University Hospitals of Leicester NHS
NHS Trust

# Nurse Criteria Led Discharge

## Childrens CMG

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|---|---|
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| **Board Director Lead:** | Chief Nurse |
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## CONTENTS



## REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Review February 2024 (R Foster

- Title change from Nurse led discharge, to Nurse criteria led discharge
- Added reference to discharge pathways being added to NerveCentre
- Added reference to UHL Trust Criteria Led Discharge Policy

## KEY WORDS

Day Care, Nurse Led Discharge, Criteria Led Discharge

## 1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the Trust policy for Nurse Criteria Led Discharge within the Children's CMG. The aim of this policy is to give directives for the implementation of Nurse Criteria Led Discharge and standards for training, documentation, audit and evaluation.

1.2 Safe and efficient discharge from hospital improves the patient experience, raises standards of care and helps to reduce waiting times for treatment by increasing capacity (The NHS Constitution, March 2013).

1.3 Discharge is one of the 10 Key Roles for nurses defined by the Chief Nursing Officer in The NHS Plan, 2000. Nurse led discharge is a process that involves nurses assessing the patient, liaising with the multi-disciplinary team and planning timely discharge based on an agreed clinical management plan (Lees, 2006).

1.4 The aim of this policy is to give directives for Nurse Criteria Led Discharge of paediatric patients who have undergone day care treatment under local or general anaesthetic, or who have been admitted with Gastroenteritis, Bronchiolitis or Viral Induced Wheeze.

## 2 POLICY SCOPE

2.1 This policy applies to Paediatric patients who have undergone day care treatment or have been admitted with Gastroenteritis, Bronchiolitis or Viral Induced Wheeze.

2.2 This policy applies to paediatric patients

2.3 Day Care incorporates discharge within 24 hours of admission.

2.4 This policy applies to all Registered Nurses (Child) working within the Children's Clinical Management Group who are involved in the discharge of children.

## 3 DEFINITIONS AND ABBREVIATIONS

None

## 4 ROLES

### 4.1 Lead Nurse & Clinical Director

a) To support the implementation of nurse criteria led discharge within the CMG and monitor it's compliance

### 4.2 Ward Sister / Charge Nurse

a) To identify registered Nurses who can facilitate nurse criteria led discharge according to the individual Pathways.

b) To ensure staff are familiar with the process and documentation

c) To attend and support the CMG training to perform criteria led discharge

d) To keep accurate records of nurses authorised to undertake criteria led discharge within their clinical area

e) To undertake audit to monitor effectiveness of the nurse criteria led discharge process and compliance with the policy and report progress to the CMG Nursing Board.

### 4.3 Consultants and Medical teams

Medical responsibilities include:

a) Document suitability for nurse criteria led discharge in the patient medical records

b) Complete discharge letter (ICE) in a timely manner.

c) Forward ICE letter electronically to pharmacy to avoid delays in take home medicines

d) Review patients deemed suitable for criteria led discharge where concerns are raised by nursing staff.

### 4.4 Nurses

Nursing responsibilities include:

a) All nurses authorised to undertake nurse criteria led discharge must be a Registered Children's Nurse with relevant experience (assessed prior to undertaking training)

b) Have attended the CMG nurse criteria led discharge training

c) Have completed supervised practice and be deemed competent to undertake nurse criteria led discharge independently

d) Have a working knowledge of discharge policies and procedures

e) Have up to date knowledge or Safeguarding children through CMG annual mandatory training

f) Be approved and supported to take on this role within their clinical area by their line manager

g) Accept accountability for their practice

h) Accurately complete discharge documentation in the patient's medical records

i) If the discharge criteria is not met, the nurse must inform the appropriate medical team.

**j) If the nurse has any doubt about the safety of the discharge, the nurse must not discharge without seeking further medical advice.**

### 4.5 Supervisor / Assessor

To be able to assess the knowledge and competence of others in nurse led discharge, a supervisor must:

a) Work in the clinical area at Band 6 or above, or be a member of the CMG education team

b) Be confident and competent in nurse led discharge

c) Have knowledge of the relevant policies and procedures

d) Registered as an LCAT assessor

## 5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

This policy is supported by the following appendices which details the procedures that must be used in conjunction with this policy:

**Appendix 1:** Criteria for Nurse Criteria Led Discharge following GA

**Appendix 2:** Flowchart for Nurse Criteria Led Discharge process

**Appendix 3:** Minimum post-op time required prior to discharge

**Appendix 4:** Medical pathways for Nurse Criteria Led Discharge please note these will be added to Nerve Centre

## 6 EDUCATION AND TRAINING REQUIREMENTS

6.1 The experience and knowledge of nurses preparing for the extended role of nurse criteria led discharge must be assessed. The assessment can be undertaken by an approved supervisor (see section 4.5)

6.2 The nurse must attend the CMG training which will cover issues relating to discharge planning, accountability, responsibilities, case studies and relevant documentation.

6.3 In order to be authorised as competent to undertake this extended role, the nurse must be supervised for 3 Nurse Criteria Led Discharges and complete an LCAT assessment with an approved supervisor.

6.4 To maintain competence, the nurse must successfully complete 1 LCAT assessment in Nurse Criteria Led Discharge prior to annual PADR.

## 7 PROCESS FOR MONITORING COMPLIANCE

7.1 Audits will be carried out by the Matron and Ward Sister to assess on going effectiveness.

7.2 The impact of Nurse Criteria Led Discharge can be monitored by auditing:

I. The numbers of children discharged by the process compared with total number of day case discharges

II. The pattern of discharge by time of day and day of the week

7.3 Other means of exploring the impact of Nurse Criteria Led Discharge could include admission rate of patients discharged by this method, the impact on delayed discharges and through patient satisfaction including complaints and incident reporting.

## 8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

## 9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

The NHS Constitution, DoH 2013

The NHS Plan, DoH 2000

Lees, L (2006) Emergency Care Briefing Paper: Modernising discharge from hospital. National Electronic Library for Health

Gabalski, Mattucci, Setzen and Moleski (1996) Ambulatory Tonsillectomy and Adenoidectomy. Laryngoscope. 106 (1 Pt 1) 77 – 80

Getting It Right First Time (GIRST) Paediatric Surgery Review report 2017. NHS Improvement.

## 10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

10.2 This Policy will be reviewed every three years or sooner in response to clinical or risk issues. This may also be updated sooner to reflect new processes or acknowledge and add new pathways as appendices.

10.3 Please note and adhere to the following new corporate/ Trust wide policy B21/2013: uhl-tr.nhs.uk Criteria Led Discharge Policy.pdf

## POLICY MONITORING TABLE

The following table lists the monitoring arrangements for this policy:

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements |
|---|---|---|---|---|
| Discharge times | Matron / Ward Sister | Audit | Quarterly (and prior to introducing nurse led discharge | Children's Nursing Board |
| Patient experience of discharge | Matron / Ward Sister | Patient experience survey / complaints / incidents | Monthly | Children's Nursing Board |

# Criteria for Nurse Criteria Led Discharge following GA

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NHS Trust

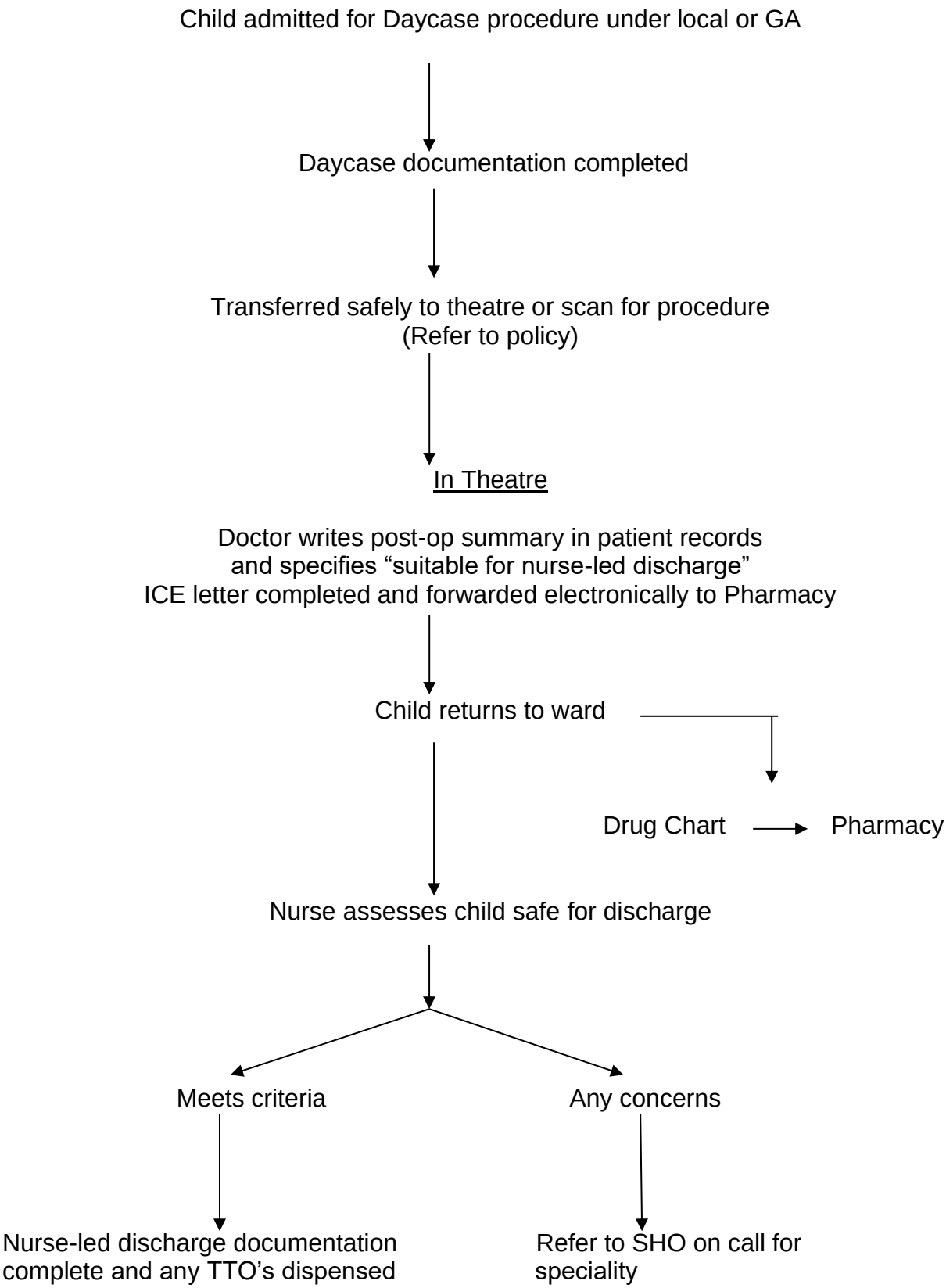
**Appendix One**

**NB. Medical staff must document suitable for Nurse Led Discharge in patient's medical records**

| Criteria | Yes | No | N/A | Comments |
|---|---|---|---|---|
| Child is over 6 months old?<br>If no, check post gestational age and only discharge within 24 hours if over 52 weeks and documented safe for discharge by medical staff | | | | |
| Child has reached minimum post-op time required for surgical procedure? | | | | |
| Child is awake and orientated? | | | | |
| Child can walk steadily (in relation to their pre-op ability) | | | | |
| Child demonstrates no evidence of bleeding? | | | | |
| Observation of pulse, resps and temp are within normal limits? | | | | |
| Child has tolerated a small drink and light food | | | | |
| IVI / sub-cut. cannula removed | | | | |
| Child is able to mobilise comfortably within expected range? | | | | |
| Parents / carer agree to take child home? | | | | |
| Appropriate transport is available? | | | | |
| Advice leaflet given? | | | | |
| TTO's provided and use explained? | | | | |
| Given copy of discharge (ICE) letter? | | | | |
| Follow up appointment arranged? | | | | |

**Additional criteria for children who require overnight stay for history of sleep apnoea:**

| | | | | |
|---|---|---|---|---|
| Oxygen saturations above 92% post-op<br>(unless stated otherwise by surgeon or anaesthetist) | | | | |
| No requirement for oxygen post-op | | | | |
| No evidence of respiratory distress | | | | |
| No other concerns about breathing | | | | |



## ENT patients

**NB Child must be over 6 months old**

The following minimum post-op times apply to ENT day case surgery and includes children with a history of sleep apnoea who will require overnight stay.

| **Procedure** | **Minimum post-op time** |
|---|---|
| Grommets | 2 hours |
| Adenoidectomy / adenoidectomy & grommets | 4 hours |
| Tonsillectomy / Tonsillectomy & adenoidectomy / Tonsillectomy, adenoidectomy & grommets | 4 hours |
| Removal of foreign body from ear or nose | 2 hours |
| Tongue tie | 2 hours |
| Minor lump/cyst | 2 hours |
| Submucous diathermy | 4 hours |

**NB** All times are calculated from the time the child returns to the ward.

### Overnight stay

Any child who requires an overnight stay for observation following day case surgery may be discharged the following morning without medical review if:

- The doctor has documented suitable for nurse led discharge in the medical records
- The nurse is confident no concerns have been raised overnight and the child meets the discharge criteria

**For children who require overnight stay for history of sleep apnoea:**
The nurse who has been caring for the child overnight should assess whether the child is safe for nurse led discharge if they have met the following criteria:

- Oxygen saturations above 92% post-op (unless stated otherwise by surgeon or anaesthetist)
- No requirement for oxygen post-op
- No evidence of respiratory distress
- No other concerns about breathing

**Any concerns, refer to relevant doctor for review**

## General surgical patients

The following minimum post-op times apply to general surgery day cases. The list below is not exhaustive therefore if the surgeon writes “suitable for nurse led discharge” in the post op notes and the nurse is confident that the post op criteria is met, the patient can be discharged without medical review.

If a child has a **caudal block** they should stay until the block has worn off (3-4 hours) to ensure they are comfortable with oral analgesia (particularly for groin surgery where the procedure is bilateral). Rectal sheath or penile block may be discharged with minimum post-op times below.

**For all procedures listed below, minimum post op time is 2 hours**

**NB Child must be over 6 months old**

| **Procedure** |
|---|
| Abscess incision & drainage |
| Anal dilatation |
| Circumcision |
| Cystoscopy |
| Cysts & lumps |
| Examination under anaesthetic (EUA) |
| Hernia repair (inguinal, umbilical, epigastric, supraumbilical) |
| Hypospadias – will need additional time post-op for parents’ education. |
| Laparoscopy for undecended testis |
| Meatal dilation |
| Meatoplasty |
| Nail bed repair / removal of nail / wedge excision |
| Orchidectomy (single or bilateral) |
| Orchidopexy (single or bilateral) |
| Peg to button change |
| PPV ligation |
| Tongue tie division |

**NB** All times are calculated from the time the child returns to the ward.

### Overnight stay

Any child who requires an overnight stay for observation following day case surgery may be discharged the following morning without medical review if:

- The doctor has documented suitable for nurse led discharge in the medical records
- The nurse is confident no concerns have been raised overnight and the child meets the discharge criteria

**Any concerns, refer to relevant doctor for review**

## Orthopaedic Patients

**NB Child must be over 6 months old**

**Elective orthopaedic procedures:**

| Procedure | Minimum post op time | Orthopaedic criteria |
|---|---|---|
| Hallux Valgus (Bunions)<br>(Mitchell's Osteotomy, Chevron Procedure) | 2 hours (one foot)<br>4 hours (two feet) | Mobilizing<br>Pain controlled<br>Cast/dressing safe & comfortable<br>Wire ends are secure |
| Flexor Tenotomy | 2 hours | Mobilizing<br>Pain controlled<br>Dressing intact |
| TA lengthening<br>(Percutaneous Tenotomy) | 2 hours | Mobilizing as post-op instructions<br>Pain controlled<br>Cast safe &comfortable |
| Botox | 1 hour | Cast safe and comfortable if no cast follow up for serial casting requested |
| Change of Spica | 2 hours | Trimmed/Padded<br>Safe and comfortable |
| Arthrogram/Arthroscopy | 2 hours | Mobilizing safely |
| In-growing Toenail procedures<br>(Zadeks, Nail Avulsion, Wedge Resection) | 2 hours | Mobilizing<br>Dressing intact<br>Instructions re dressing change |
| Trigger Thumb | 2 hours | Dressing intact<br>Instructions re dressing change |
| Osteochrondroma | 2 hours | Dressing intact<br>Instructions re dressing change |
| Excision of cyst/ganglion/ etc. | 2 hours | Dressing intact<br>Instructions re dressing change |
| Removal of Foreign body | 1 hour | Dressing intact<br>Instructions re dressing change |

**Trauma orthopaedic procedures:**

| Procedure | Minimum post op time | Orthopaedic criteria |
|---|---|---|
| MUA radius and ulna (closed reduction) | 4 hours | Neurovascular status within safe limits.<br>Swelling within an acceptable range.<br>Pain controlled.<br>Cast safe & comfortable |
| MUA tibia and fibula (closed reduction) | 4 hours | Neurovascular status within safe limits.<br>Swelling within an acceptable range.<br>Mobilizing according to post op instruction.<br>Physio sign off safe discharge<br>Cast safe & comfortable |
| Open reduction and internal fixation (ORIF) with K wires (elbow, wrist & fingers) | 4 hours | Neurovascular status with in safe limits.<br>Swelling within an acceptable range.<br>Pain controlled.<br>Exposed wire ends secure<br>Cast safe & comfortable |
| Repair of lacerations to limbs, hands and feet | 2 hours | Neurovascular status with in safe limits.<br>Swelling within an acceptable range.<br>Pain controlled.<br>Dressing intact & secure. |

**Orthopaedic patients general discharge:**

- All Patients must have documented instruction from operating surgeon that patient suitable for Nurse Led Discharge.
- A clear post op plan documented in notes and discussed and understood with patient and parents.
- Neurovascular status within safe/normal limits.
- Patient seen by Physio/OT signed off safe to discharge.
- Plaster cast trimmed/ padded, safe and comfortable.
- Advice leaflets and contact numbers provided.
- Dressing change arranged if necessary, clean dressing provided.

Criteria Led Discharge

Name: PATIENT

S Number: LABEL

DOB:

# Viral Gastroenteritis

This pathway is intended for patients admitted with viral gastroenteritis to the children's hospital who can be considered for criteria led discharge.

## Inclusion Criteria

- Children with a confirmed diagnosis of viral gastroenteritis

## Exclusion Criteria

- Children with any chronic medical condition or any suspected differential diagnosis
- Infants < 3 months of age
- Children who have been discharged from CICU or HDU within the past 24 hours.
- Children who do not meet all discharge criteria.

## Discharge Criteria

- ☐ Documented child is suitable for criteria led discharge in the medical notes by medical team
- ☐ Discharge letter pre-empted & submitted to pharmacy / authorised if out of hours
- ☐ Medication ordered if applicable
- ☐ Nurse in charge aware
- ☐ Vomiting / Diarrhoea is improving and able to tolerate some oral fluids / diet
- ☐ Appropriate / normal urine output
- ☐ No red flag symptoms
- ☐ Parent/Carer aware that child is candidate for criteria led discharge and informally consents
- ☐ Information leaflet provided to Parent/Carer
- ☐ Parent/Carer aware of Red Flag Symptoms and is confident to assess and manage at home
- ☐ Discharge letter +/- medication explained to Parent/Carer

**Criteria led discharge**
Date:
Time:

**Discharging Nurse**
Print:
Sign:

## Red Flag Symptom and Information to be Given to Parent/Carer

- Appears unwell or deteriorating
- Increasing vomiting / diarrhoea
- Tachycardia
- Tachypnoea
- Unable to tolerate fluids
- Reduced urine output
- Pale or mottled skin
- Sunken eyes
- Exhaustion, lethargy or irritability
- Pyrexia

## Key points

- Most children with gastroenteritis can be safely managed at home, with advice and support from a healthcare professional if necessary
- Diarrhoea usually lasts for 5–7 days, and in most children it stops within 2 weeks
- Vomiting usually lasts for 1–2 days, and in most children it stops within 3 days.

Criteria Led Discharge

Name: PATIENT
S Number: LABEL
DOB:

# Bronchiolitis

This pathway is intended for patients admitted with bronchiolitis to the children's hospital who can be considered for criteria led discharge.

## Inclusion Criteria

- Infants with a confirmed diagnosis of Bronchiolitis and positive NPA
- Infants with suspected Bronchiolitis and negative result on NPA

## Exclusion Criteria

- Infants who have any other confirmed diagnosis
- Infants unable to maintain oxygen saturations ≥90% in air if under 6 weeks **OR** >92% in air if over 6 weeks of age.
- Infants who have been discharged from CICU or HDU within the past 24 hours.

## Discharge Criteria

- ☐ Documented child is suitable for criteria led discharge in the medical notes by medical team
- ☐ Discharge letter has been completed
- ☐ Medication ordered if applicable
- ☐ Nurse in charge aware
- ☐ Oxygen saturations maintained (as per guidance above) for 6 hours awake AND asleep
- ☐ Tolerating adequate amount of oral fluid (2 x good breast/bottle feeds **OR** appropriate diet/fluids)
- ☐ Parent/Carer aware that Infant is candidate for nurse led discharge and informally consents
- ☐ Information leaflet provided to Parent/Carer
- ☐ Parent/Carer aware of Red Flag Symptoms and is confident to assess and manage
- ☐ Discharge letter +/- medication explained to Parent/Carer

**Criteria led discharge**
Date:
Time:

**Discharging Nurse**
Print:
Sign:

## Red Flag Symptoms and Information to be given to Parent/Carer

- Worsening work of breathing (e.g. chest recession, nasal flaring, grunting, tachypnoea)
- Further Reduced oral intake
- No wet nappies for 12 hours
- Apnoea or cyanosis
- Exhaustion or lethargy

## Key points

- Bear in mind that if you are discharging on day 1-3 of the condition this child may get worse before they get better.
- Parents/Carers should be advised that smoking (either in or outside of the home) will likely increase the severity or duration of the illness.
- Cough post-bronchiolitis is commonly seen to persist for days, if not weeks.

Leicester Children's Hospital

**Criteria Led Discharge**

# Viral Induced Wheeze

Name: PATIENT

S Number: LABEL

DOB:

This pathway is intended for patients admitted with viral induced wheeze to the children's hospital who can be considered for criteria led discharge.

## Inclusion Criteria

- Confirmed diagnosis of viral induced wheeze

## Exclusion Criteria

- Children who have any chronic medical condition or any suspected differential diagnosis
- Children unable to maintain oxygen saturations >92% in air
- Children who have been discharged from CICU or HDU within the past 24 hours.
- Children who do not meet all discharge criteria.

## Discharge Criteria

- ☐ Documented child is suitable for criteria led discharge in the medical notes by medical team
- ☐ Discharge letter pre-empted & submitted to pharmacy / authorised if out of hours
- ☐ Medication ordered
- ☐ Nurse in charge aware
- ☐ Oxygen saturations maintained >92% in air for more than 3 hours awake AND asleep
- ☐ Child tolerating 6-10 puffs salbutamol every 3-4 hours with no respiratory compromise
- ☐ Inhaler technique assessed and appropriate
- ☐ Tolerating near normal oral intake
- ☐ Parent/Carer aware that Child is candidate for criteria led discharge and informally consents
- ☐ Information leaflet provided to Parent/Carer
- ☐ Parent/Carer aware of Red Flag Symptoms and is confident to assess and manage
- ☐ Discharge letter and medication explained to Parent/Carer - including salbutamol weaning plan

**Criteria led discharge**
Date:
Time:

**Discharging Nurse**
Print:
Sign:

## Red Flag Symptoms and Information to be given to Parent/Carer

- Worsening work of breathing (e.g. chest recession, nasal flaring, grunting, tachypnoea)
- Not tolerating salbutamol weaning plan
- Needing increasing puffs of salbutamol
- Needing increasing frequency of salbutamol
- Reduced oral intake / urine output
- Apnoea or cyanosis
- Exhaustion or lethargy

## Key points

- Parents/Carers should be advised that smoking (either in or outside of the home) will likely increase the severity or duration of the illness.
- Spacer should always be used to administer inhaler for effective administration