

# Children's Attendance at a Minor Injury / Illness Service (MIS)

February 2002



## Foreword

The report by an intercollegiate working party on Accident & Emergency Services for Children “*Accident and Emergency Services for Children*” RCPCH June 1999, made a clear recommendation that children should not be seen in Accident & Emergency Departments unless there were inpatient paediatric services on site. The full recommendation was as follows: “*Only A & E Departments that are on the same hospital site as inpatient paediatric facilities should accept children, apart from those with minor injuries not requiring hospital admission. Exceptions are departments in geographically isolated trusts for whom special arrangements must be made*”.

It is acknowledged that such a position is not likely to be achievable in all districts, and that in such situations minor injury/illness services, should be provided for children – indeed this already happens in many locations, but there are no agreed national standards for these services.

The Intercollegiate Advisory Group for Accident & Emergency for Children has recognised that children who have minor medical problems or minor injuries, need ready access to local services, which must be child sensitive in their facilities and staffing. In addition those children who have or may have a serious illness or injury need expert clinical assessment, and should attend an A & E centre which has skilled paediatric cover on site.

The Advisory group, whose membership includes the Royal College of Paediatrics & Child Health, Royal College of General Practitioners, the Royal College of Nursing, The British Association of A & E Medicine, and the Faculty of A & E Medicine, has produced the following document to provide guidance for those responsible for setting up and running minor injury and illness services for children.

*Keith Dodd, Chairman, Intercollegiate Advisory Group  
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# Children's Attendance at a Minor Injury/ Illness Service (MIS)

## 1. Children in A&E

Nationally, about 3.5 million children attend A & E departments annually<sup>1</sup> – and numbers appear to be increasing. Children attend A & E with a very wide spectrum of illness and injuries – from the trivial to the life threatening, dying or already dead. Some, with obvious or minor disorders, can be managed simply, others have obscure or confusing features for which specialist paediatric opinion is essential; issues of child protection present a constant challenge. Medical staff who are inexperienced in paediatrics and generally anxious about managing younger children, often see the majority of attenders first. Moreover, because about half of them attend out of hours, supervision by more senior staff can be unsatisfactory.

It should be recognised also that children already attend MIS (ie minor injuries/illness units and walk-in centres), and the purpose of this guidance is to make recommendations about paediatric care at such facilities.

## 2. Children at MIS

**2.1** Children (defined as those < 16<sup>th</sup> birthday) presenting to A & E are currently classified as having either major illness or injury, or minor illness or injury. Minor Injury/Illness Services (MIS) are a means of providing a convenient local solution for the medical needs of the latter group. However, they lack the full services and support of an A & E department, and, may, for example, not have ready access to paediatric expertise or to major resuscitation facilities. MIS vary also in case-mix; many units see only those who have sustained a minor injury. It is crucially important that health commissioners, health care professionals working in a community setting and the public view their role realistically, understand their limitations, and use them appropriately. MIS should not be seen as a cheap alternative to full emergency care; indeed, the cost per comparable case is likely to be higher in small peripheral units because of restricted case numbers.

**2.2** MIS are already established in the sphere of general A & E work and have recently been reviewed<sup>2</sup>. The Clinical Services Committee of the British Association for Accident Emergency Medicine has also made recommendations<sup>3</sup>, with which this guidance is consistent – notwithstanding that it applies solely to children's attendance. The majority of units deal with patients of all ages although a few treat children only; alternatively, some will (or should) exclude children, if staff training or facilities are deemed to be inappropriate or inadequate. The terms "minor illness" or "minor injury" have not been defined, but units need to do so in a manner that is acceptable and sensitive to local need (see 6.1 below).

## 3. Management concept

**3.1** All MIS that see children should develop close links with a main A & E department in an Acute General Hospital (AGH) that provides a full range of secondary paediatric services. The hospital with which a MIS is linked would usually be the same for both adult and children's services - an administrative ideal. Sometimes this is not the most appropriate option. For example, in a city, locality or Trust where a MIS is linked to a large Teaching Hospital, where few if any children are seen because there is a dedicated Children's Hospital, it might

be more appropriate for the service at the MIS to be linked to the A & E dept at the latter centre whereas the adult service ought naturally to be linked to that at the (principally adult) hospital. Hence clinical provision at MIS is in essence an extension of the service provided by the AGH or Teaching Hospital.

#### **4. Managed clinical networks**

**4.1** By taking account of local demography and geography such networks also have a role in the development of care for minor illness/injuries. These consist of groups of health professionals and organisations working in a co-ordinated manner, not constrained by existing organisational or traditional boundaries, to ensure equitable provision of quality, clinically effective care. Networks of various types have been developed and may cover a speciality such as cardiology <sup>4</sup>, or a specific age group such as children, or a particular type of work - eg minor injuries. Examples exist of networks consisting of several MIS and/or walk-in centres to which the public have direct access where staff work according to agreed protocols or care pathways, and that are managed by an AGH, Community Care or Primary Care Trust. The concept is of a team approach where the focus has shifted from competition to co-operation <sup>5</sup>.

**4.2** Therefore, although a MIS may be detached – even physically remote – it should never be functionally independent. Rather, it should be an integral component of the AGH or the managed clinical network in relation to planning & resourcing, management & organisation, staffing & staff competencies, working protocols & practices, audit & CPD, risk management & clinical governance, and monitoring & peer review. The links should be clearly defined between the AGH and primary care.

#### **5. Principles [developed from <sup>3</sup>]:**

##### ***5.1 Rationale***

MIU are set up only on grounds of a particular local medical need - eg, isolated geographical communities, or a large seasonal influx of population. Categories of patient that should appropriately attend must, in the case of new units being established, be agreed in advance by local health service representatives from primary and secondary care. This may vary depending on local circumstances and current needs (see below on audit). Advice offered by NHS Direct should be consistent with these agreements.

##### ***5.2 Managerial and clinical relationships***

A MIU should be an integral part of the A & E services of an AGH (notwithstanding comments about teaching hospitals). A trained A&E Consultant should bear overall responsibility, with a designated paediatrician having liaison responsibility for children under the 16<sup>th</sup> birthday <sup>6</sup>. Clear lines of reporting and responsibility must be established which include defined relationships with senior paediatric nurses in the A & E department and the paediatric in-patient unit of the AGH.

##### ***5.3 Physical environment***

There should be separation of adults and children as far as is possible in the same way as was recommended for A & E departments <sup>1</sup>. Children should have access to a play area and appropriate safe toys, books and games; likewise to children's toilets/baby changing facilities. Facilities for nursing mothers should be conveniently situated.

#### **5.4 Practice guidelines**

Clinical protocols and documentation should as far as possible be the same as that used in the A & E department of the AGH. All policies and protocols should be agreed and amended in conjunction with the designated liaison paediatrician, the designated liaison paediatric nurse and senior paediatric nurses within the A & E department and paediatric inpatient unit of the AGH.

#### **5.5 Case-mix**

More seriously ill or injured children who require the resuscitation facilities of an A & E department must not be brought by emergency ambulance to a MIS; case-mix is discussed below. Such units may receive ambulance-borne patients only within strict selection criteria and as part of prospective, local agreements (see above).

#### **5.6 Essential training**

Medical and nursing staff induction and training should appropriately match the clinical needs of patients. In the interests of clinical governance and CPD, these staff should rotate for agreed periods through the AGH (or paediatric) A & E department, and/or acute paediatric unit at sufficiently regular intervals as to enhance best practice in the management of more seriously ill or injured children (opportunistic attenders), and update practice for those presenting with minor problems. The content and frequency of rotations should be the joint responsibility of the A & E consultant, the liaison paediatrician and the liaison paediatric nurse, and should be regularly monitored by them.

#### **5.7 Triage**

The triage process should be in accord with that in the AGH (see comments on national triage scale <sup>1</sup>).

#### **5.8 Record keeping & audit**

Full clinical records must be kept; where possible, the clinical recording system should be compatible with, and ideally be computerised and linked to that in the AGH A & E department. Regular audit of MIS work is also essential (eg. Case-mix, referral patterns, and reattendance rates).

### **6. Practical considerations**

#### **6.1 Who should be seen at MIS**

Patients who may be seen in a MIS are those with minor illnesses/injuries, who do not require the facilities, expertise, or skills found in secondary health care or an A & E dept of an AGH (see above). Such would include those with symptoms of mild pyrexial illnesses, minor respiratory or gastrointestinal disorders, or superficial soft tissue injuries. Children who have more than these features should be seen either by their GP or at A & E where there are full paediatric secondary health care services.

#### **6.2 Population information**

Every effort should be made to inform and educate the local population as to the role and limitations of MIUs using all modalities - including local media. There must be consistency of advice from primary and secondary care, local pharmacies, and from NHS Direct (see above). Research has shown that patients can usually choose appropriately between different facilities.

### **6.3 Senior staff job plans**

The job plan of the responsible A & E consultant should allow a minimum of one weekly session to manage the unit <sup>1</sup>, and this must be increased to cover physical attendance - eg. in follow-up clinics or regular telemedicine contact. Likewise, management should ensure that the time commitment of the liaison paediatrician is adequately recognised; this should form part of the job plan for new consultant posts that encompass this role <sup>6</sup>. Moreover, the care and management of children would be facilitated if there were to be a designated liaison paediatric nurse whose role should reflect that of the liaison paediatrician.

### **6.4 Frontline staff**

Staffing of MIUs may vary. In some units there will be staff grade doctors, or general practitioners working on a sessional basis, in others nurse practitioners. It is essential that there be a commitment to the ethos and working practices of the unit by all staff; in particular to the recommendations made about work rotations with the AGH (see Essential training above). This component should be reflected in staff job contracts.

### **6.5 Staff skills and CPD**

In spite of the above comments about agreements, children with serious emergencies will attend from time to time – though rarely. Maintenance of staff skills is important; emphasis should be on PLS training, recognition of paediatric emergencies, BLS training with access to high quality transportation for safe transfer of seriously ill/injured patients - ideally by a medical and nursing team, or trained paramedics. Senior members of the unit should be encouraged to undertake APLS training <sup>1</sup>.

### **6.6 Nursing staff - standards & competencies**

**6.6.1** Ideally there ought to be a registered children's nurse on duty at all times. Due to national shortages this may not be currently achievable, although Trusts should have plans in place to achieve. However there should be a minimum of one registered children's nurse employed at a senior level within the units nurse staffing in order to co-ordinate care for children, facilitate the education of other staff and link with senior paediatric nurses in the AGH A & E and paediatric in-patient departments. The role of a designated liaison paediatric nurse is crucial to ensure that policies and practice are appropriate for children and consistent with those at the AGH departments.

**6.6.2** In addition to paediatric basic life support skills, all nurses working in the MIS must receive specific training in:

- recognition of a sick child
- communicating with children and their families
- the assessment of pain and administration of analgesia
- drug choice and administration
- child protection (see below)
- issues relating to "consent".

Furthermore, there must be age-appropriate equipment provided specifically for use in children - including equipment both for resuscitation and for resuscitation training.

### **6.7 Nurse practitioners**

**6.7.1** Following additional training and supervised practice, nurses working in MIS are then able to assess, treat and discharge children according to agreed, local protocols (see above) without reference to medical staff. Agreement would be between the designated liaison paediatrician, the designated liaison paediatric nurse and

senior children's nurses in the AGH.

**6.7.2** The recommendations made about working rotations of staff will provide the expertise to recognise and manage a child with:

- serious or life-threatening illness or injury;
- suspected non-accidental injury or other welfare concerns <sup>1</sup>.

Furthermore, such a process should enable CPD and enhance staff morale, so that clinical governance is seen as a positive opportunity.

### **6.8 Child protection**

Regular attendance by a liaison health visitor for the purpose of monitoring of children's injuries is essential in the interests of child protection <sup>1</sup>. All staff must receive annual child protection training. This is clearly an important area for the liaison paediatrician <sup>6</sup> and children's nurse (or liaison paediatric nurse – see above) who should facilitate induction and training, audit and monitoring.

### **6.9 Those who should attend an A & E department**

The following should be seen in secondary care (paediatric unit, rapid access clinic or A & E department) depending on local arrangements. They include those who may have or who need:

- Detailed diagnostic investigations* – ie. Where it is thought likely that more than simple, non-invasive investigations (eg. urinalysis, simple radiographs) will be needed, or a second/specialist opinion sought. Prospective, local arrangements (see above) should address these and related issues.
- Major systemic illness*
- More than minor injury* – eg. those who have sustained a head injury and in whom any degree of brain injury is possible <sup>7</sup>
- Resuscitation*
- Suspected acute surgical conditions* – eg acute appendicitis
- Child protection problems*; this is a potentially problematic area as such cases may be children brought for other apparently innocent reasons, or in the guise of other presentations, and
- Sick newborns and infants* – ie. those < 12 months of age

Realistically, patients with these problems will attend from time to time and a safe and reasonable approach to such individuals is one aim of this guidance.

## **Summary**

This document aims to provide guidance for those responsible for setting up and running minor injury/illness services which may be used by children. It acknowledges that these services may be provided in a wide range of localities, may have a variety of different staffing structures, and relationships with Accident & Emergency and secondary Paediatric Services. Whatever the setting the aim should be to ensure that children are seen by appropriately skilled staff in a child centred environment.

## **7. References**

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