Clinical Guideline

HNEkidshealth
Children, Young People & Families

NSW GOVERNMENT
Health
Hunter New England Local Health District

Inter-facility Transfers of Paediatric Patients

Sites where Clinical Guideline applies	All HNELHD 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 HNELHD medical and nursing staff who provide services to infants, children and young people.
Description	This guideline describes the systems and recommendations to be followed when transferring a paediatric patient from a HNE LHD acute care facility to another acute care facility within HNE LHD or NSW.

Go to Guideline

Keywords	Inter-facility, transfer, transport paediatric
Document registration number	HNELHD CG 21_41
Replaces existing document?	Yes
Registration number and dates of superseded documents	HNELHD CG 13_20 Version One from 25 September 2013 HNEH CPG 09_07 from 25 November 2009, HNELHD CG 13_20- 2013.

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 (2017) GL2017_010 Paediatric Service Capability Framework.
- NSW Health (2020) PD2020_010 Recognition and management of patients who are deteriorating.
- NSW Health (2011) PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.
- NSW Health (2005) PD2005_0157 Emergency Paediatric Referrals – Policy.
- NSW Health (2010) PD2010_031 Children and Adolescents – Inter-Facility Transfers
- Agency for Clinical Innovation (ACI) Paediatric Improvement Collaborative (PIC) – Recognition of the seriously unwell neonate and young infant.
- HNEH Policy (2019) PD2010_033: PCP 1. Security of Children Admitted to HNE Health Facilities.
- Patient Flow Unit. Business Rules. (May 2016) Patient Flow Unit, Health Transport Unit.
- HNE LHD (2020) Inter-Facility Transfer for Patients requiring Specialist Care PD2019_020: PCP2011_031: PCP 1
- NSW Health (2019) PD2019_020 Clinical Handover

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GUIDELINE SUMMARY

This document establishes best practice for HNELHD. 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 (newly born babies in Delivery Suite), 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

HNELHD 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 HNELHD of proving 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 timely and 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 clincian.

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

All non-emergency transfers into or out of facilities in HNE LHD are arranged by the Patient Flow Unit

(PFU) via the Patient Flow Portal. When the Patient Flow Unit is close, (between the hours of 2100hrs and 0700hrs), referring clinicians are required to communicate directly with the paediatric service, medical officer/Emergency Physician at the destination hosptial and coordinate the transfer of the infant/child.

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

For further information see: HNE LHD PCP PD2019_020:PCP 3: 'Inter-facility Transfer for Patients requiring Specialist Care.'

http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0003/118497/PD2019_020_PCP_3_and_PD2011_031_PCP_1_Inter-facility_Transfer_for_Specialist_Care.pdf

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 clinical 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)	The patient flow units primary role is to co-ordinate and monitor inter-facility inpatient and emergency department transfers in and out of HNE LHD hospitals, for all 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.
Patient Flow Portal	Provides access to tools for NSW Health staff to use resources efficiently and improve capacity and transfer of patients

CHANGES IN THIS REVIEW FROM THE PREVIOUS GUIDLEINE

1. HNE LHD (2020) Inter-Facility Transfer for Patients requiring Specialist Care PD2019_020: PCP2011_031: PCP 1 has been referenced throughout this guideline a hyperlink to the document is provided when necessary. Please read HNE LHD (2020) PD2019_020: PCP2011-0031, in conjunction with this revised guideline.

2. Child restraint best practice guidelines have been updated to align with national standards, see appendix 2.

3. The Clinical Practice Guideline Recognition of the seriously unwell neonate and young infant which provides cues for triaging staff to assist in the allocation of appropriate triage level according to the Australian Triage Scale is included.

GUIDELINE

Emergency/urgent transfers for critically ill newborns, infants 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/Specialist Attending Medical Officer or Nursing staff member, Registrar or Senior Emergency Department Medical Officer at the Rural/Referral or Tertiary Hospital should contact the appropriate consultant/consultant Paediatrician or ED Consultant on-call at the proposed destination hospital, to discuss the need for transfer. This will be done through Patient Flow Unit (PFU) when open for HNE LHD Hospitals. When the Patient Flow Unit is close, (between the hours of 2100hrs and 0700hrs), referring clinicians are required to communicate directly with the paediatric service medical officer at the destination hosptial and coordinate the transfer of the infant/child.

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

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 care hospitals will be dependent on the clinical condition of the child and the local circumstances. If there is no Medical Officer, the Senior Nurse will initiate the transfer. In most instances the Admitting Medical Officer/Paediatrician and Emergency Department Physician at the nearest Rural Referral or Tertiary Hospital will be contacted.

If the patient is being transferred by NETS then a telephone call would be made directly to NETS.

If PFU is not involved the following applies.

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 in not critical.
- If the patient requires retrieval call NETS. NETS will provide advice, include relevant clinicians from a higher level hospital, and 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 infant/child's medical condition and requirements.
- Ensure the infant/child's condition has been assessed to be stable prior to transfer. It is good practice to review the patient's condition just before transfer.

Referring Nursing staff should:

- Provide an ISBAR clinical handover to the transport team with the 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
- For a planned transfer, book via the Patient Flow Portal.
- Ensure a full explanation is given to parent/carer and patient, as appropriate
- Ensure all relevant documentation accompanies infant/child.

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.

Feedback to referring facility

- 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. Appendix One
- 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.

Involvement of Parents/Primary Care-givers.

When a decision is made to transfer the infant/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 HNELHD website, services and facilities index.

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.

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 witl various teams within the destination hospital will be decided by NETS in consultation with the destinatio 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

The Recognition of the seriously unwell infant and young child:

The Clinical Practice Guideline Recognition of the seriously unwell neonate and young infant 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 infants and children should be done in consultation wi parents, 'as parents know their child best'.

https://www.rch.org.au/clinicalguide/guideline_index/Recognition_of_the_seriously_unwell_neonate_and_young_infant/

Immediately Life Threatening, Limb Threatening or Urgent - NETS

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

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

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.

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.

NETS is available 24hrs/day, 7 days per week to discuss patient issues: **1300 36 2500.**

NETS acts as a 'clinical gateway' into the tertiary paediatric system as well as providing critical care transport services.

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.

Electronic monitoring appropriate to the patient's clinical condition should be in place.

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.

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.

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.

The MO should complete a comprehensive and concise written clinical handover to accompany the infant/child.

All investigative results should be forwarded in a timely fashion to the accepting hospital.

Ensure that the retrieval team is provided with all relevant patient history and clinical data. This information will be conveyed to the destination hospital.

If all test results are available at the time of transfer, they should be forwarded to the destination hospital as soon as possible.

The MO/Senior Nurse will verbally handover to the team on their arrival.

NETS will coordinate the communication by the retrieval team with the destination hospital clinician via conference call.

Transfer for Non-Urgent Cases

Please refer to HNE LHD PCP 'Inter-facility Transfer for Patients Requiring Specialist Care PD2019_020: PCP 3. Page 11.

http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0003/118497/PD2019_020_PCP_3_and_PD2011_031_PCP_1_Inter-facility_Transfer_for_Specialist_Care.pdf

Please see 'Paediatric Transport Matrix' Appendix 3.

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 2.
- 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.
- The patient must be observable at all times, by the escort nurse.
- 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.
- In accordance with the Service Level Agreement between Ambulance Service of NSW and HNELHD, 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 (ie: NICU patients) are accompanied by neonatal nurses from NICU.

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. See appendix 2
  - 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.
- The child/infant does 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 2.
- A functioning telephone - in the event of an acute deterioration in the child's/infant's condition.

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.

Hospital, back transfer will be organised through Patient Flow Unit. Neonatal back-transfers are arranged via NETS.

IMPLEMENTATION PLAN

In addition to inclusion on the PPG Directory, 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 CE News.

EVALUATION PLAN

IMS+ 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 the Executive Team.

CONSULTATION WITH KEY STAKEHOLDERS

2021
Nurse Manger PFU
Critical Care Stream
CYPFS Clinical Quality Patient Care & Strategic Leadership Committee
NETS
Hunter Retrieval Service

2013

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. Child Restraint Best Practice
3. Patient Transport Matrix

REFERENCES

- Kidsafe NSW Inc. *Child Restraint Guidelines* accessed 26/4/21 @kidsafe.com.au/crguidelines
- NSW Health. (2015) PD2011_01 *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.*
- NSW Health. (2010) PD2010_034 *Children and Adolescents – Guidelines for Care in Acute Care Settings*.
- NSW Health (2017) GL2017_010 *Paediatric Service Capability Framework.*
- NSW Health (2005) PD2005-157. *Emergency Paediatric Referrals* - Policy
- NSW Health (2010) PD2010_032 *Children and Adolescents – Admission to Services Designated Level 1-3 Paediatric Medicine and Surgery.*
- NSW Health. (2010) PD2010_031 *Children and Adolescents – Inter Facility Transfers*.
- NSW Health. (2010) PD2010_033 *Children and Adolescents Safety and Security of Children in NSW Health Facilities.*
- NSW Health (2002) *Guidelines for the Networking of Paediatric Services in NSW*
- Australasian College of Emergency Medicine (2000) The *Australian Triage Scale*.
- HNE PCP PD2019_020:PCP3 and PD2011_031:PCP 1 *Inter-facility Transfer for Patients requiring Specialist Care.*

FEEDBACK

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

Appendix One

HNEMR20

HUNTER NEW ENGLAND LOCAL HEALTH NETWORK

Facility: ______________________

PAEDIATRIC TRANSFER FEEDBACK FORM

Ward ______________________

PLEASE USE GUMMED LABEL IF AVAILABLE

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

HOSPITAL/WARD:

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 – April 2011

PAEDIATRIC TRANSFER FEEDBACK FORM

Paediatrics

DO NOT PRINT

Appendix Two

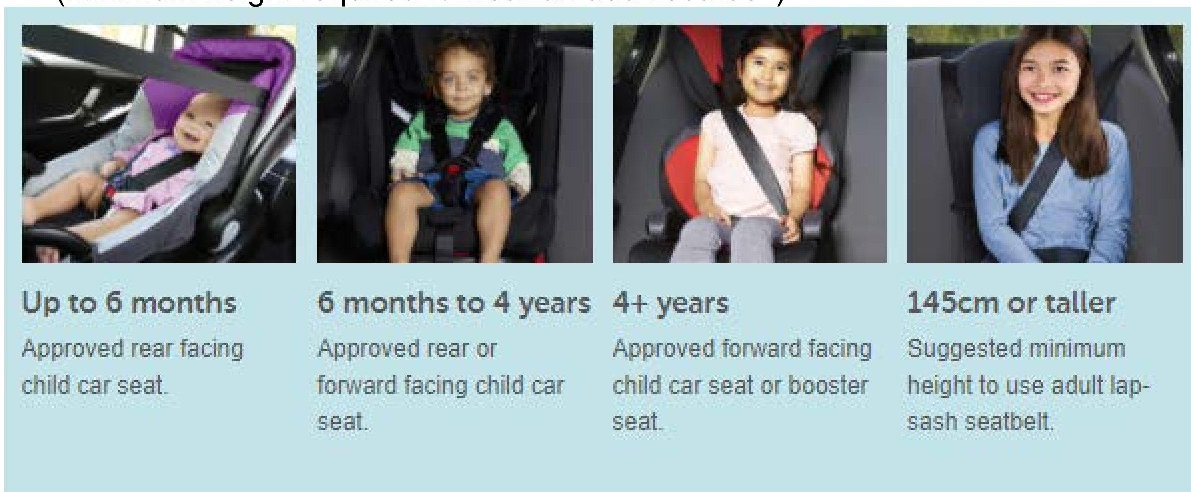
Child Restraint Best Practise: For information about current legislative requirements regarding safety of children in cars go to:
http://www.racv.com.au/wps/wcm/connect/internet/primary/road+safety/child+safety/child+restraints/the+law+and+standards+on+child+restraints/

- **Babies under six months** must use a rearward-facing restraint. Only move to a forward-facing restraint once babies shoulders are above the top shoulder height marker on the restraint.

- **Children six months to four years** must use either a rearward or forward-facing restraint. Use forward-facing restraint until child outgrows and shoulders are no longer within range on restraint.

- **Children four to seven years** must use either a forward-facing restraint **or** booster seat. Booster seats should be used with a lap/sash seatbelt.

- **Children over seven** must use a booster seat until they have outgrown it, then use an adult seatbelt. Continue using a booster seat until children are at least 145cm tall (minimum height required to wear an adult seatbelt).



Following best practise is as simple as continuing to use a car seat as long as a child fits in the restraint, regardless of their age. Compared with children in dedicated child restraint systems, children in adult seatbelts are 3.5 times more likely to sustain a significant injury, particularly to the head.

A child restraint must meet Australian Standards, be correctly installed in the vehicle and adjusted properly to fit the baby or child.

As a general rule children should sit in the back seat (second row of seats). The law requires that:

- From birth to under 4 years children must travel in the back seat in cars with two or more rows of seats.
- From 4 years to younger than 7 years children can only travel in the front seat if all available back seats are in use by younger children.
- Children 7 years and older can legally travel in the front seat.
- Never install a rearward facing restraint where there is an active front passenger airbag due to the high risk of injury. (Kidsafe NSW Inc. Child Restraint Guidelines).

Paediatric Transport Matrix

CLINICIAN TO CLINICAN CONSULTATION MUST OCCUR BEFORE TRANSFER

CATEGORY	ESCORT	CHILD	TRANSPORT & DESTINATION
A RETRIEVAL	**Critical Care Expertise**	**Condition critical / serious / unstable** • Requires intensive care • Requires airway management • Requires inotropic support • Requires continuous monitoring e.g. cardiac monitoring or Sp02	**Mandatory discussion with appropriate retrieval services:** NETS 1300 36 2500 Transport Modality: Road/Helicopter/Fixed Wing Transport team; NETS, Hunter Retrieval Sevice, Tamworth Retrieval Servcie
B URGENT	**Critical Care Nurse and ASNSW Level 4-5, with paediatric ALS**	***Condition serious / stable*** • Major oxygen dependence • Severe tachypnoea • Risk of deterioration enroute • Any drug infusion that requires medicaton alteration enroute • Any history of apnoeas requiring stimulation/ airway support/ resuscitation in last 24 hours	**Mandatory discussion with appropriate retrieval services:** NETS 1300 36 2500
C INTRA TRANSPORT CARE	**RN or EEN with current paediatric experience**	**Care required enroute and condition stable** • Ongoing intravenous therapy, intravenous medication administration or nebulised therapy • Oxygen therapy • Patient Controlled Analgesia (PCA). • Suctioning	**Mandatory discussion with appropriate MO** Contact Patient Flow Unit via Patient Flow Portal between hours 0700hrs-2100hrs or call 1800 892 700 or 4985 5300. 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** • No IV therapy but may have cannula / PICC insitu (capped) • Suspected of being at risk i.e. Non-accidental injury	**Mandatory discussion with appropriate medical officer at destination facility.** Contact Patient Flow Unit, via Patient Flow Portal or call 1800 892 700 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** • 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.** Contact Patient Flow Unit via Patient Flow Portal or call 1800 892 700. Transport modality: Road/Fixed Wing Private transport / Hire Car, Taxi

Fixed Wing or Air Transport

- 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> and <u>Inter-facility Transfer of Patients requiring Specialist Care.</u> These conditions are examples only and should not replace the judgment of attending clinicians or advice from the attending hospital