Family Nursing & Home Care

Standard Operating Procedures

Children's Community Nursing Team (CCNT) Admission to Discharge Pathway

1 September 2021

Document Profile

Type	Standard Operating Procedures
Title	Children's Community Nursing Team (CCNT) Admission to Discharge Pathway
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Category	Clinical Paediatric
Version	1
Approval Route	Organisational Governance Approval Group
Approved by	Organisational Governance Approval Group
Date approved	1 September 2021
Review date	3 years from approval
Document Status	This is a controlled document. Whilst it may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, it should not be saved onto local or network drives but should always be accessed from the intranet.

Version Control / Changes Made

Date	Version	Summary of changes made
August 2021	1	New document

Contents

Introduction

These Standard Operating Procedures (SOPs) have been developed to guide the practice of staff working in the Community Children's Nursing Team (CCNT). The SOPs provide a framework for the provision of safe and effective care.

These SOPs do not replace professional judgement which should be used at all times. Where registrants work outside the SOP informed by their professional judgement they should always record the rationale and evidence base for this decision. A clear rationale should be presented/recorded in support of all decision making. Practice should be based on the best available evidence.

Where care is delegated to a non-registrant, the Registered Nurse remains accountable for the appropriateness of the delegation and for ensuring that care has been given. They are also responsible for the overall management of the patient that includes a regular review of their care.

Where potential safeguarding issues are identified, FNHC will adhere to the Jersey Safeguarding Partnership Board's adult and child's safeguarding procedures, seeking safeguarding supervision as per organisational policy.

Staff will be alert to the identification of patients who may require palliative care support and will follow the correct referral onto this pathway. Referrals onto this pathway can only be made by a paediatrician.

SOP 1 Referral to Children's Community Nursing Team

Purpose

To promote a robust referral process to CCNT (including children with a clinical need attending Mont a L'Abbe school (MAL)) which will ensure access is available to all patient information in order for safe and effective decisions about patient care to be made

Scope

This SOP applies to all children aged 0-17 years (inclusive) who are resident or visiting Jersey, who are entitled to be seen by CCNT if referred by a local paediatrician and following agreement from the Operational Lead

Core Requirements

- Referrals to CCNT can be received from Jersey General Hospital (predominantly Robin Ward), Health Visitors and School Nurses. GPs may also refer where continuity of care can be established and care requested is within the capacity of the CCNT
- Referrals can be sent as e-mail to Childrenscommunitynurses@fnhc.org.je or as hand written referrals which are scanned onto EMIS by the Team administrator to allow any previous notes to be obtained and any current care to be recorded
- The administrator will ensure all details are correct when registering the patient
- Children requiring only one post-operative phone call do not require completion of primary assessment or physiological observations
- The Registrant under the guidance of the Team Lead and Palliative Care Sister will ensure the child is admitted onto the appropriate care pathway (see Box 1)
- Any notes held from before October 2016 can be obtained from archiving
- The nursing front sheet is completed and filed in alphabetical order in the CCNT file and an electronic copy added to EMIS
- Where required, addressograph labels are printed off
- The primary reason for referral must be clearly indicated on the referral form – if not present the Grade 5 or 6 will redirect to the referrer to request clarity
- All Registrants are responsible for ensuring that EMIS notes reflect care required
- Children admitted onto the CCNT caseload or who are readmitted to hospital whilst on the caseload are recorded on EMIS as a Significant Event. Re-assessment and alterations to care plans are made and recorded on EMIS following discharge from hospital

- Where a referral requires the administration of medication a hospital prescription chart signed by a paediatrician must be sent with the referral and scanned onto EMIS, as per FNHC Medicines Policy
- Patients should be categorised by the Grade 5 or 6 and the following response times applied:

Box 1

Referral Category	Time frame	Examples
Core	Contact will be made with the family within 24 hours of receiving the referral or discharge from hospital (local or UK). The exception to this is when a child has had a tonsillectomy or circumcision in which case a phone call should be made on the 4th day post-operative.	Renewal of dressings. Postoperative assessment of pain/mobility. Training for enteral feeds. NG tube insertion. Intravenous antibiotics. Finger-prick bloods. Palliative care children returning to Jersey following treatment or discharge to home for pain control/terminal care.
Palliative Care	5 working days from date of diagnosis to the significant news meeting. Following this contact should be made from the key workers within 24 hours	All children on Children's Palliative Care Pathway (CPCP) who have a life limiting or life threatening condition.
Packages	If a child requires a high cost package of care contact will be made whilst the child is in hospital to ensure smooth transition into the community.	A child with a high level of medical need, for example child with tracheostomy.

SOP 2 Assessment following referral to CCNT caseload

Purpose

To complete a primary assessment of the patient's needs to inform appropriate care planning, delivery and risk management

Scope

All patients referred to the CCNT as outlined in SOP1

Core Requirements

- It is expected that a registrant will undertake the initial assessment on all patients. The grade 5 or 6 should review the assessment and care plans outlined by their team member within 48 hours (equitable to Scope for children on Children's Palliative Care Pathway). Discharge planning should commence at the point of admission.
- Children requiring only one post-operative phone call do not require completion of primary assessment or physiological observations
- For children requiring only one visit or simple wound care such as removal of sutures – a 'short term assessment' needs to be completed in place of the 'primary assessment' form
- Admissions undertaken by a Grade 4 must be discussed with Grade 5 or 6 Nurses before the end of their shift. If the Grade 4 has any concerns it is their responsibility to raise these with the Grade 5 or 6 before going off duty
- A Paediatric Care Worker (PCW) will not undertake initial/review assessments
- The admitting registrant should review any existing records on EMIS for information regarding previous admissions/safeguarding concerns. This is to inform clinical decision making and promote staff safety
- The information listed below is the minimum requirement on first visit which is recorded as a 'Significant Event':
    - Primary Assessment/Short Term Assessment
    - Completion of Staff Safety Checklist
    - Appropriate Risk Assessments
    - Care plans agreed by child/parent/guardian*
    - Voice of the Child
- All care plans are to be personalised to reflect the individual patients needs and consent and agreement sought from the child/parent/guardian for the planned care
- If any of above has not been completed within the first visit – the reason needs to be recorded on EMIS and Team Lead made aware and a plan put in place for the completion

- When saving care plans as documents on EMIS they should be clearly labelled with type of care plan and date. Once a care plan is no longer required, this needs to be clearly stated and recorded on EMIS as discontinued
- Ensure all relevant equipment, consumables and dressings are available for the first planned home visit
- Send liaison letter to GP and any other relevant professionals involved in the patient's care having first obtained verbal consent from parent/guardian
- Give and explain the CCNT information leaflet or CPCP leaflet as appropriate. Other information leaflets to be sourced and provided as relevant
- Grade 5 or 6 to visit MAL School termly and discuss assessments from Induction to CCNT or transition to secondary school site

** There are 2 care plans for core patients on CCNT caseload. These are:*

1. *CCNT – Nursing Interventions care plan. This care plan should be used if the nurse is completing a procedure on the child including blood test, re-passing naso -gastric tubes or any intervention that cannot be delegated to a parent or carer. The document will pre-populate with the child's name etc throughout the care plan and there are prompts on information to be added.*

2. *CCNT – Delivery of care by parents or carers care plan. This care plan should be used if the nurse is delegating care to the parent or carer including ensuring securing tapes on naso-gastric tubes, delivery of growth hormone or similar injectable medications or changing gastrostomy buttons. The document will pre-populate with the child's name etc throughout the care plan and there are prompts on information to be added*

SOP 3 Caseload Management (Core, MAL School and Packages)

Purpose

To enable the registrant to safely meet the needs of all children on the CCNT caseload

Scope

This SOP pertains to patients who are admitted onto the core, palliative care, MAL or package of care caseloads

Core Requirements

Each patient will have a general information sheet completed on admission to the caseload by the admitting nurse. Information recorded will include:

- Past medical history:
  - Document all relevant medical history directly under the patient label

- Next of Kin:
  - Include name, relationship to patient and telephone number(s) – landline and mobile if available. These must be updated as they change

- Diagnosis section to include**:**
  - Admission date to caseload (to inform review period)
  - Reason for admission. This needs to be specific.
  - If the patient has been admitted to the caseload for wound management, information must include type of wound (eg pressure/trauma/postsurgical) and site of the wound (e.g. medial aspect of left lower leg)
  - If the wound is due to pressure trauma the category must be documented and an ASSURE incident report to be completed. For pressure trauma ranked category 2 and above specialist guidance should be sought from the FNHC Tissue Viability Nurse, as per the FNHC Pressure Ulcer Prevention and Management Policy (currently under review).

- Directions and access arrangements:
  - If the address is difficult to locate, provide details of directions and/or landmarks. These should be documented on both EMIS and on the patient's front sheet.
  - Document any Key Codes or specific access requirements as needed

- Risks and hazards:
  - Include any allergies (if none known this must be documented rather than space left blank)
  - Any infection risks/hazards e.g. MRSA, C. diff, Hep B/C. These must be clearly documented on both the patients' front sheet and on EMIS
  - Any lone worker risks

- Planning visits/meetings:
  - As visits are arranged with families, these need to be recorded on the weekly schedule sheet. Meetings need to be written in CCNT information sharing diary and where possible an invite sent electronically
  - The daily activity sheet will be prepared prior to completion of shift the previous day so visits can be fairly allocated and patients are seen by the staff with the appropriate and necessary skills

- During the Visit:
  - The CCNT Nurse must wear and display identity badge.
  - The CCNT Nurse admitting the patient should complete:
    - Staff Safety checklist
    - Significant Event due to admission to caseload
    - Primary Assessment/ short term assessment
    - Appropriate Risk Assessments
    - Care plans agreed by child/parent/guardian
    - Capture Voice of the Child

  - If more than one team member is required for home visit – this needs to be highlighted and recorded on EMIS clearly stating the rationale for this decision eg. Safeguarding, Clinical need, Environmental
  - The registrant will signpost to any other relevant professional involved in the child's care eg Social Worker. Complete referral forms for other specialities such as SALT, Dietician and Paediatric Care Worker (PCW). Referral forms available on EMIS.
  - The registrant will complete the weekly activity sheet stating when a visit or phone call is next due
  - All notes are to be completed on EMIS including any general information within 24 hours. Any important information must be shared with the team

SOP 4 No Access / Services Refused

Purpose

To guide staff in their assessment of risk associated with patients not accessing services (Was Not Bought) to allow them to receive the care they need to ensure their safety

Scope

All children referred to and admitted to CCNT caseload

Core Requirements

- No access is defined as when a staff member is unable to gain access to provide care/services as arranged and the staff member is unable to establish contact with the patient as a result of:
    - No response
    - Access refused by patient/family/guardian

- Staff members have a duty of care to patients/families, however patients also have a responsibility wherever possible to inform staff if they will be unavailable to receive care in the home or in a venue mutually agreed

- Families should be given the contact details for CCNT to contact should they wish to cancel a planned home visit

- If a staff member is unable to gain access to the home for a planned visit – contact should be attempted by telephone. If contact is unsuccessful the staff member should discuss with Team Lead/Operational Lead

- If it is known that a child will often not be at home for planned visits then a risk assessment should be completed, detailing the actions staff should take should they arrive to deliver care and the child is not there

- Families have the right to decline the services offered by the CCNT, however if the staff member considers the visit to be non-urgent or there is cause for concern they must seek the support of their Team Lead/Manager On Call or Safeguarding Lead

- If care is considered urgent and entry refused – then escalation is essential. If condition is deemed an emergency and imminent help is needed an ambulance is to be called and paediatrician/hospital consultant informed ASAP.

- It is important to inform the GP and the referrer (if appropriate) that the family has declined the service and record any discussions, plans and actions in the patient EMIS records

SOP 5 Discharge from CCNT caseload

Purpose

To promote safe and effective discharge of children from the CCNT caseload

Scope

This SOP pertains to children on the CCNT caseload assessed by a paediatrician or CCNT to be ready for discharge and encompasses checking all goals have been met, liaison with other agencies completed and correct completion of care records.

Core Requirements

- The nurse should review all care plans to ensure goals have been met and appropriately evaluated. Once all nursing needs have been achieved and established that the child does not require ongoing care – they can be discharged from the CCNT caseload
- If ongoing care is required the nurse should ensure that this is documented and the family signposted to the appropriate services
- Every care plan must have a clear evaluation indicating its outcome
- Team members must discuss all planned discharges with the Grade 5 or 6 prior to the patient being discharged from the caseload
- Inform other professionals of patient discharge and copy in all relevant services involved in the patient's care (ensuring family is aware)