Mid Essex Hospital Services NHS Trust

GUIDELINE FOR TRANSFERRING CHILDREN (0-16 years)	**Guideline** **Register no 09005** **Status: Public**

Developed in response to:	Good practice
CQC Fundamental Standards:	10,11

Consulted With	**Post/Committee/Group**	**Date**
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Document History:

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1.0	Carol Newman / Caroline Fox	January 2009
2.0	Carol Newman	October 2011
2.1	Carol Newman, Dr M Datta, Sue Wright to include informing GOSH of any child on a Child Protection Plan	October 2012
3.0	Andrea Stanley	October 2014
3.1	Andrea Stanley - Flow chart for transfer of a child to a paediatric tertiary centre added Appendix C. Appendices C-F reordered as D-G	3rd September 2015
4.0	Mel Chambers	27th June 2018

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1.0 Purpose

1.1 Infants, children and young people requiring transfer either within the hospital or outside of the hospital to other providers of care have specific needs not fully addressed by the Trusts patient transfer policy.

1.2 The purpose of this policy and its supportive documents is to ensure safe and appropriate transfer of the patient with minimal risk. The aim is to clarify the clinical accountability of the nursing staff, medical team and supportive staff who are responsible for the patient's care to ensure that safe appropriate transfer of patients does occur and their care continues with minimal interruption and risk.

1.3 All patients within Mid-Essex Hospitals Trust that require transfer from one area to another either internally or externally must have the appropriate documentation completed to ensure that patient care is not compromised as a result of the transfer.

2.0 Scope

2.1 This guideline applies to all staff, professional, administrative, bank, agency and locum who may be involved in the transfer of sick infants and children either within the hospital or outside of the hospital to other providers of care.

2.2 This policy is to be used for all types of hospital transfers.

2.3 This document outlines the procedure for the transfer of all patients both within the hospital and outside of the hospital to other providers of care.

3.0 Background

3.1 Advances in technology and differing service provision means it is increasingly common for sick children to be transferred between hospital facilities for different elements of their care. It is important to ensure that guidelines are available to make sure that patients, and their records, are transferred safely.

3.2 Maintaining the well being of an acutely ill child is the principle concern. However, there are more factors to be considered:

- Nursing staff
- Medical staff
- Ambulance support
- Planned or Emergency transfer
- Documentation
- All necessary medicines and equipment
- Parental involvement or legal guardians

3.3 The referring physician assesses and initiates the need for the transfer of the child / young person, deciding on the appropriate level of transfer need required i.e. 1-5 (Refer to appendix A). The level of transfer required should match the patients identified needs and any potential needs that could occur during transportation.

3.4 The assessment of the level of transfer of the child does not depend on the destination for example inter or intra hospital but on the clinical need or dependency of the child (refer to Appendix A)

3.5 Stabilisation of the patient should include evaluation and initiation of treatment to ensure that transport will not result in death or loss of or serious impairment of bodily functions, (within reasonable medical probability). This should include the establishment and securing of appropriate intravenous (or equivalent) lines prior to transport.

4.0 Roles and Responsibilities

4.1 Managing Director

The Managing Director is responsible for ensuring that processes are in place and are working. This responsibility is delegated to the Medical Director and Director of Nursing.

4.2 Medical Director and Director of Nursing

The Medical Director and Director of Nursing are responsible for ensuring that systems are in place to support the implementation of this policy.

4.3 Associate Directors of Nursing and Clinical Directors

The Associate Directors of Nursing and Clinical Directors are responsible for ensuring that systems are in place to support the implementation of this policy.

4.4 Medical and Nursing Staff

All medical and nursing staff have a responsibility to ensure they understand this policy and act on its contents in an appropriate way.

5.0 Planning the Transfer

5.1 The basic principles of good transport should be applied to all sick children moved within and between hospitals, whether or not a specialist team is involved. Effective preparation and planning are the keys to safe, successful, smooth transport of ill children. This will ensure that the right patient is taken at the right time by the right people to the right place by the right form of transport and receives the right care throughout.

5.2 Important considerations:

- How urgent is the transfer?
- Is the child in optimal condition for transfer?
- Does the benefit of transfer outweigh the risks involved?
- Who are the most appropriate people to transfer this child?
- What type and mode of transfer is required for this child?

5.3 It is essential to evaluate, resuscitate and stabilise a child's condition before moving him or her – no child must be stabilised "on the way".

5.4 Before the transfer of a child can take place the level of risk and the type of transfer that is required should be determined by senior medical and senior nursing staff. An assessment should be undertaken using the transfer guidance tool (refer to

appendix A & B) to ascertain which level of transfer is appropriate and what considerations should be made for that transfer including mode of transport, equipment required and transfer personnel. The decision and level of transfer to be undertaken should be documented in the patients' notes.

6.0 Moving and Transferring Critically ill Children (Level 1 and Level 2)

6.1 For all children assessed as a level 1 (Red) transfer, the on-call consultant paediatrician and attending anaesthetist will formulate a joint management plan. Discussion may need to take place with the Children's Acute Transport Service (CATS) on the appropriate mode of transport for the child and optimal PICU destinations.

6.2 Children may move between level 1 & level 2 during stabilisation as their condition fluctuates. Reassessment of the child's condition will ensure that the child is moved to the most appropriate destination in the safest manner

6.3 When a decision is made to transfer a critically ill child to a paediatric intensive care unit at another hospital CATS should be contacted at the earliest opportunity to allow a rapid response. It is important that they are kept updated of the child's progress as deterioration in the child's condition may prompt a higher urgency category and elicit earlier mobilisation of the retrieval team.

6.4 For non-intubated high dependency children a discussion should take place with the Children's Acute Transport Service (CATS) on the appropriated mode of transport for the child. CATS generally will not transfer high dependency patients but may be able to offer advice.

6.5 Any such child with actual or potential risk of significant airway, breathing or circulatory compromise must remain on the ward for further or continued assessment and stabilisation (CEWT score of a red 3 or 4 and above).

6.6 If a child meets HDU criteria and needs to be transferred to another hospital, appropriate preparations need to take place which should include decisions about personnel, equipment and mode of transport.

7.0 Time Critical Transfers e.g. Head Injuries and Cranial Bleeds

(Refer to Appendix E)

7.1 All these patients should be considered to be either a level 1 or a level 2 transfer.

7.2 The consultant paediatrician and attending anaesthetist will formulate a joint management plan. The main thrust of the plan should be to provide the appropriate intensive care support and rapid transfer within the time critical period to a Paediatric Intensive Care Unit.

7.3 All patients should be transferred by staff trained in European Paediatric Advanced Life Support (EPALS). Assess and transfer as Level 1 (red).

7.4 The Equipment and Drugs Transfer bags and appropriate electrical equipment (e.g. infusion pumps and monitoring equipment) should be taken when accompanying the patient (unless transferring with CATS).

8.0 Moving and Transferring Children at Level 3

8.1 Children who are assessed as level 3 have the potential for deterioration.

8.2 Children should be assessed and stabilised before transfer takes place. It is not appropriate to transfer sick unstable children.

8.3 All children assessed as a level 3 type transfer may need to be referred to the paediatric registrar on-call. Further assessment and stabilisation by senior paediatric medical staff will help to identify those at greater risk of airway, breathing or circulatory compromise who may have the potential for deterioration during transfer.

8.4 Any such child with actual or potential risk of significant airway, breathing or circulatory compromise must remain in the department/ward for assessment and stabilisation (CEWT score of a red 3 or 4 and above).

8.5 These children should be reviewed by middle grade staff or consultant, if present. Discuss these cases with anaesthetic staff if appropriate. The consultant paediatrician can be contacted directly by the staff as soon as possible to discuss further management of these critically ill children if the on call registrar is not available.

8.6 Once a decision has been taken that the child is stable for transfer it is the responsibility of the registrar to communicate all relevant information to the nursing staff on the ward.

8.7 The original notes or other documentation must be transferred with the patient.

9.0 Moving and Transferring Children at Level 4

9.1 Stable children with no airway or cardiovascular compromise but requiring continuous monitoring of physiological parameters are transferred as level 4. These may include one of the following interventions:

- Operative intervention
- Received sedation / opiates
- Condition may change at short notice e.g. head injury
- Condition may reasonably evolve e.g. allergic reaction
- Received some from of resuscitation

9.2 A joint decision should be made between the registrar and nursing staff about the appropriate mode of transfer and escort e.g. moving to and back from theatre, imaging, stable children from A&E and OPD at tertiary hospitals. All transfers must take place in accordance with Appendix A

9.3 The registrar should make sure that the transfer is appropriate and the transfer is made in the safest possible mode.

9.4 If additional medical staff is thought to be necessary careful consideration should be given regarding the appropriateness of the transfer.

10 .0 Moving and Transferring Children at Level 5

10.1 Stable patient with no airway or cardiovascular compromise and not requiring continuous monitoring of physiological parameters, but requiring hospitalisation or investigation away from department

10.2 Well children who only need Specialist opinion and/or a planned elective admission can be sent in parent's car/by public transport

11.0 Preparation for Transfer (transfer requirements and documentation to accompany the patient)

11.1 Prior to all transfers, arrangements should be made for admission to the receiving hospital and / or ward.

11.2 The nurse caring for the child should ensure that the appropriate planning takes place.

11.3 For high dependency transfers to another hospital the nurse in charge with the consultant on call is responsible for ensuring that the nurse/doctor transferring the child is experienced in 'out of hospital' transfers, and suitably experienced in the child's condition.

11.4 Any child that requires HDU level care requires a doctor and nurse escort. Consider the potential for the child's condition to deteriorate en route, discuss with the consultant on-call and consider discussing with CATS who may be able to give advice with 'out of hospital' transfers.

11.5 After discussion with the on-call consultant consider the need for the consultant to come in to cover the registrar if they are required to transfer the child to another hospital.

11.6 If there are concerns or further advice is required for the planned transfer discuss with the co-ordinator and/or on-call manager.

11.7 If nursing staff levels are insufficient to permit the safe 'out of hospital' transfer of the child discuss with the co-ordinator and/or on-call manager.

11.8 Inform the child and family of the reason for the transfer and obtain their verbal consent.

11.9 Arrange ambulance or porters depending on the destination. Ensure that all other necessary preparations are made prior to arranging for transport.

11.10 Check all equipment required for the transfer, is available and in working order. Batteries should be fully charged and that there is enough oxygen to last during the transfer.

11.11 All appropriate notes, x-rays, imaging, blood results and charts should be photocopied and sent with the child

11.12 If blood products need to be transferred with the patient then this should be done following the Trusts Blood Transfusion Policy.

11.13 If the patient has any medicines currently prescribed for them, then these should be checked against the patient prescription sheet before being transferred with the patient.

11.14 Appropriate monitoring should be attached to the patient if required. Monitors should be secured appropriately and not rested on the trolley, bed or patients knee. Infusion devices should be attached to a drip pole and not laid on the trolley or bed with the patient. They should be at or below heart level.

11.15 Clinical observations should be recorded prior to transfer and Children's Early Warning Scoring under taken in order to establish child/young persons' clinical status. Transfer should be delayed if these give cause for concern.

11.16 Prior to leaving the clinical area the transferring nurse will check that the patient is appropriately clothed for the transfer and bedding supplied as necessary to prevent heat loss and maintain the patients dignity during the journey.

11.17 The child's property should be placed in a bag ready for transfer and given to the parent or carer if they are present, (or transferred directly with the child if not present).

11.18 Where possible the parent/carer should be present during the transfer of the child. Parents of critically ill children, in most cases, will be able to accompany them in the ambulance with the retrieval team. When this is not possible or is not appropriate it is recommended that a hospital taxi is arranged for the transfer of the parent/carer to take them to the receiving hospital as they are usually unfit to drive due to stress. If they are transferring themselves, they should be given a route map to the hospital and advised not to attempt to keep up with the ambulance.

11.19 **Transfer requirements**: all transfer requirements should be provided as indicated (refer to appendix F) and documented on the internal / external transfer check list (Appendix C) and the original sent with patient if appropriate. A photocopy of the transfer checklist should be filed in patient's notes.

11.20 **Documentation to accompany the patient**: a Nursing Transfer Letter should be completed by the nurse caring for the child dependant on the type of transfer prior to transfer and sent with the patient (Appendix D).

11.21 A letter should be completed by the doctor caring for the child and sent with the patient. A consultant to consultant referral should be requested.

12.0 Observation during Transfer

12.1 Appropriate observations of the vital signs should be performed during the period of transfer depending on the clinical diagnosis and severity of the patients. The

Children's Observation Policy will guide decision making. These should be noted and handed over to the receiving Department or external Hospital staff.

12.2 Observation notes while recorded during transfer should be photocopied at the receiving hospital and inserted into the child's MEHT notes on return.

12.3 Any adverse events / incidents that occur during the transfer should be documented and a datix report form completed.

13.0 Staff Training

13.1 All medical and nursing staff are to ensure that their knowledge, competencies and skills are up-to-date in order to complete their portfolio for appraisal.

13.2 All registered nurses will be trained in basic life support

13.3 All senior nurses (bands 6 and 7), registrars and consultants will be trained in Advanced Paediatric Life Support (EPLS/APLS).

13.4 During induction process for junior medical staff.

13.5 At case presentation and junior doctor teaching sessions.

14.0 Infection Prevention

14.1 All staff should follow Trust guidelines on infection prevention ensuring that they effectively 'decontaminate their hands' before and after each procedure.

14.2 All staff should ensure that they follow Trust guidelines on infection prevention using Aseptic Non-Touch Technique (ANTT) when carrying out procedures

15.0 Equality and Diversity

15.1 Mid Essex Hospitals is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

15.2 An Equality Impact Assessment is attached to the policy at appendix

16.0 Monitoring compliance with Policy Requirements

16.1 All incidents relating to this guideline will be investigated, an action plan drawn up and recommendations made for improving care provided.

16.2 An annual audit of compliance with key requirements of this policy will be undertaken by the Lead Nurse for Children and Young People with the support of clinical audit. As a minimum this will assess compliance with:

- the transfer requirements for each patient group
- the documentation that should accompany the patient when being transferred
- the process for transfer out of hours

16.4 The findings of the audit will be reported to the Clinical Director for Women and Children and reviewed at the Women and Children Governance Meeting. Where indicated, actions will be developed to address deficiencies with named leads and timescales. Progress with any actions will be monitored at subsequent meetings.

17.0 Implementation and Communication

17.1 The policy will be uploaded on the Trust Intranet site and will be communicated to staff via staff focus.

17.2 The policy will be circulated to the Clinical Lead for paediatrics and Lead Nurse for children & young people for dissemination.

18.0 References

Advanced Life Support Group [ALSG] (2011) Advanced paediatric Life Support: The practical Approach Fifth Edition. Wiley-Blackwell publishing: Chichester

Dixon, M et al editor (2009) Nursing the Highly Dependent Child or Infant - A Manual of Care Wiley-Blackwell publishing

DOH (2001) High dependency care for children – report of an advisory group

DOH (2003) Hospital standards document: Children's national service framework

DOH (2006) The acutely or critically or injured child in the district general hospital: A team response

Guidance on the provision of paediatric anaesthetic services. Royal College of anaesthesia (Revised April 2010)

Health care commission (2009) Improving the services for children in hospital

Joint statement from the society of British neurological surgeons and the royal college of anaesthetists regarding the provision of emergency paediatric neurosurgical services (2010)

Paediatric intensive care society (2010) Standards for the care of critically ill children 4th edition

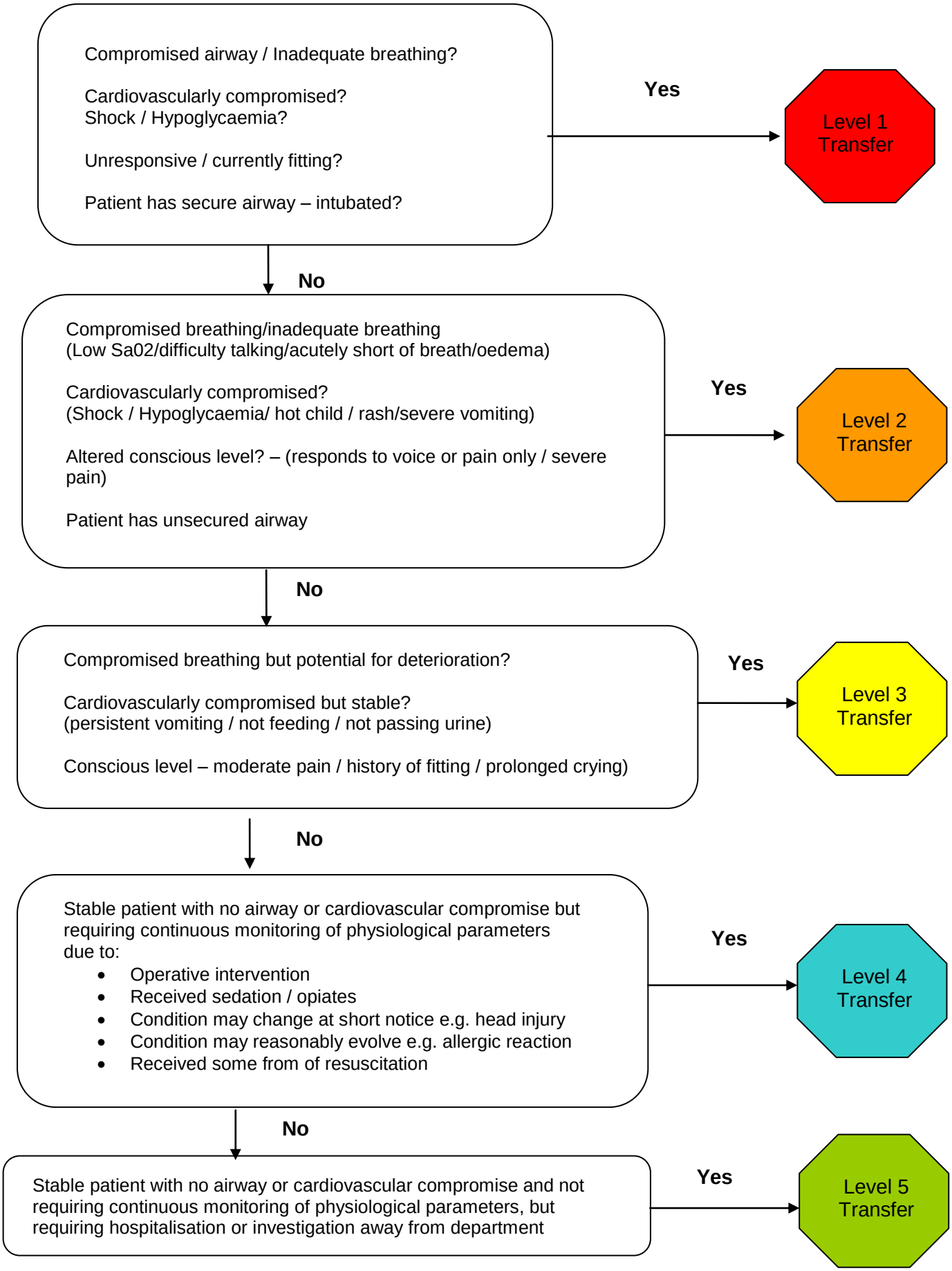
RCN (2011) Transferring children to and from theatre. Position statement and guidance for good practice

Report of the intercollegiate committee for services for children in emergency departments. (2007) Services for children in emergency departments

The Royal college of surgeons of England (2007) Surgery for children

Children's Acute Transport Retrieval Service (online) accessed 24/10/2014 http://www.cats.nhs.uk

Clinical Dependency Assessment tool for transfer of children



Appendix B

Recommended Resources for safe transfer of children

Transfer of level 1 patient with:

- Secure airway
- Vascular access
- Monitoring equipment – ECG / SaO2 / RR / BP
- Resuscitation pack including oxygen
- Retrieval team e.g. CATS
- Consultant
- Anaesthetist } If using local team
- Senior Nurse

Inter-hospital transfer – regional transport team optional (local and CATS decision regarding most appropriate)

Transfer of level 2 patient with:

- Vascular access
- Monitoring equipment – ECG / Sa02 / RR / BP
- Resuscitation pack including oxygen
- Consultant Anaesthetist if possible
- Senior Nurse

Strong consideration should be given to converting to level 1 and securing airway

Transfer of level 3 patient with:

- Vascular access
- Monitoring equipment – ECG / SaO2 / RR / BP
- Resuscitation pack including oxygen
- Senior nurse
- Paramedic crew and 'blue light' for inter-hospital transfer

Transfer of Level 4 patient with:

- Unrestricted access to patient
- Continuous monitoring required for patient condition e.g. SaO2 monitoring
- Full oxygen cylinder
- Accompanied by nurse or paramedic crew

Transfer of Level 5 patient with:

- Wheelchair or bed / stretcher
- Car seat transfer with parents and/or appropriate accompanying member of healthcare team

Appendix C

Internal/External Transferring Children Safely Checklist

Surname: First Name:	DOB:___ / ___ / _____	Hospital No: NHS No:

Clinical Dependency (see guidelines) ✓ applicable level following assessment

Level 1	CATS or local critical care team transfer	
Level 2	Senior doctor & nurse; anaesthetist if possible. Consider converting to level 1	
Level 3	Senior nurse & paramedic crew and blue lights	
Level 4	Nurse &/or paramedic crew	
Level 5	Car with parents	

Date & time of assessment:		Date of Transfer:	
Dr authorising transfer:		Consultant aware of transfer:	Y / N
Receiving ward / hospital:		Telephone number of receiving ward:	
Receiving consultant / doctor:		Contact details of receiving consultant / doctor:	

Pre-departure check list

Discussion with nurse in charge on Phoenix	Y / N	Receiving hospital / dept contacted	Y / N	Handover	Y / N		
Ambulance control / Porter contacted	Y / N	Ambulance booked	Y / N	Arrival of ambulance confirmed	Y / N	Parents aware of transfer	Y / N
Ventilator	Y / N	Oxygen	Y / N	Suction	Y / N	Monitoring	Y / N
Transfer bag	Y / N	Drugs bag	Y / N	Mobile phone	Y / N	High visibility jacket	Y / N

Photocopied documents sent ✓ if applicable

Drug treatment card		Fluid chart		Map for parents	
IV prescription chart		Nurse letter		Notes	
Observation chart		Doctor letter		x-rays/imaging	

Name Dr accompanying			
Name Nurse accompanying			
Parent / Carer / Other accompanying			
Original checklist provided to patient / parent / carer	Yes / No / NA	Copy of doctor letter provided	Yes / No / NA

Contact details of parent / carer	

Transfer details

Departure time		Arrival time	
Evaluation/notes/additional information/communication during transfer:			
Signature of accompanying Doctor:			
Signature of accompanying Nurse:			
Care handed over to:			

Adverse events/incidents during transfer:
Document detail of equipment failure/patient deterioration/delays etc

N.B. Send original checklist with patient. File photocopied checklist in patient's notes. Any adverse incident requires a datix to be completed. Please ensure all equipment / transfer bags are checked and restocked on completion of transfer.

Appendix D

Nurse Transfer Letter

MID ESSEX HOSPITALS
TRANSFER LETTER - WARD E1.1 PHOENIX UNIT (122)

Patient No: 009 Known As: _____

Name:
Address:
GREAT NOTLEY
BRAINTREE
ESSEX

Age: 3Y
D.O.B: 25/10/2007
Marital Status: SINGLE
Religion: UNKNOWN
Occupation: infant

N.O.K:
GREAT NOTLEY
BRAINTREE
ESSEX

GP:
LITTLE WALTHAM SURG
30 BROOK HILL
LITTLE WALTHAM
CHELMSFORD ESSEX

Phone (h):
Phone (w): 01245
Fax:

Relationship: MOTHER Next of Kin Aware of Transfer: Yes/No

Preferred/2nd Contact: _____

TRANSFER FROM: E11

Date Admitted: 26th January

Consultant: MR J CYRIAC

Spec: PAEDIATRICS

Provisional Diagnosis: _____

Current Weight: _____

Nursing Information: _____

Copies Sent of:-
Care Plan: Yes/No Fluid Chart: Yes/No
Prescription Chart: Yes/No T.P.R Chart: Yes/No

Contact Name: _____
(PRINT NAME)

Appendix E

Time critical transfer of the Critically Ill Child

1.0 Purpose

1.1 Used in conjunction with the transferring children guideline the transfer of critically ill children by a local team can be undertaken safely.

2.0 Background

2.1 Some children, including but not limited to those with a suspected intra-cranial haemorrhage or suspected blocked ventriculo-peritoneal shunt or penetrating trauma, the critical factor in outcome is time to definitive surgical treatment. Waiting for a retrieval team would lead to unnecessary delay in this process. Such children will need to be transferred by local staff usually a senior Anaesthetist with a senior ITU nurse or ODP. The decision to transfer a critically ill child should always be made with full advice and support from the receiving PICU and CATS (Children's Acute Transport Service) – emergency referral hotline 0800 085 0003).

2.2 These transfers must be discussed with Paediatric and Anaesthetic Consultants but by their nature time is critical and plans should be made for transfer as soon as possible. CATS should be contacted and can provide advice, find a bed and liaise with sub-specialities such as neurosurgery.

Refer to CATS website for guidance. Refer to Neurosurgical Emergency and Traumatic Brain Injury guidelines for neurosurgical transfers.

3.0 The Transfer Team

3.1 This would usually consist of:

A suitably experienced anaesthetic specialist trainee or specialist doctor who has completed intermediate level paediatric anaesthesia training and holds a current advanced paediatric resuscitation qualification; or a Consultant Anaesthetist.

An anaesthetic assistant who is an ODP, with paediatric training and/or a senior children's nurse with HDU or ICU experience

3.2 In the case of an un-intubated child with a GCS > 9 and CEWT score < 3, requiring transfer, where there is risk of the airway or breathing deteriorating during the transfer, the accompanying doctor should be an anaesthetist.

3.3 Neonates should be managed by the paediatric team who are more familiar with the special equipment required for this age group.

3.4 Ultimately, where there is no other suitable doctor available (see above), a consultant anaesthetist will always be the best person to undertake the transfer.

4.0 Equipment

4.1 Transfer equipment is available from main theatres, A&E and general ICU. The following equipment should be available for transfer:

- Equipment Bag appropriate to the age of the child, which contains the emergency equipment required for transfer.

- Oxylog 3000 ventilator, set for the appropriate child's weight and age (Transport ventilators for small children are available in A&E, Pheonix and General ICU)

- Drugs: as a minimum, the following drugs should be drawn up in suitable dilutions and available for immediate use**;
  - Sedation – morphine and midazolam infusions.
  - Neuromuscular blockers – suxamethonium boluses available, as well as atracurium or vecuronium infusions
  - Inotropes – advice about which is the most appropriate should be sought from the CATS team
  - Resuscitation drugs – atropine, adrenaline
  - Raised ICP – Mannitol or 3% Hypertonic Saline boluses, Fentanyl for bolus

- Mobile telephone, with all relevant numbers appended

- High visibility jackets

- Transfer Documentation for en Route Observations.

**CATS electronic drug chart / prescription card printed } Refer to CATS website www.cats.nhs.uk

5.0 Mode of Transport

5.1 This will usually be by road ambulance, as the distances involved are small.

5.2 Ambulance control are required to meet strict targets for dispatch of vehicles to public calls and may give a lower priority to calls from a hospital to transfer a patient than calls from the public due to a perception that the patient in hospital is less likely to die.

5.3 East of England Ambulance Service have agreed to provide a rapid response to requests for time critical transfers by our own team for example neurosurgical emergencies, intra-abdominal haemorrhage etc requiring emergency operative intervention.

5.4 In order for appropriate prioritisation of transfers by our own team early warning of the need for a vehicle to transfer a patient must be given and correct information shared with ambulance control.

5.5 Contact Ambulance Control as soon as possible and inform them of the impending need for a rapid response vehicle and the approximate time by which the rest of the

preparations will be ready: kit, drugs, monitors, staff etc. Call again when the team is almost ready to leave requesting an immediate response.

5.6 It is important that this system is not abused in less time critical situations to put pressure on ambulance control to inappropriately increase the priority for example to avoid 'loosing a bed in a tertiary hospital' or because the staff are nearing the end of their shift etc.

6.0 STABILISATION of the child

6.1 This should occur prior to any transfer taking place. There are very few indications for a 'scoop and run' policy, which carries a high mortality.

6.2 Airway and Breathing

- Where deterioration of the airway is anticipated, the child should be intubated before transfer***.
- The ETT should be securely fixed in place, and the child adequately sedated. The position of the ETT should be confirmed by CXR. Neuromuscular blocking drugs should be used for the journey to reduce the likelihood of inadvertent extubation.
- Pneumothoraces should be drained prior to transfer.
- Monitoring should include: SaO2, capnography, airway pressures, ABGs prior to transfer, and CXR.
- A nasogastric or orogastric (in the case of head injury) tube should be placed in the intubated patient.

***CATS clinical guidelines: Induction of Anaesthesia refer to CATS website

6.3 Circulation

- Bleeding should be controlled prior to transfer, and hypovolaemia adequately corrected.
- Inotropic infusions should be prepared in accordance with CATS guidelines prior to transfer where deterioration is anticipated. (please refer to MEHT guidelines as well for preparation of inotropes and other infusions)
- At least two cannulae should be inserted to guarantee vascular access.
- Invasive monitoring is not essential unless the underlying condition warrants it.
- A urinary catheter should be inserted

6.4 Disability

- Advice should be sought from the receiving unit regarding management of raised intracranial pressure.*
- Ensure adequate sedation and neuromuscular blockade.
- Establish adequate ventilation prior to transfer.
- Avoid ties around the neck.

* CATS Clinical Guideline: Neurosurgical Emergency, Traumatic Brain Injury & Local team transfer refer to CATS website

6.5 Exposure

- All lines should be accessible without exposing the child to heat loss.
- Airway tubes, other tubing and lines should be securely fixed.

- The child should be well wrapped, with the head covered to avoid heat loss.

6.6 Glucose

Monitor blood glucose prior to leaving and in transit if journey time is greater than 2 hours (1 hour if child has had previous blood glucose instability).

6.7 Documentation

The following should accompany the patient to the receiving unit;

- Patient details
- Copy of the patient notes
- Transfer chart.
- All treatment administered by the transfer team.
- Relevant consent forms.
- Blood tests and radiographs.
- Check list.
- Telephone numbers of the receiving hospital, with the names of the receiving doctor.

6.8 Pre-transfer checklist

Ensure transfer checklist is completed and using the pneumonic **'TRANSFER'** to ensure a structured approach is adopted and all potential problems considered before transfer takes place.

- **Timing**: Ensure communication has taken place between the MDT in both the referring hospital and receiving hospital and the family.

- **Resources**: Ensure the most appropriate staff to facilitate the transfer are available including any additional staff

- **Assessment:** Full assessment should be undertaken prior to the child being moved.

- **Notes:** Ensure all appropriate documentation is available and up to date and an identity bracelet is clearly on the child

- **Safety:** Ensure that the personnel accompanying the child are suitably trained to undertake any care required during the transfer. Equipment should be secured and there should be enough oxygen available to complete the journey.

- **Family:** Ensure the child's family are kept informed and updated on a regular basis. They should be given full contact details of the new ward/hospital. Transport should be provided for parents/carers if unable to accompany child in ambulance and parents are unable to provide own.

- **Equipment:** Ensure the equipment to be used during the transfer is in full working order and charged

- **Report:** Handover nurse to nurse prior to transfer to facilitate preparation for the child's arrival.

6.9 Print and complete the following checklist prior to transfer

CHECKLIST FOR TRANSFER OF CHILDREN BY THE LOCAL DGH TEAM

Please Print

Appropriate staff identified	
Local ambulance service notified	
State 'Time Critical Emergency Patient Transfer'	
Expect ASAP response time	

Essential equipment

Ensure ETT well secured/good position/no leak.	
Airway bag (tape, mask, T piece, ambubag, ETT, laryngoscopes)	
Drug bag (Fluid boluses, resuscitation drugs)	
Ventilator and sufficient oxygen	
Infusion pumps (sedation, muscle relaxant, vasoactive infusions)	
Run continuous infusions of sedation and muscle relaxant	
Ensure adequate venous +/- arterial access	
Prepare and connect inotropes ready to commence if required	

Adequate monitoring

ECG	
SpO2	
Blood pressure (NIBP cuff **or** arterial)	
End tidal CO_2	

Physiological targets

SpO_2 >95%	
Mean BP = age appropriate target	
End tidal CO_2: 4-5 kPa	
Sedation and paralysis	

Appendix F

Transfer and documentation requirements specific to each type of transfer

Type of transfer	Transfer requirements	Documentation to accompany patient
A&E to children's ward	Ward informed Verbal handover Patient & parent/guardian informed & to accompany to the ward on transfer Escort if required Appropriate equipment if required	Original A&E card Drug chart & O2 prescription if indicated Risk assessment if indicated CEWT score in A&E if indicated
External transfer out to another acute hospital Trust	Ward/dept informed Verbal handover prior to leaving Patient & parent/guardian informed & to accompany on transfer Escort if required Appropriate equipment if required Appropriate mode of transport Liaise with CATS retrieval service for specific requirements on an individual basis	Transfer checklist Nursing and medical transfer letter Copy of notes Copy of radiological imaging and laboratory results Parent information Risk assessment
External transfer in from another acute hospital Trust	Ward/dept informed Verbal handover prior to leaving Patient & parent/guardian informed & to accompany on transfer Escort if required Appropriate equipment if required Appropriate mode of transport	Copy of medical & nursing notes Transfer letter
Transfer to other wards/departments in MEHT including radiology	Ward/department informed Verbal handover Patient & parent/guardian informed & to accompany to the ward on transfer Escort if required Appropriate equipment if required	Nursing & medical notes Drug chart & O2 prescription Risk assessment if indicated CEWT score in ward
Children's ward to Theatre	Appropriate member of the nursing team to escort to theatre and anaesthetic room Parent/guardian to accompany escort to theatre and into anaesthetic room (presence in the anaesthetic room is under the direction of the anaesthetist)	Pre op safety checklist Consent form Baseline observations Allergy status Risk assessment if indicated
Theatre to Children's ward	Verbal handover Parent allowed to be in recovery room and escort child back to ward Registered nurse as a minimum to escort child to ward from recovery Appropriate equipment identified Transfer to ward on trolley/bed (where babies are carried then a trolley must be present)	Op sheet Post op instructions Drug chart O2 prescription CEWT score in recovery Risk assessment if indicated
Recommended level of transfer following a risk assessment using tools in Appendix A & B		
Level 1	CATS or local critical care team	
Level 2	Senior doctor & nurse; anaesthetist if possible. Consider converting to level 1	
Level 3	Senior nurse & paramedic crew	
Level 4	Nurse &/or paramedic crew	
Level 5	Car with parents	

Appendix G

Equality Impact Assessment (EIA)

Title of document: Guideline for Transferring Children 0-16 years

Equality or human rights concern. ***(see guidance notes below)***	**Does this item have any differential impact on the equality groups listed? Brief description of impact.**	**How is this impact being addressed?**
Gender	None	
Race and ethnicity	Patients and/or parents may require translation services.	Trust uses The Big Word for translation services.
Disability	Access to children's wards, emergency dept and OP clinics. Patients and/or parents with cognitive or sensory impairment may have difficulty with understanding information.	All facilities meet building standards. Hospital Liaison Specialist LD Nurse will support these patients and their families with LD
Religion, faith and belief	None	
Sexual orientation	None	
Age	Children may have difficulty in understanding procedures. Ensure the views of all children and young people are considered.	Hospital Play Specialist and parents/carers will support these children.
Transgender people	None	
Social class	Those patients with limited vocabulary or reading skills may have difficulty accessing and understanding patient information. Access to services and information may be affected by financial constraints.	Authors are directed to use short sentences, everyday language, and avoid the use of jargon. Information on transport and reimbursement of costs is available.
Carers .	Issues relating to race, ethnicity and disability may apply.	As above

Date of assessment: April 2018

Names of Assessor (s): Andrea Stanley