Community Children’s Nursing Service

**Appendix 1**

**Enteral feeding Discharge Checklist**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS number: \_\_\_\_\_\_\_\_\_\_\_\_**

**Type and size of device: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **Yes/No** | **Date and sign** | **Comments** |
| Has a discharge planning meeting taken place? If not, state why  Planned date for discharge  \_\_\_\_/\_\_\_\_/\_\_\_\_ |  |  |  |
| Has a referral been made to the community dietitian and other services e.g. Speech and Language therapist? |  |  |  |
| Have any risks been identified? For example, continuous overnight feeding for NGT (**Must** have written confirmation from consultant accepting responsibility) |  |  |  |
| Has at least one parent/guardian/carer been assessed as competent to feed via enteral feeding tube? |  |  |  |
| Do you have a copy of the competency and has it been signed by a registered nurse or nurse associate? |  |  |  |
| Have Fresenius Kabi carried out feed pump training and do parents/cares have a copy of their certificate? |  |  |  |
| Has the parent or guardian received training in insertion, care and maintenance of enteral the feeding device? If so, must obtain copy of competency |  |  |  |
| Has the parent/guardian received Basic Life Support training? **Must** be delivered to those on continuous NGT overnight feeds |  |  |  |
| Has the hospital supplied the family with 7 days’ worth of supplies (including pH strips, syringes, NGT and dressings) |  |  |  |
| Additional comments and actions |  |  |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**