



PROTOCOL

SUBJECT: PAEDIATRIC BED MANAGEMENT

DOCUMENT NUMBER: 3.2
DATE DEVELOPED: June 1998
LAST REVISED DATE: May 2008
PLANNED REVIEW DATE: May 2011

DISTRIBUTION:

All Clinical Areas Kaleidoscope GNS.
 JHH Admissions Office
 Emergency Department
 After Hours Resource personnel.

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JHCH Operations Manager

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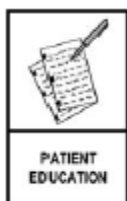
Kaleidoscope GNS Quality Committee

Disclaimer:

It should be noted that this document reflects what is currently regarded as a safe and appropriate approach to care. However, as in any clinical situation there may be factors that cannot be covered by a single set of guidelines, this document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. It does not replace the need for the application of clinical judgment to each individual presentation.

S.W.P.

SAFE WORK PRACTICE



PROTOCOL:

General Comment

It is in the best interests of children and adolescents to be cared for in an environment that is suited to their needs. This aim will be facilitated by:

- An appropriate physical environment and paediatric safe bed as defined by HNEAHS Security of Children Admitted to Hunter New England Facilities (see below).
- Access to appropriate play/activities.
- Staff who can competently meet their health and developmental needs in a safe environment (NSW Health, 1997).
- Designated paediatric/adolescent beds.
- Appropriate patient placement to reduce cross infection. (Any unresolved issues are to be referred to Kaleidoscope GNS Senior Management.)
- An environment that effectively manages the vulnerability of children in general and the specific child protection requirements of the individual child or youth.
- Not co-locating children and adults.

It is recognised that in an environment of fiscal restraint it is essential to safely maximise the utilisation of inpatient beds and other resources. The following bed management policy has been developed to support the achievement of these aims.

Paediatric Safe Bed as defined by HNEAHS Policy - Security of Children Admitted to Hunter New England Facilities, 2007.

4.4.4 Children should be in readily observed and monitored area. This includes play areas and / or paediatric beds.

4.4.5 Other patients, who pose a known psychological, physical or sexual risk to the children, must not have access to the paediatric setting.

4.4.6 The bed must be functionally separated from any adult patients preferably with a secured door that cannot be opened by young children.

OUTCOMES:

- Effective and appropriate management of JHCH resources.
- Child protection is given appropriate priority in bed management.
- Bed allocations are managed effectively and efficiently.
- Risk of cross infection is minimised.
- HNEAHS Policy compliance achieved.
- Private bed utilisation is achieved whenever possible.

J2 Adolescent Unit Admission Criteria.

The following criteria apply to patients suitable for admission to J2:

- Adolescents with primarily medical and surgical conditions who have turned 12 but not reached their 19th birthday. Youth suitable for the unit will be functioning as a child or adolescent and not living an independent adult lifestyle.
- Children and youth who are admitted for management of a mental health presentation consistent with the Provision of Care Agreement between JHCH and Mental Health Services.
- Cystic Fibrosis patients must be Berkholderia Cepacia Negative.
- Oncology / Haematology patients with an infection that will compromise other immune suppressed patients.
- Surgical patients who have reached their tenth birthday when beds are not available in J1.
- Patients not more than 20 weeks pregnant.

The following criteria identify patients who are unsuitable for admission to J2:

- Patients with unstable spinal injuries requiring log rolling by more than 2 staff are not suitable for J2A due to insufficient staffing numbers.

J2 Day Stay Admission Criteria.

- Accommodates paediatric and adolescent day stay patients excluding Oncology and Haematology patients
- The Paediatric Day Stay routinely operates between 0700 – 1530 with the exception of Tuesday which operates from 0700 – 1830. Patients returning from surgery after these hours or experiencing delays in recovery will be transferred to the inpatient units.
- Up to 4 NICU parents and their babies may be accommodated in J2 Day Stay between Friday afternoon and Sunday evening. (See 3.17 Rooming-In for NICU Parents in J2 Day Stay)

J1 Admission Criteria.

The following criteria apply to patients suitable for admission to J1:

- Infants and children (up to 14th birthday) with a surgical condition.
- Oncology patients – the following criteria apply:
 - a. No child with suspected varicella zoster or measles (or recent contact with) is ever to be admitted to J1.

- b. Patients with other suspected infective respiratory illnesses or gastroenteritis or known MRSA, need to be isolated in a single room until pathology results are clear and should only be admitted to J1 as a last resort.
 - c. If any patient with an infection or potentially infectious disease must be admitted to J1, then this patient should not be allocated to the same staff who are caring for the oncology patients. It is also advisable to admit these patients to the eastern end of the ward (H1 end).
 - d. If patients with a febrile illness are considered to be suitable to be admitted to J1, they should be admitted to the eastern end (H1 end) and allocated to non-oncology staff.
- J1 will manage surgical overflow from the adolescent unit.
 - Children with Haemophilia will present straight to J1 after hours for their treatment. (See 13.37)

H1 Admission Criteria.

The following criteria apply to patients suitable for admission to H1:

- Infants and children with medical conditions who have not reached 12th birthday.
- Children with Cystic Fibrosis who are Berkholderia Cepacia negative and who have not reached 12th birthday. Children should be nursed in a single room if possible (preferably room 22), but must be isolated from any child who is Cepacia Positive.
- Children with Cystic Fibrosis who are Cepacia Positive and have not reached their 14th birthday are to be admitted to the EAST END (Preferably Beds 20) of H1 until Bed 1 becomes available as a negative pressure room (It is currently a positive pressure room and is not suitable for any patient with an infective illness.)
- Children with a mental health problem who have not reached their 12th birthday (who do not meet the criteria for admission to Nexus or have medical issues that would best be cared for in an acute medical ward as per the Provision of Care Agreement JHCH and Mental Health Services).
- Children and youth who are admitted for management of mental health presentations consistent with the Provision of Care Agreement between JHCH and Mental Health Services.
- Children with infectious illnesses.

- Children and youth who are admitted for management of mental health presentations must be consistent with the Provision of Care Agreement between JHCH and Mental Health Services (See 3.15 Provision of Care Agreement), and should only occupy H1 if J2 is full.

F2I:

- Adolescent children aged >14yrs with Cystic Fibrosis who are positive for Berkholderia Cepacia are to be nursed on F2I. They are to be admitted under the care of the Paediatric Cystic Fibrosis (CF) Respiratory Team but the Adult CF Team / CF CNC & F2I NUM are to be made aware of their admission.

OVERFLOW MANAGEMENT:

It may become necessary to move patients between wards at any time of the day, however planned transfers should occur between 7am and 10pm to minimise disruption, and only very necessary transfers should occur from 10pm to 7am. Transferred patients must meet the admission criteria for the new ward, as listed above.

- J1 is not to exceed 19 patients.
- J2A is not to exceed 13 patients.
- H1 is not to exceed 24 patients.

Patient transfers between J1 and H1 are to occur through the main hallways, not via the adjoining fire doors due to the risk proposed by the stairwell.

- Generally J1 will overflow to H1 or J2A (depending on age).
- Generally H1 will overflow to J1 or J2A. There is a need to consider patient placement in relation to infection control issues (contact Infection Control if required).
- If all other JHCH beds are occupied, J2Day Stay may be opened for the management of low acuity overnight patients and staffed appropriately.
- J2A will overflow to J1 or H1 depending on bed availability and clinical diagnosis.
- Consideration to be given for appropriate patients to be transferred from JHCH or redirected from JHH Emergency Department to Maitland Hospital - Children's Ward. This process is to be managed by the Paediatrician on call, Emergency consultant and/or ED coordinator at JHH, paediatric registrar, Nursing Director and after hours nurse manager in conjunction with Maitland Hospital and the Maitland Paediatrician on call.

Flexible Bed Management:

If demand for inpatient beds reduces to the point where it is appropriate to close the adolescent unit, every effort will be made to establish an adolescent wing/area in H1 which is staffed by adolescent nursing staff.

SPECIAL CONSIDERATION:**Private Patient Accommodation.**

Patients with private insurance should be accommodated in single rooms unless there are no single rooms available due to patients whose clinical needs demand that they be isolated.

Patient Transfers:

Whenever it is proposed to transfer a patient between units or wards on the JHH/JHCH campus, or to an external hospital, every attempt must be made to inform the Admitting Medical Officer of the proposal before carrying it out. (See 3.6 The Patient Flow Unit.)

Patients presenting with skin infections, boils and infected wounds:

Due to the prevalence of community acquired multi-resistant organisms, it is reasonable to be cautious in relation to such presentations. Patients presenting with the above infections should be isolated in a single room until it is clear that multi-resistant organisms cannot be cultured from the patient.

Patients presenting with gastroenteritis:

Children with gastroenteritis must be isolated, ideally in single rooms with an ensuite facility. If there are multiple children with gastroenteritis admitted and insufficient single rooms, babies and young children (i.e. wearers of nappies ideally) can be cohorted in isolated 4 bed rooms with a toilet and shower isolated and labelled for use by infectious patients/parents/caregivers. Infection control with regard to linen and waste must be observed as if isolated in a single room. The nurse caring for patients with gastroenteritis should not also care for high risk patients.

Bed Management of Bronchiolitis and Respiratory Infections.

(See 6.1 "Collection of an Nasopharyngeal Aspirate" for NPA procedure)

RSV Positive status confirmed:

Literature and benchmarking evidence recommends isolation of children with RSV positive status. This can be achieved by:

- Placement in a four bedded room with other RSV positive children or in a single room.
- Once a four bedded room is deemed an RSV positive area it should be treated as an isolation room and only bronchiolitis children placed in that room.

NB Isolation of the child within the 4 bed bronchiolitis room must be attended utilising Standard Precautions. This will minimise risk to the child if they are RSV negative.

RSV Negative:

- If a single room is not available place child in a 4 bed room with children over the age of 2 yrs.

Pertussis Positive Bed Management:

Any child with a pertussis positive PCR or any child suspected of having pertussis with a PCR pending must be isolated in a single room behind the nurses station in H1.

At Risk Patients:

It is important to consider babies and children at risk of significant morbidity and/or mortality from exposure to infection:

- Babies with cardiac conditions
- Premature infants
- Babies with Downs Syndrome
- Babies with chronic lung disease
- Children with auto immune disorders

These babies/children should all be protected by isolating them in singles rooms – especially during seasons of infective outbreaks e.g. bronchiolitis in the autumn winter months.

- Endocrine patients should also be considered for placement away from any infective patients.

REFERENCES:

- HAHS Infection Control Manual (1994).
- HNEAHS Policy - *Security of Children Admitted to Hunter New England Facilities* (2007)
- NSW Health (1997), *Guidelines for the Hospitalisation of Children*.
- CAYHNet – JHCH Policy No. 8.5 -*Care of Patients with Burkholderia Cepacia*.
- JHH Policy No. 3.2.158 – *Precautions for Cystic Fibrosis patients colonised with Burkholderia Cepacia*.
- Association for the welfare of Child Health (2005) *National Survey Report*.

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SIGN OFF:

Kaleidoscope CPGAG approval 7th July 2008

KGNS Quality approval 4th August 2008