

# ‘FROM HOSPITAL TO HOME. . . AND BEYOND’

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### The Hospital...

Fairfield is one of the most multicultural areas in Sydney with over half the population having been born outside Australia. The Department of Community Paediatrics at Fairfield is a newly established paediatric service that aims to meet the diverse needs of this young multicultural population. The service promotes child health through community based activities, ambulatory paediatric medical services and provision of a Community Paediatric nursing care program, known as the Paediatric Outreach Service.

In the Fairfield Local Government Area (LGA) there are approximately 45,000 children aged 14 years and under.<sup>1</sup> This equates to 26% of the local population. Each year there are approximately 2,000 births. Many families in the Fairfield LGA have come from overseas, with the principal countries being Vietnam, Yugoslavia, and Italy.<sup>2</sup> Overall 47.9% of families in Fairfield are from a non-English speaking background.<sup>3</sup>

The priority of Community Paediatrics, as part of a local health service, is to provide child health services appropriate to the needs of the local community. Promotion of child health programs includes immunisation programs, child protection services, advocacy for children and child development surveillance. One of the major projects of Community Paediatrics is the Paediatric Outreach Service (POS). POS is able to provide ongoing nursing support for children in their own home during an acute illness. This subsequently is for the child's benefit during the illness, as it reduces the trauma and stress of hospital admission and separation from family.

Families with children in the Fairfield LGA often have their first experience with the Health Service by use of the Fairfield Emergency Department. For these families, it is essential that they have "a satisfactory" experience, as this first encounter is likely to influence their subsequent trust in returning to the Emergency Department on another occasion, as well as their use of other health services provided by the Fairfield Health Service. This is addressed through the provision of ambulatory paediatric medical services.

Paediatric and adolescent patients account for 33.4% of the daily presentations to the Emergency Department.<sup>2</sup> Common paediatric presentations account for most of these presentations including asthma, gastroenteritis, abdominal pain, croup and viral infection.<sup>2</sup> Less than 20% of these presentations lead to hospital admission.<sup>4</sup> Many of these paediatric presentations are for primary health care problems.

Ambulatory paediatric support to the Emergency Department requires a presence in the Emergency Department. This extends to all paediatric related activities undertaken. Rather than

concentrate on an individual patient focus, the focus is on the system of how children and adolescents are cared for in the Emergency Department. This starts from the triage process through to the subsequent management and admission or discharge.

This requires support and resources in numerous areas. Paediatric triage guidelines aim to ensure that children are seen within an appropriate period of time, and allow for appropriate review and management to be commenced soon after presentation. Education sessions on paediatric problems and paediatric case reviews improve knowledge and confidence of both the nursing and medical staff with assessment and management of paediatric patients. Direct clinical support and review of individual children address specific questions about individual management strategies. In addition, review of daily paediatric case files provides comprehensive details of paediatric activities in the Emergency Department throughout the day. This also allows for management strategies initiated after hours to be reviewed and followed up where required. Telephone contact with families who have presented to the department, but 'did not wait' is also an important area that is addressed.

As part of the goal to assist families with obtaining primary health care within their community, communication with the child's general practitioner is encouraged. For children who are seen in the Emergency Department and ongoing medical review during the course of the illness is required, attempts are made to discuss this with the General Practitioner and involve them in the overall Emergency Department management. Discharge and treatment letters are frequently provided to assist the General Practitioner with their subsequent management. The family are also provided with appropriate information regarding the child's illness and encouraged to seek follow up review with the General Practitioner. If additional community support is required, for example support from POS, then a referral is made.

Whilst every child who presents to the Emergency Department does not require a hospital admission, there are times when admission cannot be avoided. Some of these children who do require admission, now have earlier discharge facilitated by referral to POS. This allows the child's continuing care to be provided for at home by their parents and family in the security of their own home. Ongoing education about the illness and support is provided by paediatric nurses who are able to visit the child at home. In addition, communication about the child's progress is provided to the child's General Practitioner and/or Paediatrician so that optimal care can continue to be provided for in the community.

### **Home and Beyond...**

When the concept of outreach nursing is discussed, some may equate it with a shortened hospital length of stay; others may consider it in terms of a hospital in the home program. However, it is our contention that the Paediatric Outreach Service (POS) at Fairfield is much more than this. Occasionally we are able to assist a child to achieve a reduced length of stay in the hospital environment but with an average length of stay of a little over two days for most conditions, a reduction in duration is often hard to achieve. The service does provide nursing care in the home in many instances where a hospital admission is not required but where the child's condition warrants home nursing attention. This is really the purpose of such a service. What we have identified over the 18 months we have provided care to the children of Fairfield and their families is that the service has so much more potential to address issues much broader than were initially

planned for in the development of POS.

To use an analogy, one might consider the POS staff as tour guides, in a sense. A tour guide on a trip can plan as many activities as they like, but the effort is wasted unless they are meaningful to the traveller. Unless the traveller commits to the experience and participates, the trip is meaningless. In addition, if a traveller chooses a tour guide because they want to end up at destination 'wanna-go-there' but instead, the tour guide takes it upon themselves to guide the traveller to 'gotta-go here', the traveller would probably complain, be dissatisfied and unfulfilled and fail to use the service again.

Using this analogy, POS staff are the tour guides and the patients (and their families) the travellers. The trip taken is through the healthcare system's maze. For many, it is their first experience of travelling in this world. Consequently, they seek and/or welcome the assistance of an experienced 'guide' to facilitate their arrival at their destination.

On this trip, the first stop (after the hospital, the doctors room, or other source of referral) is home, followed by recovery and finally arrival at the level of optimum health. This may be a quick trip for some whilst for others a very slow one.

For many families, this 'trip' requires them to learn skills they've never needed before. Some are required to learn observation skills – to be able to read the 'map' of their child's illness. They are expected to recognise forks in their road or dead-ends; they are expected to be able to jump hurdles if placed on their pathway to recovery and to recognise 'unsteady ground' when it appears. In many situations, families are not only required to see this map (which is the illness pattern) but also to act to implement action to avert or prevent complications. In this new world, families can find this a very formidable task.

It is in circumstances such as these that parents look to the POS nurses for clear, concise, easy to understand instructions to follow. Knowing that the POS nurses attend but a snap-shot in their journey, parents seek to develop strategies and contingency plans that will meet the needs of their child and their family. This is done with the nurse. Home visits are scheduled around the family's requirements wherever practical. This is in an attempt to re-focus the family from an illness model to that of normalcy.

Staff negotiate with parents the amount of involvement they want to have in the procedures that are required to assist the child along their trip to recovery. For example, the parents of a child requiring dressings following a burn injury may only be happy to give their child's pre-procedure pain relief and be able to tolerate no further involvement; or they might do this and remain present to provide moral support throughout the procedure. Others might want to be involved in the whole procedure including the bath and dressings. Interestingly, parents often move along a continuum like this altering their role in the process, sometimes on a daily basis. Nursing staff must be willing to accommodate this need; they must be open to the cues given by families that indicate their needs. Cues may be verbal or non-verbal.

As stated previously, the 'trip' must be meaningful to the family in order that they participate in the experience – for it is only when the situation is meaningful to them that parents will remain committed to their part throughout the whole journey. Without parental commitment, services

such as POS are doomed to fail, because then the only alternative would be hospitalisation. This is exactly what services such as POS are developed to avoid.

As guides, it is our responsibility to observe and scour the terrain we traverse during our home visits. We may receive a referral to support a baby at home through an episode of bronchiolitis. In this situation, we would take a nursing history, perform a respiratory status assessment and review the child's input and output. Additionally, this home visit may lead to the discovery or disclosure of a domestic violence situation or a settling problem or a suspicion of post-natal depression. Due to our commitment as guides, we use our contacts to network this family to the correct resources. This often involves the expenditure of vast quantities of time and/or effort, but generally it is very worthwhile investment as it may ultimately affect the net outcome for the child and their family.

It is situations like this where it is crucial that services are not compartmentalised. POS staff readily acknowledge when the families needs are beyond the scope of their expertise. The travellers are reassured that they are not alone. Instead, with the family's consent, they are booked onto another 'tour' where the guide has the expertise to meet their needs. It is about engaging inter-service and/or inter-agency networks to ensure that the most appropriate service provides the most appropriate care at the most appropriate time for the child and their family.

Turning our attention back to the analogy, the other thing of paramount importance to remember is that, as nurses and as healthcare providers, we need to hear what parents ask of us. This is so we can facilitate the child's travel along the care continuum to reach their optimal level of well-being. It is about staying focused on what the family needs, rather than what we think they need. As providers of care, support, and knowledge we must be mindful to pace the journey at a rate that the family can tolerate. For families to be empowered to provide the care for their sick child, they must feel confident in their own ability and understanding. If we push them too hard or too fast, the family is likely to disengage before their needs are met. This will inevitably lead to either a poor outcome for the child or the family will go 'health-care shopping' to find the one they believes hears what they are asking for.

To coin an adage, the aim of a service such as POS is to put the family 'in the driver's seat'<sup>5</sup>. This means to facilitate and empower the family to provide for their child's health care needs, knowing they have the full back-up and support of the POS team when they feel uncertain. Ensuring that parents know there is someone to provide care in their home or to phone for advice as their child's condition changes.

To put POS into context within the department of Community Paediatrics, if we are the tour guides, then Ambulatory Paediatrics is the travel agency. The presence of the Staff Specialist Paediatrician in the Emergency Department at Fairfield Hospital helps to ensure that the families passing through there are 'booked' onto the appropriate trip (be that hospital admission, referral to POS or re-direction back to their primary health care provider).

Despite the best planning, rain or other adverse conditions cannot be avoided in some travels. So too, in health care planning, despite attention to detail and personalised, individualised care, there will be the occasions when needs cannot be met to the consumer's satisfaction. It is these experiences we use to try to improve and change our service, for our goal is to benchmark best practice to offer families the very best we can.

For an outreach service to be successful, it must strive to do more than merely shorten the hospital length of stay or cut the cost of health-care provision. Both of these are desirable spin-offs of such a service but the aim of the service must be to meet the needs of the family in a way that they find meaningful and consequently value. The service needs to have guidelines of operation but it also needs to be portable (to be able to move about within the defined geographical region, for example between the homes where the child's care is provided). The service must focus on not only getting the child recovered from the condition for which they were referred but also on equipping families with strategies to manage the child in the future in a similar circumstance. The focus must be beyond the illness model. An investment in the child health and health promotion of today's children may be an investment in the aging population of tomorrow. We can make a difference in our communities at a number of levels both for today and beyond.