Policy for the Discharge and Transfer of Children and Young People from Child Health

V5.0

April 2017
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1. **Introduction**

1.1. This policy has been developed to support Trust Staff in the discharge and transfer of children and young people. It is a requirement of the “NSF for Children Young People & Maternity Services” to have in place a policy that meets the specific needs of this group. This policy for discharge and transfer must be adhered to when discharging or transferring children and young people.

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

- DH: Working Together to Safeguard Children 2015
- DH NSF For children young people and maternity services (2004)
- DH: Framework for Assessment of Children in Need and Their Families 2001
- Children Act 2004
- DH: Discharge from Hospital, Pathway, Process and Practice 2003

1.3. This version supersedes any previous versions of this document.

2. **Purpose of this Policy/Procedure**

2.1. The purpose of this document is to outline the Trust policy for the Discharge and Transfer of children and young people and contains the responsibilities, procedures and the documentation required to carry out the process. The policy becomes effective from the date of ratification.

2.2. To ensure that consideration is given to appropriate and timely discharge or transfer arrangements. Carers, children and young people are entitled to expect to be fully involved in the planning of these arrangements including an explanation of the process. The decision to transfer a child or young person is a clinical one but planning should involve children/young people and their families.

2.3. To ensure that any information collected from the children/young people and carer follows a standardised format, which is agreed by the multidisciplinary team. Discharge planning should commence at the time of admission.

2.4. To ensure that the responsibility for the co-ordination of assessment and discharge or transfer plan for all children/young people with continuing health and/or social care needs is undertaken by the multi-disciplinary team. Children/young people who require continuing support from other health or social care agencies should not be discharged in the evenings, at weekends or during a bank holiday without prior consultation with involved agencies, if a need or potential need for intervention is perceived prior to the next working day. Children/young people may be discharged at these times at the discretion of the Consultant, provided agreement has been reached that the family are able to provide adequate support. This must be documented in the nursing and medical records. In the case of transfer of this group of children and young people from our services, this should be carried out in consultation with them and their families, ensuring that, whenever possible, the multi-agency team involved in the care of this group are in full agreement with any transfer arrangements.
3. **Scope**

3.1. This policy applies to all staff members, and their Line Managers, who are involved with the discharge or transfer for children or young people.

4. **Definitions / Glossary**

- Clinical Review - This may be an assessment of how the patient is doing in regard to the reason for admission and current clinical problems; it may be undertaken by a responsible practitioner, Clinical Review - This may be an assessment of how the patient is doing in regard to the reason for admission and current clinical problems; it may be undertaken by a responsible practitioner, e.g. Consultant or other experienced doctor or nurse. The review will enable progress to be assessed when planning for discharge.

- Discharge - When the policy talks about” discharge" this should apply to any transfer of a patient from the acute setting to home/place of residence.

- Transfer – This refers to the transfer of children/young people from child health to another hospital or other health or social care facility

- Foundation Doctor (F1 & F2) - A doctor who is on a structured training programme, usually in the first 1-2 years of their qualification.

- PAS – patient administration system – real time bed management system which all patients are admitted onto.

5. **Ownership and Responsibilities**

5.1. Staff involved with the discharge or transfer planning of children and young people are required to follow this policy and be clear with regard to their individual roles and responsibilities within the process. The Policy will be available on the Document Library with a link on the Child Health Intranet site.

5.2. All staff have shared responsibility for the completion of the Discharge Plan and Checklist – Appendix 5.

5.3. **Role of the Consultant Medical Staff & Medical team**

- The consultant staff and those to whom they delegate duties:

- Must discuss with the parents and children/young people, the reason for their admission to hospital/contact with the service, the treatment involved and likely outcome, including discharge and expected length of stay/length of treatment and intervention plans and whenever possible any necessary transfer arrangements.

- 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 or transfer plan for the patient.

- Have a responsibility to seek and record the views of children/young people and their carers where relevant.
Will ensure that an electronic discharge summary will be emailed to the children/young people’s General Practitioner (GP). This should be within 24 hours of discharge. Parents must be given a copy prior to them departing the ward.

Must inform the GP at the earliest opportunity of any child/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 home a child/young person against medical advice and will advise as to whether the child/young person would be classed as ‘at risk of significant harm’.

When necessary Children’s Social Care and the Police can be contacted to enable the child/young person to be returned to hospital. Please refer to RCHT Children presenting to acute healthcare services at the Royal Cornwall Hospital who leave without being seen Policy. See appendix 4 for example of form to be completed.

Must ensure, that, whenever possible, 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.

Must liaise with relevant other providers when a transfer is required to ensure acceptance of the transfer and to agree any necessary arrangements.

When a decision has been made to transfer, the consultant or senior doctor will ensure that the receiving service has a full written account of care delivered within RCHT stating clearly the reasons for transfer. This must be discussed fully with the parents/carers and whenever possible with the child or young person.

5.4. Role of Nursing Staff

Nursing Staff involved in the discharge/transfer of children or young people:

Should collect and clearly document accurate information relating to the child/young person’s individual social circumstances as soon as possible following admission/service contact. This information will form the basis of their discharge planning arrangements and will be included in any transfer documentation.

Best practice that staff should discuss all babies under 2 years of age with the health visitor to inform of admission and ensure this discussion is documented.

Should assess children/young people over age of 2 years and if further input is required by Health Visitor/School Nurse discuss with appropriate HV/SN team and if not an open case will need to complete an Early Help Hub referral and ensure this discussion is documented. See Appendix 3.

Identify any specialist medical equipment or support required along with the multi-disciplinary team and inform Community Nurse, Midwife, Health Visitor or School Nurse to allow for equipment to be in place at time of discharge.
Will provide any written information concerning discharge in the form of written information. If appropriate, alternative information should be sort from Acute Learning Disabilities Liaison Nurses.

Will ensure that a discharge summary is sent to the children/young people's health visitor/school nurse. This should be within 24 hours of discharge. Parents are to be given a copy, prior to them leaving the ward.

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/transfer plan for the children/young people. If the child has nursing needs, the Children’s Community Nurses should be notified as soon as possible following admission via a Paediatric Community Nursing referral process Appendix 3. All members of the multidisciplinary team involved in the child or young person’s care must also be made aware of any transfer.

Have a responsibility for ensuring that the relevant community nurse/health visitor/school nurse is invited to attend any multidisciplinary meetings regarding discharge or transfer. Adequate notice of such meeting must be given whenever possible.

Will ensure that transfers of children/young people to other provider units from acute paediatric services use the same standards as discharges, and that the current transfer documentation is completed, transport is arranged and personal property and the relevant medical records are transferred with the child/young person.

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. When transport is required for transfer this will also be arranged by the nursing staff who must at all times liaise with Patient Transport Services (PTS) ensuring a risk assessment is carried out when considering mode of transport

Should ensure that the children/young people’s carers are involved in assessments and discharge or transfer plans. Their views should be sought, recorded and communicated with other members of the multidisciplinary team.

Will ensure that, if necessary, the community nursing services have full written details of nursing requirements, equipment and disposable supplies required for discharge and continuing care at home by helping them to complete their nursing assessment documentation. This may be part of the agreed discharge plan or a copy of the discharge summary.

Should follow **RCHT Children presenting to acute healthcare services at the Royal Cornwall Hospital who leave without being seen Policy.** For children who are removed from Child health without being seen by medical staff.

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. The guidance for Open Access to the Paediatric Wards should be followed for those who may require this facility.

- Should ensure child/young person is discharged from PAS

6. Standards and Practice

6.1. Discharge of Children/Young People without continuing healthcare need

When the hospital admission has been straightforward, discharge planning need not be elaborate, but must include:

- Written information to the GP and Health Visitor/Midwife (under 5’s) and School Nurse (over 5’s). All parents and carers must be informed of this sharing of information and they must be given the opportunity to let us know if they do not wish this to happen. This information must be copied to the parents and/or young person.
- Enter record of admission in parent held record including height and weight.
- Appropriate information, in writing, where available for the parents/young person about any likely after effects and follow on treatment. Alternative advice, information or communication methods should be sought via the hospital Acute Learning Disability Liaison nurses if appropriate.
- Provision of written information to parents/carers about medication, including safe storage and side effects. The instructions/advice on the discharge summary is acceptable, as are patient information leaflets. Alternative advice, information or communication methods should be sought via the hospital Acute Learning Disability Liaison nurses if appropriate.
- What to do should their child/young person’s condition deteriorate.
- Written point of contact in case of difficulty.
- Written arrangements for follow up.
- Written and verbal health promotion/illness prevention advice.
- Whenever there is information sharing or verbal consent, details should be documented in the health record.
- Discharge Plan and Checklist (Appendix 3) is completed and filed in the child’s notes.
- Discharge from PAS

6.2. Discharge of Children/Young people with Complex and On-going Healthcare Requirements

Where there is a more complex hospital episode and/or the child has on-going healthcare needs (e.g. long term illness, disability or life limiting conditions) discharge or transfer planning must include all of the above and, appropriate consideration must be given to:

- Medical information being sought from the previous NHS Trust(s) before discharge where a child is admitted to hospital with an on-going medical problem. (To include information about any social or child protection concerns).
- Children’s Social Care contact and follow up arrangements.
- Primary Care contact and follow up arrangements.
- Community Children’s Nursing / Allied Health Professional contact and follow up arrangements - the ward needs to be aware of the roles of these groups, their referral processes and the information they will require, prior to discharge, to support children who are discharged with additional needs.
- Community Paediatric contact details and follow up
- On-going hospital contact and follow up arrangements
- Equipment needs.
- Parent/Carer’s proficiency in managing their child’s condition and associated needs

A discharge planning meeting should be provisionally booked within 24-48 hours of admission for those children with complex needs whose discharge may not be straightforward.

It is the responsibility of the hospital nursing staff in consultation with the medical staff to coordinate which multi-agency teams need to be involved in the assessment and discharge or transfer of children and young people. Due to the complexity of some of these discharge or transfer arrangements there must be a named person, known to the child and family, who will co-ordinate on-going care. This person will act as the single point of contact should the family experience difficulty with on-going care arrangements. This person can be identified via the common assessment framework process.

If the child and family have Well-Child Clinical Nurse Specialist for Complex Needs involvement they must be involved with every stage of the discharge planning process.

Ward staff should ensure that parent's/carer's are adequately trained in the care of their child before discharge. This applies to the administration of medicine, in addition to the management of any equipment.

### 6.3. Discharge of Children and Young People in Special Circumstances

**Child Protection Concerns**

- Where there are concerns about possible child protection issues, there must be a multi-agency action plan agreed and recorded before the child leaves hospital.
- Any legal orders arising from the admission should be recorded (with copies filed if available)
- The child must be registered with a GP before discharge
- No child can be discharged or transferred from hospital, where there are child protection concerns without the permission of the responsible Consultant Paediatrician. This can only be given once a clear, agreed action plan is in place and confirmation that the child is being discharged/transferred to a place of safety.
- So far as possible, all investigations should be completed before discharge/transfer, even if the child is deemed medically fit, with clearly documented plans in place for any remaining/follow up investigations.
- Medical information should be sought from the previous NHS Trust(s) before discharge where a child admitted to hospital with an ongoing medical problem, or is recognized as at risk of harm, has already been treated at another hospital.
- All follow-up plans, for all agencies, must be clearly documented and confirmed.
- If the child is discharged to an address other than their home address and/or into the care of someone other than their parent, this must be clearly recorded in the health record, taking care with regard to confidentiality.
- Whenever possible the child, parents/carers should be informed of all arrangements made, whilst taking care with regard to confidentiality.
- The Named Nurse for Safeguarding Children can be contacted for further advice via RCHT switchboard in working hours.
- The Multi Agency Referral Unit (MARU) can be contacted in office hours on 0300 123 1116. Out of hours service 01208 251300.

6.4. Transition to Adult Services
When a young person has on-going care needs, and is reaching the age where adult services will be assuming responsibility for this, the transition of care should be recorded in the notes. A named person known to the young person and their family should be identified where possible for contact in case of difficulty. The ‘Ready, Steady, Go’ process must be followed and children and families should be provided with information from the ‘Ready Steady Go’ folders in all ward and outpatient areas. The ‘Ready’ process should be commenced at secondary school age for all relevant children.

6.5. Children who have remained in hospital for 3 months or longer
These children will be subject to Section 85 of the Children Act 2004. The Trust has a responsibility to notify social services in these circumstances and when the child is discharged or transferred to another health provider. Please refer to multi agency guidance re children who are in hospital for more than three months as directed by named professionals for child protection.

6.6. Palliative care needs
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, details of which have been agreed with the family and shared with the community teams prior to discharge.

6.7. Discharge of Infants from the Neonatal Unit (NNU)
The previous standards all apply to infants being discharged from NNU who may also have a co-ordinated programme of follow up, with special arrangements for vision, hearing, developmental progress and ongoing support. All of this should be recorded in the child’s notes. The principles of children with continuing healthcare need outlined above is likely to apply to this group of patients.

6.8. Discharge of Children and Young people with Mental Health Issues
Where a child has an identified mental health need, arrangements must be made in the discharge or transfer plan for follow up from the Child and Adolescent Mental Health Service (CAMHS). Where this is not thought to be necessary the reason(s) for
this decision need to be agreed with the child/young person’s consultant and
documented in the health record.

6.9. Discharge from the Emergency Department

Many children will be seen and assessed in the Emergency Department and deemed
medically fit for discharge during the working day, evenings, weekends or bank
holidays. For most children this can occur safely and without concern for the social
circumstances.

The clinical staff discharging the patient must ensure that, in addition to a full medical
assessment, they make & document an assessment of the social circumstances and
consider if the child and their accompanying carers can safely return home. If there is
any concern that the child may not be able to return home safely and in a timely way,
consideration should be made of provision of hospital transport or admission to child
health until such time that public transport is easily accessible.

Where a child and their parent/carer have arrived by ambulance and are deemed
medically fit for discharge, it is the parent/carers responsibility to arrange transport
home. If the discharge is to occur during unsocial hours parents/carers should still try
and arrange transport home. In exceptional circumstances where this may not be
possible and parents/carers have exhausted all avenues, further advice can be
sought from Child Health, specifically in relation to the availability of the Macdonald
Suite Family accommodation.

A discharge summary should be sent to the GP.

The Health Visitor/Midwife (under 5’s) and School nurse (over 5’s) should be notified
of the attendance.

6.10. Transfer of Children and Young People

- When children/young people are being transferred within the hospital details of
  the transfer should be documented in the health record.

- When children/young people are transferred to another provider the current
  transfer document should be completed and the Patients Transport Service
  (PTS) at RCHT should be consulted to book appropriate transport.

- Out of hours transfers should be minimal and based on risk assessment of the
  clinical situation as outlined in RCHT Guideline for Critical Care Transfers.
  Arrangements for this type of transfer will be made with SWAST directly and the
  RCHT site co-ordinator notified.

- The personnel who accompany the child /young person will be decided by
  senior clinical staff based on clinical need and staff availability – this will be
  documented in the health record or on the transfer document. Clinical
  assessment should be done in line with RCHT Policy for Observation and
Monitoring in Child Health and recorded on the patient records for intra hospital transfers and on the transfer document if being transferred to another provider.

6.11. **Discharge involving Children and Young People from The Isles of Scilly (IoS)**

- When planning a discharge/transfer to the IoS due regard must be given to the additional time needed to reach the Islands because of the limited transport services available, particularly at weekends. In addition consideration should also be given to transfer times involved if onward transport by boat from St. Mary’s is required when the child/young person lives on an off-island.

- It will need to be confirmed that the child/young person is medically fit to travel to the airport, and onward by air.

- If the family have a return ticket nursing staff will provide assistance/advice, if necessary, about how to book a flight.

- If the family do not have a return ticket it will be necessary for them to contact the Patient Transport Service Office (PTS) on 01872 252211 to request a travel warrant to return to the Isles of Scilly and to arrange a flight.

- Nursing staff will provide families with information regarding transport to the airport.

- Where a child and their parent/carer have arrived by ambulance and are deemed medically fit for discharge, it is the parent/carer’s responsibility to arrange transport home. If the discharge is to occur during unsocial hours further advice can be sought from Child Health, specifically in relation to the availability of the Macdonald Suite Family accommodation.

7. **Dissemination and Implementation**

7.1. Ward and Department Managers are responsible for ensuring adequate dissemination and implementation of the policy within their own areas.

7.2. All managers will be aware of the contents of this policy and will ensure that their staff have read and understood the procedures and processes relating to the discharge and transfer of patients. New versions of the policy will be circulated to all managers for dissemination to their staff with a summary of all amendments made to the updated version.

8. **Monitoring compliance and effectiveness**

| Element to be monitored | Completion of a discharge plan, Documentation of liaison with other professionals and agencies, |

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Policy for the Discharge and Transfer of Children and Young People from Child Health

<table>
<thead>
<tr>
<th><strong>Lead</strong></th>
<th>Senior Matron Child Health.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tool</strong></td>
<td>An agreed audit tool developed by the Directorate and registered with clinical effectiveness as part of the annual records audit, to include the elements to be monitored described above. Monthly quality audits will monitor the completion of discharge plans.</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Annually for the whole policy through audit of records. Monthly for ward quality audits on discharge plans.</td>
</tr>
<tr>
<td><strong>Reporting arrangements</strong></td>
<td>Audits will be reported via the Divisional Audit and Guidelines meeting in the Directorate. Action plans, incidents and complaints related to discharge and transfer will be brought back to the Directorate via Clinical Governance meetings. Reports should be discussed at the appropriate Operational Board.</td>
</tr>
<tr>
<td><strong>Acting on recommendations and Lead(s)</strong></td>
<td>Reports should be discussed at the appropriate Operational Board and any high risk areas highlighted and action plans developed to address any gaps identified.</td>
</tr>
<tr>
<td><strong>Change in practice and lessons to be shared</strong></td>
<td>Lessons will be shared with all the relevant stakeholders by presentation at Child Health audit and guidelines meetings and via the Child Health risk management newsletter. Following liaison with relevant stakeholders, any required changes to practice will be discussed at Directorate Clinical Governance meetings, prior to being reflected in this policy and implemented clinically.</td>
</tr>
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</table>

9. **Updating and Review**

9.1. The policy author is responsible for ensuring the policy is kept up to date, with reviews being carried out at least once every 3 years, reflecting changes in legislation where necessary. The author must also ensure the policy has been screened to establish if it requires a full Impact Assessment against the Race Relations Amendment Act to ensure no minority group is discriminated against within the document.

10. **Equality and Diversity**

This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.1. **Equality Impact Assessment**

10.2. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Policy for the Discharge and Transfer of Children and Young People from Child Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>April 2020</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Melanie Gilbert. Child Health Matron</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 252411</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>This policy states the responsibilities of the multidisciplinary team when discharging or transferring children/young people from child health.</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Paediatrics, Children, Young People, Neonates, Discharge, Transfer.</td>
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<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director.</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Policy for the discharge and transfer of children and young people from child health. V1</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Child Health Senior Nurses, Consultant Paediatricians Child Health, RCHT Site management. Named Nurse for Safeguarding Children. Child health Business and Guidelines meeting.</td>
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<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
<td>David Smith.</td>
</tr>
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<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Not Required</td>
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<tr>
<td><strong>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>Name: Helen Ross-Magill</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet</td>
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### Links to key external standards

- Care Quality Commission Outcomes 1,2,4,6,7,9,14, and 21
- NHSLA Risk Management Standards 4.9 and 4.10
- Multi Agency Safeguarding Children Policies
- RCHT Adult Discharge Policy
- RCHT Policy on Clinical Record Keeping Guideline
- Policy for Children who are in Hospital for more than three months
- RCHT Policy for patient observation and monitoring in Child Health
- Clinical policy for safe transfer of patients between care areas or between hospitals
- DH: Working Together to Safeguard Children 2013 2015
- DH NSF For children young people and maternity services (2004)
- DH: Framework for Assessment of Children in Need and Their Families 2001
- Children Act 2004
- DH: Discharge from Hospital, Pathway, Process and Practice 2003
- Appendix 7- original document from Cornwall Foundation trust
- Appendix 8- Original document from regional critical care group.

### Related Documents:

- Multi Agency Safeguarding Children Policies
- RCHT Adult Discharge Policy
- RCHT Policy on Clinical Record Keeping Guideline
- Policy for Children who are in Hospital for more than three months
- RCHT Policy for patient observation and monitoring in Child Health
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- Appendix 7- original document from Cornwall Foundation trust
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### Training Need Identified?

No

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>May 09</td>
<td>V1.0</td>
<td>Final amendments approved; EIA Completed; document published</td>
<td>Mary Baulch Senior Matron Child Health</td>
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<tr>
<td>May 11</td>
<td>V2.0</td>
<td>Full review &amp; consultation</td>
<td>Mary Baulch Senior Matron Child Health</td>
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<tr>
<td>Date</td>
<td>Version</td>
<td>Revision Details</td>
<td>Author</td>
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<tr>
<td>Dec 11</td>
<td>V3.0</td>
<td>Rewingding of transfer element to clarify process</td>
<td>Mary Baulch</td>
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<td>Jan 14</td>
<td>V4.0</td>
<td>Full review &amp; consultation</td>
<td>Caroline Amokusana</td>
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<td>April 2017</td>
<td>V5.0</td>
<td>Full review &amp; consultation</td>
<td>Melanie Gilbert.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Matron.</td>
</tr>
</tbody>
</table>

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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

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### Appendix 2. Initial Equality Impact Assessment Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)  
Provide brief description: | Policy for the Discharge and Transfer of Children and Young People from Child Health |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Child Health</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Melanie Gilbert</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872252411</td>
</tr>
</tbody>
</table>

1. **Policy Aim***

Who is the strategy / policy / proposal / service function aimed at?

This policy has been developed to support Trust Staff in the discharge and transfer of children and young people. It is a requirement of the “NSF for Children, Young people and Maternity Services” to have in place a policy that meets the specific needs of this group.

2. **Policy Objectives***

To ensure safe and effective discharge and transfer of children and young people from the Child Health Directorate

3. **Policy – intended Outcomes***

Safe and timely discharge and transfer of patients

4. **How will you measure the outcome?***

Annual audit of discharge documentation

5. **Who is intended to benefit from the policy?***

RCHT Staff and Patients

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

NO
7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No x

9. If you are not recommending a Full Impact assessment please explain why.

No areas indicated.

Signature of policy developer / lead manager / director
M. Gilbert

Date of completion and submission
March 2017

Names and signatures of members carrying out the
1.  
2.  

Policy for the Discharge and Transfer of Children and Young People from Child Health
Page 17 of 22
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ___ M.Gilbert

Date _____ March 2017
Appendix 3: Referral process for Children’s Community Nurses and Health Visitor /School Nurse Referral for children who are not currently open cases to HV/SN teams

REFERRAL PROCESS

Where the referral is for the Children’s Community Nurses, call the team first on 01872 221444 to discuss referral details and ensure the team are able to take the referral

↓

Complete appropriate referral form (accessed via the Early Help Hub webpage www.cornwall.gov.uk/earlyhelphub)

Please fill in all boxes.

Enter N/A if there is no information to be added

↓

Referrals must be emailed to the Early Help Hub:

earlyhelphub@cornwall.gov.uk

Please state the service you are requesting in the subject box of your email.

↓

If the referral form is not fully completed it may be returned.

Please do not hesitate to contact the Early Help Hub, if you have any questions about your referral - 01872 322277
Monday to Thursday 8.45am to 5.15pm
Friday 8.45am to 4.45pm
Appendix 4: Please see Policy - Children presenting to Acute Healthcare Services at the Royal Cornwall Hospital who Leave Without Being Seen (LWBS) for full information on the process to follow.

Sample of CHA3771 V1 available on Forms to print and Child Health Intranet page.

| NHS number: |  
| Name: |  
| Address: |  
| Date of birth: |  
| CR number: |  

**File within 3rd spine**

---

**Child Health**

**- Leave without being seen (Discharge)**

---

For the parent / guardian or young person that leaves without being seen by a medical practitioner

To be completed by the parent / guardian / young person prior to the patient being taken from this hospital.

**Ward / Department:**

**Hospital:**

---

**Discharge information**

I have chosen to discharge my child / myself from this hospital before being reviewed by the appropriate medical team. I have discussed my decision with a nurse / doctor and understand the consequences of my decision.

I have received support / advice and information about the condition for which I attended the hospital and understand this.

If my child becomes more unwell or if I am worried about them, I understand that I can change my mind at any time and return for treatment. I know I will be contacted in the next 24 hours to ensure my child is not at risk from further deterioration.

---

**Parent / guardian signature:**

**Parent / guardian telephone number:**

**Parent / guardian print name:**

**Witness signature:**

**Witness print name:**

**Designation of witness:**

**Date:**

---

This form when completed must be retained in the patient’s medical record and a DATIX of the discharge without being seen event completed in every case by the relevant involved multi-disciplinary team member.

---

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One + all = we care

CHA3771 V1 Printed 01/2017
## Appendix 5: Example of CHA2960 V5 Paediatric Admission Assessment.

<table>
<thead>
<tr>
<th>Child discharge</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Details</th>
<th>Name - Designation</th>
<th>Date/Time - Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge plan discussed with parent/carer and child? (Document name and relationship to child)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact HV for all infants &lt;12 months and for older infants / children if concerns (Document date/time/person spoken to or left message)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child protection notes completed (if in use)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health Record (red book update if appropriate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Ensure newborn screening and admission documented)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents advised / information given? (EG ward leaflets, parent education, vouchers)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Discharge leaflet given (for all new patients on admission) and date?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Open access leaflet given with explanation if appropriate. (If LD/D present please contact ALLDN for specialist information)</td>
<td></td>
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</tr>
<tr>
<td>Equipment loaned? (EG medical equipment, apnoea monitor, OT aids)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Consultant outpatient follow-up appointment required?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Any other follow-up / referrals? (Allied professionals / investigation to include newborn screening) Date and referral</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Identify transport for discharge (EG own, relative collecting, voluntary car)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date discharge medication ordered (if required)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge medication given to parent / carer and discussed with explanation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own medication returned?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant contact details for community services/support given and date?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of final discharge summary given to parents, GP &amp; relevant community services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was this discharge delayed? if yes, give details</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final discharge complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sign:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
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<td></td>
<td></td>
<td>Print:</td>
<td></td>
</tr>
<tr>
<td>Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Designation:</td>
<td></td>
</tr>
</tbody>
</table>
## OTHER PROFESSIONALS INVOLVED

<table>
<thead>
<tr>
<th>PROFESSIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
</tr>
<tr>
<td>Health Visitor</td>
</tr>
<tr>
<td>School Nurse</td>
</tr>
<tr>
<td>Childminder</td>
</tr>
<tr>
<td>Community / Outreach Nurses</td>
</tr>
<tr>
<td>Community Paediatrician</td>
</tr>
<tr>
<td>Social Worker: Child Parent</td>
</tr>
<tr>
<td>Partnership Services for children, young people and families (CAMHS)</td>
</tr>
<tr>
<td>Therapists</td>
</tr>
<tr>
<td>Dietician</td>
</tr>
<tr>
<td>Education Services</td>
</tr>
<tr>
<td>Acute Liaison Learning Disability Nurses</td>
</tr>
</tbody>
</table>

### INDEX OF INVESTIGATIONS - INPATIENT

<table>
<thead>
<tr>
<th>Date requested</th>
<th>Investigation / Specimen</th>
<th>Obtained: Date/Initial/Time</th>
<th>Result</th>
<th>Action taken</th>
<th>Completed by (Signed)</th>
</tr>
</thead>
</table>

### INDEX OF INVESTIGATIONS - TO BE COMPLETED AS AN OUTPATIENT

<table>
<thead>
<tr>
<th>Date requested</th>
<th>Arranged Yes / No</th>
<th>Completed by (Signed)</th>
</tr>
</thead>
</table>