TRIAGE AND TRANSFER OF PATIENTS BETWEEN SYDNEY CHILDREN'S HOSPITAL EMERGENCY DEPARTMENT AND PRINCE OF WALES EMERGENCY DEPARTMENT

PROCEDURE ©

DOCUMENT SUMMARY/KEY POINTS

- This document describes the process for the triage and transfer of patients between the Sydney Children's Hospital (SCH) Emergency Department (ED) and the Prince of Wales Hospital (POW) ED.
- All staff will be professionally accountable and work within their scope of practice.

CHANGE SUMMARY

- Revised Document for new transfer route between SCH and Acute Services Building (ASB)

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st December 2023	**Review Period**: 3 years
Team Leader:	Nurse Educator	**Area/Dept**: Emergency Department SCH

READ ACKNOWLEDGEMENT

- All SCH Emergency Department Nurses are to read and acknowledge the understand the contents of this document

TABLE OF CONTENTS

Purpose/Scope

The purpose of this document is to ensure the safe triage and transfer of patients between the Sydney Children's Hospital (SCH) Emergency Department (ED) and the Prince of Wales (POW) ED in the Acute Services Building (ASB).

Responsibilities

Management is responsible for ensuring that staff who undertake this process have read and understood this document.

Triage Process

Inclusion Criteria:

1. **SCH ED:** Patients who are ≥ 16* years of age
2. **POW ED:** Patients who are <16 years of age

Note current patients of SCH 16-18yrs can attend SCH for all presenting problems.
(NB: Please discuss all Mental Health Patients with the NUM before triaging or redirecting)

In principle all patients that present should be registered and triaged. However, a person may present asking for reasons such as looking for directions to the other department. In situations such as this, the triage nurse should confirm with that person the reason for their presentation and screen the patient for any risk factors using the appropriate tools. If no risk factors are identified the patient may be re-directed to the other department as per the transfer process. If the Triage nurse is unsure they should consult with the NUM/TL prior to transfer being arranged.

At SCH ED nursing staff should refer to the following tools to help identify risk factors and allocate the appropriate triage category.

- Adult Triage Descriptors
- ACEM Recommendations for Adults
- Triage in the Emergency Department- Workplace Instructions POW
- Adult Trauma Call Criteria

At POW nursing staff should refer to the following tools to help them identify risk factors and allocate the appropriate triage category.

- Trauma Call Criteria- ED SCH
- Paediatric Triage Descriptors and ACEM Recommendations

Triage Flow Charts

SCH ED.

Patient's ≥ 16 years of age presents to SCH ED Triage
Triage nurse confirms reason for presentation and triages patient if indicated[1]

Category 1, 2, or 3

1. Place patient in resus or appropriate clinical space as per Infectious considerations
2. Review by Senior MO & escalate care as appropriate

Category 1:
Call 2222 and state "Code Blue Adult Patient Sydney Children's Hospital ED *Location…*"

Category 2 & 3:
1. Senior MO to discuss with SCH NUM/TL
2. Arrange for transfer to POW ED

Category 4, 5

1. Place in appropriate clinical space as per Infectious Considerations.
2. Arrange for transfer to POW ED

SCH NUM/TL contacts or allocates an RN to contact POW NUM/TL on
Mobile: 0428652614 OR Extension: 29987:

1. Handover using ISBAR principle including:
   a. Red Flags
   b. COVID Status
2. Transfer coordinated including:
   - Bed or wheelchair needed
   - Staffing[2] required
     - Medical
     - Nursing
     - Porter
   - Equipment to be taken: O[2] Twinovac, monitoring, BVM, HM

Patient Transfer Principles[2]

1. SCHN NUM/TL must be informed of any patient that requires transfer to POW.
2. Transferring team from POW to make contact with SCH NUM/TL upon arrival.
3. Patient handover occurs with appropriate Clinicians.
4. Patient discharged on firstnet as "departed for another facility" by SCH NUM/TL "
5. Receiving department to provide porter for transfer. If this is not possible NUMs to coordinate alternative porter.
6. Transfer RN completes A-G Assessment of patient before leaving department to ensure safe to transfer.
7. Ensure transferring RN has appropriate level of experience & equipment for safe transfer.

NOTES:

1. **Triage:** If a person presents asking for directions, the triage nurse should confirm the reason for the presentation and screen the patient for risk factors. If no risk factors are identified the patient may be re-directed to POW as per the transfer process. If the triage nurse is unsure they should consult with the NUM prior to transfer (*NB: Refer to Transfer Process section in procedure document for more information)*

2. ***Note current patients of SCH 16-18yrs can attend SCH for all presenting problems.***

3. **Transfer:** Standard practice is that an RN/MO from POW attends SCH ED, receives handover and then transfers them to POW. There may however be circumstances where it is appropriate for the patient to be transferred without a clinical team or transferred by staff from SCH. This is to **ONLY** to occur after discussion with the NUM/TL at both SCH and POW

POW ED.

Patient's < 16 years of age presents to POW Triage
Triage nurse confirms reason for presentation and triages patient if indicated[1]

Category 1, 2, or 3

1. Place patient in resus or appropriate clinical space as per Infectious considerations
2. Review by Senior MO & escalate care as appropriate

Category 1:
Call 2222 and state
Code Blue Paediatric Patient
Prince of Wales ED *location…*

Category 2 & 3:
1. Senior MO to discuss with POW NUM/TL
2. Arrange for transfer to SCH ED

Category 4, 5

1. Place in appropriate clinical space as per Infectious Considerations.
2. Arrange for transfer to SCH ED

POW NUM/TL contacts or allocates an RN to contact PSCH NUM/TL on
Mobile: 0428864136 OR Extension: 20028 and:
1. Handover using ISBAR principle including:
   a. Red Flags
   b. COVID Status
2. Transfer coordinated including:

- Bed or wheelchair needed
- Staffing[2] required
  - Medical
  - Nursing
  - Porter
- Equipment to be taken: O^2 Twinovac, monitoring, BVM, HM

NOTES:

1. **Triage:** If a person presents asking for directions, the triage nurse should confirm the reason for the presentation and screen the patient for risk factors. If no risk factors are identified the patient may be re-directed to SCH as per the transfer process. If the triage nurse is unsure they should consult with the NUM prior to transfer(*NB: Refer to Transfer Process section in procedure document for more information)*
2. **Transfer:** Standard practice is that an RN/MO from SCH attends POW ED, receives handover and then transfers them to SCH. There may however be circumstances where it is appropriate for the patient to be transferred without a clinical team or transferred by staff from POW. This is to **ONLY** to occur after discussion with the NUM/TL at both SCH and POW

Patient Transfer Principles[2]
1. Transferring to team from SCH to make contact with POW NUM/TL upon arrival
2. Patient handover occurs with appropriate Clinicians.
3. Patient discharged on firstnet as "departed for another facility" by POW NUM/TL "
4. Receiving department to provide porter for transfer. If this is not possible NUMs to coordinate alternative porter.
5. Transfer RN completes A-G Assessment of patient before leaving department to ensure safe to transfer.
6. Ensure transferring RN has appropriate level of experience & equipment for safe transfer.

Transfer Process

Transfer process for patients requiring clinical care

Standard practice is that an RN/MO from the receiving ED retrieves the patient and transfers them. There may however be circumstances where it is appropriate for the patient to be transferred with a clinical team from the referring ED. This should **ONLY** occur after discussion with the NUM/TL at both SCH and POW.

The NUM/TL's are responsible for phoning or allocating an appropriate nurse to phone the receiving ED to notify them of the patient and to coordinate transfer of patient.

- **SCH ED NUM/TL** Mobile: 0428864136 OR Extension: 20028
- **POW ED NUM/TL** Mobile: 0428652614 OR Extension: 29987

If the patient/carer has not been collected within 30 minutes of referral NUM to call again and clarify ETA.

All patients should be transferred by appropriate number of team members relevant to the patient's condition. They must be transferred internally using the designated transfer route.

The transferring team must ensure they are informed of the:

- Patient's Name and clinical condition
- Equipment required for transfer
- Location within department to collect from **OR** take to
- Phone numbers of NUM/TL's

Patients with infectious considerations

All staff involved in the transfer of a patients with infectious considerations must wear the appropriate PPE. Any surfaces inadvertently contaminated should be cleaned with clinell wipes. If significant contamination e.g., patient vomits on the floor in the lift, ensure the POW NUM/TL is notified so that cleaning of the lift can be arranged.

Transfer process for patients not requiring clinical care

After screening the patient for risk factors the triage nurse can make the decision that a transfer can occur without the need for triage or the assistance of a clinical team. The triage nurse **MUST** consult with the NUM/TL if they have any concerns.

Option 1: Patient or parent /carer has access to car

Clear driving and parking directions **must** be given to the patient/carer. If there are concerns that they do not understand these instructions, they should be escorted to the receiving department as per option 2.

- **POW ED to SCH ED**: Advise parents to park in 15-minute parent parking outside the SCH ED entrance on High Street. If there is no parking in the 15-minute bay advise parents to park in the ambulance bay. Proceed to Registration Desk
- **SCH ED to POW ED**: Advise patient or patient carer to park in POW emergency department 5-minute drop-off zone, at Magill Street entrance, then follow signage to the emergency department entrance. If parking for longer periods, advise patient, or patient carer to park in Prince of Wales paid parking at Barker Street entrance, then follow the signs to the ASB Emergency. Upon arrival to POW ED, they should then follow the directions of the POW Emergency department staff.

Option 2: Patient or parent/carer does not have access to car

- ***Patients with infectious considerations***: RN wearing the appropriate PPE, escorts patient to receiving department. Any surfaces inadvertently contaminated should be cleaned with clinell wipes.
    - **POW ED to SCH ED:** Patient escorted to SCH using transfer route. Take lift to level 1 and link bridge to SCH. Upon arrival to SCH ED, POW RN to contact SCH NUM/TL and then patient and parent/carer should be escorted to the front triage area of SCH ED. RN then to advise parent/carer of process for triage and registration.
    - **SCH ED to POW ED:** Patient escorted to POW using transfer route. After exiting lifts on level B2 of ASB patient should be escorted to the front entrance of POW Emergency Department (Reception area). The escorting staff member should then follow the directions of the POW staff.
- ***All other patients***: Clear instructions must be given to the patient/carer on how to walk to the receiving department via the most direct internal route. If there are concerns that they do not understand these instructions, they should be escorted to the receiving department by a porter/AIN/RN using the designated transfer route.

Personal Protective Equipment (PPE)

Staff

All staff **MUST** wear the appropriate PPE relevant to the patients/carers clinical condition.

Patient/Carer

Masks are mandatory in clinical spaces for anyone aged over 12 years and over and strongly recommended for children aged 5 years and over.

APPENDIXES

Adult Triage Descriptors

	AIRWAY	BREATHING	CIRCULATION	DISABILITY	PAIN	NEURO-VASCULAR	BEHAVIOURAL/ PSYCHIATRIC
1	**Immediately life threatening - immediate simultaneous assessment and treatment**						
	Obstructed Immediate risk to airway-impending arrest	Respiratory arrest Apnoea Respiratory rate < 10 Extreme respiratory distress	Cardiac Arrest Life threatening haemodynamic compromise Significant bradycardia/tachycardia	Unresponsive or responds only to pain (GCS<9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation			Severe behavioural disorder with immediate threat of dangerous violence
2	**Imminently life-threatening or important time-critical treatment or very severe pain - assessment and treatment within 10 minutes**						
	Partially obstructed-severe stridor or drooling with distress	Severe respiratory distress	Severe Circulatory compromise - Clammy or mottled skin, poor perfusion - HR<50 or >150 (adult) - Hypotension with haemodynamic effects - Severe blood loss	Drowsy, decreased responsiveness any cause (GCS< 13) Acute stroke Fever with signs of lethargy	Chest pain of likely cardiac nature Very severe pain	Severe to moderate neurovascular compromise	Violent or aggressive Immediate threat to self or others Requires or has required restraint Severe agitation or aggression
3	**Potentially life-threatening or situational urgency - assessment and treatment start within 30 minutes**						
	Partially obstructed with mild respiratory distress	Moderate respiratory distress	Moderate haemodynamic compromise	Seizure (now alert) Head injury with short LOC-now alert	Moderate to severe pain Chest pain likely non-cardiac and mod severity	Mild neurovascular compromise	Very distressed, risk of self-harm Acutely psychotic or thought disordered Situational crisis, deliberate self-harm Agitated / withdrawn Potentially aggressive
4	**Potentially serious or situational urgency or significant complexity or severity - assessment and treatment start within 60 minutes**						
	Patent/normal	Mild respiratory distress	Mild haemodynamic compromise	Normal GCS Minor head injury, no LOC	Mild-moderate pain,	Normal	Semi-urgent mental health problem Under observation and/or no immediate risk to self or others
5	**Less urgent or clinical - administrative problems - assessment and treatment within 120 minutes**						
	Patent/normal	Normal	Normal	Normal GCS	No pain	Normal	No danger No behavioural disturbance No acute distress

SPECIFIC RECOMMENDATIONS BASED OF ACEM 2016

1	2	3	4	5

• Cardiac Arrest
• Respiratory Arrest
	• BSL< 3 mmol/L
	• Testicular Pain
	• Febrile neutropenia
	• Suspected sepsis- physiologically unstable
	• Severe localised trauma- major fracture, amputation
	• Acid or alkali splash to eye- requiring irrigation
	• Sudden onset eye pain, blurred vision and red eye
	• High risk history
	  ○ Significant sedative or other toxic ingestion
	  ○ Significant/dangerous envenomation
	  ○ Severe pain or other feature suggesting PE, aortic dissection/AAA or ectopic pregnancy
		• Suspected sepsis - physiologically stable
		• Moderate limb injury- deformity, severe laceration, crush
		• Limb- altered sensation, acutely absent pulse
		• Trauma- high risk injury with no other high risk features
			• Foreign body aspiration, no respiratory distress
			• Difficulty swallowing, no respiratory distress
			• Eye inflammation or foreign body- normal vision
			• Minor limb trauma- sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention- normal vital signs, low/moderate pain
				• Low-risk history and now asymptomatic
				• Minor symptoms of existing stable illness
				• Minor symptoms of low risk conditions
				• Scheduled visit- eg wound review
				• Immunisation only

Note: Only **one** symptom is required for a triage category to be allocated

These tools were adapted from the**:, ETEK, 2011, ACEM Recommendations 2016, Triage in the Emergency Department- Work Place Instructions v4 POW 2020**

ATS clinical descriptor	*Suggested marker(s)/variable(s)*	Recommended triage category
Extreme respiratory distress	• RR >30; unable to speak; cyanosis; feeble respiratory effort; silent chest sounds; • Diminishing consciousness; increasing confusion	1
Severe respiratory distress	• RR 25-30; cannot complete sentences in one breath; tachycardia. • Use of accessory muscles – tracheal tug, posturing	2
Moderate shortness of breath	• RR 20-25; speaks in short phrases between breaths	3
Severe hypertension	• Raised BP (20-40mmHg above normal resting BP) in the spinal cord injury (at T6 or above) patient **with suspected autonomic dysreflexia**	2
	• SBP >140mmHg or DBP >90mmHg in pregnancy or post-partum patient (**up to12-weeks post-delivery**) – consider eclampsia	2
	• SBP >180mmHg	3
Chest pain of likely cardiac nature, or cardiac sounding chest pain symptoms/features occurring at rest that were prolonged (>10mins) or repetitive within the last **48hrs**.[8]	• Central crushing chest pain • Pain radiating to right or left shoulder or both arms • Pain precipitated with exertion • Pain associated with diaphoresis • Sudden orthopnoea, syncope, epigastric discomfort or jaw pain • PMH: Diabetes, HTN, smoking, raised cholesterol, obesity, first-line family Hx, Aboriginal, past AMI • Signs of pulmonary oedema	2

ATS clinical descriptor	*Suggested marker(s)/variable(s)*	Recommended triage category
Minor head injury	• Acute blunt head trauma with no LOC, no amnesia, no anticoagulants/bleeding disorder, aged <65, nil neurological deficits; nil neck symptoms. • No respiratory/circulatory compromise, GCS 15 throughout, minimal pain only.	4
Moderate head injury	• Acute blunt head trauma +/- brief (<5mins) LOC • With/without brief (<5mins) amnesia; aged <65, vomited, on anticoagulants/bleeding disorder. • Neck symptoms (e.g. pain) with no neurological deficits presents. • GCS 14-15, or GCS 15/15 2hrs post injury.	3
Severe head injury	• Acute blunt head trauma +/- brief (<5mins) LOC; • >1 vomit; aged >65; on anticoagulants/has bleeding disorder; neurological deficits present. • GCS ≤13 • Seizure • Persistent abnormal alertness/behaviour/cognition • Suspicion of skull fracture	2
Persistently vomiting	• >10 per day OR every time post eating/drinking. • Signs of dehydration.	3
Possible Diabetes Ketoacidosis (DKA)	• BGL >14mmol/L **and** capillary ketones ≥3.0mmol/L or urinary ketones >4mmol/L (>56mg/dL)	2

ATS clinical descriptor	*Suggested marker(s)/variable(s)*	Recommended triage category
Non-specific abdominal pain	• Non-localisable abdominal pain • <65 years old • Mild level of pain • Non-dehydrated	4
Localised abdominal pain	• Pain localisable • Not suspected ectopic Mild to moderate pain Signs of dehydration	3
Acute abdomen	• Rigid abdomen (e.g. peritonitis) • Or suspected ectopic/AAA	2

Note: Only **one** symptom is required for a triage category to be allocated

These tools were adapted from the**:, ETEK, 2011, ACEM Recommendations 2016, Triage in the Emergency Department- Work Place Instructions v4 POW 2020**

Adult Trauma Team Activation Flowchart

Emergency Department Trauma Team Activation POWH CLIN184

4.2 Trauma Call Criteria (adapted from *Trauma Triage Activation Criteria- SGH*)

MOI Criteria Only | **MOI + any other criteria**

TRAUMA TEAM STANDBY

Mechanism of Injury (MOI)

1. Motor vehicle collision at speed >55Kph
2. Motor bike collision at speed > 30kph
3. Pedal cyclist collision at >30Kph
4. Adult pedestrian struck by motor vehicle at > 30Kph
5. Child pedestrian struck by motor vehicle at any speed
6. Fall greater than three (3) metres
7. Torso crush/pinning/entrapment
8. Patient ejection from vehicle
9. Assault with blunt object
10. Burns ≥ 10% TBSA/ Facial Burns/ Suspected inhalation
11. Traumatic asphyxiation – e.g. – drowning/hanging
12. Penetrating injury to head, neck, torso or groin

TRAUMA TEAM REQUIRED

Vital Signs

1. Airway compromise
2. RR <10 or >30 per minute (or abnormal for child's age)
3. Cyanosis or oxygen saturation <90%
4. Systolic BP <90mHg, no palpable BP (or abnormal for child's age)
5. Heart rate <50 or >120 beats per minute (or abnormal for child's age)
6. GCS <14 or fitting
7. Pupil(s) dilated or non-reactive

Injuries

1. Obvious fracture of two or more long bones (humerus/femur/tibia)
2. Suspected spinal cord injury (motor weakness/paralysis)
3. Crush injury or amputation of a limb proximal to wrist/ankle
4. Age > 65 or pregnant patient with suspected torso or major head injury
5. Severe abdominal pain / involuntary guarding

OTHER CIRCUMSTANCES FOR TRAUMA TEAM ACTIVATION (TTA)

1. If the patient doesn't meet any criteria for TTA, the assessing person should have a low threshold for activating a Trauma Team Standby if they have any concerns re an injured patient.
   This response is appropriate and encouraged.
2. If the above criteria or history of trauma are not identified on initial presentation, the appropriate TTA should be activated immediately on recognition, regardless of time after presentation.
3. **All inter-hospital trauma transfers** should receive the appropriate trauma activation based upon Trauma Triage Activation Criteria.

Transfer Route: Between SCH ED and POW ED