

**Standard Operating Procedures**

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

May 2025

**Document Profile**

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**Version Control**

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| **Date** | **Version** | **Summary of changes made** |
| August 2021 | 1 | New Document |
| May 2025 | 2 | Scope – change age to 0 – 18  When referring to local Paediatrician throughout document adding in Emergency Department (ED) Consultant  Change of word – patient to child.  SOP1 – add in reference to triage.  Change primary assessment to CCNT Nursing Assessment  Add in references to EMIS Templates where required  SOP 2 – Add in reference to regular team discussions of individual cases  SOP 2 – Removal of reference to leaflet  SOP 4 – Amendment to wording and adding of completing of Incident Record  SOP 5 – Amendment to wording  Contents Page amended  Added to new SOP Template |
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# 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 always be used. 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, Family Nursing Home Care 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 Community Children’s Nursing Team

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| ***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 for safe and effective decisions about patient care to be made

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| ***Scope*** |

This SOP applies to all children aged 0-18 years who are resident or visiting Jersey, who are entitled to be seen by CCNT if referred by a local paediatrician or Emergency Department (ED) Consultant and following agreement from the Operational Lead

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| ***Core Requirements/Procedure*** |

**Source of referrals to CCNT**

Referrals to CCNT can be received from Jersey General Hospital (predominantly Robin Ward or Emergency Department), 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 [communitychildrensnurses@fnhc.org.je](mailto:communitychildrensnurses@fnhc.org.je) or as handwritten 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

**Administrator Role**

The Administrator will ensure all details are correct when registering the patient.

**Triage**

The Nurse in Charge will triage any incoming referrals and delegate to appropriate person. 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)

Children requiring only one post-operative phone call do not require completion of primary assessment or physiological observations

The nursing front sheet is completed and filed in alphabetical order in the CCNT file and an electronic copy added to EMIS. 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

Any notes held from before October 2016 can be obtained from archiving. These are requested by the Nurse in Charge.

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**

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| **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/IV 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

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| ***Purpose*** |

To complete a CCNT Nursing assessment (EMIS Template) of the patient’s needs to inform appropriate care planning, delivery and risk management

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| ***Scope*** |

All patients referred to the CCNT as outlined in SOP1

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| ***Core Requirements/Procedure*** |

It is expected that a registrant will undertake the initial assessment on all patients.

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 the first visit which is recorded as a ‘Significant Event’:

* CCNT Nursinng Assessment/Short-term Assessment (EMIS Template)
* Completion of Staff Safety Checklist
* Appropriate Risk Assessments
* Care plans agreed by child/parent/guardian\*
* Capture Voice of the Child

\*There are two care plans for children on the CCNT caseload. These are:

* CCNT Nursing interventions care plan – This care plan should be used if the nurse is completing a clinical procedure on the child such as performing a blood test, passing a nasogastric tube, or any intervention which cannot be delegated to a parent or carer. The document will prepopulate with the child's details and provide prompts for further information required.
* CCNT Delivery of care by parents or carers care plan – This care plan should be completed if the nurse is delegating care to the parent or carer such as securing naso-gastric tubes, administration of injectable medications or changing gastrostomy buttons. The document will prepopulate with the child’s details and provide prompts for further information required.

All registrants are responsible for ensuring EMIS records and care plans reflect the care required

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 ‘CCNT Nursing Assessment’.

Prior to the first visit the nurse will ensure all relevant equipment, consumables and dressings are available for the first planned home visit

A letter is sent to the GP and any other relevant professionals involved in the child’s care having first obtained verbal consent from parent/guardian

If children on the caseload are hospitalised, on discharge from hospital this is recorded as a ‘Significant Event’. The child will require reassessment and review of existing care plans. This is recorded on EMIS.

Individual, complex cases are discussed in the Team Huddle which are held a minimum of every 4 weeks.

The Grade 5 or 6 will visit MAL School termly and discuss annual assessments, including admission to CCNT caseload, transition to secondary school site and transition to adult services.

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

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| ***Purpose*** |

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

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| ***Scope*** |

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

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| ***Core Requirements/Procedure*** |

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**:
  + name
  + relationship to child
  + 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 Incident Report 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[.](https://www.fnhc.org.je/media/43128/pressure-ulcer-prevention-management-policy-2015.pdf)

**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 child’s front sheet and on EMIS

Document 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
* CCNT Nursing 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 e.g. Safeguarding, Clinical need, Environmental

The registrant will signpost to any other relevant professional involved in the child’s care e.g. 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/Service Declined

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| ***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 health, safety and wellbeing

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| ***Scope*** |

All children referred to and admitted to CCNT caseload

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| ***Core Requirements/Procedure*** |

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 child/family/guardian

Staff members have a duty of care to children/families; however families and carers also have a responsibility wherever possible to inform staff if they will be unavailable to facilitate care delivery in the home or in a venue mutually agreed. When care delivery is declined an Incident Report needs to be completed

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. An Incident Report needs to be completed.

Children and families have the right to decline the services offered by the CCNT, however if the staff member considers there is a cause for concern, they must seek the support of their Team Lead/Manager On-Call or Safeguarding Lead

If it is known that a child will often not be present for planned visits then a risk assessment should be completed which will include the actions staff should take should they arrive to deliver care and the child is not there. An Incident Report needs to be completed.

The CCNT require awareness and understanding of Gillick/Fraser competence when negotiating, planning and delivering care. If care suggested is declined, an Incident Report will need to be completed.

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

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

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| ***Purpose*** |

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

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| ***Scope*** |

This SOP pertains to children on the core, palliative care, MAL or package of care caseload assessed by a paediatrician or CCNT to be ready for discharge and encompasses evaluation of care plans to ensure that needs are met. Liaison with other agencies completed and correct completion of care records (EMIS)

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| ***Core Requirements/Procedure*** |

The nurse should review all care plans to ensure evaluation of care plan and needs have been met. 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 child’s discharge and copy in all relevant services involved in the child’s care (ensuring family is aware). This will be all members of the ‘team around the child’.