Discharge of Children and Young People from inpatient ward at Worcestershire Acute Hospitals NHS Trust

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Approved by:	Paediatric Quality Improvement meeting	
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Date of review: **This is the most current version and should be used until a revised document is in place**	9th February 2027	

Key Amendments

Date	Amendment	Approved by
19th Nov 2020	Document extended for 1 year	Dr J West/Paediatric QIM
26th March 2021	Approved with no amendments	Paediatric QIM
9th Feb 2024	Together for Short Lives – amended from WM Palliative Care Tool kit	Paediatric Guideline Review Day
	PEWS to National PEWS	

Introduction & Definitions

Introduction

The NHS Institute for Innovation and Improvement undertook extensive work in 2008 related to discharge planning and developed a Quality and Service Improvement Tool.

They found that planning for discharge with clear dates and times reduces patient's length of stay, emergency readmission rates and releases pressure on hospital beds. This was found to be the case for all patients, regardless of the complexity of the discharge.

They also identified some common key elements when planning for discharge, irrespective of whether a patient is receiving emergency or elective (inpatient or day case) care. These are:

- Specifying a date and / or time of discharge as early as possible (ideally within 24-48 hours or, prior to admission for day case/elective surgery)
- Identifying whether a patient has simple (80 per cent of all patients) or complex discharge planning needs
- Identifying what these needs are and how they will be met
- Deciding the identifiable clinical criteria that the patient must meet for discharge

Operationally the CYP ward should:

- Plan the date and discharge time early
- Plan for patients to be discharged before the peak in admissions – for Riverbank this tends to be in the afternoon.

- Plan for discharge seven days per week – so logistically ensure that all equipment and medications ordered to facilitate weekend discharge.
- Discharge CYP using a criteria based process and facilitate Nurse Led Discharge
- Involve CYP and parent throughout the process to ensure open and honest discussion of options, negotiate care as necessary, whilst maintaining CYP safety, to allow informed consent from CYP where appropriate and their parent.
- Co-ordinate and check everything is in place at the earliest opportunity before discharge to ensure that everything is ready. (NB: if it is a complex discharge, check 48 hours before planned discharge date)
- Communicate timely and accurately for discharge

With elective care, discharge planning should start before admission. This allows everyone to focus on a clear endpoint in the child/young person's care. It also reduces errors and unnecessary delays along the patient pathway.

This guideline will assist the team in identifying and implementing the most effective approaches to planning and organising an individual needs led discharge. This will similarly help to ensure provision of on-going high quality, safe and efficient care for the child/young person and their respective families, having the added benefit of minimising hospital stay and maximising bed use within the Children and Young Peoples Ward.

Safeguarding the Child / Young Person will be given the highest priority

Definitions:

CYP:	Children and Young People Aged 0-17 years, 364 days.
Parent:	Parent or main carer with parental responsibility
ED:	Emergency Department
GP:	General Practitioner
HV	Health Visitor
Orchard Services	Community Children's Nurses
Open Access	Allows CYP and parents access to telephone advice and review on the ward for a specified period e.g. 24 hrs., 48 hrs, Long term
RN C	Registered Children's Nurse
PEWS:	Paediatric Early Warning Score which is age related and helps to identify patient deterioration at an early stage to allow proactive management on the ward and therefore reduce the rate of emergency resuscitations on the ward and intensive care admissions
PAP:	Paediatric Assessment Pathway
SBAR:	Team communication tool – Situation, Background, Assessment, Recommendation (See Appendix 1)
TTO's:	To take out discharge medicines
EDS:	Electronic Discharge Summary (copy for parent, medical records, GP and HV)
NLD	Nurse Led Discharge

Details of pathway

Preparation for discharge home should begin at the time the CYP is admitted or attends pre-admission clinic/GP/ED. It is important to determine the support families are likely to need, taking into account any multidisciplinary input prior to admission and how this may change due to the child's presenting condition and progress.

A discharge planning meeting will be necessary where a child has complex medical or social problems. This will enable the team to communicate care and take into consideration the child's social, physical, psychological and educational welfare.

It is important to ensure that the CYP and their parent have a 'safety net' of information available to them so that should the CYP develop a health-related problem, they know what action to take and when, along with where and how to access the appropriate service. All verbal information should be reinforced with written information whenever possible. Access to interpreting or advocate services can be arranged.

In order to support the CYP and parent at home, the family may be given 'open access' to their CYP inpatient ward for a specified length of time. In addition to this, The Childrens Community Nursing team (Orchard Services) may be utilised.

Open Access' refers to a system in which parents are able to access advice and support from the CYP ward should they feel that their child's condition is causing concern; this can also lead to the child being reassessed on the ward if required.

It is well documented and evidenced that children recover better and quicker in their own home and recommendations have followed that the child should stay in hospital for the briefest time necessary for safe and effective treatment. However this will be mitigated if the CYP or parent voices concern about discharge. The threshold for discharge in young infants / vulnerable parents will be lower and it is expected that the CYP and parent be invited to stay overnight and be re-assessed the following morning.

Paediatric Community Resources

Children's Community Nursing Team (Orchard Services) is a 7 day service and provides assessment, planning and evaluation of care for:

- Children who would otherwise need to receive treatment within the acute service
  • preventing admission
  • promoting early discharge
  • provision of care packages if technology dependant or highly unpredictable
  (NB additional funding agreements with commissioner required prior to discharge)

- Children with life threatening conditions who are receiving treatment that may fail or is intended to prolong their life expectancy.

- Children with degenerative or progressive life limiting conditions that have no cure.

- Children who are dependent on technology.

- Any other child who requires the skill of children's trained nurse to provide treatment or care within the community.

They also provide:

- Liaison with multiagency teams to ensure a seamless, co-ordinated service is provided.

- Ensure appropriate equipment is provided for safe care of the child or young person.
- Provide training for the child, carers, school staff and respite care in support of meeting the child/ YP health care needs.
- Manage individual care packages for children and young people with significant health care needs (NB with additional funding agreement).

Before referring to the Children's Community Nursing Team (Orchard Services) ensure that the:

- Family has a telephone, or close access to a phone.
- Family has own transport, or easy access to transport.
- Distance from hospital is appropriate for child's condition.
- Parent has been given the Orchard Service's information sheet, depending on the area they live in (North/South Worcestershire)
- If dressings or equipment are required for continuing care, adequate supplies (at least 48 hours supply) must be given to the family.

NB: Check Community Children's Nurse Team availability if same day / or early next day review is likely to be required

A further valuable resource is the Paediatric Liaison Health Visitor. They are responsible for:

- Liaising with the ward 3 times a week and collecting completed Paediatric Liaison Nurse forms and discharge summaries for children admitted to the ward.
- Ensuring the information on the forms is shared with the appropriate health professional i.e. health visitor or school nurse. If urgent, a telephone conversation/message will take place that day.
- Discussing any children on the ward as required, providing advice and support. Refer to Named Nurse for Safeguarding, Acute Trust as necessary.
- Ensure health visitors receive discharge summaries of pre-school children in a timely manner. These are sent by internal post the same day.
- Screen discharge summaries of school-age children and send to school nurses as appropriate.
- Forward information to other areas on children admitted who live out of area/attend schools out of area.

Please note that if the CYP is not registered to a GP, the parents should be encouraged to register them within the area that they live as quickly as possible. If the CYP has complex or immediate on going health needs, they should be registered with a GP before discharge from the CYP ward.

1. Roles and Responsibilities

1.1 Roles and Responsibilities of the medical team in discharge planning:

- Start planning for discharge or transfer before or on admission
- Identify whether the patient has simple or complex discharge planning needs, involving the CYP, parent and nursing team in your decision
- Identify patients who are eligible for nurse led discharge, with clear set criteria to be reached prior to discharge
- Develop a clinical management plan for every patient within 6 hours of admission
- Set an expected date of discharge or transfer within 24-48 hours of admission, and discuss with the CYP and parent
- Review the clinical management plan with the CYP and parent each day, take any necessary action and update progress towards the discharge and transfer date. Complete EDS and discharge medication requests.
- Involve CYP and parents so that they can make informed choices that deliver a personalised care pathway and maximise their independence.
- Liaise with the appropriate Nurse Specialist e.g. Diabetes, Oncology, Respiratory and Epilepsy

1.2 Roles and Responsibilities of the ward nurse in discharge planning:

Simple Discharge Planning (Appendix 2 simple overview of admission to Simple discharge planning))

- Allocated nurse to identify and promote individualised discharge plan for CYP in their care from time of admission to the CYP ward.
- Provide effective communication between CYP, parent and pertinent agencies, negotiating an appropriate discharge time / date.
- Ensure close liaison with CYP's medical team and work to clinical management plan
- Identify and adhere to discharge criteria.
- Involve CYP and parents in discharge planning and ensure plan is reviewed and further adapted to their needs as required.
- Ensure that all relevant agencies are aware of the CYP's discharge from the ward and any further intervention / follow up required by their agency is agreed to and documented.
- Ensure that nursing and medical electronic discharge summary is complete and prescribed medications are available on the ward prior to discharge. All discharge medications must be validated, checked and Dispensed by 2 RN C nurses
- Correct patient identification will be undertaken by 2 RN C and the discharge nurse will give a full explanation of medications, possible side effects etc.

- Check the CYP for peripheral vascular devices, if present ensure that it is removed (unless further access is required post discharge).

- Check NPEWS within 2 hours of departure from the ward; use SBAR to communicate findings, escalate care if appropriate.

- Check that CYP and parent are happy for discharge to take place, i.e. concerns have been appropriately addressed. Parents/CYP to sign appropriate paperwork to confirm happy for discharge

- Ensure CYP is dressed appropriately for the weather conditions and has suitable transport home in the care of a responsible adult. Ideally this should be someone with parental responsibility.

- Ensure copy of medical Electronic discharge summary is sent electronically to GP or if GP is not set up to receive EDS electronically to Print and post EDs to GP.

Simple Discharge planning – Nurse Led Discharge / Criteria Led Discharge
Nurse led discharge is intended to provide patients with a quicker and more efficient discharge.by enabling the nurse to assess if criteria led discharge elements are attained.
If simple discharge (See 1.2) is identified the CYP may be eligible for Nurse Led Discharge (NLD).

- Clear set criteria for discharge are identified and clearly written in medical notes and NLD criteria form (See Appendix 3)/operation sheet.

- TTO's ordered if required

- EDS to be completed when NLD identified to save delay when patient has fulfilled criteria for discharge

- Nurse in charge to be informed of discharge criteria

- CYP continually assessed against discharge criteria by appropriate nurse

- CYP will need to fulfil criteria for Simple Discharge ie NPEWS within 2 hours of discharge, parents happy for discharge, CYP appropriately dressed

- If parents CYP are not happy with discharge plan or criteria is not met further medical review is required – ward nurse to facilitate this

- Elective surgical admissions – The surgical admission document has discharge criteria embedded. If this is accompanied by clear post-operative instructions on the operation note this can be used for assisting nurse led discharge. If all criteria are met the child can be discharged without further review. If child deviates from expected plan ie continuous post op vomiting/wound ooze. Child must be reviewed before discharge.

Patient exclusions to NLD:
Patients who require complex discharge planning ie those with training requirements
Neutropenic patients.
Complex cardiology patients
Endocrine (CAH) and diabetic patients
Complex Social or child protection cases
CYP with airway problems
Emergency ENT patients
Orbital cellulitis,

Complex ear surgery
Patients with outstanding medical investigations

Patients for NLD:
Recovering Bronchiolitis
Febrile illness (as long as focus known)
Febrile convulsions (as long as focus known)
Uncomplicated Exacerbation Asthma/Wheeze
Day case/elective procedure

Complex Discharge Planning: (See Appendix 4-7)

In addition to the criteria outlined in 'simple discharge planning' the allocated nurse should also:

- Set realistic achievable goals re: teaching plan for two or more carers of their child (if there is a shared responsibility for caring for the child such as grandparents etc.). Carers should demonstrate knowledge and skill of expected tasks and each carer have signed documentation from the nurses in the child's medical records to evidence the carers' competence. Identify a core ward nursing team to care for the child and support family.
- Initiate referral to multi-agency teams, arrange a Discharge Planning meeting as soon as possible after admission to identify key issues, action plan and agree an estimated discharge date. Document agency involvement, their contact details, actions required by whom, and review dates.
- If child is subject to Advanced Care Planning (Together for Short Lives) please refer to planned care and support child and family wishes.
- Ensure that all support agencies are aware of the child's discharge and all relevant equipment, consumables etc. are in place before the child leaves the ward

2. Safeguarding CYP Discharge Planning: (See Appendix 8)

A CYP admitted with safeguarding needs will fall into the category of 'complex discharge planning' the nurse must adhere to the Trust's Safeguarding CYP Policy and should not be discharged from the CYP ward unless sanctioned by the Consultant responsible for the care of the CYP.

The nursing and medical team should liaise with Children's Services so that they are aware of the CYP and their anticipated discharge date and time.

An agreed discharge date and time should be arranged (if the CYP remains an inpatient on the ward when medically fit, but is awaiting a suitable residential placement, please complete a clinical incident report via DATIX and escalate via respective clinical, managerial and executive teams for WAHT and Children's Social Care Services as appropriate).

Should a CYP be discharged into the care of Children's Services/Local Authority, the CYP must be collected by an identified Children's Services Social Worker, who will be expected to produce their Social Services identity badge. It is not acceptable for the CYP to be collected by anyone else and the CYP should remain on the ward. It is the Social Worker's responsibility to handover the care of the CYP to the residential placement.

In these circumstances guidance should be sought from Children's Services as to whether it is appropriate for the parents to be present at the time of the CYP's discharge from the ward.
If the CYP is in an established foster placement and the foster parents identity is already known to the ward (agreed and verified with Children's Social Care Services), it is reasonable for the CYP to be discharged into their care.

The nurse will also ascertain the CYP's new contact details and note where further correspondence should be sent. This information will be entered on to the electronic OASIS and Blue Spier system for future reference.

Please note that the Foster parents address must not be disclosed. This is under the remit of Children's Social Care Services only.

In the case of complex discharges involving on-going or new involvement with Childrens Social Care Service, the discharging nurse will be required to collate information from the admission and email this to the Childs Named Social Worker.

3. Self-Discharge or Discharge Against Medical Advice (AMA) (See Appendix 8)

Should a parent opt to discharge their child from the ward against medical advice, despite explanation of concerns and possible consequences, offer 'open access' for their child to the parent, advise on how to care for the CYP, when to seek help and ascertain if they have access to a telephone. Ask the parent (please check that the person with parental responsibility is with the CYP) to sign the Self Discharge form (or discharge against medical advice). Nursing or medical staff speaking to the parent must also complete the checklist in Appendix 8.

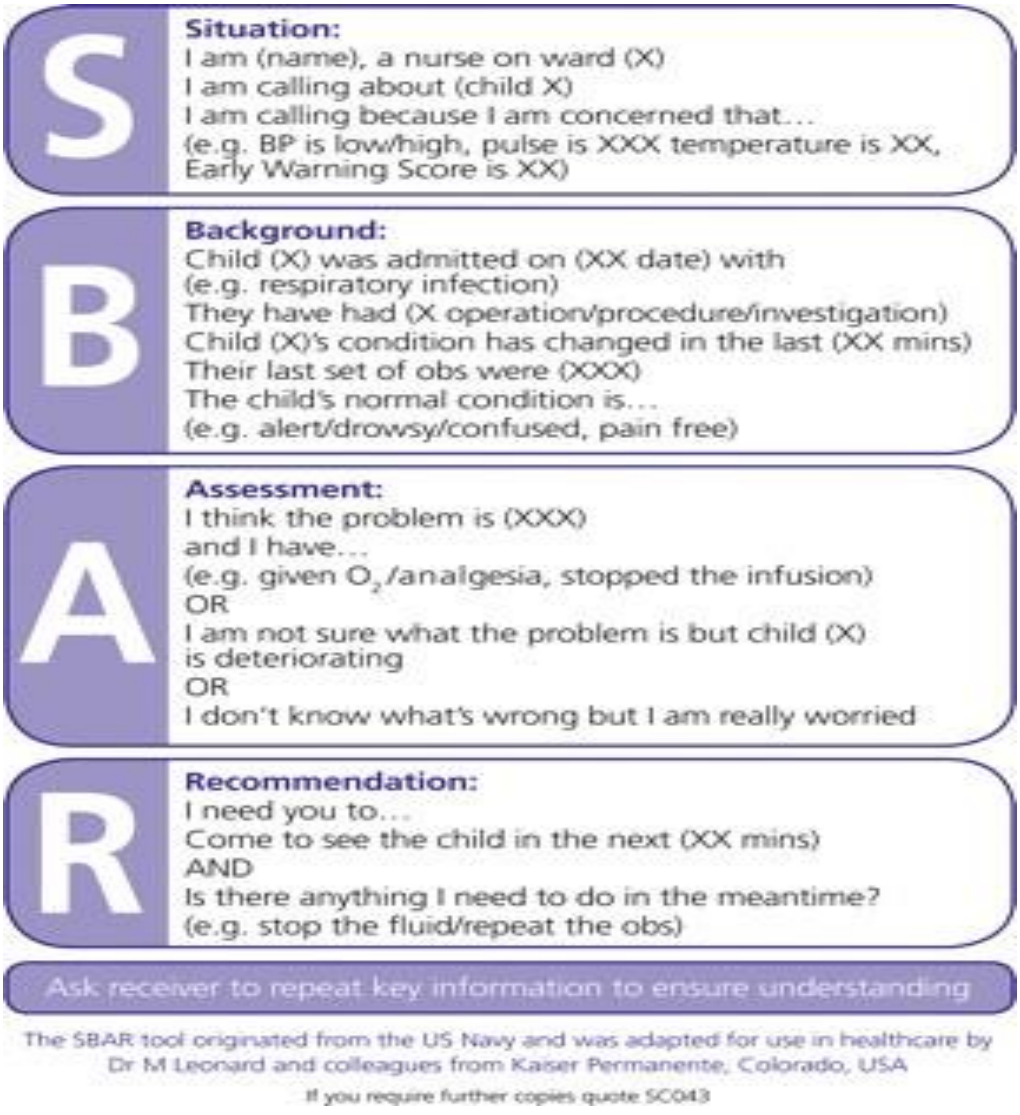
Young people who are 'Gillick Competent' may also seek 'self-discharge' the same process used for the parent of the CYP must be followed. The medical team have the responsibility to determine whether the Young person is Gillick competent.

Consideration should be given in liaison with Registrar/Consultant to the need for informing:

- Children's Services (Safeguarding)
- Police – for safe and well check or to return CYP to the ward for an urgent medical review.

Complete clinical incident report via DATIX system and speak to / email Lead Integrated Safeguarding team

APPENDIX 1: SBAR Communication Tool

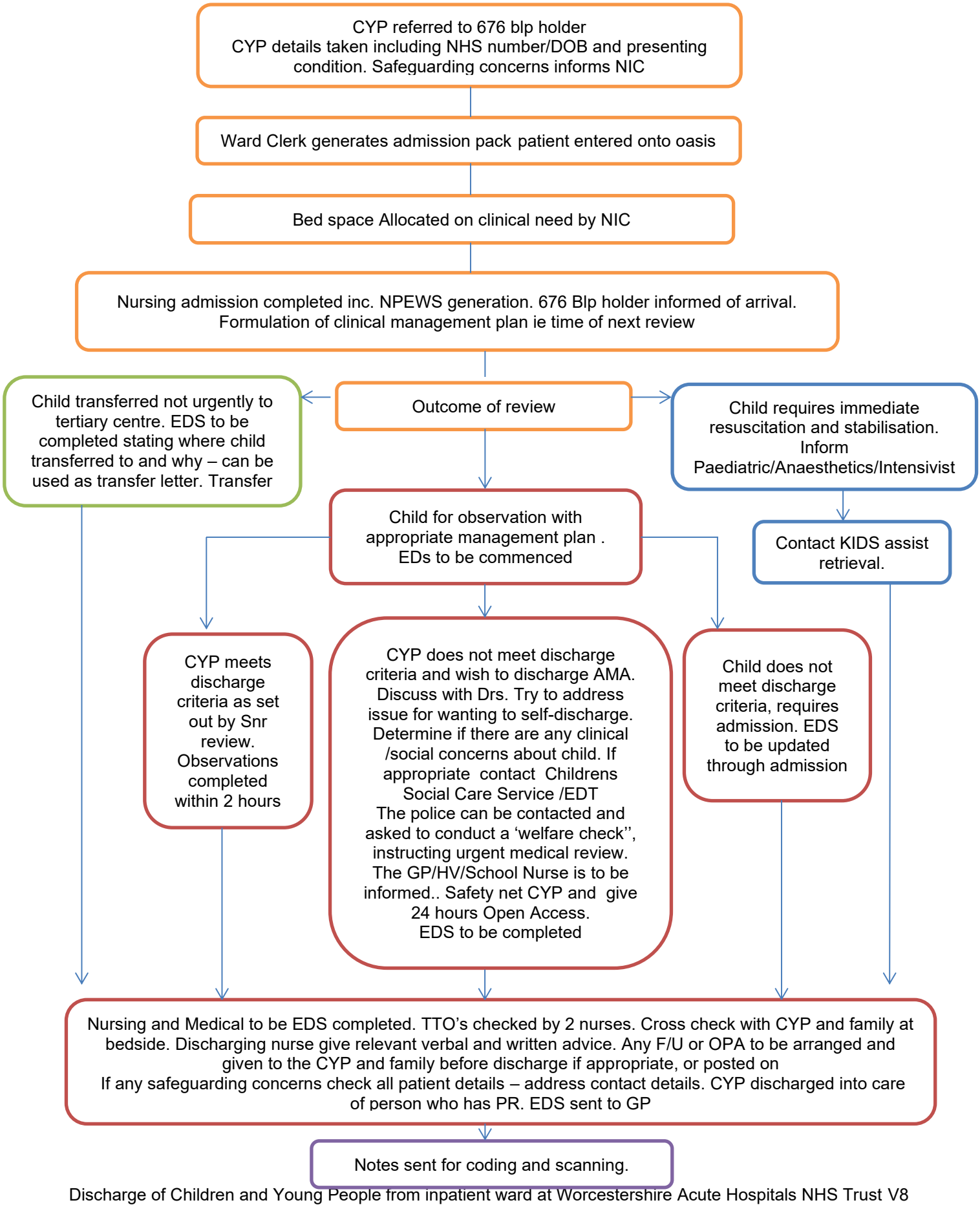


The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

If you require further copies quote SC043

Please note that clinical key documents are not designed to be printed, but to be viewed on-line. This is to ensure that the correct and most up to date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours

APPENDIX2: CYP Admission to Simple Discharge



APPENDIX3: Nurse led Discharge Form

Nurse Led Discharge Form (to be completed with the patient prior to discharge)

Name of procedure/diagnosis:

Responsible consultant:

Affix Patient Label	All patients details correct on admission form Y/N	
	Parents name	
	Contact tel No	
	GP	
	Address	

Inclusion Criteria for Nurse Led Discharge	**Satisfactory**	**Comments**
Tolerating diet and fluids	Y/N	
Temperature within normal range	Y/N	
Pulse within normal range for age and individual	Y/N	
BP within normal range for age and individual	Y/N	
Respiratory rate within normal range for individual	Y/N	
Passing adequate amount of urine without difficulty	Y/N	
Oxygen saturations above ……%	Y/N	
Tolerated fluid challenge	Y/N	
Taken ……. Feeds as asked	Y/N	
Do parents want to speak with Dr before discharge		
Additional criteria set by consultant		
	Y/N	
	Y/N	
	Y/N	

Any columns marked as No, will required child to have further medical review.

Expected date of discharge ___/___/___Date of Discharge ___/___/___

Discharge nurse signature _____ Designation _____ NMC _____

Date completed ___/___/___ Time completed __:__

I _____ (CYP/Parent) have completed the discharge form with the nurse, and confirm that I am able to go home and am fully aware of all instructions given. _____ (CYP/Parent signature)

Copy to be stored in patients notes when complete.

APPENDIX 4: Complex Discharge Process

Complex Discharge identified
(Discharge has multiple elements such as parental teaching, multiple input from MDT) Decision made for discharge. Allocate 3-4 named nurses

Refer to relevant multi agency teams if appropriate ie Physiotherapy, Childrens Services, Community Nursing team (Orchard North/South) Specialist nurses
Email referral must be sent to Community nurses
WHCNHS.CCNWorcester@nhs.net (Worcs)
WHCNHS.CCNRedditch@nhs.net (Kidd+Redditch)
Consider Discharge planning meeting with all involved professionals

Discharge Criteria made along with time frame to accomplished by Named nurses (See Appendix 5)

Involve carer in the discharge planning as appropriate. Be clear what needs to be achieved to enable discharge. Agree timeline for any teaching, equipment ordering etc. Document this in the notes.

Commence EDS

Parental training identified

TTO's to be ordered 24-48 hours prior to discharge. A stock of at least 1-2 weeks should be dispensed. Once available on the ward. Parents should be encouraged to give medications once available in TTO form

Track progress with the child's carers and Orchard Services of availability of equipment and supplies for home use. Including arrangements for home delivery. Record updates on action plan

Competency training package commenced . Identify who needs training, by whom and by when

TTOs to be checked by nursing staff once arrived on the ward

Inform Community nurses potential date of discharge to ensure adequate support at home

Once competent carers should be encouraged to fully care for their child in preparation for home

Once available on the ward. Parents should be encouraged to give medications in preparation for home

Inform community nurses on day of discharge child has been sent home as planned

Discharge with EDS, medications indefinite open access and if necessary follow up appointments, contact details of any other professional involved in the child care. Copies of EDS to relevant professionals including GP. Named Social worker informed of nursing perspective during admission via email(if required)

Encourage parents to room in and discuss opportunity for staggered discharge

Consultant to write to ward manager informing them of Indefinite open access if required. Ward Clerk to update oasis system with open access details. Where appropriate written treatment plan should be kept on the ward, all other notes should be sent for scanning

Appendix 5: Complex Needs Discharge Planning

Affix Patient Label	Named Nurses:

Teaching for Discharge? Identify Teaching package and for which carer(s)				Equipment for discharge When ordered expected delivery date				Medications for discharge		Children s service referral sent?	Community team input Referral made
Carer	Teaching package required	Training by (RN/Physio)	Completed (date)	Equipment	Ordered by:	Expected Delivery date:	Delivered Y/N	TTOs ordered Y/N	Medications explained		

Appendix 6: Complex needs discharge action plan

Affix Patient Label	Named Nurses:

Date and Time	Meeting / Discussion & Attendees/Roles Action to be taken	Date to be completed. Person Responsible	Reviewed on: --- / --- / --- Is further action required?	Date to be completed. Person Responsible Review Date	Further Comment	Name (Completing) Sign Role

Appendix 7: **Action Plan/Communication log.**

Affix Patient Label

CYP/ Parent Discharge Planning Communication Record

Key Professionals		
Name	Role	Contact Details

Referrals

1. Made to _____ on --- / --- / --- at __:__ hrs by: _____
2. Made to _____ on --- / --- / --- at __:__ hrs by: _____
3. Made to _____ on --- / --- / --- at __:__ hrs by: _____
4. Made to _____ on --- / --- / --- at __:__ hrs by: _____

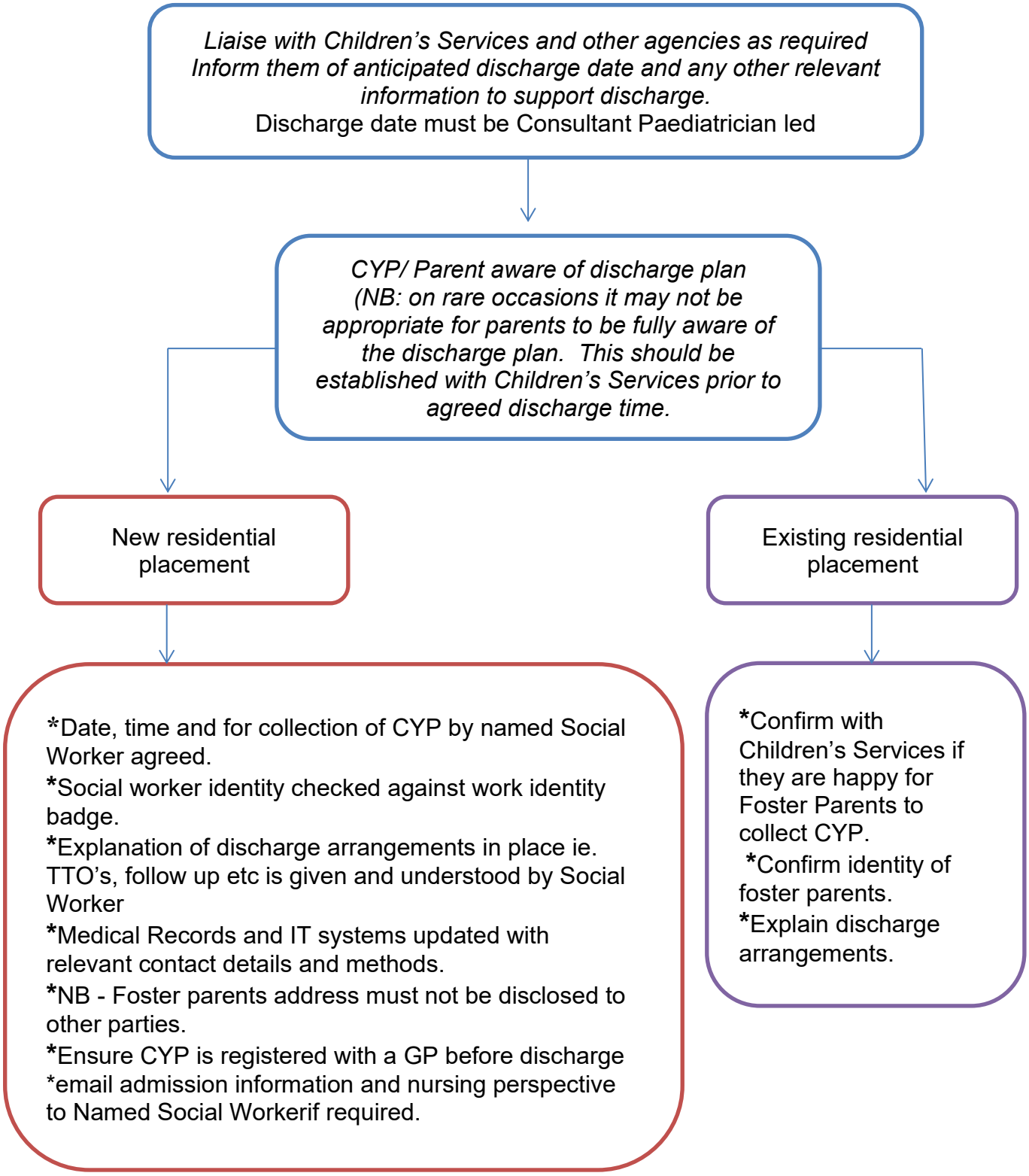
CYP / Parent informed of referral (please write name)	Date informed	Name and role
1		
2		
3		
4		

Document discussion on joint continuation sheet in the medical records and any decisions made as a result:

- Discussion with CYP (and in what context)
- Discussion with Parent
- Discussion with Managers
- Information provided to Multi-disciplinary team
- Apply Safeguarding Record Keeping Standards if applicable
- Discharging nurse to email Named Social worker admission details and nursing perspective during admission period.

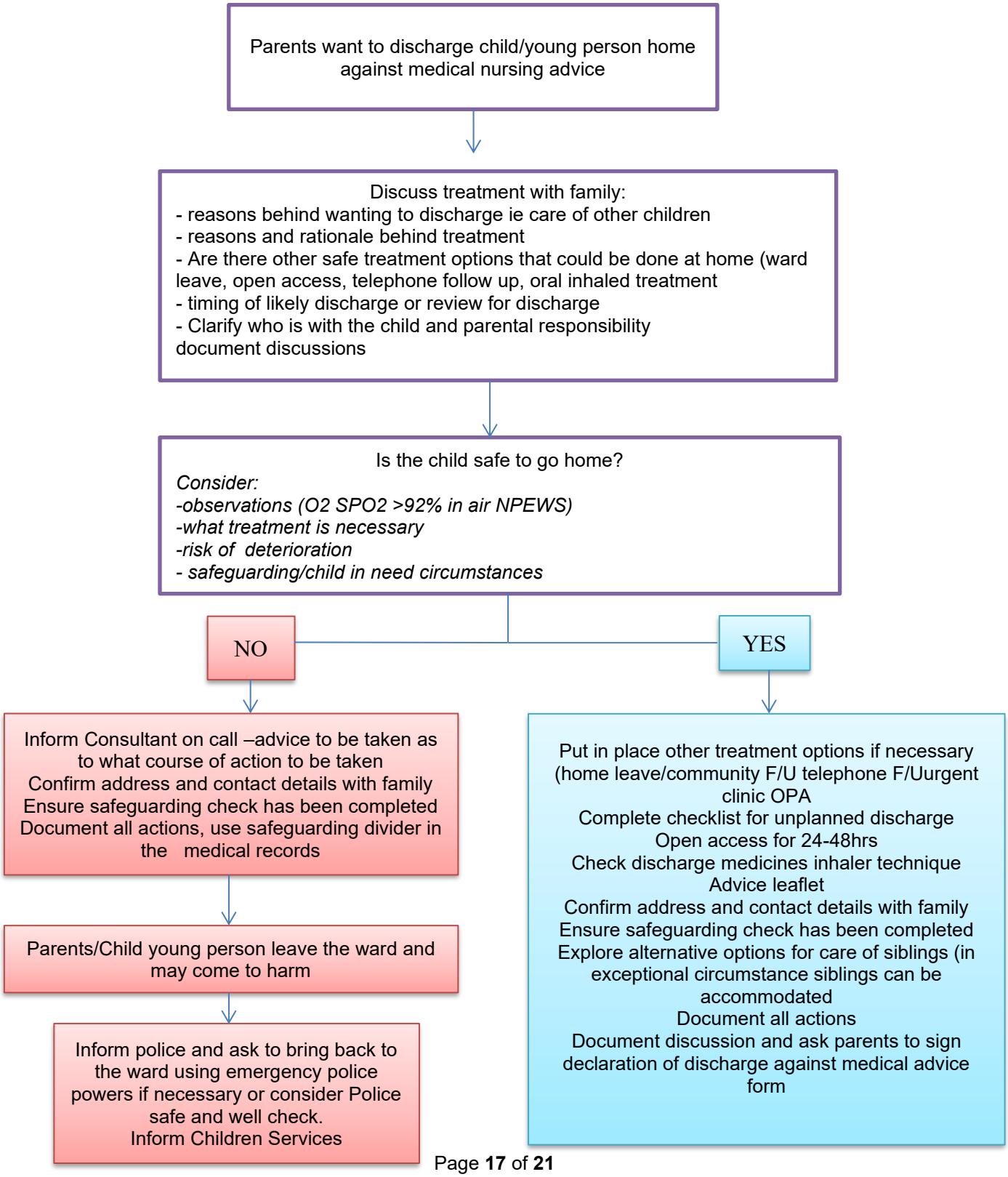
Appendix 8: Discharge process of CYP being discharged into Children's Services / Local Authority Care

To be used in conjunction with Appendix 2 – Complex Discharge Planning and if Safeguarding concerns are generated as a result of CYP/ Parent taking discharge against medical advice, refer to Appendix 7.



APPENDIX 9: Self Discharge Against Medical Advice (AMA)

Usually plans of care for children and young people are made in partnership with parents and families. However on some occasions parents may disagree with medical and nursing recommendations and wish to take their child home against advice. The following flowchart and appendices include guidance on how to manage this situation.



Affix Patient Label

Checklist for CYP Discharged against medical advice: Date: ___ / ___ / ___ @ ___: ___ hrs.

Action Taken	**Comment**	**Sign and Role**
Confirm Discharge Address and contact details		
Confirm person discharging CYP has parental responsibility. Yes / No		
Open Access explained and leaflet given: Yes / No		
CYP / Parent Information Leaflet given: Yes / No	Name of Leaflet:	
Discharge Medication given: Yes / No / NA		
Medication administration explained to parent. Yes / No / NA	Advice given:	
Advice given to CYP and parent on when and how to seek help. Yes / No / NA		
Outpatient Appointment arranged if needed: Yes / No / NA	Appointment Details:	
Person with parental responsibility has signed Declaration Form	Yes / No Name of PR: _____	
Discharge letter completed documenting discharge against medical advice Yes / No		
Health Visitor / School Nurse aware: Yes / No / NA	Name of HV / School Nurse:	
Inform Children's Services if CYP has a named Social or Family Support Worker: Yes / No / NA	Name and contact details of professional:	
Consider referral to Children's Services re: Safeguarding. Yes / No / NA		
Consider referral to Orchard Services Yes / No / NA		
Telephone follow up to be undertaken by: Nurse Doctor Specialist Nurse Orchard Services	Details of follow up call:	

Completed by: _____ (Signature) _____ (Print name) _____

Role: _____

Affix Patient Label

DISCHARGE AGAINST MEDICAL ADIVCE DECLARATION FOR CHILDREN AND YOUNG PEOPLE

STATEMENT OF PARENT

I,……

Parent / carer of……

Hereby declare that I wish for my child to bed discharged immediately from ……

……hospital, and affirm that I have made the decision to leave the hospital of my own free will, fully realizing that it is contrary to the medical advice which I have received.

Signed…… Date……..

Name (print)……..

Relationship to the child……..

STATEMENT OF HEALTH PROFESSIONAL

I have explained to the above parent / carer that I advise that ……

……is not discharged from……hospital.

I have explained the risks of discharge. In particular I have explained:

……

……

……

……

……

……

Signed…… Date……..

Name (print)…… Job title……

Monitoring and Compliance

This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Treatment pathway. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance.

WHAT?	HOW?	WHO?	WHERE?	WHEN?
These are the 'key' parts of the process that we are relying on to manage risk.	*What are we going to do to make sure the key parts of the process we have identified are being followed?*	*Who is responsible for the check?*	*Who will receive the monitoring results?*	*Set achievable frequencies.*
	Clinical Audit	Paediatric Clinical Governance Committee		Every 12 months
	Staff Electronic Record system	Local Managers/Staff		8-10 weeks
	Clinical Audit/Observation	Paediatric Clinical Governance Committee		
		S Weale, K Haley & R Delves		Yearly
	Review of Datix and completed "escalation trigger list"	Nursing Staff		
	6 Monthly Audit	CYP Nursing and Medical Staff		6 monthly
Viewing Arrangements	Spot checks	Children's wards or Emergency Departments	CYP Standards Committee, escalating to Trust Children's Board if required	Three times a year
Documentation – Completion of Checklist: Following the death of a CYP in hospital. Professional Contact List	Audit of checklists via CYP medical records	Children's Wards or Emergency Departments	CYP Standards Committee, escalating to Trust Children's Board if required	Three times a year

References

- CEN [Children with exceptional healthcare needs] 2010. National Managed Clinical Network. NHS Scotland.

- NHS Institute for Innovation and Improvement (2008) Discharge Planning Tool for Quality and Service Improvement Tool

- House of Lords (1985) Fraser Guidelines. Victoria Gillick v West Norfolk and Wisbech Area Health Authority