Re-designing Community Children’s Nursing to Alleviate the Pressure on Acute Care

COAST
Children’s Outreach Assessment and Support Team

Nicky Packham  Team Leader
Lindsay Harrison  CCN
with thanks to
KELLY OWENS  Clinical lead / APNP
OBJECTIVES

• Background and aims of the COAST service
• COAST as part of a systems approach
• An acute community children’s team - how does it differ?
• The COAST model and referral pathway
• Challenges and some solutions
• Activity and admission avoidance data
• The future
BACKGROUND

- Unplanned paediatric hospital admission rates rising
- Zero length of stay increasing
- Mortality and morbidity from infectious childhood illness have declined
- Changes in population and health seeking behaviour of carers
- Currently 40% of GP’s completing training with minimal paediatric experience
- Reductions in working hours of junior hospital doctors has resulted in less experienced staff in the frontline of emergency care.
- ALL RESULTING IN INCREASED PRESSURE ON SECONDARY CARE.
SYSTEMS APPROACH TO REDUCING PAEDIATRIC ADMISSIONS

Admission avoidance schemes – Fareham & Gosport CCG & South East Hampshire CCG

Children's Outreach, Assessment and Support Team (COAST)

Admission Avoidance Service - South East CCG and Fareham & Gosport CCG, Portsmouth City and Southampton City

Evidence that COAST is having a direct impact reducing CAU admissions compared to CCG’s without COAST

Health Hub (Vanguard Project)

Health Hub Alliance of GP practices Acute/same day appointment

Paediatric arm Children seen and managed by APNP
Integrated Model
Paediatric
Unscheduled
Care

Commissioning Intentions 2015/2016 to commission a fully integrated model based around Paeds ED

All stake holders signed up
Action plan in place

Consultant
Telephone Advice
Line (CTAL) &
Rapid Access
Clinics

Admission Avoidance-telephone line run by paediatricians within PHT. Allowing Primary Care to talk with a paediatrician rather than send direct to CAU

Monitored monthly to review numbers of calls received and outcomes/admissions avoided

24 Hour Opening
Paediatric ED

Future plans to moving forward the integrated service.

Working with Paediatric ED at PHT to develop a model for 24 hour opening. This will include the redesign of clinical space to develop an Observation/CAU area adjacent to ED.
AIMS OF SERVICE

• To provide a same day, high quality nursing assessment for acutely ill children in the community setting.
• Prevent unnecessary hospital admissions/attendances
• Facilitate safe and early discharge of children from hospital
• Provide support and education to families, empowering self management and encouraging appropriate use of health care professionals.
• Develop relationships with Portsmouth City GP’s, HANTS GP’s and Southampton City GP’s and the acute trust.
SOLENT NHS TRUST
Geography covered by COAST
<table>
<thead>
<tr>
<th>Features of service</th>
<th>COAST, Solent NHS trust (COAST East)</th>
<th>Commissioned by NHS Portsmouth</th>
<th>Commissioned by NHS Hampshire, F &amp; G and South East</th>
<th>Commissioned by NHS Southampton</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Early discharge referrals from CAU and inpatient wards</strong></td>
<td><strong>Hospital Avoidance</strong> Referrals from ED, GP, OOH GP’s</td>
<td><strong>Hospital avoidance</strong> Referrals from ED, GP, OOH GP’s.</td>
<td><strong>Early Discharge referrals from PAU</strong></td>
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<tr>
<td></td>
<td><strong>Hospital Avoidance</strong> Referrals from ED, GP, OOH GP’s</td>
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<td></td>
<td><strong>Hospital Avoidance Referrals from ED, GP’s, OOH GP’s, WIC</strong></td>
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<tr>
<td></td>
<td><strong>Children's Community Respiratory Nurse</strong></td>
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<td><strong>Children’s Community Respiratory Nurse</strong></td>
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**WHAT IS OUR USP?**

**Traditional CCN Teams**
- Care packages
- Elements ‘task driven’
- Long and short term
- Underlying chronic health needs
- Specialist knowledge
- Palliative care/end of life
- Primarily within normal working hours

**COAST**
- Acute assessment skills/decision making
- Risk assessment
- Short term
- Usually ‘well’ with acute episode of illness
- Immediate/responsive
- Out of hours
COAST

Service Hours

COAST East  Mon - Fri   08.00 - 22.00  
Sat/Sun/BH   09.00 – 18.00  

COAST West  Mon – Fri  10.00 – 20.00 
Sat/Sun/BH   09.30 – 17.30

Taking referrals from GP’s / OOH / CAU PAU / WIC / ED

Referral Process

Nurse makes telephone contact with family within 2 hours 
Advice / Visit / Clinic appointment given 
Keep for 48-72 hrs

Referral condition

Protocols for 10 common childhood illnesses 
Chronic Asthma management
## COAST – THE MODEL

<table>
<thead>
<tr>
<th>CHILDREN’S</th>
<th>OUTREACH</th>
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<tbody>
<tr>
<td></td>
<td>Secondary care acute assessment skills in community setting</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
<td>Risk Assessment/decision making</td>
</tr>
<tr>
<td>SUPPORT</td>
<td>GP’s – Decision making ????</td>
</tr>
<tr>
<td></td>
<td>Feedback from team</td>
</tr>
<tr>
<td></td>
<td>GP trainees working with team</td>
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<tr>
<td></td>
<td>Family – empowerment and education</td>
</tr>
<tr>
<td></td>
<td>Secondary care – hospital avoidance and early discharge</td>
</tr>
<tr>
<td>TEAM</td>
<td>As a collective – extensive/paediatric knowledge/skills</td>
</tr>
</tbody>
</table>
Referral Received

COAST completes telephone assessment within 2 hours

Nurse/Parent not happy with child

Visit

Assess child using protocol

Stay at home and maintain contact
OR
Stay at home and plan next visit
OR
Assessment on CAU/PAU/ED

Admit

COAST Follow up

Nurse/Parent happy with child

No Visit

Maintain phone contact with family

If any concerns, visit

Discharge when improved
# COAST Protocols

Please refer to user guide before using this protocol.

## COAST

### Generic Assessment

<table>
<thead>
<tr>
<th>COAST</th>
<th>White</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
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</thead>
</table>
| **Respiratory** | - No respiratory compromise  
- Coryzal  
- Intermittent cough  
- No green/amber/red respiratory features | - Mild recession with no other amber/red respiratory features  
- Wheeze but inhalers effective  
- Mild tachypnoea  
- No amber/red respiratory features | - Moderate recession  
- Nasal flaring  
- Tracheal tug with moderate recession  
- Inspiratory stridor intermittent/when upset  
- Grunting – likely fever related  
- Tachypnoea:  
  - RR > 50 breaths/minute age 6–12 months  
  - RR > 40 breaths/minute age > 12 months  
  - Oxygen saturation ≤ 95% - 92%  
  - Crackles  
  - Reduced air entry  
  - No red respiratory features | - Severe recession  
- Head bobbing  
- Stridor at rest/bi-phasic stridor  
- Grunting – not fever related  
- Tachypnoea:  
  - RR > 60 breaths/minute  
  - Oxygen saturations < 92%  
  - History of or white nessed apnoeas  
- Silent chest  
- Not lasting 4 hours between inhalers  
- Too breathless to feed (infants)  
- Unable to talk in sentences  
- Agitated |
| **Cardiovascular** | - No cardiovascular compromise  
- No green/amber/red cardiovascular features | - Normal colour of skin, lips and tongue  
- Mild tachycardia (likely associated with fever and/or being upset)  
- Cap refill ≤2 secs  
- No amber/red cardiovascular Features | - Pallor observed by nurse  
- Tachycardia  
- Capillary refill 3 -4 seconds  
- Peripherally cool  
- Mottled (without temperature)  
- No red cardiovascular features | - Mottled/ashen/blue  
- Capillary refill > 4 seconds  
- Tachycardia without fever or other known reason  
- Thread pulse/poor pulse volume |

* Sign that requires 999

July 2012
<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Green</th>
<th>Amber</th>
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</thead>
</table>
| **Hydration**        | Well hydrated:  
- Normal skin/eyes  
- Eating and drinking normal amounts | Mild dehydration:  
- Active and alert  
- Warm extremities  
- Drinking half normal volumes  
- Nappies wet/passing reasonable volume of urine  
- **No amber/red hydration features** | Mild-Moderate dehydration:  
- Dry mucous membrane  
- Poor feeding in infants/reduced intake in children  
- Reduced urine output  
- Slightly sunken fontanelle in infants  
- **No red hydration features** | Moderate-severe dehydration:  
- Looks sick  
- Vomiting all fluids/not tolerating/refusing/too tired  
- No urine output for 12 hours  
- Eyes sunken  
- Reduced skin turgor  
- Significantly sunken fontanelle  
- Deteriorating |
| **Activity/Behaviour** | No parental or nurse concerns about activity/behaviour | Responds normally to social cues  
- Content/smiles  
- Stays awake or awakens quickly  
- Strong normal cry/not crying  
- Intermittently miserable  
- **No amber/red activity or behaviour features** | Not responding normally to social cues  
- Wakes only with prolonged stimulation but appropriate when awake  
- Decreased activity  
- Prolonged periods of sleep | Decreased level of consciousness *  
- No response to social cues  
- Appears ill to nurse  
- Unable to rouse or if roused does not stay awake *  
- Weak, high-pitched or continuous cry |

* Sign that requires 999

July 2012
<table>
<thead>
<tr>
<th>Other.</th>
<th>Social circumstances</th>
<th>Lower threshold for referral to CAU in following: Prematurity &lt; 35 weeks Underlying cardiac disease Underlying lung disease &lt; 3 months old New safeguarding concerns</th>
<th>Looks TOXIC* Bulging fontanelle Disorientated. Symptoms not improving/deteriorating. Parents feel child needs to attend CAU and reluctant to stay at home despite reassurance Pain difficult to control Swollen limbs/joints Temperature ≥ 38° C Age 0-3 months Temperature ≥ 39° C Age 3-6 months Non-blanching rash with no history of mechanical cause Neck stiffness Status epilepticus* Focal neurological signs Focal seizures* Bile-stained vomiting History of/witnessed abnormal movements.</th>
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<tr>
<td>✅Parents confident with management at home. ✅Nurse satisfied that parents/carers able to monitor/manage condition at home ✅No green/amber/red 'other' features</td>
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</table>

This list of ‘other’ features is not exhaustive. Therefore any other signs/symptoms that the nurse is concerned about should be documented and considered when making a decision.
**Decision Making Guide**

To be used in conjunction with COAST generic protocols.

<table>
<thead>
<tr>
<th>All white boxes OR All green boxes OR Combination of green and white boxes NO amber or red boxes</th>
<th>Liaise with parents re: further contact/visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 amber boxes NO red boxes</td>
<td>Arrange telephone contact and consider follow-up visit</td>
</tr>
<tr>
<td>More than 2 amber boxes NO red boxes</td>
<td>Book follow-up visit. Consider review by GP/CAU</td>
</tr>
<tr>
<td>1 or more red boxes</td>
<td>Consider:</td>
</tr>
<tr>
<td></td>
<td>• Review by GP</td>
</tr>
<tr>
<td></td>
<td>• Prompt assessment on CAU</td>
</tr>
<tr>
<td></td>
<td>• 999</td>
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<tr>
<td></td>
<td><strong>If clinical sign has an asterix (*) 999 is mandatory</strong></td>
</tr>
</tbody>
</table>

The generic protocol and decision making guide is NOT a substitute for professional clinical judgement and as such the clinical judgement of the practitioner should override this decision making guide.
If these children *would have* been in hospital - how can their safety be assured?

How do we engage GP/primary care?

Can we really make a difference?

What outcomes should we be measuring?

Are we creating a new layer of work?

Does COAST prevent GP’s from managing risk?

Neighbouring commissioners commissioning different aspects of the service – *postcode lottery*!

Working with commissioners
• Evidence based assessment protocols (audited 2012)
• Patient Information Leaflets
• CCN service and acute trust governance groups
• Strong relationship with paediatric department in acute trust
• Case based discussion group/ supervision
• Monitoring of individual nurses referrals to secondary care
• Education/competencies – *spotting the sick child, history taking and physical assessment module*
• APNP/Clinical Lead has clinical supervision with paediatric consultant
• Monitoring of feedback / clinical incidents
Any hospital avoidance schemes MUST have the engagement and support of GP’s/primary care
Identify a ‘consortia’ of key GP’s
Practice meetings
GP education events / Target Meetings / Genscan
CCG publications
Face to face contact
Emails are NOT the answer!
## NUMBER OF REFERRALS TO COAST & AVOIDED ADMISSIONS

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<td>Portsmouth City</td>
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<tr>
<td>and F&amp;G) COAST</td>
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<td>115</td>
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<td>710</td>
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<td>194</td>
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<td><strong>Total Number of avoided admissions</strong></td>
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<td></td>
<td></td>
<td><strong>6736</strong></td>
</tr>
</tbody>
</table>
OVERALL REFERRAL TO COAST EAST

Managed by COAST 93.7% (1293)

COAST Nurse referral to CAU 6.3% (87)

April 2014 – March 2015 = 1380 patients

OUTCOME OF THE CAU REFERRAL

Discharged 18.5% (16)

Admitted 54% (47)

Treated and discharged 27.5% (24)

April 2014 – March 2015 = 87 patients
COAST & CAU Monthly Activity
SCW CSU BI & Analytics | report 1867 | data source: directly from COAST, SUS PbR IP with supporting information from PHT
The Future

- Commissioned by neighbouring CCG’s
- Rebalancing of the ‘numbers’ – greater proportion of appropriate referrals to COAST
- Continual monitoring of data and outcomes
- Improved/on-going engagement with GP’s
- COAST staff development
- Paediatric Children’s Respiratory/ Asthma Nurse for Hampshire
- COAST entering a new chapter
“The COAST team provides an excellent level of care and support to babies and young children at home with acute illness. We found this service to be both innovative and responsive to meet the needs of the local population.”

Care Quality Commission
(March 2014)
THANKYOU & ANY QUESTIONS

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