency should be contacted by phone prior to transfer.
- If a child becomes critically unwell during a sleep study then call a "rapid response" per usual emergency procedures.

SURGE CAPACITY:

It may become necessary to move patients between wards at any time of the day. However, planned transfers should occur between 7am and 10pm to minimise disruption. Only very necessary transfers should occur from 10pm to 7am. Transferred patients must meet the admission criteria for the new ward, as listed above.

- J1 is not to exceed 19 patients
- J2A is not to exceed 14 patients
- H1 is not to exceed 24 patients

Patient transfers between J1 and H1 are to occur through the main hallways, not via the adjoining fire doors due to the risk proposed by the stairwell.

- Generally J1 will overflow to H1 or J2A (depending on age)
- Generally H1 will overflow to J1 or J2A (depending on age & infectious status)
- J2A will overflow to H1 or J1 dependent on diagnosis and suitable bed availability

For all overflow there is a need to consider patient placement in relation to infection control issues (contact Infection Control if required).

After discussion with JHCH Executive and only if all other JHCH beds are occupied, J2Day Stay may be opened for the management of low acuity overnight patients and staffed appropriately.

- Consideration should be given for appropriate patients to be discharged or redirected from JHH Emergency Department to Maitland Hospital Children's Ward. This process is to be managed by the Paediatrician on call; and/or the ED consultant; JHH ED coordinator; Paediatric Registrar; JHH AHNM in conjunction with Maitland Hospital and the Maitland Paediatrician on call.

PROCESS:

• At times of high demand the JHH Bed Manager will notify the NM Acute, or after hours JHCH Manager on call (SD 68538, mobile 0409917908) to liaise with units/wards to free up any possible beds through appropriate transfers and discharges in consultation with the patient's Medical Officer.

• If the high demand persists the Co-Director Manager (or on call delegate) is to be notified to authorise opening of any additional surge beds.

• Consideration should be given to transfer or re-direct to The Maitland Hospital Paediatric Unit or Special Care Nursery

EMERGENCY BED MANAGEMENT TRIGGERS:

i. Inability to off-load ambulance patients
ii. Inability to accommodate patients requiring an emergency department bed for assessment and management, and who are temporarily in the waiting room
iii. Inability to optimally manage incoming trauma/resuscitation patients because of overcrowding in department and overflow of patients into the resuscitation area

This excludes patients requiring admission to a specialty unit such as PICU, and those requiring isolation for febrile neutropenia.

If one or more of the above triggers occurs and all JHCH hospital beds are occupied the following should occur:

- Following consultation between the ED Coordinator and Senior Medical Officer the ED Coordinator will request the JHH BM/AHM to activate the bed alert via the paging system to ensure that all possible discharges are expedited by staff.
- On weekdays the JHH BM/AHM will notify the Co-Director Manager or NM Acute and on weekends / public holidays the JHCH Manager on-call is to be notified to plan contingency arrangements.
- Patients identified for discharge maybe requested to sit in another area where possible until discharge completed. The vacated bed should be cleaned immediately and prepared for the patient who has been transferred from the Emergency Department.
- The NM Acute /JHH AHM may contact the manager Housekeeping to prioritise bed making. In the event that the bed makers are unable to attend the cleaning of the bed unit, the nursing/midwifery staff are to attend to this duty.

FLEXIBLE BED MANAGEMENT:

If demand for inpatient beds reduces to the point where it is appropriate to close J2A, every effort will be made to establish an adolescent wing/area in H1 which will be staffed by adolescent nursing staff.

Otherwise beds are only to be flexed to allow both safe and fiscally responsible staffing of JHCH.

NEONATAL INTENSIVE CARE ADMISSION (NICU):
Newborn infants meeting the criteria for admission to the Neonatal Unit will be assessed and admitted safely and efficiently. Parents will be welcomed and will receive appropriate and timely support and information. Babies will be transferred within the Neonatal Unit (between Intensive Care, High Dependency and Special Care as their condition merits) and within the JHCH to the Paediatric wards or PICU.

The following guide describes infants up to 44 weeks postconceptional age (< 4 weeks corrected gestational age)

1. Infants requiring HDU/ICU care

- If an infant presents in the first weeks of life with collapse, the current pathway of initial stabilisation and initial treatment should commence with onsite paediatric and ED team in consultation with the Paediatric Consultant on call. NICU staff may be requested to attend ED to review and assist if the newborn is critically unwell. This request must be made at a senior level.
- If HDU/ICU admission is likely, ED/ General Paediatrics should consult PICU and NICU for infants < 4 weeks CGA. The team should discuss where care can be best delivered and the availability of an isolation-bed where clinically needed. It is emphasised that these discussions should occur at a senior level.
    - Ex-preterm infants may be better cared for in the NICU
    - PICU would be comfortable looking after infants with bronchiolitis
- If an infant on the ward deteriorates – MET call and PICU will attend. PICU team will consult with NICU where care can be best delivered for this infant.

2. Infants well enough to not require HDU/ICU care

- Non HDU/ICU infants that are well may be cared for on the paediatric wards with mothers. Some clinical presentations are better cared for in the NICU, e.g. jaundice, FTT due to poor feeding in the first week after birth.

3. Special circumstances:

- Negotiation with PICU and Paediatric Wards is required when no bed is available in NICU and/or infant requires transport to Sydney
- Either NICU or PICU team may be required to transport infant subject to availability of team

TRANSFERS FROM NICU:
Babies will be transferred to a special care unit closest to their home as soon as they meet the criteria for transfer (see document – Transfer of Care).

Infants in NICU >44 weeks postconceptional age (>4 weeks corrected gestational age)

SCU/NICU may no longer be an appropriate place for provision of holistic care required for an infant >4 weeks CGA. Transfer out of NICU to either the paediatric wards or to PICU should be arranged and this should occur in a timely manner.

This will be through a planned approach with prior communication between the NICU NUM and ward NUM (or ICU NUM) to discuss the infant's ongoing care. Parents should be given the opportunity to meet with the admitting ward NUM and orientation to the ward should occur prior to the baby's transfer. NICU Guideline: Refer to – (Admission of babies to NICU, HDU and SCN; JHCH_NICU_01.01)

PAEDIATRIC INTENSIVE CARE (PICU):

Critically unwell children are referred for PICU consultation from ED or from the ward. It is anticipated that ISBAR communication, conveying the relevant information will be made from the most senior available ward doctor by phone or face-to-face where a Rapid Response has been called. When a child is transferred to PICU, the admitting Medical Officer MUST be notified; usually by the ED doctor (when transferred from ED); and the Inpatient Registrar (if admitted from an inpatient ward)

SECURITY OF WARDS:

Between the hours of 2130 to 0630 H1, J1 and J2 will have the entry doors to the wards locked. Access to the wards will be either by intercom, which is positioned at the front of the entry doors or by swipe care access.

Patient Preparation

It is mandatory to ensure that the patient has received appropriate information to provide informed consent and, that patient identification, correct procedure and correct site process is completed prior to any procedure or movement of patient throughout the JHCH.

IMPLEMENTATION AND MONITORING COMPLIANCE:

Distribution of this procedure will be via the Nurse Managers and Medical Leads of the streams.

Communication of the procedure will occur at ward level via ward meetings and through the Senior Paediatric Registrar.

Ratification will occur at the JHCH Clinical Quality and Patient Care Committee

Monitoring of this procedure will occur through IIMS and communication with NM and NUMs.

FEEDBACK

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

CONSULTATION

Nurse Manager Acute
Nurse Manager Ambulatory
Nurse Manager Neonatal Intensive Care
General Manager CYPF
Director CYPF

APPROVAL

JHCH Clinical Quality and Patient Care Committee – 28th November 2017.