Nam	Shrewsbury and Telford Neonatal Unit
Unit	2
Date of audit	
Audit number (1, 2, 3 etc)	
Aud	Samantha Davies
Job	Neonatal Unit Manager
Ema	samantha.davies@sath.nhs.uk

PRINCIPLE 1

Ref	Summary of standard	Ref	G	A	R	Evidence of current practice	Secondary	Bliss feedback
Standard 1.1 – Dignity and privacy								
1.1 A	All babies are referred to by their given name and parents/care givers are referred to by their preferred name.	NPS D11	G			On admission staff ask parents if they have chosen a name for their baby and refer to baby by name. Whenever care is given or discussed baby is always referred to by name. All medical and nursing notes and identify bands have babies name. At every cot space we have a cot card with baby name and baby's full		**More information:** how do you ensure parents are referred to by their preferred name?
1.1 B	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 is open access for parents and siblings for 24 hours. Dedicated visiting hours for grandparents between 4pm and 7pm. Under special circumstances we allow a nominated person to have open visiting to support the parent if required. Our restriction are to support the infection prevention policy and this is explained to parents at time of admission and in our "Parents' Guide to the Neonatal Unit at the		**Recommendation:** consider the use of the word 'access' rather than 'visiting'

1.1 C	Parents are offered privacy when feeding their baby, during skin-to-skin care and when clinical procedures are taking place	QF ref: 3.1.2; QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	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. The curtains are closed when clinical procedures are being performed and when a baby is being admitted.		**Recommendation**: Screen:cot ratio. Unit philosophy. Facilities including side rooms.
1.1 D	Parents and visitors are encouraged to respect other babies' and families' privacy on the unit e.g. not approaching other cots or accessing other babies' medical information.		G			Parents are made aware that they should not approach other babies or cot spaces due to confidentiality and infection control. Parents are encouraged to be present for the discusions around their babies care but are asked to leave the room when other babies are being discussed.		**Recommendation:** parents have unrestricted access to their baby including during ward rounds and nursing handover. Does privacy and dignity form part of the unit's mission statement?
1.1 E	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.	QF ref: 3.1.2; QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	G			Parents are encouraged to be involved in their babies care and there are curtains around each cot space to provide privacy if required. There is a cubicle available to provide extra privacy for palliative care.		How many rooms do you have for this purpose? How do parents know that they can request private time with their baby?
1.1 F	Unit makes provision for private consultation with health professionals in an appropriate environment.	NICE 5a and 5b; QF ref: 3.1.4; NHS Service Spec 1.2; QF ref: 3.4.7	G			There is a dedicated Quiet Room for parents to have private discussion with health care professsionals. There is also a consultant office where discussions with parents can take place. An Multi Disciplinary Team room is also available		What facilities do you have in place for this? What signage is in use when the room is in use? How are parents empowered to ask for private consultation e.g. sign up sheets at reception?
1.1 G	Parents are involved in the choice of clothing for their baby as their clinical condition permits.		G			Parents may bring there own clothing for their baby if they wish. We then place a sign saying " I am wearing my own clothes" to prevent them from getting		How do parents know about appropriate clothing for their baby e.g. list of items in welcome pack?
Standard 1.2 - Comfort								

1.2 Ai	Your unit has a guideline for reducing infant stress that is adhered to.	NICE 5b; DH Toolkit 3.5; RCOG 15.2; QF ref: 3.4.7	**G**		Within the Neonatal Guidelines 2015 – 2017 (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"		How do you ensure that your guideline is followed and adhered to by staff e.g training (FINE, NIDCAP)? How often is the guideline reviewed? Within this guideline consider the role of the parent in supporting and comforting their baby during painful procedures.
1.2 Aii	Your unit uses a range of techniques to minimise pain and distress for the baby during and after interventions.		**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 or when baby is unsettled. Sucrose is used for many clinicla procedures giving a small amount of expressed breast milk during procedure can alos help to comfort baby. We have a number of positioning aids which can be used to ensure comfort during and after a procedure if performed. Morphine is used fo babies who are ventilated, we also give oral morphine for babies with neonatal		Do you have a pain management lead?
1.2 B	Staff are expected to observe and respond appropriately to the baby's behavioural cues in line with established models of individualised family centred developmental care.		**G**		Our staff all have annual training on developmental care and teaching on cues and interpretations are covered in this. We refer Bliss document "Look at me- I'm talking to you" 2012.		**Recommendation:** parents encouraged to observe and respond to baby's cues, communication sheet for parents to make notes.
1.2 B	Information about 'touch' and their baby is shared in active partnership with parents		**G**		Parents are actively encouraged to touch their baby and arew taught about containment holding. We refer Bliss document "Look at me- I'm talking to you" 2012.		**Recommendation:** A developmental care noticeboard on the unit
1.2 C	Timing and pacing of care takes into account the availability of parents, the individual baby's sleeping pattern, strees thresholds and tolerance of handling.		**G**		A baby is individually assessed daily by the nurse who will decide when and how often a baby needs care performing.		**Recommendation:** consideration of parents availability.

1.2 D	The baby's responses to care giving, positive or negative, are documented in their records.		**G**			A baby's responses to interventions which may be uncomfortable are assessed every shift by the nurse caring for the baby. We observe for negative and positive responses and document accordingly.		How is care individualised (e.g. nurse of day drawing up individual care plans) and how do you ensure that it is baby-led? How is this communicated with parents and how are they involved?
Standard 1.3 - Touch								
1.3 A	Close contact between parents and their babies is integral to the unit philosophy. Whenever possible, comforting touch should be baby-led and individualised by interpreting the baby's cues.	NICE 5b; DH Toolkit 3.5; RCOG 15.2	**G**			We actively encourage family centred care and parental involvement with their babies. Plan nursing care around parent visits and involve them in their care and ward round decisions.		How do you ensure that your guideline is followed and adhered to by staff e.g training (FINE, NIDCAP)? How often is the guideline reviewed? How are staff confident supporting and encouraging skin to skin? Specifically, what strategies do you have in place to promote skin to skin on your unit e.g. photos/certificates of a baby's first "cuddle", skin to skin champions, reclining chairs, posters around unit, milestone cards etc.?
1.3 C	Responses to contact between parent and baby are documented in clinical notes/care pathway documentation.		**G**			Baby's responses to any touch or social interactions are documented daily and handed over to oncoming nurse. The medical staff will write in daily summary how the baby handled on examination		**More information:** do parents have access to these notes?
Standard 1.4 - Positioning								
1.4 A	Your unit implements evidence based guidelines for positioning that are readily available.	NPS F2	**G**			All staff adhere to Neonatal Guideline 2015-17 policy on positioning and handling. Developmental care team are also involved in providing teaching sessions for the team on new positioning		How do you ensure that your guideline is followed and adhered to by staff e.g training (FINE, NIDCAP)? How often is the guideline reviewed?
1.4 B	The baby's position is changed according to individual needs and cues.		**G**			Each baby is assessed each shift regarding positioning and their individual need.		Where are position changes recorded? How are parents encouraged to contribute? What comfort checks are carried out by staff and how frequently?
1.4 C	Staff inform parents about placing babies in the most comfortable positions to regulate babies' comfort and stability.	QF ref: 3.1.2	**G**			Staff involve and inform parents on how to position their baby for comfort.		**Recommendation-** Display visual images of positioning for parents to see so they can also ensure baby is comfortable.

1.4 D	The baby's responses to position changes are recorded		**G**			Any changes in the infant's vital signs during or after repositioning are noted and recorded.		see 1.4B
Standard 1.5 - Light								
1.5 A	Your unit has evidence based guidelines for lighting that are safe and comfortable for infants, parents and staff, and these are	QF ref: 3.4.7	**G**			All staff adhere to our guideline on light and noise in Neonatal Guidelines 2015-17.		
1.5 B	The unit uses a range of mechanisms to minimise stress from bright or continuous light		**G**			Incubator covers are used to minimise sound and light transfer and from 36 weeks onward we gradually remove these to aid sleep/awake cycles. We have dimmed light and encourage periods of quiet time to allow babies to sleep and no		**Recommendation**: dimmer lights, blinds, incubator covers, spot lights for procedure cares (not pointing directly at baby), eye masks during phototherapy.
Standard 1.6 - Sound								
1.6 A	Your unit has evidence based guidelines to create a safe and comfortable sound environment for infants, parents, and staff, and these are readily available.		**G**			We have a guideline on sound and noise which staff adhere to - Neonatal Guideline 2015-17.		How do you ensure that your guideline is followed and adhered to by staff? How often is the guideline reviewed?
1.6 B	Your unit uses a range of mechanisms to minimise a baby's stress from loud and continuous noise		**G**			The use of incubator covers reduces sound conductivity. Quiet times are protected and notice on doors indicates when this is happening so everyone is aware.		**Recommendation:** sound ears as part of individualised care plans, soft close bins, positioning of work stations, signage around unit, buzzers on silent, training for staff.
1.6 C and 1.6 D	Your unit promotes a quiet and restful environment e.g scheduling specific periods for the baby and the parents with no clinical cares.		**G**			The unit promotes a quiet environment at all times. Clinical procedures are planned to allow the infant to have as much quiet and rest time as possible.		**Recommendation:** if protected time is offered, ensure that it is for at least 2 hours to allow for an effective skin to skin experience.
Standard 1.7 Taste and Smell								

1.7 A	Your unit has evidence based guidelines for optimising the olfactory environment for infants.			**A**		Draft guideline in progress on the use of EBM for mouthcare.		What is the progress of this guideline?
1.7 B	Your unit uses a range of strategies to optimise the olfactory environment for infants.		**G**			The use of expressed breast milk is used for mouthcare. Non-nutritive sucking devices are used to promote a positive oral experience.		Good.

PRINCIPLE 2

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or	Se	Bliss feedback
						Standard 2.1 Decision making		
2.1 A	On admittance, all families receive a copy of the *Bliss Family Handbook* or *Your Special care baby.*	QF ref: 3.1.1	**G**			On admission all families receive a Bliss Family Handbook and the Shrewsbury and Telford Parent Information Booklet. We also have a unique booklet for both grandparents and siblings. Parent Passports are also given out on admission.		This is great! We would love to share your booklets for siblings and grandparents on our website. Please complete our Best Practice online form. https://www.bliss.org.uk/forms/baby-charter-best-practice
2.1 B	Parents receive adequate and timely communication regarding their baby's condition.	NICE 5a and 5b; BAPM: 6.1; QF ref: 3.1.1; NHS Service Spec. 3.2.14.3	**G**			Parents are encouraged to attend daily ward and to be involved in decision making. Open visiting policy allows parents to vistit at any time and ask the nurse caring for their baby for an update. On admission parents are seen by a senior medical practitioner as soon as		see 1.1D

2.1 C	Clear guidelines on consent are followed and parents are sufficiently informed and understand when consent is needed.	QF ref: 3.1.1	**G**			There is a trust guideline which is followed regarding consent. Explanation of consent is contained in the Bliss Faily handbook. Parents are informed of any invasive procedures which their baby may require and verbal consent is obtained and writen in the medical notes.		What procedures require written or verbal consent? How are staff and parents aware of this e.g. training, information packs? Where is consent recorded? **Recommendation:** View our best practice example http://www.bliss.org.uk/principle-2
2.1 D	For routinely anticipated care, explanations are given in advance and parents are referred to local leaflets or Bliss publications.	QF ref: 3.1.1	**G**			Parents are informed of all anticipated care and related leaflets are given Parents are given opportunity to ask questions.		How is Bliss information made available? **Recommendation**: Bliss noticeboard.
2.1 E	For immediate interventions, an explanation is given as soon as possible and any discussion is documented.	QF ref: 3.1.1	**G**			All immediate investigations are explained to parents. If parents are unavailable then the nurse caring for baby will telephone the parnet to verbally update them.		Where is this recorded?
2.1 F	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.	QF ref: 3.1.1	**G**			Parents are continually updated on child's condition and if unavalable, telephone contact is made. All signed consent is filed in the babies notes.		How is the MDT involved in these discussions? How are parental concerns taken into consideration? How is communication tailored to meet the needs of the parents? **Recommendation:** SBAR technique.

2.1 G	Decisions/changes in care where parents may express a preference should always involve them.	NICE 5a and 5b; QF ref: 3.1.2	**G**			Parents are encouraged in decision making on ward round and care is discussed with nurse caring for baby and medical team.		
2.1 H	Parents have regular access to their baby's named consultant or senior medical staff and are invited to be present at ward rounds.	QF ref: 3.1.1; NHS Service Spec. 3.2.14.4	**G**			Parents have access to medical staff 24 hours a day. Parents are informed of ward round decisions and encouraged to attend the daily consultant ward round.		
2.1I	Parents are provided with information about how to access their baby's records.	BAPM 6.1		**A**		Parents are only informed of the methods of accessing the medical notes if they request to do so but have access to the nursing cotside records.		**Recommendation:** Consider how parents are encouraged to access their baby's records E.g. records labelled "read me", "your baby's notes"...
Standard 2.2 Care plans								
2.2 A	Staff follow pathways and use the prompts within the pathway to direct or anticipate care.		**G**			There are nursing care guidelines which staff follow when delivering care.		What care pathways are in place? **Recommendation:** Care plans are usually updated at the end of each shift. Review the need for care plans for common areas of neonatal practice.
2.2 B	Care plans are reviewed regularly and kept up to date.			**A**		Staff use careplan to evaluate babies needs during their shift. Currently updating careplans.		How frequently are care plans reviewed? How are parents involved? How do you establish a consistent approach to updating care plans?

2.2 C	Parents of babies with complex needs have an identified individual, who proactively provides regular information on the care pathway and provides support during transition and discharge.	NICE 5a; DH Toolkit 3.9; BAPM: 6.1; QF ref: 3.1.2; NHS Service Spec. 3.2.14.4	**G**			Each baby has a named nurse and consultant who co-ordinates care. On planning for discharge, the Outreach Sister will support the transition from hospital to home.		How do the named Nurse/Consultant support families to build confidence before discharge? How are parents involved in care decisions/planning? Hospice teams and palliative care community teams can be very supportive - what local availability is there for this?
2.2 D	Parents are provided with information about who to contact with queries or advice regarding their baby's condition and treatment and know where to go for further information, including useful websites.	RCOG 16.9; QF ref: 3.1.1; NHS Service Spec. 3.2.14.3	**G**			On admission parents are given the unit contact numbers and are encouraged to phone regularly for updates. Nurse caring for the baby for the shift will update the parent. Parents are given the Bliss information website and there are 3 Bliss representatives are available on the unit. Parents are encourage to download the Network app for information on the unit.		
2.2 E	Parents are provided with adequate information, by trained staff, about their baby's long-term outcomes.	QF ref: 3.1.1; NHS Service Spec. 3.2.14.3	**G**			Parents are regularly updated by consultant team. For complex issues appropriate specialist services are accessed.		Where are details of discussions recorded? **Recommendation:** Consider the use of communication sheets/diaries for parents to write down their thoughts and queries.

2.2 F	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 implementation Plan 2011-15; NHS Service Spec. 3.2.17.2	**G**			Health visitors are informed of admission of baby and the liaison health visitor co-ordinates information and visits of HV to the unit prior to discharge.		**Recommendation:** HV and GP send badger admission sheet
Standard 2.3 Psychosocial support								
2.3 A	Families, including siblings, are offered social and/or psychological support while on the unit	DH Toolkit 3.8 and 3.12; BAPM 6.4; RCOG 16.9; QF ref: 3.1.3 and 3.2.4; NHS Service Spec. 3.2.14	**G**			Families are offered support daily bythe nurse caring for the baby. If palliative or long term support is needed an appropriate referral is made.		**Recommendation**: provide regular access to a dedicated and trained counsellor on the unit, with a clear referral pathway to this support. Bliss can provide a letter of support to the trust if needed and suggest ways that other units have embedded this at little cost. Signpost parents to the Bliss Helpline, a confidential telephone service that offers a listening ear, emotional support and information to families. Resources to display on your unit are available via the shop http://www.bliss.org.uk/pages/shop/department/heal
2.3 B	Families, including siblings, have access to support from community neonatal teams while on the unit.	DH Toolkit 3.8 and 3.12; BAPM 6.4; RCOG 16.9; QF ref: 3.1.3 and 3.2.4; NHS Service Spec. 3.2.14	**G**			There is a Neonatal Outreach Team who offer support to families prior to discharge of babies who fit the criteria for home support. Discharge weight less than 1.8kg, oxygen dependant babies, NAS babies. Paediatric Outreach Team may be involved with babies who are anticipated to require long term support.		**Recommendation:** Look at different models of outreach including regular neonatal updates for HV and community paediatric nursing staff to enhance cover and support for families.

2.3 C	Staff provide families with written information about local social/psychological support and advice services, organisations and networks, including relevant literature and information on how to contact them when they are ready.	QF ref: 3.1.1; NHS Service Spec. 3.2.14	**G**			Parent passports incude information regards support groups and Bliss volunteers are able to offer signpoting to relevant suppot agencies. Small Wonders DVD is available to all families.		**Recommendation**- Consider putting up a Bliss noticeboard highlighting areas of support we offer (helpline, volunteers, information).
Standard 2.4 Sensitive news								
2.4 A	Your unit provides comfortably furnished private rooms for parents to have confidential, sensitive or difficult discussions.	QF ref: 3.1.4; NHS Service Spec. 1.2	**G**			The unit has dedicated counselling rooms with comfortable chairs where private discussion can take place.		
2.4 B	Staff have received specific training on how to communicate difficult news (as appropriate).	RCOG 16.9; QF ref: 3.1.1; NHS Service Spec. 3.2.13	**G**			Human factors training has been provided for all staff in the past 12 months and Advanced Communication Study day also available for MDT.		**Recommendation:** SANDS and child bereavement UK run good courses in relation to this. All staff should have in house training in this area. It will be helpful to cascade external teaching and experience by senior team to all staff members.Consider regular study days or mandatory training.
2.4 C	When staff break sensitive or difficult news to parents, they try to have at least two members of the family present to support each other.		**G**			Consultant and nurse will ensure parents are supported by wider family when breaking sensitive news.		
2.4 D	Families are offered psychological/emotional support after receiving sensitive news	BAPM 6.1; NHS Service Spec. 3.2.14	**G**			Families are offered support following breaking bad news and the Bereavement Midwife is involved along with Hope House Hospice, and SANDS if required by the family.		**Recommendation:** access to chaplaincy and a psychologist should be available to parents following receiving sensitive news. Information for families and staff about how to access this support should be made available together with support groups such as SANDs, Winstons wish or specific local support groups.

2.4 E	Staff help families to access bereavement counselling if their baby has died on the unit.	QF ref: 3.1.3	**G**			All families are referred to bereavement services.		**Recommendation-** Consider the use of memory boxes
2.4 F	Parents have access to or are offered faith/spiritual support within the hospital.	QF ref: 3.1.3	**G**			Spiritual support is always available and the trust have on-call chaplains and families are invited to bring in their own spiritual support.		
Standard 2.5 Palliative and end of life care								
2.5 A	Units have clear criteria for assessing which babies require palliative care, taking into account diagnosis and prognosis.	QF ref: 3.1.2; NHS Service Spec. 3.1	**G**			The NNU has a clear SaTH criteria for assessing babies who require palliative care.		What training have staff benefitted from in relation to palliative care? **Recommendation**: Examples of Palliative care guidelines also available for review on our Best practice page. http://www.bliss.org.uk/principle-2
2.5 B	Palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.	QF ref: 3.1.2	**G**			End of life decisions are made by discussion with family and MDT. Second opinions are sought when dealing with palliative care decisions.		How is parent choice facilitated?
2.5 C	Palliative care is coordinated by a named lead professional and involves a multi-agency, multi-disciplinary team.	QF ref: 3.4.1	**G**			End of life decisions are made by discussion with family and MDT. A Link Nurse for Palliative Care is available on the NNU and provides training and advice for the team.		

2.5 D	The baby's documented care plan is agreed with parents and based on a multidisciplinary assessment. There is an ongoing discussion with parents about personal faith or spiritual wishes and place of death.	QF ref: 3.1.2	**G**			All discussions regards palliative care involves the family and MDT. This is clearly documented in the babies notes. Parents are supported with their decisions and given choice over place of death and spiritual support.		What options do parents have available to them around palliative care? e.g. can they take their baby home. How are these options communicated to parents? **Recommendation:** Establish a staff flowchart/checklist so that they follow a consistent path with families.
2.5 E	Units have links with children's hospices to support parents and their choices on the baby's place of death.	BAPM 6.1; QF ref: 3.1.2	**G**			There are Links with Hope House Hospice which provide hospice care with infants with life limiting illness.		
2.5 F	Staff are experienced in supporting end of life care and have received appropriate training.		**G**			There is a Link Nurse for Palliative Care who supports the team with training and updates in palliative care.		
2.5 G	A lead clinician talks through the Bliss booklet *Making Critical Care Decisions* with parents and notes the conversation in the baby's record.	QF ref: 3.1.2		**A**		Full documentation of any discussions with parents is made in the medical notes. Booklet Making Critical Decisions		We no longer produce the making critical decisions booklet so the standard has been removed.
2.5 H	Bereavement support coordinated by a named professional is made available if needed.	QF ref: 3.4.1	**G**			Bereavement services are notified of any death and coordinate support for families		What information do families receive before discharge? Is a bereavement pack available? How are parents referred to the bereavement support coordinator, and are home visits available? What support do they offer?

2.5l	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 discrete level of support to the family during this period.		**G**			Staff are trained to support a family taking baby home for end of life care and involve multi agency services for eg . Hope House Childrens' Hospice		

PRINCIPLE 3

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or	Se	Bliss feedback
Standard 3.1 Trained specialist staff								
es	Adequate numbers of staff are specifically trained to meet nationally agreed minimum clinical standards in all levels of neonatal care.	BAPM 2010; DH toolkit 2009 - Principle 2; QF ref: 3.2.2 and 3.2.3; QF ref: 3.2.7; NHS Service Spec. 3.1		**A**		The unit is currently working towards BAPM and Neonatal Toolkit staffing levels.		Please share staff numbers and rotas. Share your action plans for working towards national standards.
3.1 B	All staff are competent and able to: stabilise the baby; assess them; and initiate an action plan.	BAPM 2010; DH toolkit 2009 - Principle 2; QF ref: 3.2.2 and 3.2.3; QF ref: 3.2.7; NHS Service Spec. 3.1				68% of staff on unit are Qualified in specialist neonatal intensive care, with a rolling programme of staff undertaking training. This ensures competent stabilisation and initation of care pathways		Please complete the rag rating here.

3.1 C	The unit has an identified competency framework including developmental care, breastfeeding and discharge planning that staff are regularly assessed against.	NHS Service Spec. 3.2.13	**G**			The unit has a designated breast feeding lead and also the Trust employs a Infant Feeding Co-ordinator and several breast feeding support leads . Yearly mandatory training on breast feeding updates . Unit has allocated hours per week for discharge planning Lead to coordinate discharges . Unit has designated		
3.1 D	Staff training included components to develop knowledge and skills in baby and family-centred care, including the areas listed in 3.1C	BAPM 2010; DH toolkit 2009 - Principle 2; QF ref: 3.2.2 and 3.2.3; QF ref: 3.2.7; NHS Service Spec. 3.1	**G**			Family -centred care is promoted. Staff updated in family -centred care on national and network study days . Bliss volunteers actively promote family-centred care by visiting families and sharing their own personal experience. We encourage staff to attend the Foundation and Neonatal ITU course where Family Centred care is included in programme.		**Recommendation**: All neonatal staff sign up to the Bliss Journal - quarterly newsletter for HCP's.
3.1 E	Staff are trained in safeguarding procedures and are aware of indications to prompt.	BAPM 2010; DH toolkit 2009 - Principle 2; QF ref: 3.2.2 and 3.2.3; QF ref: 3.2.7; NHS Service Spec. 3.1	**G**			All staff are trained in safeguarding procedures. The hospital has a lead Safeduarding Nurse and Midwife and Safeguarding training is mandatory. A Neonatal Sister acts as a link to Safeguarding / Vulnerable Women's Group.		
Standard 3.2 Multidisciplinary team								
3.2 A	Babies have timely access to allied health professionals with specific neonatal or paediatric training.	DH Toolkit 2.5; QF ref: 3.2.4		**A**		Allied health professionals are available ie SALT, Dietetics, OT services, physio. Dedicated neonatal dietetic support is not currently available but has been highlighted as an ideal.		Are AHP's available to attend ward rounds? How regularly are they available for consultation with parents?

.

3.2 B	Families have access to social workers for assessment and provision of support services or are signposted to the relevant local agencies.	QF ref: 3.1.3	**G**			Social services availabel for assessment and provision of support services for emotional, financial and practical.		**Recommendation**- Do mention your Bliss Champions and your plans for your support group
3.2 C	Care plans reflect a multidisciplinary approach to neonatal care, both within primary care and community teams.	QF ref: 3.1.2		**A**		On -going review of care plans to promote daily care planning. Comprehensive discharge planning in place to ensure all services involved. We are currently updating careplans to be contemporaneous.		**Recommendation:** Consider recording MDT plans in patient notes and clear pathways for signposting to other teams.
Standard 3.3 Near to home								
3.3 A	Your unit follows network transfer guidelines for admission to appropriate specialist services or return to an appropriate local service.	QF ref: 3.5.3, 3.6.3 and 3.6.4 QF ref: 3.2.4	**G**			Unit follows Network guidelines for transfer of babies outside of care pathway for Level 2 Unit.		
3.3 B	Parents are encouraged and have the chance to visit a new unit in advance of a transfer.	NICE 5a and 5b; DH Toolkit 3.2, 3.4 and 3.8; BAPM 6.1;		**A**		We give parents an information leaflet at antenatal visit regarding how the network functions regarding levels of care. We are able to arrange a visit prior to transfer.		**Recommendation:** telephone call to transferring unit where a visit is not possible.
3.3 C	If transferred, parents are given comprehensive information on the new unit in advance.	NICE 5a and 5b; DH Toolkit 3.2, 3.4 and 3.8; BAPM 6.1; QF ref: 3.1.2	**G**			Parents are given explanation as to the reason why need for transfer . Unit telephone numbers ,maps ,and general information of new unit		**Recommendation**: Provide parents with details of the network app.
3.3 D	Parents are given an explanation and involved in discussions on transfers, with the choice to accompany their baby.	NICE 5a and 5b; DH Toolkit 3.2, 3.4 and 3.8; BAPM 6.1; QF ref: 3.1.2	**G**			Parents are given explanation on the reasons to transfer, involved in discussions on transfer and if possible are given choice to accompany their baby.		**Recommendation:** View our best practice transfer leaflet http://www.bliss.org.uk/principles-3-and-4

3.3 E	Parents who have had a long-distance transfer are offered a range of support, including an agreed financial support package.	QF ref: 3.1.3	**G**			Parents will be offered accomodation if available . Meals offered and concessionary parking .		
Standard 3.4 Consistency across the neonatal network								
3.4 A and 3.4 B	Your unit has the same visiting policy as other units of equal clinical level within your network.			**A**		Throughout our network there are variations in visiting policies . Work on -going within five hospitals of network to unify visiting policy to unify this.		We look forward to hearing how this progresses
3.4 C	Your unit follows network-wide guidelines on procedures on breastfeeding, day-to-day cares, developmental care etc.		**G**			Network guidelines followed for breast feeding ,family -centred care and developmental guidelines		

PRINCIPLE 4

Ref	**Summary of criteria**	Ref	**G**	**A**	**R**	**Outline of current practice and/or**	**Se**	**Bliss feedback**
Standard 4.1 Monitoring and benchmarking								
4.1 A	Benchmarking activity is routinely included in your units' quality improvement programme.	QF ref: 3.4.5	**G**			Monthly Governance meetings are held with the Neonatal/Maternity team and a bi monthly feedback meetings are held with designated consultant for governance, ward staff and other members of the		Do you have a data manager to coordinate this? Give examples of topics you have contributed to and actions taken as a result.
4.1 B	Feedback from parents is regularly sought, collated and fed into decision making processes.	NHS Service Spec. 3.2.15	**G**			Trust Friends and Family Questionaire encouraged on discharge to gain feedback of family experience whilst on the unit. Any improvements required are addressed and shared with team. Parent Passports implemented on unit 3 years,		**Recommendation**: consider a range of feedback methods/timings (not just a discharge questionnaire) e.g. comments box, parent interviews.

4.1 C	Your unit works together with other units within your network on agreed benchmarking/audit programmes.	QF ref: 3.4.5	**G**		Mortality and Morbidity meetings held between hospitals to share experience and learning points for babies who have been transferred and care has been		
4.1 D	Your unit participates in the national neonatal audit programme.	QF ref: 3.4.5	**G**		The unit participates in the national neonatal audit programme. All parents are given the information on audit in the Parent Guide book on admission. The		How does the unit share and action annual report data? E.g. NNAP posters on display.
				Standard 4.2 Service improvement			
4.2 A	There is a continuous process for involving parents in improving your delivery of family-centred care.	NHS Service Spec. 3.2.15	**G**		Parents opinions on service improvement actively encouraged through feedback questionaires. The unit has Bliss volunteers who are available regularly to talk to parents regarding their wishes for improving family-centred care and then feeding back to trained staff with parental		
4.2 B	Parents are included in the planning and development of services improvements throughout the network.	NHS Service Spec. 3.2.15	**G**		Parents were encouraged and participated in the planning and design of the new neonatal unit layout and facilities. Bliss volunteers are able to offer suggestions regards service improvement.		**Recommendation:** consider the use of Parent Representatives. Bliss can help you recruit these. For further information, please see http://www.bliss.org.uk/be-a-parent-representative
4..2 C	Benchmarking and audit inform future service improvement activities and action plans.		**G**		Action plans on the back of audits are implemented on the unit. Parent passport implementation is an example of this .		
4.2 D	Improvements are introduced to the unit in response to feedback from both staff and parents.	NHS Service Spec. 3.2.15	**G**		Feedback is sought through exit questionaires and improvements are made on reflection of these.		How do you share what you have done in response to parent/staff feedback e.g. you said, we did board? How do you proactively seek and collect staff feedback? E.g. staff meetings.

PRINCIPLE 5

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or	Se	Bliss feedback
Standard 5.1 Introduction to the unit								
5.1 A	Parents with a predicted need for neonatal care should be offered a prior visit to the unit and an opportunity to meet staff.	NICE 5a and 5b; DH Toolkit 3.1; QF ref: 3.1.1	G			Unit visit is offered to all preterm expectant mothers with explanation of ITU rooms, HDU rooms and progression to Special Care rooms . Family facilities are also explained and shoewn to expectant mother If a mother is to be transferred to another hospital, we are aiming for parent[maybe just a father is able to visit] to make contact with the hospital baby is		
5.1 B	All parents are fully inducted on entry to the neonatal unit so they can orient themselves and are aware of the different equipment, noises and alarms within the unit.	NICE 5a and 5b; DH Toolkit 3.2; BAPM 6.1; QF ref: 3.1.1; NHS Service Spec. 1.2 and 3.2.14.2	G			As part of admission procedure , full orientation to the unit is given to both parents ,outlining breast feeding /expressing facilities , parents' rooms ,refreshment facilities . Unit leaflets are given . Parents are inducted on policy and procedure [visiting times , hand washing ,unit facilities]If mother not physically able to visit , anominated support person is orientated to ward environment .All equipment ,alarm noises , staff roles are		**Recommendation:** establish an induction checklist for staff so that all parents receive consistent information about the unit.
5.1 C	Attention is paid 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.	NICE 5a and 5b; QF ref: 3.1.1 and criteria review	G			If mother unable to visit , medical team /experienced neonaatl nursing team will update her on baby's conditionPhotograph encouraged to be taken by visitor to give to mother in her absence.For babies that are transferred from another hospital , telephone update is made to keep mother informed of transfer and condition of baby . We also start the parent passport which can be used as a diary for mother . In case of mother being unwell and unable to		Great that you allow the use of photos. For families that do not have access to their own equipment is there access to unit equipment to take photos?
5.1 D	Parents are given a named contact for practical queries and advice.	NHS Service Spec. 3.2.14.3	G			All staff introduce themselves when meeting parents Parents are encouraged to ask staff any questions . They are made to feel welcome to visit at anty time Unit leaflets with contact numbers are		**Recommendation** Consider a parent telepone line.

5.1 E	Staff inform parents about relevant policy and procedures on the unit, e.g. infection control.	NICE 5a and 5b; DH Toolkit 3.2; BAPM 6.1; QF ref: 3.1.1; NHS Service Spec. 1.2 and 3.2.14.2	**G**		Policies and procedures explained . Information on visiting , hand washing and prevention of infection leaflets given Parents are asked to remove outdoor coats before visiting baby . All proc3edures explained Consential issuese covered with Bliss leaflets , verbal explaination and written consent in case of treatment for Retinopsathy of		
5.1 F	Unit staff introduce themselves to parents and explain their role in relation to their baby's care and the running of the unit.	NICE 5b; DH Toolkit 3.2	**G**		Members of staff introduce themselves to parents /support visitor and explain their role in relation to baby's care . With shift change , full introduction of staff and designation is given Ward manager introduces herself regularly to parents and explains her role . Medical team introduce themselves with examination of baby and Consultant will also introduce themselves on ward rounds .		**Recommendation:** ID badges. Consider a uniform key to inform parents of the different staff members on the unit.
5.1 G	Parents are provided with a 'welcome pack' (ideally provided in languages and formats relevant to the local community) giving practical information about the unit. Parents should also receive information about local amenities, such as taxi service, free or reduced parking, meal vouchers, restaurants, particularly if they have not been admitted to their local unit.	DH Toolkit 3.8.3.12; QF ref: 3.1.1; NHS Service Spec. 1.2 and 3.2.14.6	**G**		Welcome pack given to parents on admission . Local amenities , including advice about cafeterias , cash machines , taxi companies , religious services [eg prayer rooms] Small wonders video made available . Unit has nominated Small wonders champin .Infection conterol leaflets given . Unit information available in other languages .Hospital interpreter service available on request .		**Recommendation:** consider providing parents with a checklist from admission that they can use to empower them to seek out relevant information and to understand exactly what they can be involved with and support with on the unit. http://www.bliss.org.uk/principle-5. Utilise visual prompts to support parents who don't have English as their first language.

5.1 H	Written information explaining the local neonatal network and how it operates should be available in languages and format appropriate to the local community. This should include basic information about each unit and an explanation of the transfer service.	NHS Service Spec. 1.2 and 3.2.14.6	**G**			In case of transfer to different hospital , unit contact details are given to parents/nominated suppport person . Transport team will inform parents when baby to be transferred Receiving unit will telephone parents to let them know baby has safely arrived		**Recommendation:** consider establishing a network map to support the explanation. Also encourage the use of the SSBC app if being transferred within Network.
5.1I	There are staff photo boards at the entrance to the unit which are kept up to date.				**R**	Staff photo boards not available at present. Staff photo board is an option for the future .		
Standard 5.2 Facilities								
5.2 A	Babies are safe and secure while on the unit and parents are informed of security arrangements.	DH Toolkit 3.11	**G**			Secure environment in place with security doors and buzzer system when reception is closed .The buzzer system is available in all clinical areas to allow access of visitors . During the day the ward clerks man the entrance and the door is always locked Staff authorise entrance of of all visitors : if not recognised ,visitors will be questioned on who they are visiting . Once staff happy , the visitors will be allowed access. If breach of security		**Recommendation:** consider providing passes to parents so that they can readily access the unit.

5.2 B	Parents of baby's on the neonatal unit are able to access overnight accommodation with bathroom facilities, as close as possible to their baby and without cost.	NICE 1e and 1f; DH Toolkit 3.11; BAPM 6.3; QF ref: 3.1.4; NHS Service Spec. 3.2.14.6	**G**			There are 3 family rooms available on our unit, all with en-suite facilities and one of the rooms has disabled facilities also . In the case of all 3 rooms being occupied , we liase closely with post -natal ward and if mother still an in -patient ,extra nights of accommodation can be offered .	
5.2 C	Easily accessible facilities are made available for parents to store their personal belongings safely and securely.	QF ref: 3.1.4	**G**			Secure lockers available for parents and visitors to secure valuables whilst visiting their baby . Incubators and cots have some storage space for personal belongings	**Recommendation:** lockers free of charge
5.2 D	Unit facilities for families are clean and comfortable, free of a charge and of an appropriate size to the scale of the unit.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	**G**			All of our facilities for parents and families are maintained in a clean and comfortable state ,free of charge . Cleaning is performed daily and more often if required in case of spoilage or spillage	
5.2 E	Families have easy access to a parent/family sitting room, and a small kitchen to make hot drinks and snacks.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	**G**			Within the unit we have a designated family room for parents to freely use an time of the day . It has access to hot and cold drinks with a kitchen area and a seating area for meals. The unit provides supplies of basic provisions [milk ,cereal and bread] A fridge and microwave are	
5.2 F	Child-friendly areas for siblings are available, easy to access and safe.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	**G**			Child -friendly areas are available which has toys which are regularly rotated and cleaned	**Recommendation:** consider the use of portable DVD players and sibling packs. See our best practice example for a story book for siblings; http://www.bliss.org.uk/principle-2

5.2 G	Families are informed of the whereabouts and opening hours of the hospital canteen and other facilities for having meals within the hospital.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	**G**			Parents are informed of the whereabouts of the hospital canteen and its opening times . Parents can obtain a hot meal at concessionary Trust rates. There is a café available in the Women and Childrens centre . All mothers are given access to tea and coffe -making facities and to		
5.2 H	Parents have access to a dedicated separate room for counselling and/or to have private conversations with staff.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	**G**			We have a designated counselling room set away from the ITU enviroment . We also have a Consultant of the week office wherby private conversations can be held .		
Standard 5.3 Support networks								
5.3 A	Parents are given information on how to contact national and local support groups (e.g. Bliss Helpline, Bliss Family Groups)	DH Toolkit 3.8 and 3.12; BAPM 6.4; RCOG 19.4; QF ref: 3.1.1; NHS Service Spec. 3.2.14.3	**G**			The unit satff give out Parent passports on admission with explanation of support groups available .leaflets are given out with explanation . We also have a breast pump hire scheme operational on our unit wherby every mother is able to loan a breast pump for home use for the duratiojn of baby's stay on the unit .The breast pump loan service is free of charge . On discharge we provide information for		**Recommendation-** Create a Bliss noticeboard promoting relevant Bliss services
5.3 B	Parents are informed on where to get further information, including advice on financial support and useful websites.	DH Toolkit 3.8 and 3.12; BAPM 6.4; RCOG 19.4; QF ref: 3.1.1; NHS Service Spec. 3.2.14.3		**A**		Health visitors and community midwives offer support and advice on financial issues . We do not have a designated social worker for Neonatal Unit . Child benefit information is include in the bounty packs which are given to all mothers post delivery .		Explain information and support provided for other issues parents may experience e.g., information on baby's condition, parents mental health and sibling support. Which local charities do you signpost to? Any support groups?

5.3 C	Parents are made aware of local parents for peer support and contact is facilitated as appropriate.	DH Toolkit 3.8 and 3.12; BAPM 6.4; RCOG 19.4; QF ref: 3.1.1; NHS Service Spec. 3.2.14.3		**A**	We do not have a designated local support group . We do have Bliss volunteers who have had their babies on the Neonatl Unit and who provide excellent practical , emotional and Social support We are working towards setting up a parent supoort group locally .		What is the progress of your support group? How are you signposting to local support in the community?
Standard 5.4 Consistent information							
5.4 A	Parents are fully involved in discussions about their baby's care and receive consistent information from staff caring for their baby.	QF ref: 3.1.2; NHS Service Spec. 3.2.14.4	**G**		Parents are involved in discussions around their baby's care. They are encouraged to be present for ward rounds and are encourage to be part of planning around care . Parents are updated daily when they visit or verbally over the telephone if unable to visit		
5.4 B	Verbal and written information is provided at appropriate times to help parents' understanding of neonatal care (including. clinical conditions, procedures, risks, complications, tests, investigations etc)	NICE 5a and 5b; DH Toolkit 3.4 and 3.9; QF ref: 3.1.2; NHS Service Spec. 3.2.14.4	**G**		Parents verbally updated regarding their baby's progress by nursing and medical team For any procedures to be undertaken ,parents are informed , assent obtained and in the case of consent , verbal or written is obtained dependant on procedure .We adhere to the Network fguideline 2012-2013 on consent issues Leaflets [Bliss publications are made		
5.4 C	Translation services and/or professional interpreters are accessible and secured in a timely way.	NICE 5a and 5b; DH Toolkit 3.9; BAPM 6.4; QF ref: 3.1.2	**G**		We offer a full interpreters service free of charge to parents in need . Interpreters are organised for all conversations with medics if needed and for discharge planning and parentcraft sessions .		

5.4 D	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 is given in clear simple terms and explained as many times as needed to parents and extended members of the family network .		
Standard 5.5 Use of data								
5.5 A	Staff understand data protection principles and inform parents how data about their baby is used.		**G**			Within our unit information booklet which is given out on admission , a full explanation of data collection is given.Data protection Act 1998 is adhered to .		
5.5 B	Parents are fully informed about clinical trials and the consent process and value of research.		**G**			All clinical trials /audit which the unit is undertaking are explained in full to parents Parents are given oppoertunity to opt out of trails or audits at anty time. For which ever trail is being undertaken , there is a designated Audit lead who will explain		
5.5 C	Staff are taught how to transmit information to third parties securely and confidentially.		**G**			All staff complete Information Governance training yearly so are regularly updated on the importance of confidentiality . Confidential call are taken in separte room Socail concerns are documented in baby's notes and on the badger system . All staff		
Standard 5.6 Daily cares								
5.6 A	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.	NICE 5b; DH Toolkit 3.5; BAPM 6.1; QF ref: 3.1.2; NHS Service Spec. 3.2.14.5	**G**			Both parents are encouraged to be actively involved in performing cares . Crae is demonstrated first , then parents are emncouraged to participate with the nurse and when demmed confident , they are encouraged to carry out care		What cares are parents supported to carry out? How do you know that they are confident delivering these e.g. parent passport?
5.6 B	The level of involvement of the parents in the baby's daily care is facilitated and increased from admission.	NICE 5b; DH Toolkit 3.5; QF ref: 3.1.2	**G**			As baby nears discharge , parents are encouraged to do their babies cares independently to prpare for transition to home . Nurse deliver comprhensive parent education programme to prepare		

PRINCIPLE 6

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or	Se	Bliss feedback
Standard 6.1 Promote and support breast milk expression								
6	Unit is undertaking Unicef Baby Friendly Initiative		**Are you taking part in the Unicef Baby Friendly Initiative? If yes,**			Which stage of BFI are you at? (Certificate of commitment, Stage 1 Accreditation, Stage 2 Accreditation, Full Accreditation) When was this awarded? When will you be re-assessed? Have you completed the maternity or neonatal standards?		Attaining full BFI accreditation is fantastic. Well done! For your second audit, please provide evidence of what your unit is doing against each standard. I have provided some information in the feedback tab of the evidence we will need to see. During an assessment we will ask you to provide us with the relevant documents for your BFI Accreditation.
6.1 A	Your unit has a breastfeeding policy adhered to by staff					**Trust has attained full BFI Accreditation on 13/01/16**		How do you ensure that your guideline is followed and adhered to by staff e.g training? Could you share NNAP data and any local audits on breastfeeding training and compliance with policy?

6.1 B	Following the birth of any preterm or sick baby, your unit takes into consideration: a. Status of mother's recovery from birth. b. Mother's level of energy. c. Any previous breastfeeding experience. d. Any antenatal breastfeeding preparation. e. Mother's feelings about breastfeeding. f. Mother's support network. g. Mother's general health and any prescribed medication.							How is this achieved consistently? Where is information recorded?
6.1 C	Mothers receive practical support to enable them to establish lactation in the first six hours after birth							What specific practical support do mothers receive? What training have staff benefitted from to deliver this? **Recommendation:** Breastfeeding log. Consider use of breast feeding buddies and lactation suppport volunteers to support mothers at cotside with latching on and expression.
6.1 D	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 double pumping and skin-to-skin.							How are staff consistently using the best techniques to support mothers? E.g. consider annual updates that are provided to staff. How is skin to skin promoted on the unit?

6.1 E	Parents are given clear and consistent information on the benefits of breastfeeding and the importance of frequent expression is explained.						How is breastfeeding promoted on your unit? E.g. through informal teaching sessions, peer support groups, noticeboards, verbal information etc. How are the medical staff included in breastfeeding support and initiation? What training and support has your breastfeeding coordinator had?
6.1 G	The unit has a dedicated professional to support mothers in establishing lactation and increasing milk production in the following days.						What training has this dedicated professional benefitted from?
6.1 H	Staff receive training on the benefits of breast milk, physiology of lactation and how to provide practical support to mothers.	NHS Service Spec. 3.2.13					Provide details of what is covered in the training programmes. How regularly are these training programmes reviewed? What happens for new starters?
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.	NICE 6; DH Toolkit 3.10; BAPM 6.2; RCOG 15.5; QF ref: 3.1.4					**Recommendation:** If insufficient stock available, look at applications to hospital funds and local charity funds to purchase additional breast pumps.
6.1 J	Your unit promotes safe and hygienic handling and storage of breast milk and ensures parents are informed of these measures.	NICE 6; DH Toolkit 3.10; BAPM 6.2; RCOG 15.5					What is your unit guideline re. safe handling and storage? How is information about the handling and storage of breast milk shared with parents? **Recommendation:** ensure storage of donor and breast milk meet NICE guidelines.

6.1 K	Private and comfortable facilities are provided for mothers to express their milk and expression at the baby's cot side is encouraged.	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6				**Recommendation:** expressing rooms, reclining chairs by cot side, screens/curtains for privacy, parent accommodation.
6.1 L	Your unit has a policy for and consistent practice guidelines on the fortification of breast milk.					
Standard 6.2 Breastfeeding						
6.2 A	Parents receive adequate and timely support to aid transition from tube feeding to breastfeeding, for example, with recognition of feeding cues, help with attachment and positioning, and signs that baby is feeding well.					How is the partner also supported here?
6.2 B	Mothers are provided with a private and comfortable space for breastfeeding.	NICE 6; DH Toolkit 3.10; BAPM 6.2; RCOG 15.5, 16.5 and 15.7; QF ref: 3.1.4; NHS Service Spec. 3.2.14.6				See 6.1k

6.2 C	Mothers are consistently supported to establish breastfeeding on the unit, before going home.							What are your breastfeeding rates? What does parent feedback reveal about this?
6.2 D	Breastfeeding is a discrete part of a discharge planning process in which mothers are provided with the support and motivation necessary to continue breastfeeding/expression once at home.	NHS Service Spec. 2.1.11						What support is available to mothers once discharged? e.g. post discharge network.
6.2 E	Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding and encourage a supportive culture.							What training or study days are organised?
Standard 6.3 Alternative to maternal breast milk								
6.3 A	Parents are informed on how to donate any surplus milk, if the meet donor criteria.							How are babies from other units who are using donor milk accommodated following transfer? Is there a network or unit policy?

6.3 B	Both mothers and fathers are supported and are shown how to make feeds and sterilise bottle and teats.	BAPM 6.1; RCOG 15.6						**Recommendation:** consider also the use of a training video.
6.3 C	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.							
6.3 D	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. (Donor milk is available to any neonatal unit that requests it and free couriering is usual).							How are parents made aware of this?
6.3 E	The unit has a policy on using preterm formulae (appropriate formula, follow-on milk, nutritional supplements etc) which is adhered to by staff.	DH Toolkit 2.5.11						

PRINCIPLE 7

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or	Se	Bliss feedback
Standard 7.1 Coordinated discharge planning								

7.1 A	Your unit has an established discharge planning policy which is adhered to by staff	NICE 7a and 7b; DH Toolkit 3.15; BAPM 6.4; NHS Service Spec. 23.2.17 and 3.2.19	**G**			Staff adhere to discharge policy in the Neoanatal Guidelines 2015-2017		
7.1 B	Your unit demonstrates a multi-disciplinary approach to its discharge planning, which includes facilitating access to social services and other support professionals.	QF ref: 3.1.3 NHS Service Spec. 3.2.12.2, 23.2.17 and 3.2.19	**G**			A holistic approach is used when planning discharge. All babies are discussed at a weekly MDT meeting. Dedicated meetings are made for Complex babies who have individual discharge planning meetings with appropriate health care professionals[dietician,social services,Hope House hospice ,health		
7.1 C	Discharge plans are established from the point of admission and are continually reviewed, involving both parents and a multi-disciplinary team.	NICE 7a and 7b; DH Toolkit 3.15; BAPM 6.4; NHS Service Spec. 23.2.17 and 3.2.19	**G**			Dedicated discharge planning documentation commenced on admission and continued throughout time on neonatal .Updated and reviewed throughout and completed on discharge . A copy of these is given to the health visiting teams .parents are involved throughout process, and we have a dedicated parent quiet discussion room.		We would love to see a copy of this planning planning documentation for our best practice example please complete our form https://www.bliss.org.uk/forms/baby-charter-best-practice
7.1 D	Baby's discharge plan is well-coordinated and managed throughout with a high level of continuity between staff.	NHS Service Spec. 23.2.17 and 3.2.19	**G**			The whole team are involved in discharge planning during baby's stay to encourage continuity.		

7.1 E	Parents have access to a trained health professional who can provide emotional/psychological support during and post discharge.	QF ref: 3.1.3		**A**	All nurses and medical staff can provide emotional support to parents whilst on the unit. For complex families and babies we liaise closely with Hope House Hospice for additonal emotional support.		**Recommendation:** See 2.3a
Standard 7.2 Rooming in							
7.2 A	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.	NICE 1e, 1f and 7b; DH Toolkit 3.15; QF ref: 3.1.4; NHS Service Spec. 1.2	**G**		We have 3 bedrooms available for families within the unit with en suite facilities, one of which has disabled access facilities. There is oxygen and suction within each room. Prior to discharge parents are encouraged to spend a couple of nights rooming in with		
Standard 7.3 Meeting the baby's needs at home							
7.3 A	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	NICE 1e, 1f and 7b; DH Toolkit 3.15; QF ref: 3.1.2; NHS Service Spec. 3.2.17	**G**		We have a discharge preparation check list which includes temperature control, safe sleeping practice, correct feed preparation, medication administration. We offer basic life support DVD which is always accompanied with a practical demonstration,with parent participation		
7.3 B	The family is supported through appropriate training to deliver all aspects of their baby's care at home (including basic life support).	NICE 1e, 1f and 7b; DH Toolkit 3.15; QF ref: 3.1.2; NHS Service Spec. 3.2.17	**G**		Health visitor liaison within the hospital who has close links with the unit and informs the appropriate health visitor of admission and discharge of baby to Nnu. Birth visits take place for many on the neonatal unit. A neonatal outreach service is available for babies who are deemed to required the support of this service.		

7.3 C	Community support is provided by an integrated hospital-community neonatal team or an identifiable team of community health professionals.	DH Health visitor implementation plan 2011-15; QF ref: 3.2.2; NHS Service Spec. 3.2.20	**G**			Support is available to families from community neonatal outreach service where appropriate. For more complex babies referal is made to other community health professionals.		
7.3 D	Before discharge, parents are given the opportunity to meet with the community team supporting them at home.	DH Health visitor implementation Plan 2011-15; NHS Service Spec. 3.2.20	**G**			Health visitors are encouraged to carry out the birth visit while the familiy are on the unit, this is not always possible due to geographical distances. Those babies being referred to neonatal outreach or community children's nursing team meet with the professional prior to discharge.		
7.3 E	Community health teams are given up-to date information about baby and any home care arrangements from care plan, as well as the opportunity to meet neonatal staff and parents before discharge.	DH Health visitor implementation Plan 2011-15 NHS Service Spec. 3.2.20 Implementation Plan 2011-15	**G**			Community teams are made aware of babies well in advance of discharge and if appropriate may visit the families on the unit. We inform the health visitor of discharge and this is followed up by a written letter and a copy of the discharge planning documentation.		
7.3 F	Parents are informed and understand who to contact should the baby become unwell at home, and when they may need to take them to hospital.		**G**			As part of discharge planning programme parents are given advice of who to contact in emergency situations, recognising signs and symtoms of an ill baby and referring to appropriate health service. Complex babies and babies on home oxygen have open access to children's assessment unit		