Bliss Baby Charter Principle 1

Every baby should be treated with dignity, respecting their social developmental and emotional needs as well as their medical and surgical needs,

Objectives

- All parents are able to have regular private time with their baby.
- Care provision is designed to minimise the stress of the NICU environment.

Outcomes

- Babies' long-term developmental outcomes are enhanced
- There is a strong attachment between the baby and their family which is actively supported by staff on the unit.

Green (G) = Unit fully meets criteria		Amber (A) = Unit partially meets criteria, more work needs to be done			Red (R) = Unit does not currently meet any aspect of the criteria	
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 1.1 – Dignity and privacy						
1.1A	All babies are referred to by their given name	NPS D11	G			As soon as a baby is admitted to the unit – Staff ask parents if they have chosen a name for their baby. Whenever baby's care is discussed healthcare professionals always use baby's first name. All medical notes, care plans and identity bands are updated with baby's first name. Within the unit at every bed space we have identity cards above the baby's bed, which includes information like the baby's name.
1.1B	All parents have unrestricted access to their baby, unless individual restrictions can be justified in the baby's best interest	NICU 5b: DH Toolkit 3.3: BAPM 6.1	G			The visiting policy within our unit is 24 hour visiting for parents (or a chosen support person). Siblings are able to visit with parents or with grandparents. Grandparents can visit between 1pm and 3pm, no other family members are able to visit – we have a strict visiting policy for infection prevention purposes. Our visiting policy is given to parents on baby's admission and discussed. There are some situations when parents are not allowed to visit their baby, this can be for the baby's best interests. (There tends to be a social worker involved in these cases).
1.1C	Parents are offered privacy when feeding their baby, during skin-to-skin care and when clinical procedures are		G			All the patient spaces within the unit have curtains around them to allow privacy when having skin to skin, breastfeeding, or if mum wishes to express at the bed side.

	taking place					The curtains are closed when clinical procedures are being performed and when a baby is being admitted. NMC – Code of professional conduct – respecting patients dignity and confidentiality.
1.1E	Parents have the opportunity for private time with their baby in a separate room or cot side with screens, as their baby's condition allows		G			We have 6 family rooms within our unit that are available for parents to use. The curtains around the baby's bed space can be drawn to allow them some privacy. We have a designated room for palliative care – which allows other family members to visit baby with parents, this room is also set away from the busy ITU environment, to try to allow them quiet time and privacy.
1.1F	Your unit makes provision for private consultation with health professionals in an appropriate environment	NICE 5a, 5b: NPS D5	G			We have a consultation room, which is used to have consultations with other healthcare professionals, it can also be used to discuss baby's condition with parents. A seminar room is also available on the unit for consultations.
1.1G	Parents are involved in the choice of clothing for their baby as their clinical condition permits		G			We actively encourage parents to bring their baby some clothes in, when the baby is clinically well enough to be dressed. We also encourage them to bring in their own blankets for baby. We then place a sign on the baby's cot or incubator stating " I am wearing my own clothes and/or have my own blankets, please save them for my family to wash" To prevent them from getting mixed up with the units clothing. Parental involvement is paramount within our unit, parents are actively involved in all their baby's care. A wide variety of clothes in various sizes and colours available on the unit for the babies to use.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 1.2 - Comfort						
1.2A	Your unit has a guideline promoting comfort which is regularly referred and adhered to by staff	NPS E3, F2, NICU 5b: Toolkit 3.5: RCOG 15.2	G			Within the Neonatal Guidelines 2011 – 2013 (Staffordshire, Shropshire and the Black country) there is a section on positioning and handling a baby/neonate. All staff have access to this guideline. We also have access to the bliss leaflets: "Handle me with care" and "look at me I'm talking to you".
1.2A	Your unit uses a range of techniques to minimise pain and distress for the baby during and after		G			Within our unit we use a range of techniques to minimise pain. Containment holding – performed by nursing staff or parents when many clinical procedures are being performed

	interventions					or when baby is unsettled. Sucrose is also used for many clinical procedures . Giving a small amount of expressed breast milk during a procedure can also help to comfort the baby. We have a number of positioning aids that can be used to ensure the baby is comfortable during and after a procedure is performed. Morphine is used on our unit for the baby's who are ventilated, we also give oral morphine to baby's with neonatal absence syndrome. We have a guideline to follow: Neonatal Guidelines 2011 – 2013 pain and stress.
1.2B	Staff are trained to observe and interpret baby's cues and respond appropriately		G			Our developmental care team teaches about baby cues and interpretations on our yearly mandatory education day. Feeding cues are also taught on the Foundation programme ran with our network.
1.2B	Information about 'touch' and their baby is shared in active partnership with parents		G			Parents are actively encouraged to touch their baby and are taught about containment holding by the staff. A number of leaflets are used and given to the parents: "Handle me with care" Bliss and the Bliss family handbook.
1.2C	Timing, pacing and clustering of care takes into account the individual baby's stress thresholds and tolerance for handling		G			A baby's individually assessed daily by the nursing staff – who will then decide when and how often a baby needs their cares performing. As a unit we have introduced a new tissue viability scoring chart which helps to ensure a baby's position is checked and changed according to their condition, the equipment they are using and how premature they are.
1.2D	The baby's responses to interventions are documented		G			A baby's response to interventions being positive or negative are assessed every shift by the nurse looking after him/her and documented with the baby's medical notes. They are also handed over to the next member of the nursing team looking after him/her.
Standard 1.3 - Touch						
1.3A	Your unit has a guidance for social interaction and touch which is regularly referred and adhered to by staff	NPS E4,NICE 5b; DH Toolkit 3.5; RCOG 15.2	G			Although there is no a specific guideline for social interaction and touch. It is outlined within the network guidelines on positioning and handling.
1.3A	The guideline for social interaction and touch is promoted and shared with parents		G			All staff encourage and guide parents on positive touch of the preterm or sick infant.

1.3C	Responses to touch/social interaction are documented in clinical notes/care pathway documentation		G			A baby's responses to any touch or social interactions are documented daily and handed over to the next member of the nursing team to look after him/her i.e. tolerated being handled or examined. The doctors frequently write in their daily summary in the baby's notes how the baby handled on examination.
Standard 1.4 - Positioning						
1.4A	Your unit has a guideline on positioning that is regularly referred and adhered to by staff	NPS F2	G			All staff adhere to the Neonatal guidelines 2012-2013 policy on positioning and handling, which can be found via intranet or a copy is available with the unit. The developmental care team are also have a notice board which they change regularly including information regarding appropriate positioning of the infant.
1.4B	The baby's position is changed according to individual needs and cues as appropriate		G			Each baby is assessed per shift regarding positioning and their individual need. Using our tissue viability score chart also helps us to work out how often a baby should have their position changed to prevent pressure areas. Every bed space has a score chart tool to use, the chart looks at the baby's gestation, type of support and equipment they are using i.e. ventilatior or cpap and the total score gives an idea to how often the baby's position should be changed.
1.4C	Staff inform parents about placing babies in the most comfortable positions to regulate babies' comfort and stability					When positioning the infant staff inform and guide paents through the process empowering them with the knowledge to feel confident with time to position the baby themselves .
1.4D	The baby's responses to position changes are recorded		G			Staff record the baby's responses to changes in position in the baby's notes and hand over relevant information to the next member of staff. Any changes in the infants vital signs during or after the position change are also recorded.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 1.5 - Light						
1.5A	Your unit has a guideline that is regularly referred and adhered to by staff	NPS F2	G			All staff adhere to our guideline on light which can be found on the intranet or a hard copy is available on the unit. Neonatal Guidelines 2011 - 2013
1.5B	The unit uses a range of mechanisms to minimise stress from bright or continuous light		G			We use incubator covers for our very preterm infants to protect their eyes from the bright lights of the unit, as the baby gets older these are gradually removed in aid of sleep awake cycles. All of our 3 room ITU, HDU and SC have lights which can be dimmed or

						switched off.
Standard 1.6 - Sound						
1.6A	Your unit has a guideline on sound that is regularly referred and adhered to by staff		G			Our unit has a guideline on sound with our Neonatal guidelines 2011-2013 environment and noise. All staff adhere to this policy, it can be accessed via the intranet or a paper copy is available on the unit.
1.6B	Your unit uses a range of mechanisms to minimise a baby's stress from loud and continuous noise			A		We aim to minimise the noise on our unit by: Minimising the use of the top of our incubators – they are only used for nappy changing times. No conversations over the top of the incubators Opening and closing the incubator doors quietly and answering alarms quickly. The unit has all quiet closing bins.
1.6D	Your unit promotes a quiet and restful environment e.g scheduling specific periods for the baby and the parents with no clinical cares			A		The unit promotes a quiet environment at all times, Clinical procedure when planning allows is perfomed allowing the infant to have as much quiet resting time as possible.

Principle 1

SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review Date**
1,6 B Amber	To bring back the big ear (Audiology ear) in ITU to display when the room is too noisy for the babies.	Lyn Cronin	
1,6 D Amber	Reduce clinical procedures in grandparents visiting time, allowing a more restful environment. Aim to have a quieter environment throughout the day. Staff teaching by using a notice board to make all staff aware of possible sources of noise.	Lyn Cronin	

Bliss Baby Charter Principle 2

Neonatal care decisions are based on the baby's best interest, with parents actively involved in their baby's care.

Objectives

- Multidisciplinary neonatal care is responsive to the medical, surgical and psychosocial needs of babies.
- Decisions made in the baby's best interest are based on evidence and best practice, and are informed by parents who are encouraged and supported in the decision-making process.
- Parents are actively supported to participate in providing comfort and emotional support to their baby.

Outcomes:

- Parents feel respected and act confidently as partners in their baby's care.
- The balance between baby and family-centred care is maintained.

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Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 2.1 Decision making						
2.1A	On admittance all families receive a copy of the Bliss *Family Handbook*				R	There are currently no set criteria for parents receiving the handbook. All staff are made aware of the leaflets that are available to parents and they are dispensed at their discretion
2.1B	Parents receive adequate and timely communication regarding their baby's condition	NPS B10; NICE 5a, 5b BAPM 6.1	G			Parents are given daily updates on their baby by both nursing and medical team. Parents are given twenty four hour access to visit the unit. Parents are given the telephone number on admission and encouraged to telephone for updates. Doctors are always available to updates parents.
2.1C	Clear guidelines on consent are followed and parents are sufficiently informed and understand when consent is needed.		G			The unit closely adhered to the network (Staffordshire, Shropshire and Black country) guidelines covering consent. The guidelines are based on the BAPM 'Good practice framework for consent in neonatal clinical care'
2.1D	For routinely anticipated care, explanations are given in advance and parents are referred to local leaflets or Bliss	NPS G4; NICE 5a; DH Toolkit 3.9; BAPM 6.1	G			Parents are informed of all anticipated care, explanations and relevant leaflets are given. Parents have the opportunity to ask questions regarding their child's care at any point during the care

	publications.					
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
2.1E	For immediate interventions, an explanation is given as soon as possible and any discussion is documented.	NPS D3, E6; NICE 5a, 5b; DH Toolkit 3.4; BAPM 6.1	G			All immediate investigations are explained to parents and clearly documented by medical team. Parents are telephoned and updated if they are not present at time the intervention is required.
2.1F	All significant changes in the baby's condition requiring new interventions or care are discussed with parents as soon as possible. Where necessary, signed consent is obtained and filed.	NPS D3,E6; NICE 5a,5b, DH Toolkit 3.4; BAPM 6.1	G			Parents are continually updated on the child's condition whilst,they are present with the child. If the parents are unavailable telephone contact form beside the patient can be made. All signed consent is filed within the patients notes in a designated area and parents are given a copy of the consent
2.1G	Decisions/changes in care where parents may express a preference should always involve them.	NPS E7; NICE 5a; DH Toolkit 3.4; BAPM 6.1	G			Decisions are always made on a multi-disciplinary basis. Care is discussed with the designated nurse, consultant and parents.
2.1H	Parents have regular access to their baby's named consultant/senior medical staff and are invited to be present at ward rounds	NPS E5; NICE 5a,5b; DH Toolkit 3.4;BAPM 6.1	G			Doctors are based on the unit and they are available at all times. The parents are informed of the ward round and encourage to be present if possible. There is a consultant led ward round daily in intensive care and high dependency and twice weekly in special care.
2.1I	Parents are provided with information about how to access their baby's records	NPS G6; NICE 5a; DH Toolkit 3.4,3.9' BAPM 6.1		A		Parents are informed of the bedside note keeping and encouraged to partake in the completion of the paperwork. Parents are only informed of the methods of accessing the medical noted if they request to do so.
2.2B	Care plans are reviewed regularly and kept up to date.			A		The unit loosely basis the care planning on the Oram model of care. A team is being put into place to create care plans.
Standard 2.2 Care plans						
2.2C	Parents of babies with complex needs have an identified individual, who proactively provides regular information on the care pathway	NPS G5; NICE 5a;DH Toolkit 3.9; BAPM 6.1	G			Each baby has a named consultant. The consultants name is clearly documented above the infant cot and on the daily care charts. The consultant regularly update the parents on the care pathway.
2.2D	Parents are provided with information about who to contact with queries or advice regarding their baby's	NPS D4; RCOG 16.9	G			On admission to the unit parents are given the unit telephone number and encouraged to phone for regular updates on their baby if they are unable to visit. The named nurse looking after

	condition and treatment and know where to go for further information, including useful websites					the baby for the designated shift is clearly documented above the infants cot. Parents are given the Bliss information website and the parents support group contact information
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTIONPLAN**
2.2E	Parents are provided with adequate information by trained staff about their baby's long-term outcomes.		G			Parents are regularly updated by the consultant team. For complex issues appropriate specialist services are accessed. For example genetic counselling.
2.2F	Health visitors are informed of a new admission as soon after birth as possible and mechanisms are in place to facilitate appropriate contact with the family on the unit, particularly in preparation for discharge	DH Health visitor imple-mentation Plan 2011-15	G			Health visitors are automatically informed of a birth, and then contact the unit for further information. Staff liaise with named health visitors prior to discharge to arrange discharge follow-up. All staff are aware of children's safeguarding procedures and the need to contact health visitors.
Standard 2.3 Psychosocial support						
2.3A	Families, including siblings, are offered social and/or psychological support while on the unit	NPS G7; DH Toolkit 3.8,3.12; BAPM 6.4; RCOG 16.9		A		Families are offered social and psychological support upon their request. There is a family counselling service available through referral.
2.3B	Families, including siblings, have access to support from community neonatal teams while on the unit			A		There is currently no such neonatal community teams however, systems are in place to ensure families have the necessary support upon discharge. The unit works closely with the Hospital at Home team who provide nursing care in the home and the FAB team.
2.3C	Staff provide families with written information about local services and organisations, advice on lay support networks, relevant literature and information on how to find websites which may be of assistance when they are ready to make contact.		G			Families are given information on helping hands, the infant feeding team, breast feeding cafes. They are given relevant Bliss information leaflet which outlines the relevant website. On admission all babies are given the small wonders DVD. Inside the small wonders there is a list of relevant websites.
Standard 2.4 Sensitive news						
2.4A	Your unit provides comfortably furnished private rooms for parents to have confidential, sensitive or difficult discussions	NPS F1	G			The unit has a specific counselling room with comfortable chairs. It is a private quiet room allowing for sensitive discussions to take place.
2.4B	Staff have received	NPS		A		Staff receive breaking bad news training

	specific training on how to communicate difficult news (as appropriate)	D6,D7; RCOG 16.9				during their specified nurse training however further training is only undertaken upon request.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTIONPLAN**
2.4C	When staff break sensitive or difficult news to parents, they try to have at least two members of the family pesent to support each other.		G			When bad news is broken to parents, the consultant ensure they have all the relevant support with them. The consulatant ensures the named nurse caring for the baby is also present.
2.4D	Families are offered psychological/emotional support after receiving sensitive news			A		Families are offered emotional support from nursing staff and are offered psychological support when requested.
2.4E	Staff help families to access bereavement counselling if their baby has died on the unit.		G			All families are referred to bereavement services if they have suffered a bereavement.
2.4F	Parents have access to or are offered faith/spiritual support within the hospital after hearing sensitive news.		G			All parents are offered access to spiritual support at any point during their journey . All staff are trained in accessing the support. There are on site hospital chaplains who will visit the family twenty-four hours a day. The unit has facilities to allow for in hospital baptism and naming ceremonies.
Standard 2.5 Palliative and end of life care						
2.5A	Units have clear criteria for assessing which babies require palliative care, taking into account diagnosis and prognosis.		G			The unit closely follows the BAPM guidelines.
2.5B	End of life/palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.		G			Decisions are made after discussion with the family and all trained clinician including second opinions when necessary who are caring for the infant.
2.5C	Palliative care should be coordinated by a names lead professional and involve a multiagency, multidisciplinary team.		G			The unit has a specific palliative care link nurse who has undertaken steps to fulfil her masters in palliative care studies. She cascades the training she receives with all staff. She liaises closely with community setting and hospice settings,
2.5D	The baby's documented care plan is agreed with parents and based on a multidisciplinary assessment, ongoing		G			All agreed care is clearly documented in the baby's clinical notes. All staff are made aware of the plan. Parents are given options if appropriate of the place of death. Parents are given the opportunity to have spiritual support

	discussion with parents incl. personal faith or spiritual wishes and place of death					throughout their stay.
P	Units have links with children's hospices to support parents and their choices on the baby's place of death.		G			The palliative care link nurse liaises closely with the Donna Louise Trust which, provides hospice care for infants with life-limiting illness. All staff can access the services and communicate plans or gain advice from the hospice.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
2.5F	Staff are experienced in supportive end of life care and have received appropriate training.		G			Staff are supported in end of life care by senior staff on the shift. All staff are encouraged to access bereavement study days. A vast number of staff received bereavement training recently.
2.5G	A lead clinician talks through the Bliss booklet *Making Critical Care Decisions* with parents and notes the conversation in the baby's record.				R	The lead clinician discuss at length with parent regarding critical care decisions however recognise the booklet will help and have ordered appropriate stock.
2.5H	Bereavement support coordinated by a named professional is made available if needed		G			Bereavement services are notified of any death and coordinate support for the families.
2.5I	Staff support the rapid discharge of a dying baby to home if the parents wish it. They are competent in involving a GP in this process and can provide a discreet level of support to the family during this period.		G			Although we find this is rare, should a family wish to take the baby home staff are trained to support this.

Principle 2 SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**
2.1 A RED	A copy of the Bliss Family Handout to be placed in the admission packs.	Amber Evans	
2.3 A AMBER	Information in poster format to be placed in parents areas offering them support.	Amber Evans	
2.2 B AMBER	A team has been created to develop new patient care planning.	Fiona Horsnall	
2.4 B AMBER	Liaise with management to seek further training for staff	Amber Evans and Lynn Davies	
2.4 D AMBER	The Bliss Champion to cascade to staff how to access psychological support for parents.	Amber Evans	
2.5 G RED	Order making the critical care decisions booklets	Amber Evans	

Bliss Baby Charter Principle 3

Babies receive the nationally recommended level of specialist care in the nearest specialist unit to the baby's family home.

Objectives

- All units have sufficient numbers of trained health professionals with the specialist skills and competencies required to care for preterm babies.
- Units have transparent arrangements for transfers to the most appropriate unit as determined by the baby's condition.

Outcomes

- Parents are confident that their baby is in expert hands.
- Parents are able to access the neonatal services their baby needs as close to home as clinically possible.

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Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 3.1 Trained specialist staff						
3.1A	Adequate numbers of staff are specifically trained to meet nationally agreed minimum clinical standards in all levels of neonatal care			A		The unit is currently working towards a new business plan to meet the BAPM criteria.
3.1B	All staff are competent and able to stabilise the baby assess them and initiate an action plan	DH Toolkit 5.1.1	G			Ninety six per cent of staff on the unit are Qualified in specialist neonatal intensive care practice
3.1C	The unit has an identified competency framework including developmental care, breastfeeding and discharge planning that staff are regularly assessed against.		G			The unit has a designated breastfeeding coordinator and discharge planning senior nurse. Staff have included in their yearly mandatory training a breastfeeding assessment. The unit regularly holds teaching days which include discharge planning and developmental care.
3.1D	Staff training included components to develop knowledge and skills in baby and family-centred care, including the areas listed in 3.1C		G			The unit promotes an ethos of family centred care. The unit always supports staff to attend national and network family centred care study days. Family centred care is covered during the neonatal foundation programme which all new staff complete.

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements for ACTION PLAN
3.1E	Staff are trained in safeguarding procedures and are aware of indications to prompt		G			All staff are trained in child protection and safeguarding procedures. The hospital has a lead child protection nurse. The child protection training days are mandatory.
Standard 3.2 Multidisciplinary team						
3.2A	Babies have timely access to allied health professionals with specific neonatal or paediatric training		G			Ninety six per cent of staff are qualified in neonatal intensive care specialist. Ninety eight per cent of staff are paediatric trained.
3.2B	Families have access to social workers for assessment and provision of support services.		G			If parents require support from a social worker the FAB service are involves. This involves giving the family emotional, financial and practical support. The unit works closely with the local children's centres.
3.2C	Care plans reflect a multidisciplinary approach to neonatal care, both within primary care and community teams.					A multi-disciplinary approach to daily care planning is used. Comprehensive discharge planning is undertaken to ensure all services and appropriate support is implemented.
Standard 3.3 Near to home						
3.3A	Your unit follows network transfer guidelines for admission to appropriate specialist services or return to an appropriate local service.		G			The unit closely adheres to the Staffordshire, Shropshire and Black country neonatal guidelines on transferring babies.
3.3B	Parents are encouraged and have the chances to visit a new unit in advance of a transfer	NPS C5; NICE 5a,5b; DH Toolkit 3.4	G			If the transfer is a planned transfer the parents are encourage to visit the transferring unit. The nurse caring for the babies will make arrangements for this.
3.3C	If transferred, parents are given comprehensive information on the new unit in advance	NPS c7:DH Toolkit 3.2,3.8			R	An action plan will be put into place to create a designated folder containing information about all referring hospitals.
3.3D	Parents are given an explanation and involved in discussions on transfers, with the choice to accompany their baby.	NPS C4; NICE, 5a,5b; DH Toolkit 3.4;BAPM 6.1	G			Parents are involved in the discussions to move the infant and this is done with the consultant of the week. Parents are given explanations for the need to transfer baby and given the opportunity to ask questions. It is deemed unsafe for the parents to travel alongside the infant.
3.3E	Parents who have had a long-distance transfer are offered support, including an agreed financial support package			A		Accommodation and meals are providing to parents who have had a long distance transfer. Free car parking is available to them. The Bliss Financial advice leaflets are given out to parents.

Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 3.4 Consistency across the neonatal network						
3.4B	Your unit has the same visiting policy as other units of equal clinical level within your network			A		The unit has open visiting for parents and sibling, and a designated 2 hour window for grandparents. This varies slightly from other units of equal level.
3.4C	Your unit follows network-wide guidelines on procedures on breastfeeding, day-to-day cares, developmental care etc.		G			The unit closely adheres to The Bedside Clinical Partnership guidelines. The guidelines are kept within the neonatal intensive care room and other copies are readily available on the unit

Principle 3 Summary of Actions			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**
3.3 C RED 3.1 A AMBER 3.3 E AMBER 3.4B AMBER	A designated folder will be created which will contain all relevant information about referring units. This will include postcodes, parking areas, telephone numbers and visiting policies. The unit is currently working towards a new business plan to meet this criteria. Agree upon a financial support package to be put into place and its contents. To discuss with the unit manager and lead consultant.	Amber Evans Lynn Davies Amber Evans	

Bliss Baby Charter Principle 4:

Units encourage parents to be involved in plans and processes for continuous service improvement, and outcomes of care are benchmarked against local and national standards.

Objectives

- Units monitor their care outcomes against local/national/international benchmarks.
- Units fully commit to delivering national standards and ensuring local levels of excellence.

Outcomes

- There is a culture of continuous improvement, that involves and is informed by parents.
- Families are confident that high-quality care standards are being met and maintained.

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Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 4.1 Monitoring and benchmarking						
4.1A	Benchmarking activity is routinely included in your units' quality improvement programme		G			A monthly meeting is help between a unit consultant, ward sister and quality nurse to review any issues/errors that have arisen throughout that month. A action plan is then created to promote best practice. The unit has a specific quality nurse whom partakes in benchmarking.
4.1B	Feedback from parents is regularly sought, collated and fed into decision-making processes		G			Parents are given a questionnaire to give their feedback to the unit and thus improve their experiences. Representatives from the unit undertake the yearly stakeholders meeting. Parents representatives are present at the stakeholders meeting. With the support of the unit parent representatives have launched a facebook support group. Parents on the unit are made aware of the contact details for the group. Once a month the senior discharge nurse runs a 'helping hands' group where parents and their child are invited to meet with other parents. Feed back is regularly sought and fed back to management.
4.1C	Your unit works together with other units within your		G			The unit partakes in the agreed benchmarking and audit programs as agreed at the annual meeting. The unit

	network on agreed benchmarking/audit programmes					feeding coordinator attends the feeding and nutrition group. The developmental care team have representation at every meet.
4.1D	Your unit participates in the national neonatal audit programme		G			The unit partakes in the national neonatal audit program. All parents are given the information leaflet in the admission welcome pack
Standard 4.2 Service improvement						
4.2A	There is a continuous process for involving parents in improving your delivery of family-centred care		G			The unit participated in the Bliss national survey looking into financial costs. This has resulted in the management of the unit agreeing free car parking for parents. The unit participates in the Europain trail. The unit is currently participating in the SIFT trial.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
4.2B	Parents are included in the planning and development of services improvements throughout the network		G			There are two parent representative within he network that are involved in planning and development of services. The unit was involved in the National parents survey ran by the Picker Institute.
4..2C	Benchmarking and audit inform future service improvement activities and action plans		G			Action plans created on the back of audits are implemented on the unit. A recent example of this is the introduction of the parent passport.
4.2D	Improvements are introduced to the unit in response to feedback from both staff and parent		G			As outlined in the Picker report feedback is sought through the parent support group and parental exit questionnaires and improvements are made in reflection of this. Recent changes on the unit have involved introducing the children's centre to parents, informing the health visitor earlier and the introduction of the hospital at home team who continue to support infants with a nursing need beyond the neonatal unit.

Principle 4 SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**

Bliss Baby Charter Principle 5

Parents are informed, guided and supported to help them understand their baby's care processes and feel confident in caring for their baby.

Objectives

- All parents receive relevant verbal and written information about clinical conditions, tests and treatment, breastfeeding, financial support, transfers to other units and local facilities (in an appropriate format and language) throughout their baby's stay on the unit.
- All parents are proactively shown/informed how they can help to care for their baby while on the unit and in preparation for discharge.

Outcomes

- Parents feel fully informed and supported.
- There is a strong relationship between the parents and their baby.
- Parents are confident in caring for their baby on the unit and feel fully prepared for discharge.
-

Green (G) = Unit fully meets criteria		Amber (A) = Unit partially meets criteria, more work needs to be done			Red (R) = Unit does not currently meet any aspect of the criteria	
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 5.1 Introduction to the unit						
5.1A	A prior visit to the unit and an opportunity to meet staff should be offered to parents with a predicted need for neonatal care, or a transfer to another unit for ongoing care	NPS A2; NICE 5a,5b; DH Toolkit 3.1	**G**			For all parents who may have their baby born prematurely or with a medical condition which need observation or transferral to another hospital, a visit and tour around the unit is offered. A member of staff will quide them around the unit, showing them all the 3 different rooms ITU, HDU and SC which they may visit during their baby's stay. They can also discuss and questions or concerns they have. Our family unit is also shown to all parents and offered if their baby is very sick or ready for home. If the baby is being transferred out to another hospital it is sometimes possible for the parents to visit that unit before baby is transferred.
5.1B	All parents are fully inducted on entry to the neonatal unit so they can orient themselves and are aware of all different equipment and noises or alarms within	NPS B13; NICU 5a,5b; DH Toolkit 3.2; BAPM 6.1	**G**			On admission to the unit all parents are introduced to the member of staff looking after their baby. A guided tour is given to parents, sometimes dad or support person will be shown around and orientated around the unit 1st. due to mum not being well

	the unit					enough. All of the equipment is discussed to allow parents to understand what all of the equipment is for and what the alarms mean, so that they don't panic when their baby sets their alarms off.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
5.1C	Attention is paid in particular to those mothers who have not been able to access the unit straight away, either due to their own health or having one or more other babies in a different unit	NPS B5,B6; NICE 5a,5b	**G**			When baby is admitted to the unit a photograph is taken of baby by the staff (if parents wish for one). If mum is unable to visit, we aim to ensure the medical team update her on the baby's condition. For babies that have been transferred from another hospital, we aim to ensure mum is kept fully updated on her baby's condition, this can be done by telephone updating mums midwife on baby's condition. We can also start a diary for parents on their baby, to allow them to have some information and pictures as a memory of their baby's journey through NICU.
5.1D	Parents are given a named contact for practical queries and advice		**A**			All staff introduce themselves when they meet baby's parents. Parents are also made aware of the sister or nurse in change of the shift. They are free to ask the staff any queries or for advice. The unit contact number is also given on admission, and we give the direct room number if they wish to call for an update on their baby's condition or for advice at any time. We often use leaflets to help with parents queries and to offer advice which may help to explain or answer any of their questions. Bliss family handbook Tommy's having a premature baby handbook
5.1E	Staff inform parents about relevant policy and procedures on the unit, i.e. infection control	NPS B12,B14; DH Toolkit 3.2	**G**			Policies and procedures are explained to parents – i.e. infection prevention – within the visiting pack a hand washing technique leaflet is provided. Prents are also asked to remove their outdoor coats before holding their baby. Proceedures are also explained to ensure parents understand what will be being performed. The nursing team and the medical team explain them. Consent is obtained either written or oral. Neonatal guidelines 2012-2013 consent.
5.1F	Unit staff introduce themselves to parents	NPS d1; NICE 5b;	**G**			Members of staff introduces themselves to the parents/ support person, and

	and explain their role in relation to their baby's care and the running of the unit	DH Toolkit 3.2				explains their role in relation to the baby's care. When each shift changes new members of staff will make sure parents are aware who they are. Our ward manager also walks around the unit and introduces herself to all parents. Neonatal Guidelines 2012-2013
5.1G	Parents are provided with a 'welcome pack' (ideally provided in languages and formats useful to the local community) giving pratical info about the unit. Parents should also receive information about local amenities, such as taxi service, restaurants, particularly if they have not been admitted to their local unit	NPS G8, DH Toolkit 3.8. 3.12	**A**			On admission to the unit and the baby's condition has been explained with parents/ support person, our welcome pack is given and discussed. The pack includes Any audit that are being undertaken on the unit Local amenities – shops, café restaurant nearest cash machine and town centre. Contact numbers for the unit Help prevent infection in the NICU guidance for parents – if unwell stay at home Hand washing step by step guide – encouraging grandparents and siblings to wash their hands No soft toys in cots or incubators due to infection prevention Small wonders dvd Data protection information Local taxi companies
5.1H	Written information should be available (in languages and format appropriate to the local community) about their neonatal network and networks in England. This information should cover: i. Transfer service and repatriation ii. Services to which a baby is being transferred, including a named contact and telephone number		**G**			When a baby is being transferred the neonatal transport team ensure they have parents contact numbers for when baby has arrived at awaiting hospital. Parents are also given the contact number for the awaiting hospital and the ward in which baby is being transferred too. The unit will call parents to inform them baby has left there unit and is on transfer to awaiting unit if parents weren't visiting when the baby was collected.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
5.1I	The unit has staff photo boards at the entrance to the unit which are kept up to date				**R**	**At this time we don't have a staff photo board.**
Standard 5.2 Facilities						
5.2A	Babies are safe and secure while on the unit and parents are informed of security	NPS F1, F4; DH Toolkit 3.11	**G**			Within our unit we have security doors with a buzzer system for out of hours when reception is closed. The buzzer system is used in all 3 rooms. The

	arrangements					receptionist mans the entrance during the day and the entrance is always locked. All visits have to report to reception to enter or use the buzzer system when no receptionist is available. Parents and grandparents who are not recognised will be questioned on who they are visiting and staff will have to authorise access to the unit. Parents are made aware of all security on admission We have on site security men who can be called if there is a breech of security.
5.2B	Parents of babies in intensive care are able to access accommodation with bedroom facilities, as close as possible to their baby and without cost. One bed per intensive care cot should be available	NPS F5; NICU 1e,1f: DH Toolkit 3.11; BAPM 6.3	**G**			We have a family unit with 6 bedroom available all with ensuite bathrooms on the unit that are offered to parents who have an intensive care baby. If these rooms become full we do have access to Grindley court where parents can stay too. This is situated on the hospital site.
5.2C	Easily accessible facilities are made available for parents to store their personal belongings safely and securely		**G**			We have lockers available in the family unit area, which are available for all parents to use to store their personal belongings while visiting their baby.
5.2C	Families are provided with informal storage at the cot side for their own and their babies belongings		**G**			The incubators and cots have a small amount of storage to which parents can store their baby's belongings. We do have access to additional storage draws if needed, which can be stored next to the baby.
5.2D	Unit facilities for families are clean and comfortable, free of a charge and of an appropriate size to the scale of the unit		**G**			All of our facilities for parents and families are clean and comfortable and free of charge. Cleaning is performed twice a day in all areas, and more often if needed.
5.2E	Families have easy access to a parent/family sitting room, and a small kitchen to make hot drinks and snacks	NPS F8; DH Toolkit 3.11	**G**			Within the unit we have a family room for all parents to access. It has access to hot and cold drinks with a kitchen area, and seating area for eating. A fridge and microwave are available, and a lounge area with a tv.
5.2F	Child-friendly areas for siblings are available, easy to access and safe		**G**			Within our special care room we have an area for children to play, which has tables and chairs a train set unit and much more. The toys are regularly rotated and cleaned daily. They are easily accessible to all children and some toys can be moved into the other rooms.
5.2G	Families are informed on the whereabouts and opening hours of the hospital canteen		**G**			Parents are informed where the hospital restaurant is and its opening times. Within the maternity building there is a café.

	and other facilities for having meals within the hospital					For breastfeeding mothers we offer a discount voucher for the restaurant and we also provide all meals for mums in the family unit.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
5.2H	Parents have access to a dedicated separate room for counselling and/or to have private conversations with staff		**G**			We have a counselling room set away from the ITU environment, this room is designated for private conservations with parents/ support person.
Standard 5.3 Support networks						
5.3A	Parents are given information on how to contact national and local support groups (e.g. Bliss)	NPS G9; DH Toolkit 3.8,3.12; BAPM 6.4; RCOG 19.4	**G**			We have our own local support group called “helping hands” for all parents who have had a baby on the unit which is ran by our discharge co-ordinator. Parents are made aware of this group and can access their face book page. Mum to mum contact number is given to all mums expressing or breastfeeding, if they have any concerns or need to loan a breast pump when baby is discharged home. Leaflets are given and discussed with parents for support groups including: Bliss family handbook Tommy’s having a premature baby, which both have numbers and websites for support groups.
5.3B	Parents are informed on where to get further information, including advice on financial support and useful websites		**G**			Parents who need further financially help can be referred to a local children’s centre who can help with any financial needs advising on any benefits they may be entitled too. Child benefit information is included in the bounty pack, which is given to all mums post delivery. Health visitors can also be contacted and social services, who can also give financial advice.
5.3C	Parents are made aware of local parents for peer support and contact is facilitated as appropriate		**G**			We have our own local support group called “helping hands” for all parents who have had a baby on the unit which is ran by our discharge co-ordinator. Parents are made aware of this group and can access their face book page. This group offers families a chance to get together and offer each other advice. Parents are encouraged to use of family area to encourage them to speak to other families on the unit who are in similar situations, who can offer peer support and pass on information of peer support groups or facilities they have used.
Standard 5.4 Consistent information						

5.4A	Parents are fully involved in discussions about their baby's care and receive consistent information from staff caring for their baby		**G**			We aim to ensure parents are fully involved in any discussion regarding the care of their baby. They are encouraged to join us for the doctors round when we discuss their baby and help us to devise a plan of care. Parents who unable to visit or wish for an update are able to telephone and speak to the nurse looking after their baby. Parents are updated daily when they visit by the nurse looking after their baby.
5.4B	Verbal and written information is provided at appropriate times to help parents' understanding of neonatal care (incl. clinical conditions, procedures, risks, complications, tests, investigations etc)	NPS G1;NICE 5a,5b; DH Toolkit 3.4,3.9	**G**			Parents are verbally provided with information regarding their baby's care daily by the nursing or medical team. Procedures are verbally explained to parents, and parents are asked if they understand what has been explained to them, if they don't the team will re-explain the procedure sometimes using diagrams as a tool. Verbal consent is obtained, and sometimes written consent is needed. Neonatal guidelines 2012-2013 consent We also have leaflets that can explain conditions or procedures to for parents Bliss family handbook Tommy's having a premature baby Retinopathy of prematurity.
5.4C	Translation services and/or professional interpreters are available and contacted promptly	NPS G2; NICE 51,5b;DH Toolkit 3.9; BAPM 6.4	**G**			We are able to obtain interpreters via the telephone and also for face-to-face consultations. We aim to have an interpreter as soon as possible from when the baby is admitted to discuss the baby's condition with parents. A face-to-face discussion is not always possible for the same day, but telephone conversations can normally be made for the same day. Language line
5.4D	Health professionals understand the potential difficulties parents may face in taking in complex information and there are unit strategies to overcome this		**G**			Complex information can be difficult for parents to absorb – all staff are happy to discuss any parental concerns as many times as needed for them to understand the information given to them. Another member of staff can be used to explain the information to as it can be explained differently and could be easier to understand. Ensuring we use none medical technical language.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 5.5 Use of data						
5.5A	Staff understand data protection principles and inform parents how		**G**			Within our welcome pack we have a section that explains data protection, how as a unit we only provide

	data about their baby is used					information about a baby to its parents or support person. No one else will be given information on the baby's condition unless authorised. Data protection Act 1998
5.5B	Parents are fully informed about clinical trials and the consent process and value of research		**G**			Any clinical trials, which the unit are undertaking or participating in are explained to parents. The unit recently participated in a pain audit, this was discussed with parents and an information leaflet was provided. It is also explained how valuable research can be for the future. Parents can opt out of any clinical trails Any information that is wished to be used for research is also discussed with parents i.e. any clinical photography Consent is also discussed with parents as some procedures require written consent and others only require verbal. Neonatal guidelines 2011 –2013 consent – implicit or explicit Bliss community professionals guide Bliss family handbook – staying informed and making decisions
5.5C	Staff are taught how to transmit information to third parties securely and confidentially		**G**			Staff are taught how to safely transmit information to third parties to ensure information is kept confidential. Confidential telephone calls are taken in a separate room away from other families. If information needs to be divulged i.e. child protection cases or issues being raised to social services, this is also done confidentially. Social concerns are documented in the baby's notes and on the badger system. Multidisciplinary team meetings can aid the transmission of information All staff attend the child protection study day as part of their mandatory training.
Standard 5.6 Daily cares						
5.6A	Both mothers and fathers are supported to learn to carry out their baby's day-to-day cares and are actively encouraged to do so	NPS E1,E2; NICE 5b;DH Toolkit 3.5 BAPM 6.1	**G**			Depending on the baby's condition all parents are encouraged to take part in their infants care. This can range from just talking to their baby to helping with everyday care i.e. nappy changing mouth care feeding. We often show parents how to perform an area of care first to allow them to watch and then the next time they can carry out the procedure with a nurses assistance, until they feel confident to perform it alone. We actively encourage them to talk to their baby, as this can bring comfort to their baby.

						Carrying out these activities can help build the bond between parent and baby especially when baby isn't able to have a cuddle. Bliss family handbook Tommy's having a premature baby Handle me with care – Bliss leaflet Look at me, I'm talking to you – Bliss We were there – parents experiences of having a premature baby – poppy project.
5.6B	The level of involvement of the parents in the baby's daily care is increased prior to discharge	NPS E9;NICE 5b;DH Toolkit 3.5	**G**			As the baby's condition improves the amount if input the parents have will increase, encouraging parents to eventually be able to fully care for their baby when he/she is ready for discharge. The family can room in for one or a few nights until they feel fully confident they are able to look after their baby when they take him/her home. Whilst they stay in the family unit they are fully supported by they staff, but given more privacy with baby. This will aid the bond between baby and parents. We also have a discharge pack to be completed by the nursing team to ensure everything has been arranged for discharged and teaching parents every day skills have been performed. I.e. infant resuscitation Sterilisation of bottle or expressing equipment, outpatient appointments made etc.

Principle 5 SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**
5.1. D	Named nurse for all babies – to allow continuity of care for both baby and parents	Laura Farnell	
5.1. G	Welcome packs – to be produced in different languages	Laura Farnell	
5.1. I	Obtain staff photo notice board - for main entrance	Laura Farnell	

Baby Bliss Charter Principle 6

Breast milk expression and breastfeeding are actively promoted, and mothers receive practical support to achieve successful lactation.

Objectives

- Health professional are supported to gain the knowledge and skills required to facilitate and support breastfeeding and/or expression following a preterm birth.
- Mothers are supported to breastfeeding by trained staff and have access to facilities designed to encourage successful lactation.
- Parents are informed of the benefits of breastfeeding their baby, and understand why staff promote it on the unit.

Outcomes

- Babies benefit from improved growth and tolerance of enteral nutrition.
- Few babies contract infections or suffer from related complications such as necrostising entercolitis.
- Mothers feel valued and have improved self-esteem in relation to their role as the baby's parent (and primary care provider).

Green (G) = Unit fully meets criteria		Amber (A) = Unit partially meets criteria, more work needs to be done			Red (R) = Unit does not currently meet any aspect of the criteria	
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 6.1 Promote and support breast milk expression						
6.1A	Your unit has a breastfeeding policy adhered to by staff		**G**			All staff adhere to the breastfeeding guideline in the Neonatal Guidelines 2011-2013 (Staffordshire, Shropshire and Black Country Newborn Network).
6.1C	Mothers receive practical support to enable them to establish lactation in the first six hours after birth	NPS E10,E14; NICE 6;DH Toolkit 3.10;BAP M 6.2,6.4;R COG 15.5	**G**			When mothers first visit the unit following admission, they are given advice & practical support on the correct way to express, advised to begin with hand expression & can be given a practical demonstration if they wish. It is documented in the Breastfeeding Care Plan when mothers are advised about expressing guidelines.
6.1D	To ensure good milk production in the following ten to 14 days, mothers are shown how to make the best use of techniques such as		**G**			Mothers are advised of current expressing guidance ie to express 8-10 times in 24 hours, the use of breast massage, how long to express for etc & this is documented on their Breastfeeding Care Plan. All mothers are given the leaflets 'Off

	double pumping and skin-to-skin					to the Best Start' (DOH) & 'Breastfeeding Your Premature Baby' (Bliss), these highlight techniques to establish milk production. Mothers are given two pumping funnels to encourage 'double pumping'. Skin to skin & kangaroo care is encouraged as soon as baby's condition allows to enhance mothers milk production.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
6.1E	Parents are given clear and consistent information on the benefits of breastfeeding and the importance of frequent expression is explained		**G**			Healthcare professionals adhere to the Breastfeeding Guideline in the Neonatal Guidelines to ensure continuity on the information mothers are given regarding milk expression. Further guidance is provided in the milk expression room so that information is consistent. Mothers are informed of the importance of expressing 8-10 times in 24 hours & in particular to express through the night.
6.1G	The unit has a dedicated professional to support mothers in establishing lactation and increasing milk production in the following days		**G**			Our unit has a dedicated professional to support mothers in establishing lactation & increasing milk production- Liz Jones (Infant Feeding Co-ordinator). The unit has the ability to analysis breast milk.
6.1H	Staff receive training on the benefits of breast milk, physiology of lactation and how to provide practical support to mothers		**G**			Staff are given regular training to remain up to date with current guidance & equipment, a database of staff training is maintained to ensure regular training.
6.1I	Your unit has adequate stock of equipment for all mothers wishing to express their breast milk, including breast pumps, different sized funnels and storage bottles etc	NPS E11;NICE 6;DH Toolkit 3.10;BAPM 6.2;RCOG 15.5	**G**			Symphony pumps are available to all mothers when they visit the unit or are resident in the family unit, they include the 'preemie card' to ensure adequate milk expression cycle. Various pumps are loaned to mothers when they are discharged from postnatal care so they can continue to express milk at home. If there are none available, a pump can be sourced from the 'Mum 2 Mum' service in the Staffordshire area. There is a dedicated area for stock of expressing equipment, where funnels of various sizes are kept in adequate supply. Mothers have access to two different sized storage bottles- 100ml & 200ml.
6.2A	Parents receive adequate and timely support to aid transition from tube		**G**			When babies are showing a readiness for oral feeding feeding cues are highlighted to parents & breastfeeding is encouraged.

	feeding to breastfeeding; for example, with recognition of feeding cues, help with attachment and positioning, and signs that baby is feeding well					Mothers are again shown the Breastfeeding leaflets to support practical advice & demonstrations of good positioning & attachment. Nurses use the Breastfeeding Assessment Chart to assess whether a baby is feeding well, this can also be used to show mothers how to assess whether their baby is latched well & feeding well.
6.2B	Mothers are provided with a private and comfortable space for breastfeeding	NPS E14.E15; NICE 6;DH Toolkit 3.10;BAPM 6.2;RCOG 15.5,16.5, 15.7	**G**			Mothers are able to breastfeed at the cot side as curtains can be drawn around the bed space for privacy. Breastfeeding chairs are available to ensure comfortable positioning when feeding. When mothers are resident with their babies in the family unit they have a private room & healthcare professionals knock before entering their room.
6.2C	Mothers are consistently supported to establish breastfeeding on the unit, before going home		**G**			Nurses & other healthcare professionals use all tools- Breastfeeding policy, Breastfeeding care plan, Breastfeeding assessment chart, Breastfeeding leaflets in conjunction to provide consistent information & support to mothers when establishing breastfeeding. Mothers who wish to breastfeed are not discharged before successful breastfeeding is established.
6.2D	Breastfeeding is a discrete part of a discharge planning process in which mothers are provided with the support and motivation necessary to continue breastfeeding/expressi on once at home		**G**			Mothers are encouraged to ask all questions regarding breastfeeding before discharge, various other agencies are highlighted- health visitor, Mum 2 Mum & Children's Centres are highlighted for support after discharge.
6.2E	Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding and encourage a supportive culture		**G**			Within the unit breastfeeding is heavily promoted, nurses & medical staff advocate it for all mothers who are able to. The Infant Feeding Co-ordinator ensures staff have adequate support to do this, keeping staff up to date with training & research & providing support.
6.2F	Parents are informed on how to donate any surplus milk, if the meet donor criteria		**G**			Parents are advised how to donate any surplus milk before discharge, mothers with a surplus are identified & given a leaflet so they can make an informed decision.

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements for ACTION PLAN
Standard 6.3 Alternative to maternal breast milk						
6.3A	Both mothers and father are supported and are shown how to make feeds and sterilise bottle and teats	NPS E16;BAPM 6.1:RCOG 15.6	**G**			Parents are given a practical demonstration on how to make up formula safely & in accordance with WHO recommendations, this is then recorded in patient notes. Parents also receive a bottle feeding leaflet for further information & reference when discharged. Parents sign the discharge paperwork confirming they know how to safely make up infant formula & sterilise feeding equipment, giving them further opportunity to ask any questions they may have.
6.3B	The unit follows the NICE Guideline Donor Breast Banks and the United Kingdom Association for Milk Banking (UKAMB) Guideline(s) on the collection and use of donor breast milk		**G**			Yes, policy is in place in the Neonatal Guidelines 2011-2013 that follows NICE Guidelines.
6.3C	The unit has access to donor breast milk for babies who would benefit from it and who do not have access to their mother's expressed milk		**G**			A supply of donor breast milk is kept in the unit freezer, leaflets are available for appropriate parents & medical staff/Infant Feeding Co-ordinator provide information for parents allowing them to ask any questions they have. There is always a supply of donor breast milk in the freezer.
6.3D	The unit has a policy on using preterm formulae (appropriate formula, follow on milk, nutritional supplements etc) which is adhered to by staff		**G**			The unit adheres to guidelines regarding which formula to use for babies of varying gestational age/weight. This also includes nutritional supplements & when to prescribe vitamins.

Principle 6 SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**

Bliss Baby Charter Principle 7

Discharge planning is facilitated and coordinated from initial admission to discharge date, to ensure both the baby and their family receive the appropriate care and access to resources.

Objectives

- Discharge plans are coordinated from admission.
- Resources are utilised to ensure that staff can provide a seamless and supported journey from the unit to home.

Outcomes

- Babies are safely, appropriately and effectively discharged home.
- Families feel confident that their baby's ongoing health and social care needs will be met after discharge.

Green (G) = Unit fully meets criteria		Amber (A) = Unit partially meets criteria, more work needs to be done			Red (R) = Unit does not currently meet any aspect of the criteria	
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
Standard 7.1 Coordinated discharge planning						
7.1A	Your unit has an established discharge planning policy which is adhered to by staff	NPS H11,H12; NICE 7a,7b:DH Toolkit 3.15; BAPM 6.4	**G**			Staff adhere to the discharge policy in the Neonatal Guidelines 2011-2013.
7.1B	Your unit demonstrates a multidisciplinary approach in its discharge planning, which includes facilitating access to social services and other support professionals		**G**			A holistic approach is used when planning discharge. The wider multidisciplinary team is used to support parents & baby, dieticians, social services, breastfeeding support, orthopaedics, GPs, health visiting team & children's centres can all be involved within the discharge process as required.
7.1C	Discharge plans are established from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team		**G**			Discharge planning is commenced from the point of admission, where appropriate. This is then built upon as the baby progresses throughout the neonatal unit.
7.1D	The unit identifies a dedicated individual to coordinate a baby's discharge plan from the moment of admission		**G**			Rose Ciavucco is the unit's 'Discharge Planning Co-ordinator' who first commences the babies discharge planning & oversees this aspect thought their stay on the neonatal unit.

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements for ACTION PLAN
7.1E	Parents have access to a health professional who can provide emotional/psychological support during and post discharge		**G**			All nurses & medical staff can provide emotional support to parents. Upon discharge parents are referred to their nearest Children's Centre by the Health Visitor Liaison, within the centre the have access to a counselling service, alongside other services.
Standard 7.2 Rooming in						
7.2A	Sufficient rooms are available on or adjacent to the unit for rooming in (with space and resources for any oxygen equipment) to help the family prepare for the discharge	NPS H4; NICE 1e,1f,7b:DH Toolkit 3.15	**G**			6 rooms are available for families within the unit. There are facilities for oxygen within each room. Parents can room in for several nights until they feel confident to care for their baby at home. There is one larger room for disabled access or parents of twins/multiples.
Standard 7.3 Meeting the baby's needs at home						
7.3A	Before discharge, the family is given relevant and appropriate information to make sure they are able to meet their baby's ongoing needs at home	NPS H7,H8'NICE 5b,7b;DH Toolkit 3.8, 3.15	**G**			Parents can be trained to provide nasogastric tube feeding at home where appropriate. Basic Life Support is given too all parents, they receive a Basic Life Support DVD (Bliss) & quick prompt card, alongside a practical demonstration if they require.
7.3B	The family is supported through appropriate training to deliver all aspects of their baby's care at home (including basic life support)	NPS H7,H8'NICU 5b,7b;DH Toolkit 3.8,3.15	**G**			Upon discharge support is given to families by the health visiting team, the Health Visitor Liaison visits the unit weekly to identify babies who have been discharged. Families with more complex care requirements upon discharge are referred to 'Hospital @ Home' a children's community nursing team, the team is liaised with prior to discharge.
7.3C	Community support is provided by an integrated hospital-community neonatal team or an identifiable team of community health professionals	DH Health visitor imple-mentation Plan 2011-15	**G**			Upon discharge support is given to families by the health visiting team, the Health Visitor Liaison visits the unit weekly to identify babies who have been discharged. Families with more complex care requirements upon discharge are referred to 'Hospital @ Home' a children's community nursing team, the team is liaised with prior to discharge.
7.3D	Parents are given the opportunity to meet with the community team supporting them at home before the baby is discharged from the unit	DH Health visitor imple-mentation Plan 2011-15	**G**			Health visitors may contact the family prior to discharge & arrange a visit. The 'Hospital @ Home' team may contact parents before discharge to arrange a visit.
7.3E	Community health teams are given timely	DH Health visitor	**G**			Community health teams are made aware of babies needs well in

	information about the baby and any home care arrangements from the baby's care plan, as well as the opportunity to meet neonatal staff and parents before discharge	imple-mentation Plan 2011-15				advance of discharge, the discharge planning process ensures adequate planning. This allows time to arrange any visits to the neonatal unit or parents' homes.
Ref	**Summary of criteria**	**Ref**	**G**	**A**	**R**	**Outline of current practice and/or requirements for ACTION PLAN**
7.3F	Parents are informed and understand who to contact should the baby become unwell at home, and when they may need to take them back to hospital		**G**			All contact information is given to parents, advice is given regarding signs their baby maybe unwell & to seek medical advice if they have any concerns. Parents sign the discharge paperwork that advises they have the contact details of GP, health visitor, hospital @home, who to contact at night & weekends if they require support & neonatal unit telephone number should they need advice.

Principle 7 SUMMARY OF ACTIONS			
Criteria rated RED or AMBER	**Suggested action/improvement to be taken forward for development**	**Person responsible**	**Review date**