

Name:

DOB:

NHS Number:

Paediatric Pan London Oxygen Group (PPLOG)

Discharge Bundle

Version 1.5

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Website: <https://pplog.co.uk>

This document has been endorsed by:



London Neonatal
Operational Delivery Network



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Paediatric Pan London Oxygen Group (PPLOG)

Background

Prior to PPLOG being founded a mapping exercise identified that practices of caring for children with oxygen therapy within the tertiary and community settings varied hugely and had limited to no evidence. In 2016, a Respiratory Nurse with a link to all of the Children's Services in London (Caroline Lock, Clinical Nurse Advisor at Air Liquide) encouraged as many Children's Nurses including Community Neonatal Nurses to share their concerns and find solutions to make the transition from hospital to home of every child on oxygen therapy seamless. The aim of the Paediatric Pan London Oxygen Group (PPLOG) is to bring the knowledge and experience of Respiratory Nurses, Community Children's Nurses and Community Neonatal Nurses together, and set standard guidance that will ensure the management of children on oxygen therapy is holistic, safe and uniform within the London and other regions. Moss and Bond (2002) states that having a child on home oxygen therapy could be a complicated process that requires planning and precise communication (cited by Nzirawa et al. 2017). Hence, the role of the health professional would be to reassure, support and give all relevant information to the families when needed (Nzirawa et al., 2017; Nzirawa, 2015 pg 35). According to the National Institute for Health and Care Excellence (NICE, 2010), neonatal units must show evidence of having trained and competent multidisciplinary teams who can deliver care in neonatal settings. PPLOG discharge bundle fills this gap by providing competency documents (page 17) to be used by both staff and caregivers during the training, while planning and managing oxygen the therapy pathway. Finally, is it important to remember that any decisions made in a child's best interest should be based on evidence-based practices and this information given to caregivers/parents' to support and encourage informed decision-making processes (Bliss, 2012; 2020).

Objectives

1. To set standard guidelines for oxygen within children services
2. To establish standard guidelines for oxygen weaning within tertiary and community settings
3. To streamline the discharge process for children on home oxygen therapy
4. To facilitate educational programmes for hospital staff preparing to discharge a child on home oxygen therapy
5. To support the families with evidence-based information on how to care for their child on home oxygen therapy
6. To set a platform and create a Pan London Oxygen protocol for education and management of all children on oxygen therapy within tertiary and community settings
7. The PPLOG to audit every setting using the set guidelines/pathways annually through staff, parents and children satisfaction feedback
8. Guidelines and pathways to be reviewed every three years or earlier if advised of new evidence-based practices

PPLOG Discharge Bundle Documents Contents:

This Paediatric Pan London Oxygen Group document contains the following 7 separate documents to aid the safe and timely discharge of a child requiring home oxygen across Greater London. The Paediatric Pan London Oxygen Group is made up of Health Professionals involved in the discharge process of children requiring home oxygen daily and includes medical, nursing and educational representation from community, tertiary hospital, Neonatal Intensive Care and commissioned Oxygen Provider settings. These professionals are committed to streamlining the discharge process of children requiring home oxygen across London and other regions in England. This PPLOG discharge bundle is available online on various platforms and for the use by clinical teams. The bundle elements should not be changed but the format and presentation of the documents can be amended for local use. Please acknowledge PPLOG as the source.

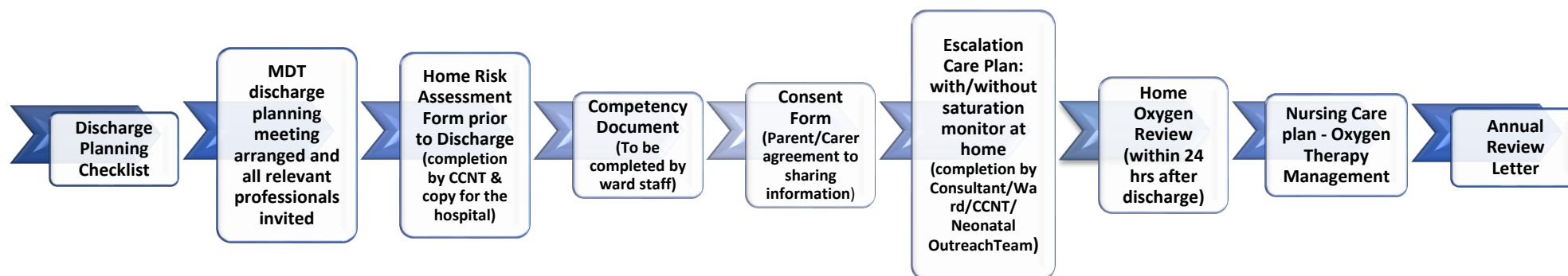
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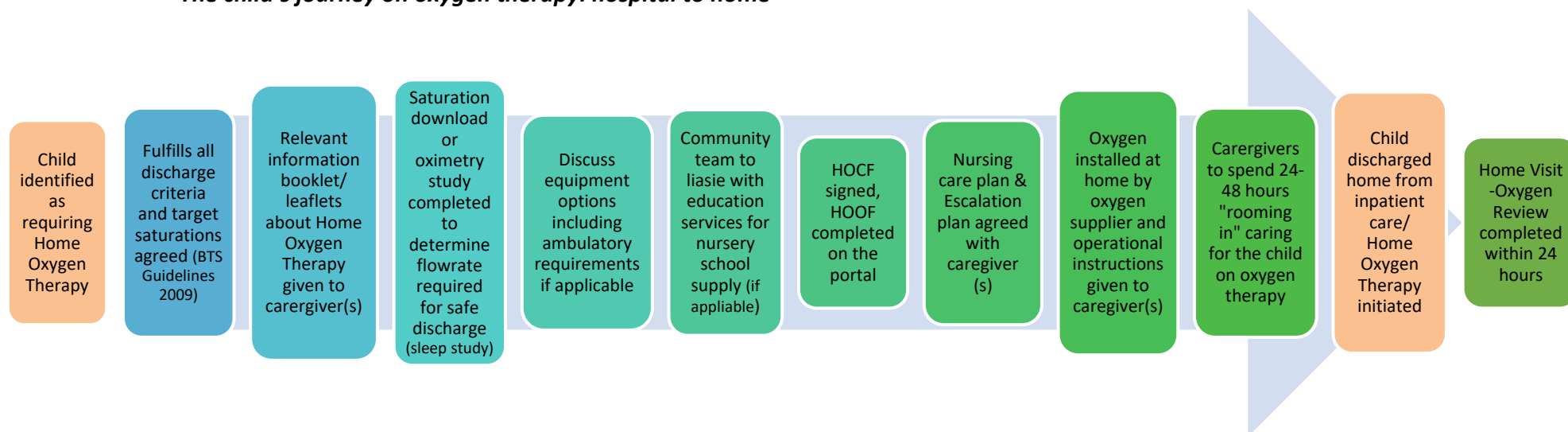
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Home Oxygen Discharge Pathway using PPLOG Discharge Bundle

Adapted using BTS guidelines for home oxygen in children (2009), NICE Scope (2019) PH40 Social and emotional well-being, Nzirawa (2018), NHS Primary Care Commissioning (2011) Home Oxygen Service – Assessment and Review: Good practice guide



The child's journey on oxygen therapy: hospital to home

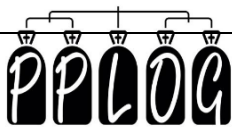


Forms to be completed by the ward staff

HOME OXYGEN DISCHARGE PLANNING CHECKLIST- (to be completed by ward staff)

NAME: DOB: NHS Number: CONSULTANT:	ADDRESS:
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CRITERIA	Sign & Date completed	COMMENTS
1. Oxygen		
Family know why the child is going home on oxygen		
Sleep study / pulse oximetry study downloaded to determine flow rate required for safe discharge		
PPLOG Home Oxygen Risk Assessment form completed and copy filed in patient notes		
Home Oxygen Consent Form (HOCF) completed, signed and filed in notes (page 12)		
Home Oxygen Order Form (HOOFF) completed (min 48hrs pre discharge) including portable cylinders if requiring continuous oxygen (NHS Primary Care Commissioning, 2011) and emailed or completed on the Oxygen Portal): 1. oxygen company (Air Liquide/ Dolby Vivisol/ BOC) <input type="checkbox"/> 2. GP <input type="checkbox"/> 3. CCNT/ Clinical lead (CNS) <input type="checkbox"/> 4. Filed in notes <input type="checkbox"/>		
Home Oxygen Therapy annual review letter (Appendix 3) given to parents		
Home Oxygen has been installed Yes <input type="checkbox"/> No <input type="checkbox"/>		
Portable cylinder brought in from home is on the ward <i>(to travel home on)</i>		
Car Seat/ seated trial completed if applicable <i>(30 minutes, saturating >93%)</i>		
Immunisations up to date? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Advise flu vaccine at the start of winter if eligible</i>		
Eligible for RSV Vaccine (Palivizumab)? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(Refer to NHS England Commissioning document for this year for eligibility & Green book, 2015)</i>		
Oxygen Competency document completed by main parent(s)/ carer(s) Date:		
Oxygen competencies emailed via a secure email address to CCNT for reassessment at home		
Home Oxygen Escalation Plan has been completed Yes <input type="checkbox"/> No <input type="checkbox"/>		
Parent/ carer has "roomed in" and is able to provide 24hrs of continuous care Date:		
Explained to parents that oxygen is a drug, managed as a medication, therefore it must be prescribed. Too much or too little can be dangerous. Unless advised to do so, do not change the flow rate of the oxygen.		
2. Discharge planning meeting required Yes <input type="checkbox"/> No <input type="checkbox"/> Date of the meeting:		
3. Emergency- check family: Had Basic Life Support (BLS) training & demonstrated understanding Date:		



Know who to contact when unwell and have correct contact details for Children Community Nurses Team, Respiratory Clinical Nurse Specialist, Hospital@Hospital, Neonatal Community Outreach Team

Has handheld discharge summary and escalation care plan been given to the parents/carer? **Yes** ☐ **No** ☐
(To be used to present in A&E in event of urgent care)

4. Home assessment completed

on:..... by:.....(Children Community Nurses Team& Neonatal Community Outreach Team)

Is the family home safe for home oxygen installation?

Yes ☐ **No** ☐ **advise changes to be made and reassess**
(Copy of Home Assessment form filed in notes)

5. Follow up:

Has a referral to Children Community Nurses Team/Neonatal Community Outreach Team been made?

Initial health professional home visit arranged within 24hrs of discharge (BTS, 2009, Nzirawa et al, 2017 & Wilson et al, 2019)?

Discharge summary sent to:

GP ☐
CCNT ☐
Parents ☐

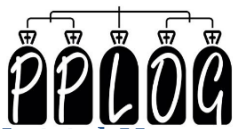
Hospital Outpatients Appointment follow up booked for 4-6 weeks post discharge (BTS, 2009)

Appointment Date:..... Time:

Discharged on: **At:**

☐ **Checklist checked and complete**

Discharging clinician: **Signature:**



Initial Home Oxygen Risk Mitigation Form (IHORM) and Home Oxygen Consent Form (HOCF) for new patients only.

BOTH FORMS MUST BE COMPLETED AND SIGNED BEFORE OXYGEN CAN BE INSTALLED.

DO NOT SEND FORMS TO SUPPLIER FORMS WILL BE PLACED IN PATIENT NOTES

THERE ARE CONFIRMATION BOXES ON THE HOME OXYGEN ORDER FORMS.

Oxygen can pose a risk of harm to the user and others in the event of fires, falls and inability to use complex equipment. The initial identification and onward communication of these risks is the responsibility of the health care professional ordering the oxygen and remains so until that prescription ceases or is superseded. The table below reflects risk factors that are based on evidence of real life serious and untoward incidents, 90% of which are smoking, and e-cigarette/charger related.

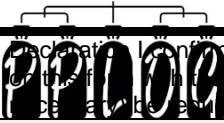
The Initial Home Oxygen Risk Mitigation (IHORM) is to be completed in conjunction with the Home Oxygen Consent Form (HOCF) prior to oxygen being ordered from the oxygen supplier via the Home Oxygen Order Form (HOOF). **It is the responsibility of the registered health care professional who is gaining consent to complete and add the IHORM with the HOOF and HOCF to the patient's notes. If all documents are not confirmed as being completed in full the Home Oxygen Order cannot be fulfilled.**

If the risks identified on the IHORM indicate significant levels of risk the patient should be discussed directly with the local Home Oxygen Service or Clinical Oxygen Lead for a full risk assessment prior to oxygen being ordered as recommended in the British Thoracic Home Oxygen Guidelines June 2015. **Regardless of risk or diagnosis all adult patients should be referred the Home Oxygen Assessment and Review Service (HOS-AR) for the team to determine next steps if deemed relevant.**

If any responses below fall within a shaded box, please refer to the Required Action column and supporting notes.

All actions should be explained to the patient and why they are being taken in line with service contracts. Ensure that both verbal and written information has been given to the patient or their representative

Patient Name		DOB	
Address		Oxygen requested?	Yes - Sending HOOF No - Risk is too high
Recorded at	Please indicate:- Hospital / Clinic / Home / other location	NHS No	
Risk Level	Risks	No	Yes
HIGH	Does the patient smoke cigarettes / e-cigarettes?		
	Have they smoked in the last 6 months?		
	Quit date.....		
	Does anyone else smoke at the patients premises?		
	A recent history of drug or alcohol dependency?		
	Patient reported they have had a fall in the last 3 months?		
	Have they had previous burns or fires in the home?		
	Does the person have identified mental capacity issues?		
MODERATE	Can the patient leave their property un-aided?		
	Is the patient or any dependents/ in the property vulnerable? E.G. disabilities/ children		
	Do they live in a home that is joined to another?		
	Patient reports they have working smoke alarms at home? (if unknown please state no)		
	Do they live in a multiple occupancy premises (Bedsit/flat)		
Mitigation actions taken e.g. contacted falls team Referred to Fire and Rescue			

 I declare that I am the healthcare professional responsible for the care of this patient. I have discussed the risks listed on this form with the patient/carer/ guardian (delete as necessary) and from the responses given Oxygen can/cannot (delete as necessary) be used at this time.			
Clinicians Signature		Profession	
Print Name		HOS team	Yes / No
Contact No.		Date	
Lead Consultant is	(Hospital Discharge only)		

Patient agreement to sharing information



Form issued by:			
Unit/Surgery		Address	
Contact name			
Tel no.			
Email			
		Postcode	
Patient			
Name		Address	
D.O.B.			
NHS number			
Tel/mobile no.			
E-mail		(only include if the patient agrees to email contact)	

My doctor or a member of my care team has explained the arrangements for supplying Oxygen at my premises, that my personal information will be managed and shared in line with the Data Protection Act 1998, Human Rights Act 1998, and common law duty of confidentiality and I understand these arrangements, such that:

1. Information about my condition/condition of the patient named above* will be provided to the Home Oxygen Service (HOS) Supplier to enable them to deliver the Oxygen treatment as per the Home Oxygen Order Form (HOOF).
2. The HOS Supplier will be granted reasonable access to my premises, so that the Oxygen equipment can be installed, serviced, refilled and removed (as appropriate).
3. Information will be exchanged between my hospital care team, my doctor, the home care team and other teams (e.g. NHS administration) as necessary related to the provision, usage, and review, of my Oxygen treatment, and safety.
4. Information will also be shared with the local Fire Rescue Services team to allow them to offer safety advice at my premises and where appropriate install/deliver suitable equipment for safety.
5. Information will also be shared with my electricity supplier/distributor where electrical devices have been installed.
6. From time to time, I may be contacted to participate in a patient satisfaction survey/audit.
(delete *should you wish not to participate*)
7. I understand that I may withdraw my consent at any time (at which point my HOS equipment will be removed).

* Delete as applicable			
Patient's signature		Date	
(see note 4 where signed and witnessed on patient's behalf)			
I confirm that I have responsibility for the above-named patient e.g. parental responsibility, lasting power of			
Signature		Name	
Relationship to patient		Date	
I confirm that I am the healthcare professional responsible for the care of this patient and I have completed this form on his/her behalf as s/he is unable to provide/withhold consent. The patient has been given a copy of this form			
Clinician's signature		Date	
Name			

Escalation Care Plan: With saturation monitor at home

(to be completed by CNS/Consultant/Neonatal Outreach Nurse)

Date:

Patient Details:

Name of Child:

Date of Birth:

Address:

Hospital Number:

Landline/ Mobile phone number:

Clinical Team Details:

Managing Team Consultant in charge of case:

Main site of care:

Local Consultant Paediatrician:

Local hospital:

Community Nurse Team:

Phone no:

Email:

Diagnosis:

1.

2.

3.

Oxygen Ordered: ____ L/min continuous/ at night only *(delete as appropriate)*

Variable flow rate: Min ____ L/min to Max ____ L/min / No variable flow rate set *(circle/ delete as appropriate)*

Home Oxygen Supplier:

Home Plan:

- Saturations should be ____ % in ____ L/min Oxygen.
- When well does not require regular monitoring of oxygen saturations during the day
- Continuous oxygen saturation monitoring at night
- Check saturations more frequently if concerned or unwell e.g. when increased secretions (has a cold), coughing, or increased work of breathing compared to usual or lethargic (quieter/ more sleepy than usual)

Emergency Plan at home:

- Ensure good trace on saturation monitor
- If saturations <92%: increase oxygen to ____ L/min and continuously monitor oxygen saturations
- If oxygen increased: continuously monitor oxygen saturations, try interventions such as suction (if available), removing causes of distress such as pain or wet nappy and slowly try to wean back to usual amount of oxygen over 15- 30 minutes.
- If able to get back to usual amount of oxygen with oxygen saturations maintaining within the normal range continue to check saturations more frequently e.g. every hour until unconcerned.
- If concerned or unwell:

- **increased secretions (has a cold)**
- **coughing**
- **increased work of breathing/ faster breathing compared to usual**
- **lethargic (quieter/ more sleepy than usual)**
- ❖ **Contact Community Nursing Team for advice/ review even if saturations are within normal range**
- ❖ **If saturations 89%, blue/ grey colour, particularly at the lips or unable to wean oxygen back to usual amount after 30 minutes call 999 and increase oxygen to ____L/min while waiting for ambulance**
- ❖ **Take this care plan with you to hospital**

Hospital Emergency Plan:

1. **Follow local escalation policy**
2. **Consider checking capillary blood gas**
3. **Consider chest x-ray**
4. **If Oxygen requirement > 40%, raised CO₂ on blood gas or child appears tired consider commencing High Flow Nasal Cannula Oxygen (if available)**
5. **Perform Bacterial cough swab and viral screen**
6. **Check previous microbiology and consider commencing_____ as first line antibiotic unless previous microbiology indicates otherwise**
7. **Consider contacting Managing Team for advice**

Parents Signature:

Parents Name:

Date:

Managing Team Consultants Signature:

Consultant's Name:

Date:

Escalation Care Plan: Without saturation monitor at home

(to be completed by CNS/Consultant/Neonatal Outreach Nurse)

Date:

Patient Details:

Name of Child:

Date of Birth:

Address:

Hospital Number:

Landline/ Mobile phone number:

Clinical Team Details:

Managing Team Consultant in charge of case:

Main site of care:

Local Consultant Paediatrician:

Local hospital:

Community Nurse Team:

Phone no:

Email:

Diagnosis:

1.

2.

3.

Oxygen Ordered: ____ L/min continuous/ at night only *(delete as appropriate)*

Variable flow rate: Min ____ L/min to Max ____ L/min / No variable flow rate set *(circle/ delete as appropriate)*

Home Oxygen Supplier:

Home Plan:

- **Should be pink and well perfused (good colour) in ____ L/min Oxygen.**
- **Community nursing team can be contacted to check oxygen saturations if required when unwell.**

Emergency Plan at home:

- **If concerned or unwell:**
 - **increased secretions (has a cold)**
 - **coughing**
 - **increased work of breathing/ faster breathing compared to usual**
 - **lethargic (quieter/ more sleepy than usual)**
- ❖ **contact Community Nursing Team for advice/ review**
- ❖ **If pale or blue/ grey colour, particularly at the lips, call 999 and increase oxygen to ____ L/min while waiting for ambulance.**
- ❖ **If few, gasping breaths/ no breaths at all, start Basic Life Support**
- ❖ **Take this care plan with you to hospital**

Hospital Emergency Plan:

1. **Follow local escalation policy**

2. **Consider checking capillary blood gas**
3. **Consider chest x-ray**
4. **If Oxygen requirement > 40%, raised CO₂ on blood gas or child appears tired consider commencing High Flow Nasal Cannula Oxygen (if available)**
5. **Perform Bacterial cough swab and viral screen**
6. **Check previous microbiology and consider commencing _____ as first line antibiotic unless previous microbiology indicates otherwise**
7. **Consider contacting Managing Team for advice**

Parents Signature:

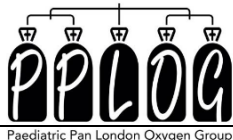
Parents Name:

Date:

Managing Team Consultants Signature:

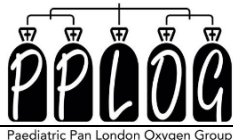
Consultant's Name:

Date:



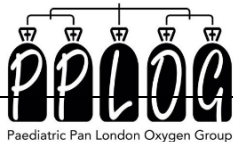
Home Oxygen Competency document- COMPETENCIES		Achieved Yes/No	Comments	Review date	Assessor's signature & date	Learner's signature & date
Awareness of why home oxygen is required and understanding of medical condition	<ul style="list-style-type: none"> • Definition of condition <input type="checkbox"/> • Rationale for home oxygen <input type="checkbox"/> • Have read and understood relevant oxygen information booklet <input type="checkbox"/> 					
Awareness of signs of respiratory distress	<ul style="list-style-type: none"> • Respiratory rate/ normal breathing pattern <input type="checkbox"/> • Colour <input type="checkbox"/> • Chest movement <input type="checkbox"/> • Noises associated with breathing <input type="checkbox"/> • Head bobbing <input type="checkbox"/> • Recession <input type="checkbox"/> • Tracheal tug <input type="checkbox"/> • Nasal flaring <input type="checkbox"/> 					
Awareness of deterioration and appropriate actions to follow	<ul style="list-style-type: none"> • Recognises signs of respiratory distress • Aware of care plan and actions- call CCNT or 999 <input type="checkbox"/> • Aware of appropriate health professionals to contact <input type="checkbox"/> 					

	COMPETENCIES	Achieved Yes/No	Comments	Review date	Assessor's signature & date	Learner's signature & date
Awareness of health and safety in the home environment	<ul style="list-style-type: none"> • Flammable issues at home i.e. appliances, incense, candles/naked flames and creams (oils and petroleum jelly creams) <input type="checkbox"/> • Dangers of smoking/ electronic cigarettes <input type="checkbox"/> • Pets e.g. chewing on tubing <input type="checkbox"/> • Fire brigade notified <input type="checkbox"/> • Notify your gas/electric (<i>if applicable</i>) and home/car insurance <input type="checkbox"/> 					
Can safely use and maintain equipment at home	<ul style="list-style-type: none"> • Aware that Oxygen is a drug and should not be adjusted unless advised to do so <input type="checkbox"/> • Aware of the amount of oxygen they are on <input type="checkbox"/> • Aware how to use an oxygen cylinder <input type="checkbox"/> • Aware of back up cylinders <input type="checkbox"/> • Aware of portable cylinders <input type="checkbox"/> • Aware how to use concentrator (<i>if applicable</i>) <input type="checkbox"/> • Aware how long each cylinder will last <input type="checkbox"/> • Knowledge of the appropriate use of the concentrator and when to use cylinders <input type="checkbox"/> • Understand when to use standard cylinders/ concentrator or portable cylinders appropriately? <input type="checkbox"/> • Aware that the length of oxygen tubing is depend on the risk assessment – trips/tangles. (<i>Putting consideration, the room layout and/or other young children/pets</i>) <input type="checkbox"/> 					



Paediatric Pan London Oxygen Group

COMPETENCIES		Achieved Yes/No	Comments	Review date	Assessor's signature & date	Learner's signature & date
Awareness of equipment necessary to administer oxygen	<ul style="list-style-type: none"> • Demonstrate how to OPEN and CLOSE the main cylinder valve <input type="checkbox"/> • Check oxygen cylinder is working <input type="checkbox"/> • Use of reduction gauge? <input type="checkbox"/> • Demonstrate how to attach and detach the low flow/micro flow regulator to all types of cylinders installed <input type="checkbox"/> • Demonstrate how to select the correct flow <input type="checkbox"/> • Delivery mechanism <input type="checkbox"/> • Cannula - awareness to place the end of the cannula into a saucer/ cup of water to ensure water bubbles <input type="checkbox"/> • Parent aware to wipe cannula dry after tipping into water before placing into the child's nostrils <input type="checkbox"/> 					
Able to give oxygen via nasal prongs/cannula/mask/ ventilator/ tracheostomy	<ul style="list-style-type: none"> • Able to apply prongs correctly ensuring prongs are round the front (if applicable) <input type="checkbox"/> • Aware of face/nose care <input type="checkbox"/> • Checks nasal prongs daily <input type="checkbox"/> • Can secure cannula using tapes and changes weekly-monthly? <input type="checkbox"/> • Recognises when nasal prongs are blocked and aware of troubleshoots <input type="checkbox"/> • Aware how to apply a face mask and adjust straps- face mask to be 					



	<p>changed 6 monthly or when necessary <input type="checkbox"/></p> <ul style="list-style-type: none"> Aware of how to connect oxygen to ventilator/ tracheostomy (if applicable) <input type="checkbox"/> Label tubing with date and time <input type="checkbox"/> Aware to ensure spare nasal cannula/ tubing and tapes to secure (if applicable) are taken out with the child in case tubing needs replacing <input type="checkbox"/> 					
Aware of BLS	<ul style="list-style-type: none"> Can perform BLS <input type="checkbox"/> (For palliative care CYP please follow agreed care plan) <input type="checkbox"/> 					
Aware of the ordering process	<ul style="list-style-type: none"> Aware of Oxygen Company contact details <input type="checkbox"/> Aware how to order oxygen <input type="checkbox"/> Aware if ordering oxygen, a significant amount of time should be allowed <input type="checkbox"/> 					

Following completion of training and supervised practice, I (Print name) have undertaken the above skills and assessment. I feel confident to manage and care for [child's name].....'s home oxygen.

Signature: **Name:** **Relationship to the child/ job title:** **Date:**

Assessor's signature: **Name:** **Date:** (Assessor must be competent)

Forms to be completed by the Children's Community Nursing Team/Community Neonatal Teams

HOME OXYGEN RISK ASSESSMENT FORM PRIOR TO DISCHARGE (completion by CCNT/CN and copy for the hospital and caregiver) (See accompanying guidelines on our website/appendix for completion)

Name of Child/Young Person:	
Address:	
Date of Birth:	Date of Visit:
Parent/Carers - Present on assessment:	
Property Access	
Property Type:	<input type="checkbox"/> House <input type="checkbox"/> Bungalow <input type="checkbox"/> Flat. Number of occupants _____ <input type="checkbox"/> x 1 Lift Access <input type="checkbox"/> x 2 Lift Access
Access:	<input type="checkbox"/> Building level <input type="checkbox"/> Steps- How many _____ <input type="checkbox"/> Hallway/exit route free from obstruction?
Doors:	<input type="checkbox"/> ? Width appropriate for buggy/wheelchair

Levels:	How many levels is the property situated over? _____
Home Insurance:	<input type="checkbox"/> Family are aware that they need to let their landlord and home insurance company know if they have oxygen in the home.
Physical Environment	
Space for equipment:	<input type="checkbox"/> Storage for 3 months-worth of consumables <input type="checkbox"/> Storage For Oxygen Cylinders/Concentrator Comments:
CYP Bedroom:	<input type="checkbox"/> Wall Plug Socket available if having concentrator <input type="checkbox"/> Appropriate space for equipment, away from heat sources and direct sunlight <input type="checkbox"/> Is this the only address the child will sleep at?
Kitchen:	Open plan living space/kitchen area: <input type="checkbox"/> Yes <input type="checkbox"/> No Cooker: <input type="checkbox"/> Electric <input type="checkbox"/> Gas If Gas, aware of risk of open flames <input type="checkbox"/>
Electricity Payment:	<input type="checkbox"/> Billed <input type="checkbox"/> Pay as You Go <input type="checkbox"/> Direct Debit <input type="checkbox"/> Family aware of electricity rebate scheme for O2 concentrator?
Smoke Alarms:	<input type="checkbox"/> How Many ____ Location: <input type="checkbox"/> Working
Carbon Monoxide Alarms:	<input type="checkbox"/> How Many ____ Location: <input type="checkbox"/> Working
Fire Brigade:	<input type="checkbox"/> Are family aware that they can contact the Fire Brigade on the non-emergency number to assess their property and formulate an escape plan for their family and home?

Heating:	<input type="checkbox"/> Yes <input type="checkbox"/> No- is the heating functioning? <input type="checkbox"/> Central Heating <input type="checkbox"/> Electric Heaters <input type="checkbox"/> Gas Fire <input type="checkbox"/> Log Fire
Condition of Property	
Is the property in	<input type="checkbox"/> Good Condition <input type="checkbox"/> Significant Disrepair
Is there mould in the property?	<input type="checkbox"/> Yes Location: _____ <input type="checkbox"/> No
Any visible signs or smells of damp in the property?	<input type="checkbox"/> Yes Location: _____ <input type="checkbox"/> No
Do you have any other concerns regarding the property in regards to the supply and installation of oxygen?	
Safety	
Telephone:	<input type="checkbox"/> Ensure family have access to a telephone
Car Insurance:	<input type="checkbox"/> Family are aware that they need to let their Car insurance company know if they intend to travel with oxygen in the car?
Fire Safety:	<input type="checkbox"/> Discussed smoking (including e-cigarettes) around the child and oxygen. <input type="checkbox"/> Discussed use of emollients and flammable skin care products. <input type="checkbox"/> Discussed use of candles and incense.

	<input type="checkbox"/> Discussed use and storage of any other flammable liquids/materials.
General safety:	<input type="checkbox"/> Oxygen tubing can pose a trip hazard. Discuss dangers for children and the elderly <input type="checkbox"/> Pets- discuss hazard of pets chewing on oxygen tubing
OTHER:	
Transport	
How will the family travel?	<input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Tube/train <input type="checkbox"/> Other _____ <input type="checkbox"/> Discuss access to transport and ability to travel with oxygen equipment. <input type="checkbox"/> Discuss parking and for eligibility for Blue Badge application.
Family	
Support	<input type="checkbox"/> Is there family support at home to help care for the child? Who will be the main carer? _____ Yes <input type="checkbox"/> No <input type="checkbox"/> Are the family known to Social services? <input type="checkbox"/> Do they have details for Disability Living Allowance?
Language	What is their preferred language? _____ Is an interpreter required? _____

Discharge	
Is a discharge planning meeting required?	Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ <input type="checkbox"/> Family aware that they will need to bring one portable cylinder with them to hospital for discharge home
Is home suitable for oxygen?	Yes <input type="checkbox"/> No alteration required. Yes <input type="checkbox"/> But, but some steps advised to reduce risk, inform hospital and document in notes. No <input type="checkbox"/> Home Unsuitable for oxygen due to _____ _____
Risk assessment completed by:	Name: _____ Signature: _____ Designation: _____ Date: _____
Parent/ Carer present at risk assessment:	Name: _____ Signature: _____ Date: _____

Please send a copy of this form to the clinician requesting/ordering home oxygen



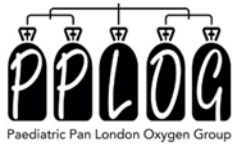
Home Oxygen Review Form: Post Discharge from hospital

(Home Visit Review completed within 24 hours) – Please see guidelines on our website for completion

Name of Child/Young Person:	
Address:	
Date of Birth:	Date of Visit:
Parent/Carers Present on assessment:	
Property Access	
Oxygen:	<input type="checkbox"/> Installed correctly with correct flow dial <input type="checkbox"/> Family aware of child's oxygen requirements and how to escalate (according to plan) <input type="checkbox"/> Family aware of care and can fit interface (nasal prongs/face mask/ventilator/tracheostomy mask/Swedish nose to oxygen). <input type="checkbox"/> Family aware of contact details if equipment or supplies required, i.e. oxygen cylinders, oxygen tubing and length safe enough to move in the room however considering risks of trips/tangle if child is active. <input type="checkbox"/> Frequency and care of nasal prongs or face mask discussed. <input type="checkbox"/> Aware how to check oxygen cylinder is working and when to contact oxygen supplier for a refill. <input type="checkbox"/> Check that the oxygen prescription is correct and relates to equipment provided in home.
Emergency:	<input type="checkbox"/> Escalation plan is present in the home and family of how to follow it. <input type="checkbox"/> Family aware of what to do in the event of an emergency? <input type="checkbox"/> Understand the signs of a deteriorating child. <input type="checkbox"/> BLS completed.
Social Support:	<input type="checkbox"/> Do the family have a good support network? <input type="checkbox"/> Do they receive Disability Living Allowance (DLA) for children/Personal Independence Payment (PIP) (if applicable). https://www.gov.uk/pip/what-youll-get & https://www.gov.uk/disability-living-allowance-children



CCNT Support:	<input type="checkbox"/> Do family have correct contact details for CCNT, H@H, NCOT, CNS, Ward? <input type="checkbox"/> CCNT role and level of support explained (follow nursing care plan on next visit see (appendix 2)) CCNT should visit within 24hours of discharge home.
Follow up	<input type="checkbox"/> SpO2 monitoring at least weekly (please see local policy/ PPLOG weaning guidelines). <input type="checkbox"/> Hospital OPA in 4-6 weeks with managing team (BTS, 2009). <input type="checkbox"/> Developmental team: physiotherapy, hearing, eyes (if required) <input type="checkbox"/> Dietician <input type="checkbox"/> Other appointments: <input type="checkbox"/> Annual review letter (see appendix 3)
Safety	<input type="checkbox"/> Oxygen stored safely <input type="checkbox"/> Reinforce no smoking/open flames <input type="checkbox"/> Check smoke alarm installed and working
Baseline Observations:	<input type="checkbox"/> SpO2..... <input type="checkbox"/> HR..... <input type="checkbox"/> RR.....
Plans for saturation monitoring and sleep studies:	<input type="checkbox"/> Plan for 1 st oximetry/sleep study discussed.
First Home Visit Assessment Completed by:	Name: Signature: Designation: Date:
Parent/ Carer present at first home visit assessment:	Name: Signature: Date:



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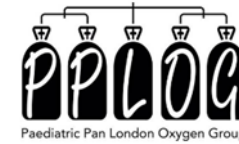
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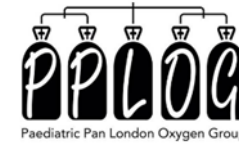
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APPENDIX 1: Glossary of Terms and Abbreviations

A&E	Accident and Emergency Department also known as Emergency Department (ED) or Emergency Room (ER)
BLS	Basic Life Support
BTS	British Thoracic Society
CCNT	Children's Community Nursing Team
Child	Throughout this document the term 'child' is used to refer to babies, children and young people
CNS	Clinical Nurse Specialist
DLA	Disability Living Allowance (Under 16 years of age)
DPM	Discharge Planning Meeting
EHC or EHCP	Education Health and Care Plan
EHIC	European Health Insurance Card
GP	General Practitioner/ Family Doctor
HOCF	Home Oxygen Consent Form
HOOF	Home Oxygen Order Form
HR	Heart Rate
Managing team	The team that made the decision that the child requires Home Oxygen Therapy and/ or will be following up the management of the Home Oxygen Therapy
MDT	Multi-Disciplinary Team



OPA	Out-Patient Appointment
PIP	Personal Independence Payment (16 years+)
PPLOG	Paediatric Pan London Oxygen Group
Rooming in	Parent(s)/ Carer(s) stay by the child and care for all of their care needs including any new healthcare needs in order to ensure that they are confident at caring for the child independently. This is usually for a minimum of a 24 hour period so that they are aware of how to care for the child's needs both day and night if applicable
RR	Respiratory Rate
RSV	Respiratory Syncytial Virus (a common virus that causes coughs and colds in winter; the most common cause of bronchiolitis in infants)
SEN	Special Educational Needs
SpO₂	Peripheral capillary oxygen saturation



APPENDIX 2: Nursing Care Plan to Facilitate the Safe Discharge Planning of an infant/child/young person on Home Oxygen

Nursing Care Plan-Oxygen Therapy Management

The following care plan must be discussed and agreed with the parent/carer. It can be amended according to the needs of the patient. If there are any changes required after the 'completion of the care plan' the current plan must be reviewed and signed again with agreement of the parent/carer.

To be kept in the patient file by the Community Nursing Team.

Name	NHS number	Date of birth	Hospital and Hospital number

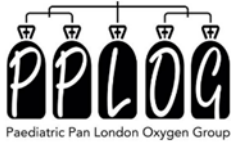
Issues Identified: Oxygen dependent Child

Goal/Aim: Oxygen therapy is used to decrease work of breathing by increasing alveolar oxygen tension

- For the oxygen therapy to benefit the child's clinical status and improve health
- For the child to be able to receive oxygen therapy in their home safely and for parents to be aware of the risks and adhere to appropriate measures to optimise safety
- For the child to be successfully be weaned off oxygen as tolerated/ if appropriate (refer to the PPLOG weaning guidance)

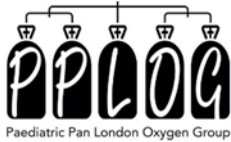
Action/Intervention:

Checklist	Date	Signed by nurse
Assessment post discharge completed		

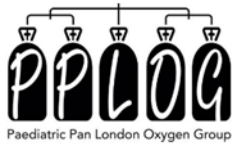


Documents/information leaflets given to parents		
Competency completed		
All supplies in place		
Contact numbers provided		

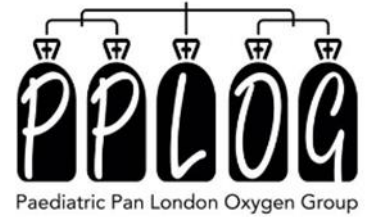
Medical history	
Oxygen requirement currently	<p>Oxygen Provider: _____</p> <p>Amount of oxygen: _____ Litres</p> <p><u>Method of administration:</u> (Please circle) e.g.: Mask/ Cannula (Type- please give details)</p> <p>Other: _____</p> <p>Device: (Please circle) Cylinder: Compressed gas/ Liquid (Please circle) Concentrator</p>
Baseline observation	<p>Heart Rate:</p> <p>Effort in breathing:</p> <p>Saturation:</p> <p>Respiratory rate:</p>
If child's observations are within these parameters, they must go hospital to be reviewed	<p>Heart Rate below:</p> <p>Heart Rate above:</p> <p>Saturations below:</p> <p>Respiratory Rate above:</p> <p>Respiratory Rate below:</p>
Parents understand signs of symptoms of	<p>Yes <input type="checkbox"/> No <input type="checkbox"/>:</p> <p>No? -Action plan:</p>



an emergency and what actions to take	<p>Details/Notes:</p> <table border="1"> <tr> <td>Oxygen Increase Amount</td><td>_____ Litres</td></tr> <tr> <td>Contacts in emergency</td><td> Name: _____ Position: _____ Number: _____ </td></tr> </table>	Oxygen Increase Amount	_____ Litres	Contacts in emergency	Name: _____ Position: _____ Number: _____
Oxygen Increase Amount	_____ Litres				
Contacts in emergency	Name: _____ Position: _____ Number: _____				
Agreed frequency of visits	Preferred days and time (According to local guidelines):				
What would you expect from your visit?					
What would you like your nurse to do for your child? (Parent's perspective)					
First visit conducted	Date: _____ Notes: _____				
Plan for oxygen weaning:	<p>According to local policy usually oxygen weaning will take place after a successful sleep study/ room air challenge.</p> <p>We will attempt this:</p> <p>_____ Months _____ Weeks</p>				
Signature to confirm agreement with care plan	<p>Parent/carer name and signature: _____</p> <p>Named nurse name and signature: _____</p> <p>DATE: _____</p>				



APPENDIX 3: Annual Review Letter



Home Oxygen Therapy annual review letter

Date:
NHS no:

Dear Parent/Carer,

RE:

Following updated requirements from Air Liquide Homecare Healthcare Provider, The Paediatric Pan London Oxygen Group (PPLOG) and London Clinical Oxygen Network (LCON), it is mandatory for your child's oxygen requirement and prescription to be reviewed on an annual basis. This may differ if your child is on a weaning regime, in which case this would be a more frequent occurrence.

Please remember that oxygen is a drug and it must be reviewed like all other medication to ensure your child is receiving the appropriate amount for their medical need and meeting health and safety regulations (NICE guidance, 2017).

Your community nurse, outreach nurse or clinical nurse specialist will also make you aware that the oxygen prescription is being reviewed and if there are any amendments to the equipment that you are using. This includes arrangements for the removal of the oxygen equipment when it is no longer required.

If you have any concerns with the above or your amended prescription please speak to your community nurse, outreach nurse or named clinical nurse specialist.

Yours sincerely,

Supported by the Paediatric Pan London Oxygen Group (PPLOG)