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## **Document Control**

Title of document:	Multi Agency Protocol for Children who present to the Children Emergency Department (CED) at Bristol Royal Hospital for Children (BRHC) who are medically fit but there is an unclear pathway for safe discharge
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## **Principles**

- Agencies in Bristol work to the shared principle that the use of an acute hospital bed is not appropriate placement for a child or young person who does not require physical medical intervention.
- Agencies in Bristol commit to working together to enable a timely solution for the child by identifying an appropriate safe discharge destination and facilitating a safe discharge.
- As far as possible, agencies will attempt to avoid duplication in assessments and will coordinate resources to ensure a timely initial response, particularly if an incidence takes place out of hours.
- Bristol agencies recognise the importance of early involvement by Senior Management to ensure that
  resources and response are coordinated across complex services and to nominate a single point of
  contact known in this protocol as the Lead Case Manager for the agency.
- Where there is professional disagreement about the pathway required to meet a child's needs or the findings of an assessment, all agencies will take steps to resolve this in a timely and constructive way using the local escalation policy if required.

## Overview

BRHC is not an agreed place of safety however there are times particularly out of hours when children and young people cannot be discharged safely as either their current place of residence is not suitable and/or there is no alternative place of residence for the young person to be discharged to. Often this situation also involves an assessment of the child or young person by the CAMHS service. Children who have experienced trauma, abuse and neglect may present at hospital with dysregulated, risk taking or self-injuring behaviours. For these children there can be professional disagreement about whether a mental health or safeguarding response is required to meet their needs. Often, even if the child does not have a mental health diagnosis, mental health services input or support is required to enable safe discharge and risk associated with the behaviour to be reduced. It is imperative that high-quality decisions are made by the agencies around children to ensure that children are not in acute hospital beds unnecessarily. This requires collaborative partnership working and multi-agency assessment which recognises competing pressures but ensures that the child's needs and safety is paramount.

Therefore if a child or young people presents to BRHC who is medically fit but there is an unclear pathway for safe discharge, all agencies recognise this as a situation requiring a multi-agency response and commit to work together in line with the following protocol.

**Multi-agency Protocol** 

Child presents to CED who are medically fit but concerns by individual or family/carer of escalating behaviours which means there is an unclear pathway for safe discharge

Booked into CED and triaged by CED nurse using the mental health risk assessment matrix as well as exploring social circumstances/parental responsibility and if known to social services (CED Nurse reviews Connecting Care and CPIS). CED Nurse to record outcome using the matrix and follow the mental health pathway if indicated.

If required Doctor undertakes an assessment

Doctor/Nurse in Charge contact relevant social care team (EDT out of hours) and CAMHS team to gather any relevant further information about the family. Once confirmed patient does not have any physical medical needs but is unable to be discharged home, Doctor/Nurse in Charge asks the relevant social care team to support with a plan to discharge safely

If no options for a safe discharge, Clinical Site Manager (CSM)/Duty team, Nurse in Charge and most senior doctor in the CED/registrar for acute take at this time (+/- support from on-call Consultant if OOH) review the current state of the hospital including the number of patients in the CED, beds in The Observatory and the hospital and impact of admitting including the risk of the patient on themselves and others. CSM should consider options to mitigate any risk including using a safe cubicle, 1 to 1 support/security input, be clear to staff to call police if concerned about safety using the 'assistance needed from the police' protocol

If only decision is to admit then CSM informs BRHC duty manager & matron or on-call manager of decision and records on datix. If out-of-hours CSM/Nurse in charge to speak to EDT and inform of admission and need for priority handover to area team first thing in the morning the next working day for the area team to prioritise action to support discharge. Nurse in charge or medical team to make referral to CAMHS for assessment if relevant

If admission overnight CSM to provide clear handover of what happened and details to the day duty team. Duty team make a plan with BRCH safeguarding team and nurse in charge of ward and consider level of patient risk and whether 1 to 1 or security support is needed

Duty team to allocate lead case manager at 8.15 meeting to co-ordinate with nurse in charge/sister, acute consultant, BRHC safeguarding team, social services and named CAMHS manager.

8.30am first working day after admission - Lead case manager to contact relevant social services team and CAMHS and request identification of a lead case manager in each agency (in social care this should be Deputy Service Manager or above) to co-ordinate the case. For Children in Care this should also involve the CAMHS Thinking Allowed Team who will agree with CAMHS MHP who will take the lead. Lead Case Managers to hold a telephone professionals meeting by 10.30am to plan the response to the child. In this meeting, Lead Case Managers to agree plan so that a joint assessment undertaken by the social worker and CAMHS MHP/Psychiatrist is begun by no later than 2pm. Social care will require this assessment in writing from CAMHS MHP/Psychiatrist by the end of the day to enable safe care planning

Unless the assessment concludes there are no concerns and the child can be discharged home safely, a professionals meeting should be coordinated to take place that same day following the assessment with the lead case managers and relevant stakeholders to determine next steps and plan. This meeting should be chaired by Social Care and hosted in the hospital. The meeting should focus on the needs of the child, the findings of the assessment and inform any ongoing placement or inpatient bed searches, and the support that is available from the multi-agency partnership to meet the child/ carers needs.

Where there are no mental health or safeguarding concerns but social care plan to discharge to alternative place to home the expectation is that this should be made that same day

Where the discharge is delayed and not going to be achieved within the day, lead case manager from social care to inform BRHC lead case manager, discuss the rationale for revised timescales and review plan. Where delay continues beyond the initial 24 hours, BRHC will consider charging social care for any additional care required. Where there are continued delays in a plan the BRHC Lead Case Manager will escalate to the Deputy Chief Operating Officer/ Chief Operating Officer to escalate to counterparts in Social Care (Head of Service/Director for Children and Families) as well as inform CCG through service wide daily escalation calls.

Where predominant needs are in respect of the child's mental health then it is CAMHS' responsibility to follow mental health pathways and escalation to support safe discharge

Where predominant needs are in respect of safeguarding concerns then it is children social care's responsibility to follow safeguarding processes and identify safe accommodation to enable a safe discharge

When, as a result of the trauma, abuse or neglect a child has suffered, it is assessed at the point of discharge that repeat attendance at CED is likely but the child is not assessed as having a mental health disorder, the BRCH Lead Case Manager and Social Care Lead Case Manager will agree a management plan that will be attached as an alert to the child's electronic BRCH medical record. For Children in Care the creation of the plan will include Thinking Allowed. This management plan will set out: Named points of contact for the child; likes/dislikes; deescalation strategies that have been found to be effective; key information about behaviour triggers; contingency plan to be followed in the event of CED presentation. Where possible the child should be involved in creating this plan. These will be reviewed by the social worker and BRCH Lead Case Manager after every CED presentation/as agreed to be appropriate.