



National Policy National Procedure National Protocol National Guideline
National Clinical Guideline

HSE Procedure for Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs within HSE Regional Health Areas

DOCUMENT GOVERNANCE ¹

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Note: HSE National 3PGs should be formally reviewed every 3 years, unless new legislative/regulatory or emerging issues/research/technology/audit etc. dictates sooner.

¹ Records the senior management roles involved in the governance and development of the document.

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HSE procedure for Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs (CCHN) within HSE Regional Health Areas (RHA).
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Paediatric Homecare Package (PHCP) Coordinators Nurse Practice Group Access and Integration
Short summary:
HSE procedure to Initiate a Paediatric Homecare Package for Children within HSE RHA.
Description:
This HSE procedure has been developed to provide clear guidance to all CCHN Children with Complex Healthcare Needs governance groups and PHCP Coordinators in the HSE of the procedure for initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs within HSE RHA. This procedure provides a framework to support HSE PHCP Coordinators in the initiating procedure and to ensure a standardization of the process across HSE RHA's.

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Planning

1.1. Purpose

This HSE procedure has been developed to provide clear guidance to all HSE Health Region governance groups when initiating a Paediatric Homecare Package (PHCP) for Children with Complex Healthcare Needs (CCHN).

This procedure should be read in conjunction with other CCHN PPPGs, local relevant policies/protocols/guidelines that include the Completion of a PCAT, Review of a PHCP, Planned Parental Absence and transfer of a PHCP and any other relevant documents that incorporate best practice.

1.2 Scope

This procedure applies to all HSE Health Region governance groups when initiating a PHCP for CCHN.

Out of Scope; this procedure does not apply to homecare packages funded solely by HSE social care.

1.3 Target population

This HSE Procedure applies to all staff involved in the initiation of a paediatric home care package which is funded by HSE RHA's for Children with Complex Healthcare Needs (0-18 years)

1.4. Target users

This procedure applies to all HSE Health Region governance groups when initiating a PHCP for CCHN.

1.5 Objective(s)

- Provide clear guidance to all HSE Health Region governance groups when initiating a PHCP for CCHN .
- Ensure standardised initiation of a PHCP for CCHN.

1.6 Outcome(s)

There will be a standardised procedure for initiating a PHCP for CCHN in HSE RHA's.

1.7 Disclosure of interests

No conflicts of interest are declared.

1.8 Rationale / alignment with HSE national priorities

This procedure is required in order to standardise the Procedure for initiating PHCP for CCHN. Caring for children close to home is a key priority for Irish healthcare policy (Government of Ireland, 2018, HSE 2018a, HSE 2017). Sláintecare (Government of Ireland, 2018) & Sláintecare Action Plan (2023) identifies the need to transfer care from acute to community settings (including homecare) and outlines a strategy to expand community- based healthcare in order to achieve the delivery of care closer to home. This model of care is also supported by the HSE Strategic Plan for 2019 (HSE 2018a), Leading the Way; A National Strategy for the Future of Children's Nursing in Ireland 2021-2031

and the National Model of Care for Paediatric Healthcare Services in Ireland (HSE 2017).

1.9 Supporting evidence

- Nurses and Midwives Act (2011).
- Health Act (2007).
- Health Information and Quality Authority (2012) National Standards for Safer Better Healthcare.
- Health Services Executive (2019a) Child Protection and Welfare Policy
- Health Services Executive (2019b) Data Protection Policy
- Health Service Executive (HSE) (2020b) Incident Management Framework
- National Quality Assurance Initiative (2021)
- Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives
- Nursing and Midwifery Board of Ireland (2015a) Recording Clinical Practice Professional Guidance
- Nursing and Midwifery Board of Ireland (2015b) Scope of Nursing and Midwifery Practice Framework
- Health Services Executive (2011) Standards and Recommended Practices for Healthcare Records Management
- Health Services Executive (2022v2) National Consent Policy, HSE National Office for Human Rights and Equality Policy

Legislative Documents

- Nurses and Midwives Act (2011).
- Government of Ireland (1947) Health Act. www.irishstatutebook.ie
- Government of Ireland (1970) Health Care Act. www.irishstatutebook.ie
- Government of Ireland Freedom of Information Acts 1997 and 2003,
- Government of Ireland Health Act (2007).
- Government of Ireland Pharmacy Act (2007).
- Government of Ireland (2011) Nurses and Midwives Act. www.irishstatutebook.ie
- Government of Ireland (2015) Children First Act. www.irishstatutebook.ie
- Safety Health and Welfare at Work Act (2005) Dublin: Government of Ireland, Stationery Office, Dublin.
- Safety Health and Welfare at Work Act (General Application) Regulations (2007) Dublin: Government of Ireland, Stationery Office, Dublin.

2.0 Methodology

2.1. List of key questions this National 3PG will answer

- What are the key procedures to follow in the initiating a PHCP for a CCHN within HSE RHA's to ensure standardisation of the process

2.2. Describe and document the evidence search

The Paediatric Home Care Package Coordinators Nurse Practice Group undertook an extensive literature review. The objective of the literature review was to establish current evidence and best practice, and seek new and emerging evidence, in relation to initiating a PHCP for CCHN's within HSE RHA's. Included in the search was the literature search completed with Version 0 of this procedure.

A literature search was undertaken by the National Quality Assurance Initiative reviewers in 2017, revised in 2019 and re-revised in 2025 by the PHCP Coordinators Nurse Practice Group. The search terms were "Children with complex healthcare needs" and 'homecare package', 'nursing' "homecare" "discharge planning". All major library search databases were used to retrieve the latest publications to inform this PPPG, including: CINAHL PubMed and Medline to access relevant peer reviewed articles. The search was limited initially to 2007-2019 and updated to include 2019 to 2025. The Cochrane Library was searched and two systematic reviews relating to the topic were identified as well as relevant literature on discharge and homecare for CCHN. The search yielded no policies and guidelines for initiating a paediatric homecare package. However, one policy was sourced from the Health and Social Care Board in Northern Ireland- Discharge pathway for children with very complex health needs.

2.3. Describe the method of screening and evidence appraisal

There was a dearth of research based literature directly related to policies and guidelines for initiation of a paediatric homecare package for CCHN's within a community setting. However, there is a number of key articles supporting a formalised process for initiation of a PHCP. The NQAI (2021) findings offered data on the initiation of HSE PHCPs in Ireland at the time of the review.

2.3.1 Process the NQAI reviewers used to formulate recommendations for initiation of PHCP (2021)

The NQAI (2021) found that Paediatric Home Care Packages were initiated for children at different times; where parents have had their child at home already and the PHCP is a response to a change in the child's circumstances, it often grows organically in response to the increasing needs of the CCHN. This is in contrast to the child being discharged

home from the hospital with a new PHCP; there is urgency and pressure in both processes, however the degree can vary. Regardless of where the PHCP is initiated, similar principles and processes apply to ensure that the child's care is continuous and the parents receive the support and education that enables them to provide safe care without undue stress (Page et al, 2020). It was reported in the NQAI (2021) by both parents and HSE staff that the discharge planning process was often an ad hoc arrangement and there was no evidence of a systematic standardised approach across the country. Even where there was evidence of good discharge planning, there were still some communication difficulties between professional groups concerning who did what and when. This included misperceptions over who agreed the number of support hours and the skill mix of the homecare package in the business case. These inconsistencies in discharge planning do not support a seamless discharge and service delivery.

Multi-professional team work with clarity of roles and responsibilities are central to an effective process that involves the child and family working collaboratively with the various services and professionals towards one common goal: to ensure early planned discharge and continuing home care (Noyles et al, 2005; Page et al, 2020). Communication is essential in the discharge process for a standardisation in care co-ordination and communication (Rush et al., 2020, Glick et al., 2023 and Huth et al., 2023). Modern clinical practice seeks to reduce a patient's time in an acute hospital to a minimum. In order to ensure continuity of care during the transition from secondary or tertiary care to community setting, effective communication between practitioners is required and this is an important step towards improving the whole care pathway and enabling the delivery of safe, person-centred care (Statile et al, 2016; HIQA, 3rd July 2013).

2.3.2 Transition to regional/local paediatric units

In the NQAI (2021) the families, where there was evidence of good discharge planning systems, suggested that it had been a predominantly positive experience, but all families stated that the time to discharge was long and that the process may have improved if they had been transferred back to a local hospital earlier. Transition of CCHN to paediatric units at a regional level as part of the discharge pathway has many benefits. It allows for the development of competencies of local hospital staff, enables family life to get back on track rather than being "on hold", and facilitates a phased discharge home. Parents and staff highly valued a phased discharge and found it gave them the opportunity to identify knowledge or skill gaps (Brenner et al, 2015). It can also support local re-admission pathways and enables local hospitals to prepare for unplanned admissions and have access to equipment and supplies pertinent to the CCHN if required (Gibbs et al 2010; Hudson et al, 2014).

The following five principals from the HSE Integrated Care Guidance: A practical guide to discharge and transfer from hospital (2014) were applied by the NQAI reviewers when formulating the original procedure when initiating a Paediatric Homecare Package

for Children with Complex Healthcare Needs in RHA (2021) and these remain relevant today.

- Services should be organised around the service user.
- All stakeholders recognise they are interdependent and understand that action in one part of the system has an impact elsewhere
- Vision, values, objectives and actions (including redesign of services) are all shared.
- Service users experience services as seamless and the boundaries between services providers are not apparent
- One size of integrated care does not fit all, it is service user centred.

2.4 Provide a summary of the evidence from the literature

The future direction of care to CCHN should be to provide as much care as close to home as possible, and to achieve this we must strengthen both primary and community care of CCHN and work together across disciplines throughout the country to develop a child health service that meets the current and future needs of our children (HSE, 2014: Sláintecare (2018) & Sláintecare Action Plan (2023)). The initiation of a paediatric home care package strengthens links between primary, secondary and tertiary care, and provides additional support to parents, General Practitioners and Public Health Nurses to manage CCHN closer to home. A range of services are now provided in the community to support CCHN to be cared for at home including PHCP's which provide nursing support to children at home. A PHCP can be initiated at the time of discharge or while the child is at home. Initiation and discharge process must be underpinned by formal standard protocols between the acute paediatric hospitals and the regional hospitals; between the acute paediatric hospitals and community services; between the regional hospitals and community services. A fundamental prerequisite of the initiation/discharge process must be early engagement between case managers/ coordinators, hospital discharge planners and managers and receiving clinicians in the community (HSE, 2014). An integrated care pathway for children and young people that enables them to move from primary to secondary to tertiary care as required, and back again, is the cornerstone of the national model of care for paediatrics (2017). A study undertaken by Noyes (2004) asserts that parents have reported consistently that discharge meetings are managed ineffectively and fail to bring about any meaningful or desired actions to enable their child to be discharged home with supports in place. Multiple factors influence comprehension and adherence to discharge instructions for children with complex medical conditions.

2.4.1 HSE PHCP Coordinators and Multi-disciplinary input into discharge

Hillis et al. (2016) goes on to affirm that the inclusion of a named care coordinator or Case Manager in a multidisciplinary team is pivotal in ensuring the discharge process is effective and care needs are sustained in the community. This is also echoed in the National Policy (DOHC 2010a).

Baxter et al (2023) also notes the viewpoint that improvements in care for the family and child existed where there was a multidisciplinary approach adopted. Peter et al. (2011) acknowledges that care coordination can be complex and time consuming but is clear in the message that the role remains key to the effective and sustained management of the many complex and individual issues surrounding the care of children with complex healthcare needs. This is supported by the recommendation for standardisation in care co-ordination and suggest where continuity of care may become fragmented or break down there is increased risk post discharge to community (Rush et al, 2020).

Hall et al (2023) continues with the view that there needs to be clear defined roles, responsibilities and accountability with the proactive involvement of parents as part of the team. Hillis et al. (2016) suggests that a tailor made service for each child with complex needs is required prior to discharge to ensure that community healthcare services are viable and sustainable and suggests that effective home care alleviates the isolation children and families experience during the transition from hospital to home and further argues that adopting a child centred approach can significantly reduce re-hospitalisation and the cost of care for children with complex and life-limiting conditions.


Effective communication systems are pivotal to ensure that everyone involved receives the correct level of information in a timely manner that is easily understood (DOHC 2010b) Glick et al (2023) emphasises the importance of health literacy combined with a family centred approach in the effective management of the discharge process. This is also echoed as an essential component in discharge as documented in the National Rapid Discharge Guidance (HSE 2015b). Recognition is also given that rapid discharges required multidisciplinary input and coordination as these discharges are most often complex processes. Communication interventions are required and when introduced led to a reduction in readmissions and Emergency Department visits (Huth et al. 2023). This procedure introduces a PHCP discharge nursing letter in step 6, (Appendix 6) to support the discharge process.

Documents and check lists like the newly rolled out 'Abhaile Planner' Booklet (2023) which is being used by the Children's Hospital Ireland Group supports discharge planning and bridges the gap between hospital and community care. The prompts are pertinent to such discharges and are utilised as a basis for the check list. Although the option for discharge should never be rushed, there is no reason why discharge should be delayed due to a lack of clarity or familiarity with procedural arrangements and processes. These CCHN are entitled to the same opportunities as others; however they face many barriers in exercising their basic human rights (Donnelly & Kilkelly, 2011).

3.0 Procedure.

Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs within HSE Regional Health Areas (RHA's).

Where steps of the process are not being met in a timely manner, the PHCP Coordinator must identify any issues influencing the delay. These issues must be brought to the Integrated Health Areas (IHA) operational governance group for discussion and management.

Stage 1
All referrals for Paediatric Homecare Packages (PHCP) should be forwarded to the Director of Public Health Nursing (DPHN) and/or PHCP Coordinator. The DPHN delegates the referral to the HSE PHCP Coordinator. However, on occasion the DPHN may redirect the request to a service more appropriate to meet the child's needs.

Stage 2 (Recommended to be completed within 2 weeks of Stage 1)
The HSE PHCP Coordinator completes an assessment of the nursing requirements for a PHCP within 2 weeks of receipt of the request for a PHCP. This includes ; For the CCHN within the hospital setting <ul style="list-style-type: none">• Consultation with the relevant medical clinicians and lead <small>Clinical Nurse Specialist</small>• If required the HSE PHCP Coordinator organises a multidisciplinary “Team Around the Child” TAC meeting. The meeting may involve any or all of the professionals involved at management or case assessment level should include the family.• Linking with the Abhaile Planner in the acute setting if appropriate• P-CAT assessment completed by the PHCP Coordinator with another registered nurse involved in the clinical care of the child (refer to P-CAT PPPG). All PCAT submitted as part of PHCP application must have been completed within 2 months of the application.• Ascertain with medical team if child is medically stable for discharge home, exception being if discharge is for palliative care.• Confirm CCHN/family has been assessed as safe for discharge with all safeguarding issues considered and addressed.• Meet with the child and family to outline the PHCP process and provide parental information including parental information leaflet.• Agree the nursing care hours required to meet the CCHNs clinical nursing needs with relevant stakeholders. This is the PHCP agreed quantum of service.• Consider with relevant stakeholders a phased discharge home to the local paediatric unit if appropriate. Tertiary hospital services to lead on phased discharge.• Organise referrals to Children’s Disability Network team (CDNT) or other HSE Care teams as appropriate.• Identify specific education and training requirements of staff.• Identify equipment and consumable requirements and procure same.

For CCHN cared for at home

- Ascertain if the child is already known to the PHN service, HSE PHCP Coordinator to link with area PHN.
- Link with or meet with the medical clinicians and lead CNS.
- P-CAT assessment completed by the PHCP Coordinator with another registered nurse involved in the clinical care of the child (refer to P-CAT PPPG). PHCP Coordinator meets with the child and family to outline the PHCP process and provide parental information including parental information leaflet. All PCAT submitted as part of PHCP application must have been completed within 2 months of the application.
- The PCAT assessors agree a quantum of service for CCHN with relevant stakeholders.
- Following risk assessments a Planned Parental Absence may be agreed if appropriate
- Identify specific education and training requirements of staff.





Stage 3 (Recommended to be completed within 2 weeks of Stage 2)

- The HSE PHCP Coordinator presents for discussion the request for a PHCP at the IHA CCHN operational governance group meeting.
- The presentation should be prioritised on the agenda.
- The IHA operational governance group may require further clarification or information prior to proceeding with the PHCP.
- The IHA operational governance group must confirm funding is available from REO for the PHCP.
- Following review of the request for PHCP the CCHN IHA operational governance group will agree the proposed quantum of service and any planned parental absence if appropriate.
- Or alternatively, the request may be redirected to a more appropriate service for the child within the HSE or outside the HSE.
- PHCP Coordinator should engage with the local paediatric unit if a phased discharge home is required to inform and assure the unit that a PHCP has been secured and support a smooth transition home.



Stage 4 (Recommended to be completed within 5 weeks of Stage 3)

- A PHCP business case is prepared and forwarded with PCAT assessment to the IHA manager for approval
- Once the PHCP hours are approved confirmation is issued from IHA manager's office. the PHCP Coordinator requests a procurement number and the approved service providers under the Dynamic Purchasing System HSE 4693 are invited to submit a tender for homecare services. Closing date for receipt of submissions is

<p>within 2 weeks of invitation or to align before the expected date of discharge of the child.</p> <ul style="list-style-type: none">• Tenders are evaluated by the CCHN IHA operational governance group utilising the Dynamic Purchasing System within 2 weeks of the closing date of the submissions.• Written confirmation of the outcome is forwarded to the family and service provider and to the initial referral agent.• The CCHN PHCP details are included in the Service Arrangement by the CCHN IHA operational governance group.• The HSE PHCP Coordinator completes an environmental paediatric home nursing risk assessment. Control measures are identified and applied to any risks identified including for planned parental absence if appropriate. The HSE will endeavour to lessen as far as is reasonably practicable all realistically foreseeable risks associated with caring for a child with complex healthcare needs while being cared for at home.• The HSE PHCP Coordinator organises a multidisciplinary “Team Around the Child” TAC meeting. The meeting may involve any or all of the professionals involved at management or case assessment level and should include the family. In certain circumstances, particularly where urgent, the case discussion may take the form of a less formal contact such as teleconference. The purpose of the case discussion is:<ul style="list-style-type: none">➤ To share available information and formulate a multidisciplinary care plan➤ To consider what immediate actions should be taken to support the child and , family and allocate responsibility for actions decided at the case discussion.➤ To develop a care plan and implement any early interventions required and identify other areas of support that may benefit the child and family.➤ To determine and agree timeframes

Stage 5 to run concurrently with 4 (completed within 2 weeks of Stage 4)
Service Provider- finalise the completion of a staff roster and formulate a care plan. All care plans are submitted to the HSE PHCP Coordinator for review.

Stage 6 (Recommended to be completed 2 weeks prior to expected discharge/ initiation)
Final discharge/initiation of PHCP A final discharge/initiation of PHCP meeting is convened; The following to be confirmed and documented prior to discharge/initiation of PHCP; <ul style="list-style-type: none">• The CCHN Agreement of Care is finalised and signed by HSE, service provider and parents

- The CCHN parents have received training on the care needs of the CCHN and are competent to carry out the child's care needs.
- The CCHN has a medical card & is registered with a GP and has a named lead medical consultant.
- The parent has access to a telephone.
- The agreed quantum of service continues to meet the child's needs and no new clinical needs have arisen since the homecare plan was finalised.
- The CCHN has a home medical management plan. This plan should outline the acceptable parameters of nursing observations that indicate if and when a clinical medical review or intervention is required e.g. temperatures, o2 saturations, sputum etc.
- The frequency and schedule for medical, allied health review for the CCHN at the discharging hospital including follow up appointments are known to the HSE PHCP Coordinator.
- If discharge is being phased to a local hospital, responsibilities and governance arrangements between the discharging hospital and Health Region are agreed and in place.
- A plan is in place in the event of an emergency
 - That ambulance control has included the CCHN on their data base (if required).
 - That parents have requested priority electricity reconnection.
 - That Gardai can facilitate urgent transfer to hospital (if required).Written confirmation is required of the above (If required).
- The CCHN has a written emergency protocol for admission to local hospital if required to include.
 - What area of hospital will they attend; e.g. A & E or paediatric ward.
 - An admission letter from the CCHN consultant outlining any requirements the consultant may have if the CCHN presents at the hospital.
- Equipment and consumable requirements are finalised and procurement process ascertained.
- If the CCHN is being discharged from hospital the PHCP Nursing Discharge letter Appendix 6 is to be completed 24-48 hours prior to the hospital discharge by the hospital staff and emailed to the HSE PHCP Coordinator.

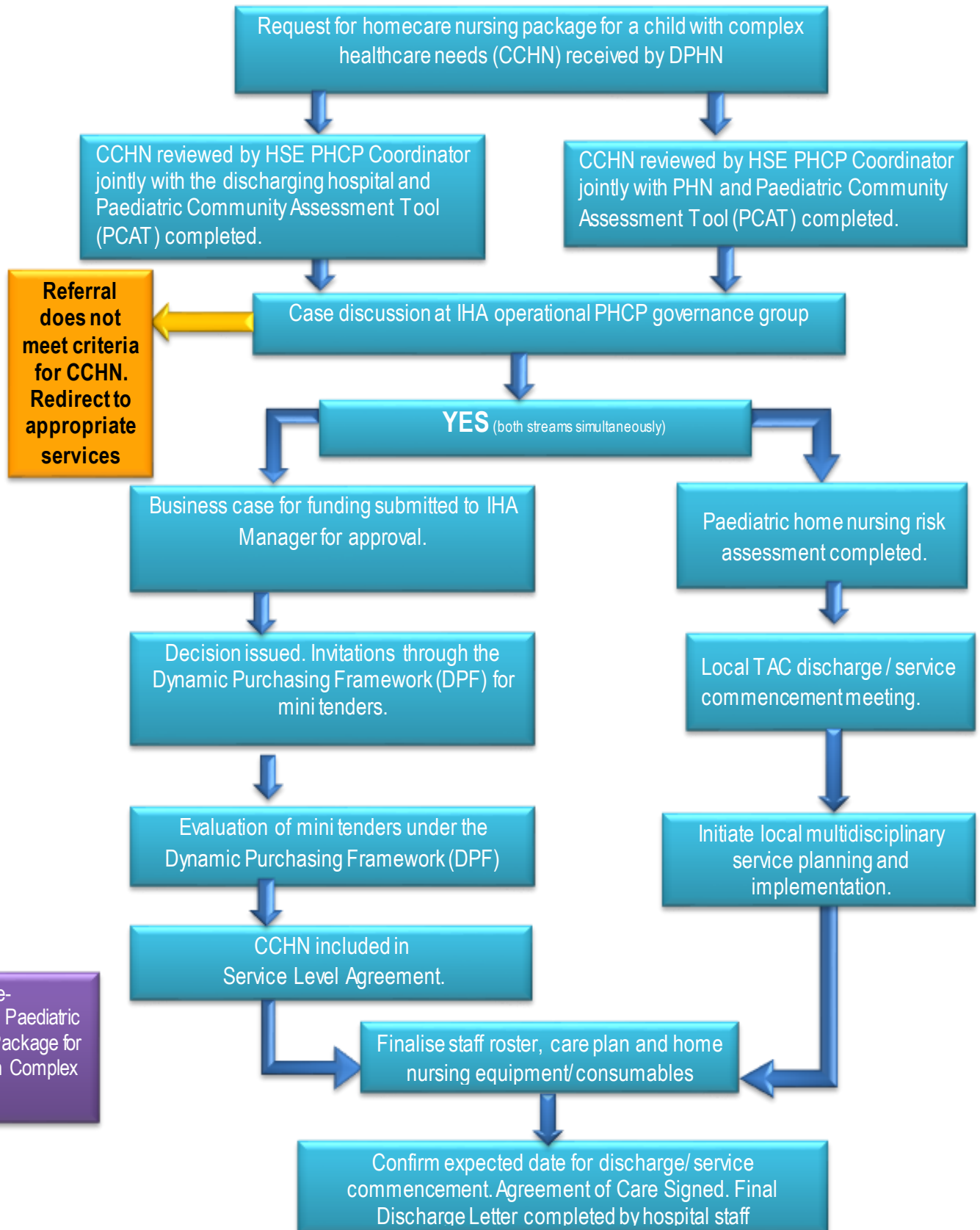
The CCHN is reviewed in the home by the HSE PHCP Coordinator in the first week post discharge.



Stage 7 (completed at 3 months post discharge/ initiation)

A review of the PHCP is undertaken within 3 months of discharge/ initiation of CCHN PHCP and 6 monthly thereafter as per PHCP review guideline.

PHCP Initiation Flow Chart



See guideline-
Reviewing a Paediatric Homecare Package for Children with Complex Healthcare

4.0 Specific roles and responsibilities

4.1 HSE Regional Health Area

The REO's have lead responsibility for regional implementation of this Procedure throughout HSE health region.

4.2 Health Region CCHN Governance Groups

The Regional PHCP Clinical and Corporate Governance Group is a governance management group whose role is directly concerned with establishing, developing and implementing RHA wide quality and safety structures are responsible for ensuring that all healthcare staff who are involved in any aspect of the initiation of the child's PHCP read, sign, implement and adhere to the Procedure within the scope of their work practice (Appendix 5). The IHA operational governance group will implement the procedure.

4.3 HSE PHCP Coordinator

Under the leadership of the Regional PHCP Clinical and Corporate Governance Group and as a member of the IHA PHCP Operational Governance Group, the HSE PHCP coordinator will be responsible for the management of Nursing Services to children cared for in the community who have complex healthcare needs. HSE PHCP coordinator will coordinate the initiation of a PHCP for the CCHN and will work collaboratively with parent(s) to support them in their role as the Primary Carer to ensure a seamless initiation of care where their child's health and development needs are met and that the best possible care is provided thereby maintaining their child at home. HSE PHCP coordinator will develop and manage working relationships with a team around the child multidisciplinary team to ensure continuity of services into the Health Region.

5.0 Consultation

5.1. Stakeholder involvement

National consultation workshop with HSE PHCP coordinator group to inform and agree procedure for Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs.

Consultation with acute services nurse specialists department.

Consultation with PHN and CCHN services within the HSE.

All feedback received was reviewed and agreed by the Paediatric Home Care Package Coordinators Nurse Practice Group. Agreement was reached on the whether to accept or reject the feedback. The procedure was developed following this and all feedback received is retained by Margaret O'Meara

5.2. External review

The procedure was reviewed by the National Practice Development Coordinator for PHNs ONMSD.

6.0 National implementation plan

6.1 Resource implications

It is necessary for all Health Region's to have a Regional PHCP Clinical and Corporate Governance Group and for each IHA to have a IHA PHCP Operational Governance Group and a HSE PHCP coordinator for CCHN's identified. RHA will disseminate the Procedure to all relevant staff via the Health Region CCHN Governance Groups.

The procedure will be available to staff on The HSE National PPPG Central Repository.

6.2 Describe the structure and governance of the national implementation team.

HSE management has approved this procedure

6.3 List tools and resources developed to support local implementation of the National 3PG.

- Parent Information Leaflet
- Agreement of Care form
- PCAT Assessment Form

6.4 Expected date of full implementation

01/10/2025

7.0 Governance and approval

The Procedure was commissioned by the HSE to support delivery of PHCP services. Following development of the Procedure, a checklist was used in assessing that the Procedure met the standards outlined in How to Develop HSE National PPPGs – A Practical Guide, and signed and dated by the Chairperson of the Development Group.

The PHCP Coordinators Nurse Practice Group recommended the Procedure to HSE management with a signed and dated copy of the checklist and submitted the final document and checklist to for sign off by National Director of Access and Integration.

Once approved, the final version was converted to a PDF document to ensure the integrity of the Procedure and uploaded to the HSE National Central Repository. A signed and dated copy of the checklist was attached to the master copy, which is retained in Primary Care Access and Integration.

8.0 Communication and dissemination plan

- This Procedure will be issued through the RHA governance structures for dissemination to IHA PHCP Operational Governance Groups.
- The Procedure will also be issued to each of the approved service providers.
- The Procedure will be issued to the acute children's services including CHI and local paediatric units.

The document can be accessed only on the [HSE National Central Repository](#) which is the single trusted source for accessing, storage and document control for National 3PGs. No duplicate copies of the procedure should be accessible in any secondary electronic locations, only the link to the document on the Repository should be used on other locations. This link will automatically update in all locations if changed on the Repository.

It is the responsibility of each Health Region PHCP Clinical & Corporate governance group to implement the procedure in each IHA outlining actions required, specific roles and responsibilities, and timelines etc. As part of the implementation it is essential there are IHA PHCP Operational Governance Groups.

9.0 Sustainability

9.1 Describe the plan for national monitoring and audit

It is the responsibility of each Regional PHCP Clinical and Corporate Governance Group and IHA PHCP Operational Governance Group to outline actions required, specific roles and responsibilities, and timelines etc. As part of the implementation it is essential there is a Regional PHCP Clinical and Corporate Governance Group and IHA PHCP Operational Governance Group. A barrier to the implementation of this procedure is the absence of active Governance groups.

Managers are required to monitor and audit the implementation of this procedure within their area of responsibility using the Audit Checklist in Appendix 4 and maintain evidence of same.

10.0 Review/ update

10.1 Next review date

This procedure will be reviewed in 3 years unless there is a change in best practice

- Method for amending procedure if new evidence emerges.

If new evidence emerges, the Paediatric Home Care Package Coordinators Nurse Practice Group will be reconvened and the new evidence will be considered for integration into the procedure.

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<https://www.wellchild.org.uk/wp-content/uploads/2024/05/10-Principles-for-Complex-Discharge-May-2024.pdf>

12.0 Glossary of terms

CCHN ; Children with Complex Healthcare Needs	Children with Complex Healthcare Needs have substantial medical healthcare needs as a result of one or more congenital, acquired or chronic conditions, with functional limitations that often requires technology assistance and ongoing nursing care primarily to support their parent(s) to care for them at home thereby preventing hospital readmission, in some instances to avert death and in others to provide palliative and end of life care. A home care package is required when a child has nursing needs that cannot be met by existing HSE and Children's Disability services. (Elias E et al, 2012)
HSE PHCP Coordinator	This term applies to the HSE case coordinator for CCHN who has responsibility for managing PHCP's.
NQAI	HSE National Quality Assurance Initiative (2021) was commissioned by the HSE to determine planning, development and delivery models nationally and to inform the development of a national standard service framework for Children with Complex healthcare needs.
PHCP Paediatric Home Care Package	is a home nursing service provided by HSE when a child has healthcare and/or nursing needs that cannot be met by existing HSE and social care services.
REO's	Regional Executive Officers who are accountable and responsible for the HSE operational service delivery within their respective regions

Health region (RHA)	Regional Health Area. The Health Service Executive (HSE) new structures to commence in 2024 delivers health services in the community through 6 Regional Health Areas in Ireland.
IHA PHCP Operational Governance Group	The Integrated Health Area (IHA) Paediatric Homecare Packages (PHCP) Operational Governance Group provides operational management and coordination of PHCP for Children with Complex Healthcare Needs (CCHN) within the designated Integrated Health Area (IHA).
RHA PHCP Clinical & Corporate Governance Group	The Regional PHCP Clinical and Corporate Governance Group is a governance management group whose role is directly concerned with establishing, developing and implementing RHA wide quality and safety structures, processes, standards and oversight across the PHCP service which promote compliance with NQAI recommendations and standards, service user experience and safety..
Service/Private Provider	Is a company commissioned by the HSE to administer a Paediatric homecare Package to Children with Complex Healthcare Needs and a service arrangement is drawn up. The Private Healthcare Provider is responsible for providing staff with the relevant skills/competencies for the child as identified. The reporting relationship will be to the service provider nurse manager on professional and clinical matters. Clinical Governance for care of the Child remains with the service provider.
Service Arrangement	The HSE enter into an arrangement for the provision of services to Service Users. The terms and conditions of the clinical, corporate and financial governance standards are specified in the agreement.
Team Around the Child (TAC)	Team Around the Child (TAC) is “an individualised and evolving team of the healthcare practitioners who see the child and family on a regular basis to provide practical, coordinated support in therapy and treatment. The purpose is to provide a more coordinated thorough and consistent approach to supporting a child and their family.

13.0 Appendices

Appendix 1: Membership of Development Group

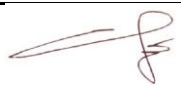
Membership of Paediatric Home Care Package Coordinators Nurse Practice Group	
Name	Role and position
Margaret O'Meara	PHCP Clinical Lead Primary Care Access and Integration
Joanna Mc Carthy	SW RHA HSE PHCP Coordinator /DPHN West Cork
Fiona Moriarty	SW RHA HSE PHCP Coordinator Kerry
Mary Cott	SW RHA HSE PHCP Coordinator North Lee Cork
Ann Marie Healy	SW RHA HSE PHCP Coordinator South Lee Cork

Appendix 2: Membership of Approval Governance Group

Membership of PHCP PPPG Approval Group	
Name	Role and position
TJ Dunford	Assistant National Director Primary Care Access & Integration
Maeve Raeside	General Manager Primary Care Access and Integration
Margaret O'Meara	PHCP Clinical Lead Primary Care, Primary Care
Helen Martin	Director Of Public Health Nursing Galway

Sign-off by Chair of Approval Governance Group

HSE National procedure for Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs within HSE Primary Care Access & Integration was formally ratified on 01/09/2025.

Name: (print)	TJ Dunford
Title:	Assistant National Director Primary Care Access and Integration
Signature: (e-signatures accepted)	

Appendix 3: Sample implementation plan template

Adapted from National Clinical Effectiveness Committee (NCEC) Implementation Guide and Toolkit (Department of Health 2018)

National 3PG Title: HSE National Procedure for Initiating a Paediatric Homecare Package for Children with Complex Healthcare Needs					
Expected date of implementation 01/10/2025					
Implementation lead/role: Health Region PHCP Clinical & Corporate Governance Group					
Implementation Plan					
IMPLEMENTATION ACTION	Implementation barriers/ enablers	List of tasks to implement the action	Lead responsibility for delivery of the action	Expected completion date	Expected outcomes
PHCP SOP circulated to RHAs	SOP with integrated PPPGs circulated to RHA's	Notice	National Director of Access and Integration	Oct 2025	Implement Initiation Procedure
HSE PHCP Coordinators group	Notice to all HSE PHCP Coordinators	Notice	PHCP Clinical Lead	Oct 2025	Implement Initiation Procedure
Private Providers	Notice To all Private Providers	Notice	PHCP Clinical Lead	Oct 2025	For Information
Dissemination and action of Health Region staff	No Governance Group	Roll Out	REO	Oct 2025	Implement Initiation Procedure
Information/Education / training required to implement the National 3PG:					
HSE PHCP SOP					

Appendix 4: National Audit Tool

Methodology

Population: A sample of target users

Sampling: A total of 10% or 10 target users, whichever is greater, should be selected.

Frequency: To be determined locally at least annually.

Method: Record **Y** for **Yes**, if the criteria are met. Record **N** for **No**, if criteria are not met or **N/A** for **Not applicable**.

Compliance requirement:

[Should have a 100% compliance requirement unless your National 3PG allows flexibility – compliance levels should be set].

Is standard/criteria being met for the following statements:	Yes	No	N/A	Evidence
The Development Group should identify the core statements that should be audited at least annually.				
Statement 1 All CCHN PHCP initiation of PHCP are via a written referral requesting the PHCP.				
Statement 2 Parents has been provided with the parent information leaflet for PHCP				
Statement 3 The agreement of care is signed by the parents the private provider and HSE PHCP Coordinator				
Statement 4 All CCHN PHCP have a risk assessment completed at the home address				
Statement 5 All Mini tenders are returned within a 2 week time frame				
Statement 6 A TAC meeting has taken placed prior to the CCHN initiation of the PHCP				

Date of Audit:
Audited by (name/title):
Compliance Rate %:
Calculation of Compliance Rate %: The score, expressed as a percentage, is calculated by dividing the number of “yes” and “no” answers. “Not applicable” answers are excluded from the calculation of the percentage score. Example: If there are 6 “yes” and 2 “no” answers, the score is calculated as follows: 6 (yes answers) divided by 8 (total of yes and no answers) multiplied by 100 = 75%

Appendix 6 Final Discharge Letter **Final PHCP Discharge Letter**

To be completed by ward staff 48 hours prior to discharge.

Purpose; to provide updated information on child's Clinical Nursing Needs at time of Discharge.

Form to be emailed to HSE PHCP Coordinator. Email _____

Child's Name:	Date of Birth:	
Address:	Medical card /LTI No.:	
Eircode:	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCAT Score: Date of PCAT:
Name & Address of Parents/Guardians:	Phone 1: Phone 2: Email:	
Have parents/guardian consented to transfer and sharing of information with relevant healthcare teams? Yes <input type="checkbox"/> No <input type="checkbox"/> Parent/Guardian signature:	PHN & Health Centre Details:	
GP Name & Details:	Primary Consultant:	
Diagnosis:		
		Date of diagnosis (if known)
Relevant Clinical History & Identified Nursing Need::		

Infection control status:
Equipment Requirements:
Monthly Consumables Required: (Attach Copy of Order)
Other professionals involved:
Please list current medications:

Has the child any allergies? If yes please specify:	Are there any safety concerns at home? If yes please specify:
Has child Advance Treatment Plan: (Please include copy of same) Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the child been referred to any other services? If yes please specify:
Referrer Name & Address:	Contact details Phone:
	Email:

Please include copies of all relevant letters, risk assessments and correspondence including contact details for Medical and Nursing Teams in Tertiary and Local Hospitals.

For office use only Date Received _____ Received by: _____