



Paediatric Transfer Protocols

Acute Transfers & Retrotransfers

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BACKGROUND

The Child Health Network for the Greater Toronto Area (CHN) is based on a partnership of community and hospital providers working together to build an integrated, high-quality, family-centred *regionalized* health system for mothers, newborns, children and youth.

Current membership of the CHN includes 20 hospitals that provide maternal/newborn, acute paediatric and rehabilitative services and the 9 Community Care Access Centres (CCACs) in the GTA. The Network is supported by membership fees and by contributions from the Ontario Ministry of Health and Long-Term Care.

Facilitating the development, implementation and monitoring of a common and consistent set of clinical, organizational and system guidelines across the Network is an important part of building the regionalized system of care in the GTA.

CLINICAL GUIDELINES - *Reflect care for patients with specific illnesses, diagnoses, or problems. They can encompass groups of patients and/or reflect broad care recommendations.*

ORGANIZATIONAL GUIDELINES - *Assist individual organizations in providing appropriate care to patients or groups of patients by addressing issues related to availability and abilities of people and facilities.*

SYSTEM GUIDELINES - *Support development of a regionalized system by facilitating access, quality, integration and coordination of services, and enhancing the network's function as a system.*

The system guidelines included in this document were developed by the CHN's Paediatric Services Task Force. The purpose of the guidelines is to facilitate implementation of standardized protocols for the transfer of paediatric patients within the Network model. The guidelines include:

- A Paediatric Acute Transfer Protocol to facilitate transfers of acutely ill children from a lower level of care to a higher level of care (includes transfers from Emergency Departments and Paediatric Inpatient Units).
- A Paediatric Retrotransfer Protocol to facilitate retro-transfers for children from a higher-level facility to a less acute level of care, including long-term and complex continuing care (include transfers from Emergency Departments, RCHCs and tertiary units). [Note: Retrotransfers are not necessarily directed back to the hospital of origin.]

Standardizing transfer protocols will help to ensure appropriateness of care and consistent and equitable support for children across the GTA.

Definitions

Paediatrics: 28 days of age to 19 years of age (i.e., up to the 19th birthday). [Network hospitals and CCACs may choose to provide services for adolescents over the age of 16 within their adult services program, and thus some critical care patients may not be managed at the Hospital for Sick Children.]

Unstable child: A child with a clinical condition that may require interventions during transport, where vital signs are unstable, where the airway is compromised or where there is potential for deterioration of condition during transport.

Underlying Assumptions for Implementation of Transfer Guidelines

- Whenever possible, transfers should support the framework of the CHN regional system model with a focus on:
 - Making every effort to FIRST accommodate transfers to a higher/lower level of care to an appropriate facility within the Cluster of the referring hospital or physician in keeping with the concept of “care closer to home”.
 - Transferring higher needs patients to higher level of care facilities according to the level of care designations outlined in the Ministry of Health Policy Statement (February 2000) [See Table 1].
 - Utilizing the role of Regional Children’s Health Centres (RCHCs) in accordance with their scope of services to help deflect demand on Level III beds.
 - Facilitating *retrotransfers*, as appropriate, to ensure “care closer to home” at the most appropriate site.
 - Utilizing the HSC-ACTS Team or CCTU Team (paramedic/HSC MD) and ambulance services as per the CHN’s transfer protocols.
 - Updating bed registries at individual facilities regularly (i.e., at least twice daily) as per the current bed registry expectations/protocol. [This includes Paediatric Critical Care beds where CritiCall requires up to date information across the province.]
 - Agreeing on the following definitions with respect to “open”, “closed”, and “restricted” designations:
 - Open: More than 2 beds available at facility.
 - Closed: No beds available at facility.
 - Restricted: Facility nearing full bed capacity (≤ 2 beds available at facility).
 - Utilizing CritiCall¹ for bed identification when hospitals within the Cluster (of the referring hospital or physician) are unable to accommodate the patient or when HSC Critical Care, Mental Health, NICU or Paediatric Medicine beds are full.
- Hospitals within each cluster work together in the development of education strategies for their patients/community regarding the transfers of children in accordance with the designated care levels.
- There are two specialized Transport Teams available to perform inter-facility transport of unstable paediatric patients in the GTA:
 - The HSC Acute Care Transport Services (HSC-ACTS) Team provides transport for all unstable children less than two years of age (within the Central East Region of the Province). A Physician will accompany the transport team when indicated.
 - The Toronto EMS Critical Care Transport Unit (CCTU) Team provides transport services for all unstable children two years of age and over (within the Greater Toronto Area). An HSC physician (from the Emergency Department or CCU) will accompany the transport team when indicated.

The decision to involve a physician on the transport team will be made by the Team physician, in consultation with the referring physician.

¹ The mandate of the Ontario CritiCall Program is to facilitate emergency patient referrals by assisting physicians in community hospitals to access the resources of hospitals, not transport teams, throughout the province. Through the *CritiCall Bed Registry for Paediatrics*, CritiCall can locate an available bed at CHN hospitals for any level of care within the Network (e.g., Short Stay Unit, Regional Children’s Health Centre) and tertiary care facilities across the province.

- The need to provide a Transport Team for the transfer will be determined by the acuity of illness of the patient and in consultation with the referring physician and the receiving centre. In general, patients requiring the services of a Transport Team would include:
 - Patients with a compromised airway.
 - Patients receiving infusion(s) of inotropes/prostaglandin.
 - Patients with unstable vital signs.
 - Patients with the potential for deterioration and/or requiring multiple or complex interventions during transfer.

Table 1: CHN Regional Model of Care - Level of Care Designations by Cluster²

CLUSTER AND LEVEL OF CARE DESIGNATIONS FOR CHN HOSPITALS*		
CLUSTER	HOSPITAL	DESIGNATION
Central	Humber River Regional Hospital (Finch site)	RCHC
	St. Joseph's Health Centre	RCHC
	Toronto East General Hospital	RCHC
	The Hospital for Sick Children	Level III
East	Lakeridge Health Corporation (Oshawa site)	RCHC
	Rouge Valley Health System (Centenary site)	RCHC
	Markham Stouffville Hospital	SSU
	Scarborough Hospital (General and Grace sites)	SSU
North	Southlake Regional Health Centre	RCHC
	York Central Hospital	SSU
	North York General Hospital (General site)	RCHC
	Bloorview MacMillan Children's Centre	Level III (Rehab)
West	William Osler Health Centre (Brampton site)	RCHC
	Halton HealthCare Services Corporation (Oakville site)	SSU
	Trillium Health Centre	SSU
	The Credit Valley Hospital	RCHC

RCHC – Regional Children's Health Centre

SSU – Short Stay Unit

Level III – Tertiary Facilities

² Ministry of Health and Long-Term Care, Ministry Action Plan: Responding to the Expert Advisory Panel Report Submissions from the Child Health Network for the Greater Toronto Area, February 1, 2000.

Table 2: CHN Regional Model of Care - Definitions for Paediatric Level of Care Designations

LEVEL	GOALS AND CARE PROVIDED
Short Stay Units	<ul style="list-style-type: none"> • Provide care as close to the patient's home as possible. • Provide primary and ambulatory care in short-stay units to children with limited acuity of illness and high probability of discharge within 48 hours.
Regional Children's Health Centres	<ul style="list-style-type: none"> • Provide care for children who have more complex health problems requiring the expertise of multi-disciplinary teams including sub-specialists. • Provide the maximum scope of services of a short stay unit for their own local geographic community.
Tertiary Care Centres	<ul style="list-style-type: none"> • The <i>Hospital for Sick Children</i> provides acute, tertiary and quaternary level medical and surgical services throughout the GTA and primary/secondary services to the local community. • <i>Bloorview-MacMillan Children's Centre</i> provides tertiary developmental, complex continuing care and rehabilitation services including inpatient, day patient and outreach services in the GTA and primary/secondary rehabilitation services to the local community.

PAEDIATRIC ACUTE TRANSFER PROTOCOL

Purpose

To facilitate transfers of acutely ill infants and children with a focus on providing the most appropriate level of care for infants, children and youth as close to home as possible within the regionalized model of the CHN.

Standards

1. Transfers will be facilitated for children to an appropriate facility according to and consistent with criteria included in the *Guidelines for the Clinical Scope of Paediatric Services* (CHN, March 2001).
2. Health care professionals and hospitals working within the CHN are accountable for working together in a manner that will ensure development of an effective regionalized system of care with transfers, as required, in accordance with the Guidelines.
3. Physician-to-physician communication is mandatory. Collaborative decision-making will occur among the referring and receiving physicians and charge nurses at the referring and receiving centres.
4. For unstable children over 1 month of age requiring transfer by a transport team, the *HSC CCU Line (1-866-HSC-CCU1; 1-866-472-2281)* should be contacted for:
 - Advice regarding care.
 - Access to a transport team (HSC-ACTS or CCTU Team depending on age).
 - Facilitation of transfer.
 - Appropriate bed identification.

[Note: If no bed is available within the Central East region or GTA, HSC will contact CritiCall to locate an appropriate bed at another tertiary centre. See Algorithm 1.]
5. For stable children over 1 month of age requiring a tertiary bed, the HSC access number **(416-813-7500 – ask to speak to the Paediatric Associate on Call)** should be contacted for advice regarding care, bed identification and facilitation of transfer (i.e., timing, mode of transfer). If no bed is available at HSC, HSC will contact CritiCall to locate an appropriate bed at another tertiary centre. If the transfer is not an emergency, the HSC physician may arrange transfer to HSC at a time when an appropriate bed becomes available. [See Algorithm 1.]
6. Arrangements for transfer of stable infants or children (regardless of the level of care required) will be the responsibility of the referring physician/hospital. Decisions about personnel (RN, RRT) to accompany the child will be made by the physician/hospital arranging the transfer based on the condition of the patient. Consultation with other members of the health care team should be considered. The HSC access line may be contacted for advice if uncertainty exists regarding patient stability. When no bed is available within the cluster at a SSU or RCHC (in accordance with CHN Scope of Services), CritiCall should be contacted by the referral physician to identify an appropriate bed within the GTA or outside the region.
7. Retrotransfer of infants and children requires a physician's order and notification to parents/guardian or to the patient (when appropriate) of the readiness to be transferred to another level of care closer to home as well as the potential risks associated with transferring or not transferring the child.

[Note: It is imperative that communication and education of parents about the CHN and the transfer process is carried out as part of the effective implementation of the transfer protocols.]

8. Responsibility for the patient remains with the referring physician/hospital until the child reaches the final destination, or until the HSC ACTS Team physician or CCTU Team physician assumes responsibility for the patient at the referring hospital.
9. Selected indicators will be monitored to review system effectiveness and to identify opportunities for quality improvement. The four areas to be considered in the evaluation are accessibility, accountability, effectiveness, and satisfaction.

Practice Guidelines

- The need for transfer will be determined by the attending physician in consultation with the receiving centre.
- The decision to consult and/or the need to transfer is based on the criteria outlined in the *Guidelines for Clinical Scope of Paediatric Services* (CHN, March 2001).

Table 3: Criteria for Transfer of Care

	FROM LEVEL I PAEDIATRIC AMBULATORY CENTRE	FROM SHORT STAY UNIT (SSU)	FROM REGIONAL CHILDREN'S HEALTH CENTRE (RCHC)
Indications for transfer to another facility	Patients who require additional intervention beyond the Level I scope of services or ambulatory care centre (clinic, after-hours clinic, and physician's office).	Patients who require additional intervention beyond the SSU scope of services (anticipated length of stay beyond 24-48 hours, inpatient stay surgery, paediatric sub-specialty consultation/inpatient management).	Patients who require additional intervention available at the Hospital for Sick Children (tertiary centre). Conditions requiring special diagnostic procedures or surgical care beyond the scope of services for a RCHC.

Algorithm 1: Acute Transfer

Procedure for Paediatric Acute Transfers

1. The referring physician (or delegate) will discuss the need for transfer with the parent(s), guardian and patient (if appropriate). Information to be discussed by the referring physician (and reinforced by the nurse as information becomes available) includes:
 - Reason for transfer.
 - When transfer will occur.
 - Length of time transfer will take.
 - Mode of travel.
 - Type of care during transfer.
 - Staff members who may accompany patient during transfer.
 - Directions to receiving hospital by car or other mode of transportation.
2. Transfers for stable patients will be facilitated by the referring hospital. The referring physician will contact the on-call physician at the receiving hospital to discuss the transfer of the patient. For transfer to HSC, consult the HSC Access Line:

416-813-7500

and request the Paediatric Associate on call. Your call will be directed to the most appropriate physician at HSC.

The HSC physician will discuss the specific situation with the referring physician and determine whether admission to HSC or an alternate level of care is required. *(See Procedure for Transport of Stable Children, Page 10.)*

3. Transport for unstable patients will be arranged according to age:
 - For patients over 1 month of age, the referral physician will call the HSC-CCU Line:

1-866 HSC-CCU1

1-866 472-2281

The HSC physician will discuss the care requirements with the referral physician. If a transport team is required, the HSC physician will contact the appropriate Transport Team (depending on the age of the patient) and will facilitate the appropriate bed identification at HSC.

- If the patient is under 2 years of age, the HSC Acute Care Transport Services Team (HSC-ACTS) will transport the infant/child. *[The team is composed of specially trained Registered Nurses and Registered Respiratory Therapists and is also involved in the transport of neonates. A physician accompanies the team when indicated.]*
- If the patient is 2 years of age or over, the Critical Care Transport Unit Team (CCTU Team) will be used. *[The team is composed of specially trained paramedics (Level IV). A physician (from HSC Emergency Department or Critical Care Unit) accompanies the team when indicated.]*

- The decision regarding final destination (level of care) will be made in accordance with the *CHN Guidelines for the Clinical Scope of Paediatric Services* document.
4. Physician to physician communication is mandatory to provide complete information on the patient including reason for transfer and interim management measures. For all critically ill patients, team dispatch must be the priority to ensure optimal resuscitation and stabilization of the patient with bed identification as a secondary event. When an appropriate bed is not available, the tertiary care physician will assist with resolution of the problem including consideration of alternative transport options to expedite transfer of the patient to an appropriate bed. CritiCall should be used to identify an alternate tertiary bed within the Province (or outside the Province, if necessary).
 5. The referring and receiving physicians will decide the appropriate mode of transfer and level of supervision required for transport/accompaniment (RRT, RN, MD, and Paramedic).
 6. The referring physician will prepare the transfer order.
 7. The nurse will:
 - Collect all relevant documentation (refer to item 8 below).
 - Closely monitor the child's condition while awaiting transfer.
 - Ensure the patient has an identification bracelet.
 - Ensure ongoing drug therapy (if necessary) managed with a battery operated infusion pump.
 8. Documentation/information to accompany the patient will be prepared by the referring staff and include a legible copy of the following:
 - *CHN Paediatric Acute Transfer Record* (see sample form in Appendix II).
 - Intake and output record.
 - Medication record.
 - Nursing notes.
 - Physician's notes/consultation.
 - Relevant laboratory reports.
 - Relevant Diagnostic Imaging reports/films.
 9. Transport personnel will check that all of their equipment is readily available and functioning as dictated by the needs of the patient.
 10. Accompanying transfer/transport personnel will notify receiving hospital of time of departure and estimated time of arrival.
 11. Paramedics or transport service personnel will transfer the patient and equipment to transport vehicle.
 12. Accompanying personnel will monitor the patient during transit and document information on the *CHN Paediatric Acute Transfer Record*. Frequency of monitoring dependent on child's condition and judgement of attendant.

13. All necessary interventions to maintain patient stability during transport will be documented on transport record.
14. Accompanying personnel to provide a report on patient's clinical status to staff at the receiving hospital upon arrival.
15. Follow-up communication with parents and the referral hospital will be the responsibility of the destination hospital. There should be direct communication with the referring paediatrician or MRP (most responsible physician).
16. One copy of the transport documentation stays on the chart at the referral hospital, one copy goes on the chart at the destination hospital and one copy stays with the HSC-ACTS team or the CCTU team for purposes of education and audit.
17. Satisfaction surveys to be completed and returned to CHN.

PROCEDURE FOR TRANSPORT OF STABLE CHILDREN

(NOT Involving the HSC ACTS or CCTU Team – See Algorithm 2)

In keeping with the concept of “care closer to home” within a *regional system* of paediatric care; every effort should be made to FIRST accommodate transfers to an equal or higher level of care (non-tertiary) to an appropriate facility within the cluster.

At the discretion of the referring physician these patients may be transported by the appropriate transport system in accordance with the following procedure:

1. The referring paediatrician will determine the need to transfer the infant or child to an equal or higher level of care. [See Algorithm 1.]
2. The referring physician will contact the appropriate hospital(s) within the cluster to determine whether or not there is an available bed within the cluster at the appropriate level of care.
3. If no bed is available within the cluster, the referring paediatrician will contact CritiCall (1 800 668-HELP) and will be patched through to the on-call paediatrician at a hospital (appropriate level of care) where a bed is available and together confirm that the infant or child is stable for transfer by the referring hospital without the HSC ACTS team or CCTU Team via land ambulance.
4. The referring physician (in consultation with other members of the health care team) will make the decision about the mode of transport, including accompaniment of the patient. See Algorithm 2 “*CHN Guidelines for Method of Transportation of Paediatric Patients*”.
5. The referring paediatrician will discuss details of the patient’s destination with the parents/guardian.
6. The information about the transfer process that should be discussed with the parents includes:
 - Reason for transfer, medical condition, short-term implications and longer-term prognosis (if indicated).
 - When transfer will occur.
 - Length of time transfer will take.
 - Mode of travel.
 - Staff and family members who may accompany the infant or child during transfer.
 - Visiting hours and telephone number of the receiving hospital.
 - Directions to receiving hospital by car or other mode of transportation.
 - Accommodations for significant other(s).

The referring physician and nursing staff will provide ongoing support of and communication with the parent(s)/guardian and family.

7. Transfer of an infant or child requires a physician’s order.
8. Documentation/information to accompany the patient will be prepared by the referring staff and should include (when available) a legible copy of the following:
 - *CHN Acute Paediatric Transport Record* (see sample form in Appendix I).

- Nursing notes.
 - Medication Record.
 - Physician's notes/consultation and transfer summary.
 - Relevant lab reports and x-rays.
9. Referral hospital staff to contact ambulance (or private transfer vehicle) to transfer the patient or arrange transport by taxi or parent's vehicle (See Algorithm 2.) Accompanying hospital personnel will be at the discretion of the referring paediatrician and the availability of resources.
 10. Referral hospital staff will notify destination hospital of the time of the departure and estimated time of arrival.
 11. The charge nurse or unit clerk at the destination hospital will notify their admitting department of the infant's/child's admission and name of the responsible physician.
 12. Accompanying personnel will check that all transport equipment is available and functioning before leaving hospital and stock additional equipment as warranted by the patient's condition (see Equipment List for Stable Patients, Page 16).
 13. Follow-up communication with parents and the referral hospital will be the responsibility of the receiving hospital. There should be direct communication with referring paediatrician or MRP (most responsible physician).
 14. Transfer/receiving personnel to complete CHN Paediatric Acute Transfer Record on arrival.
 15. One copy of the transport documentation stays on referral hospital chart. One copy goes to the destination hospital and a third copy is sent to the ACTS Program at the Hospital for Sick Children for purposes of data collection (for MoHLTC) and audit.
 16. Evaluations of this process (including satisfaction surveys) to be completed and returned to CHN.

Algorithm 2: CHN Method of Transfer

CHN PAEDIATRIC TRANSPORT - EQUIPMENT LIST FOR STABLE PATIENTS

*Basic Equipment **

The referring hospital must ensure that all equipment is available and functioning before leaving the hospital. The equipment and kits should be ready at all times and all staff should know their location.

- Check with the local ambulance to determine what equipment is available in the ambulance.

- A cell phone should be available for use by the health care provider accompanying the patient.

<p>GENERAL EQUIPMENT</p> <ul style="list-style-type: none"> • CHN Paediatric Acute Transfer Record • Stethoscope • Thermometer • K\Emesis basin • Flashlight • Sphygmomanometer • Infusion pump (battery operated) if required • Sterile gloves - three pairs various sizes. 	<p>IV FLUIDS AND MEDICATIONS</p> <ul style="list-style-type: none"> • 1000 ml 5% D/W • Normal Saline • 1000 ml Ringer's Lactate • Two Solusets • Tape • Tourniquet • Intracaths: two of each #16, #18, #20, #22, #24 • Butterfly 2 of 21 • Assorted needles and syringes • Alcohol swabs • Medications as appropriate for patient's condition
<p>RESUSCITATION EQUIPMENT</p> <ul style="list-style-type: none"> • Oxygen - check availability and amount in ambulance • Ambu bag and masks • Airways #1 - #3 • Laryngoscope with blades 	

** Equipment for patients being transported by a Transport Team will be available through accompanying team (HSC ACTS Team or CCTU Team) and the maintenance of the equipment is the responsibility of the team(s).*

PAEDIATRIC RETROTRANSFER PROTOCOL

Purpose

To facilitate effective retrotransfers for children from a higher level facility to a less acute level of care to ensure the appropriate level of care for optimal paediatric outcomes as close to home as possible within the regionalized model of the CHN.

Standards

1. Retrotransfers are classified as non-acute transports that occur between levels of care as described in the *Guidelines for the Clinical Scope of Paediatric Services* (CHN, March 2001).
2. Retrotransfers will be arranged consistent with the description of the scope of services described in the *Guidelines for the Clinical Scope of Paediatric Services* (CHN, March 2001).
3. Health care professionals and hospitals working within the CHN are accountable for working together in a manner that will ensure development of an effective regionalized system of care and facilitating retrotransfers which will maintain accessibility to higher levels of care for acutely ill patients.
4. Retrotransfer of infants and children requires a physician's order and notification to parents/guardian or to the patient (when appropriate) of the readiness to be transferred to another level of care closer to home.
5. Physician to physician communication is mandatory. Collaborative decision-making will occur among the referring and receiving physicians and the charge nurses at the referring and receiving centers.
6. Selected indicators will be monitored to review system effectiveness and to identify opportunities for quality improvement. The four areas to be considered in the evaluation are accessibility, accountability, effectiveness, and satisfaction.

Practice Guidelines

- Retrotransfers will be made to a RCHC or SSU when appropriate, in a timely manner, and in consultation with an appropriate centre of care closer to home.
- Suitability for retrotransfer will be determined by the attending physician based on the *Guidelines for the Clinical Scope of Paediatric Services* (CHN, March 2001).
- The following table contains criteria to assess suitability for transfer to appropriate level of care facilities. These criteria were developed by a subcommittee of the Paediatric Services Task Force to provide guidance for paediatric transfers within the CHN.

Table 3: Criteria for Retrotransfer

	SHORT STAY UNIT	REGIONAL CHILDREN'S HEALTH CENTRE
Centres should accept children with the following...	<p>Infants or children with continuing inpatient care needs expected to be ready for discharge within 48 hours.</p> <p>Short-term monitoring/observation and/or treatment for minor ailments not expected to exacerbate (e.g., asthma, mild head injury, post febrile seizure observation, mild fever requiring short-term observation).</p> <p>Treatment and observation after simple fracture treatment and observation after cast placement.</p>	<p>Infants or children who require intervention within the RCHC scope of services.</p> <p>Children requiring short or long term inpatient care, but no longer requiring tertiary level services.</p> <p>Infants or children requiring paediatric subspecialty monitoring/ care including endocrinology, nephrology, and cardiology.</p> <p>Infants or children requiring complex pain management including PCA, continuous opioid infusion and sedation with the requisite monitoring required.</p> <p>Infants or children requiring frequent interventions e.g., suctioning, masks, vital signs, and close observation.</p> <p>Infants or children with tracheostomies (not fresh post operatively).</p> <p>Infants or children with complex, chronic health care needs awaiting placement in a paediatric long term care facility.</p> <p>Infants or children requiring G or G/J tube feeding or TPN.</p> <p>Infants or children with central venous lines or those requiring intermittent subcutaneous injections via Insufflon.</p> <p>Infants or children requiring palliative care.</p>

Procedure for Paediatric Retrotransfers

1. The referring physician (or delegate) will discuss the decision for retrotransfer with the family. Information to be discussed with the parents should include:
 - Reason for transfer.
 - When transfer will occur.
 - Length of time transfer will take.
 - Mode of travel.
 - Type of care during transfer.
 - Staff members who will accompany the patient during transfer.

- Directions to destination hospital by car or other mode of transportation.

[Note: A written physician order is required for transfer.]

Additional written information about the paediatric unit at the destination, if available, should be shared with the family at this time.

2. Staff at the referring centre will ensure that physician and nursing staff at the receiving centre are fully informed of the patient's background and have the following written communication ready:
 - Paediatric Retrotransfer Patient Record.
 - Medical Discharge Summary.
 - *CHN Non-Acute Transport Checklist* (see Appendix I).
3. Staff at the referring hospital will notify the ambulance (or private ambulance) service and book/arrange time for non-urgent transfer. Decisions about alternate methods of transport may be made. Consult Algorithm 1 for guidance regarding decision-making.
4. Follow steps included on the *CHN Non-Acute Transport Checklist* (Appendix I).
5. Accompanying personnel (RN/RRT or paramedic) will document assessments and interventions (as required) during transfer.
6. Parent may accompany the child on the transfer at the discretion of the ambulance personnel.
7. On arrival at the destination hospital, the ambulance personnel move the patient from the transfer vehicle and escort child to the paediatric unit. The child will be transferred to a bed in the receiving unit with assistance from receiving hospital staff as necessary.
8. Accompanying personnel (RN/RRT or paramedic) to confirm patient identification with staff at destination hospital, provide verbal report on child's clinical status and hand-over documentation and patient possessions.
9. Evaluations of this process (including satisfaction surveys) to be completed and returned to CHN.

DISSEMINATION OF TRANSFER PROTOCOLS

Dissemination of the guidelines is the first step in the process of implementing and testing the guidelines across the Network. Information/Training sessions will be held at the cluster level. The objectives of these sessions will be:

1. To officially launch the transfer protocols and clarify expectations concerning adoption of their use across the Network.
2. To introduce the protocols and provide an opportunity for members to learn about their content, including the availability of the 'generic' forms accompanying the protocols, and the proposed monitoring/evaluation tool that will support uptake of the transfer guidelines.
3. To provide an opportunity to 'test' and receive input from CHN members concerning application of the transfer protocols across the Network.

MONITORING OF TRANSFER PROTOCOLS

- Specific indicators will be developed to monitor and track performance with respect to each set of transfer protocols (i.e., paediatric acute transfers; paediatric retro-transfers).
- Monitoring performance with respect to implementation of the transfer protocols will be based on qualitative and quantitative data resulting from the following criteria (and indicators):

CRITERIA	INDICATORS
Accessibility	<ul style="list-style-type: none"> • Transfer patterns/ issues within the system • Time of decision to transfer and transfer initiation (time to bed identification and time to ambulance pick up) • Transfer cancellations or refusals
Accountability	<ul style="list-style-type: none"> • Appropriateness of transfer • Appropriateness of destination (acuity and LOS) • Appropriateness of mode of transfer including personnel and accompaniment • Transfer refusals
Effectiveness	<ul style="list-style-type: none"> • Complications during transport including ambulance/transfer vehicle and equipment issues • Morbidity & mortality
Satisfaction	<ul style="list-style-type: none"> • Family/Patient satisfaction • Stakeholder satisfaction

- To the extent possible, quantitative data will be collected through existing data collection sources (i.e., CritiCall, ambulance services including CCTU Team, CCU Transport Database, and the HSC-ACTS Team Transport Utilization Database). These data will be reported quarterly to the Ministry of Health and Long Term Care.
- To the extent possible, indicators will be consistent with those collected as part of the CHN's overall performance evaluation project. However, it is understood that additional data (i.e., more specific/detailed information) will need to be collected initially to track implementation with respect to the transfer guidelines.

APPENDIX I: CHN NON-ACUTE TRANSPORT CHECKLIST

(For Transfer of Stable Children and Retrotransfers)

Initials	Tasks
	<i>Verify notification of the ambulance departure time:</i>
	Preparation
	Ensure parents (or legal guardian) are advised of the reason for transfer.
	Obtain and complete documentation including: <ul style="list-style-type: none"> - Physician's Order - Medical Discharge Summary - Retrotransfer Patient Record - Follow-up appointments if applicable
	Copy of relevant diagnostic test results
	Place child on stretcher secure straps and monitors
	Attach resuscitation bag to O ₂ tubing, put monitors on (if applicable)
	Cover the child with a blanket
	Ambulance paramedics will lift stretcher
	Arrange return of equipment and staff
	Prepare transport equipment (as indicated by patient's condition)
	Cardiac respiratory monitor
	Batteries for cardiac respiratory monitor
	Pulse oximeter
	IV pump charged and secured to stretcher
	Portable suction
	Check O ₂ tank full at 2000 psi.
	Check the portable battery
	Resuscitation bag and masks and O ₂ tubing
	Prepare the transport bag supplies
	Extra blanket
	Extra cardiac leads
	Stethoscope
	#10, #12, #14 suction catheters
	½" clear tape
	20 ml syringe (x2)
	Airways
	Diapers (if appropriate) appropriate for weight
	Appropriate feeding, if indicated
	Prepare child
	Check patient identification
	Prepare patient possessions (and breast milk, if applicable)
	Ensure airway patency by positioning and suctioning as needed
	Ensure IV patency
	Monitor vital signs
	(Note the FiO ₂) Adjust FiO ₂ to maintain SpO ₂ as per physician's order
	Confirm ETA at receiving hospital
	Upon return to referring centre
	Arrange for cleaning of equipment
	Check FiO ₂ tank – RT will replace tank if less than 2000 psi
	Return batteries for cardiac respiratory monitor to base
	Ensure transport documentation placed in child's chart

APPENDIX II: TRANSFER FORMS

Paediatric Acute Transfer Record

Paediatric Retrotransfer Record