Appendix 1

Business Rules – ECC Paediatrics – WTH

1. Overview

This document details the operational business rules for Children's area of the Waitakere Hospital Emergency department.

2. Contents

3. Key Principles – Summary

Beds	9 acute assessment beds in the emergency department children's area; 1 resus room.
Max. LOS	Maximum length of stay (LOS) in ED is 6 hours from Triage.
Patient priority	Triage 1 seen in resus by both teams Triage 2 seen ASAP (<10 minutes) by either team Triage 3, 4, 5, injury cases seen by Emergency Medicine (EM) team Triage 3, 4, 5, non-injury cases seen by either team (includes GP referrals) All GP referrals seen by EM team to be discussed with paediatric team
Decision to admit	Made within 4 hours of triage.
Discharge	When LOS > 6 hours, admission is to Rangitira or an appropriate facility When LOS < 6 hours child discharged from the Emergency department to community, Rangitira or an appropriate facility.
Contingency	Early notification and prompt discharge of children in both Rangitira and ED are essential.

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4. Introduction

4.1	**Purpose**	The business rules provide guidance for the provision of acute assessment/ treatment services for Children within the Emergency Department at Waitakere Hospital.
4.2	**Function**	The Emergency Department will provide initial assessment, stabilization and/or treatment of children for up to 6 hours until their admission/ transfer to an inpatient unit or discharge to the community.
4.3	**Governance**	Emergency Medicine
4.4	**Organisational Structure**	The Children services within the Emergency Department are managed by the Clinical Director Emergency Medicine at Waitakere Hospital.
4.5	**Ownership & authorisation**	These business rules are owned by the Emergency Medicine Clinical Leader at Waitakere Hospital.
4.6	**Amendments**	Recommendations for changes should be directed to ED Clinical leader who will consult with the Pediatric Clinical leader and the Emergency Department Charge Nurse Manager in the first instance. The ED Clinical leader will manage any redevelopment and consultation.

5. General Operations

5.1	**Operating hours**	24 hours, 7 days a week from 1 July 2010
5.2	**Length of stay**	Children will stay for less than 6 hours in ED. When it becomes apparent that the patient needs to stay for longer patients will be admitted to the paediatric ward or transferred to another facility. The decision to admit will be made no later than 4 hours from Triage.
5.3	**Services exclusions**	Children transported by ambulance will follow the ambulance by pass criteria.
5.4	**Transfer decisions**	Children requiring surgery and other specialist assessments or procedures not available at Waitakere Hospital should be referred to Starship or another facility. For Child Protection issues see Child abuse referral guidelines policy.

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6. Patient processes

6.1	**GP/ HC4K/ OPD referrals**	Children may be referred into ED through the Paediatrician/ Paediatric Registrar For GP referrals he Paediatrician/ Paed registrar must inform the GP to fax/phone the child's details to the admitting clerk in the Emergency Department The paediatrician/ Paed registrar will log the Childs name, Date of Birth and NHI (if know) on the electronic referrals board. GP referrals will be accepted whether or not there are beds available on Rangitira.
6.2	**Single point of entry**	All Children presenting to WTH acutely (Emergency Medicine, GP/ HC4K referrals, Ambulance and self referrals) will come through a single point of entry located at the triage area of ED. Ward to ward referrals will bypass the Emergency Department assessment process. The Duty manager will ensure that a ward bed is available prior to the child being transferred. The duty manager will inform the ward and the ED clerical staff. The ED clerical staff will admit the child onto PIMS
6.3	**Medical assessment**	• All patients will be seen by a triage nurse and allocated a triage category. • All triage 1 patients will be seen immediately by both teams • All triage 2 patients will be seen by either team in < 10 minutes. • Triage 3, 4, 5 injury cases seen by EM team • Triage 3, 4, 5 non injury cases (including GP referrals) seen by either team. Patients whom the nurses are most concerned about should be seen first. In the event of multiple team patients requiring Doctor assessment by either service, the paediatric team will see GP referrals to their service and then those most likely needing paediatric input i.e. < 3 months of age, children requiring oxygen or those needing admission. All GP referrals to the Paediatric medical team who are seen by the EM team are to be discussed with the paediatric team prior to disposition. Once a child is referred to the Paediatric medical team the paediatric service is responsible for the child's care until disposition
6.4	**Representation in less than 72 hours**	Children representing within 72 hours of discharge from the Paediatric team (ED, HC4K or Rangitira) should be triaged under the Paed team so that readmission can be expeditiously resolved. The child should be placed on the Paediatric medical team screen on PIMS.
6.5	**Patient registration**	C**hildren presenting to triage at ED will have their registration completed in ED.**
6.6	**ED nurse assessment**	**The time taken from Triage to assessment should be immediate for triage categories 1 and 2 and no more than 15 minutes for triage categories 3, 4, and 5**

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6. Patient processes cont.

6.7	**ED acute Treatment and Management**	Children who have a triage category of 1 should be continuously monitored Children who have a triage score of 2- 3 should have a minimum of half hourly observations until seen by a doctor. Children who have a triage score of 4-5 should have a minimum of hourly visual observation documented until seen by a doctor Once seen by a doctor ongoing assessment will be based on clinical concern.
6.8	**ED documentation**	All nursing cares and assessments should be recorded in the nursing assessment form or the resuscitation record All medical assessments should be recorded on clinical note paper and placed with the clinical records All documentation/ clinical records should be placed in their correct place after use. Although no care plan needed all plans need to be documented in the ED assessment form of on the clinical notes page.
6.9	**ED discharge**	Families should be given a hard copy of the electronic discharge summary at time of discharge. If this is not possible a hard copy of the electronic discharge summary will be sent in the mail Should the child be referred to Home care for Kids (HC4K) a referral form will faxed to the number on the form. See flow chart for referral to HC4K At physical discharge the child will be removed from the electronic whiteboard by the clerical, medical or nursing staff
6.10	**Transfer to Rangitira Ward**	Once a bed has been assigned by the duty Manager, the ward must accept the child Should a bed not be available, the duty manager and Rangitira Shift Coordinator will follow the contingency process (See section 9.2) Should staffing be an issue on Rangitira the Rangitira Shift coordinator will inform the duty manager. Patients will be transferred to Rangitira by a HCA or an RN depending on clinical need. Once the child is ready for transfer the EC ward clerk will lodge the child onto the PIMS inpatient ward system. The child will then be scanned out of ED as they exit the department. At times a full work up may not have been completed prior to transfer to the ward. Transfer will be based on what is in the best interests of the child if investigations have not been completed.

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6. Patient processes cont.

6.11	**Transfers to Starship or other facility**	Children who meet the criteria for a PICU team retrieval will be transported by the PICU team Children who do not require PICU retrieval, the decision who will escort the child will be based on patient acuity. • For Children requiring a nursing escort the Duty Manager in conjunction with the CCN (ED) and/or CNM (Rangitira) will assist in finding nursing resource. • For children requiring a Doctor escort ED medical officer and the Paediatric SMO will organize medical resource.
6.12	**Child Protection**	Children may not require medical admission or referral to Starship's Te Puaruruhau, but need protection. In these cases staff will work collaboratively with CYFS and the police to provide a place of safety for the child. WDHB has a Memorandum of Understanding with the police and regional director for CYFS that WDHB will provide a place of safety for the child for the first 24 hours During this time, WDHB will continue to liaise with CYF and the Police in regards to a safe discharge plan.

7. Ownership & Responsibility

7.1	**Responsibility**	The Paed or ED team "owns' the child during their ED stay and is responsible for their care and final outcome. The responsibility within the nominated Clinical Team is: (1) On call Consultant (2) Registrar/Moss.

8. Staff

8.1	**Nursing/ HCA/ Clerical**	The ED nursing staff, clerical staff and Health Care assistants are responsible to the ED CNM The nursing staff will rotate through the adult and child areas of ED but will be assigned a specific area for each shift. The child Health liaison nurse will provide discharge planning support Monday to Sunday 0800-1800. In the event of high and uneven workload there is an expectation that nurses will assist in the care of children regardless of the department they are working in. the Duty manager will manage the fluidity of nursing resources in this event.
8.2	**Orientation Support Supervision & Education**	Sharing of skills and knowledge will be encouraged between all specialties. All staff will be provided with an appropriate orientation, support and supervision. The ED and the Rangitira Clinical Nurse Educators will liaise in preparing Paediatric study days.

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8. Staff cont.

8.3	**Paediatric Team**	Registrar cover on site and based in ED: 0800- 1630 Monday to Friday the Paediatric Registrar covers only ED 1630 - 0800 Monday to Friday the Paediatric Registrar covers ED, SCBU and Rangitira shared with the SMO and SCBU Credentialed nurse 0800 - 0800 Saturday/ Sunday/ Public Holidays the Paediatric Registrar covers ED, SCBU and Rangitira shared with SMO and SCBU Credentialed nurse Senior Medical Officer cover: 0800-1630 Monday to Friday the Paediatrician covers only ED, and is on site 1630 until 2300 Monday to Friday the Paediatrician covers ED, SCBU and Rangitira and is on site 0800- 2300 Saturday/ Sunday/ Public Holidays the Paediatrician covers ED, SCBU and Rangitira on site 2300 -0800 Monday to Sunday the Paediatrician is on call. SMO call back will be based on patient acuity rather than departmental business and is at the discretion of the Duty Manager and Paediatric Registrar. Changes to the Roster will be updated on the Master Roster.
8.4	**Emergency Medicine Team**	FACEM cover on site 0800- 0100 On call cover 0100- 0800 MOSS cover : 2 MOSS's for whole dept 0800-2400 1 MOSS for whole dept 2400-0800 The Emergency Medicine MET call Doctor is on site for immediate MET call response (See Paediatric MET call policy) FACEM call back should be based on patient acuity rather than departmental business, when the child is under the Emergency Medicine Team and the issue is unable to be resolved in consultation with the Paediatric Medicine team.

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9. Bed management

9.1 Bed Management

To assist in Bed management the following will occur:

- Early notification to Rangitira from the duty manager that ECC need to admit children to Rangitira.
- Rangitira Bed status updates from the Rangitira shift Coordinator to the Duty Manager/ ED CCN will occur when the bed status changes and whenever possible at the following approximate times: 1200, 1600, 2000, 2400..
- Emergency Medicine team and Paediatric team to work collaboratively to ensure that children are treated and reviewed to expedite discharge or transfer.
- Swabs and Naso Pharyngeal Aspirate's taken as soon as possible if clinically indicated
- Multidisciplinary approach to defining threshold of activation of alternative care options e.g. early discharge of children to HC4K or transfer to Rangitira
- Bed spaces are cleaned in a timely manner

9.2 Contingency

The following will be implemented in the event Rangitira is full:

- When Rangitira has only 2 isolation rooms or 4 general beds the Duty Manager and ED CCN should be informed.
- The Duty Manager will consult with clinical staff in relation to contingency options
- When all contingencies have been exhausted the WTH Duty Manager will discuss regional bed availability with the Starship/ CMDHB Duty Managers.

9.3 Overflow into acute adult bed spaces

Adult beds spaces in the emergency department are not to be used unless negotiated with the CCN.