NZNIFRS
National Intestinal Failure & Rehabilitation Service

Checklist – Discharge planning for Home IVN/PN

Patient and caregiver requirements for all patients with IF

☐Primary caregiver identified & can be reliably contacted
☐Patient and caregiver/s feel able to participate in health-related decision making
☐Demonstrates an understanding of the risks and benefits of IVN/PN
☐Knows how and when to seek advice
☐Engages with Intestinal Rehabilitation plan 'goal setting' in partnership with the clinical team
☐Engages with Social Work to facilitate patient/whānau support
☐Caregiver training completed

Specific requirements for children and young people under 15 years of age with IF

☐Two caregivers require training
☐If the patient is a young person, consideration should be given to training them to promote self-care and increased independence
☐Patient transition to home may be staged depending on caregiver confidence, patient stability and geographic location

Care team composition requirements for all patients with IF

All people with IF will be managed by an individualised multidisciplinary team (MDT). The MDT will comprise of a minimum of: medical, nursing, dietetic, pharmacy and psychology clinicians. Access to the following may also be required: nutrition nurse specialist, stoma nurse, gastroenterologist, gastrointestinal surgeon, vascular surgeon, interventional radiology, social worker and psychiatrist

☐Local care coordinator identified (in a shared care setting this may include a coordinator from the NIFRS)
☐Appropriate referrals identified and completed
☐ Personalised care plan to be developed in partnership with patient and whānau
☐Discharge planning meetings and actions agreed
☐Establish if remote monitoring of IVN/PN administration is recommended via Micrelcare and consent obtained
(this will influence clinician selection of IVN/PN provider)
☐Caregiver/s may be required to maintain individualised symptom management and fluid balance records (to be trialled in the inpatient setting prior to discharge)

Planning for emotional safety

☐Patient and caregiver/s encouraged to engage with psychology assessment and intervention if indicated to support maximal engagement with the Intestinal Rehabilitation plan and improve outcomes

Home assessment to confirm suitability for all patients with IF

☐Has access to power
☐Has access to refrigeration
☐Patient and caregiver/s can be contacted by phone
☐Patient and caregiver has access to transport (both routinely and in an emergency)
☐Has access to heating
☐Has hot and cold running water
☐House is clean and not overcrowded

Home assess specific requirements for children and young people under 15 years of age with IF

☐Patient has own room (to minimise risk of infection)

Patients receiving IVN/PN are Medically dependent consumers of electricity - https://www.health.govt.nz/our-work/environmental-health/medically-dependent-consumers-electricity

Respite and social supports for all patients with IF

☐Financial supports in place
☐Social supports identified
☐Risk mitigation plan in place if patient is isolated with limited supports

Respite and social supports for children and young people under 15 years of age with IF

☐NASC referral completed
☐NASC caseworker identified
☐NASC plan completed, circulated and filed in clinical record
☐If indicated training plan identified and delivered for in-home caregivers
☐In-home caregivers demonstrate competency and confidence in providing allocated cares, including observation of CVAD exit site and recognition of clinical deterioration

Patient and Caregiver training (Inpatient nursing team) for all patients with IF

☐Viewed available teaching resources Baxters Home PN DVD; Micrelcare online platform
☐Read Home IVN/PN patient/family/whānau guide
☐Hand washing competency achieved
☐Can demonstrate operation and programming of home ambulatory pump
☐Demonstrates competency and confidence in preparing IVN/PN
☐Demonstrates competency and confidence in connecting IVN/PN
☐Demonstrates competency and confidence in disconnecting IVN/PN
☐Demonstrates competency and confidence in changing the needleless connector
☐Demonstrates competency and confidence in changing the CVAD dressing (in the paediatric patient group the recommendation may be for this to be completed by the community nursing team)
☐Caregiver training completed (signed off by senior nurse overseeing training)

Preparing for transition home - home IVN provider logistics for all patients with IF

☐Purchase order and registration with Home IVN provider arranged
☐Fridge delivery arranged
☐Plan for consumable ordering in place
☐Delivery schedule for home IVN/PN arranged with pharmacy and whānau aware of the arrangements

Home IVN/PN prescription for all patients with IF

☐Home IVN/PN prescription finalised
☐Patient/whānau received a copy of the finalised prescription

Pharmacy related planning for all patients with IF

☐Patient/whānau have identified a community pharmacy
☐Patient/whānau have access to a patient held 'medication record' which is reviewed and updated at each review

Emergency management planning for all patients with IF

☐Clinical Nurse Specialist develops an emergency management plan for possible rapid deterioration with medical and dietetic staff
Includes

- Risk factors for deterioration (dehydration, hypoglycaemia, sepsis)
- First response plan (includes requirement for fluids, oxygen and antibiotics)

Transportation plan metro versus rural location (an isolated rural location may require helicopter transfer)
Care team point of contact
☐Patient and caregiver/s provided with a copy of the plan, along with an "Open letter for emergency services'
☐Emergency management plan available on the electronic health record
☐St John Ambulance Communications have been alerted prior to discharge of pending discharge of a medically fragile patient via liaison with St John 'Patient Care Plan Coordinator'

Civil emergency planning for all patients with IF

Contingency planning should also factor in guidance for patients and whānau in the setting of a civil

emergency. Considerations include:

- Disrupted IVN/PN supply – pre-emptive planning for alternative fluid management and supply (Standard versus individualised emergency bags)
- Disrupted power supply – note: an ambulatory pump battery will hold charge for 24 – 48 hours (model dependent); IVN/PN can be at room temperature for 24 hours
- Disrupted travel/road access
- When to present to hospital

Monitoring and follow up

☐Symptom management plan trialled and finalised prior to discharge (weight and fluid management)
☐Routine investigations (monthly blood and urine) – forms provided
☐Community nursing follow up in place
☐Stomal therapy nursing follow up in place if indicated
☐Outpatient follow up in place
☐Shared care discussed with whānau if NIFRS to provide remote support and advice