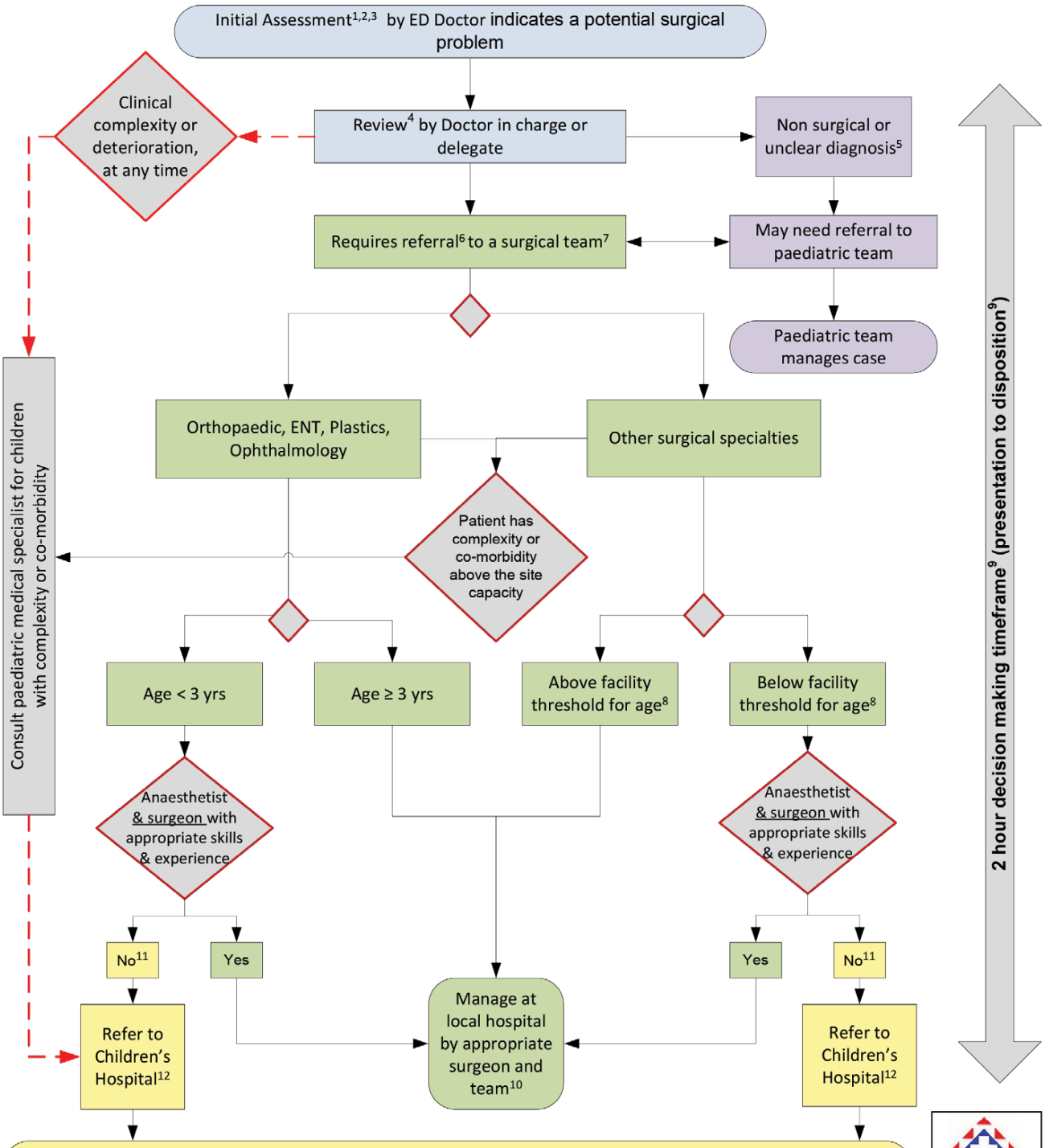
SURGERY FOR CHILDREN IN METROPOLITAN SYDNEY STRATEGIC FRAMEWORK
APPENDIX 4 – NSW HEALTH: ED ALGORITHM TEMPLATE

Management of Children (up to 16th birthday) with Surgical Problems in the Emergency Departments of Metropolitan Sydney LHD – Designated Paediatric Surgical Sites

"Years" or "Years of Age" refer to respective birthday onwards. Superscript refers to items on page 2.



Key Considerations in Referral to or Advice from Sydney Children's Hospitals Network Sites

- Advice and support from the appropriate surgical service at SCHN will be available at all times[11]
- Doctor in charge of ED to approve all transfers and consider NETS consultation if appropriate[12]
- Doctor in charge of ED to see child in-person if NETS retrieval is proposed[12]
- Arrange appropriate transport and continue to monitor for deterioration prior to transfer[13]

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Patients of all ages with scrotal or testicular pain should be urgently reviewed by a senior doctor to consider torsion and expedite immediate surgical consultation and procedure as appropriate.

Additional Notes relating to Superscripts:

1. Within triage category time Australasian Triage Scale. If clinically referred (eg. GP) consider referral information.

2. Children in extremis must be taken to the resuscitation room and managed by a resuscitation team led by the Doctor in Charge of the Emergency Department (ED). In these circumstances surgical treatment at the presenting hospital in children of any age may be necessary and senior surgical anaesthetic and paediatric assistance should be summoned as rapidly as possible. Clinicians should be specifically credentialed in their scope of practice that they "can act in an emergency to preserve life and/or reduce life-long serious disability if the risk of immediate intervention is less than the risk of transfer and subsequent delay".

3. Consideration for non-accidental injury should occur and this should be managed according to state-wide and hospital policies, with clear communication to the receiving team of actions taken and those which remain outstanding.

4. An in-person review by Doctor in Charge of ED (or delegate) should take place whenever possible. However a telephone consultation could be negotiated in exceptional circumstances and at the discretion of the Doctor in Charge/delegate. This should be decided on a case by case basis or as clinically indicated.

5. Where the assessment/review outcome of a child by ED staff and/or surgical teams is "non surgical" or an "unclear" diagnosis, advice from the paediatric medical team should be readily available. A period of observation in consultation and collaboration with the paediatric medical team may be appropriate. This may be particularly the case for younger children or those with medical histories.

6. For all ages, appropriate surgical review and management should be available within one hour of request by ED staff.

7. If presentation is surgical and a surgical team within the hospital is not involved in the management of the patient reasons and actions must be documented.

8. Metropolitan LHD to set lower age thresholds in "other surgical specialties" for each LHD-Designated Paediatric Surgical Site. Thresholds must be 12 years old or less, given prior SST recommendations for patients over 12 years. The goal is to progress towards a threshold of 3 years for most activity without complexity or co-morbidity. For intra-abdominal surgery, the comparable goal is to progress towards a threshold of 8 years, within the context of the LHD process for scope of practice.

9. The aim of the decision making time frame is to encourage working together across all hospital teams (and NETS staff where applicable) for timely response. Disposition refers to the end decision point decision to admit/operate or a decision to transfer.

10. Role delineation dictates that only Children's Hospitals will undertake surgery in the first months of life.

11. The SCHN should have 24/7 expert rosters to support LHD clinicians at the metropolitan referring sites, as well as consider the appropriate timing and site of transfer. Beyond metropolitan Sydney, JHCH will be part of the support system.

12. Ultimate responsibility for the decision to transfer rests with the Doctor in Charge of ED at the presenting hospital. Transfer related communication between senior doctors (ED and Surgical) is recommended. If there are concerns about aspects of transfer, this should be rapidly escalated to the relevant senior doctors at both hospitals for resolution. Transfer should not be delayed by unnecessary investigation. The contacted receiving hospital should assist the referring site to locate an alternative hospital should they be unable to accept the patient.

13. It is the responsibility of the ED team to ensure all children awaiting transfer from that ED continue to be monitored for deterioration prior to leaving (in partnership/consultation with other hospital teams and NETS as appropriate).

The Algorithm is intended as an accompanying guide to existing policies, procedures and guidelines including (although not restricted to):

- Triage of Patients in NSW Emergency Departments PD 2008_009
- NSW Health Clinical Practice Guidelines for Paediatric Care
- Recognition and Management of Patients Who Are Clinically Deteriorating PD 2011_077
- Children and Adolescents - Guidelines for Care in Acute Care Settings PD 2010_034
- Critical Care Tertiary Referral Networks (Paediatrics) PD2010_030
- Emergency Paediatric Referrals - Policy PD2005_157
- Emergency Department Patients Awaiting Care PD 2010_031
- Clinical Handover - Standard Key Principles PD 2009_060
- Guidelines for Networking of Paediatric Services in NSW (2002)
- Australasian Triage Scale and Guidelines for the Implementation of the Australian Triage Scale in Emergency Departments (Australasian College of Emergency Medicine - ACEM 2000)
- Australian College of Emergency Medicine's Statement on Responsibility for Care in Emergency Departments
- Ideal Emergency Department Patient Journey (NSW Emergency Care Taskforce)