CYP ED STANDARD OPERATING PROCEDURE

PROCEDURE FOR CHILDREN AND YOUNG PEOPLE AGED <18 YEARS WHO DO NOT WAIT IN THE PAEDIATRIC EMERGENCY DEPARTMENT

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1. Background

Patients who do not wait to be seen by a decision-making professional can pose a significant clinical risk. A primary reason for patients leaving before assessment is due to long waiting times in usually overcrowded emergency departments. Systems must be in place in emergency care settings to review cases where children and young people leave before being assessed as highlighted in RCPCH Facing the Future: Standards for Children in Emergency Care Settings document. This is to ensure the physical wellbeing of the child and proactivity in identifying safeguarding concerns.

Audit data from Children and Young People Emergency Department (CYPED) at St Peter's Hospital shows on average 0.06% of presentations leave the department before assessment and treatment is completed. Between 1st October - 27th October 2024, 46 patients left the department before assessment and treatment, averaging 1-2 patients per day. 72% of these patients presented out of hours between 19:00 and 07:00. In almost all cases, the patient was triaged but did not wait to be seen by a doctor. An information sharing form (ISF) was only completed in those where safeguarding concerns were suspected at triage.

Definitions:
Did Not Wait / Left without being seen - left before assessment by a decision-making clinician.

Left Before Treatment – left before treatment without informing staff but has been assessed by a decision-making clinician.

Self-Discharge – left CYPED after review and discussion with decision making clinician.

Absconds – left CYPED at any time unexpectedly without informing staff and poses a risk of harm to self or others either through neglect or deliberate means.

2. Aims and Scope

This standard operating procedure (SOP) has been designed to ensure safety of children and young people who leave before completion of assessment in our CYPED. It is relevant to all trust staff working within CYPED. This policy does **not** cover children and young people less than 18 years who have **absconded** from the Emergency Department. In that case please refer to the Trust's **Missing Patient** policy (via Trustnet) and the Royal College of Emergency Medicine Best Practice Guideline: The Patient who Absconds, Last revised July 2024.

If the patient is admitted to hospital, please refer to Policy for the self-discharge of a child (0-18 years inclusive) against medical advice (via Trustnet).

3. Did Not Wait Procedure

The following management flow charts should be used to guide action when a child or young people <18 years old does not wait in CYPED.

In all children and young people that leave before being assessed an information sharing form (ISF) must be completed and shared with Paediatric Safeguarding team and relevant agencies involved with the child. ISF completion is a shared responsibility amongst the whole team. ISF can be completed on Cerner.

In cases identified to be at significant risk of harm or safeguarding concern, the responsible clinician should also complete a Request for Support form (RSF) for Surrey Children's Services. It is best practice, where possible, that the parent/guardian is aware that this referral is being made.

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Children and young people (CYP) who wish to leave before being discharged by ED clinician

- Nursing team:
  - Document reasoning for discharge against medical advice
  - Encourage family to stay
- Escalation
  - Inform CYPED ED doctor (Ext. 3572) and Paediatric Nurse in Charge
  - Complete a focused risk assessment (in person or virtually) for high risk medical/safeguarding concerns (use RED traffic light criteria)
- If *no* significant concerns:
  - Family may leave against medical advice
  - Ensure:
    - Against Medical Advice Discharge leaflet given
    - Safety netting given
    - Contact details confirmed
- If *significant* concerns identified:
  - Advise family to stay
  - If they choose to leave, manage as per red traffic light criteria

Once patient has left:

1. An ISF (Information Sharing Form) must be completed.
2. Clearly document all reasoning, timings, conversations, and subsequent call attempts and outcomes in the notes.

If patient has left before a Doctor's full risk assessment, stratify into one of the following traffic light categories based on information available:

Red flag concerns:

These would be any presentation deemed to require urgent assessment in ED with significant morbidity or mortality if not properly managed.

This would include but not be limited to:
A: Severe stridor or signs of impending airway obstruction
B: Severe respiratory distress or cyanosis
C: Concerns of shock (e.g.mottled appearance, disproportionate tachycardia)
D: Floppy or unresponsive child
E: Rapidly spreading non-blanching rash

Any significant abnormal result or imaging finding (e.g missed tension pneumothorax, critical bloods)

Significant safeguarding concerns (ie NAI, other forms of abuse with immediate significant risk).

Next Steps
1. Immediately contact the patient/parent/carer:
   - Call and instruct them to return to CYPED without delay.
   - Depending on clinical status this may be by own transport or ambulance.
2. If unable to contact them:
   - Refer to the Paediatric Team and inform ED Consultant.
   - Paediatric Team will escalate with involvement of police or social services as appropriate.
3. If patient is returning:
   - Refer to the Paediatric Team and inform ED Consultant.
   - Manage as medical priority on arrival.

Amber flag concerns:

These would include presentations that are deemed to require further monitoring or assessment which would include but not be limited to:

Difficulty in breathing/ wheeze
Persistent Tachycardia
Fever in unwell child
Persistent painful limb
Rash that has evolved or was inadequately assessed
Known multiple attendances for same illness to healthcare settings

A safeguarding concern with no immediate significant risk to child (e.g. repeated left without being seen).

Next Steps:

1. Contact the Patient/Parent/Carer:
   - Make up to two phone calls over a period of 60 minutes to request the CYP be brought back to the Emergency Department for further review.
   - If appropriate, based on clinical judgement and family preference, it may be advised that the CYP can be seen at an alternate healthcare provider such as GP/UTC. These patients can then be discharged from Firstnet.
2. If unable to reach them after two attempts:
   - Discuss the case with ED Consultant.
   - If the Consultant agrees that the child warrants review then refer to the paediatric team.

Green flag concerns:

These would include presentations that are deemed to not require a return to the Emergency Department which would include but not be limited to:

Minor viral illness (normal observations and well looking child)
Minor soft tissue injury (moving limb, pain managed)
Low risk head injury (no red flags as per NICE guidelines)

Next Steps:

1. Check documentation for safety netting:
   - If appropriate advice given, no further contact with the patient/parent/carer is required.
2. If safety netting was not given:
   - Attempt to contact the patient/parent/carer up to two times.
   - If contact cannot be made, discuss with ED Consultant to determine whether the case requires amber flag follow-up or can be safely discharged.
3. Complete the discharge summary and remove the patient from FirstNet.

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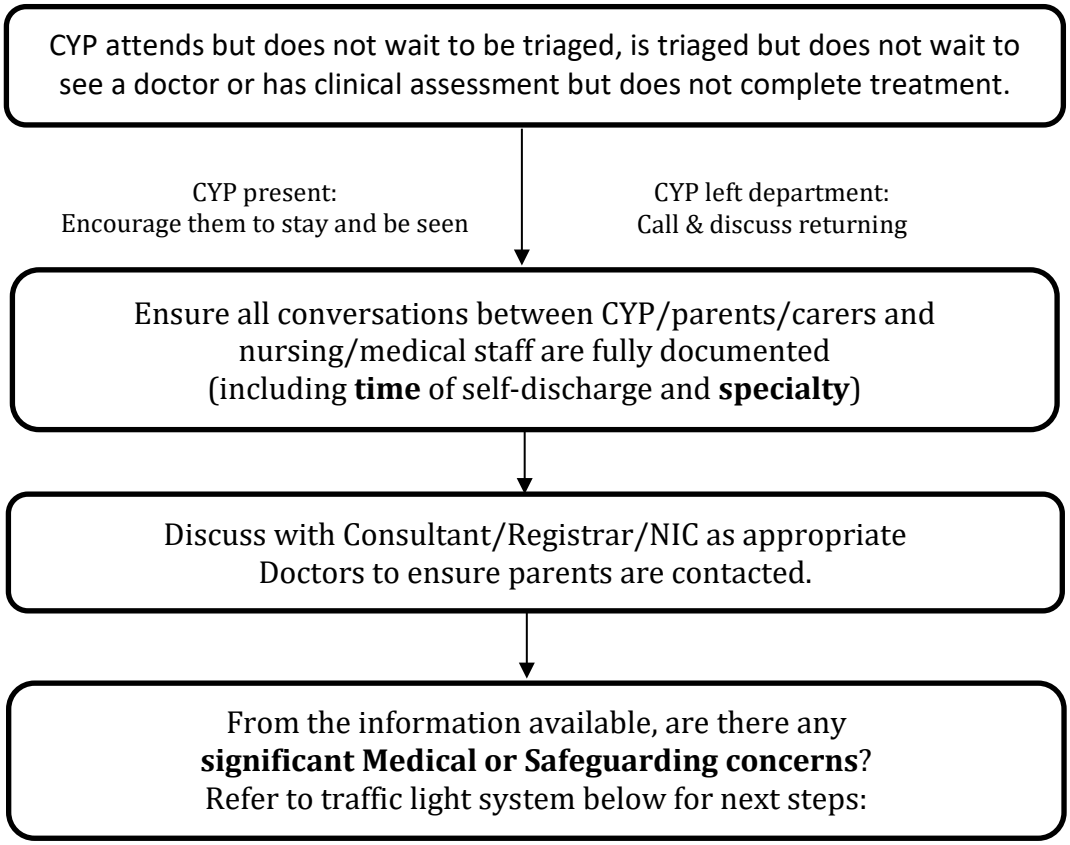
Children and young people who wish to leave before being discharged by Paediatric Team



Green flag concerns

This would include presentations that are deemed to not require a return to the Emergency Department, which would include but not be limited to:

- Minor viral illness (normal observations and well looking child)
- Minor soft tissue injury (moving limb, pain managed)
- Low risk head injury (no red flags as per NICE guidelines)

Next steps:

1. Ensure appropriate safety netting advice given: No need to contact if this has been done. If no evidence of safety netting, attempt contact up to two times. If unable to contact, document attempts and discuss with registrar/consultant if requires amber flag management or can be discharged.
2. Complete discharge summary and ISF. Remove patient from First Net within 24 hours.

Amber flag concerns

This would include presentations that are deemed to require further monitoring or assessment which would include but not be limited to:

- Difficulty in breathing/ wheeze
- Persistent Tachycardia
- Fever in unwell child
- Persistent painful limb
- Rash that has evolved or was inadequately assessed
- Safeguarding concern with no immediate significant risk to child (e.g. repeated left without being seen)
- Multiple attendances to healthcare settings for same illness.

Next Steps:

1. Contact the Parents or Carers: Request the child be brought back to the Emergency Department for further review.
If appropriate, based on clinical judgement and patient/parent/care preference, it may be advised that the child can be seen at an alternate healthcare provider such as GP/UTC.
Document all call attempts, times and outcomes.
2. If Unable to Reach the Family:
Discuss the case with Consultant. If the Consultant agrees that the child warrants review and there is concern about the inability to contact the family, this can be escalated to Safeguarding Team/Emergency Duty Team.

Red flag concerns

This would include presentations that are deemed to require urgent assessment in ED with significant morbidity or mortality if not managed. This would include but not be limited to

- A: Severe stridor or signs of impending airway obstruction
  B: Severe respiratory distress or cyanosis
  C: Concerns of shock (e.g. mottled appearance, disproportionate tachycardia)
  D: Floppy or unresponsive child
  E: Rapidly spreading non-blanching rash
- Any significant abnormal result or imaging finding (e.g missed pneumothorax, critical bloods)
- Significant safeguarding concerns (ie NAI, other forms of abuse with immediate significant risk)

Next Steps:

1. Contact the Parents or Carers Immediately: Call and instruct them to return to the Emergency Department without delay.
2. If Unable to Reach the Parents: Document all call attempts, times and outcomes. Inform NIC & Consultant.
3. If Unable to Reach the Family: Call safeguarding team/emergency duty team (SS)/ Police as appropriate.

4. Stakeholder engagement and communication

Engagement and consultation for this policy was completed within the Accident and Emergency and the Paediatric department senior medical and nursing teams.

5. Approval and Ratification

This policy will be approved and ratified by the Paediatric Department in conjunction with the Accident and Emergency Department.

6. Dissemination and Implementation

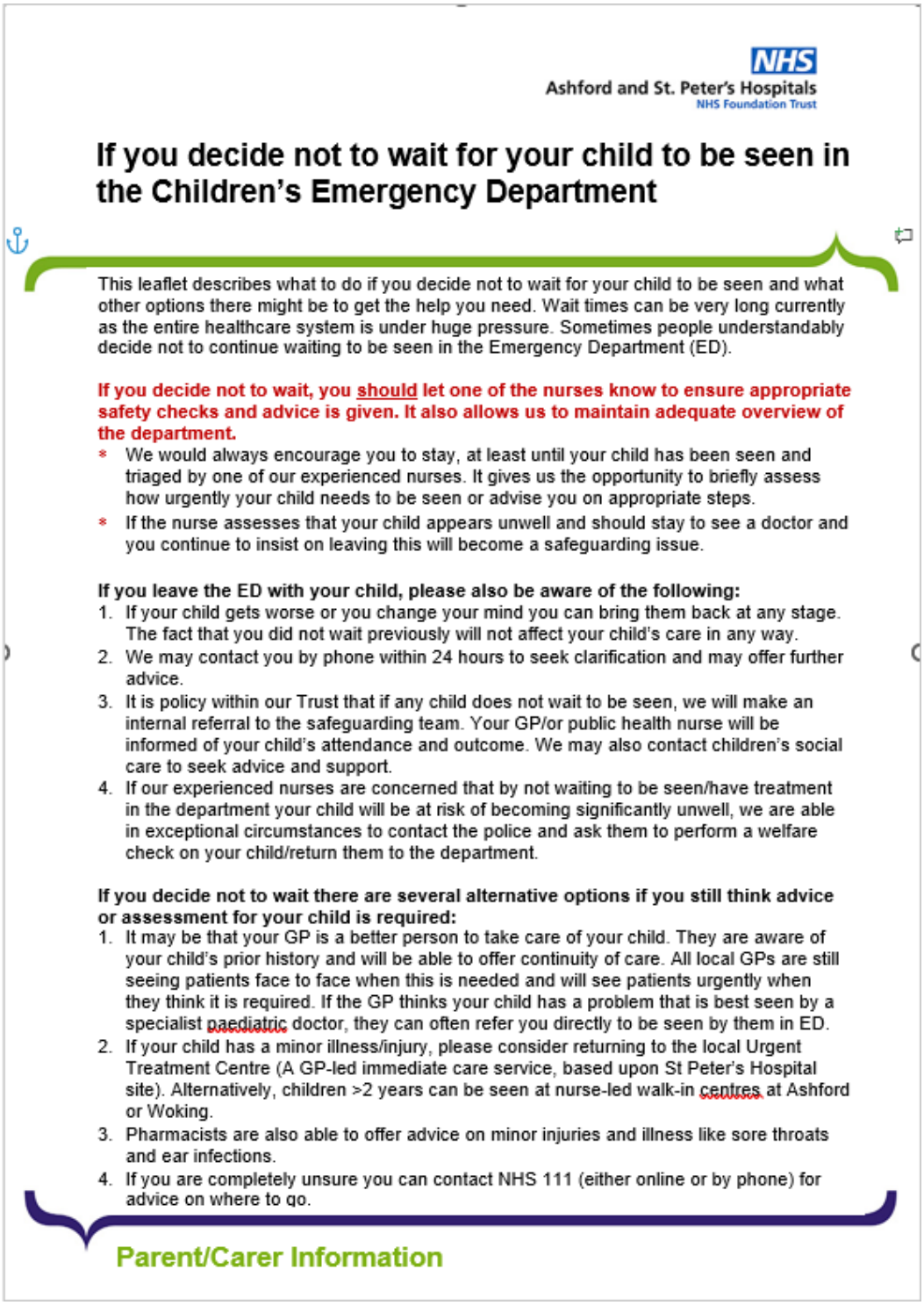
a. This policy will be uploaded to the trust intranet Accident and Emergency and Paediatric department pages and thus available for common use.
b. This policy will be shared as part of ongoing education within the Accident and Emergency and Paediatric Departments for both medical and nursing staff.
c. All members of staff are invited to attend and give comments on the policy as part of the ratification process.

7. Review and Revision Arrangements

d. This policy will be reviewed on a 3 yearly basis by the appropriate persons.
e. If new information comes to light prior to the review date, an earlier review will be prompted.
f. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

8. Appendices

8.1. DNW Patient information leaflet – access via trustnet



NHS
Ashford and St. Peter's Hospitals
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If you decide not to wait for your child to be seen in the Children's Emergency Department

This leaflet describes what to do if you decide not to wait for your child to be seen and what other options there might be to get the help you need. Wait times can be very long currently as the entire healthcare system is under huge pressure. Sometimes people understandably decide not to continue waiting to be seen in the Emergency Department (ED).

If you decide not to wait, you should let one of the nurses know to ensure appropriate safety checks and advice is given. It also allows us to maintain adequate overview of the department.

* We would always encourage you to stay, at least until your child has been seen and triaged by one of our experienced nurses. It gives us the opportunity to briefly assess how urgently your child needs to be seen or advise you on appropriate steps.
* If the nurse assesses that your child appears unwell and should stay to see a doctor and you continue to insist on leaving this will become a safeguarding issue.

If you leave the ED with your child, please also be aware of the following:

1. If your child gets worse or you change your mind you can bring them back at any stage. The fact that you did not wait previously will not affect your child's care in any way.
2. We may contact you by phone within 24 hours to seek clarification and may offer further advice.
3. It is policy within our Trust that if any child does not wait to be seen, we will make an internal referral to the safeguarding team. Your GP/or public health nurse will be informed of your child's attendance and outcome. We may also contact children's social care to seek advice and support.
4. If our experienced nurses are concerned that by not waiting to be seen/have treatment in the department your child will be at risk of becoming significantly unwell, we are able in exceptional circumstances to contact the police and ask them to perform a welfare check on your child/return them to the department.

If you decide not to wait there are several alternative options if you still think advice or assessment for your child is required:

1. It may be that your GP is a better person to take care of your child. They are aware of your child's prior history and will be able to offer continuity of care. All local GPs are still seeing patients face to face when this is needed and will see patients urgently when they think it is required. If the GP thinks your child has a problem that is best seen by a specialist paediatric doctor, they can often refer you directly to be seen by them in ED.
2. If your child has a minor illness/injury, please consider returning to the local Urgent Treatment Centre (A GP-led immediate care service, based upon St Peter's Hospital site). Alternatively, children >2 years can be seen at nurse-led walk-in centres at Ashford or Woking.
3. Pharmacists are also able to offer advice on minor injuries and illness like sore throats and ear infections.
4. If you are completely unsure you can contact NHS 111 (either online or by phone) for advice on where to go.

Parent/Carer Information

8.2. Abbreviations and Definitions

DNW – did not wait

CYP – Child or young person

CYPED – Children and Young People Emergency Department

ISF – information sharing form

RSF – referral for support form

RCPCH- Royal College of Paediatric and Child Health

8.3. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Authors and Senior Medical and Nursing staff from Emergency and Paediatric Departments.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There is no evidence of discrimination.
Conclusion

• Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This policy is appropriate for use.

8.4. Document checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.
Title of the document:
Policy (document) Author:
Executive Director:

		Yes/No/ Unsure/N A	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Y**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Y**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Y**	
	Is the purpose of the document clear?	**Y**	
	Are the intended outcomes described?	**Y**	
	Are the statements clear and unambiguous?	**Y**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**Y**	
	Who was engaged in a review of the document (list committees/ individuals)?	**Y**	**Paediatrics/ CYPED/ ED**
	Has the policy template been followed (i.e. is the format correct)?	**Y**	

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		Yes/No/ Unsure/N A	Comments
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Y**	
	Are local/organisational supporting documents referenced?	**Y**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Y**	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	**Y**	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Y**	
	Does the plan include the necessary training/support to ensure compliance?	**Y**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**Y**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Y**	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Y**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

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Committee Approval (insert name of Committee)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	**Alexandra Jones**	**Date**	**16/9/25**
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			