

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Hospital Discharge Policy for Children and Young People

Effective: January 2010

Review: January 2013

1. Introduction

1.1 The National Service Framework for Children, Young People and Maternity Services, Standards for Hospital Services (2004), states that;

“For children and young people requiring more than just the simplest of hospital care, there should be an agreed process to plan care, involving primary care, and all relevant hospital departments and other agencies, including education and social services, to provide a joined-up, co-ordinated care package so that children, young people and their parents can access the different services easily.

1.2 Hospital stays should be kept to a minimum through the co-ordinated delivery of care. Planning for discharge and the prevention of unnecessary readmission should be the norm for all children and young people. Where the hospital episode has been simple, discharge planning need not be elaborate, but should at least include a letter to the GP (copied to patient at their request) and a briefing for the patient and their parent about likely after effects, any follow-on treatment needed, any continuing drug therapy, and the implications for school attendance, together with point of contact in case of difficulty or confusion.

Where applicable the role of the social worker in discharge needs to be effectively linked in. Where needs are more complex, detailed planning may be required, for example, for equipment or to ensure that rehabilitation programmes can be continued at home, or that social care are addressed.

1.3 Where there are concerns about a possible child protection issue, it is particularly important that there is a multi-agency action agreed before the child leaves hospital. The Victoria Climbié Inquiry highlights the needs for this and recommends that:

- No child (or young person) known to social services who is an in-patient in a hospital and about whom there are child protection concerns is allowed home until it has been established by social services that the home environment is safe, the concerns of the medical staff have been fully addressed, and there is a social worker plan for the ongoing promotion and safeguarding of that child's welfare
- No child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. The plan must include follow-up arrangements.

The need to safeguard a child should always inform the timing of their discharge, so that the likelihood of ongoing harm can be assessed while he or she is still in hospital.

Discharge of disabled children and those with long-term problems is important. After reassessment of need, the multi-agency plan and personal health record will need to be updated and information prepared... ”

Discharge from hospital is a process and not an isolated event which needs to be planned and co-ordinated at the earliest opportunity with effective communication between agencies.

The increased pressure on in-patient beds has led to a trend towards shorter admissions and greater concentration of discharge planning within tighter timescales. Premature discharge may leave the family being poorly prepared for home and with unmet needs that could lead to an increase in readmission.

1.4 This discharge policy states the responsibilities of the multidisciplinary team when discharging children/young people from hospital. It conforms to guidelines for discharge from hospital laid down in the following documents.

- DH: Working Together to Safeguard Children 1999
- DH: Framework for Assessment of Children in Need and Their Families (2001)
- Children Act (2004)
- Child Protection Medical Workbook
- Lord Laming's Report into the Death of Victoria Climbié
- Trust Child Protection Procedures
- Local Safeguarding Children's Board Child Protection Procedures
- Trust's Discharge Policy No. 6
- DH: Discharge from Hospital, Pathway, Process and Practice (2003)
- National Service Framework for Children, Young People and Maternity Services: Standards for Hospital Services (2004).

2 Key Principles

- 2.1 All children/young people and their carers are entitled to expect that due consideration will be given to appropriate and timely discharge arrangements. Carers, children and young people should be fully involved in the planning of these arrangements.
- 2.2 Any information collected from the children/young people and carer should follow a standardised format, which is agreed by the multidisciplinary team. Discharge planning should commence at the time of admission.
- 2.3 The multi-agency team is responsible for the co-ordination of assessment and discharge plan for all children/young people with continuing health and/or social care needs. Such children/young people who require continuing support from other health or social care agency should not be discharged in the evening, at weekends or a bank holiday without prior consultation with these agencies where possible. Children/young people may be discharged at the discretion of the Consultant Paediatrician, provided agreement has been reached that the family are able to provide adequate support. This must be documented in the nursing notes and in the medical records.

3 Roles and Responsibilities

Consultant Medical Staff

- 3.1 The consultant staff and those to whom they delegate duties should discuss with the parents and children/young people, the reason for their admission to hospital, the treatment involved and likely outcome, including discharge and expected length of stay.
- 3.2 Will be responsible, in consultation with other members of the multidisciplinary team, for deciding which professionals and agencies need to be involved in the assessment of the discharge plan for the patient.
- 3.3 Have a responsibility to seek and record the views of children/young people and their carers where relevant.
- 3.4 A short discharge summary will be available for the children/young people's General Practitioner (GP), Health Visitor (HV) or School Health Advisor (SHA) within 24 hours of discharge.
At the Consultant's discretion or GP's request, a typed report will be sent to Primary Care Team (PCT).
- 3.5 When a child is discharged to another hospital a copy of any relevant records, plus copies of any Child Protection / Safeguarding plans must be sent with the child. A copy of the transfer letter must be kept in the hospital notes.
- 3.6 Must inform the GP at the earliest opportunity of any children/young person whose carer takes his or her discharge against medical advice. The Consultant along with other relevant team members will be notified if a parent takes a child/young person's discharge and will advise as to whether the child/young person would be classed as 'at risk of significant harm'. Social Services and the
- 3.7 Police can be contacted to enable the child/young person to be returned to hospital. A legal order may be obtained by Social Services or the Police may place the child in Police Protection (S46.C.A.)
- 3.8 Must ensure, where possible, that discharge prescriptions are completed in advance, to allow adequate time for the dispensing of medicines and the provision of information to the child/young person and carer.
- 3.9 A two week supply of consumable equipment to be given on discharge including a 7 day supply of dressings to be prescribed where wound management is ongoing. Identify any specialist medical equipment that is required and inform Community Nurse, Midwife or Health Visitor to allow for equipment to be in place at time of discharge.

4. Hospital Nursing

- 4.1 Should collect and clearly document accurate information relating to the child/young person's individual social circumstances, GP as soon as possible following admission. This information will form the basis of their discharge planning arrangements.

- 4.2 Have a responsibility, in consultation with medical staff for co-ordinating which multidisciplinary team members and agencies need to be involved in the assessment and discharge plan for the children/young people. If the child has complex nursing needs, the Children's Community Nurses should be notified on admission or as soon as possible following admission especially if the child has undergone a significant change to needs. Have a responsibility for ensuring that the relevant staff are invited to attend any multidisciplinary meetings giving as much notice as possible. Should ensure that the children/young people's carers are involved in assessment and discharge plans. Their views should be sought, recorded and communicated with other members of the multidisciplinary team.
- 4.3 Will ensure that, if necessary, the community nursing services have full written details of nursing requirements, equipment and disposable supplies required. This may be part of the agreed discharge plan or a copy of the discharge checklist.
- 4.4 Will co-ordinate transport arrangements at the earliest opportunity to ensure that the timing, takes account of the care arrangements made for the day of discharge.
- 4.5 Should ensure that children/young people and carers are given relevant information, verbally and in writing, regarding medication, follow up services, health education and where to get help if needed. A two week supply or dispensing pack of relevant medications and specialist equipment should be given to the patient on discharge along with a copy of their completed Newcastle upon Tyne Hospital's Foundation Trust discharge record. A 7 day supply of dressings should be given where wound management is ongoing.
- 4.6 Will ensure that when children/young people attend the Accident and Emergency (A & E) Department that a copy of the A & E documentation is sent to the Health Visitor or School Health Advisor and the child/young person's GP. The carer should be given advice about what to do should their child/young person's condition deteriorate.
- 4.7 Will ensure that children/young people transferred to other provider units should be treated as discharges, and that necessary documentation is completed, transport is arranged and property are transferred with the child/young person. Copies of relevant medical and nursing notes, plus a comprehensive account of any special arrangements e.g. Child Protection / Safeguarding plans, plus a copy of the transfer letter must accompany the child/young person to ensure the child/ young person's continuing safety
- 4.8 Nurse Led Discharge. On wards where Nurse Led Discharge is in practice, staff must follow locally agreed protocols and guidelines. It is the responsibility of staff on these wards to review/revise these systems.

5. Social Workers

- 5.1 The Assessment may involve a hospital social worker, a locality social worker or member of the community multidisciplinary team. The Assessment will take place in the most appropriate setting.

Hospital Social Workers:-

- Will provide a central access point for patients and their carers offering information and advice relating to their specific social care needs.

- Will be available to accept or consider referrals from all units via the designated social workers, or in their absence, the duty social worker.
- Will, where appropriate, be responsible for ensuring that assessment of social care needs of children/young people and/or carer takes place to inform and insure a safe discharge.

5.2 Where social care needs have been identified following assessment, the social workers alongside any relevant members of the multidisciplinary team, child/young person and/or carer will formulate a care plan to ensure a safe and appropriate discharge.

5.3 Refer and liaise with receiving local authorities for patients from outside of Newcastle who require a social care plan, if applicable.

Will be involved in the formulation and review of discharge arrangements within the Trust.

6. Paramedical and Rehabilitation Service

6.1 Occupational Therapists, Physiotherapists, Speech and Language Therapists and Dieticians as part of the multidisciplinary team, will undertake assessments, draw up treatment plans and be involved in the discharge plans. All members of the multidisciplinary team must be invited to discharge planning meeting.

6.2 Occupational Therapy is able to offer functional assessment of the patient's activities of daily living, (for self-care, play, leisure and school) and their home environment to identify areas of dysfunction and potential risk to allow a safe discharge home. An environmental risk assessment may be undertaken to include family/carers and community services to identify and problem solve any potential difficulties for returning home.

Where appropriate this may lead to a pre-discharge home assessment. As part of the assessment process, pre-discharge home assessment will take place where appropriate. Occupational Therapy will be responsible for arranging the visit in consultation with the multidisciplinary team within the hospital and Community setting, Primary health care staff, community therapists, school or nursery staff and Children's Community Nursing Service may be involved as appropriate. Written reports to hospital and community staff involved in the plan, with recommendations, will be completed as soon as possible (Reference: 5.7 Trust's Discharge Policy).

6.3 Speech and language Therapy offers ongoing assessment and management of communication and feeding difficulties within the hospital multidisciplinary team setting. Ongoing feeding difficulties will be discussed with the community Speech and Language Therapy Feeding specialist pre-discharge, and written multidisciplinary feeding plans and recommendations for the management of nutrition at the time of discharge will be provided to the local Primary health care staff, community therapists, school or nursery staff and Children's Community Nursing Service, as appropriate.

6.4 The continuing need for the use of Augmentative or Alternative Communication systems, (AAC), low and high technology, will be identified pre-discharge and arrangements for the continuing loan of hospital communication equipment for an

agreed period, or for the transfer of the loan of any equipment borrowed from Communicate will be negotiated and agreed with the community Speech and Language Therapy services and other relevant community therapists. Written advice and recommendations about any other aspects of the child's communication will be provided at the time of discharge.

- 6.5 School age children will be seen by the Hospital Teaching Service and liaison with their local school / Education Department will take place. Return to school / provision of home tuition will be determined with patient, parent / carer, MDT.
- 6.6 The Therapists will ensure that all recommendations essential to safe discharge are carried out and will notify relevant staff when this has happened. Where there are other needs that are the responsibility of the Community Therapy teams, the recommendations will be passed on. Detailed referral, community liaison, joint working and shared handover will take place as early as possible.

7. Children and Young People in Special Circumstances

- 7.1 **Children who have remained in hospital for 3 months** or longer will be subject to Section 85, Children Act 2004. The Trust has a responsibility to notify Social Services in these circumstances and when the child is discharged.
- 7.2 **Children who are at risk**, or have suffered, significant harm require comprehensive plans for discharge. These plans will be agreed at a multi-agency meeting, e.g. Strategy Meeting or Child Protection Case Conference as defined in DH "Working Together to Safeguard Children". If such children/young people are **not** registered with a GP, then Social Services **must** be contacted. The Named Nurse for Safeguarding Children should be informed of any child at risk in hospital and especially in relation to discharge through the Cause for Concern process.
- 7.3 **Children who have palliative care needs** must have an identified key-worker to co-ordinate an appropriate support network within the home setting. They require a written plan of treatment and intervention and details of which have been agreed with the family and shared with the community.
- 7.4 **Children with specialist or complex health needs** who require frequent admissions to hospitals (see Appendix 2). When such children are discharged it will be the responsibility of the Specialist Multidisciplinary Teams to ensure that children/young people and their carers have the necessary knowledge and skills to ensure the safe and competent management of their condition. Follow-up appointments and home visits will be arranged as appropriate, depending on the child/young person's needs.
- 7.5 **Children and Young People in Local Authority Care:** the Social Worker for the child/young person must be notified of the discharge, preferably before it actually happens. The Designated Nurse for Looked After Children and Young People to be included in the discharge letter circulation.

8. Monitoring and Review

- 8.1 This policy will be reviewed every 2 years by the Matron, Children's Services. Comments, queries and suggested amendments should be addressed to the Directorate Manager and Matron, Children's Services.

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Hospital Discharge Policy for Children and Young People	Policy Author:	Helga Charters
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If "yes", please answer sections 4(b) to 4(d)).</i>	No	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

Comments: No change to Policy	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Helga Charters Date: 04/02/2011
 Names & Designations of those involved in the impact assessment screening process:

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.