Paediatric Patient Transfer Protocol

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Review Date 01/07/2017
Sponsor Director of Nursing, Midwifery and Quality
Expiry Date 07/07/2015
Withdrawn Date

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This policy supersedes all previous issues
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<th>Version</th>
<th>Release</th>
<th>Author/Reviewer</th>
<th>Ratified by/Authorised by</th>
<th>Date</th>
<th>Changes (Please identify page no.)</th>
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<td>1.0</td>
<td>19/08/2015</td>
<td>Gill Thompson</td>
<td>SafeCare Council</td>
<td>08/07/2015</td>
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Paediatric Patient Transfer Protocol

1. Introduction

This protocol is intended for use when transferring children and young people from Gateshead Children’s Short Stay Assessment Unit (CSSAU) and Gateshead Emergency Department to any hospital with inpatient provision.

The protocol has been developed from work carried out by the Children’s Clinical Reference and steering Group (2012) working collaboratively with the following organisations:
- Gateshead Health NHS Foundation Trust
- South Tyneside NHS Foundation Trust City Hospitals
- Sunderland NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust

The protocol aims to standardise practice and assist medical, nursing and ambulance staff in the safe transfer of sick and injured children and young people between hospitals.

The protocol includes those children and young people who require transfer with complications following day case surgery and who require inpatient care.

Existing Paediatric Intensive Care Unit (PICU) transfer procedures will apply for those children and young people being transferred for tertiary care. Existing arrangements will also apply for neonatal transfers.

2. Purpose and Scope

The purpose of this protocol is:
- To clarify arrangements when ambulances respond to 999 calls for children confirming where the children should be taken.
- To provide staff with protocol about transferring children and young people from The Queen Elizabeth Gateshead to hospitals providing inpatient care.
- To ensure that an assessment of risk to both staff and children and young people is undertaken prior to any transfer in order to maintain safety.
- To ensure that there is effective communication with the child or young person and their family/carers.
- To meet professional standards and comply with Health and Safety legislation

3. Duties and Responsibilities

Clinical Director, Children’s Services Manager, Clinical Matrons, Ward Managers and Line Managers in all the organisations listed above are responsible for ensuring that staff comply with this procedure and ensure that the standards set within this document are adhered to.

4. Definitions

A Children’s Short Stay Assessment Unit offers medical advice and treatment to patients who require a stay of up to 24 hours in a hospital setting.

An Inpatient Unit offers longer term medical treatment to patients who require a stay of longer than 24 hours.
The Hospitals which have Childrens Short Stay Assessment Units (CSSAU) only on site are:
• Queen Elizabeth Hospital (Gateshead Health NHS FT)
• South Tyneside District Hospital (South Tyneside NHS FT)

The Hospitals which will have an inpatient unit (which could be in addition to a CSSAU) are:
• Sunderland Royal Hospital (City Hospitals Sunderland NHS FT)
• The Great North Children’s Hospital (Newcastle upon Tyne Hospitals NHS FT)

References to children throughout this procedure should be taken to include young people and infants. The document does not apply to Neonatal or Paediatric Intensive Care transfers or trauma.

RESPONSE TO 999 CALLS FOR CHILDREN

NEAS will continue to take children to the nearest children’s emergency department irrespective of whether the site has an inpatient unit. This will enable a rapid response and stabilisation prior to transfer if necessary. There is only one exception to this arrangement:

• where a child presents with torsion of the testes the ambulance will take a child directly to an inpatient unit. This condition is not life threatening but timing of surgery is critical and therefore better outcomes for the child will be achieved by going directly to a paediatric inpatient unit.

TRANSFER FROM CSSAU TO INPATIENT UNIT

5. Principles/responsibilities

5.1 The safety of children and young people who are being transferred between hospital sites is paramount. The overall aim is to ensure that all children & young people will be able to be transferred safely with an appropriate escort from Children’s Short Stay Assessment Units (CSSAU's) directly to inpatient units for admission.

5.2 In order to ensure this, children and young people who develop sudden, life threatening illness or injury should be taken to their nearest Children’s Emergency Department (A&E) for stabilisation prior to transfer to an inpatient unit.

5.3 It is the responsibility of the consultant who authorises the child or young person’s departure to decide the level of transfer requirements i.e. whether they require a paramedic, nursing or medical escort, which mode of transport is required, equipment, medicines and appropriate documentation required to accompany the child or young person.

5.4 A decision on the level of transfer requirements required should be taken in conjunction with the Consultant in charge at the receiving inpatient unit. This discussion could take place with the most senior staff member in charge. If there is no agreement on the transfer requirements then the decision should be escalated to the consultant on call.

5.5 Responsibility for the patient remains with the consultant at the referring unit and the health professionals/paramedic team undertaking the transfer until the safe handover of the patient upon arrival at the inpatient unit. At an operational level the decisions referred to above can be taken by any appropriately trained clinical staff member (e.g. Advanced Nurse Practitioner or Registrar).
5.6 Accompanying parents or guardians may be accommodated at the discretion of the ambulance crew.

5.7 Gateshead CSSAU will identify together with parents/carers the inpatient unit which they will transfer a patient to considering the choice of the patient and their family and healthcare needs.

Arrangements for transfer should be made with:
• Sunderland Royal Hospital or
• The Great North Children’s Hospital

5.8 The child or young person’s parent or carer must be informed about the transfer before this takes place wherever practicable.

5.9 If the child or young person is transferred from the CSSAU escorted only by their parent or carer this must be documented in the notes together with the reasons why this was judged to be an appropriate course of action to take.

5.10 A Transfer Checklist must be completed for all transfers and a copy of this and any other required information must be transmitted to the accepting hospital and the Ambulance Service. The original checklist should then be filed within the child or young person’s case notes.

A transfer flow chart and the transfer checklist are attached as Appendices One and Two respectively.

6. Safeguarding

If there are any safeguarding concerns they should be acted upon in line with local safeguarding procedures. Transfer information should make it clear whether a referral has been made to children’s social care, and what has been said to parents.

There should be a Consultant to Consultant discussion at all times and on every occasion to ensure that responsibility for ongoing management of any child protection concerns is agreed within the receiving Trust.

7. Transfer

Prior to transfer, an assessment of the child must be undertaken by an experienced paediatric practitioner (Registrar at ST3 level or above or advanced nurse practitioner). This is crucial if surgical and anaesthetic assessments are required in addition to a paediatric assessment.

The level of risk to the patient should be assessed so that appropriately qualified staff can be identified to undertake the transfer. It can be very difficult to assess and categorise children (specifically very young infants) and young people but all patients categorised as high risk must be transferred by senior medical and/or nursing staff. The following are suggestions of what to consider when categorising children and young people (specifically very young infants) for transfer.
7.1 Transfer of a stable patient with no airway or cardiovascular compromise and no need for continual physiological monitoring

Depending on the individual circumstances, a child requiring treatment or investigations at a specialist hospital may be transported in any of the following: Parent’s car, hospital taxi or a non-urgent ambulance with the appropriate child restraint.

It is important to ensure that transport orders are written and prescribed; x-rays and lab results are recorded. All patient records and information transferred between hospitals must be treated confidentially, as governed by the Data Protection Act 1998.

All relevant patient medical records/clinical notes/nursing documentation/medicine kardex must be completed and up to date. A clinical summary letter must be prepared by the referring consultant and the nurse caring for the child. The nurse must ensure that the child has their identity band in place.

Parental information from an early stage will hopefully reduce the anxieties associated with transferring a sick child to a different hospital. Explanations as to why this is necessary should be given by the child’s paediatrician / consultant. Maps to the receiving hospital need to be provided along with the name of the ward the child will be taken to. One parent may be able to travel in the ambulance with their child where this is appropriate.

It is the responsibility of the referring trust to ensure that staff and equipment are enabled to return to their base following the safe delivery of the patient to the receiving unit.

Low risk patients who are being transferred by ambulance should be transferred within 2 hours as an “urgent transfer”

7.2 Transfer of a stable patient who is sick and has the potential for deterioration

When a sick child requires transfer as their condition is not improving and has the potential to deteriorate, a paramedic crew will transport the child with the appropriately trained children’s nurse. There must be no concerns regarding the child’s airway; vascular access x2 must be in place, ideally prior to transfer and the paediatric emergency transfer pack must be taken with the patient.

Some non-high dependency patients can be difficult to categorise in terms of potential risk. This group of patients require the consensus of medical and nursing staff (see appendix 3 section 2) & as a good practice, the team should aim for a formal discussion between on call Paediatric Consultant, ITU/Anaesthetist Consultant (at QEH) and on call Paediatric Consultant at the receiving (inpatient) hospital.

The child’s safety during transfer remains the highest priority.

Any condition listed on the “Disorders Constituting High Dependency Care” list should be considered to be Intermediate or High risk. (See appendix 4 for list)

Patients from this list should be transferred by ambulance using the NEAS definition “Green 2 or 3”.

Paediatric Patient Transfer Protocol v1
7.3 Transfer of the critically ill child

When a child is critically ill, PICU referral will be initiated by the referring Consultant Paediatrician in discussion with duty ITU Consultant.

Following consultation with the PICU team at Newcastle, appropriate arrangements for the safe transfer of patient including staff to accompany the patient will be made. The PICU team have the responsibility for locating the nearest available paediatric intensive care bed and organise the retrieval, once the child has been adequately resuscitated and stabilised.

Any condition listed on the “Disorders Constituting High Dependency Care” List (marked for PICU) should be considered high risk (see appendix 4 for list). This is not an exhaustive list and provides a guide only.

Any child who meets the Level 2 and Level 3 criteria as defined by Paediatric Intensive care “A Framework for the Future” (1997), or in the opinion of a senior referring clinician, should be considered high risk.

These patients should be transferred via ambulance immediately using the NEAS definition “Red 1 or 2” (see section 7.8.1 for clarification).

If the condition of a child or young person deteriorates and endotracheal intubation is required, contact must be made with PICU colleagues at the Great North Children’s Hospital and a decision taken regarding whether the Paediatric Intensive Care Retrieval Team should retrieve the child or young person. The decision to transfer must be documented in the child or young person’s case notes, nursing care plan or Observation & Assessment/Accident + Emergency chart, and the child or young person’s Consultant(s) informed prior to transfer.

Further guidance can be found in appendix 3 section 2.

7.4 The Transfer Team

The transfer of patients between hospitals should be undertaken by appropriately qualified clinicians based on assessment of clinical needs, in consultation with the receiving hospital, prior to departure.

When selecting staff for the transfer of a child or young person their training and experience should be taken into account. Consideration should be given to type of escort, and equipment requirements.

It is essential for the ongoing safety and continuity of care that when a child or young person is moved from one site to another that all relevant clinical information (i.e. health records, x-rays and observation charts) accompany the child or young person or are transmitted to the receiving unit prior to their arrival there (see Transfer checklist).

NEAS must be advised of any particular requirements regarding the transfer and an approximate time for the transfer to take place should be confirmed.

7.4.1 Transfer team arrangements for children classified as intermediate risk

The following list (although not exhaustive) gives an indication of the type of children who will require a paramedic/nursing escort with paediatric airway skills:
1. A child or young person who requires oxygen therapy via face mask or nasal cannula at a rate less than five litres per minute to maintain saturation levels within the child or young person’s normal saturation levels
2. A child or young person with altered behaviour due to Mental Health problem following a full assessment
3. A child or young person receiving an intravenous infusion for simple fluid maintenance – these can often be stopped during ambulance transfer reducing risk
4. A child or young person where child protection issues are involved
5. A child or young person who is at risk of hypoglycaemic episodes

Any other circumstances where it is deemed necessary by the paediatric clinician(s) responsible for the child or young person following discussion with the receiving consultant(s)

7.4.2 Transfer team arrangements for children classified as high risk

The transfer of a high risk patient should involve consultants from the referring and receiving inpatient unit. The following list (although not exhaustive) gives an indication of the type of children who will require a medical escort with advanced paediatric airway skills:

1. Potential for deterioration of airway or breathing
2. When the child is potentially unstable
3. A child or young person who has had or is at risk of apnoeic episodes
4. Any child receiving intravenous fluids which cannot be stopped prior to transfer by ambulance
5. Is sedated or has fluctuating levels of consciousness
6. A child or young person who has an altered level of consciousness indicated by a Glasgow Coma Score between 12-14
7. A child or young person who requires high flow oxygen therapy during transfer above 5 litres per minute of 40% ambient oxygen
8. Any child requiring surgery, with unstable physiological parameters

Any other circumstances where it is deemed necessary by the paediatric consultant responsible for the child or young person following discussion with the receiving consultant(s)

In any child or young person with unstable physiology the risks and benefits of transfer must be borne in mind and medical personnel undertaking the transfer must be skilled in the ongoing assessment of such children and young people and management of any potential complications. Appropriate equipment should be taken to allow the continual monitoring and reassessment of such children and young people and treatment of any potential problems.

7.5 Paediatric Intensive Care Retrieval

Please note that current PICU guidelines continue to apply to all PICU retrievals.
7.6 Transfer process

7.6.1 Before Transfer

The referring CSSAU should telephone the receiving inpatient hospital just before setting off.

The transfer checklist should be completed and the patient signed as “Safe for Transfer”.

For paramedic only transfer the handover of clinical information to allow safe transport must be clear and unambiguous e.g. oxygen requirement.

In the case of paramedic only transfer there shall be a telephone handover between registrars at the referring CSSAU and receiving inpatient hospital.

7.6.2 During transfer

Children and young people need to be transported safely and securely.

7.6.3 Actions during transfer

Any care that is given during the transfer should be clearly documented in the patients records as soon as is practical. This may be on arrival at the receiving area.

7.6.4 On Arrival at transfer Destination

The registered nurse in charge of the child’s care must ensure that they are transferred with the required supporting information with them e.g. previous x-rays and scans and copies of medical records. In some circumstances this may require the registered nurse to give the receiving ward / hospital a full “telephone handover”.

GNCH will receive transferred patients with medical or surgical conditions (including orthopaedic) via their A&E. The transfer location for surgical patients will be discussed and guided by surgical opinion. Patients will be reviewed by the paediatric team to ensure their condition has not deteriorated during transfer. (These pathways are shown in Appendix 5).

CHSFT will receive the patient directly to the ward unless the receiving registrar requests that the child is received in the paediatric emergency department. If the child deteriorates on the transfer, the paramedic or professional escorting the child may decide that for patient safety reasons the child is best reassessed in the children’s Accident and Emergency department.

The communication with parents between the transferring and receiving inpatient unit must be consistent.

If there was a need for communication about the appropriateness of transfer this will not be conducted in front of parents or patients.

A transfer flow chart is attached at appendix 1.
7.7 Special Considerations

In circumstances where a child or young person (or parent/carer) refuses to have an escort or to transfer to the inpatient unit, an assessment of risk should be undertaken and an outcome agreed between medical and nursing staff. Discussion with CAMHS may be required to assess this risk and plan care. On every occasion this should be documented clearly in the child or young person’s notes.

7.8 Modes of Transport

7.8.1 Ambulances

The mode of transport and the skills of ambulance crews required will be decided by NEAS on receipt of a request to transfer.

<table>
<thead>
<tr>
<th>Incident Category</th>
<th>Definition</th>
<th>Contact Number for NEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red 1</td>
<td>For patients who are in respiratory or cardiac arrest. The response target is 8 minutes. (999 response)</td>
<td>999</td>
</tr>
<tr>
<td>Red 2</td>
<td>All other life threatening emergencies. Response time target within 8 minutes (Blue lights and sirens) (999 response)</td>
<td>999</td>
</tr>
<tr>
<td>Green 2</td>
<td>Emergency response within 30 minutes (blue lights and sirens) (999 response)</td>
<td>999</td>
</tr>
<tr>
<td>Green 3</td>
<td>Response time within 1 hour (999 response non-blue light)</td>
<td>999</td>
</tr>
<tr>
<td>Urgent Transfer</td>
<td>Within an agreed timeframe e.g. 1 hour, 2 hour and 4 hour</td>
<td>0191 4143144</td>
</tr>
</tbody>
</table>

Vehicles used to transfer Red category patient would be manned by two members of staff (a driver and an attendant). If the skill level of Paramedic is required then this must be specified when requesting the vehicle. The ambulances will contain all necessary equipment required for administering oxygen and performing suction. They will also carry fluid resuscitation equipment and other emergency equipment.

When needing to transfer a patient in an emergency then ambulance control should be contacted by phone to discuss the transfer. The clinician responsible for the patient must determine what skill level of crew is required e.g. Paramedic or Ambulance Technician.

If the patient needs to be transferred immediately or quicker than the times available in an Urgent Transfer then ring 999 and ask for an immediate transfer.

Under ordinary circumstances it would not be considered to be within a child’s best interests to be transferred after 10.00pm at night.

Where it is clinically appropriate to do so and parents have suitable transport a child could be taken to the inpatient unit by parents/carers.
8. **Discharge**

Children from Gateshead that have had an inpatient stay at CHSFT or GNCH will be discharged back to local services and the local CSSAU and GP will receive a timely discharge summary. The discharge checklist (Appendix 6) will be used for all children.

9. **Monitoring**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Method of assessment</th>
<th>Frequency</th>
<th>Body to whom this is reported</th>
</tr>
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<tbody>
<tr>
<td>Number of transfers</td>
<td>Not applicable</td>
<td>Report</td>
<td>Monthly data reported quarterly</td>
<td>SafeCare Council</td>
</tr>
<tr>
<td>All transfers are</td>
<td>100%</td>
<td>Report</td>
<td>Monthly data reported quarterly</td>
<td></td>
</tr>
<tr>
<td>appropriate</td>
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10. **Equality and Diversity**

The Foundation Trusts involved in drafting this guidance are committed, as far as is reasonably practicable, to ensuring that the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

11. **Dissemination, Implementation and Training**

Dissemination will take place via email to Senior Managers and Clinicians within the relevant Trusts. They will be responsible for the training and awareness of staff.

12. **References**


High Dependency Care for Children (2001 DH)

Guidelines for the inter-transfer of paediatric patients - East Cheshire NHS Trust 2015
Stable Patient needs Admissions

Phone call from ANP/Registrar to Inpatient Unit Registrar –
overseen by Consultant

CSSAU determines need for nurse/medical staff to accompany patient

CSSAU contacts NEAS
Agree transfer time

CSSAU loads patient (+ other staff) and documentation into NEAS ambulance

Inpatient Unit receives patient Emergency Department
or inpatient Ward (site and time dependent – always ED at Newcastle)

Brief Assessment (standard response time to be agreed)

Patient admitted to ward in the inpatient unit

Discharge Communication Proforma
Flag action required
Safety Net –
communication with parents
## Appendix Two

### TRANSFER CHECKLIST

<table>
<thead>
<tr>
<th>Patient demographics</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
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<tr>
<td>Age</td>
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<tr>
<td>Address</td>
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<tr>
<td>Mobile Number</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is a hard copy of the clerking sheet (including standard history and examination) attached?</td>
</tr>
<tr>
<td>2. Clinical Observations recorded?</td>
</tr>
<tr>
<td>3. Early Warning Score undertaken?</td>
</tr>
<tr>
<td>4. Copy of current observations included?</td>
</tr>
<tr>
<td>5. Drug Kardex – copy included?</td>
</tr>
<tr>
<td>6. Patients name band in situ and correct?</td>
</tr>
<tr>
<td>7. Hospital number corresponds with medical records?</td>
</tr>
<tr>
<td>8. Hard copies of laboratory results printed and attached?</td>
</tr>
<tr>
<td>9. Pending tests chased and provided to receiving hospital?</td>
</tr>
<tr>
<td>10. Blood products required and authorised via the Trust Blood Transfusion Policy?</td>
</tr>
<tr>
<td>11. Are copies of x-rays images attached/transferred?</td>
</tr>
<tr>
<td>12. Are there any safeguarding issues?</td>
</tr>
<tr>
<td>If yes has the local consultant been informed?</td>
</tr>
<tr>
<td>Has the consultant at the receiving unit been informed?</td>
</tr>
<tr>
<td>11. Transport ordered and organised with appropriate level of escort?</td>
</tr>
<tr>
<td>12. Equipment: Check that all equipment is to hand and in working order before transfer.</td>
</tr>
<tr>
<td>13. Have travel arrangements for parents discussed?</td>
</tr>
<tr>
<td>14. Document if parent is accompanying by ambulance.</td>
</tr>
<tr>
<td>15. Information pack about receiving hospital given to parents?</td>
</tr>
<tr>
<td>16. Parents/Carers advised about MRSA screening?</td>
</tr>
<tr>
<td>17. Has Registered Nurse ensured that privacy, physical comfort and dignity will be maintained during transfer?</td>
</tr>
<tr>
<td>18. Confirmation that patient is “Safe to Send” – sign and print name, date and time?</td>
</tr>
</tbody>
</table>

Please complete all elements of checklist by circling Yes, No, or Not Applicable.

When patient leaves CSSAU please telephone the receiving ward to confirm that they are on their way.

**Ward F64, Sunderland Royal Hospital – 0191 569 9764**
**Great North Children’s Hospital -On call Paediatric Registrar 01912829228 or A&E 01912826111**
Appendix Three

Section 1 PICU Transfers currently by retrieval team – system in place

Section 2 HDU Transfers

- Medically “Unstable”-traditionally more difficult – a decision to transfer should be made following discussion between on call Paediatrician, ITU/ Anaesthetic Consultants on site and Paediatric Consultant at the receiving/inpatient unit (seek PICU guidance, if needed)
- Outcome of above discussion should be documented in patient’ hospital notes
- The safe transfer remains the responsibility of the transferring hospital
- There should be standard documentation in place for transfer (appendix 2-Transfer check list)
- Patient to be prepared for transfer then request to North East Ambulance Service for blue light transfer (category Red 2, i.e. within 8 minutes) or alternative timing according to needs of patient (see NEAS Ambulance transport categories)
- This category of transfers is being considered as part of a regional review of a designated Paediatric and Neonatal retrieval service which is not yet available.

Section 3 Medically “Stable” including orthopaedics

- Transfers by NEAS– agreement by all contributors that needs to be within 2 hours
- Could be escorted by paramedics on most occasions (Northumbria experience).
- Nursing or Paediatric escort deemed to be competent and feel clinically safe – needs to be flexible according to need but eg if airway problem anticipated consider someone with APLS skills (discuss with Paediatric & ITU Consultant on call)
- Draft transfer document contains details of retrieval times as agreed with NEAS
**Appendix Four**

“**Disorders Constituting High Dependency Care**

This list is illustrative but not exhaustive

<table>
<thead>
<tr>
<th>Disorder of patients</th>
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<tbody>
<tr>
<td>Prolonged (e.g. over 1 hour) or recurrent convulsions</td>
</tr>
<tr>
<td>Bacterial Meningitis</td>
</tr>
<tr>
<td>Glasgow coma score 8 to 12</td>
</tr>
<tr>
<td>Circulatory instability due to hypovolaemia other than meningococcal disease</td>
</tr>
<tr>
<td>Diabetic ketoacidosis with drowsiness</td>
</tr>
<tr>
<td>Patient with pain which is difficult to control</td>
</tr>
<tr>
<td>Meningococcal septicaemia – stable state</td>
</tr>
<tr>
<td>Continuous intravenous fluid resuscitation &gt;10ml/kg &lt;30ml/kg</td>
</tr>
<tr>
<td>Acute renal failure (urine output&lt;1ml/kg/hour)</td>
</tr>
<tr>
<td>FiO2 &gt;0.5 via head box or facemask or, nasal CPAP for bronchiolitis</td>
</tr>
<tr>
<td>Recurrent apnoea’s</td>
</tr>
<tr>
<td>Upper airway obstruction – close observation</td>
</tr>
<tr>
<td>Asthma on iv drugs or hourly nebulisers</td>
</tr>
<tr>
<td>Poisoning/substance misuse with potential for significant problems</td>
</tr>
<tr>
<td>After/during sedation for procedure</td>
</tr>
<tr>
<td>Pre or post-operative patients with complex fluid management analgesia, bleeding, complex surgery, (booked or emergency)</td>
</tr>
<tr>
<td>Cardiac arrhythmia which has responded to first line therapy (other than cardio version)</td>
</tr>
<tr>
<td>Cardiac abnormality/ failure</td>
</tr>
<tr>
<td>Chronic lung disease</td>
</tr>
<tr>
<td>The need for intravenous infusion of vasoactive drugs to support cardiac output or control BP</td>
</tr>
<tr>
<td>Nebulised adrenaline for upper airway obstruction after 2 doses or more</td>
</tr>
<tr>
<td>Any Airway intervention (e.g. Tracheal Intubation)</td>
</tr>
<tr>
<td>Uncontrolled shock needing repeated volume &amp;/or inotropic or greater than 30mg/kg resuscitation volume</td>
</tr>
<tr>
<td>Diabetic Ketoacidosis with deteriorating level of consciousness after start of therapy</td>
</tr>
</tbody>
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Appendix Five

Paediatric Abdominal Pain Pathway

- Walk in centre
- Self
- GP
- AMBULANCE

PAEDIATRIC EMERGENCY ASSESSMENT
Review by paediatric / A&E teams

HOME
CSSAU Observation up to 24 hours +/- Paediatric Surgical opinion from RVI

ADMIT
Home with open access to RVI

Paediatric Orthopaedic Pathway

Patient referred to orthopaedic on-call team

Review in the Paediatric Assessment Area by orthopaedics

Outpatient management
Operative management

Discuss with paediatric and anaesthetic teams

Discharge & trauma clinic follow-up
Discharge & return to CSSAU as a day case
Admit CSSAU for surgery
Transfer to A&E at GNCH(RVI) or Sunderland (orthopaedic teams to discuss)
## DISCHARGE CHECKLIST

### Patient demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Mobile Number</th>
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### Name

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### Telephone Number

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### Checklist

1. **Discharge summary sent to referring hospital within 8 hours of discharge** – preferably before Clerking Sheet (including standard history and examination) – hard copy to be sent (proforma to be developed)  
   - Yes  No  N/A

2. **Drug kardex - hard copy attached?**  
   - Yes  No  N/A

3. **Laboratory results – hard copies printed and attached?**  
   - Yes  No  N/A

4. **Discharge drugs and prescriptions given to parent/carers?**  
   - Yes  No  N/A

5. **Laboratory results and tests pending?**  
   - **Responsibility of discharging hospital to chase and communicate to the receiving hospital.**  
   - Yes  No  N/A

6. **PAC X-Rays sent?**  
   - Yes  No  N/A

7. **Plan communicated with parents?**  
   - Yes  No  N/A
   - Give details.

8. **Travel arrangements for parents confirmed?**  
   - Yes  No  N/A

9. **Referral to Paediatric Community Nursing Team?**  
   - If Yes complete referral form.  
   - Yes  No  N/A

10. **Is Outpatient review required? Timescale?**  
    - **(responsibility of the initial referring CSSAU)**  
    - Yes  No  N/A

11. **All information faxed to the CSSAU dedicated fax line?**  
    - Yes  No  N/A

12. **Critical results: should the discharging hospital receive a critical result e.g. high potassium level?**  
    - **The discharging registrar must make the receiving hospital aware.**  
    - Yes  No  N/A

13. **Confirmation that patient is “Safe for Discharge” – Signature: Print name: Date and time:**  
    - Yes  No  N/A