East London NHS
NHS Foundation Trust

Community Children's Nursing Service Operational Policy

Directorate:	Specialist Services and CHN Children's services
Version:	1.0
Date Finalised:	May 2017
Policy Author/s:	Community Children's Matron
Name of Responsible Committee:	Paediatric clinical Governance group
Review Date:	May 2020

Version Control Summary

Version	Date	Author	Status	Comment
1.0	03/05/2017	Rebecca Daniels		

Contents

Contents

Appendices

Team Model and Structure

Introduction:

Community Children's Nursing service (CCNS) is a multidisciplinary team caring for children and young people within the London borough of Newham who require either technical nursing care, palliative care, dietetic support, psychology or play services. CCNS forms part of Children's services within Specialist services directorate of East London NHS Foundation Trust.

1. Purpose of the policy

This policy provides information and guidance about the operational procedures for staff working within Community Children's Nursing service (CCNS) and external staff to the service. This policy is an overview and is linked into individual operational policies for the sub teams within CCNS. The service comprises of five sub teams:

- Community Children's Nursing Team
- Multi-disciplinary Diana team (palliative care)
- Children's Continuing care team
- Epilepsy nursing service
- Home enteral tube feeding (HETF) and special needs dietetic service

The aims of our service are to provide expert nursing, play, psychology and dietetics care to children and young people who have health needs residing within the London borough of Newham. The team delivers all care in a mixture of settings within the community, including service user homes, local authority schools, children's centre's, health centres, local hospice and also the acute outpatient setting.

2. Statement of Purpose

Our service aims:

- To provide specialist nursing care to children and young people (birth up to 16yrs) that require nursing intervention within the community setting.
- To provide multi-disciplinary care to children and young people (birth up to19yrs) who have a palliative care condition (are not expected to live in to adulthood), including symptom control management, end of life care, play specialist interventions, and clinical psychology support and consultation.
- To provide specialist nursing knowledge and support to children and young people (birth up to16yrs) who have epilepsy including assessment, education, support and monitoring of their condition.
- To provide assessment and on-going care to children and young people (birth up to16yrs) who require a continuing care package in the community. This includes training, support and management of health care support workers who provide the care to the child and family within the patients' home. This is extended to 19yrs where the young person has a palliative care diagnosis.
- To provide community based dietetic support and advice to children and young people (birth up to 16yrs) who require home enteral tube feeding or have special needs. This is extended to 19yrs, where the young person has a palliative care diagnosis.

Our service objectives:

- To deliver proactive care which is consistently high in quality, patient centred and sensitive to the physical, psychological and social health needs of the child or young person and their family/carers.

- To ensure all children and young persons have individualised care plans to meet the changing needs of their condition.
- To reduce the length of stay and prevent readmission to hospital through continual assessment and the provision of individualised clinical care in the community as appropriate for each child or young person.
- To ensure all children and young persons under our service are able to maintain a fulfilling life through supporting them in a variety of community settings for example school by providing education and support for non health professionals to enable inclusion.
- To provide psychological and physical support for the child or young person and their family during the end of life phase and, where practically possible, to enable this care to be provided in the family's preferred setting.
- To provide the child and young person with holistic care by working with the multi-disciplinary team across primary, secondary and tertiary services.

Location of the service.
Community Children's Nursing Service is based within a general practitioner surgery in East Ham. However the office base is not accessible for children young people or their families to attend to receive care delivery. We deliver our care to service users in appropriately accessible settings for example, within their own homes, school settings, children's centre (clinic), London hospitals, local health centres and other community settings.

Service Composition:
Our Community Children's Nursing Service is a multi-disciplinary team consisting of:
Community children's matron
Practice development facilitator
Epilepsy nurse specialist
Continuing care nurse specialist
Team leader Diana team
Team leader CCNT
Junior sisters and staff nurses
Health care support workers band 3-4
Community paediatric nutrition support dietitian (HETF) and Community paediatric dietitian (special needs)
Lead and specialist clinical psychologists
Admin team band 3-5
Health play specialist

Each nursing team has a team lead/specialist nurse (band 7) who are supported by band 6 Junior sister (generic role rather than specialist) working across the service rather than in individual teams.

Safe.
Community children's nursing service staffs are appropriately trained within the Trust for safeguarding children and adults. Clinical staff who have direct contact with the child, or young person are trained to level 3 and attend updates within a 3year period to remain up to date. This training enables our staff to recognise signs of abuse and know the correct procedures to follow to ensure they are referred to the correct services within a specific time frame to protect the child, young person or family member.

Ongoing safeguarding concerns are monitored and managed by staff in accordance to their child protection plan or child in need (CIN) plan, this includes attending core groups, CIN meetings, case

conferences, completing reports, liaising with key professionals involved with the child's care and working with the families to ensure the child remains safe from harm.

All care delivery for safeguarding by the community children's nursing service is delivered in accordance to East London Foundation NHS Trust safeguarding policies and staff are supported through 3monthly child protection clinical supervision.

Children, young people and their families are offered care with the provision of a health advocate (interpreter) where English is not their primary language to ensure they are provided with the correct information about their health at all times.

All staff are aware of Patient Advisory Liaison service (PALS) and local trust guidance on management of complaints and will therefore support and signpost any family wishing to make a complaint.

When children have additional physical, health, social and/or emotional needs beyond the remit of Community Children's nursing service provision, staff work with families to make onward referrals to appropriate statutory and third sector services. This could include (but not exhaustive) Speech and Language Therapy, Child and Family Consultation Service, Children's Hospice and Rainbow Trust.

Community children's nursing service staff seek consent from families to liaise and share information with other professionals in the multiagency team around the child and family, to ensure coordinated and holistic care, that addresses all aspects of the child's wellbeing and development are delivered.

Risk assessments are completed to ensure all clinical needs are met safely, identifying any potential risk to the child, young person and family or staff member and put in place safety measures to minimise the risk.

Effective

Good patient outcomes are at the centre of all our care delivery. This includes supporting the child, young person or family to become autonomous in their own caregiving, providing continuing care packages for children with our own health care support workers enabling children with complex conditions to live well within the community, close working with schools to ensure every child with a medical condition is supported and included within education and providing proactive care which is consistently high in quality, patient centred and sensitive to the physical, psychological and social health needs of the child or young person and their family/carers.

All our clinical care is supported by local policy or national guidance to ensure we deliver the best possible evidenced based care at the time of care delivery. We have a practice development facilitator who works on supporting and guiding our service, developing policies and working trust wide to share knowledge and evidence in all aspects of our care.

Regular audits are conducted to ensure our care delivery and record keeping maintains in line with policy and achieves a high standard.

Service user surveys are conducted on a regular basis with our children, young people and families to ensure we continually evaluate our service provision and make necessary improvements where required to ensure good patient outcomes and satisfaction.

Caring

Our staff continually listen to the child, young person and families within their care to ensure they involve them within every aspect of their health care delivery.

Staff work in partnership with families in a relationship of mutual trust and respect.

Care is delivered with compassion and kindness at all times and this is sometimes reflected in thank you cards received from children, young people and their families upon discharge from our service.

Our staff demonstrate the importance of respect especially when entering into the family home. They provide health advocates where required, respect cultural and spiritual needs of the child and family, visit at alternative times to when the family attend prayer and do not enter into a prayer room within the home unless asked by the family.

Healthcare support workers who deliver packages of care within the community, attend local in house training and have competency based assessments on maintaining privacy and dignity, which includes respect and confidentiality whilst working within a patient home.

All registered nurses work within their NMC Code of professional conduct.

All Clinical Psychologists are registered “Practitioner Psychologists” with the Health and Care Professions Council and adhere to the HCPC standards of conduct, performance and ethics and the British Psychological Society Code of Ethics and Conduct.

All Paediatric Dietitians are registered with the Health and Care Professionals Council and adhere to the HCPC standards of conduct, performance and ethics and the British Dietetic Associations Code of Ethics and conducts.

Responsive

The child, young person and family are offered flexibility around the time (within constrains of service working hours) and location (within the borough of Newham) of their appointments, to meet their individual needs.

Our service offers a 24hrs answerphone facility to enable families to leave (non urgent) messages as required which are actioned during working hours. Families are signposted to alternative out of hour’s service provision to ensure their needs are met when our service is unavailable.

Once a child or young person is known to our service they can self refer back to us after discharge should the need arise again.

Our service runs clinics in education settings to prevent the child or young person missing more school than is required.

Our service recognises visiting the child and family within their own home reduces anxiety and encourages better health outcomes.

Families within the palliative care service are all offered an introductory session to explain how any member of the family can self-refer to the psychology service.

Where continuing care packages are offered to families who require them, these are tailored to the child, young person and families needs, providing support to enable the child and family to live well in the community, whilst also encouraging "normal" family time when the health care support workers are not present in the home.

Well-led
All staff are encouraged to work in an open and honest environment, to report any clinical incidents, to aid future learning and be free from blame culture.

There is a proactive and motivated learning environment for continual personal development of individuals which links into the development of our service.

Community children's nursing team run a nurse-led wound dressing clinic in a local children's centre which allows children to be seen in a relaxed environment with the expertise of paediatric staff trained within wound care.

The development of Quality improvement projects are inspiring the service to review current practice and develop new strategies so we continue to develop our service to ensure we deliver high quality patient centred care.

Weekly service meetings take place to share knowledge, increase communication and develop effective team working across the multidisciplinary team.

3. Introduction to the team

3.0 Community Children's Nursing Service (CCNS) is a community based multidisciplinary team providing care for children from birth (sometimes prenatal for palliative care). The service is managed by a Community Children's Matron and supported by the Diana team lead Clinical Psychologist and the Practice Development Facilitator.

3.1 Criteria:
We are a provider service, commissioned by Newham CCG and accept children who reside in London Borough of Newham who meet our criteria's.

Currently our services are commissioned to cover the following age ranges:

- Community Children's Nursing Team: Birth – 16yrs
- Multi-disciplinary Diana team (palliative care): Prenatal/Birth – 19years
- Children's Continuing care team: Birth – 16yrs, extended to 19yrs where the young person has a palliative care diagnosis in coordination with the Diana team.
- Epilepsy nursing service: Birth -16yrs
- Home enteral tube feeding (HETF) and special needs dietetic service: Birth – 16yrs, extended to 19yrs where the young person has a palliative care diagnosis in coordination with the Diana team.

Please refer to the following operational policies, which can be found on the Trust's Intranet for further information regards additional criteria for each team as this varies across the service:
Community Children's nursing team operational policy
Diana Team operational policy
Continuing Care Team operational policy
Epilepsy Nursing Service operational policy
Community Paediatric Dietetics team operational policy.

Further information regards referral forms and process can be found in section 7 (clinical processes).

3.2 Looked after children.
If a child is moved out of borough because they are Looked After, we would transfer their care to the community team in the new borough and discharge from our service once they are registered with a GP in the new borough. Exceptions are children who receive a continuing care package as this package will continue to be funded through Newham CCG and provided by our service. Universal services (supplies) will be provided by the local community team but management of the package remains the responsibility of CCNS continuing care team.

3.3 Child attends a Newham school but lives out of borough.
If a child on our caseload move out of borough but continues to attend a school within Newham, CCNS will continue to provide training and supervision to the school around the medical needs. However if the child receives enteral feeding from a different feeding company to Newham, CCNS can not provide support and training around this. School would be advised to contact the company rep for the feeding company to attend the school to support with training and competence around the pump and feeds.

4. Hours of operation

4.1 Core operating hours:
The service currently operates core hours Monday-Friday 9am – 5pm for service delivery although continuing care packages are provided outside of these core hours to support the families in caring for their child with continuing care needs. Staff will adapt flexibility regards home visits which may be required outside of these core working hours to fit in with the child or young person's routine, for example attending school. Staff will work flexibility to accommodate visits before or after school hours which may require them to work outside the core operational hours. If they are visiting out of hours they are required to sign on and off to the on call manager as per the Trust out of hours and lone worker procedures ***(please refer to procedures on the intranet)***

4.2 Continuing care packages:
The standard hours for children receiving continuing care outside the core operating hours of the service are 0800hrs-1800hrs day time week days, 2200hrs-0800hrs night shift and 0800-1400hrs weekend days. The staff (health care support workers- HCSW) providing care during out of hours are supporting by the On call manager and must sign on at the beginning of their shift and sign off at the end ***(please refer to out of hours and lone worker procedures on the intranet)***

4.3 CCNS lone working
Staff working within CCNS who attend a visit at the beginning or end of the day (instead of attending the office first) must contact the in service on take phone, which is carried by a member of the senior nursing team 24hrs a day, to inform them of their safe arrival or leaving.

All staff within CCNS who lone work within the community is provided with a Trust mobile and Sky guard device. They must take responsibility to ensure their mobile phone and sky guard are charged and fully functioning at all times. Staff must ensure their sky guard device is activated at the beginning of the day and deactivated when they have safely finished work. ***(Please refer to the Trust procedure on Lone working)***

4.4 Contact details
CCNS has a 24hrs telephone/answerphone for the service. This is answered by the admin team during core operating hours and at all other times the answerphone facility can be used. Messages are picked up throughout the core operating hours and transferred to the relevant professional via email and documented on RiO progress notes. Any phone messages left out of hours will be actioned on the next working day.

24hr answerphone for CCNS: 0208 475 8580
Secure team email: elt-tr.CCNSNewham@nhs.net

Fax number CCNS: 0208 475 8591
On call manager pager: 07623546546
In service On Take number: 07956720972.

4.5 Staff sickness:
4.5.1 CCNS Staff must contact the in service on take phone to report their sickness during working hours and the out of hours pager if they are reporting sickness outside of core hours. Staff must update the on take senior nurse with regards to the following and the senior nurse will inform their line manager:

- Nature of sickness
- Length of time likely to be sick
- Date/time when they will update on take with how they are feeling and whether they are fit to return to work.

A return to work interview must be completed before the staff member can resume normal duties of care to ensure they are fully recovered and safe to do so. This must include a discussion regards their Bradford score and next steps identified according to the Trust managing sickness and absence policy ***(please refer to policy on the intranet).***

The on take nurse must arrange (this can be delegated) for all clinical visits to be rebooked or reallocated within the team and ensure the families are informed of the changes.

If staff are due to take annual leave following from sick leave, the on take senior nurse must be contacted to confirm the sickness episode has either ended so annual leave can be taken as planned or sickness episode continues so annual leave is cancelled.

4.5.2 Health care support workers (HCSW):
HCSW must contact the out of hours on call manager as soon as possible to inform them of sickness if this falls out of the core operating hours. During core operating hours, HCSW must inform their line manager (continuing care team leader) of their sickness as follows:

- Nature of sickness
- Length of time likely to be sick
- Date/time when they will update on take with how they are feeling and whether they are fit to return to work.

HCSW must have a return to work interview conducted before they can return to clinical work to ensure they are full recovered and safe to do so. This must include a discussion regards their Bradford score and next steps identified according to the Trust managing sickness and absence policy. If they are contacting the on call manager, this interview may not cover the Bradford score as this information may be unavailable at the time, but this must be completed by the continuing care team leader on the next working day.

The Continuing care team will need to make cover arrangements to cover the HCSW sickness including:

- Identifying whether any staff can work bank to cover the shift and booking them via health roster or
- Contact the agencies to request cover for the shift/s
- Request the booking reference number
- Update the weekly rota and agency spread sheet
- Contact the family to inform them of the changes
- Contact the on call manager to inform them of the changes.

The on call manager must contact the agencies to try and make cover arrangements if the sickness is reported out of core hours and the continuing care team must be copied into all email correspondence for effective communication. The on call manager must also inform the family of

cancellation of shifts if this affects immediate shifts and this must be recorded on the on call records. The on call manager however is not expected to request booking reference numbers or amend rotas as this can be managed by the continuing care team on the next working day.

5. Team meetings

Community Children's nursing service (CCNS):
Weekly service wide meetings take place every Thursday morning from 9am-10am in the office base. The meetings are chaired by either the Community Children's Matron (CCM) or lead psychologist and have a rolling agenda items including:

- Minutes and actions from previous meeting
- PREMS and PROMS
- Datix
- Complaints and compliments
- AOB

Other agenda items are added prior to the meeting, and all staff have the opportunity to add to the agenda, either via email prior to the meeting or during the AOB part of the meeting. The meetings are an opportunity for us to share learning and enhance communication across the disciplines within our service. All agendas and team meeting minutes can be found at ..\CCNS Team Meeting

The last team meeting of the calendar month (after payday) we incorporate a bring and share breakfast element to support team building within the service.

5.1 Caseload meetings:
Individual teams hold caseload team meetings to review and update their caseloads and review RiO together. Please refer to the individual team policies as identified in 3.1 which can be found on the Trust Intranet for further information about frequency and content of caseload meetings.

5.2 Senior management meetings:
Senior management meetings take place monthly and include attendance from the CCM (chair), Lead psychologist (minutes), Lead dietitians and band 7s (nursing) within the service. Minutes are recorded electronically during the meeting and circulated to the senior management team. Agenda varies depending on the needs but will include staffing (management of) and service development.

5.3 Other meetings:

- East London NHS Foundation Trust (ELFT) Nursing development steering group (third Thursday every month attended by CCM/practice development facilitator)
- Children's services (ELFT) Paediatric governance meeting (bimonthly last Wednesday month attended by CCM)
- Psychosocial meeting Newham University Hospital (NUH)/Barts Health (weekly, attended by psychology team)
- Paediatric Shared Care Oncology Unit (POSCU) meetings with Barts Health (NUH- /Royal London Hospital -)
- ChirP
- Child health panel

6. Supervision and leadership

Community Children's Nursing Service (CCNS) adheres to the Trust policy for supervision ***(please refer to trust policy)*** and ensures all staff have access to monthly management supervision which will cover the following topics (this is not an exhaustive list):

- Health and wellbeing
- Annual leave
- Sickness, including Bradford score and sickness history where applicable.
- Training – mandatory and external training
- Caseload review

- Staff management (for staff who line manage only)
- Service development/projects

The service is in process of developing standards for supervision which will also include the following:

- Dip sample record keeping
- Revalidation (nursing only)
- RiO monthly activity and un-outcomed activity.

6.1 Supervision contract:
A supervision contract is completed at the beginning of a new supervisor/supervisee relationship and will be filed within the staff files on the N-drive. The contract is a mutual agreement which the supervisor and supervisee must agree to adhere to.

6.2 Supervisors
Supervisors within the team currently include band 7 and above. Band 6 staff can take on the role of supervisor with support if the need arises as this can provide a good learning and leadership development opportunity which should be incorporated within staffs' annual appraisal objectives. Band 4 Health care support worker (HCSW) can support the team leader for continuing care with telephone supervision of HCSW who are in the community, however the responsibility for ensuring staff receive face to face supervision and all notes are reviewed/discussed lies with the team leader for Continuing care team.

6.3 Clinical and Professional supervision:
The current delivery of clinical supervision for nursing staff is incorporated within their management supervision as the supervisee's supervisor will be a registered nurse. CCNS are in the process of developing a peer reflective model of supervision for band 5 and 6 nursing staff with the support of the psychology team ***(please refer to Diana team operational policy for further information).***

6.4 Documentation/storage records:
All supervision is documented within the supervision meeting, signed and dated by the supervisee and supervisor at the end of the supervision meeting to demonstrate mutual agreement of the content discussed within the supervision session. A copy given to the supervisee either by hand or email for their own reference/storage. A copy will be stored electronically within the individual staff file of the supervisee within CCNS Matron folder/staff files. All supervision dates must be recorded within the CHN Supervision folder ..\..\..\CHN - Supervision before the last day of the calendar month. If supervision did not occur due to sickness or annual leave, this must be reflected within the supervision folder. If supervision is completed by an interim supervisor (due to sickness of original supervisor) the initials of the interim supervisor should be documented with the date in the supervision folder. A temporary supervision contract should also be completed.

6.5 Child protection supervision:
All clinical (working with children and families) registered staff working within CCNS must access 3 monthly child protection supervision and document records in line with the Trust Safeguarding policy ***(please refer to policy on the Trust intranet).***

6.5.1 Health care support workers:
Health care support workers (HCSW) are responsible for reporting any child protection concerns they have to their line manager immediately, or another member of the senior management team in the absence of their line manager. HCSW will not access 3 monthly child protection supervision but must have monthly child protection discussions within their monthly management supervision with their line manager.

6.6 Introduction of new staff:
All new staff working within CCNS will have a local induction programme, enabling them to feel settled within the environment, update themselves with local/trust policies and procedures and to meet key staff members within our service and wider Children's services.

A timetable will be completed prior to the new staff member's start date and will include the following (this list is not exhaustive):

- Orientation to the office base and meet key staff members of the teams
- Time with admin team to ensure IT access is obtained, mobile phone is allocated, personal information form completed and access to follow Qprint is obtained.
- Appointment with Human resources to complete documentation.
- RiO card training and activation
- Laptop training (for registered staff who are lone working and required to use a laptop during their clinical visits).
- Allocation of a mentor/supervisor
- Time to complete on line learning with OLM to ensure all mandatory training is up to date.
- Time to familiarise self with local and trust wide policies.
- Trust induction dates
- A period of shadowing/supernumery time to enable the staff member to feel confident within the new workplace
- Competency training and assessment (nursing and HCSW only)

6.6.1 Nasogastric tube competency

All nursing staff who are actively involved with nasogastric tube care must complete the Trust Enteral feeding workbook and be assessed as competent to pass a nasogastric tube before they are allowed to carry out this skill. ***Please refer to the Trust policy on Enteral feeding (nasogastric) for details of the training and competency based assessment/workbook documents (can be found on the Intranet)***. An electronic spread sheet must be kept identifying the following:

- Nursing staff name
- Date training
- Date completion competency

A copy of the staffs' workbook and competency document must also be stored on the CCNS N-drive for purposes of record keeping and evidence for yearly clinical audit.

6.6.2 Student nurses

The practice development facilitator will facilitate student nurse placements within CCNS liaising with the practice education facilitator (ELFT) and City University link lecturer and allocations team. The PDF will over see the allocation of student nurses to mentors within CCNS and keep this documented within the Student spread sheet to ensure fair allocation/rotation of Mentor's occurs within the service.

All student nurses must be sent a copy of CCNS welcome pack and a welcome email prior to them commencing placement within CCNS, including details of CCNS placement location, dress code, their mentor and co mentor names. They will also have a timetable devised prior to them commencing placement to include the following (not exhaustive):

- Orientation to the office base
- IT access details
- Initial, midpoint and final assessment dates
- Pre booked/agreed visits within CCNS and wider specialities including eczema clinic.

Student nurses must always visit accompanied by a professional in the community setting. For safety they must adhere to the Trust lone worker policy and ensure the team has their personal contact details.

At the end of their placement all student documentation related to the CCNS placement (including Practice Assessment Document, Clinical hour records and evaluation) must be copied, scanned and stored within CCNS N Drive (student folder) as evidence for staff mentor triennial reviews and NMC revalidation. This also supports the student who can access their documentation at a later date should they be unfortunate enough to lose/misplace their Practice Assessment Document and record of clinical hours.

6.6.3 Trainee psychologist
The Diana team offers placements for final year trainee clinical psychologists from the North Thames region Doctorate in Clinical Psychology Training Courses. When there is a trainee on placement with the team, they are employed by Camden and Islington NHS Trust at the Band 6 AfC level and have an honorary contract with East London Foundation Trust for a six month placement working 0.5 wte with the Diana Team. ***Please refer to the Diana team operational policy for further information.***

Clinical Processes

7. Referral

7.1 Generic referral
Community Children's nursing service has a generic referral form (appendix 1 page 25) which is for the following parts of the service:-

- Diana palliative care (play, nursing and psychology)
- Community Children's Nursing team
- Continuing care team
- Epilepsy nursing service

Referrals are accepted by fax (0208 475 8591) or secure email elt-tr.CCNSNewham@nhs.net

Referrals can also be discussed verbally via 0208 475 8580 but must be followed up with a written referral. Only written referrals on CCNS referral form will be accepted and triaged.

If a child requires a continuing care assessment, the CCNS referral form should be completed. Once accepted the continuing care team will send the "children and young people's continuing care pre-assessment checklist" to the referrer for completion before a continuing care assessment is carried out ***(Please refer to Continuing care team operational policy for further information).***

Referrals will be triaged within 1 working day and initial contact made to the family/referrer as follows:
Diana/CCNT/Continuing care team – within 2 working days
Epilepsy service – within 6 weeks.

Referrals received after 4pm will be actioned the following working day.
For further details of individual team's referral criteria and triage please refer to the following:
Community Children's nursing team operational policy
Diana Team operational policy
Continuing Care Team operational policy
Epilepsy Nursing Service operational policy

7.2 Community Paediatric Dietetic team referral.
The community paediatric dietetic team have a specific referral form which includes criteria for referrals and can be found by referring to the ***Community Paediatric Dietetics operational policy.***

7.3 RiO
Once referrals have been accepted and triaged by the appropriate team, admin must admit the child and open the referral on RiO under the specific teams' referral. Initial contact must be recorded within the health care professionals (HCP) diary as first contact either by admin or the HCP themselves. A corresponding progress note must also be written to identify referral has been accepted, triaged and state the plan for first contact. The referral form will be uploaded onto RiO

documents. The admin team must place the initial face to face visit in the relevant daily team planner on RiO. See section 12 for further information about RiO within the service.

7.4 Caseload:
Referrals must be recorded on the CCNS referral spread sheet by the admin team (CCNS Ndrive, caseload folder) and each individual caseload manager must maintain their own caseload spread sheet to manage their own caseloads effectively. Individual caseloads must be reviewed during staff monthly supervision sessions to ensure needs of the service are being met and service users are being seen as their care dictates. This provides the opportunity for reflection, support and guidance to occur.

7.5 Inappropriate/declined referrals.
Referrals received which do not meet the team referral criteria, including residing outside London borough of Newham, must be declined. The referrer must be informed the referral has been declined verbally and a written decline must be sent back to the referrer with the original referral received stating clearly the reasons why the referral has been declined. The referral must not be admitted on RiO (unless a lot of activity is required to be completed before declining) but must be added to the CCNS referral spreadsheet clearly identified as declined. A progress note must also be entered onto the service user's RiO case record. Support and advice can be given to the referrer in terms of onward referral (for example refer to Health visitor (weights), Community team out of borough or GP).

8. Discharge procedures

Discharge from the service may occur in several cases, for example:

- Care complete
- Parent/carer self discharge
- Relocation of service user to another borough
- Relocation of service user to another NHS or non NHS provider
- Transition to adult services
- Service user death

8.1 Care complete:
Where care has been completed, the family must be informed of discharge during the last contact and this must be documented within the RiO progress note. A discharge letter must be completed (using RiO template discharge letter) identifying the following:

- The input provided from the service
- Discharge date/reason for discharge e.g. moved from borough, child death
- Any services the child/young person has been referred to.

The discharge letter must be printed and given to admin team to send copies to relevant professionals and family of the service user. The minimum copies to be sent are Parents, GP and either health visitor or school nurse depending on the child's age. A RiO progress note must be completed by the relevant health care professional (HCP) to confirm the discharge letter has been completed and given to admin, clearly identifying whom the letter is being sent to. Admin must send signed copies to the persons identified by the HCP and upload the discharge letter to RiO documents. Corresponding activity must be clearly documented within the HCP's RiO diary for non face to face activity for reporting purposes.

8.2 Service user/family self-discharge
Where a family self- discharge it must be clearly documented within RiO progress notes by the relevant HCP that parents have chosen to self-discharge and the reasons (if known) for this. If the

HCP identifies the child is being placed at risk by being discharged before treatment/care has been completed, they must discuss their concerns immediately with their line manager and safeguarding advisor to see whether a referral to Triage is required to protect the child (please refer to the Trust safeguarding Policy for further information). The HCP must also contact the GP to inform them of the self-discharge.

8.3 Relocation of the service user (either out of borough or different provider)
If the service user requires relocation either out of borough or to a different NHS/Non NHS provider, the relevant HCP must ensure they have up to date accurate information and complete a referral to the appropriate accepting provider. This must include contacting the relevant provider to verbally inform them of the pending move and requesting their referral form. Liaison must also take place with their acute provider if appropriate.
Referral should include the following information (list not exhaustive):

- Service users new address
- Current GP (as this is likely to still be in London borough of Newham)
- Current needs and requirements from the provider being referred to
- Current equipment and supplies required for the management of care.
- Any child protection concerns
- Professionals involved with the service user and contact details

8.3.1 Equipment and supplies
If the child is moving out of borough and has equipment from Newham Integrated Community Equipment stores (NICEs), for example suction machine which is essential equipment to be with the service user, a plan must be agreed between the HCP, service user/family and NICES prior to transfer. The agreement must be detailed within the RiO progress notes and clearly identify how and when the equipment will be returned.

All other supplies ordered through ELMs/NICES must be stopped by the relevant HCP and must be documented on RiO as action completed.

8.4 Transition to adults.
Please refer to all individual policies regards the transition to adult services for further information as identified within section 3.

8.5 Child death
All HCP must follow the Trust policy on Child death notification for notifying professionals of the child death, including discontinuing all supplies from NICES and external companies for example feeding companies. ***Please refer to the Diana palliative care operational policy and Trust policy on child death notification policy for further information.***

8.6 Discharge from Acute setting to Community Children's Nursing service (CCNS).
Service users who have complex medical needs and are being discharged into CCNS, must have a discharged planning meeting (DPM)organised by the acute setting with at least two days prior notice. Examples of service users who require a DPM are as follows (although not exhaustive):

- Service user has home enteral feeding requirement
- Service user has home oxygen therapy
- Service user has been referred to the palliative care team
- Service user has been referred to the continuing care team

Where parents are expected to continue managing a nursing intervention in the community independently (for example enteral feeding, oral suction or tracheostomy/ventilation care), copies of completed parental competencies must be sent from the acute setting to CCNS. These must be reviewed and uploaded onto RiO. A corresponding RiO progress note must be documented to stated completed competencies have been received, reviewed and uploaded. Any concerns must be identified and an action plan clearly documented within the progress notes.

If competencies are not present/send through, the acute setting must be contacted immediately. In the rare cases the service user has already been discharged and the acute setting can no longer access the records, a visit must be conducted immediately to observe the family carrying out the intervention and community competency completed and uploaded to RiO. All interaction must be clearly documented within RiO progress notes and corresponding activity recorded within the HCP's RiO diary.

8.6.1 Meeting the family at home
For particular service users it will be essential for the HCP from CCNS to meet the service user/family at home on the same day as discharge from the acute setting (for example a child on home oxygen therapy, trachy/ventilated child or a child with palliative care needs). Good clear effective communication must be in place to support this process. Any difficulties encountered must be clearly documented within RiO progress notes. ***Please refer to individual team policies as identified in section 3 for further information and pathways developed with the acute settings.***

8.6.2 Setting up supplies.
The HCP will be responsible for assessing the need for disposable supplies, long term equipment required within the community setting and prescription items to enable the child to be safely managed within the community setting.

8.6.2.1 Disposable supplies:
For example nasogastric tube, enteral syringes, tracheostomy tubes. These are assessed by the HCP and requested via online ordering ELMS. Orders should be calculated on the daily or weekly use and requested on a 4 weekly cycle. Once the order is placed on ELMS, an email must be sent to "Enabled living healthcare" (previously Newham integrated equipment stores – NICEs) to inform them about the order so it can be placed on a delivery to the family.

Examples of frequency: long term NGT – ordered 1 a month plus a spare as reusable
Balloon gastrostomy – one every 3 months
Reusable syringes – calculate daily requirement = monthly cycle as used up to 30times.
Gastrostomy extension sets – 4 per month (weekly changes) even if child attends school.
Tracheostomy tubes – monthly tubes can be sterilised up to three times = one every 3 months plus a spare.

Supplies should be reviewed at least three monthly during face to face visits by the HCP, including recalculation of disposables for daily/weekly use and supplies amended accordingly. Families must not stock pile and must inform the HCP if they have excess. The HCP must then place the supplies on hold and before reordering must recalculate to ensure supplies are reduced to prevent overstocking occurring again.

Supplies must not be collected or delivered by HCP (unless end of life and emergency). This is the responsibility of Enabled living health care or the parents.

8.6.2.2 Equipment
Equipment (for example suction machine/nebulisers) is ordered via ELMS according to client need. This is assessed by the HCP or ordered via the HCP following recommendation from the hospital clinicians. Enabled living health care are responsible for ensuring the equipment is swapped annually for servicing. Parents or Enabled living health care are responsible for delivery and collection not the HCP.

8.6.2.3 Prescription items
If a child requires dressings, tapes or items which are available on a FP10, they must write a request letter to the relevant GP stating the request. The request must be emailed (to GPs nhs.net) or faxed and followed up by a telephone call to ensure the request has been received and seen. The admin team will support the HCP with this process.

The family are responsible for collecting the prescription from the GP and taking it to the pharmacy. If this will be ongoing supplies needed by the family, the request must state “this is required as repeat prescription”.

9. Service-user and carers involvement

During every service user face to face contact, the RiO progress notes must reflect the persons present during the face to face contact and identify a section of discussion and intervention which takes place during the face to face contact. For Dietitians, this is recorded within their clinic record which is uploaded to RiO documents.

9.1 Care planning:
All service users are encouraged to be involved with care planning. Upon admission to Community Children’s Nursing service (CCNS), initial contact must be made with the family to mutually agree the first face to face visit (date, time and venue), where an initial assessment will take place and a plan of care agreed. This will be clearly documented within the RiO progress notes and a corresponding activity entry in the health care professionals (HCP) RiO diary. All evidence of assessments completed must be uploaded onto RiO documents by the team and this documented within the progress notes.

9.2 Permission to share.
All service users will be given the Trust permission to share consent form during initial visits and this explained to them by the visiting HCP. The signed copy must be uploaded to the RiO progress notes.

9.3 Patient Reported Experience Measures (PREMs)
CCNS currently has two PREMS tablets which are taken out for face to face visits to gain service user feedback regards the service. Currently this is a CCNS Quality improvement project and a rota is being tested to allocate the PREMS devices to particular HCP’s on particular days. Feedback from the PREMS influences our “You said, we did” information. PREMS is a rolling agenda item within the CCNS weekly team meetings to ensure effective communication is in place and service user feedback is shared across the service, to support the service in developing accordingly. It is good practice to document within the progress note whether the PREMs has been offered or not during the face to face contact.

9.4 Patient Reported Outcome Measures (PROMs).
CCNs are in the process of developing individual goal based outcome measures which will be specifically set with individual service users during face to face contact. This is being led by the Diana Psychology team.

10. Team documentation

All health care professionals within Community children’s nursing service are provided with a trust laptop to enhance their time management within the community setting. Staff are not expected to carry paper notebooks to record their notes, but are encouraged to use Word documents on the laptop (this can be used and saved on the desk top without the use of Wi-fi) as this has been shown to significantly reduce the time spent writing records.

10.1 Referral forms –
CCNS Appendix 1 (page 25)
Dietetic Appendix 2 (page 27)

10.2 Permission to share form – can be downloaded from Trust Intranet

10.3 Pressure ulcer risk assessment form – can be found Appendix 3 (page 29)

10.4 Pressure ulcer algorithm Appendix 4 (page 32). This was developed as part of an action plan, following a serious incident where a child developed a pressure ulcer. The child had been

assessed using the SSKIN bundle but only equipment had been placed within the child's home and not in the child's school. HCP's within Community children's nursing service must use this as a guidance for prevention and management of pressure ulcers in line with the Trust's pressure ulcer prevention and management guidelines.

10.5 Discharge summary. There is an editable letter within RiO which prepopulates the child's demographic information.

11. Equality and Diversity
All policies adhered to and written by the community children's nursing service will have a completed equality and analysis procedure to ensure equality and diversity.

11.1 Access to interpreting.
Where there is an identified need (either from initial referral form or initial contact/assessment) for the family to have access to interpreting services, this must be requested for all face to face contacts. The HCP must ask the admin team to book the interpreter specifying the date, venue and length/nature of visit. Confirmation of booking must be recorded within the child's progress notes on RiO. When there is no availability for an interpreter (due to short notice visit being required including emergency visit), language line can be used within the home/community setting as an alternative if clinical information is being given during the visit.

Quality and Governance

12. RiO
All clinical staff and admin staff working within community children's nursing service must have access to a working RiO card.

12.1 Opening and closure of patients on RiO
As discussed within sections 7.3 (referrals) and 8 (discharge), the admin team are responsible for opening the referrals on RiO following the triage and acceptance by the health care professional (HCP) within the relevant sub team. Once a patient has been discharged and the discharge summary completed by the relevant HCP, admin team will discharge the patient from RiO once the discharge summary has been sent out.

12.2 Daily team planner
All visits for the nursing teams (CCNT, Diana and Continuing care) must be placed in the daily team planner for the relevant team. The current teams available on daily team planner for use are as follows:

- CCNT long term
- CCNT short team
- CCNS community children's nursing team
- CCNS continuing care specialist
- CCNS Diana team
- CCNS Diana Continence
- CCNS Community nursing team continence

Currently Epilepsy is not using the daily team planner as there is only one nurse so her diary is self-managed.

Individual HCP are responsible for placing visits within the daily team planner in line with the care required from their caseload and following visits which have taken place. Admin team will place an initial visit following a new referral on the daily team planner.

Recurring visits must be set up for children who require regular visits. No more than 6 visits within a recurrence should be set up due to changing needs. The exception to this is children who receive

continuing care packages as their monthly/weekly recurring visits can be placed within the continuing care team planner for longer periods.

Allocation of team planner takes place the day before to ensure all staff are away of their visits and can arrange their diary for the following day. Staff must hand over to the team if a visit has been booked with a specific time and this information must be placed within the comments box on the daily team planner and saved for future reference.

Cancellation of visits/HCP must be completed if the visit has been cancelled, postponed or change of HCP. The reason for the cancellation must be recorded, including lack staff availability, parental cancellation, change or completion of care (not exhaustive).

The daily team planner will identify which activities have not been allocated to a HCP (blue/green) and which activities have not been outcomed (remains brown). Daily team planner must be used within staff supervision sessions to identify gaps in staff performance.

12.3 Contact recordings
All client contact must be recorded within the HCP diary as follows:

- Telephone contact (initial or follow up): outcome either “telephone contact achieved” or “no response”
- Appointment (initial or follow up): outcome must reflect the care given and next stages, for example “attended, see in 3 months”.
- Group contact: more than one person on the visit or telephone conference call.
- Non face to face activity: for emails, letter writing, writing records: outcome must be recorded as “non-face to face activity completed”.

Where possible activity must be placed within the relevant HCP’s diary and the outcome and progress note completed and validated via the outcome function on the HCP diary. It is noted that at times (mainly after core hours) RiO does not allow this function and the progress note is lost. To prevent loss or work, staff can use word to complete their progress note and copy this across into RiO’s progress note. In the instances where outcoming via the diary function is not working, the progress note and outcome must be carried out as separate actions.

Where staff have documented within a client’s progress note there must be a corresponding diary entry within their HCP diary to reflect the activity completed.

12.4 Clinical Document upload:
Once clinical documents have been completed by the health care professional (HCP), the documents are given to the admin team to upload to the child’s RiO documents. It is essential the clinical documents must have the following recorded:

- Child’s full name
- Child’s date of birth
- Child’s NHS number
- Printed name and signature of health care professional
- Date of document.

All clinical documents for community children’s nursing service which are uploaded to RiO, the title recorded on RiO must start with “CCNS” for clear reference and identification.

Once a clinical document has been uploaded to RiO, a corresponding progress note and diary contact must be recorded to reflect the completed activity.

12.5 Progress note recording.
Written notes must be taken at the time of the clinical contact, especially face to face. All health care professionals have been provided with laptops to aid their time management and enable them to complete their written notes on a word document whilst with the client. This is saved and

transferred to RiO progress note (it may require expanding on if only bullet points were recorded at time of visit) once they have access to reliable Wi-Fi and RiO. RiO progress notes must be factual, concise and contemporaneous, following the trust's record keeping standards and professional standards. Notes should be available to view on RiO within five working days of activity being completed. Individual staff must identify with their line manager if they are unable to meet this standard so a review of the individuals work and caseload can be taken to ensure staffs are supported to use the most time effective mechanisms for record keeping. A dip sample of records template is being developed to enable line managers to review individual HCP's records during monthly supervision for support and guidance.

Clinical documents are available for initial assessments, client contacts and wound assessments (not exhaustive list) which are both paper and electronic. When paper documents are completed, these must be given to admin for upload in accordance with section 12.4 above.

13. Incident management

All staff within Community Children's Nursing Service (CCNS) are responsible for reporting clinical incidents and must report them as soon as possible via Datix. All incidents should be reported within 48hrs. Staff must also inform their line manager of the incident immediately for support and guidance.

13.1 Health care support workers (HCSW)
HCSW must contact their line manager immediately to report an incident when it occurs. If the incident occurs out of core operating hours (see section 4), the HCSW must contact the on call manager and request a call back to discuss the incident so appropriate action can be taken and documented. The on call manager must document within the on call manager notes.

13.2 Documentation:
Staff must record any service user incidents within the service user's RiO progress notes detailing the type of incident and action taken as a result of the incident. Details of the completion of Datix must be recorded within RiO progress notes.

13.3 Pressure Ulcers
All pressure ulcers grade 3 and 4 must be reported on Datix ***(please refer to Pressure ulcer prevention and management policy on Trust intranet***). When reporting a pressure ulcer, the incident type must be recorded as follows to ensure it is accurately reported:

*Type Care and treatment
*Category Pressure Ulcer/moisture lesion

13.4 Child death
All child deaths which occur where the child is known within CCNS must be reported on Datix. When reporting a child death it must be recorded as follows to ensure it is accurately reported:

*Type Death
*Category Death of a child

Staff must follow the Trusts policy on child death notification for contacting and liaising with professionals to inform them appropriately and ensure the family are not contacted by mistake ***(please refer to the policy on the intranet for further information).***

13.5 Incident reviews:
The service must respond immediately to requests to completed 48hr reports and partake in investigations for any Serious Incidents (SI). The service must also complete Duty of Candor where harm has been caused as a result of Community Children's Nursing service (CCNS). Pressure ulcers grade 3 and 4 is one area which is subject to Duty of Candor. Community Children's Matron is responsible for completing the Duty of Candor for CCNS.

13.6 Lessons learnt

Datix is a rolling agenda item on the CCNS weekly team meeting to encourage open discussions, reporting of incidents and to share learning across the service.

14. Governance: quality, safety and performance monitoring

14.1 Clinical audit

Clinical audit is carried out to ensure quality and safety is maintained in accordance to Trust and local policies. Community children's nursing service (CCNS) carries out annual audits as follows:

- Enteral (nasogastric tube) feeding Policy
- Adult transition pathway from Community Children's Nursing team (CCNT) to Extended Primary care Trust (EPCT)
- Continuing care audit

Each audit is written up in a report which is shared at the bi monthly Paediatric Clinical governance meetings. The reports are also shared at the weekly CCNS team meetings and action plans followed to ensure all standards are met and adhered to.

At least twice a year the service must also complete High Impact Interventions on the following areas (refer to NICE guidelines infection control):

- Wound care
- Hand hygiene
- Enteral feeding
- Central line care
- Catheter care
- Tracheostomy care

The results must be fed back to the infection control team via the link infection control nurse and learning shared across CCNS.

CCNS also partakes in the Trust Quarterly audit for infection control and record keeping.

The Practice development facilitator will facilitate the audit schedule and ensure all audits are completed on time and action plans implemented, with the support of the Community Children's Matron.

14.2 Complaints

Complaints are a rolling agenda item on the Community Children's Nursing service (CCNS) weekly team meetings to support open communication, honesty, transparency and shared learning across the service.

14.2.1 Formal Complaints.

All staff working within CCNS must ensure they are familiar with the trust's formal complaints procedure and be able to support and inform families of the correct information, should the family identify to staff, they wish to formally complain. Staff will be supported by their line manager and Community Children's Matron throughout a formal investigation procedure.

14.2.2 Informal complaints.

All informal complaints should be reported immediately to the persons' line manager and subsequently Community Children's Matron (CCM, or next senior management in the absence of the CCM) for action and support for the individual within CCNS. The line manager and CCM will act immediately to meet with the family involved and aim to resolve the complaint at a local level to prevent the complaint escalating to a formal complaint. The offer for the family to complain formally must always be offered to the family at the time of meeting. A log of informal complaints should be kept and emailed to the governance team at the end of each month.

14.2.3 Documentation.

Documentation of meetings held with families regards the complaint must be documented as appropriate within the child/families RiO progress notes.

15. References

NB East London NHS Foundation Trust = (ELFT)

- ELFT Community children's nursing team operational policy
- ELFT Diana Team operational policy
- ELFT Continuing Care team operational policy
- ELFT Epilepsy nursing service operational policy
- ELFT Community Paediatric dietetics operational policy
- ELFT (2015) Care planning in Education settings
- ELFT (2014) Pressure ulcer prevention and management – clinical practice guidelines.
- LSCB, London borough of Newham and ELFT (2016). Procedure for notification and dissemination of information regards a child death (up to the age of 18yrs)
- ELFT (2016) Safeguarding children Policy
- ELFT (2016) Enteral feeding policy – Nasogastric tube feeding.
- ELFT (2013) Managing sickness absence policy
- ELFT (2016) Supervision policy.
- ELFT (2016) Out of hours procedure for children, young people and women's services
- ELFT (2016) Lone worker procedure for children, young people and women's services.
- NMC (2015) The Code
- HCPC Health Professions Council Standards of Conduct, Performance and Ethics
- Health Professions Council Standards of Proficiency
- Health Professions Council Standards of Continuing Professional
- British psychology society code of Ethics and conduct.

APPENDIX 1

Newham Children's Community Nursing Service – Referral Form

Which Service do you require? (Please tick)

☐ Children's Community Nursing Team

☐ Epilepsy Nursing

☐ Diana Palliative Care Nursing (Nursing, Psychology and Play Specialist)

☐ Continuing Care

Section A: Details of child

Surname:	Date of birth:	**Female**
Forenames:	Also known as:	NHS No. RiO No.
Address:		Post code:
Ethnicity: Religion: Language:	Parent/Carer name: Relationship to child: Telephone/Mobile:	Parent/Carer name: Relationship to child: Telephone/Mobile:
Interpreter Required Language: English	Weight:	Alerts/Allergies:
Paediatric Consultant:	Base:	Hosp No.
GP:	Address:	GP Tel No.
School/Nursery:	School Nurse/Health Visitor:	Tel No:

Child Safeguarding issues? **CIN / CP Plan / None** *(circle)*	Social Worker Contact:
Have you discussed referral with parents? **Yes / No** *(circle)*	Do they agree to referral? **Yes / No** *(circle)*

Section B: Reason for referral

Diagnosis:
Reason for referral (including previous medical history and details of equipment needed): Discharge letter/ other report attached **Yes / No** *(circle)*

For hospital referrals: Date of hospital admission/attendance:	Planned date of discharge:

Discharge planning **meeting** date: ***CCNS Must have at least 48hr notice of DPM to attend and may require 24- 48 hours' notice to visit family at home for acute patients.***		
IF REFERRAL IS FOR WOUND PLEASE COMPLETE BELOW SECTION, WOUND REFERRALS WILL BE SEEN IN OUR DRESSING CLINIC. WE WILL CONTACT FAMILY/CARERS WITH DETAILS. ***IF NOT PLEASE CONTINUE TO SECTION C***		
Last wound review:	Last Dressing Change:	Dressings supplied: Yes No *(circle)*

Section C: Services involved

Please tick, to your knowledge of other services involved		Dietetics	Speech & Language
Child Development Service	Physiotherapy	Occupational Therapy	Wheelchair Services
CFCS/CAMHS	Social Services	Voluntary Sector / Other	PSHVT
Richard House	Tertiary Consultant Name & Hospital:		
Have Clinical Psychology services been offered to family already from outside the Diana Team? **Yes / No** *(circle)*			

Section D: Details of person making referral

Name:	Job Title:
Base:	Telephone Number:
Email:	Fax Number:
Referral Date	Signed:

Section E: OUR OFFICE USE ONLY

Date referral received:	Team:	Triaged by:
Initial contact date/time:	Contact with:	Named Nurse: Lynn
Associate Nurse:	Planned date for visit:	Long Term Short Term *(circle)*
Priority		

ICES REF no

APPENDIX 2

Community Paediatric Dietetic Team - Referral Form

(Home Enteral Feeds and Special Needs)

Community Children's Nursing Service
The Boleyn Medical Centre
Third Floor, 152 Barking Road
London E6 3BD
Tel: 020 8475 8579 / 8580 Fax: 020 8475 8591

(See page 3 for referral criteria)

Referrer Details

Name of Referrer	
Profession	
Contact No	Tel: _ _ _ _ _ _ _ _ _ _ _ Fax: _ _ _ _ _ _ _ _ _ _ _
Email Address	

Patient Details

Patient Name			
NHS no		Date of Birth	_ _ / _ _ / _ _ _ _
Address			
Postcode		Male/ Female	
Contact no:	Home: _ _ _ _ _ _ _ _ _ _ _ Mobile: _ _ _ _ _ _ _ _ _ _ _		
Parents Email Address:			
Ethnicity		Consent for referral	Yes No
Language		Interpreter required?	Yes No

GP Details

GP Name	
Address	
Postcode	
Contact No	Tel: _ _ _ _ _ _ _ _ _ _ _ Fax: _ _ _ _ _ _ _ _ _ _ _

Medical Information

Diagnosis	
Medical History	

Medication	

Other Health Professionals involved: Consultant, Nurse, SLT, Physio, OT, HV etc…

Reason for Referral.

Anthropometry On The Date Of Referral.

Weight (kg)		Height (cm)		BMI (kg/m^2)	
Centile		Centile		Centile	
Growth History					

Oral Intake and/ or Enteral Feeding Regimen As Appropriate

Please include details of the types and amounts of foods, fluids and oral supplements consumed. Please include any advice given on textures, volumes, thickeners, pacing and foods to be avoided

Additional Information

Is a home visit required (see page 4 - home visit criteria):	Yes No
If a home visit is required, please state the reason:	
If a home visit is required are there any known safety concerns for staff:	Yes No
If there are safety concerns please provide further information:	
Are there any social issue? If yes please provide further information and the social workers details if applicable.	

Print Name:……..……

Date:……..……..……..……

Signature:……

APPENDIX 3

Pressure Ulcer Risk & SSKIN BUNDLE Assessment Form

Date:	**Completed by:**

Patient's Name:	**NHS No**:

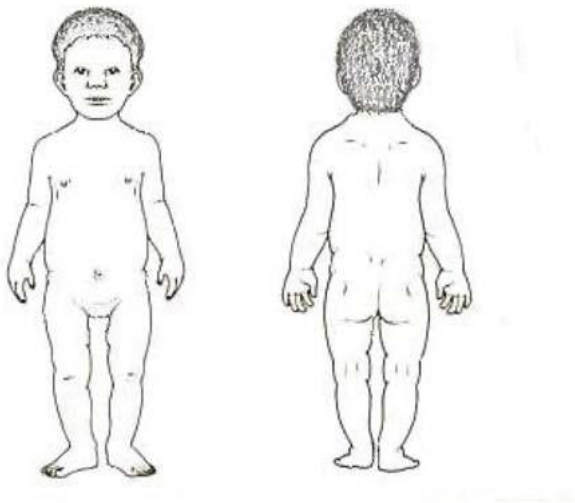
Assessment: Braden Score								
Pressure Ulcer Risk Level	No Risk		At Risk		High Risk		Very High Risk	
Comment:								

SSKIN BUNDLE ASSESSMENT

SURFACE

Equipment in place	Equipment ordered

SKIN INSPECTION



List signs of skin damage & pressure ulcer (s) grade

KEEP MOVING

Mobility / Repositioning Issues	Repositioning regime / Mobility aids

CONTINENCE

Passing Urine and opening Bowels Issues
Products

NUTRITION

Nutritional issues:

Pressure ulcer prevention information leaflet given	Date	Signature:

Next Review Date:		

BRAIDEN SCORE:

Notes for use:

- Look at the categories. Go across and read the acuity of illness statements in each box. Match the score to the statement that reflects your patient's current condition. Total the scores for the five categories and your patient will then have a 'at risk' score.
- Scores of 10 or less indicate your patient is at risk of developing a pressure ulcer. You will need to implement the nursing interventions that can be found overleaf.

Risk factor	Score 1	Score 2	Score 3	Score 4
Mobility	**Completely immobile** – does not make changes in body or extremity position without assistance. Patient cannot physiologically tolerate position changes.	**Very limited –** Makes occasional slight changes in body or extremity position but unable to turn self independently.	**Slightly limited** – Makes frequent changes in body or extremity position independently.	**No limitations** – Makes major changes in position without assistance.
Activity	**Bed bound** – Confined to bed.	**Chair bound** – Ability to walk is severely limited or non-existent. Cannot bear own weight. Needs help to get into chair or wheelchair.	**Walks occasionally** – Walks occasionally for short distances with or without help. Spends majority of the time in bed or chair.	**Patients too young to walk or patient walks frequently** – Walks frequently.
Sensory perception	**Completely limited** – Unresponsive to painful stimuli due to altered GCS or sedation. Inability to feel pain over most of body surface.	**Very limited** – Responds to painful stimuli. Cannot communicate discomfort verbally or has sensory impairment, limiting ability to feel pain over half of body.	**Slightly limited** – Responds to verbal commands but cannot always communicate discomfort. Has sensory impairment, limiting ability to feel pain or discomfort in 1 or 2 extremities.	**No impairment** – Responds to verbal commands. Has no sensory deficit that limits ability to feel or communicate pain or discomfort.
Moisture	**Constantly moist** – Skin is kept moist almost constantly, by perspiration, urine, drainage etc. Dampness is detected every time child is moved. Linen, nappy/pad or dressing changes are constant.	**Very moist** – Skin is often but not always moist. Linen, nappy/pad or dressing changes every 2 to 4 hours.	**Occasionally moist** – Skin is occasionally moist. Nappy/pad changes as routine. Dressing/linen changed up to 3 times per day.	**Rarely moist** – Continent. Dressing changes as routine. Linen changed as parent wishes.
Tissue perfusion	**Extremely compromised** – Hypotensive or on inotrope support. Requires mechanical ventilation. Cannot physiologically tolerate position changes.	**Compromised** – Normotensive. Oxygen saturation of <95%. Haemoglobin may be <10mg/dl. Capillary refill may be >2 seconds. Serum pH is <7.35.	**Adequate** – Normotensive. Oxygen saturation of <95%. Haemoglobin may be <10mg/dl. Capillary refill may be <2 seconds. Serum pH is normal.	**Ideal** – Normotensive. Oxygen saturation normal. Normal haemoglobin level. Capillary refill <2 seconds. Normal serum pH.

SSKIN Bundle – Preventing Pressure ulcers

Surface	**S**	• Static foam / alternating pressure relieving mattress • Mattress calibrated to correct weight of patient if required • Pressure relieving cushion • Wheelchair / cushion • Repose boot / pillow / Aderma dermal pad • Patient education on use of equipment
Skin Inspection	**S**	✓ Skin assessment ✓ Pressure ulcer graded and reported and referred as per guidelines ✓ Wound size recorded at initial assessment and re-measured every 4 weeks ✓ Care plan in place to guide treatment and preventive interventions ✓ Teach carers / family ✓ Complete the Shared Care Approach to Pressure Ulcer Prevention SSKIN Bundle Guidelines with carer (s) / family
Keep Moving	**K**	○ Regular repositioning using 30 degree tilt ○ Repositioning schedule regime in care plan ○ Check carers are following the repositioning schedule ○ Does the patient understand the need for repositioning
Incontinence/ Moisture	**I**	✚ Continence assessment / management ✚ Catheter ✚ Bowels

		✚ Incontinent pads ✚ Barrier cream ✚ General skin care
Nutrition	**N**	❖ Nutritional assessment ❖ BMI or Estimation of BMI category from mid upper arm circumference ❖ Eating & drinking ❖ Nutritional supplements / thickened fluid ❖ Speech and Language Therapist / Dietician

APPENDIX 4

Pressure ulcer prevention flowchart

Child admitted to Community children's nursing team (CCNT) or Diana Team

Initial assessment documentation is completed (on first visit) including:
Risk assessment and Braden Score

Child "At Risk"of developing pressure ulcer – **Braden score 10 or less**

Child "No Risk" - Braden score above 10

Implement SSKIN bundle prevention care plan.
Discuss shared care (SC) with parents or carers. Complete SC document (copy at home upload copy to RIO).
Consider all community settings child accesses (ie school).

When condition or home circumstances change reassess Braden Score and skin assessment.
Follow pathway depending on score.

Ensure parents are aware of how to contact community nurse if they have concerns regards their child's skin.

When carrying out visit ensure the following are reassessed:

- SSKIN bundle care plan and Braden Score
- Complete new Skin assessment and record
- Readjust care plan as required depending on assessment

If Pressure ulcer is identified please follow Pressure Ulcer Management flowchart

APPENDIX 4

Pressure Ulcer Management Flowchart

1st Contact Pressure Ulcer identified

↓

Complete Skin assessment and Braden Score
Grade Pressure Ulcer
Implement SSKIN bundle treatment care plan

↙ ↓ ↘

Grade 1 Pressure Ulcer
Continue to follow Pressure ulcer prevention flowchart

Grade 2 Pressure Ulcer
Report via Datix
Dress wound appropriately
Refer to Tissue Viability Nurses (TVN) if no improvement after 1 week.

Grade 3 or 4 Pressure Ulcer

Report via Datix

Dress wound appropriately

Refer to TVN immediately

Raise Safeguarding Alert (significant harm, whether intentional or not)

Visit frequency depends on wound

Complete wound assessment every visit

Document as follows on RIO:

- Wound measurement, length, width and depth
- Description of wound
- Dressing applied (right time)
- Frequency of visits required
- Assessment following the SSKIN bundle treatment care plan