Plymouth Hospitals NHS
NHS Trust

# Discharge Policy for Children and Young People

| Date | Version |
|---|---|
| January 2018 | 2 |

## Purpose

The purpose of this policy is to facilitate the safe and effective discharge of babies, children and young people from Paediatric wards over the 24 hour period. The discharge needs of every patient will be comprehensively assessed and planned to ensure continuity of care from hospital to community. The policy is based on the key principles of planning, patient and carer partnership and multi-agency working to ensure that the child's welfare is paramount throughout the process.

## Who should read this document?

All staff groups who are responsible for the discharge of children.

## Key messages

All children will be discharged following completion of the discharge checklist.
No children will be discharged where there are safeguarding concerns unless they have been assessed by the safeguarding team.
Effective communication with the child, family and other agencies involved with the child is essential to the achievement of a smooth transition from hospital to home or another location

## Accountabilities

| | |
|---|---|
| **Production** | Author: Louise Cork Ward Manager<br>Contributors: Alison O'Neill Named Nurse for Safeguarding Children and Young People and Dr Carolyn Adcock Named Consultant for Child Protection |
| **Review and approval** | Paediatric Clinical Governance Group |
| **Ratification** | Greg Dix, Director Of Nursing |
| **Dissemination** | Louise Cork Ward Manager |
| **Compliance** | Director of Nursing |

## Links to other policies and procedures

PHNT Child Protection Policy

PHNT Information Sharing Policy

## Version History

| | | |
|---|---|---|
| **1** | August 2012 | Clinical Governance Meeting |
| **2** | January 2018 | Clinical Governance Meeting |

| Last Approval | Due for Review |
|---|---|
| January 2018 | January 2023 |

*The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better*

*meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.*

**An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.**

## 1 Introduction

The National Service Framework for Children, Young People and Maternity Services (2004) recognises that hospital admission of children should be avoided where possible and if admission becomes necessary discharge should be expedited to minimise the psychological impact on the child. Planning for prompt discharge and the prevention of unnecessary re-admissions should be the norm.

The Laming Inquiry (2003) highlighted the importance of discharge decisions and the vital role of thorough multi-agency discharge planning along with the potential disastrous consequences of inappropriate discharge for the child. This discharge policy is explicitly linked to the Trust Safeguarding Children Policy and must be read in conjunction with this policy.

## 2 Purpose, including legal or regulatory background

The purpose of this policy is to facilitate the safe and effective discharge of babies, children and young people from Paediatric wards and Plym Theatres over the 24 hour period. The discharge needs of every patient will be comprehensively assessed and planned to ensure continuity of care from hospital to community. The policy is based on the key principles of planning, patient and carer partnership and multi-agency working to ensure that the child's welfare is paramount throughout the process.

## 3 Definitions

- **Discharge**: discharge from Inpatient hospital-based services.
- **Safeguarding**: the process of protecting children from abuse, preventing impairment of their health and development, and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care, enabling optimum life chances.
- **Child**: A baby, child or young person aged from 7 days to 18 years.

## 4 Duties

### 4.1 Trust Board

- Ensure compliance with *CQC Essential Standards of quality and safety*;
- Ensure compliance with the NSF for Children, Young People and Maternity Services Standard 5;
- Ensure systems are in place in the organisation to meet the requirements of; The Protection of Children in England: A Progress Report (2009), the Children Acts (1989 and 2004) and Working Together to Safeguard Children (2010).

### 4.2 Chief Executive

- Introduce and monitor systems to ensure that no child about whom there are child protection concerns is discharged from hospital without the permission of either the consultant in charge of the child's care or of a paediatrician above the grade of senior house officer;

- Introduce and monitor systems to ensure that 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.

### 4.3 Managers

- Disseminate this discharge policy to all staff responsible for caring for children;
- Establish systems to implement and monitor the policy;
- Identify and address issues affecting safe, effective and efficient discharge;
- Facilitate staff training.

### 4.4 All Health Professionals

All health professionals must:

- Be familiar with Trust and national policy and guidelines;
- Work in partnership with children and families;
- Work in partnership with other agencies to plan for the ongoing care of children being discharged from hospital;
- Share information appropriately; Information Sharing HM Government (2009)
- Arrange, chair and participate in CAF and CAF review meetings on discharge as required;
- Maintain clear, concise documentation of concerns, discussions (including telephone conversations), action plans, risk assessments and decision – making processes in the child's health record including dates, times and events;
- Initiate Early Help Referral when a child / family require support with additional needs.

### 4.5 Consultants

- Provide expert leadership to discharge planning processes and decisions;
- Inform the patient/family of the anticipated discharge date as soon after admission as possible;
- Seek supervision and consultation from a consultant colleague when uncertain regarding the appropriateness of discharge;
- Where there are safeguarding concerns agree and record a discharge plan and liaise with Children’s Services to ensure completion of agreed actions;
- Ensure that no child about whom there are concerns about deliberate harm is discharged from hospital back into the community without an identified GP and a full assessment of home circumstances with the involvement of children’s services/CAMHS as required.
- The consultant or his/her delegated representative must record that the patient is medically fit for discharge in the health record;
- Ensure completion of the electronic discharge letter prior to the child leaving the clinical area.
- Allocate a named doctor to each patient who will be responsible for following up and acting upon investigation results, and completing the child’s episode of care.

- Ensure the child has a Named Consultant for ongoing care if indicated and that the consultant, all ongoing carers and the parents are aware of that allocation

### 4.6 Medical Staff

- Ensure that a satisfactory working diagnosis has been reached;
- Undertake clinical assessment for fitness for discharge;
- Ensure that discharge is safe considering the anticipated course of the illness, taken along with the knowledge of the family.
- Where appropriate, give information on signs or symptoms indicating the need for readmission.
- Ensure that there is agreement from nursing colleagues and that the parents / carers are happy for discharge; in cases of doubt, a senior opinion, ideally from a consultant, should be obtained.
- Ensure that adequate information has been given to the family in both verbal and written form.
- Ensure that significant results have been explained to the child/parent/carer and that a way of communicating any outstanding results has been agreed;
- Complete the electronic discharge letter prior to the child leaving the Children's Assessment Unit or by midday for planned ward discharges.
- If discharge medication is required complete the appropriate discharge medication prescription as soon in advance of the discharge date/time as possible. Ensure that any necessary instructions are provided to the child/parent/carer, with arrangements to collect further from the GP where needed. FP10 only to be used if out of hours. Lloyds pharmacy prescriptions should be used for all outpatient prescriptions.
- Ensure that appropriate support (e.g. Children's Community Nursing Team (CCNT), Health Visitor, GP, Midwife, Children Services including Social Worker) has been arranged and fully informed on discharge;
- Make the necessary referrals to appropriate members of the multi-disciplinary team;
- Ensure that outpatient investigations have been arranged;
- Ensure that follow up arrangements have been agreed and arranged;
- Follow up and act upon investigation results to complete the episode of care after the child's discharge.

### 4.7 Nursing Staff

- Assess the patient's fitness for discharge;
- Complete a full set of observations immediately prior to discharge
- Liaise with the child and family, medical staff and other multi-disciplinary and multi-agency colleagues to agree a discharge plan;
- Assess and respond to parent/carer concerns prior to discharge;
- SALUS- update attribute and send TTA to pharmacy
- Obtain discharge medication 24 hours prior to discharge where possible; where this is not possible dispensing of drugs outside pharmacy hours must be undertaken following the appropriate protocol;
- Nursing staff assessed in dispensing TTA's may dispense medications as per protocol.

- Discuss with parents/carers what transport is to be used and assess suitability for the patient;
- Arrange follow-up appointment where necessary;
- Ensure any further investigations have been requested and the patient/carers are aware;
- Ensure that the discharge checklist has been completed before discharge and filed in the patients notes;
- Provide suitable patient information literature and discuss the contents with the child and parents/carers;
- Provide advice on the ongoing management of the child's condition and provide a point of contact should the parents/carers have any concerns;
- Check the understanding of the child/parent/carer with regards to ongoing care;
- 72 hours open access
- Ensure a copy of the electronic discharge documentation or discharge information is provided to the child/ parent/carer before discharge
- If the patient is to be transferred to another hospital; complete a safeguarding children referral form to ensure safeguarding team are aware of transfer (even if there are no safeguarding concerns)
- Provide information to the child and family about any discharge medication and check understanding;
- Provide any specific training required by the child/parent/carer to continue care at home; assessing competence prior to discharge;
- Ensure a copy of the electronic discharge documentation or discharge information is available for the Safeguarding Children Team to ensure sharing of information with the 0-19 service.

## 5 Key elements (determined from guidance, templates, exemplars etc)

Although discharge from hospital must be part of a planned, co-ordinated pathway involving clinical risk assessment, some children will be discharged out of hours. This policy should be read and implemented in conjunction with the Trust Child Protection Policy, All discharges of children from hospital must be part of a planned, co-ordinated pathway involving clinical risk assessment. The principles set out in this policy for Assessment, Communication, Follow up and On-going care must be adhered to irrespective of the time of discharge. Some children are discharged out of hours due to the nature of their attendance in the Children's Assessment Unit.

### 5.1 Discharge assessment

Prior to discharge all children must be assessed as clinically fit by a senior doctor or advanced paediatric nurse practitioner, safeguarding concerns must have been addressed in full and the parents/carers must have received any training/information to enable them to provide ongoing care. Parents/carers must always be involved in discharge decisions and have their questions, concerns and anxieties addressed before discharge.

All children on the paediatric wards must be reviewed by a consultant or middle grade doctor at least once daily. It is the responsibility of the consultant on call for all admissions that week to ensure that ward rounds take place daily on the Children's Assessment Unit, Children's High Dependency Unit and the Paediatric Wards.

Children unfit for discharge on the morning ward round may be placed on review. It is the responsibility of the service middle grade doctor to review these children before 6.30pm and discharge if appropriate.

If a child requires referral to the Children's Community Nursing Team this should be made prior to discharge via SALUS referral. If a child/infant has complex needs a discharge planning meeting involving all relevant professionals must be held prior to discharge allowing time to obtain equipment etc. A Discharge planning meeting can be held at any point during the admission and does not have to wait until the child is medically fit for discharge; this allows more time for arrangements to be made and potentially prevents delay when the child is medically ready for discharge.

### 5.2 Communication and documentation

- Effective communication with the child, family and other agencies involved with the child is essential to the achievement of a smooth transition from hospital to home or another location. The following documents must be completed at the time of discharge:

- Entry by the discharging doctor in the health record documenting the discharge decision;
- Where discharge is anticipated for next day or later the same day, timely prescription of discharge medication should be made in order to minimise discharge delay.
- Electronic discharge letter (must be completed by the doctor prior to the child leaving a ward area and a copy given to the parent/guardian and filed in the medical notes). A copy of this discharge summary will either be: emailed to patient's GP or posted the same working day.
- Multi-agency care plan where appropriate;
- Safeguarding referrals and plan where appropriate;
- CAF assessment where appropriate.
- Completed discharge checklist in Part A (see Appendix 4)

If the child/young person is already known to/under active follow up with a Paediatrician, within Acute Paediatrics, Community Paediatrics or Neonatal service, consideration should be given to at least informing them or discussing the child's admission to and course in hospital and any discharge plan and follow up.
It is the consultant's responsibility to set up a rapper alert on any children they want to be alerted to regarding ED attendance or hospital admissions. This alert can be set up on the ED system (HAS) and the ipm system.

Appropriate information must be given to, and discussed with, the child and family regarding ongoing management of the child's condition including advice about school attendance where appropriate. An appropriate advice leaflet should be given to the child/parent. These can be found on all wards.

Where a more detailed discharge letter is required this must be provided within 7 days of discharge and a copy sent to the parent/guardian and filed in the medical notes.

If the child and family's first language is not English interpreting services must be accessed via the Language Line to ensure that information about the child's condition, ongoing care and follow-up is accurately communicated.

### 5.3 Follow-up and ongoing care

#### 5.3.1 Children's Community Nursing Team (CCNT)

The CCNT provide ongoing nursing care, support and education following discharge from hospital services and facilitate early discharge from hospital. Referrals can be made from all hospital services and directly from GPs. Children remain under the care of a hospital consultant paediatrician whist receiving input from the CCNT. It is the responsibility of the CCN and consultant paediatrician to maintain close communication and agree when the child is able to be discharged.

If the child/young person is already known to/under active follow up with the community children's nurses, consideration should be given to at least informing them or discussing the child's admission to and course in hospital and any discharge plan and follow up.

It is the community nurses responsibility to set up a rapper alert on any children they want to be alerted to regarding ED attendance or hospital admissions. This alert can be set up on the ED system (HAS) and the ipm system.

#### 5.3.2 Outpatient follow-up

It is the responsibility of the discharging doctor to decide whether follow-up is required and if so what form this should take. The discharging doctor must communicate the required follow-up to the discharging nurse who must ensure any necessary appointments are made or (out of hours) arrangements are made to forward appointments to the child/family.

If a child attending the Emergency Department requires assessment in the paediatric Fast Track Clinic the Paediatric Fast Track Clinic protocol should be followed.

#### 5.3.3 Open Access

A small number of children with highly complex needs have open access to the Children's Assessment Unit to enable prompt attention during acute illness. A list of children meeting the criteria for open access is held on CAU. Decisions to add children to this list must be taken by a consultant involved with the child's care and the ward manager. The list must be reviewed by the ward manager and relevant consultants annually.

All infants, children and young people discharged from the Children's Assessment Unit or paediatric wards are offered 72 hours open access to enable their parent or carer to seek advice on their child or follow up if needed.

### 5.3.4 Primary Care

The GP, Health Visitor and School Nurse have ongoing responsibility for the health care of children in the local population. It is vital that hospital-based professionals liaise with these professionals following a child's admission to provide the necessary information to enable informed decisions and ongoing care.

### 5.3.5 Continuing Health Care

Children with complex needs who require ongoing intensive nursing support or equipment may be eligible for a package of continuing health care. Such children should be referred to the Occupational therapists, Physiotherapists and CCNT prior to discharge. Consider CAF meeting or Team around the Child (TAC) meeting prior to discharge to incorporate all of the multidisciplinary team.

## 5.4 Specific client groups

### 5.4.1 Orthopaedic surgery

The discharging nurse must always check with the discharging surgeon whether the child requires a physiotherapy assessment and provision of supportive equipment prior to discharge.

### 5.4.2 Day care

It is best practice to undertake elective procedures on a day-case basis where clinically safe to do so. The child/family should be informed of the anticipated discharge time at the time of admission. On occasions where a child's recovery deviates from the anticipated pathway it may be necessary to admit the child overnight. It is the responsibility of the Plym Children's theatres to liaise with the ward nurse in charge to arrange the admission. Children undergoing day-case surgery must be provided with post-operative care information before discharge. Children undergoing day-case Ear, Nose or Throat surgery should be contacted by telephone the following day after discharge to check their post-operative recovery.

### 5.4.3 Children not registered with a GP

If a child is not registered with a GP the parents/guardians should be advised to register the child immediately. Information regarding GPs accepting patients can be found on www.nhs.uk.

If there are safeguarding concerns the child must not be discharged from hospital until a GP has been allocated to the child. Further help and information on how to do this can be found on www.nhs.uk or the ward clerks.

### 5.4.4 Mental health

Patients attending following deliberate ingestion or self-harm must undergo clinical and psychiatric assessment prior to discharge. This includes a risk assessment of the patient's safety and the severity of their intentions. If medically fit for discharge patients should be referred to the COT team for assessment on CAU prior to admission. Where patients attend out of working hours they should be referred the following morning for assessment as soon as possible. Patients should be referred to the CAMHS team for assessment and intervention. Consideration must be given to safety planning and a copy of the safety plan for discharge placed in the patient's notes prior to discharge.

### 5.4.5 Home oxygen

If a child is to be discharged with home oxygen the home oxygen protocol must be followed to ensure that the oxygen is fitted prior to the child's discharge. Early referral to the CCNT is essential for this client group. A CAF or CAF review meeting involving all relevant professionals and agencies should be held prior to discharge.

Children falling into this group must not be discharged out of hours.

### 5.4.6 Self discharge

If a parent wishes to take the discharge of their child against medical advice the nurse should first discuss the reasons for the parent's request and try to dissuade this course of action, explaining the possible detrimental effect this could have on the child's health. The Nurse must document the discussion, including the outcome in the patient's health record.

If the parent continues to wish to take the discharge of their child against medical advice, the relevant doctor must be informed immediately. The doctor should review the child if time allows, and explain the detrimental effect of self-discharge to the parent. If attempts to dissuade the parent are unsuccessful an assessment of the impact of discharge on the child's welfare must be undertaken by the nurse and doctor involved. If removing the child from hospital services places the child at significant risk of harm or the child is subject to a protection order then child protection measures should be initiated as set out in the Trust Child Protection Policy.

The parent should be informed of the risk that removal from the hospital poses for their child. If the parent removes the child despite being advised of safeguarding concerns the police and the Trust security department should be contacted immediately to retrieve the child and an immediate referral to Children's Social Care must be made. Staff should not place themselves in danger by trying to obstruct the parent. Referral must be made to the safeguarding team via SALUS.

If removal from hospital services by the parent or carer does not place the child at risk of significant harm this must be fully documented in the patient's health record. The parent should be advised to contact their G.P. practice for ongoing care. Referral must be made to the safeguarding team via SALUS.

A young person assessed as having capacity to understand the consequences of taking their own discharge against medical advice may wish to take their own discharge refer to- Mental Capacity Act (2005) In this case the nurse and doctor should try to dissuade the patient from doing so. When a child's parents or a young person decide to discharge against medical advice a social care safeguarding children referral form should be completed. The parent or young person should be informed that the Health Visitor, School Nurse, GP and Children's Services will be informed as necessary. In all cases the child's GP and Health Visitor/School Nurse and any other key professionals involved in the child's care must be informed within 24 hours that the child has left / been removed from the ward. Referral must be made to the safeguarding team via SALUS.

If a parent expresses that they wish to discharge their child due to a complaint or concern about care every effort must be made to address and resolve the complaint /concern, with reference to the Trust Responding to Formal Complaints SOP to enable care to continue, refer to PALS and informal complaints.

## 5.5 Safeguarding

### 5.5.1

When a child is admitted to hospital where there are child protection concerns or where such concerns are arise during admission it is important that a Multi-Agency Plan is agreed before the child leaves hospital. The Victoria Climbié Inquiry highlights the need for this and recommends:

- no child (or young person) known to Social Care who is an inpatient in hospital and about whom there are child protection concerns is allowed home until it has been established by Social Care that the home environment is safe, the concerns of the medical staff have been fully addressed and there is a Social Worker Plan for 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.

The child should not be discharged at weekends or Bank Holidays unless the social worker has agreed that it is safe to do so and this is documented in the child's medical record and a Multi-Disciplinary Discharge Plan has been completed and agreed. Referral must be made to the safeguarding team via SALUS.
If social planning for safe discharge delays discharge of medically fit children for more than 24 hours a DATIX incident form must be completed and the safeguarding team informed to escalate concerns.

### 5.5.2 Planning for Discharge

A strategy discussion or meeting should be held prior to discharge of all children admitted where there are child protection concerns or where such concerns arise during admission. There should be a Strategy Meeting in all cases of suspected non-accidental injury. The Strategy Meeting should be held at Derriford Hospital whilst the child is still an inpatient and all agencies should be represented.

The purpose of a Strategy Meeting is:

- to pull together information from different agencies to inform risk
- to decide whether a Section 47 Inquiry is required
- to plan ongoing assessment
- to formulate an agreed Multi-Agency Safety Plan for the child and to decide how this is to be implemented

All information required to assess risk of ongoing harm to the child should be available at the meeting. This should include results of investigations, photographic evidence (where possible), medical information from other Trusts where the child may have been seen or admitted previously

If information is outstanding at the time of the strategy meeting/discussion this should be collected before it is determined that a child is safe to return home.

A Strategy Meeting should be held as early as possible in the day once information has been collated. A child should remain in hospital until an agreed Safety Plan can be implemented. This may mean that children remain in hospital for longer than medically required (it should rarely be necessary for children to remain in hospital for more than two days after being considered medically fit for discharge). If a child needs to remain in hospital safe supervision arrangements need to be decided at the strategy meeting. Social Care are responsible for arranging safe supervision for children except when there is medical need.

A copy of the required actions decided at the Strategy Meeting and the Safety Plan for the child should be available to attendees immediately after the meeting to ensure a common understanding between agencies.

In situations where there is uncertainty regarding an injury, the consultant should inform the Named or Designated Doctor for Safeguarding Children who should also be involved in the relevant meeting.

Parents should be advised of any meeting taking place in relation to their child and their view should be represented at the meeting. If it is a professionals meeting then feedback to the parents should take place as soon as possible.

Where a medical practitioner does not consider that their concerns have been properly addressed, that the Safety Plan is inadequate or that more information is required to inform the Safety Plan this should be documented in the medical notes and a request made to record this opinion in the Strategy Meeting Minutes. If a difference of opinion cannot be resolved at the meeting, the Professional Differences Policy should be followed prior to discharge of the child. In practice it may be difficult to keep a child in hospital once Social Care have decided it is safe for a child to be discharged. If it is not possible to keep a child in hospital;

- the practitioner should immediately inform a Senior Social Worker of their concerns for the safety of the child
- the Professional Differences Policy should be followed immediately, rapidly escalating to the most senior level
-

### 5.5.3 Discharge arrangements

Once an agreed Safety Plan has been formulated it is the responsibility of a Consultant Paediatrician (usually the Paediatrician who has taken the lead for the child protection investigation) to authorise discharge of the child. The person authorising discharge should be clearly stated in the medical records.

Where authorisation for discharge of a child is devolved to another consultant this consultant should ensure that they are familiar with all aspects of the case, have read all the case notes and that they agree with the Safety Plan.

The GP should be informed as soon as possible in working hours by phone about the concerns and Safety Plan for the child. If a child is discharged at a weekend, the GP Out of Hours Service should be informed. If a child is not being discharged home it may be necessary to arrange for the child to be a temporary resident with a different general practitioner.

An E-discharge summary should be completed by a doctor of at least Registrar (ST4) grade and above. This should detail the child protection concerns, results of investigations, medical opinion and the agreed Multi-Agency Safety Plan. Follow up arrangements should be noted. A copy of this summary should be dispatched to the GP (+ acting GP) and to the health visitor or school nurse immediately. The discharge address of the child should be stated.

The examining doctor should produce a Child Protection Medical Report within two working days (if not the Lead Consultant should be under supervision of the responsible Consultant). Dependent on the circumstances an additional Police Statement and Court Report may be required.

Nursing discharge documentation should also detail the child protection concerns and Safety Plan.

If a Child Protection Case Conference has been arranged the Lead Consultant should inform the Reviewing Officer of their availability and make arrangements to attend.

### 5.5.4 Children Discharged into Local Authority Care

The named Social Worker and appointed carer should be appraised of all aspects of the child's medical history and of their requirements for ongoing care.

No child should be discharged into the care of a foster carer unless an identified Social Worker is present at discharge.

The following information should be documented prior to discharge:

- name and address of placement (record if secure address)
- who has parental responsibility
- where follow up appointments are to be sent
- how birth parents are to be informed of discharge and follow up arrangements
- who will be providing ongoing primary care. If there is to be a change in GP this should have been decided prior to discharge
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### 5.6 Transport

It would usually be expected that the child's family provide transport home. It is the responsibility of the nurse caring for the child to establish that the parent has access to transport. On rare occasions when the parent is not able to provide transport it may be appropriate to provide transport via ambulance liaison office or a hospital taxi. Senior nurse must contact the relevant Matron for authorisation during office hours and the bed manager outside these times. Children who are unfit to travel in a taxi or in parent's transport may require an ambulance or adapted vehicle and can be arranged through ambulance liaison service during working hours.

### 5.7 Delayed discharges

Delays in discharge must be avoided. Delays may occur as a result of delays in placing children who are going to foster care, delays in reviews being undertaken, delays in obtaining equipment etc. Any child who is medically fit for discharge but not able to leave the ward must be notified to the lead nurse for child health or senior nurse on duty.

Datix should be completed for all delayed discharges when a child has been medically fit for 24 hours awaiting safe social or mental health placement and highlighted on SALUS.

## 6 Overall Responsibility for the Document

Paediatric Matron

## 7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved through clinical governance and ratified by the executive director – Greg Dix

Non-significant amendments to this document may be made, under delegated authority from Greg Dix, by the nominated author. These must be ratified by the Executive Director and should be reported, retrospectively, to the approving clinical governance

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

## 8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author will be responsible for agreeing the training requirements associated with the newly ratified document with the Executive Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

## 9 Monitoring Compliance and Effectiveness

The policy will be monitored by audit using the tool in Appendix 5 and analysis of the findings undertaken by the policy author. Gaps and omissions in the policy will be action planned and outcome assessed.

Where monitoring has identified deficiencies, recommendations and action plans will be developed and changes implemented accordingly. Discussions regarding the identified actions will take place at the monthly Children's Clinical Governance meetings. Progress on these will be reported to the Lead Nurse for Children and young people's health directorate and at Risk Management Group meetings.

## 10 References and Associated Documentation

Department of Health, Home Office, Department for Education and Employment (1999) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.* The Stationary Office. London.

Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services.* DH. London.

Department of Health, Home Office, Department for Education and Employment (2000) *Framework for Assessment of Children in Need and their Families*. The Stationary Office. London.

Lord Laming (2003) *The Victoria Climbie Inquiry: Report of an Inquiry by Lord Laming*. The Stationary Office: London.

| **Core Information** | |
|---|---|
| **Document Title** | Discharge Policy for Children and Young People |
| **Date Finalised** | January 2018 |
| **Dissemination Lead** | Louise Cork |
| **Previous Documents** | |
| **Previous document in use?** | Version 1 |
| **Action to retrieve old copies.** | Louise Cork |

**Dissemination Plan**

| Recipient(s) | When | How | Responsibility | Progress update |
|---|---|---|---|---|
| All staff | Upon ratification | Email | Document Control | |
| | | | | |
| | | | | |

| Review and Approval Checklist | Appendix 2 |
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| Review | | |
|---|---|---|
| **Title** | Is the title clear and unambiguous? | Y |
| | Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP? | Y |
| | Does the style & format comply? | Y |
| **Rationale** | Are reasons for development of the document stated? | Y |
| **Development Process** | Is the method described in brief? | Y |
| | Are people involved in the development identified? | Y |
| | Has a reasonable attempt has been made to ensure relevant expertise has been used? | Y |
| | Is there evidence of consultation with stakeholders and users? | Y |
| **Content** | Is the objective of the document clear? | Y |
| | Is the target population clear and unambiguous? | Y |
| | Are the intended outcomes described? | Y |
| | Are the statements clear and unambiguous? | Y |
| **Evidence Base** | Is the type of evidence to support the document identified explicitly? | Y |
| | Are key references cited and in full? | Y |
| | Are supporting documents referenced? | Y |
| **Approval** | Does the document identify which committee/group will review it? | Y |
| | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | U |
| | Does the document identify which Executive Director will ratify it? | Y |
| **Dissemination & Implementation** | Is there an outline/plan to identify how this will be done? | Y |
| | Does the plan include the necessary training/support to ensure compliance? | Y |
| **Document Control** | Does the document identify where it will be held? | Y |
| | Have archiving arrangements for superseded documents been addressed? | Y |
| **Monitoring Compliance & Effectiveness** | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Y |
| | Is there a plan to review or audit compliance with the document? | Y |
| **Review Date** | Is the review date identified? | Y |
| | Is the frequency of review identified? If so is it acceptable? | Y |
| **Overall** | Is it clear who will be responsible for co-ordinating the | Y |

| | | |
|---|---|---|
| **Responsibility** | dissemination, implementation and review of the document? | |

| **Equalities and Human Rights Impact Assessment** | **Appendix 3** |
|---|---|

| **Core Information** | |
|---|---|
| **Manager** | Anita Dykes |
| **Date** | January 2018 |
| **Directorate** | Women and Children's Services |
| **Title** | Discharge Policy Children and Young People |
| **What are the aims, objectives & projected outcomes?** | To facilitate the safe and effective discharge of babies, children and young people from Paediatric wards and Plym Theatres over the 24 hour period. |

| **Scope of the assessment** |
|---|
| This policy applies to all inpatient, day care and assessment clinical settings within the Trust that are accessed by children and young people on level 12. This includes the Paediatric wards and Children's Assessment Unit (CAU). The discharge policy does not cover discharge from the Emergency Department although many aspects of the policy may be relevant. |

| **Collecting data** | |
|---|---|
| **Race** | There is no evidence to suggest that there is an impact on race regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored.<br><br>The document has considered if the child or family's first language is not English and interpretation services will be offered. Consideration will also be made if information provided is required in a different language. |
| **Religion** | There is no evidence to suggest that there is an impact on religion or belief and non-belief regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored. |

| | |
|---|---|
| **Disability** | There is no evidence to suggest that there is an impact on disability regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored.<br><br>It should be recognised that literacy rates do impact on the level of understanding that a child/family member may have in order to understand information provided about the discharge of a child.<br><br>The document has considered children with complex needs who may require ongoing intensive nursing support or equipment. It also considers mental health issues and clinical and psychiatric assessments and risk assessment will be undertaken if required. |
| **Sex** | There is no evidence to suggest that there is an impact on sex regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored. |
| **Gender Identity** | There is no evidence to suggest that there is an impact on gender identity regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored. |
| **Sexual Orientation** | There is no evidence to suggest that there is an impact on sexual orientation regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored. |
| **Age** | This document is for the effective discharge of babies, children and young people from Paediatric wards and Plym Theatres over the 24 hour period.<br><br>Data collected from Datix incident reporting and complaints will ensure issues are monitored for a child up to the age of 16 only. There is a separate policy for the discharge of adults. |

| | |
|---|---|
| **Socio-Economic** | There is no evidence to suggest that there is an impact on socio-economical issues regarding this policy.<br><br>However, data collected from Datix incident reporting and complaints will ensure this is monitored.<br><br>It should be recognised that literacy rates do impact on the level of understanding that a child/family member may have in order to understand information provided about the discharge of a child. |
| **Human Rights** | The document has considered safe guarding issues which will be addressed following the Trust safe guarding processes.<br><br>Data collected from Datix incident reporting and complaints will ensure this is monitored. |
| **What are the overall trends/patterns in the above data?** | No comparative data has been used to date which means that no trends or patterns have been identified |
| **Specific issues and data gaps that may need to be addressed through consultation or further research** | No gaps have been identified at this stage but this will be monitored. |
| **Involving and consulting stakeholders** | |
| **Internal involvement and consultation** | Leah Brooks, Equality and Diversity Lead<br><br>Alison O'Neill, Safeguarding Named Nurse<br><br>Child Protection Committee<br><br>Clinical Governance meeting for child health |
| **External involvement and consultation** | No external consultation has been undertaken. |

| Impact Assessment | |
|---|---|
| **Overall assessment and analysis of the evidence** | Data collected from Datix incident reporting and complaints will ensure this is monitored.<br><br>The document has considered if the child or family's first language is not English and interpretation services will be offered. Consideration will also be made if information provided is required in a different language.<br><br>It should be recognised that literacy rates do impact on the level of understanding that a child/family member may have in order to understand information provided about the discharge of a child.<br><br>The document has considered children with complex needs who may require ongoing intensive nursing support or equipment. It also considers mental health issues and clinical and psychiatric assessments and risk assessment will be undertaken if required.<br><br>The document has considered safe guarding issues which will be addressed following the Trust safe guarding processes. |

**Action Plan**

| Action | Owner | Risks | Completion Date | Progress update |
|---|---|---|---|---|
| Collect and monitor data collected from Datix on incidents and complaints | | | | |
| | | | | |

New

## Discharge Checklist from CAU/Ward to Home or Other Residence

- EDischarge completed and highlighted on SALUS for discharge — Yes ☐ No ☐
- Discharge Medication ready — Yes ☐ No ☐ N/A ☐
- Set of observations prior to discharge — Yes ☐ No ☐
  If not document any reason: e.g. Self discharge/Discharged by doctor

- Contact number of ward and 72hrs open access explained — Yes ☐ No ☐ N/A ☐
- Advice documented in notes — Yes ☐ No ☐
- Local anaesthetic cream removed — Yes ☐ No ☐ N/A ☐
- IV cannula removed — Yes ☐ No ☐ N/A ☐
- Follow up required — Yes ☐ No ☐ N/A ☐
- OPD booked — Yes ☐ No ☐ N/A ☐
- Family and friends survey issued — Yes ☐ No ☐

Discharged by:

Signed: Print name:

Date/Time:

| Nursing notes |
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8

## Children's Discharge Audit Tool

| | | Please circle answer | | |
|---|---|---|---|---|
| | Was there a discharge form completed | **Yes** | **No** | **N/A** |
| | Was the patient identified on the form | **Yes** | **No** | **N/A** |
| | Was there evidence that the: | | | |
| a) | Discharge date was agreed | **Yes** | **No** | **N/A** |
| b) | Patient/carer informed of discharge date | **Yes** | **No** | **N/A** |
| c) | Mobility section completed | **Yes** | **No** | **N/A** |
| d) | Equipment section completed where equipment was indicated | **Yes** | **No** | **N/A** |
| e) | Discharge medication section completed | **Yes** | **No** | **N/A** |
| | Prescription was completed | **Yes** | **No** | **N/A** |
| | Prescription obtained | **Yes** | **No** | **N/A** |
| | Explanation given re medicines | **Yes** | **No** | **N/A** |
| f) | Out-patients appointment made and given to family | **Yes** | **No** | **N/A** |
| g) | Referral made CCNT | **Yes** | **No** | **N/A** |
| | Health Visitor | **Yes** | **No** | **N/A** |
| | Social Services | **Yes** | **No** | **N/A** |
| | Other | **Yes** | **No** | **N/A** |
| h) | Advice leaflet given | **Yes** | **No** | **N/A** |
| | Where no evidence, was the section | | | |
| | Blank | **Yes** | **No** | **N/A** |
| | Documented not applicable | **Yes** | **No** | **N/A** |
| i) | Was verbal advice given | **Yes** | **No** | **N/A** |
| | Was there any other information documented on the form? | **Yes** | **No** | **N/A** |
| | Was there any evidence that the open access was offered? | **Yes** | **No** | **N/A** |
| | Was there any evidence that the patient was discharged out of hours | **Yes** | **No** | **N/A** |