Appendix B1: Discharge Checklist: child/young person with a medically complex discharge

Discharge planning starts well before the child is medically stable, ideally on admission.
All members of the MDT have a shared responsibility to complete the discharge pathway/checklist

This is a working document. Please make sure you are using the latest version by checking the version number and date updated below. The latest version of the document is available here https://www.wellchild.org.uk/10-principles-for-complex-discharge/

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South Thames Paediatric Network

WellChild
the national charity for sick children

PPLLTV
Paediatric Pan London Long Term Ventilation

North Thames Paediatric Network
Connecting paediatric services

User guide – Appendix B1: Discharge Checklist: child/young person with a medically complex discharge

Who can this checklist be used for?

- Any CYP who's hospital admission and subsequent discharge home is likely to be medically complex e.g. following initiation of NIV, tracheostomy insertion, life changing interventions/injuries, deterioration of a complex seizure disorder, premature births

When should this checklist be commenced?

- Discharge planning starts well before the CYP is medically stable, ideally prior to admission/on admission
- It is not always clear initially if the CYP will have a complex lengthy admission, in this instance commence document at the point at which you reach a length of stay of 14 days

How to use this checklist:

- This checklist should be used in conjunction with the WellChild 10 Principles for Complex Discharge (link)
- A key professional/s should be identified to oversee the discharge. This may be a discharge coordinator or other key professional/s e.g. link nurses on ward
- This/these individual/s should take responsibility for completing the form and ensuring that all required tasks have a designated responsible individual to complete them. Ideally this would be updated at regular MDT meetings, DPM
- All members of the MDT have a shared responsibility to complete the required tasks within the discharge checklist and regularly feedback to the key professional/s
- Including the date that tasks are applicable from as well as completed allows the discharge processes to be kept on track and audited. For those tasks that are not required for the CYP ensure that the N/A column is ticked
- This document is meant as a guide and will need to be adapted according to the setting, workforce and local policy
- Each CYP and discharge will be unique and patient specific, therefore time frames within the document must be used as rough guides and will likely require patient specific adaption
- The Ongoing Admission section may well need to be revisited multiple times during a patient's admission depending on CYP length of stay

On admission/Identification of a complex discharge	Responsible Individual	Date task applicable from	Date task completed	N/A
Name of CYP……..DOB…….. NHS No…….. Lead Hospital……				
MDT Tasks				
Who has parental responsibility of CYP? Document clearly on EPR				☐
Who is the lead for discharge planning? E.g. link nurse, discharge coordinator				☐
Who is the named consultant for CYP?				☐
What, if any, are the safeguarding issues that the MDT should know about?				☐
Who are the key members of the MDT? Hospital and Community				☐
Parents/carers and CYP informed and understand reason for admission				☐
Parents/carers and CYP informed and understand planned treatment/interventions				☐
Parents/carers and CYP informed and understand expected discharge pathway				☐
Has parallel planning and palliative care input been discussed? (this should be ongoing throughout admission)				☐
Will CYP require long term access e.g. Port, Hickman Line Review Date:				☐
Will CYP require long term feeding support e.g. gastrostomy Review Date:				☐
Are parents/carers clear in their roles and responsibilities during CYP's admission?				☐

On admission/Identification of a complex discharge	Responsible Individual	Date task applicable from	Date task completed	N/A
Nursing/Key Worker Tasks				
Who is CYP's GP? (If not registered, register CYP with a GP as a priority)				☐
All local teams that CYP is known to, to be informed of admission e.g. CCNT, HV, School Nurse, community therapies				☐
Team of staff e.g. nurses, nursing associates, CSW's identified to promote continuity of care				☐
Is CYP eligible for a continuing care package? Discuss with local Continuing Care Team if unsure				☐
With parental consent, complete referral to CYP's local continuing care team & social services (Children with Disabilities team)				☐
CYP referred to local CCNT (if not already known), with EDD (if possible)				☐
Request made for CCNT to complete a home oxygen assessment and review home setting (if unclear that property is suitable for oxygen/continuing care package)				☐
Parents/carers offered psychology support (if available/consent given)				☐
Play Specialist/Education Tasks				
Does CYP have regular input from hospital play team? (throughout admission as appropriate)				☐
Does CYP require input from hospital school?				☐
Dietetics Tasks				
Initial assessment of nutritional status completed				☐
Usual/proposed route of feeding identified				☐
Liaison with community team completed as appropriate				☐

On admission/Identification of a complex discharge	Responsible Individual	Date task applicable from	Date task completed	N/A
Multi Therapy Tasks				
Baseline functional, developmental, neurological, respiratory, mobility assessments and treatment plans completed as appropriate (OT/PT/SLT)				☐
Local community therapy teams contacted to see if patient known to them (OT/PT/SLT)				☐
Therapy plan and programme completed, and training needs have been identified (OT/PT/SLT)				☐
Occupational Therapy Tasks				
Home environment discussed with parents/carers and local OT (if CYP known to them)				☐
Home assessment arranged and liaison with local social care OT team underway (if it is considered CYP's home is likely to require adaptations/not be suitable)				☐
Housing assessment request to CYP's local housing team sent if required				☐
Assessment completed and provision of equipment required to support the CYP in the hospital environment e.g. seating, toileting and positioning equipment				☐
Speech and Language Therapy Tasks				
Swallow assessment completed				☐
Safe oral feeding plan if appropriate +/- enteral feeding support established				☐
Developmental/acquired communication assessment completed				☐
Communication plan +/- AAC in place				☐
Mouth care advice/support given (if non oral)				☐

Ongoing admission of CYP with complex needs	Responsible Individual	Date task applicable from	Date task completed	N/A
MDT Tasks				
Has a regular MDT meeting with hospital and community team been set up to discuss: - Care/management plans - Discharge goals - Criteria for discharge - Potential barriers to discharge - Tentative discharge date				☐
Are parents/carers engaged with care, visiting regularly and taking a lead in cares?				☐
Parallel planning and palliative care input e.g. ACP				☐
Nursing/Key Worker Tasks				
Continuing care assessment completed and date set for panel				☐
Equipment list agreed by MDT and sent to local continuing care team/CCNT including list of any consumables				☐
CCNT/parents/carers has contacted local fire brigade for a home safety check for oxygen				☐
Which parents/carers will be trained (2 or 3 individuals), identify if there are any additional training needs? E.g. language barriers/literacy of parents/carers Name: Name: Name:				☐
Relevant competencies commenced e.g. NGT, tracheostomy, feed pump (specific to locality)				☐
Local CCNT contacted to request CYP requires oxygen saturation monitor, suctioning or nebuliser machine				☐
Welfare support discussed e.g. Housing, DLA, Carers Allowance, blue badge				☐
Referral made to Children's Services under Section 85 of the Children's Act, 1989 (if child has remained in hospital continuously for over 90days)				☐

Ongoing admission of CYP with complex needs	Responsible Individual	Date task applicable from	Date task completed	N/A
Dietetics Tasks				
Ongoing monitoring of nutritional status				☐
Will CYP require long term feeding support e.g. gastrostomy Review Date:				☐
Organisation of training for parents/carers if new route of feeding introduced				☐
Multi Therapy Tasks				
Individualised developmental/therapy programme established, reviewed and regularly updated (OT/PT/SLT)				☐
Ongoing therapy with goals and outcome measures if appropriate (OT/PT/SLT)				☐
Liaison with community therapists, schools and other outside agencies with regards to ongoing care needs post discharge (OT/PT/SLT)				☐
Buggy/wheelchair requirements identified with MDT and parents/carers (PT/OT)				☐
Complete referral to wheelchair services (PT/OT)				☐
Manual handling requirements e.g. hoist and slings identified with MDT and parents/carers (PT/OT)				☐
Necessary manual handling equipment ordered/liaison with appropriate service (PT/OT)				☐
Occupational Therapy Tasks				
Cot/bed requirements identified with MDT and parents/carers				☐
Necessary cot/bed ordered following local policy				☐
Home environment advice leaflet shared and parents/carers plans for home set up discussed				☐
Liaison to ensure home modification needs identified are on schedule				☐

Ongoing admission of CYP with complex needs	Responsible Individual	Date task applicable from	Date task completed	N/A
Respiratory Physiotherapy Tasks				
Individualised respiratory physiotherapy programme established, reviewed and regularly updated				☐
If indicated, respiratory physiotherapy training commenced with parents/carers				☐
If indicated, liaise with CCG/ICS regarding procurement of respiratory adjuncts for home use and commence process for provision of these				☐
Speech and Language Therapy Tasks				
Reassessment and revision of plan provision				☐
Assessment for AAC and referral to specialist centre if required				☐
Swallow reassessment as indicated				☐
Multi Therapy/Professional Tasks (if tracheostomy)				
Assessed for appropriateness of cuff deflation (SLT/PT)				☐

No later than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
MDT Tasks				
Discharge planning meeting including inpatient and community teams held, minutes sent and EDD set				☐
Immunisations up to date? Does CYP require palivizumab/flu vaccination?				☐
All outstanding investigations organised				☐
Local hospital contacted and patient discussed (potential step down also discussed if applicable)				☐
Named local general paediatrician allocated				☐
Referral to community paediatrician completed				☐
Medical discharge summary up to date				☐
Nursing/Key Worker Tasks				
All necessary equipment/consumables ordered by continuing care team and community nurses				☐
All necessary home equipment is at the hospital e.g. suction machine, saturation monitor, nebuliser machine				☐
Parents/carers competent to use home equipment				☐
CCG/ICS funding approved and care package hours agreed				☐
Care provider (in house or private agency) allocated by CCG/ICS				☐
Relevant paperwork in place to facilitate care agency attending ward (liaise with HR and care provider)				☐
Meet and greets with staff from care package completed				☐
What are the training needs of carers/nurses from care package? Who will provide training?				☐
Training with agency carers/nurses completed				☐
Relevant competency documents completed for parents/carers e.g. tracheostomy, BLS, NIV, NGT, gastrostomy, feed pump				☐
CYP room at home ready for staged discharge				☐
Referral to local hospice for respite completed				☐
PPLOG bundle (including consent form and home risk assessment)/local oxygen discharge paperwork completed and documents uploaded to electronic records				☐

No later than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
Dietetics Tasks				
If enteral tube in-situ, CYP referred to local hospital dietitian/local home enteral feeding team as appropriate				☐
CYP on a feed regime that can be facilitated in the community e.g. feed times, number of pumps				☐
Arrange delivery of feed equipment as required (feed pump, stand, back-pack, giving sets, syringes and feed)				☐
All training required for discharge completed				☐
Multi Therapy Tasks				
Individualised developmental/therapy programme reviewed and regularly updated (OT/PT/SLT)				☐
Equipment trial of buggy/wheelchair complete (PT/OT)				☐
Parent/carer training for manual handling equipment and guidelines provided (PT/OT)				☐
Car seat discussed with parents/carers and onward recommendations made (PT/OT)				☐
Occupational Therapy Tasks				
Liaise with relevant team/s to ensure cot/bed has been delivered to home				☐
Liaise with relevant team/s to ensure home modifications are complete				☐
Respiratory Physiotherapy Tasks				
Individualised respiratory physiotherapy programme reviewed and updated				☐
Ongoing respiratory physiotherapy training with parents/carers				☐
Confirm provision of respiratory adjuncts for home				☐
Ongoing liaison with community professionals/MDT regarding respiratory care plan for home				☐

No later than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
Speech and Language Therapy Tasks				
Access to appropriate AAC				☐
Current feeding plan reviewed and updated				☐
Education re safe feeding plan, oral development and mouth care given				☐
Multi Therapy/Professional Tasks (if tracheostomy)				
Cuff deflation programme identified as appropriate by MDT and understood by parents/carers (PT/SLT)				☐
Ongoing weaning plan identified as appropriate by MDT and understood by parents/carers (PT/SLT)				☐
Ongoing consideration of one-way valve trial if patient satisfies relevant criteria (PT/SLT)				☐
Referral to ENT/SLT airway clinic for ongoing tracheostomy management completed (PT/SLT)				☐

No later than 2 weeks prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
MDT Tasks				
Discharge planning meeting including inpatient and community teams held, minutes sent and EDD set				☐
Medications rationalised and medication timings compatible with home routine				☐
Nursing/Key Worker Tasks				
Medication administration training complete (ensure medications are labelled and patient's own)				☐
CYP's hospital passport complete				☐
Agreed amount of supplies (usually 2 weeks' worth) is ready and parents/carers have taken this home				☐
Oxygen prescription completed and uploaded to electronic records				☐
Oxygen installed				☐
Parents/carers competent to go on outings				☐
All care/escalation plans and paperwork completed, this must include but is not restricted to an escalation plan in the case of an emergency, trips out equipment list, equipment policy that includes service arrangements and guidance in event of breakdown and a clear plan for follow up				☐
Does CYP require Coordinate my Care/PSP?				☐
All teams clear on discharge plan and EDD (ideally early-mid week to ensure sufficient support available)				☐
Ventilator prescription completed (NIV only)				☐
Ventilator service contract set up and parents/carers have necessary contact numbers for support (NIV only)				☐
Open access set up at local hospital				☐
Local hospital has all relevant documentation e.g. interim discharge summary, escalation care plans, ACP, competency documents (if applicable) ahead of home leave				☐

No later than 2 weeks prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
Multi Therapy Tasks				
Individualised developmental/therapy programme, reviewed and finalised (OT/PT/SLT)				☐
Liaison with community therapists, wheelchair services, school and other outside agencies with regards to ensuring equipment is in place for discharge and ongoing care needs post discharge (OT/PT/SLT)				☐
Respiratory Physiotherapy Tasks				
Individualised respiratory physiotherapy programme reviewed and finalised				☐
Completion of respiratory physiotherapy training with parents/carers				☐
Confirm provision of respiratory adjuncts for home				☐
Ongoing liaison with community professionals/MDT regarding respiratory care plan for home				☐
Parent/carer Tasks				
UK power network/local electricity distribution company have put parents/carers on priority services register				☐
Utility suppliers contacted and priority confirmed e.g. energy, water, phone				☐
Parent/carers have roomed in overnight (once competencies are complete). Whether this is a waking night or not must be discussed with MDT				☐
Home leave for the day completed (at least one day)				☐
Overnight home leave completed if possible. Whether this is a waking night or not must be discussed with MDT				☐

No later than 1 week prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
MDT Tasks				
Follow up appointments booked in (together on the same day if possible)				☐
Coordinated programme of follow up with specialist arrangements for vision, hearing, developmental progress and ongoing review in place for NICU patients				☐
Is CYP FFD/approaching being FFD				☐
Local hospital contacted and step down confirmed				☐
Named community paediatrician and named general paediatrician confirmed				☐
Medical team have finalised medication list				☐
Nursing/Key Worker Tasks				
Training documents uploaded to electronic records, in paper notes and sent to MDT e.g. CCNT, Continuing care				☐
All medical equipment/supplies in the home/hospital and operational				☐
GP updated of planned discharge. Home visit requested following discharge if GP has not already met CYP				☐
Transport plans for discharge/transfer discussed				☐
Parent/carers given necessary hospital/community contact numbers				☐

No later than 1 week prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
Multi Therapy Tasks				
Referral made to community (SLT/OT/PT) with appropriate reports/therapy programmes sent				☐
Community therapy teams contacted regarding outstanding equipment required following discharge (PT/OT)				☐
Guidelines for prescribed equipment completed and handed over to parents/carers (PT/OT)				☐
Dietetics Tasks				
All necessary equipment delivered to patient's home				☐
Parents/carers competent in managing and delivering nutritional plan in the community				☐

No later than 3 days prior to proposed discharge date	Responsible Individual	Date task applicable from	Date task completed	N/A
MDT Tasks				
Medical discharge summary complete				☐
TTO's ordered				☐
Nursing/Key Worker Tasks				
Nursing and discharge coordinators summary complete (if step down/transfer)				☐
Transport booked				☐
Parents/carers have taken as many belongings home as possible to aid with discharge/transfer				☐
No later than 1 day prior to proposed discharge date	**Responsible Individual**	**Date task applicable from**	**Date task completed**	**N/A**
MDT Tasks				
Bed confirmed				☐
Nursing/Key Worker Tasks				
TTO's present on ward and checked				☐
NGT, tracheostomy, MINI button all recently changed. Parents/carers and CCNT given dates of last changes				☐
Parents/carers have up to date copies of hospital passport, competencies, discharge letters and follow up appointments				☐
Sufficient home oxygen cylinders/home equipment on site e.g. suction, saturation machine for journey home				☐
Dietetics Tasks				
Ensure parents/carers have most up-to-date copy of feed plan and re-check they have all the necessary feed equipment				☐

Day of Discharge/Transfer	Responsible Individual	Date task applicable from	Date task completed	N/A
Nursing/Key Worker Tasks				
Bed confirmed				☐
Transport confirmed				☐
Receiving area informed prior to leaving e.g. local hospital, hospice or continuing care team, care agency				☐
Drug chart photocopied				☐
Medical devices **not** required on discharge removed e.g. cannula				☐
All belongings and equipment gathered				☐
TTO's given to parents/carers as per trust protocol				☐
Care plans uploaded to electronic records and all relevant parties have copies e.g. care agency, hospice, local hospital, local paediatrician, continuing care team, CCNT				☐
Members of MDT all aware of discharge and have copy of discharge summary				☐

Acronyms and Abbreviations	Meaning
AAC	Augmentative and Alternative Communication
BLS	Basic Life Support
Carer/nurse	Staff within care package
CCG	Clinical Commissioning Group
CCNT	Children's Community Nursing Team
Continuing Care	A referral to continuing care will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone
CSW	Clinical Support Worker
CYP	Child/Young Person
DLA	Disability Living Allowance
DPM	Discharge Planning Meeting
EDD	Expected Discharge Date
FFD	Fit for Discharge – will be unique for each CYP and family
HR	Human Resources
HV	Health Visitor
ICS	Intergrated Care System
MDT	Multi Disciplinary Team
NIV	Non Invasive Ventilation
OT	Occupational Therapy
Parents/carers	Parents, guardians, foster parent
PPLOG bundle	Paediatric Pan London Oxygen Group
PSP	Patient Specific Protocol
PT	Physiotherapy
SLT	Speech and Language Team
TTO's	To Take Out (medication)