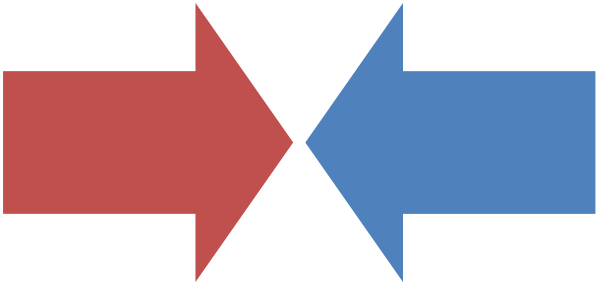
Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

PAEDIATRICS	NATIONAL CLINICAL PROGRAMME FOR PAEDIATRICS & NEONATOLOGY AND NATIONAL CLINICAL PROGRAMME FOR EMERGENCY MEDICINE	EMERGENCY MEDICINE

FRAMEWORK FOR PAEDIATRIC URGENT AND AMBULATORY CARE CENTRES



National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care

FACULTY OF PAEDIATRICS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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Definitions and Acronyms

In the context of this document, the following definitions apply:

'Emergency' care involves life-saving and limb-saving treatment, the provision of timely pain relief and the psychological care of patients and their families. It is available all of the time and is delivered by an emergency medicine team of clinical and support staff.

'Urgent' care is for the diagnosis and treatment of injuries or illnesses requiring medical review in a dedicated facility but not serious enough to require emergency department attendance or inpatient admission.

'Ambulatory' care refers to paediatric healthcare services provided on a scheduled outpatient, day care or rapid access basis, including diagnosis, observation, treatment and rehabilitation services.

'Short Stay Observation Unit' refers to units which contribute to a reduction in inpatient admissions by allowing intensive short-term assessment, observation and/or therapy.

CDGP	Constitutional Delay in Growth and Puberty
ED	Emergency Department
GP	General Practitioner
NAS	National Ambulance Service
NHS	National Health Service
RCN	Registered Children's Nurse
SSOU	Short Stay Observation Unit

Introduction

The National Clinical Programmes for Paediatrics & Neonatology and Emergency Medicine both advocate the development of appropriately located, configured and rationalised services for acutely unwell or injured children. This vision emphasises the delivery of safe and appropriate care as close to home as possible. Urgent and ambulatory care centres are a key component of the wider model of care for paediatrics, complementing the services available in primary care and preventing admissions to an acute hospital setting. The development plan for the new children's hospital, to be built on a campus shared with St. James's Hospital, envisages two urgent and ambulatory care centres (located in Tallaght and Blanchardstown) that will implement this framework of care and serve as a framework for future planning of paediatric services nationally. Development of any urgent or ambulatory centre needs to be directly linked to and governed by a fully functioning and resourced parent hospital with a lead consultant paediatrician with a special interest in Paediatric Urgent or Ambulatory Care or a Consultant in Emergency medicine with a special interest in paediatric emergency medicine, a lead nurse manager, and a business or operations manager assigned to the centre. This documented is intended to complement the model of care for Paediatric Emergency Medicine.

In 2013, Professor Keith Willett and Sir Bruce Keogh produced a report for the National Health Service (NHS) titled *Transforming Urgent and Emergency Care Services in England*. This report espoused a relatively simple vision of providing responsive, effective and personalised services outside of hospital for those with urgent but non-life threatening needs. These services were intended to minimise disruption and inconvenience to children and their families as well as relieving pressure on hospital-based emergency services. Five key features were described as needed to support this change:

1. Provision of better support with self-care;
2. Helping people with urgent care needs to get the right advice in the right place, first time;
3. Provision of highly responsive urgent care services so that people do not have to wait in emergency departments;
4. Ensuring that those with more serious or life-threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and optimal recovery;
5. Configure urgent and emergency care services so that the overall system becomes more than just a sum of its parts.

Most urgent care problems are not life threatening and these children and their families need help, advice and treatment as close to home as possible. Parents, families and the wider public want to know that if a problem arises with their child they can access a service that will ensure the right care is given at the time that they need it. Currently, more than 85% of children attending paediatric emergency departments in Dublin are discharged home. Once these children have been assessed, the child may require investigations or observation, receive advice or interventions or the parents may require reassurance alone. Many of these children can be seen close to home provided that the services available are convenient,

accessible and safe and provide access to the appropriate healthcare professionals. There must be absolute clarity about the services provided at urgent and ambulatory care centres, supported by effective communication strategies so that children and families can be directed to the appropriate setting to treat their problem.

Key Considerations in the Delivery of Urgent and Ambulatory Care to Children and Young People

Paediatric urgent and emergency care is different to adult urgent and emergency care. The key differences are well described in the joint statement by the Royal College of General Practitioners; the Royal College of Nursing; the Royal College of Paediatrics and Child Health and the Royal College of Emergency Medicine entitled *Right Care, Right Place, First Time* (2011):

- The frequency of emergency consultations is relatively high in the 0-4 age group;
- Parents perceive a far greater urgency when their child is sick;
- Ambulance calls are unusual and very sick children are likely to be brought to the emergency department by their parents;
- 0-2 year olds represent a vulnerable group in terms of difficulty of diagnosis and propensity to decompensate rapidly;
- Telephone triage in children is difficult as symptoms are often vague and face-to-face consultation may therefore be required;
- The clinical expertise resides within the two specialties of General Paediatrics and Paediatric Emergency Medicine;
- Short stay paediatric assessment / observation units have a key role in the provision of high quality care for children;
- Children are strongly affected by the context in which they live and usually the most important element of this context is the family.

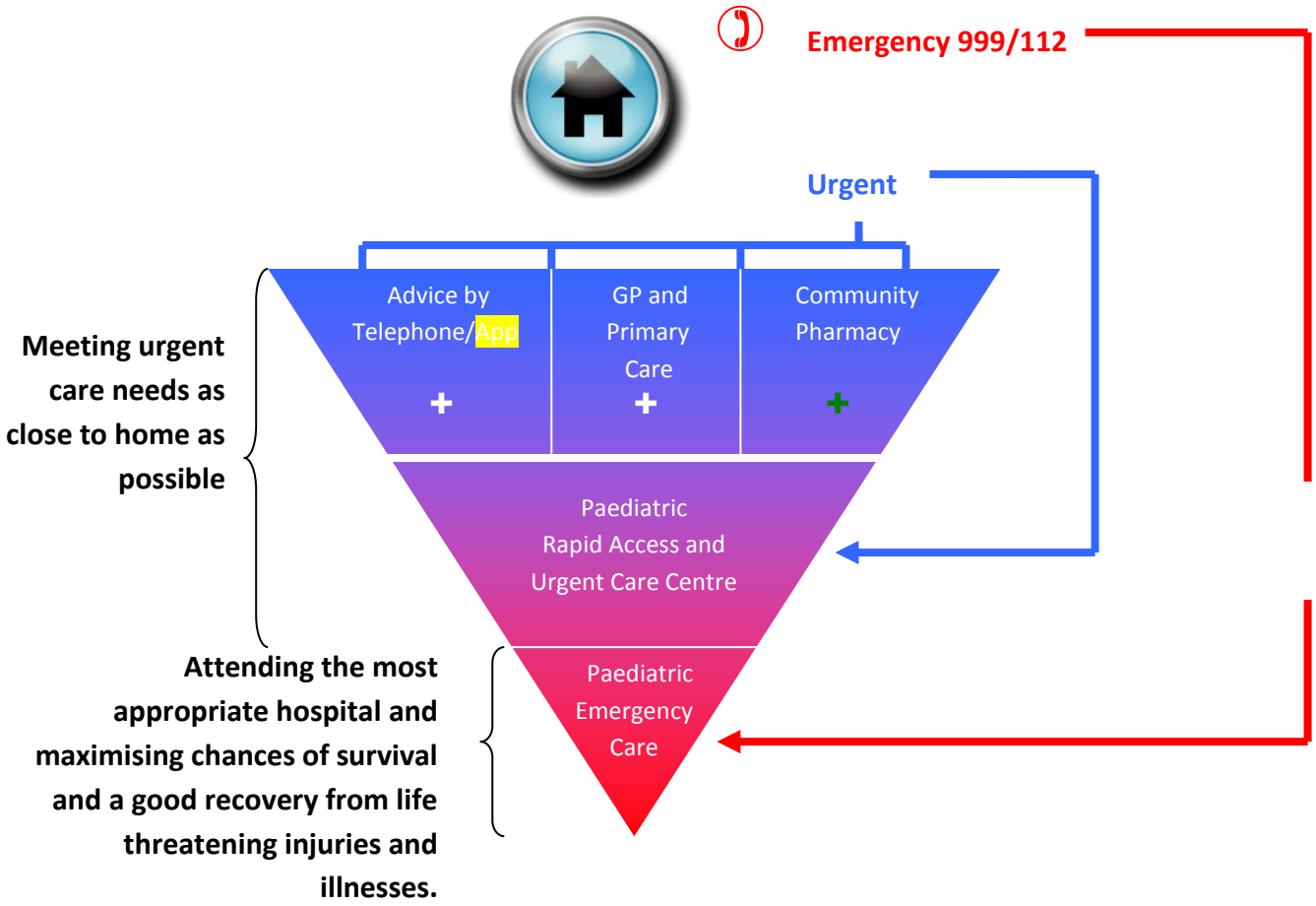
Governance

This framework of care for paediatric urgent and ambulatory care centres serves to complement the national models of care for Paediatrics and Neonatology and for Emergency Medicine. Good governance of urgent and ambulatory care centres will ensure that all children who attend receive a consistently high quality service. Each urgent and ambulatory care centre should be linked to, and governed by, a parent hospital with a lead consultant paediatrician with a special interest in Paediatric Urgent Care/ Emergency Medicine or a consultant in emergency medicine with a special interest in paediatric emergency medicine, a lead nurse manager, and a business or operations manager assigned to the centre. Paediatric consultant led care is recommended. National clinical standards and integrated care pathways should be developed and implemented. Each centre must monitor performance against the standards set and key performance metrics detailed above, review

regularly and focus on continuous quality improvement. Staff working in urgent and ambulatory care centres should be clear on their roles, responsibilities and reporting relationships. It is recommended that clinical staff rotate between the urgent and ambulatory care centre and the parent hospital in order to maintain clinical skills.

The ultimate accountability for urgent and ambulatory centres will rest with the chief executive officer within their respective hospital group.

Proposed Model of Care



Framework of Care Principles

This framework of care is based on the principles set out in the report by Willett and Keogh (2013) for the NHS *Transforming Urgent and Emergency Care Services in England:*

1: PROVIDE BETTER SUPPORT FOR CHILDREN AND FAMILIES TO SELF-CARE WITH ACCESSIBLE INFORMATION ABOUT TREATMENT OPTIONS

Service user engagement at the planning stage is paramount. Families, general practitioners (GPs) and local primary care services should be fully aware of what services are available at urgent and ambulatory care centres. There should be an intense engagement process with both the public and healthcare professionals in primary care to clearly explain the role of urgent and ambulatory care centres and how they can support self-care and make information available on treatment options. In addition, information about service choices should be provided on hospital websites and via smart phone / tablet applications and social media, as well as through GP surgeries, primary care centres, maternity units, community services and pharmacies.

2: ENSURE THAT CHILDREN WITH MORE SERIOUS OR LIFE THREATENING ILLNESS IN NEED OF PAEDIATRIC EMERGENCY CARE RECEIVE TREATMENT IN AN EMERGENCY DEPARTMENT WITH THE APPROPRIATE FACILITIES AND EXPERTISE TO MAXIMISE CHANCES OF SURVIVAL AND A GOOD RECOVERY.

All paediatric emergency departments will have the ability to assess and treat all patients and provide a full range of specialist services for children that urgently need them. Implicit in this is the availability of senior decision makers seven days a week, backed up by the full range of subspecialists required to cover all clinical eventualities including major trauma care. Children transported by emergency ambulance will receive treatment in an Emergency Department.

There are currently three paediatric emergency departments in Dublin that will transition to one paediatric emergency department in the new children's hospital. Regionally there are 16 Emergency Departments with direct access to on-site Paediatric medical expertise. In regional and local paediatric hospitals outside of Dublin, there should be medical and nursing staff with experience in managing paediatric care as part of the staff complement in every acute care setting that children attend. Each hospital requires physical and visual separation in their waiting and treatment/assessment areas for adults and children presenting to their ED. Some children may require transfer to the tertiary paediatric hospitals in Dublin (and ultimately the new children's hospital) in order to access paediatric subspecialist or trauma services. Clear written procedures should be in place for the stabilisation and transfer of the critically ill child. This should be coordinated by the Paediatric Transport Service where possible.

3: PROVIDE RESPONSIVE URGENT CARE SERVICES SO THAT CHILDREN CAN ACCESS SERVICES LOCALLY

Urgent and ambulatory care centres should provide:

- Walk-in minor injury and illness services;
- Rapid access and routine general paediatric outpatient clinics.

These services should be linked to the wider community and primary care services including GP out-of-hours services.

Urgent and ambulatory care centres are not the appropriate place to attend with a critically ill child. Notwithstanding this, any child who attends with an emergent problem should be managed by skilled staff who will stabilise the child and arrange for safe transfer to an appropriate paediatric inpatient setting in accordance with the national model of care for paediatrics.

Urgent and ambulatory care centres will have clearly defined services and be supported by radiology (plain x-rays and ultrasound) and laboratory (urine microscopy and acute bloods, point of care testing) services. Direct referral from primary care should be available and rapid access general paediatric outpatient clinics should take place at an appropriate frequency, which may be locally determined.

Mental Health Provision in Urgent and Ambulatory Care Centres

No acute mental health services will be provided to children in the Urgent and Ambulatory Care Centres. Children requiring an urgent mental health assessment or intervention should not be directed or referred to Urgent and Ambulatory Care Centre. Notwithstanding this, a child may attend for acute care in the context of a medical illness who requires a mental health assessment or intervention. A clear pathway of care for children requiring referral to the mental health services must be identified and available to staff. This pathway must address the child who needs admission, urgent or routine care in the context of local services available.

4: HELP CHILDREN AND FAMILIES WITH URGENT CARE NEEDS ACCESS APPROPRIATE CARE AND TREATMENT CLOSE TO HOME – THE RIGHT ADVICE IN THE RIGHT SETTING, FIRST TIME

General practitioners (GPs), parents and families should be aware of the services available at urgent and ambulatory care centres, and when it is appropriate to attend. This framework for the provision of urgent and ambulatory care services will include targeted care for injuries and minor illness, short stay observation units, rapid access general paediatric outpatient care, scheduled general paediatric outpatient services and selected specialist paediatric

outpatient clinics such as fracture clinics, developmental clinics and chronic disease management clinics.

Case mix for Urgent and Ambulatory Care Centres

Each urgent and ambulatory care centre must clearly identify the case mix for their service, this will be determined by the resources available locally. See Appendix 1 for a suggested casemix.

Short Stay Observation Units (SSOUs)

Short stay observation units are part of the proposed national model of general paediatric care services in Ireland, and should be considered in all urgent and ambulatory care centres. These units help to prevent inpatient admissions by allowing intensive short-term assessment, observation and/or therapy. This model of early treatment and discharge reduces the average length of stay, and subsequent cost of inpatient care. It also serves to increase parent satisfaction. Operating models for SSOU's must be described, designed around local need

http://www.hse.ie/eng/services/publications/Clinical-Strategy-and-Programmes/Paediatric-Emergency-Medicine.pdf

Outpatient Paediatric Services

Scheduled outpatient services will include rapid access general paediatric clinics as well as selected specialist clinics. Children should be seen in a rapid access clinic within 14 days of referral from their GP. All other routine general paediatric outpatient referrals should be managed chronologically in line with national hospital access policies. Rapid access clinics are essential to ensure that children who need to be seen quickly by a consultant paediatrician are appropriately fast-tracked, thereby avoiding referral by their GP to the urgent care centre or emergency department. Scheduled general paediatric outpatient clinics should be the first point of access for non-urgent or non-emergency cases. Nurse-led or therapy-led clinics may also have a role with clinical nurse specialists, advanced nurse practitioners and health and social care professionals delivering appropriate follow up, treatment and education of children and families in the outpatient setting.

5: CONFIGURE ALL PAEDIATRIC SERVICES TOGETHER SO THAT THE OVERALL SYSTEM BECOMES MORE THAN JUST THE SUM OF ITS PARTS

Emergency care networks must be integrated with high quality, responsive paediatric retrieval and critical care services. There must also be formal integration of the community and hospital components of paediatric general paediatrics, urgent, ambulatory and

emergency care with free flow of information and expertise between the various settings. Standardised national clinical guidelines and referral pathways, underpinned by the required information and communications technology, are essential. Networks of care within, and between, the hospital groups should be established.

Evaluation Metrics and Performance Indicators

There must be appropriate monitoring and evaluation of the services provided by urgent and ambulatory care centres by the business and operations management team. Suggested structure and process metrics that could be introduced include:

- Attendances by age and triage category, using Irish Children's Triage System;
- Wait times for triage and medical review;
- Number of patients transferred to higher level of care from the urgent care centre;
- Time to transfer to higher level of care;
- Number of patients who leave before completion of treatment;
- Number of SSOU attendances, types of conditions observed and duration of attendance;
- Number of hours beyond scheduled opening hours that an urgent care centre remained open;
- Number of rapid access general paediatric referrals received;
- Wait times for new rapid access appointments;
- Number, and type, of telephone consultations;
- Number of general paediatric outpatient referrals received;
- Wait time for new general paediatric outpatient appointments
- New to return ratio in general paediatric outpatient clinics;
- Number of clinics scheduled, and number of available new and return appointments, for comparison of demand and capacity;
- Rates of non-attendance.
- Patients seeking care/with care need that are outside the scope/criteria of the Urgent Care Centre

The collection of relevant clinical indicators and outcome measures in line with national and local quality and safety principles is essential.

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Appendix One

Suggested Case Mix for Urgent and Ambulatory Care Centre

Urgent and Unscheduled Care	– *Conditions requiring opinion from Paediatric Consultant with a special interest in Emergency Medicine or Consultant Paediatrician Emergency Medicine* – *Conditions that might require short periods of observation without hospital admission* Acute asthma (mild or moderate) Abdominal pain (mild or moderate except RLQ / suspected appendicitis Accidental ingestion requiring observation only Allergic reaction (except anaphylaxis) Bell's palsy Bites and stings Bronchiolitis* Chest pain (mild or moderate) Conjunctivitis Dehydration Dental pain (no trauma) Dermatitis / eczema Ear infections / ear pain Epistaxis Fever* Foreign bodies in ear or skin Gastroenteritis Headache and migraine (GCS 15 and no neurological signs) Henoch-Schonlein purpura Limp and suspected irritable hip Lymphadenopathy Rashes and skin conditions (except non-blanching rashes Respiratory tract infection / pneumonia* Skin infections (except abscess) Sprains Subungual haematoma Suspected nasal fracture Swallowed foreign body Syncope Tonsillitis Urinary tract infection Viral-induced wheeze Viral croup * age > 12 weeks
Minor Injuries	Minor head **injuries*** , minor lacerations, sprains, minor undisplaced fractures, minor scalds or burns

Rapid Access General Paediatric Outpatient Care	Assessment of failure to thrive Recurrent abdominal pain Chronic constipation Frequent episodic or persistent asthma Follow up investigations for urinary tract infection Investigation of haematuria Primary and secondary nocturnal enuresis Diurnal enuresis Assessment of chronic headaches Assessment of suspected seizures Assessment of syncope / non-specific chest pain Post-viral fatigue: assessment and management Adolescent health issues Management of mild to moderate eczema Assessment of suspected food allergies with a rational approach to investigations Behavioural or sleep issues in toddlers Assessment of short stature / CDGP / familial short stature Medical assessment of developmental issues