Patient Name: Hospital Number:

Appendix B2: Discharge Checklist: child/young person (CYP) requiring Non-Invasive Ventilation (NIV) / Tracheostomy / Tracheostomy Long Term Ventilation (TrLTV)

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.

User guide – Appendix B2: Discharge Checklist:
(CYP) requiring Non-Invasive Ventilation (NIV) / Tracheostomy / Tracheostomy Long Term Ventilation (TrLTV)

Who is this checklist designed for?

- Any CYP identified as requiring complex NIV set up as an inpatient
- Any CYP identified as requiring a Tracheostomy
- Any CYP identified as potentially requiring TrLTV

When should this checklist be commenced?

- Discharge planning starts well before the CYP is medically stable, ideally on admission
- For some CYP requiring NIV / Tracheostomy / trLTV it is possible to commence discharge planning prior to admission
- Commence discharge checklist at the point at which it is identified that CYP may require NIV/tracheostomy/TrLTV

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 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 multi disciplinary team (MDT) meetings/discharge planning meeting
- 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
- Some sections may need to be revisited multiple times during a patient's admission depending on CYP length of stay

Identification that child/young person may require NIV / Tracheostomy / TrLTV	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			
List of key MDT members commenced e.g. hospital, community, local hospital			
MDT meeting held to discuss appropriateness of NIV / Tracheostomy / TrLTV for CYP Ethical Framework for Decision Making in LTV link			
Meeting with parents/guardians to discuss if NIV / Tracheostomy / TrLTV is appropriate decision for CYP and family Ethical Framework for Decision Making in LTV link			
Life with NIV / Tracheostomy / TrLTV discussed with parents/guardians (CYP if appropriate)			
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)			
Parallel planning and palliative care input discussed (ongoing throughout admission)			
CYP registered with GP? (If not registered, register as a priority)			
Local teams informed of admission e.g. local hospital, CCNT, health visitor, school nurse, community therapies (if known)			

Identification that child/young person may require NIV / Tracheostomy / TrLTV	Responsible Individual	Date task completed	N/A
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			

Comments

Within 48hrs following decision for NIV / Tracheostomy / TrLTV	Responsible Individual	Date task completed	N/A
MDT Tasks			
Team of ward staff e.g. nurses, nursing associates, clinical support workers allocated to promote continuity of care (if possible)			
Key Worker			
Name of parents/guardians to be trained (2/3 individuals). Identify additional training needs. E.g. language barriers Name: Name: Name:			
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)			
Play Specialist/Education Tasks			
CYP receiving regular input from hospital play team and/or hospital school			
Dietetics Tasks			
Initial assessment of nutritional status completed. Tracheostomy/LTV impact on child's nutritional status and source of nutrition considered			

Within 48hrs following decision for NIV / Tracheostomy / TrLTV	Responsible Individual	Date task completed	N/A
Occupational Therapy (OT) Tasks			
Home environment discussed with parents/guardians 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			
Comments			

From 1 to 8 weeks post tracheostomy insertion / initiation of LTV	Responsible Individual	Date task completed	N/A
MDT Tasks			
Regular MDT meetings (including local team) to discuss care/management plans, discharge criteria, barriers to discharge, tentative discharge date			
Long term access requirement discussed e.g. Port, Hickman Line			
Named local hospital general paediatrician allocated (if not already)			
Key Worker/Respiratory Team			
Two portable ventilators available/ordered			
Transition CYP onto portable ventilator as appropriate			
CCNT request made for home oxygen assessment and review of home setting (if unclear of properties suitability) **PPLOG resources**			
Local fire brigade contacted for home safety check (if CYP on oxygen)			
Parental/guardian competencies commenced – **Competency wall chart for bed space**			
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			
Dry circuit time established as able (aiming to safely facilitate time off ward and discharge home)			
Consider a sleep study when stable			
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 stay 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			

From 1 to 8 weeks post tracheostomy insertion / initiation of LTV	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, schools and other outside agencies with regards to ongoing 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			
Assessment completed and provision of equipment required to support the CYP in the hospital environment e.g. seating, toileting and positioning			
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			
Respiratory Physiotherapy (PT) Tasks			
Ongoing assessment and review of mucolytic therapies			
Procurement of respiratory adjuncts for home use			
Airway clearance competencies commenced including respiratory adjuncts, if long-term chest physiotherapy input indicated			

From 1 to 8 weeks post tracheostomy insertion / initiation of LTV	Responsible Individual	Date task completed	N/A
Speech and Language Therapy Tasks			
Swallow assessment completed			
Cuff deflation programme identified as appropriate by MDT and understood by parents/guardians (PT/SLT)			
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

No less than 8 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			
Discussion with parents/guardians to confirm roles and responsibilities and ensure they continue to lead on CYP care as able			
Parallel planning and palliative care input reviewed (ongoing throughout admission)			
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)			
Immunisations up to date			
Does CYP require palivizumab/flu vaccination?			
Referred to community paediatrician			
Key Worker/Respiratory Team			
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			
Local oxygen discharge paperwork completed **PPLOG resources**			
Referral to local hospice for respite completed (with consent)			
Multi Therapy Tasks (OT/PT/SLT unless stated otherwise)			
Ongoing 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			
Car seat discussed with parents/guardians and onward recommendations made (PT/OT)			

No less than 8 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
Respiratory Physiotherapy			
Ongoing assessment and review of mucolytic therapy			
Confirm provision and funding of respiratory adjuncts			
Ongoing liaison with community professionals/MDT regarding respiratory care plan for home			
Speech and Language Therapy Tasks (SLT unless stated otherwise)			
Ongoing collaborative work with the MDT with regards to cuff deflation and tracheostomy weaning (PT/SLT)			
Consideration of one-way valve trial if patient satisfies relevant criteria (PT/SLT)			
Access to appropriate communication method			
Parent/guardian education provided as indicated			
Comments			

No less than 4 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Discharge planning meeting (to include local hospital and community teams) held, minutes sent and expected discharge date reviewed			
Medical discharge summary up to date			
Key Worker/Respiratory Team			
Paperwork in place to facilitate care package team completing shadow shifts (as per local policy)			
Training needs of carers/nurses from care package identified			
Care package meet and greets completed			
Relevant training with agency carers/nurses completed			
Home equipment at the hospital e.g. suction machine, saturation monitor, nebuliser machine			
Relevant competency documents completed for parents/guardians			
Parents/guardians competent to use home equipment			
Room at home ready for staged discharge/discharge			
Dietetics Tasks			
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)			

No less than 4 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
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)			
Cuff deflation programme identified as appropriate by MDT and understood by parents/guardians (PT/SLT)			
Ongoing weaning plan identified as appropriate by MDT and understood by parents/guardians (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)			
Liaison with community therapists, wheelchair services, school and other outside agencies to ensure equipment is in place for discharge			
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			
Comments			

No less than 2 weeks prior to proposed discharge date	Responsible Individual	Date task completed	N/A
MDT Tasks			
Is CYP fit for discharge/approaching being fit for discharge?			
Medications rationalised and timings compatible with home routine			
Key Worker Tasks/Respiratory Team			
Medication administration training complete (ensure medications are labelled and patient's own)			
Agreed amount of supplies (e.g. 2 weeks' worth) at home			
Oxygen prescription completed			
Oxygen installed and ventilators checked for compatibility with home concentrator			
Care/escalation plans and paperwork completed, must include but not restricted to respiratory action plan, trips out equipment list, equipment policy that includes service arrangements and guidance in event of breakdown and clear plan for follow up **Appendix H: Paediatric Respiratory Action Plans**			
Local hospital has all relevant documentation e.g. interim discharge summary, respiratory action plan, Advanced care plan (ACP), competency documents ahead of home leave			
Ambulance Directive (or similar ambulance alert) in place			
Ventilator prescription completed			
Ventilator service contract set up and parents/guardians given necessary contact numbers for support			
Open access set up at local hospital (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			
Assessment and review of mucolytic therapy			
Provision of respiratory adjuncts for home confirmed			
Ongoing liaison with community professionals/MDT regarding home respiratory care plan			
Parent/Guardian Tasks			
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 as required according to local policy			
Overnight home leave completed if recommended by MDT/possible			
Comments			

No less than 1 week 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			
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			
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			

No less than 1 week prior to proposed discharge date	Responsible Individual	Date task completed	N/A
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)			
Dietetic Tasks			
Ensure parent/guardians 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	**Responsible Individual**	**Date task completed**	**N/A**
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			
Safety netting discussed with CYP and family – Respiratory Action Plan			
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
MDT 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, local hospital			

Comments