HRT1504 Paediatrics Meeting – Hot Topics/Key Issues

How do we set up a Paediatric Short Stay Unit? Location? Staffing? Hours of Operation? Governance? Admission Criteria?

- 24/7 or what's the point (Waikato)
- ^ Agree
- Must have documented/defined management plan (the diagnosis can still be uncertain but the management plan must not be!) (Waikato)
- Ceres – ward inpatient short stay. Ring Michelle Hutch for model.
- Fox: Medical – ED – Nursing – Either ED or Paediatric.
- Location – Either co-located with adult Short Stay Unit or in Paediatric ward.
- Hours – 24 hours ideal but at least 8-11pm
- Admission criteria email Michelle D.
- Contact 'Pulsar' participants – commencing <48hr stay ward governed by General Medicine.

What are the Indications for ICU/HDU post T+As? How do you influence practice? Who leads the process?

- ICU outreach to non ICU areas – LCCH
- Multi professional leads – intensivisits, anaesthesists, surgeons, nursing Plus bookings
- Influence practice by using data and evidence, ongoing audit.
- Demeter – currently OSA children (suspected or proven) are booked as elective HDU beds as kids critical care. Usually stay overnight, I/V early by ENT then discharged home. Followed up in outpatients by ENT.
- “Close OBs” on 23 hour unit e.g. OSA, airway, surgery, syndromic children. Protocol based selection criteria prebooked. Managed on 23 hour patients. Karen Phillips, LCCH, Zenith.

How do we ensure the patient journey is efficient and safe in this new environment?

- Map it first – use lean. (Yes Map!)
- Seek patient/family feedback about processes/challenges and involve them in the redesign scenario/mock exercises and consider age-specific issues i.e. infant vs young person
- Use a ‘PIP’ process for all info to families so they understand expectation of them and staff. Also helps them understand discharge process and Care.
- What’s PIP?
- Ask the patient and the GP for feedback (Michael Clements Townsville)

What strategies are there for improving communication regarding management plans for complex children being discharge to surrounding districts for when they represent to local hospital?

- Making tertiary hospital cnc aware of key contact person in your area that can make your local staff aware and enter alerts. Tracey Couttie, Illawara.
- PCEHR for all complex kids and keep it updated and communicate with GP (Michael Clements, Townsville).
- Sharing of all clinic letters, EDs and acute management plans on common IT platform between all local hospitals (concerto) Chris Peterson, Waitemata.
- All parents should be cc'd into ALL clinic letters and have a folder created to hold them and bring with them at any hospital/visit. Need clear care plan created with triage etc. Sue Hobbins.
- Implement goal oriented care plans (develop with patient and families). Patient and family holds the plan – RCH Melb. Currently piloting complex care processes to lower readmissions, raise patient experience and promote patient/family ownership.
- Contact LCCH – State-wide Connected Care Program, - connected care coordinators do this well (Ipswich).
- Patient/parent held documentation care plans.
- Gold Coast. Question.

Fox – How do you get children to HDU when the receiving tertiary PICU has no beds/capacity to retrieve them?

- Retrieve to 'other' hospital with HDU beds. Develop knowledge and skills of local team to assist management.

How do we best manage these patients either locally or whilst awaiting this care: equipment, staffing (competency), location.

- Telehealth with PICU
- Definitely – communicate with intensivist at tertiary centre. Video links.
- HDU?! What's that?! (Waikato)

What strategies do you suggest to help improve the patient flow of day of surgery admissions through the paediatric ward prior to theatre (inpatient and day surgery)?

- Separate DOSA unit (Waikato)
- Patients are admitted to Day Surgery (adults) first and come to Paediatric ward post op. This gives time for discharges to happen in the ward. Looking at recliners for day cases e.g. dental (Ipswich).
- Good communication with theatre to plan time of arrival to minimise wait to theatre and help with fasting times.
- Do not 'admit' to a bed. What is the block on the ward? Improve discharge planning: Early rounds, Discharge meds, Parent education.

Criteria Led Discharge – Specific VS Generic – Improving update to cover all patients.

- Generic but ability to record/have a variance

Who has paediatric sleep study clinics – pathways/protocols?

- ADHB/SSH
- LCCH
- Waikato (Very limited)

Paediatric ED in mixed department “vision to reality”. How do we make it a reality? How do we advocate differently to change perceptions?

- NEAT and presentation
- It’s already built
- Fox: Michelle Davison – email me if you want info
- Presentations > 15,000
- Start by making allocated beds and staffing within existing Gen ED model (like Logan did)
- Paediatric Pathways
- Paediatric Equipment Separate
- Segregate waiting room chairs
- Show higher activity, higher patient satisfaction, lower NEAT times. DWW.

What support does your sub-specialist services provide for provincial/regional hospitals? For those that receive this what works?

- Outreach sub-specialist support to regional/provincial hospitals
- We receive cardiology/resp/genetics/rehab/endo/rheum. John Coghlan.
- Telehealth?? John Gavranich.
- Visiting/Fly in-fly out/+/- telehealth. Build local capacity and trust through training. Rural generalist/advanced skils GP training. Michael Clements, Townsville.
- Outreach services/clinics
- Meetings/education BT providers and receivers – audit/best practice.

How do we support GP's in providing best care and keeping children out of outpatients/ED?

- Continuous Care Pathways (e.g. Map of Medicine – we're just starting) Waikato – Hamish.
- Primary care communication with secondary care.
- Guidelines for routine presentations i.e. orthopaedic AKI/SSH
- Do clinics in the community at co located facilities. Integrated Family Healthcare Centres. Chris Peterson, Waitemata.