## Discharge Care Pathway for Infants from Neonatal Unit, CAH

<table>
<thead>
<tr>
<th><strong>CLINICAL GUIDELINES ID TAG</strong></th>
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<tbody>
<tr>
<td><strong>Title:</strong> Discharge care pathway for infants from the neonatal unit, Craigavon Area Hospital</td>
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<tr>
<td><strong>Author:</strong> Una Toland</td>
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<td><strong>Speciality / Division:</strong> Neonatal</td>
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<td><strong>Clinical Guideline ID</strong></td>
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Discharge Care Pathway for Infants from Neonatal Unit, CAH

PURPOSE

The purpose of this pathway is to facilitate the safe and effective discharge of infants from the neonatal unit to:

- The home environment where there are no safeguarding concerns or complex medical/nursing needs.

- The home environment where there are safeguarding concerns.

- The home environment requiring home oxygen therapy and input from children’s nursing team.

- The home environment requiring enteral feeding and input from community children’s nursing team.

- The postnatal ward.

- Another Neonatal Unit for ongoing care.

The discharge needs of the infant will be assessed on an individual basis and should be carefully planned. This will ensure continuity of care in the hospital, between hospitals and in the community setting.

SCOPE

This pathway applies to all neonatal nursing and medical staff and midwives and any other members of the multidisciplinary team inputting into the care of infants in neonatal setting.
DISCHARGE CRITERIA

Assessment of infants for discharge should include

- Thermoregulation - adequate maintenance of normal body temperature fully clothed in an open cot
- Feeding/ nutrition
- Cardio respiratory stability
- Colonisation / Infection risk
- Family readiness for discharge. Family training / education
- Availability of community support
- Gestational age ideally have reached 34 weeks corrected age or more
- Weight gain (ideally minimum weight of 1800 grams and showing sustained pattern of weight gain, < 1800 grams is at consultant discretion)
- Screening tests (to include ROP screening follow up)
- Immunisation status

DECISION TO DISCHARGE

- Consultant Paediatrician/Neonatologist in consultation with senior nurse in charge and ANNP.
- Medical and nursing staff to agree a date of discharge with parents /carers with parental responsibility.
- Nursing team will perform majority of discharge requirements.

DISCHARGE CHECKLIST

Where appropriate, the following should be achieved before discharge with the input from language support / interpreter if required.

All parents should be offered to room in overnight with infant.
Parental competencies

- Administration of medications to include instruction on storage, dosage, timing and administration.
- Baby cares (nappy change, top and tail bathing, bathing).
- Feeding

Parental education

- Consider the need for resuscitation training and give BLISS DVD and practical demonstration as required.
- Information on respiratory syncytial virus if applicable (give BLISS leaflet).
- Prevention of SIDs (give information leaflet).
- Storage of breast milk and cleaning of breast pump equipment if appropriate (give written information leaflet).
- Preparation of powdered infant formula feeds (give written information leaflet).
- Discuss tips for keeping infant safe from infection in home environment, proper positioning during sleep and use of car seats.

Procedures and Investigations

- Check all new-born blood spot screening tests completed to date and any follow up tests communicated to community team.
- When immunisations not complete, send copy of immunisations received to date to GP, HV and Child Health.
- Arrange BCG if required.
- Arrange audiology screening if required.
- Arrange ophthalmology screening follow up if required (<32 weeks gestation and or < 1501 grams).

Professional Communication

- Check home and discharge addresses and confirm name of GP.
- Complete NIMATS or CHS3b discharge documentation and send copy to Child Health/ Health visitor/ GP/ Community Children’s Nursing Team.
- Complete admission/discharge ledger.
- Contact Community midwife / Health visitor on day of discharge (if weekend discharge inform on next working day).
- Complete daily stats book.
- Inform TAMBA HV link if applicable.
- Update on line Regional Neonatal cot locator.
- Give parents copy of “Your experience of neonatal care” survey to complete.
Medical/ ANNP team

- Perform and record discharge examination
- Complete Part A and Part B of Infant PCHR Red Book
- Check Hip referral sent if required
- Ensure prescription for take home medications written, sent to pharmacy and drugs available in ward on day of discharge
- Complete discharge summary on Badger
- Check all follow up appointment’s made

Follow up appointments

Ensure these are written on discharge summary. Likely appointments may include

- Neonatal outpatient clinic
- Ophthalmology clinic
- Audiology referral
- Cranial ultrasound
- Brain MRI
- Physiotherapy
- Hip referral
- Dietitian
- Child developmental clinic
- BCG immunisation or Palivizumab
- Planned review for blood taking, weight check at Rainbow Clinic
- Tertiary consultant out patients
DISCHARGE CRITERIA

Discharge planning meeting should take place as soon as reasonably possible in conjunction with all relevant professionals involved in the infants hospital care and care in the community.

Consider the need for input from language support/ interpreter if required.

Ensure that no infant about whom there are safe guarding concerns is discharged from hospital back into the community without an identified GP and a full assessment of home circumstances. Ensure all actions following discharge planning meeting are completed before infant is discharged from neonatal unit. If applicable, facilitation of Adoption / Foster carers should be coordinated as advised by hospital social work team.

Professionals who may be invited to attend the discharge planning meeting pending the circumstances include (see attached template for preparation for discharge meeting re infant about whom there are safe guarding concerns appendix 1).

- GP
- Health Visitor
- Community midwife
- Children’s community nurse
- Hospital social worker
- Community social worker
- Hospital Safe guarding lead
- Member of neonatal medical team
- Member of neonatal nursing team

Assessment of infants for discharge should include

- Thermoregulation- adequate maintenance of normal body temperature fully clothed in an open cot
- Cardio respiratory stability
- Colonisation /Infection risk
- Gestational age ideally have reached 34 weeks corrected age or more
- Weight gain (ideally minimum weight of 1800grams and showing sustained pattern of weight gain, < 1800grams is at Consultant discretion )
- Family readiness for discharge. Family training / education
- Availability of community support
- Screening tests ( to include ROP screening follow up )
- Immunisation status
DECISION TO DISCHARGE

- Consultant paediatrician/neonatologist in consultation with senior nurse in charge and ANNP.
- Medical and nursing staff to agree a date of discharge with parents/carers with parental responsibility.
- Nursing team will perform majority of discharge requirements.

DISCHARGE CHECKLIST

Where appropriate the following should be achieved before discharge.

All parents should be offered to room in overnight with infant.

Parental/Carer competencies

- Administration of medications to include instruction on storage, dosage, timing and administration
- Baby cares (nappy change, top and tail bathing, bathing)
- Feeding

Parental/Carer education

- Consider the need for resuscitation training and give BLISS DVD and practical demonstration as required.
- Information on Respiratory syncytial virus if applicable (give BLISS leaflet).
- Prevention of SIDS (give information leaflet).
- Storage of breast milk and cleaning of breast pump equipment if appropriate (give written information leaflet).
- Preparation of powdered infant formula feeds (give written information leaflet).
- Discuss tips for keeping infant safe from infection in home environment, proper positioning during sleep and use of car seats.

Procedures and Investigations

- Check all new-born blood spot screening tests completed to date and any follow up tests communicated to community team
- When immunisations not complete ensure send copy of immunisation received to date to GP, HV and Child Health.
- Arrange BCG if required.
- Arrange audiology screening if required.
- Arrange ophthalmology screening follow up if required (<32 weeks gestation and or < 1501 grams).
Professional Communication

The social worker will normally provide transport for the infant on the day of discharge from Neonatal to the home of Foster / Adoptive parents.

- Check home and discharge addresses and confirm name of GP.
- Complete NIMATS or CHS3b discharge documentation and send copy to Child Health/ Health visitor/ GP/ Community Children’s Nursing Team.
- Complete admission/ discharge ledger.
- Contact Community Midwife /Health visitor on day of discharge (if week end discharge inform on next working day).
- Complete daily stats book.
- Inform TAMBA HV link if applicable.
- Update on line Regional Neonatal cot locator.
- Give parents copy of “ Your experience of neonatal care “ survey to complete.
- Complete Child Protection Discharge Checklist (ref: SHSCT Assessment, admission and Discharge Policy and Procedures for Children and Young People under the age of 18 years about whom there are Safe guarding Concerns within Acute Services).
- Send copy of completed Child Protection Discharge checklist to hospital social work team.

Medical/ ANNP team

- Perform and record discharge examination
- Complete Part A and Part B of Infant PCHR Red Book
- Check Hip referral sent if required
- Ensure prescription for take home medications written, sent to pharmacy and drugs available in ward on day of discharge
- Complete discharge summary on Badger
- Check all follow up appointment’s made

Follow up appointments

Ensure these are written on discharge summary. Likely appointments may include

- Neonatal outpatient clinic
- Ophthalmology clinic
- Audiology referral
- Cranial ultrasound
- Brain MRI
- Physiotherapy
- Hip referral
- Die titian
- Child developmental clinic
- BCG immunisation or Palivizumab
- Planned review for blood taking, weight check at Rainbow Clinic
- Tertiary consultant out patients
APPENDIX 1

Template for preparation for multidisciplinary meeting in preparation for discharge of infant with complex needs and or Safe guarding concerns

<table>
<thead>
<tr>
<th>DATE OF MEETING</th>
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<tr>
<td>TIME OF MEETING</td>
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<td>VENUE FOR MEETING</td>
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<table>
<thead>
<tr>
<th>NURSING SUMMARY ON INFANT PROGRESS READY FOR MEETING</th>
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<tbody>
<tr>
<td>MEDICAL SUMMARY ON INFANT PROGRESS READY FOR MEETING</td>
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<tr>
<td>PLANNED DATE OF DISCHARGE FOR INFANT</td>
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<thead>
<tr>
<th>Professional Group</th>
<th>Named representative</th>
<th>Contact number</th>
<th>Attendance confirmed or alternative representative designated to attend</th>
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<tbody>
<tr>
<td>NEONATAL NURSE</td>
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<td>NEONATAL MEDICAL REPRESENTATIVE</td>
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<td>GP</td>
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<td>HEALTH VISITOR</td>
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<td>COMMUNITY CHILDRENS NURSE</td>
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<td>HOSPITAL BASED</td>
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<td>SOCAIL WORKER</td>
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<td>COMMUNITY BASED</td>
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<td>SAFE GUARDING NURSE</td>
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<td>PARENTS/CARERS</td>
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<td>OTHERS</td>
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Addressograph
Summary of key actions to be taken forward by key staff following meeting

<table>
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<tr>
<th>ACTION</th>
<th>KEY PROFESSIONAL RESPONSIBLE FOR FOLLOW UP</th>
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INDICATIONS FOR HOME OXYGEN

Chronic lung disease and other neonatal lung condition at Consultant discretion.

DISCHARGE CRITERIA

- Be clinically stable or improving
- No significant cyanotic or apnoeic episodes in preceding 2 weeks

Discharge planning meeting should take place as soon as reasonably possible in conjunction with all relevant professionals involved in the infant's hospital care and care in the community. Consider the need for input from language support / interpreter if required.

Ideal timing of discharge should be start of week so that staff are available in event of problems.

Liaison with Children’s Community Nursing team is vital approaching discharge so that on site visit to meet parents/ carers / infant pre discharge can be organised and home visit on day of discharge can be facilitated.

Professionals who may be invited to attend the discharge planning meeting pending the circumstances include (see attached template for preparation for discharge meeting re infant with complex needs).

- GP
- Health Visitor
- Community midwife
- Children’s community nurse
- Hospital social worker
- Community social worker
- Hospital Safe guarding lead
- Member of neonatal medical team
- Member of neonatal nursing team

Assessment of infants for discharge should include:

- An agreement on the need for continuous or intermittent pulse-oximetry.
- An agreement on saturation levels for infant in the home environment
- Plan for management of low saturation at home
- Thermoregulation- adequate maintenance of normal body temperature fully clothed in an open cot.
- Feeding /nutrition
- Cardio respiratory stability
- Colonisation / Infection risk
- Family readiness for discharge. Family training / education
- Availability of community support
- Gestational age ideally have reached 34 weeks corrected age or more.
- Weight gain (ideally minimum weight of 1800grams and showing sustained pattern of weight gain. < 1800grams is at Consultant discretion)
- Screening tests (to include ROP screening follow up)
- Immunisation status

**DECISION TO DISCHARGE**

- Consultant Paediatrician/Neonatologist in consultation with senior nurse in charge and ANNP.
- Medical and nursing staff to agree a date of discharge with parents/carers with parental responsibility.
- Nursing team will perform majority of discharge requirements.

**DISCHARGE CHECKLIST**

- All parents/carers should be offered to room in overnight with infant.
- Parents/carers must ensure they contact Home and Car Insurance companies and alert them of need for home oxygen need.
- Complete HOOF (HOME OXYGEN ORDER FORM) [http://www.hscbusiness.hscni.net/services/2359.htm](http://www.hscbusiness.hscni.net/services/2359.htm) and fax to appropriate department as indicated on form, indicating need for concentrator, ambulatory oxygen for car/buggy etc. Once the HOOF form is submitted to the home oxygen provider for the local area, a representative will contact parents/carers to arrange delivery and installation of oxygen supply in the home.
- Medical staff to dictate a written prescription indicating clinical diagnosis, amount of oxygen required for infant and a letter should be forwarded to oxygen supplier.
- Ensure parents/carers have a list of emergency telephone numbers in event of breakdown of equipment.
- Parents/carers should have a supply of accessories required for delivery of oxygen, nasal cannulae, fixation pads, etc appropriate to needs of infant, be trained in use of all equipment, be able to trouble shoot and know who to contact in an emergency and for replenishment of stock.
Where appropriate the following should be achieved before discharge

Parental /Carer competencies

- Administration of medications to include instruction on storage, dosage, timing and administration.
- Baby cares (nappy change, top and tail bathing, bathing).
- Feeding

Parental /Carer education

- Check home and discharge addresses and confirm name of GP.
- Provide resuscitation training and give BLISS DVD and practical demonstration as required.
- Information on Respiratory syncytial virus if applicable (give BLISS leaflet).
- Prevention of SIDS (give information leaflet).
- Storage of breast milk and cleaning of breast pump equipment if appropriate (give written information leaflet).
- Preparation of powdered infant formula feeds (give written information leaflet).
- Discuss tips for keeping infant safe from infection in home environment, proper positioning during sleep and use of car seats.
- Equipment operation, maintenance and problem solving for each device needed.
- Face to face training on use of home oxygen, set up, monitoring, adjusting oxygen, safety precautions etc. Compliment with BLISS GOING HOME ON OXYGEN booklet.
- Use of oxygen nasal cannulae and care of same.
- Safety issues associated with oxygen in the home, naked flames, open fires, candles, birthday cakes, smoking etc.

Procedures and Investigations

- Check all new-born blood spot screening tests completed to date and any follow up tests communicated to community team
- When immunisations not complete ensure send copy of immunisation received to date to GP, HV and Child Health.
- Arrange BCG if required.
- Arrange audiology screening if required.
- Arrange ophthalmology screening follow up if required ( <32weeks and or <1501grams).
Professional Communication

- Check home and discharge addresses and confirm name of GP
- Complete NIMATS or CHS3b discharge documentation and send copy to Child Health/ Health visitor/ GP/ Community Children’s Nursing Team.
- Complete admission/ discharge ledger
- Contact Community Midwife /Health visitor on day of discharge (if week end discharge inform on next working day).
- Complete daily stats book
- Inform TAMBA HV link if applicable
- Update on line Regional Neonatal cot locator
- Give parents copy of “Your experience of neonatal care” survey to complete

Medical/ ANNP team

- Perform and record discharge examination
- Complete Part A and Part B of Infant PCHR Red Book
- Check Hip referral sent if required
- Ensure prescription for take home medications written, sent to pharmacy and available in ward on day of discharge.
- Complete discharge summary on Badger
- Check all follow up appointment’s made

Follow up appointments

Ensure these are written on discharge summary. Likely appointments may include

- Neonatal outpatient clinic
- Ophthalmology clinic
- Audiology referral
- Cranial ultrasound
- Brain MRI
- Physiotherapy
- Hip referral
- Dietician
- Child developmental clinic
- BCG immunisation or Palivizumab
- Open access to Children’s ward
- Planned review for blood taking, weight check at Rainbow Clinic
- Tertiary consultant out patients
DISCHARGE CRITERIA

Assessment of infants for discharge should include

- Thermoregulation - adequate maintenance of normal body temperature fully clothed in an open cot
- Cardio respiratory stability
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- Family readiness for discharge. Family training / education
- Gestational age ideally have reached 34 weeks corrected age or more.
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- Availability of community support
- Screening tests (to include ROP screening follow up)
- Immunisation status

DECISION TO DISCHARGE

- Consultant Paediatrician/Neonatologist in consultation with senior nurse in charge and ANNP.
- Medical and nursing staff to agree a date of discharge with parents/carers with parental responsibility.
- Nursing team will perform majority of discharge requirements.

DISCHARGE CHECKLIST

Where appropriate the following should be achieved before discharge with the input from language support/interpreter if required.

Discharge planning meeting should take place as soon as reasonably possible in conjunction with all relevant professionals involved in the infants hospital care and care in the community.

Agree a plan of action for parents if feeding tube is dislodged out of hours and ensure parents/carers aware of who to contact and where to go to have tube replaced.

If infant is able to suck some feeds and has stable blood sugars, it may not be appropriate to come to Paediatric ward in middle of night for tube replaced. This may be left until the next morning.
Professionals who may be invited to attend the discharge planning meeting pending the circumstances include (see attached template for preparation for discharge meeting re infant with complex needs appendix 1).

- GP
- Health Visitor
- Community midwife
- Children’s community nurse
- Member of neonatal medical team
- Member of neonatal nursing team
- dietician

All parents should be offered to room in overnight with infant.

Parents /carers should have a supply of enteral feeding equipment appropriate to needs of infant, be trained in use of all equipment, be able to trouble shoot and know who to contact in an emergency and for replenishment of stock.

Parental competencies

- Administration of medications to include instruction on storage, dosage, timing and administration.
- Baby cares (nappy change, top and tail bathing, bathing).
- Tube Feeding training and competency assessment and parents feel confident in administration of tube feed.

Parental education

- Consider the need for resuscitation training and give BLISS DVD and practical demonstration as required.
- Information on respiratory syncytial virus if applicable (give BLISS leaflet).
- Prevention of SIDS (give information leaflet).
- Storage of breast milk and cleaning of breast pump equipment if appropriate (give written information leaflet).
- Cleaning and storage of enteral feeding equipment.
- Preparation of powdered infant formula feeds (give written information leaflet).
- Discuss tips for keeping infant safe from infection in home environment, proper positioning during sleep and use of car seats.
Procedures and Investigations

- Check all new-born blood spot screening tests completed to date and any follow up tests communicated to community team
- When immunisations not complete ensure GP, HV and Child Health informed on discharge
- Arrange IF BCG required
- Arrange audiology screening
- Arrange ophthalmology screening follow up

Professional Communication

- Check home and discharge addresses and confirm name of GP.
- Complete NIMATS or CHS3b discharge documentation and send copy to Child Health/ Health visitor/ GP/ Community Children’s Nursing Team.
- Complete admission/ discharge ledger.
- Contact Health visitor on day of discharge (if weekend discharge inform on next working day).
- Complete daily stats book
- Inform TAMBA if applicable HV link
- Update on line Regional Neonatal cot locator
- Give parents copy of “Your experience of neonatal care” survey to complete

Medical/ ANNP team

- Perform and record discharge examination
- Complete Part A and Part B of Infant PCHR Red Book
- Check Hip referral sent if required
- Ensure prescription for take home medications written and sent to pharmacy
- Complete discharge summary on Badger
- Check all follow up appointment’s made

Follow up appointments

Ensure these are written on discharge summary. Likely appointments may include

- Neonatal outpatient clinic
- Ophthalmology clinic
- Audiology referral
- Cranial ultrasound
- Brain MRI
- Physiotherapy
- Hip referral
- Die titian
- Child developmental clinic
- BCG immunisation or Palivizumab
• Open access to Children’s ward
• Planned review for blood taking, weight check at Rainbow Clinic
• Tertiary consultant out patients

INFANTS DISCHARGED FROM NEONATAL TO THE POST NATAAL WARD

DISCHARGE CRITERIA

Assessment of infants for discharge to post natal ward should include

• Thermoregulation- adequate maintenance of normal body temperature fully clothed in an open cot
• Feeding/ nutrition
• Cardio respiratory stability
• Colonisation / Infection risk
• Need for intravenous drugs (antibiotics)
• Follow up blood tests and investigations still required
• Mother still an in patient

Procedures and Investigations

• Check all new-born blood spot screening tests completed to date and any follow up tests communicated to midwifery team
• Arrange IF BCG required
• Make arrangements for follow up blood tests /investigations

Professional Communication

• Complete admission/ discharge ledger
• Complete daily stats book
• Inform TAMBA if applicable HV link
• Update on line Regional Neonatal cot locator
• Neonatal nurse should contact postnatal ward and debrief named midwife on planned transfer to ward.
• Neonatal nurse should accompany the infant from Neonatal to Postnatal ward and give verbal handover to Named midwife and both staff should carry out an armband check on transfer.
• This infant should be discussed on the postnatal ward round.
• Inform social work team and safe guarding nurse if there are any safe guarding concerns.

Medical/ ANNP team

• Record any relevant information in Part A and Part B of Infant PCHR Red Book.
• Ensure medical summary/transfer examination and care plan completed in neonatal combined medical notes.
• Check Hip referral sent if required
• Complete discharge summary on Badger
• Check all follow up appointment’s made

**Follow up appointments**

Ensure these are written on discharge summary. Likely appointments may include

• Neonatal outpatient clinic
• Ophthalmology clinic
• Audiology referral
• Cranial ultrasound
• Brain MRI
• Physiotherapy
• Hip referral
INFANTS DISCHARGED FROM NEONATAL TO ANOTHER NEONATAL UNIT FOR ONGOING CARE

DISCHARGE CRITERIA

Assessment of infants for discharge to another neonatal unit should include

- Availability of a cot in the appropriate neonatal unit for repatriation care or for intensive care input in Regional Neonatal Unit (see attached appendix re repatriation care services available in each neonatal unit in Northern Ireland).
- Clinical stability of infant requiring transfer.
- Availability of key transport staff to facilitate the transfer, either local neonatal skilled team or regional transport team.
- Availability of maternal bed if required.

Procedures and Investigations

- Check pre transfusion blood spot screening card completed before transfer if applicable and ensure card accompanies infant to transferring until if transfer occurring before infant has Day 5 test completed.
- Check all new-born blood spot screening tests completed to date and any follow up tests communicated to receiving unit team.
- Record all relevant up to date blood test results and results of any relevant other investigations.

Professional Communication

- Complete the NI Paediatric Transfer form detailing all blood tests, investigations, nursing requirements, travel arrangements for parents, fluid balance observations, vital signs, drugs and personal data set details.
- Complete the Neonatal Network Northern Ireland NNNI Neonate Notification of alert organism status form.
- Complete the neonatal transfer out of unit proforma for monthly data collation.
- Update on line Regional Neonatal cot locator.
- Photocopy and attach copies of any relevant laboratory results.
- Photocopy ROP examination record sheet if applicable.
- Photocopy drug kardex
- Enclose a copy of Badger electronic centile chart.
- Complete admission/ discharge ledger
• Complete daily stats book
• Inform TAMBA if applicable HV link
• If safe guarding issue, inform safe guarding nurse and social work team in both transferring and receiving unit.
• If required neonatal staff should liaise with both transferring unit and receiving unit maternity staff to ascertain if maternal bed required and available.
• Inform parents if not present of transfer details as soon as possible.

Medical/ANNP team

• Medical staff should communicate directly with receiving unit and confirm arrangements for discharge of infant and provide verbal medical summary.
• Ensure Badger electronic medical summary updated and print copy for receiving unit.

Infants who are being discharged home for follow-up in their local hospital should have a nominated consultant for follow-up before discharge and the discharge summary plus other pertinent information must be addressed prior to discharge with parental involvement.
# Neonatal Care Pathway - Unit Specification

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<tr>
<th>Trust</th>
<th>BHSC</th>
<th>WHSC</th>
<th>NHSCT</th>
<th>SEHSCT</th>
<th>SHSC</th>
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<tr>
<td>Area</td>
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<td>Altnagelvin - LNU</td>
<td>SWAH - SCBU</td>
<td>Antrim - LNU</td>
<td>Ulster - LNU (Inc. DP &amp; LV MLUs)</td>
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### Gestational range

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<th>Trust</th>
<th>BHSC</th>
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**Neonatal Care Pathway - Unit Specification**

### Gestational range

- **23+0 - 23+6** after consultant paediatrician to consultant neonatologist discussion*, 24 weeks onwards.
- We currently look after babies of all gestations. Babies between 23+0 - 25+6 may be transferred in utero if there is cot available in RJMH.
- **34 weeks and above** 27 completed weeks and above. Capable of caring for 24-26 weeks gestation if NNNU RJMH is unable to accept. In utero or post delivery transfer to RJMH requested at this extreme prematurity.
- **28 weeks onwards** 28 weeks onwards.
- **28+ wks** 27+ wks following discussion with Consultant
- **34+ weeks and above** 34+ weeks and above; 32 weeks to 34 weeks following discussion with Consultant

### Criteria for care at Hospital – what are you routinely providing currently?

<table>
<thead>
<tr>
<th>Trust</th>
<th>BHSC</th>
<th>WHSC</th>
<th>NHSCT</th>
<th>SEHSCT</th>
<th>SHSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area</td>
<td>RJMH - NICU</td>
<td>Altnagelvin - LNU</td>
<td>SWAH - SCBU</td>
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<td>Ulster - LNU (Inc. DP &amp; LV MLUs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ventilation – what type – long term, short term</th>
<th>Short and long term.</th>
<th>Short and long term.</th>
<th>Less than 3 day</th>
<th>Short and long term</th>
<th>Short and long term</th>
<th>Short and long term</th>
<th>Short term</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFOV</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>No</td>
<td>Yes</td>
<td>no</td>
</tr>
<tr>
<td>Nitric Oxide</td>
<td>yes</td>
<td>No</td>
<td>no</td>
<td>no</td>
<td>No</td>
<td>No</td>
<td>no</td>
</tr>
<tr>
<td>Non – invasive resp. support</td>
<td>yes</td>
<td>Yes</td>
<td>yes</td>
<td>yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>TPN</td>
<td>yes</td>
<td>Yes</td>
<td>yes</td>
<td>yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgery include. NEC</td>
<td>yes</td>
<td>No</td>
<td>no</td>
<td>no</td>
<td>No</td>
<td>No</td>
<td>no</td>
</tr>
<tr>
<td>Therapeutic hypothermia</td>
<td>yes</td>
<td>Yes</td>
<td>no</td>
<td>yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Passive only until transfer out</td>
</tr>
</tbody>
</table>

### Transfer and repatriation

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<thead>
<tr>
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**If a baby from your Trust is resident in another unit.**

- A Belfast Trust baby born elsewhere will be accepted when a cot is available.
- WHSCT – all babies born elsewhere will be accepted when a cot is available.
- A southern sector western trust baby will be accepted back from another hospital when not ventilated and a cot available.
- Repatriation once Meeting clinical / infection control criteria for Northern Trust and cot and isolation room available. The Neonatal Chief / Clinical Team will override ‘isolation in a side room’ criterion depending on case mix and NNHNI requirements.
- Repatriation to SET when cot available and clinical criteria for SET met. A Southern trust baby born elsewhere will be accepted back when an isolation room cot is available.
- Repatriation will be anticipated once the baby is clinically stable and meets the clinical pathway threshold/ cot available in accepting Local Unit. A Southern trust baby born elsewhere will be accepted back when an isolation room cot is available.
- Uncommon Repatriation will be anticipated once the baby is clinically stable and meets the clinical pathway threshold/ cot available in the local unit. Once the baby is clinically stable cot available in the local unit.
- Repatriation will be anticipated once the baby is clinically stable and meets the clinical pathway threshold for NNNUCAH.
- Repatriation will be anticipated once the baby is clinically stable and meets the clinical pathway threshold for SCBU.

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*This policy is subject to change and should be reviewed regularly.*

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