THE CHILD WITH COMPLEX HEALTH NEEDS

Definition

A child with complex needs has more than one severe or profound impairment, such that no one professional has a monopoly in assessment and management and multi-disciplinary teamwork is essential.

Inclusion Criteria:

Children have severe or profound impairment in at least three of the following categories (all should be severe or profound).

Or

Two of the following categories plus one or more of the resources

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Resources</th>
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</thead>
<tbody>
<tr>
<td>• Motor impairment</td>
<td>• Therapy services</td>
</tr>
<tr>
<td>• Hearing impairment</td>
<td>• Additional educational resources</td>
</tr>
<tr>
<td>• Visual impairment</td>
<td>• Nursing care</td>
</tr>
<tr>
<td>• Learning difficulties/development delay</td>
<td>• Social work input</td>
</tr>
<tr>
<td>• Speech and language impairment</td>
<td>• Mental health services</td>
</tr>
<tr>
<td>• Behaviour problems</td>
<td></td>
</tr>
<tr>
<td>• Feeding problems</td>
<td></td>
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<tr>
<td>• Chronic health needs</td>
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The needs are sustained (more than 6 months and ongoing).

It is likely that children with complex needs will have multi-agency involvement in the provision of their care.
DISCHARGE PATHWAY FOR CHILDREN WITH COMPLEX NEEDS

**Entry:**

- This pathway is required for children who are identified as having complex needs and need multidisciplinary team input.
- Has been inpatient for more than 2 weeks
- If lead consultant wishes that such a pathway is initiated for a particular child.

**Exit:**

Pathway is completed when child is successfully discharged home and fully integrated back into the local community.

**Discharge Planning - Initiation:**

1. **Aim:**
   - To collect relevant information about child
   - To identify key discharge co-ordinator
   - To identify appropriate professionals who need to be involved
   - To agree date and venue for first meeting

2. **Core Personnel involvement:**
   - Discharge Co-ordinator (who decides/when decided) ??
   - Hospital Paediatrician
   - Community Paediatrician
   - Named nurse from ward

3. **Discharge Co-ordinator identifies other professionals, e.g.:**
   - PAMS, eg Physiotherapist, Occupational Therapist, Speech & Language Therapist, Dietitian, Psychologist
   - Specialist Nurse
   - Social Worker
   - Occupational Therapist (Social Work Dept)
   - Health Visitor (for pre-school children)
   - Educational Psychologist
   - Support for Learning Officer
   - Child’s Teacher
   - School Health Team (School Dr/Nurse)
   - General Practitioner

**NB:**

- It is good practice for a key person within education to be identified to co-ordinate representatives from authority as required.
- It is good practice to involve parents +/- child in meetings.
# First Discharge Planning Meeting

**Patient** (affix patient label if available)  
Hospital Number: __________________

Title: __________  
First Name: _______________  
Second Name: _______________  
DOB: _______________

Address: _____________________________________________________________
__________________________________________________________Post Code: _______________  
Phone No: _______________

**Patient’s Consultants:**  
Hospital: ____________________________________________  
Community: ____________________________________________

**Date/Venue**  
This initial meeting preferably should be held as part of assessment 4 – 6 weeks before discharge.

<table>
<thead>
<tr>
<th>Date</th>
<th>Venue</th>
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<tbody>
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</table>

**Aim**  
- To collect/update information of child’s current needs  
- To collect information on child’s predicted needs  
- To identify areas which need further assessment to enable successful discharge  
- To set date and identify pathway for 2nd meeting

<table>
<thead>
<tr>
<th>NAME</th>
<th>LOCATION/CONTACT NO.</th>
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</table>

**Personnel**  
Parents:  
Discharge Co-ordinator:  
Physiotherapist:  
OT:  
SALT:  
Dietician:  
Psychologist  
Occupational Therapist (SWD)  
Social worker:  
Health Visitor:  
Education Representative:  
Hospital Paediatrician:  
Community Paediatrician:  
Named Nurse:  

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3..
Medical Diagnosis:

Current Issues

Requirements:
1. Care Needs:
2. Equipment
3. Respite Care
4. Housing: (Adaptation/move)
5. Transport
6. Financial: (Remember to identify funding resource if necessary)
7. Other

Outcome/Recommendations
2nd Discharge Planning Meeting

**Date/Venue**
Should be arranged 2 weeks prior to discharge.

**Date:**

**Venue:**

**Personnel**
- Hospital Consultant:
- Community Child Health Consultant:
- Discharge Co-ordinator:
- Named Nurse:
- Parents:

**Aim**
- To review child & family’s needs and progress
- To review action points identified from 1st meeting
- To identify any new issues and action required
- To clarify timescale of discharge

**Outcome/Recommendations**

**NB:** Discharge planning meeting review can be repeated with key professionals as necessary to ensure progress with discharge. It may be possible to move directly to 3rd discharge meeting from initial meeting.

5.
3rd Discharge Planning Meeting (pre-discharge)

**Date/Venue**
Within a week prior to discharge:

**Date:**
**Venue:**

**Aim**
- To review child & family’s needs
- To check all action points have been addressed
- To plan phased discharge (graded pass from ward, reintegration to school-graded/complete)
- To discuss need for post-discharge meeting if necessary and set date & identify key persons

**Personnel**
All those invited to the first meeting

**Outcome/Recommendations**
### 4th Discharge Planning Meeting (Post-Discharge review)

<table>
<thead>
<tr>
<th>Date/Venue</th>
<th>Venue: Held in community clinic/school/nursery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
<td><strong>Venue:</strong></td>
</tr>
</tbody>
</table>

**Aim**
- To discuss ongoing areas of identified needs and action plan
- To co-ordinate follow up
- Feed back to Hospital

**Outcome/Recommendations:**