UHL NNU Guideline : Discharge home from the Neonatal Unit

University Hospitals of Leicester NHS Trust

Trust ref: C163/2008

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1. Introduction and who this guideline applies to:

This guideline is to provide a step-by-step approach for the timely discharge of a baby home from the neonatal unit with the aim to provide a safe and effective discharge procedure. This guideline applies to all Health Professionals involved with the discharge of babies from the UHL neonatal service.

The guideline should be used in conjunction with related UHL documents to facilitate safe discharge and ensure that parents / carers and families are adequately prepared for discharge of the baby and their role in caring for the baby at home.

1.1 Related UHL documents

Document	
Home Oxygen UHL Neonatal Guideline	C31/2006
Neonatal Outreach Follow Up Criteria	Appendix 1
Neonatal Consultant Outpatient Follow up Criteria	Appendix 2
Neonatal admission and discharge paperwork	Appendix 3

1.2 Duties

The duties of individual staff groups are identified within the discharge process. Where the process states 'Nursing staff' this refers to nursing or nursery staff caring for the baby at the time, unless otherwise indicated.

2. Guideline

2.1 Criteria for discharge

Baby can be discharged home from the neonatal unit when baby is:

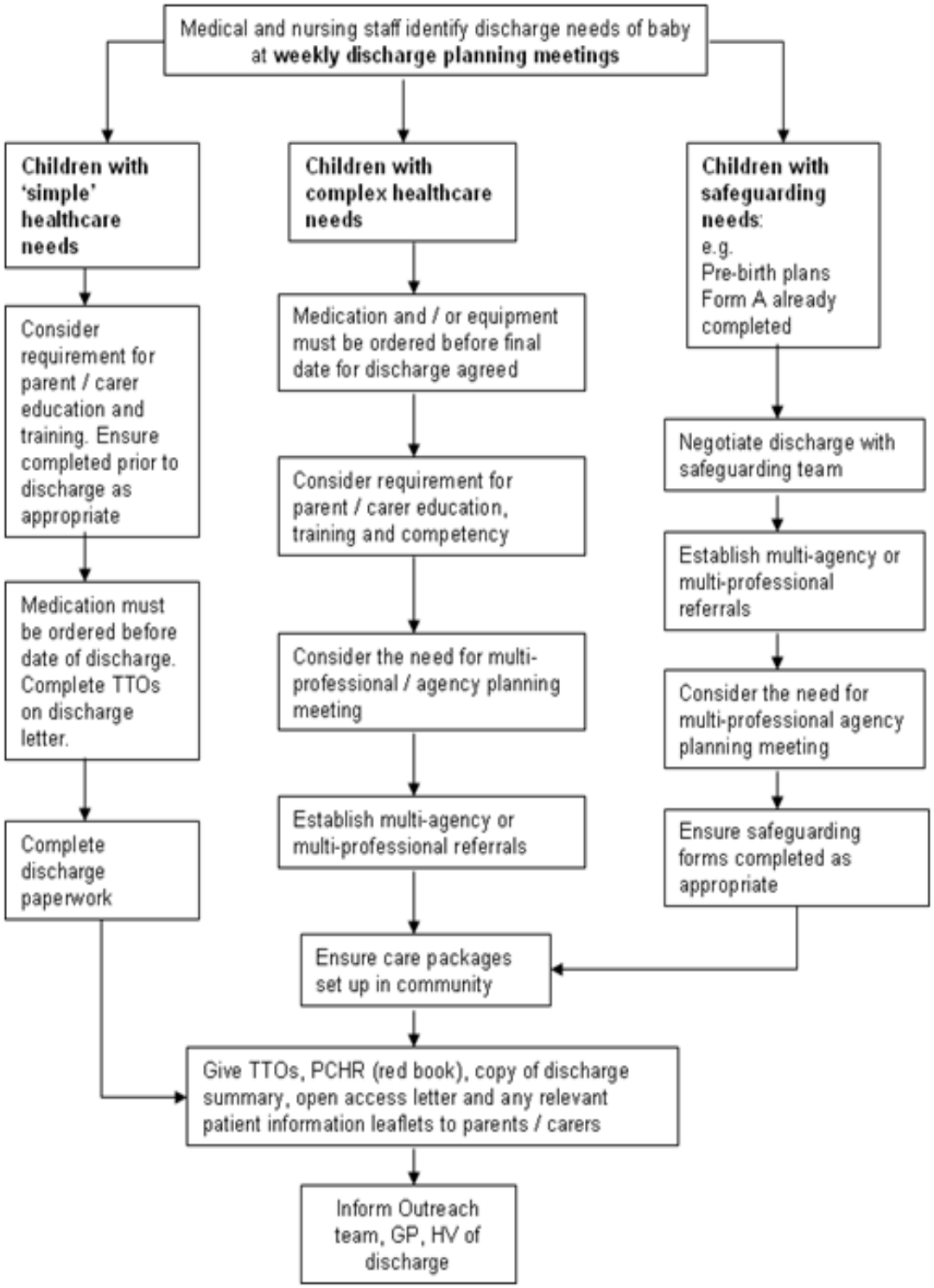
- Physiologically stable
- Self-ventilation in ambient air or with oxygen support.
- Feeding at regular interval, by preferred method, for 24 to 48 hours. If baby going on NG feeds, follow Home Tube feeding Care Pathway, when appropriate.
- Achieving satisfactory growth

2.2 Guideline for Discharge from the Neonatal Unit	
No	**Action**
1	The planning process for discharge will begin at admission. Nursing staff will commence the admission to discharge documentation on admission. The provisional date for discharge will be recorded on the nursing admission to discharge documentation and reviewed on a regular basis (if there is no date planned this should be documented and a provisional discharge date identified and documented at the earliest opportunity).
2	On admission the ward clerk will obtain contact details for HV and GP and record in baby's medical notes and unit admission book. The HV will be contacted by ward clerk or nursing staff on admission, when the plans for discharge are put into place and when baby is discharged. If admitted day 10-12 Health Visitor to contact and visit baby before discharge (as per health visitor pathway – Appendix 3).
3	Medical / nursing staff will assess at admission any identified Safeguarding issues, commence appropriate documentation and where appropriate make a referral to Divisional Safeguarding team. If there are 'safeguarding concerns' with the baby, the discharge must be negotiated with the 'safeguarding team' before discharge and the appropriate documentation completed.
4	Nursing staff will commence Personal Child Health Record (PCHR - also known as 'Red Book') on admission.
5	Before setting a final date for discharge the neonatal outreach team will ensure that all the equipment, medication and care packages are in place, the parents / carers have had all of the education and training required and are competent in the skills they may require to care for the child at home. A Multi Professional meeting will be arranged if applicable.

6	For the discharge of some babies with safeguarding or complex care needs a multidisciplinary discharge planning meeting may need to be organised. The outcome of the meeting will be documented in the case notes and all actions undertaken as part of the discharge process. All multi-professional teams unable to attend must be informed of the outcome. Relevant names and contact addresses and telephone numbers of key personnel involved and date contact made e.g. HV, GP etc. will be documented in the patient notes. This meeting will be facilitated by the neonatal outreach team.
7	For those babies requiring long term medical or surgical supplies the neonatal outreach team will liaise with the GP re: ongoing support/supplies. Where GP identifies inability to supply consumables this information to be disseminated to Service Manager for cross charging arrangements to be made. Refer to appropriate people e.g. stoma care consumables
8	If required the neonatal outreach team will ensure that any specialist equipment is available prior to discharge. Parents will be taught specific skills relating to the equipment, including how to use the equipment, how to maintain, service and clean the equipment, troubleshooting and how to obtain consumables. Parent / carer teaching packages will be completed and filed in the patient's records. Appropriate information leaflets will be provided if available.
9	Nursing staff will arrange for overnight accommodation for parents / carers to room in with baby prior to discharge, if appropriate. **N.B: It is not essential for parents to room in prior to discharge, but is recommended for Home Oxygen babies or babies on Home Tube Feeding Pathway**
10	Nursing staff will ensure any medication is available prior to discharge with suitable administration device (e.g. Right size syringe) and care givers are competent to give medications.
11	Nursing staff will ensure that breast pump has been returned where applicable
12	Nursing staff will ensure parents / carers are aware of their responsibility in safe transfer home of baby. Provide leaflet on car seat if available.
13	Nursing staff will ensure discharge checklist and all discharge documentation has been completed, dated and signed before discharge.
14	Before discharge the clinical team will ensure the baby is well enough for discharge. Medical staff will perform a discharge examination of the baby. All findings will be recorded in the NIPE smart system with a copy printed for the Child Health Record booklet and the neonatal notes. Deviations from normal should be documented as well as the subsequent actions taken and discussions with parents.
15	Ward clerks will ensure any outpatient / follow-up appointments are arranged and carers are notified of appointments – if identified on the Badger discharge summary.
16	Nursing staff or neonatal outreach team will provide parents / carers with details of who to contact in case of concern about baby. Where applicable Open access arrangements will be explained and open access letter given to parents or carers.
17	Nursing staff will ensure that parents / carers have the CHR (Red Book) and a copy of the discharge letter to take home.
18	If the baby is ready for discharge home out-of-hours nursing staff will ensure that points 2 to 17 have been followed. All babies who have neonatal admission will receive Stork Programme education.

2.3 Process for discharge home from the neonatal unit

Process for Discharge Home from the Neonatal Unit



3. Education & Training

None

4. Supporting References

NONE

5. Key Words

Child Health Record, Outreach team, Stork Programme

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review details			
Guideline Lead (Name and Title) S Mittal – Consultant guidelines lead			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
Nov 2008	**1**		Original Guideline
Nov 2011	**2**	Neonatal Guidelines Meeting	
Jun 2016	**3**	Unit Manager LGH (MP) Neonatal Guidelines Meeting	Reviewed and amended new forms added, ratified
Nov 2022	**4**	Neonatal Guidelines meeting Neonatal Governance	Follow up criteria added Ratified

Appendix 1: Neonatal Outreach Follow Up Criteria

Any babies' resident in Leicestershire or Rutland, Kettering and Northampton fitting one or more of the criteria below AND being followed up by a Neonatal Consultant.
This list is not exhaustive and not all babies requiring follow up will fit into the criteria. The team is happy to discuss any infants that do not fit into the below criteria.
Patients eligible for the service will be those who are current inpatients, under the care of a Neonatologist that meet all of the following three criteria and at least one of the additional criteria described below: -

1. Maintaining temperature without the use of a hot cot/incubator for at least 48 hours
2. Off caffeine and completed monitoring as per unit policy, with no apnoea's, desaturations or bradycardia
3. Completing at least two oral feeds in a 24 hour period, given by parents, for at least 48 hours

Additional Criteria

1. Birth weight of <1.8kg

2. All babies born less than 32 weeks gestation

3. Requiring preterm formula milk or Breast Milk Fortifier

4 Continued short term NGT feeding requirement – (Any gestation or weight)

5. Oxygen dependency at 36 weeks - Short term Micro flow or Low flow weaning of Oxygen may be considered as service provision provided by the neonatal outreach team. There will be no change made to the current follow up service for CLD patients in Leicester.

6. HIE grade 2 or 3 – Those babies requiring long term care needs such as long term tube feeding will be referred directly to the Community Childrens Nurses on discharge .

7. Babies who had a surgical procedure on the unit (excluding ROP & inguinal hernia). We aim to aid transition home and aid repatriation to the local hospitals of Kettering and Northampton.

8. Home phototherapy (see guideline for criteria)

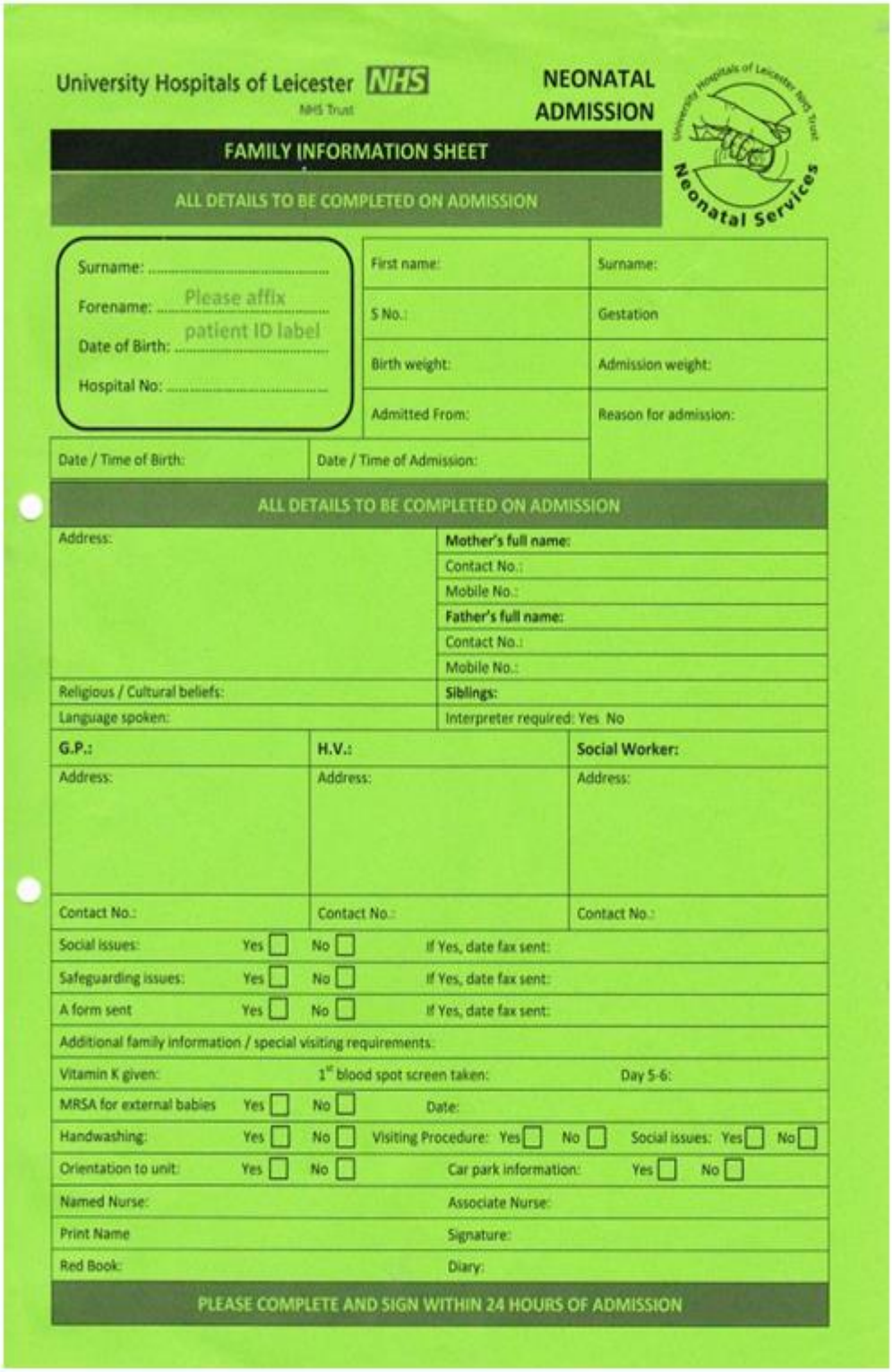
Babies requiring on going nursing needs once reach 44 weeks corrected gestation will be referred to the CCN.above criteria.

Appendix2: Neonatal Outpatient Clinic Follow Up Criteria

- Birth weight <1501g
- Gestation <32 weeks
- Bronchopulmonary dysplasia with prolonged mechanical ventilation at 36 weeks' postmenstrual age
- Postnatal steroids given <33 weeks' gestation
- Significant cranial ultrasound abnormality on final scan on NNU
- Acute neonatal encephalopathy grade 2 or 3
- Seizures (of whatever cause) Neonatal meningitis
- Neonatal herpes simplex infection
- Blood culture positive neonatal sepsis
- Abnormal neurological examination at discharge
- Severe retinopathy of prematurity
- Neonatal abstinence syndrome requiring treatment (see Abstinence syndrome guideline)
- Exchange transfusion for any reason/immunoglobulin for hyperbilirubinaemia/in-utero transfusion or serum bilirubin > 10 x gestational age (weeks) in preterm infants
- Major congenital anomalies (consider early referral to general paediatrician)
- Persistent hypoglycaemia
- Consultant discretion
- Babies who have undergone surgery in early neonatal period

Appendix 3a: Admission form

Appendix 3a: Admission form



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NEONATAL ADMISSION

FAMILY INFORMATION SHEET

ALL DETAILS TO BE COMPLETED ON ADMISSION

Neonatal Services

Surname: .....
Forename: ..... Please affix
Date of Birth: ..... patient ID label
Hospital No: .....

First name:	Surname:
S No.:	Gestation
Birth weight:	Admission weight:
Admitted From:	Reason for admission:
Date / Time of Birth:	Date / Time of Admission:

ALL DETAILS TO BE COMPLETED ON ADMISSION

Address:	**Mother's full name:**
	Contact No.:
	Mobile No.:
	Father's full name:
	Contact No.:
	Mobile No.:
Religious / Cultural beliefs:	**Siblings:**
Language spoken:	Interpreter required: Yes No

G.P.:	**H.V.:**	**Social Worker:**
Address:	Address:	Address:
Contact No.:	Contact No.:	Contact No.:

Social issues:	Yes ☐	No ☐	If Yes, date fax sent:
Safeguarding issues:	Yes ☐	No ☐	If Yes, date fax sent:
A form sent	Yes ☐	No ☐	If Yes, date fax sent:

Additional family information / special visiting requirements:

Vitamin K given: 1st blood spot screen taken: Day 5-6:

MRSA for external babies Yes ☐ No ☐ Date:

Handwashing: Yes ☐ No ☐ Visiting Procedure: Yes ☐ No ☐ Social issues: Yes ☐ No ☐

Orientation to unit: Yes ☐ No ☐ Car park information: Yes ☐ No ☐

Named Nurse: Associate Nurse:

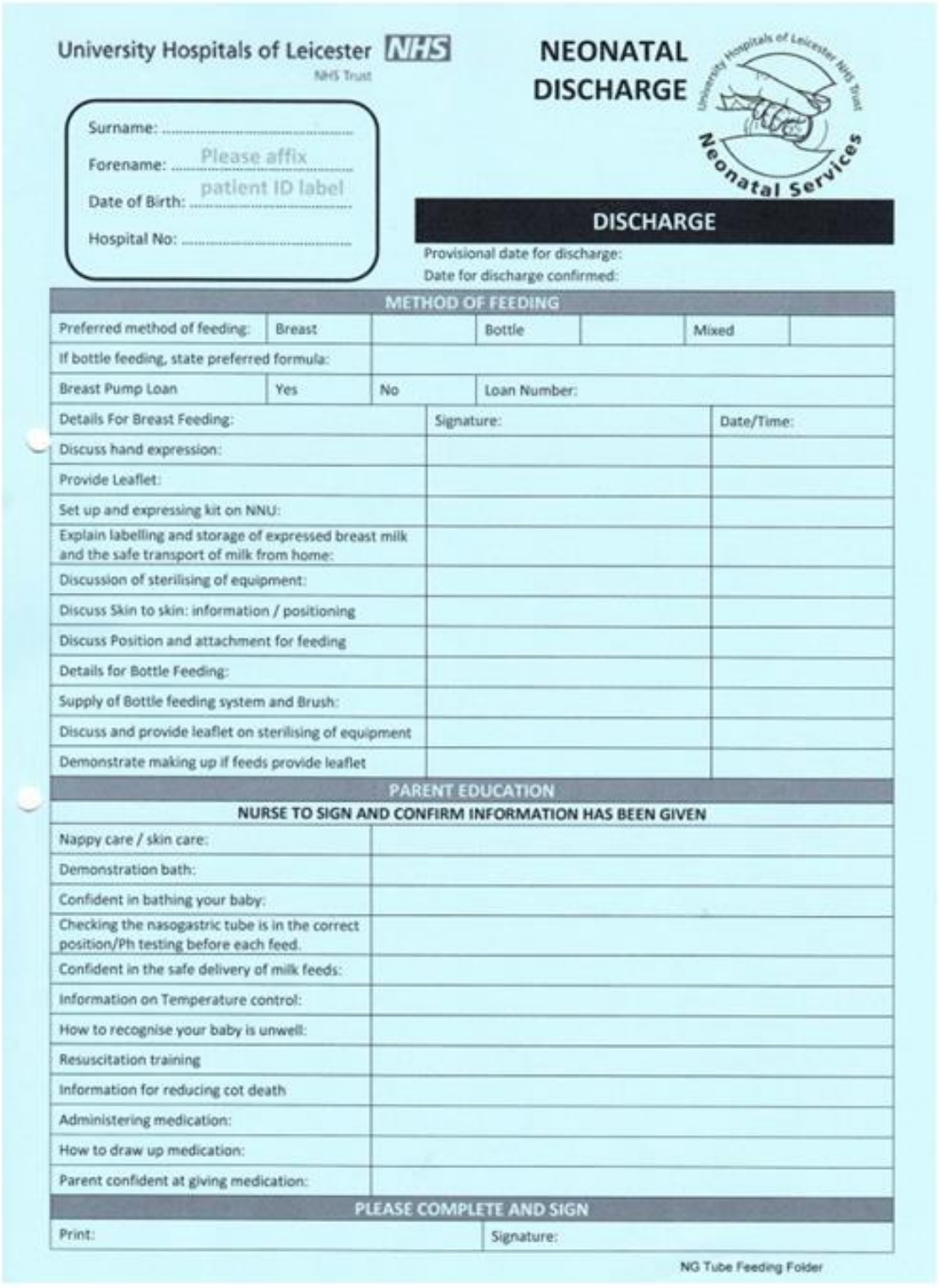
Print Name Signature:

Red Book: Diary:

PLEASE COMPLETE AND SIGN WITHIN 24 HOURS OF ADMISSION

Appendix 3b: Neonatal discharge form page 1

Appendix 3b: Neonatal Discharge form page 1



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NEONATAL DISCHARGE

Neonatal Services

Surname: .....
Forename: ..... Please affix
Date of Birth: ..... patient ID label
Hospital No: .....

DISCHARGE

Provisional date for discharge:
Date for discharge confirmed:

METHOD OF FEEDING						
Preferred method of feeding:	Breast		Bottle		Mixed	
If bottle feeding, state preferred formula:						
Breast Pump Loan	Yes	No	Loan Number:			

Details For Breast Feeding:	Signature:	Date/Time:
Discuss hand expression:		
Provide Leaflet:		
Set up and expressing kit on NNU:		
Explain labelling and storage of expressed breast milk and the safe transport of milk from home:		
Discussion of sterilising of equipment:		
Discuss Skin to skin: information / positioning		
Discuss Position and attachment for feeding		
Details for Bottle Feeding:		
Supply of Bottle feeding system and Brush:		
Discuss and provide leaflet on sterilising of equipment		
Demonstrate making up if feeds provide leaflet		

PARENT EDUCATION NURSE TO SIGN AND CONFIRM INFORMATION HAS BEEN GIVEN	
Nappy care / skin care:	
Demonstration bath:	
Confident in bathing your baby:	
Checking the nasogastric tube is in the correct position/Ph testing before each feed.	
Confident in the safe delivery of milk feeds:	
Information on Temperature control:	
How to recognise your baby is unwell:	
Resuscitation training	
Information for reducing cot death	
Administering medication:	
How to draw up medication:	
Parent confident at giving medication:	

PLEASE COMPLETE AND SIGN	
Print:	Signature:

NG Tube Feeding Folder

Appendix 3b: Neonatal discharge form page 2

Appendix 3b: Neonatal Discharge form page 2

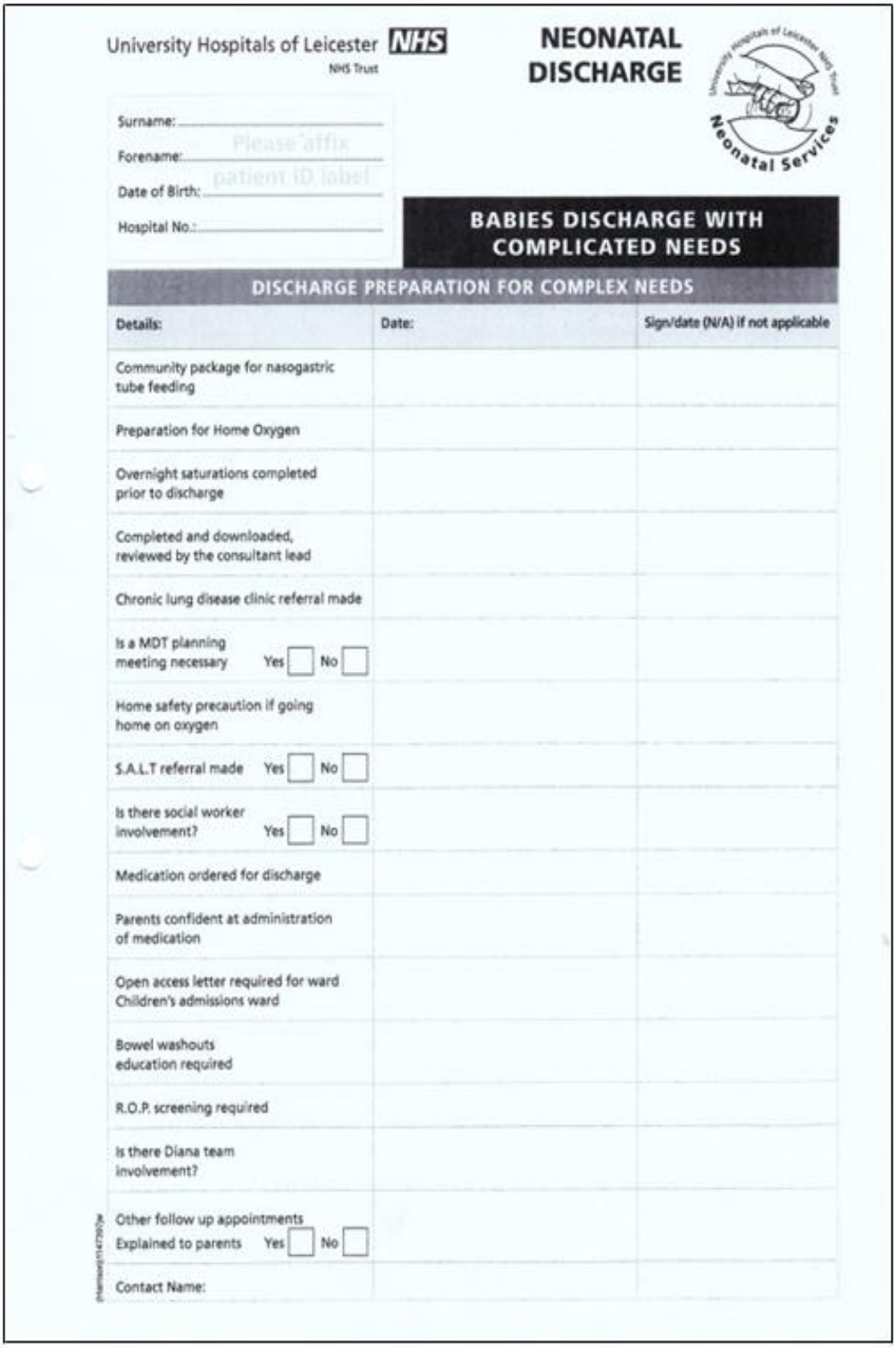
DISCHARGE COMPLETION CHECK LIST		
Details:	**Date:**	**Signature/Print name:**
Is a bedroom required prior to discharge?		
Orientation to the bedroom and the emergency call procedure:		
Information provided for accessing meals:		
Where to obtain meals and drinks during rooming in?		
Safe transfer home/Access to a car seat?		
Breast pump returned prior to discharge:		
H.V. contacted on discharge:		
Information faxed to H.V.		
G.P. contacted on discharge:		

PAPERWORK COMPLETED FOR DISCHARGE (N/A IF NOT APPLICABLE)			
Discharge preparation:	**Action:**	**Date completed:**	**Signature & Print:**
Medication:	TTO Ordered:		
Red book completed	Weights		
	Head circumference		
	Newborn screening details:		
	Hearing test complete		
	Discharge examination		
	Teddy bear page		
Badger summary discussed:	Signature & Print	Copy of badger given to parents:	

FOLLOW UP APPOINTMENTS BOOKED (N/A IF NOT APPLICABLE)			
Neonatal appointment:		Head scan if booked	
Neuro-development		R.O.P. clinic	
Cardiology		Audiology follow up	
Immunisations due rotavirus		Surgical follow up:	
Patient experience questionnaire completed:	Date:		
Discharge checklist completed:		Signature & Print	
Hip scan			

Appendix 3c: Complex needs discharge paperwork form

Appendix 3c: Complex Needs Discharge Paperwork form



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NEONATAL DISCHARGE

Neonatal Services

Surname:
Forename:
Date of Birth:
Hospital No.:

Please affix patient ID label

BABIES DISCHARGE WITH COMPLICATED NEEDS

DISCHARGE PREPARATION FOR COMPLEX NEEDS

Details:	Date:	Sign/date (N/A) if not applicable
Community package for nasogastric tube feeding		
Preparation for Home Oxygen		
Overnight saturations completed prior to discharge		
Completed and downloaded, reviewed by the consultant lead		
Chronic lung disease clinic referral made		
Is a MDT planning meeting necessary Yes ☐ No ☐		
Home safety precaution if going home on oxygen		
S.A.L.T referral made Yes ☐ No ☐		
Is there social worker involvement? Yes ☐ No ☐		
Medication ordered for discharge		
Parents confident at administration of medication		
Open access letter required for ward Children's admissions ward		
Bowel washouts education required		
R.O.P. screening required		
Is there Diana team involvement?		
Other follow up appointments Explained to parents Yes ☐ No ☐		
Contact Name:		

Appendix 4: Health visitor pathway – key visits – parent information

Appendix 4: Health visitor pathway - Key visits - Parent information

The universal health reviews – 5 key visits

As part of the transformation of the health visiting service, all families will receive 5 key visits from their health visitor.

You will also be offered a range of advice and support on everything from breastfeeding and weaning to immunisations and minor illnesses.

First visit: When you are around 28 weeks pregnant

This first visit is an opportunity to meet your health visitor and discuss how you're feeling about having a baby. The baby's father is very welcome at this visit, which usually takes place in your home.

As part of the visit, your health visitor will ask you about your plans for having your baby and answer any questions you may have. They will provide you with information on infant development, feeding, parenting, and the Healthy Start programme.

They will also give you their contact details and explain how they will support you following the birth of your baby.

Your midwife will provide immediate care and support to you for the first few days after you've had your baby.

Second visit: 10-14 days following the birth of your baby

Your health visitor will visit you in your home to see how you're getting on and support you with feeding and caring for your baby. The baby's father is very welcome to be present at this meeting.

Your health visitor will ask you how you are feeling and how your family is adjusting to the new arrival. They will also ask if you have any questions and listen to any concerns you may have about your baby's health or your health.

Examples of issues that you may wish to discuss include interacting with your baby (e.g. songs and music, books); feeding; diet and nutrition; colic; sleep; crying; establishing a routine; safety; car seats and the immunisation programme.

They may also weigh your baby during their visit.

Remember that you can contact your health visitor if you have any questions, concerns or ever feel that you need some extra reassurance.

Third visit: When your baby is 6-8 weeks old

At this visit in your home, your health visitor will see how thing are going and how you're feeling. This visit is in addition to your GP medical visit which takes place at around the same time at your GP surgery.

The Health Visitor may weigh your baby, review their general health and discuss their immunisations.

They will also give you contacts for your local health clinic or children's centre where you can get your baby weighed and access a range of support.

Fourth visit: A review of your child's development at 9-12 months

This visit may take place in your home or in your local clinic and is an opportunity to assess and discuss your child's physical health and development.

This includes lots of things, such as your child's diet, dental health and safety issues.

As part of the visit, your health visitor may weigh and measure your child and discuss their immunisations.

If you wish, your health visitor can also put you in touch with local mother and baby groups, children's centres or activities in your area.

Although the next scheduled visit isn't until your child is 2-2 ½ years, you can always contact your health visitor or your GP if you have any questions or concerns about your child's development.

Fifth visit: A review of your child's development at 2-2½ years

This is the fifth and final scheduled visit from your health visitor or nursery nurse, which can take place at your home, local clinic or children's centre.

This visit is an opportunity to talk about any issues you have regarding your child's health. This may include their hearing and vision, language development, behaviour, sleeping or toilet training.

Your child will also be weighed and measured, and you can discuss their immunisations and the various options for childcare and early years education.

Although this is the last scheduled visit, remember that your health visitor is on hand to offer you advice, information and signposting until your child is five years old.

If you have any queries please speak to your health visitor or GP.

Monitoring criteria

Monitoring table: Neonatal Discharge Guideline

What key element(s) need(s) monitoring as per local approved policy or guidance? To include minimum requirements	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/ observe/asses/ inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report? How often is the need to share the report ?	Who or what committee will the completed report go to and how will this be monitored. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?	How will system or practice changes be implemented the lessons learned and how will these be shared.
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
Discharge paperwork is commenced on admission to hospital	Matron for Neonatal Service.	Quality metric audit of discharge paperwork.	Monthly.	Results will be reviewed by Neonatal Service to identify actions required to ensure compliance with standard set. Results and actions will be discussed at Neonatal Governance meeting and documented in minutes of meeting.	Completion of action plans within identified timescales will be monitored through Neonatal Governance meeting. Lead: Chair for Neonatal Governance	Changes to practice will be identified and actioned within agreed timeframes. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant members of the multidisciplinary team.
Discharge requirements for specific patient groups (simple / complex) are identified and met.	Matron for Neonatal Service.	Audit of completed discharge preparation checklist through retrospective review of case notes.	Quarterly	Results will be reviewed by Neonatal Service to identify actions required to ensure compliance with standard set. Results and actions will be discussed at Neonatal Governance meeting and documented in minutes of meeting.	Completion of action plans within identified timescales will be monitored through Neonatal Governance meeting. Lead: Chair for Neonatal Governance	Changes to practice will be identified and actioned within agreed timeframes. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant members of the multidisciplinary team.

Discharge letter and child health record is completed.	Matron for Neonatal Service	Audit of completed discharge letter and child health record through retrospective review of case notes.	Quarterly	Results will be reviewed by Neonatal Service to identify actions required to ensure compliance with standard set. Results and actions will be discussed at Neonatal Governance meeting and documented in minutes of meeting.	Completion of action plans within identified timescales will be monitored through Neonatal Governance meeting. Lead: Chair for Neonatal Governance	Changes to practice will be identified and actioned within agreed timeframes. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant members of the multidisciplinary team.