Children’s hospital at home

This service is in line with many of the core principles contained in The NHS Plan, such as shaping services around the patient, including family members in decisions about care, and working in new and flexible ways. The team offers a service seven days a week from 8am to 10pm, with overnight on-call staff available for telephone advice.

The aim of the following case study is to demonstrate how parents can be empowered in the care of their child and encouraged to participate in care decisions.

Case study
Jake Baines is a two-year-old boy who was referred to our team with wheezy episodes on four occasions. On our first visit his mother told us that Jake was born at full term, and had an uncomplicated vaginal delivery. He had bronchiolitis at five weeks and has had recurrent chest infections since then. The GP had prescribed a course of oral prednisolone for three days, beclometasone (100 micrograms one puff twice a day), and salbutamol (100 micrograms two puffs four times a day). Jake’s mother reported that he had been prescribed inhalers before, but he did not like the spacer device so she had been spraying the inhaler directly into his mouth.

During this visit, it was very important for us to listen to the mother’s account of Jake’s problems and how she had been managing them, so that we could give relevant support and advice which would in turn empower her to develop her own skills and knowledge to care for her child at home.

Clinically, Jake was wheezy, with some chest recession and an increased respiratory rate. He had vomited with coughing and was not eating much. Yet he was cool to touch, his colour was good, he did not vomit with coughing and was not eating much. Yet he was cool to touch, his colour was good. He had bronchiolitis at five weeks and has had recurrent chest infections since then.

Access to the hospital at home scheme
Acute illness in childhood is defined as ‘childhood illness with rapid onset, severe symptoms, and brief duration’ (Neill, 2000). The Rugby Children’s Hospital at Home service is provided for acutely ill children and commonly sees children with respiratory tract infections, fever, and gastroenteritis. Most of these children are referred by their GP, and as a result of the scheme, rarely need to be admitted to hospital.

We can assess the child’s condition, provide a care plan, and implement and evaluate care, in partnership with parents at home. We are able to visit the child several times a day if needed. We also see children with an acute exacerbation of a chronic illness, such as asthma, eczema and constipation, where we can offer short-term support and advice. In addition to medical conditions, we take referrals from A&E of children with burns, scalds and wounds. Our final group of children are those who have needed inpatient care but can be discharged early, for example, for the completion of a course of intravenous antibiotics, ongoing assessment and support with inhaler technique, and further support and advice following febrile convolution.

CARE PATHWAYS
For each of the conditions we commonly see, we have written an evidence-based protocol to guide our decision-making. We use advanced skills in assessing the child’s condition and the parents’ ability to manage at home, and have direct access to a paediatric registrar if we need further advice or if we need to admit a child to hospital. We carry oxygen, suction, and ambu-bags in case of emergency situations.

We discharge children when we and the parents are happy about the child’s condition and any continuing care and we offer access to our service for 48 hours after discharge if needed. We are conscious of the value of collaborative working and liaise with primary health care colleagues whenever throughout any episode of care.

Rugby Children’s Hospital at Home is an innovative community-based service for acutely ill children (Box 1). It enables children to be cared for at home during their illness by offering a plan of care in partnership with the child’s parents. The child is visited as frequently as needed to ensure his or her safety and according to the child’s condition (Samwell, 2000).
Fourth contact  Two months later, Jake was referred again by his GP. His mother had observed that he was becoming wheezy and had increased his salbutamol inhalers, but she was still concerned so sought further advice.

When I visited them at 21.45, he was sleeping but wheezing. His respiration rate was 54 breaths per minute, his oxygen saturation was 92 per cent, his pulse was 106, and he had some chest recession. After consulting his GP and Jake’s mother, I gave him salbutamol 2.5mg via a nebuliser. He responded well and his condition improved.

Jake’s mother wanted to stay at home rather than take her son to hospital, so we agreed that she would give him five puffs of salbutamol every two hours through the night (British Thoracic Society/Scottish Intercollegiate Guidelines Network, 2003) and observe his breathing for any deterioration. I informed the ward of Jake’s condition, and suggested that his parents take Jake straight there if the wheezing became worse.

When I visited the next morning, Jake was much better although he was still wheezy with some chest recession and tachypnoea. His mother had given him inhalers throughout the night and was pleased with his improvement. She was also very pleased that they were able to stay at home. After two more visits, and a gradual continued improvement, Jake was discharged from our care.

This fourth episode demonstrated an even greater participation on the part of Jake’s parents. We valued his mother’s opinion and skill in caring for her child, and gave her the control she wanted over the services she needed.

Conclusion  This case study demonstrates the challenges and opportunities to support and teach Jake’s parents about the treatment their child needed, enabling them to make decisions about their care. It was important to carefully assess not only the child’s condition but also his parents understanding about his condition and treatment, and to listen to their concerns to ensure the information given was what they needed (Kai, 1996 a; 1996b).

We could then encourage them to continue to assess and care for their child, and choose for themselves what level of support they needed.

The Hospital at Home team at Rugby Children’s Hospital is currently reviewing its asthma care pathway in line with the new BTS asthma guidelines published in February 2003. next day, and Jake’s mother knew that she could telephone us at any time for advice or if she became concerned about her son’s condition.

It was important to give enough information and advice to ensure Jake’s safety. This was based on our assessment of his condition and of his parents’ level of understanding and ability to cope. At the next visit we planned to reinforce and add to the information we had already given them.

Response to treatment  The next day we phoned Jake’s parents and his mother reported that Jake was responding well to his inhalers. She was happy for us to visit later that day. On this visit Jake was still audibly wheezy but was happily eating his tea. His mother reported that he had been much more tolerant of his inhalers. I observed her using the inhalers with the spacer device and her technique was very good. I checked his oxygen saturation levels which were 97 per cent. This had the effect of reinforcing the benefit of the inhalers to Jake’s mother. A telephone call the following day confirmed that Jake was doing well, and that his mother felt able to continue his care without our support.

We worked closely with Jake’s parents (mainly his mother) offering not only advice but also an opportunity for her to develop her skill in managing Jake’s care. She knew that at any time she could phone us for further help or advice, but she was in control and could make that decision.

Second contact  We saw Jake again three weeks later. His parents had taken him to A&E after an episode of wheezing. He was sent to the children’s ward, where he was given salbutamol 2.5mg via a nebuliser, a course of oral steroids and then sent home to our care. Four visits were made over the next two days and with our support and advice Jake’s mother demonstrated increasing confidence in managing Jake’s condition.

She wanted to know if he had asthma, so we discussed the fact that it was difficult to make a diagnosis in such a young child but he had the same symptoms as asthma and therefore the treatment was the same. She was also given the details of the National Asthma Campaign for further literature and support (see p49).

Third contact  Two months later, Jake had another wheezy episode. This time, only telephone support was needed, as Jake’s mother felt confident to manage her son’s care and they were going on holiday the next day. We knew from our previous contact with the family that Jake’s parents were able to make safe decisions with regard to his care.