Patient Name: Hospital Number:

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Appendix B1: Discharge Checklist: child/young person (CYP) with complex needs

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 [10-Principles-for-Complex-Discharge-May-2024-2.pdf (wellchild.org.uk)]

Version	**3**
Updated	June 2024

Document developed by Pan London LTV Collaborative in partnership with WellChild.

WellChild
the national charity for sick children

NHS
King's College Hospital
NHS Foundation Trust

PPLLTV
Paediatric Pan London Long Term Ventilation

Pan Thames Paediatric LTV Programme
North Thames Paediatric Network
South Thames Paediatric Network

Royal College of Nursing
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User guide – Appendix B1: Discharge Checklist: child/young person (CYP) with complex needs

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. 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 document.
- 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
- 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 multidisciplinary team (MDT) meetings, discharge planning meetings
- 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
- 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 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 completed	N/A
Name of CYP **DOB** **NHS No** **Lead Hospital** **DGH**			
MDT Tasks			
Parental responsibility clearly documented			
Lead for discharge planning allocated			
Named consultant allocated			
Safeguarding issues and named social worker clearly documented			
Parents/guardians and CYP understand reason for admission			
Discussion with parents/guardians and CYP to ensure they understand planned treatment/interventions and expected discharge pathway			
Discussion with parents/guardians to ensure they are clear in their roles and responsibilities during admission			
Parents/guardians offered psychology support (if available)			
Nursing/Key Worker Tasks			
CYP registered with GP (If not registered, register as a priority)			
List of key MDT members commenced e.g. hospital, community, local hospital			
Local teams informed of admission e.g. local hospital, CCNT, health visitor, school nurse, community therapies (if known)			
Team of ward staff e.g. nurses, nursing associates, clinical support workers allocated to promote continuity of care (if possible)			
CYP eligibility for a continuing care package established. Discuss with local Continuing Care Team			
Continuing Care referral completed (with consent)			
Social services (Children with Disabilities team) referral completed (with consent)			
CYP referred to local CCNT (if not already known to them)			
CCNT request made for home oxygen assessment and review of home setting (if unclear of properties suitability) PPLOG resources			

On admission/identification of a complex discharge	Responsible individual	Date task completed	N/A
Play Specialist/Education Tasks			
CYP receiving regular input from hospital play team and/or hospital school			
Dietetics Tasks			
Initial assessment of nutritional status completed			
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Local hospital and community therapy teams contacted to see if patient known to them			
Baseline functional, developmental, neurological, respiratory, mobility assessments and treatment plans completed as appropriate			
Occupational Therapy (OT) Tasks			
Home environment discussed with parents/guardian and local OT (if CYP known)			
Home assessment arranged, ongoing liaison with social care OT (if home 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			

On admission/identification of a complex discharge	Responsible individual	Date task completed	N/A
Speech and Language Therapy (SLT) Tasks			
Swallow assessment completed			
Oral feeding/swallow therapy plan implemented if appropriate			
Developmental/acquired communication assessment completed			
Communication plan +/- Augmentative and Alternative Communication (AAC) in place			
Mouth care advice/support given			
Comments:			

Ongoing admission of CYP with complex needs	Responsible Individual	Date task completed	N/A
MDT Tasks			
Regular MDT meetings (including local teams) to discuss care/management plans, discharge criteria, barriers to discharge, tentative discharge date			
Long term access requirement discussed e.g. Port, Hickman Line			
Parallel planning and palliative care input discussed (ongoing throughout admission)			
Named local hospital general paediatrician allocated (if not already)			
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 consumables			
Local fire brigade contacted for home safety check (if CYP on oxygen)			
Name of parents/guardians to be trained (2/3 individuals). Identify any additional training needs. E.g. language barriers Name: Name: Name:			
Parental/guardian competencies commenced – **Competency wall chart for bed space**			
Welfare support discussed e.g. Housing, Disability Living Allowance, Carers Allowance, blue badge			
Referral made to Children's Services under Section 85 of the Children's Act, 1989 (hospital stays over 90 days)			
Dietetics Tasks			
Consideration of long-term feeding support e.g. gastrostomy considered			
Close liaison with SLT e.g. swallow assessments, progression with oral nutrition and optimal timing for enteral nutritional support			

Ongoing admission of CYP with complex needs	Responsible Individual	Date task completed	N/A
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Ongoing therapy with goals and outcome measures if appropriate			
Liaison with community therapists, school and other outside agencies with regards to ongoing care needs post discharge			
Buggy/wheelchair requirements identified with MDT and parents/guardians (PT/OT)			
Referral to wheelchair services (PT/OT)			
Manual handling requirements e.g. hoist and slings identified with MDT and parents/guardians (PT/OT)			
Necessary manual handling equipment ordered/liaison with appropriate service (PT/OT)			
Occupational Therapy Tasks			
Cot/bed requirements identified with MDT and parents/guardians and ordered following local policy			
Home environment advice leaflet shared and parents'/guardians' 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 completed	N/A
Respiratory Physiotherapy Tasks			
Respiratory physiotherapy training commenced with parents/guardians			
Procurement of respiratory adjuncts for home use			
Speech and Language Therapy Tasks			
Assessment for Augmentative and Alternative Communication (AAC) and referral to specialist centre if required			
Comments			

No less than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Discharge planning meeting held (to include local hospital and community teams), minutes sent and expected discharge date set			
Immunisations up to date			
Does CYP require palivizumab/flu vaccination?			
Local hospital contacted and patient discussed (consideration of step down if applicable)			
MDT training needs for local DGH explored e.g. nursing, allied health professionals (do not mark N/A if a DGH is identified for step down)			
Referred to community paediatrician			
Discussion with parents/guardians to confirm roles and responsibilities and ensure they continue to lead on CYP care as able			
Nursing/Key Worker Tasks			
Equipment/consumables ordered by continuing care team and CCNT			
Equipment funding approved and care package hours agreed			
Care provider (in house or private agency) allocated			
Paperwork in place to facilitate care package team completing shadow shifts (as per local policy)			
Care package meet and greets completed			
Training needs of carers/nurses from care package identified			
Relevant training with agency carers/nurses completed			
Relevant competency documents completed for parents/guardians			
Referral to local hospice for respite completed (with consent)			
Local oxygen discharge paperwork completed **PPLOG resources**			

No less than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
Dietetics Tasks			
CYP referred to local hospital dietitian/home enteral feeding team as appropriate			
CYP on feed regime that can be facilitated in the community e.g. feed times, number of pumps			
Arrange delivery of feed equipment (feed pump, stand, back-pack, giving sets, syringes and feed)			
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Equipment trial of buggy/wheelchair complete (PT/OT)			
Parent/guardian training for manual handling equipment and guidelines provided (PT/OT)			
Car seat discussed with parents/guardians 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 complete			

No less than 8-4 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
Respiratory Physiotherapy Tasks			
Confirm provision of respiratory adjuncts for home			
Ongoing liaison with community professionals/MDT regarding respiratory care plan for home			
Speech and Language Therapy Tasks			
Access to appropriate communication method			
Parent/guardian education provided as indicated			
Comments			

No less than 2 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Discharge planning meeting held (to include local hospital and community teams), minutes sent and expected discharge plan and date confirmed			
Medical discharge summary up to date			
Medications rationalised and timings compatible with home routine			
Nursing/Key Worker Tasks			
Medication administration training complete (ensure medications are patient's own)			
Agreed amount of supplies (e.g. 2 weeks' worth) in the home			
Home equipment at the hospital e.g. suction machine, saturation monitor, nebuliser machine			
Parents/guardians competent to use home equipment			
Oxygen prescription completed			
Oxygen installed			
Care/escalation plans and paperwork completed, 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 clear plan for follow up			
Ambulance Directive (or similar ambulance alert) in place			
Open access set up at local hospital (if applicable)			
Local hospital has all relevant documentation e.g. interim discharge summary, escalation care plans, advanced care plan (ACP) , competency documents ahead of home leave (if applicable)			
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Individualised developmental/therapy programme, reviewed and finalised			
Liaison with community therapists, wheelchair services, school and other outside agencies to ensure equipment is in place for discharge			

No less than 2 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
Respiratory Physiotherapy Tasks			
Provision of respiratory adjuncts for home confirmed			
Ongoing liaison with community professionals/MDT regarding respiratory care plan for home			
Parent/Guardian Tasks			
Room at home ready for staged discharge/discharge			
Utility suppliers contacted and priority confirmed e.g. electricity, gas, water, phone			
Parents/guardians have roomed in overnight (once competencies complete). Whether or not this is a waking night must be discussed with MDT			
Day home leave completed according to local policy			
Overnight home leave completed if recommended by MDT/possible. Whether or not this is a waking night must be discussed with MDT			
Comments			

No less than 1 week prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Follow up appointments booked (coordinate if possible)			
Local hospital contacted and step down confirmed if applicable			
Named community paediatrician confirmed			
GP updated of planned discharge			
Nursing/Key Worker Tasks			
Training documents uploaded to electronic records and sent to MDT e.g. CCNT, continuing care, local hospital			
Appropriate transport plans for discharge/transfer discussed			
Parents/guardians given necessary hospital/community contact numbers			
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Reports/therapy programmes sent to community therapy team			
Guidelines for prescribed equipment completed and handed over to parents/guardians (PT/OT)			
Dietetics Tasks			
Ensure parents have most up-to-date copy of feed plan and all necessary feed equipment			
Comments			

No less than 3 days prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Appropriate transport booked (with suitable car seat if applicable)			
To take out medication (TTO) ordered			
No less than 1 day prior to proposed discharge date			
MDT Tasks			
Medical discharge summary complete			
Bed confirmed (if step down)			
TTO's present and checked on ward (these may also be required for transfer to local hospital)			
Parents/guardians have up to date copies of all necessary documentation e.g. care plans, discharge letter and follow up appointments			
Sufficient home oxygen cylinders/home equipment on site e.g. suction, saturation machine for journey home/transfer			
Comments			

Day of Discharge/Transfer	Responsible Individual	Date task completed	N/A
Nursing/Key Worker Tasks			
Bed confirmed (if step down)			
Transport confirmed			
Nursing and discharge coordinators summary complete and copy of drug chart available (if step down/transfer)			
Use STOPP! Safe Transfer of the Paediatric Patient Tool– For use on ALL transfers of children BETWEEN Hospitals e.g. Safe Transfer Of Paediatric Patient (STOPP) assessment tool – Sheffield Children's NHS Foundation Trust (sheffieldchildrens.nhs.uk)			
Receiving area contacted prior to leaving unit e.g. local hospital, hospice or continuing care team, care agency			
Medical devices **not** required on discharge removed e.g. cannula			
TTO's given to parents/guardians as per trust protocol			
Discharge paperwork uploaded to records and shared e.g. care agency, continuing care team, local hospital			

Comments