Unit Walsall manor Hospital
Level 2
Trust Walsall Healthcare NHS Trust
Netwc Staffordshire, Shropshire and Black country Newborn and Maternity Network

Audit l Nicki Heath
Job Tit Sister
Email nicola.heath@walsallhealthcare.nhs.uk

PRINCIPLE 1

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	*			All babies are issued with a cot card on admission, which states their name , consultant name and Nurse caring for baby on that shift.
1.1B	All parents have unrestricted access to their baby, unless individual restrictions can be	NICU 5b: DH Toolkit 3.3: BAPM 6.1	*			The only time this is not possible is when there is an emergency situation.
1.1C	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		*		Where possible the use of screens are used around the cot space to offer some privicy, again difficult in intensive care room, due to space restictions and unit often being over capacity with admissions.
1.1D	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.		*			All Parents and visitors are asked not to look at other patients out of respect and no information is given out by staff members or the medical team. On ward round parents are asked to leave the room when other patients are being discussed.
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	QF ref: 3.1.2; QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6	*			Whenever possible babies are allocated into a single room depending on cot occupancy and if babies condition allows, if not the use of screens around cot space.
1.1F	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	*			Parents are sopken to privately either in a individual room or without others present at the babies cot side.
1.1G	Parents are involved in the choice of clothing for their baby as their clinical condition permits.		*			parents are encouraged to bring in their own clothes and to dress and change their baby when they visit as part of the daily care routine. Also we have our own selection of clothes that parents can use and the maternity shop sells a small selection

Standard 1.2 - Comfort						
1.2Ai	Your unit has a guideline promoting comfort which is regularly referred and adhered to by staff	NICE 5b; DH Toolkit 3.5; RCOG 15.2; QF ref: 3.4.7	*			A new care plan has been developed through the developmental care team that all staff can refer to.
1.2Aii	Unit uses a range of techniques to minimise pain and distress for baby during and after interventions.		*			A new pain tool has just been devised and put into practice on the unit. We advocate the use of containment holding, oral sucrose and positioning aids. Babies who are ventilated receive morphine and we also use the network guidline reguarding pain and stress.
1.2B	Staff are expected to observe and respond appropriately to the baby's behavioural cues in line with established models of		*			Staff are taught and kept up to date on the yaerly skills session run by the ANNP'S, Paediatric Phsiotherapist or Developmental care lead. Network provide an annual study day for foundation students on developmental care.
1.2B	Information about 'touch' and their baby is shared in active partnership with parents		*			Parents are enocouraged to touch their baby as their condition allows from admisssion and are shown positive touch techniques and containment holding. Skin to skin is also actively encouaged and tied in with our daily quiet and nuturing hour each day.
1.2C	Timing, pacing and clustering of care takes into account the individual baby's stress thresholds and tolerance for handling		*			Cares are clustered usually in six hourly cycles but may be dependent on babys condition and ability to cope with handling. Assessed each shift and documented in nursing care plan.
1.2D	The baby's responses to care giving, positive or negative, are documented in their records.		*			Nursing staff document in daily summary and care plan. Medical staff will also document in medical notes following daily assessment and will discuss in verbal handovers.
Standard 1.3 - Touch						
1.3A	Close contact between parents and their babies is integral to the unit philosophy. Whenever	NICE 5b; DH Toolkit 3.5; RCOG 15.2	*			Staff encourage parents in daily skin to skin contact and parents are supported and encouraged to handle their baby if babys condition allows. Bliss posters on skin to skin and touch and handling are
1.3C	Responses to contact between parent and baby are documented in clinical notes/care pathway documentation.		*			Interactions are documented in care plans and in nursing/medical notes and verbal reporting at handovers. Skin to skin sticker sheets also completed with each interaction and kept at bedside.
Standard 1.4 - Positioning						
1.4A	Your unit implements evidence based guidelines for positioning that are readily available.	NPS F2	*			We use the network guideline and staff are updated on the yearly neonatal study day as part of the developmental care component.
1.4B	The baby's position is changed according to individual needs and cues as appropriate		*			Positioning is changed as part of the clustered cares usually 6 hourly unless babys condition or cues requires earlier intervention. Documented on care sheet/observation chart.
1.4C	Staff inform parents about placing babies in the most comfortable positions to regulate babies' comfort and stability	QF ref: 3.1.2	*			Discussed with parents when carrying out cares or handling baby. Instruction given on correct positioning when babies transferred into a cot such as ' feet to foot' and lieing baby on their back to reduce cot death.

1.4D	The baby's responses to position changes are recorded		*	Documented in care plans and daily nursing summary in medical notes.

Standard 1.5 - Light						
1.5A	Your unit has evidencebased guidelines for lighting that are safe and comfortable for infants,	QF ref: 3.4.7	*			we follow the network guideline.
1.5B	The unit uses a range of mechanisms to minimise stress from bright or continuous light		*			Giraffe incubator covers used for all sick or babies less than 34 weeks gestation. Incubator covers lightend after this gestation. All rooms have reduced lighting.
Standard 1.6 - Sound						
1.6A	Your unit has evidencebased guidelines to create a safe and comfortable sound environment for infants, parents, and staff, and these		*			We have a network guidline and aim to reduce excess noise as much as possible.
1.6B	Your unit uses a range of mechanisms to minimise a baby's stress from loud and continuous noise		*			We have introduced giraffe covers which help to muffle some of the sound for very sick or preterm infants. We don't place stuff on to the top of the incubators and we have a visual ear which lights up according to noise level in the intensive care room,
1.6C and 1.6D	Yourunit promotes a quiet and restful environment e.g scheduling specific periods for the baby and the parents with no clinical cares		*			We have reinroduced quiet and nuturing time each day were parents are able to have skin to skin time if they wish, we also link music therapy to this time. This time is protected 1pm-2pm or longer if the ward allows were Drs are on board and no procedures or intervations take place.
Standard 1.7 Taste and Smell						
1.7A	Your unit has evidencebased guidelines for optimising the olfactory environment for infants.		*			Parents advised on not to wear strong perfumes or deoderants before holding baby.
1.7B	Your unit uses a range of strategies to optimise the olfactory environment for infants.		*			We try to ensure that when using alcohol wipes etc that they are opened outside of the incubator to minimise smell, we use fractionated coconut oil for baby massage.

PRINCIPLE 2

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
Standard 2.1 Decision making						
2.1A	On admittance all families receive a copy of the *Bliss Family handbook* or *Your special* care baby.	QF ref: 3.1.1	*			on admission parents are given a admission packs which include Bliss familly handbooks
2.1B	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	*			Parents spoken to by Drs or ANNP prior to admission or delivery and afterwards. Parents are encouraged to attened morning ward rounds were they can be updated on care by the Drs, ANNP and Nursing staff.
2.1C	Clear guidelines on consent are followed and parents are sufficiently informed and understand when consent is needed.	QF ref: 3.1.1	*			Follow network guideline on consent, documented in patient medical notes.
2.1D	For routinely anticipated care,	QF ref: 3.1.1	*			Parents informed of routine cares or if not present
2.1E	For immediate interventions, an explanation is given as soon as possible and any discussion is documented.	QF ref: 3.1.1	*			Parents spoken to by allocated nurse caring for their baby and medical staff if necessary. Documented in medical notes, specific page for parents consultation, forms part of Badger audit. Parents phoned if not presesnt and spoken to again when visit.
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.	QF ref: 3.1.1	*			As above in 2.1E, Consultations with medical staff recorded on a specific page in medical notes and recorded on badger for auditing purposes. Signed consent ontained where required. If verbal consent is taken then documented in medical notes.
2.1G	Decisions/changes in care where parents may express a preference should always involve them.	NICE 5a and 5b; QF ref: 3.1.2	*			Parents preferences are documented in the babys care plan in the medical notes and via verbal reporting at handover or during ward rounds if relevant. Also documentated at cot side on daily care sheet.

2.1H	Parents have regular access to their baby's named consultant/senior medical staff and are invited to be present at ward rounds	QF ref: 3.1.1; NHS Service Spec. 3.2.14.4	*			Parents are invited to morning ward rounds with the consultant, if they are unable to attened then an appointment can be made for a more suitable time with the consultant or senior medical staff.
2.1I	Parents are provided with information about how to access their baby's records	BAPM 6.1		*		Parents are able to look at the babys bedside records or charts but will only be informed of how to access medical records if they make a request.
Standard 2.2 Care plans						
2.2A	Staff follow pathways and use the prompts within the pathway to direct or anticipate					
2.2B	Care plans are reviewed regularly and kept up to date.		*			Care plans are updated at every shift handover by each allocated Nurse.
2.2C	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	*			The consultants will liase with the multidisciplinary team where there are complex medical needs and a plan of discharge and meetings which parents are invited to will be set before babys discharge date can be set.
2.2D	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	*			parents are given direct phone number to the unit on admission. They are able to speak to the allocated nurse for each shift and are invited to daily ward rounds. They are also given Bliss handbook on admission and referred to other useful websites.
2.2E	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	*			Consultants and senior medical staff give parents regular updates on any long term outcomes. Use of specialist consultants for other hospitals are used for complex cases.
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 implementatio n Plan 2011-15; NHS Service Spec. 3.2.17.2	*			Health Visitors are informed of all preterm births and again on the day of discharge. If there are social or complex medical issues we will liaise more closely with the families designated Health Visitor and they will be invited to any discahrge planning meetings. Also the community neonatal nurse will liase with them if needed.

Standard 2.3 Psychosocial support						
2.3A	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	*			Currently main support is given by nursing staff and parents are given advise and times on how to access the monthly support group. We are currently awaiting Bliss champions to start on the unit.
2.3B	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	*			we currently have 1 WTE Community neonatal Sister and 1 neonatal sister who works 1 day a week, there is also a neonatal support group run on the last Friday of the month that is very popular and expanding well.
2.3C	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		*		We have lots of information leaflets on the unit placed in parent areas. Bliss handbook and admission packs have just been revamped and all information is up to date and relevent and appropriate.
Standard 2.4 Sensitive news						
2.4A	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	*			We have private rooms or the use of the 2 parent flats for delivering sensitive news.
2.4B	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	*			Many of the senior staff have attended bereavement study days and we also have a bereavement/pallative care lead nurse and team.
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.		*			yes we do were possible, parents may also wish to have other family members or friends for support.
2.4D	Families are offered psychological/emotional support after receiving sensitive news	BAPM 6.1; NHS Service Spec. 3.2.14	*			Staff offer support and try to accommodate any requests that the family require. We will contact muti faith chaplaincy team if required. If required we can also contact Acorns childrens hospice and
2.4E	Staff help families to access bereavement counselling if their baby has died on the unit.	QF ref: 3.1.3	*			This can be done through the chaplaincy department or Acorns, also parents will have a 6 week follow up appointment with the consultant.
2.4F	Parents have access to or are offered faith/spiritual support within the hospital.	QF ref: 3.1.3	*			Parents may invite their own priest/spiritual support as requested or we can refer to our own multi faith chaplincy department.

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.	QF ref: 3.1.2; NHS Service Spec. 3.1	*			Newborn network intergrated comfort care pathway acts as a guide for pallative care and has links to further information
2.5B	End of life/palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.	QF ref: 3.1.2	*			Yes this would involve a consultant decision along with senior medical and nursing staff.
2.5C	Palliative care should be coordinated by a named lead professional and involve a multiagency, multidisciplinary team.	QF ref: 3.4.1	*			We have a pallative care team with a lead nurse and the multi disciplinary team are involved with all areas of care and we also liase closely with acorns and the community paediatric team.
2.5D	The baby's documented care plan is agreed with parents and based on a multidisciplinary assessment, ongoing discussion with parents incl. personal faith or spiritual wishes and place of death	QF ref: 3.1.2	*			We always try to accommodate the family as much as possible in planning and decision making, including any religious requests. We also have a pathway for parents advanced care plan.
2.5E	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	*			We have strong links with acorns childrens hospice and the lead pallative care nurse coordinates with them.
2.5F	Staff are experienced in supportive end of life care and have received appropriate training.		*			Many of the senior Nurses have attended courses and updates can be given on the skills day updates.
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.	QF ref: 3.1.2	*			A lead clinician involved in the care will talk through with parents.
2.5H	Bereavement support coordinated by a named professional is made available if needed	QF ref: 3.4.1	*			A lead senior nurse is available for support and planning but this is not available 24 hours.
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.		*			Staff would fully support this if requested, we have the necessary paperwork and pathway guide to use if needed.

PRINCIPLE 3

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
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	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	*			Currently (Apirl 2107) We have: 3 WTE Band 7's QIS, 14.04 WTE Band 6's QIS, 3.92 WTE Band 5's QIS (in training) and 16.99 WTE Band 5's.
3.1B	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	*			We have sufficient skill mix on each shift to facilitate this , we also have clinical support workers on shift but would not be able to do this.
3.1C	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	*			Annual mandatory training for all staff includes breast feeding and developmental care and discharge palnning. We also have set teams for both 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	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	*			Included in manadtory training for all staff on the unit. Updates on ANNP skills study days annually. Also staff to complete E - learning modules. Staff attendance records kept by education and learning centre.
3.1E	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	*			Trust have mandatory requirements for all staff to regularly attend training and e- learning modules.

Standard 3.2 Multidisciplinary team						
3.2A	Babies have timely access to allied health professionals with specific neonatal or paediatric training	DH Toolkit 2.5; QF ref: 3.2.4	*			Referrals made by the consultants to releveant professional speciality where needed, we often liase with Birmingham Childrens Hospital. Also have access to Paediatric physion, dieticians and SALT team.
3.2B	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	*			This forms part of the admission process, if they already have social service input its documented and they are contacted. Referrals made as necessary, Liaise with child protection team.
3.2C	Care plans reflect a multidisciplinary approach to neonatal care, both within primary care and community teams.	QF ref: 3.1.2	*			Care plans are adapted according to individual needs. Babies with complex needs will have discharge planning meetings involving the multi disciplinary team which includes the community team and individualized plans made. Information for parents in parent passport.
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.	QF ref: 3.5.3, 3.6.3 and 3.6.4 QF ref: 3.2.4	*			Aim to keep babies in network/region as much as possible dependent on bed availability. Sometimes have difficulty getting babies back to our unit due to frequently over occupancy.
3.3B	Parents are encouraged and have the chances to visit a new unit in advance of a transfer	NICE 5a and 5b; DH Toolkit 3.2, 3.4 and 3.8;		*		Yes whenever possible although transfers are often done at short notice so parents do not have time to visit before transfer.
3.3C	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		*		Transfer team will give information at time of transfer. We are planning a information folder of our own on local hospitals.
3.3D	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	*			Transfers always discussed with parents. Neonatal transfer team will take parent if they have space in the ambulance, BCH paeds team will take parents, both teams have their own guidelines to adhere to.
3.3E	Parents who have had a long-distance transfer are offered support, including an agreed financial support package	QF ref: 3.1.3			*	we do not have a support package reguarding finances on the unit, so we would direct parents to social services, bliss etc for advice or help. Long distance transfers normally occur in utero and are dependent on accepting hospitals notifying us of any problems. We do noW provide free car parking for
3.4A and 3.4B	Your unit has the same visiting policy as other units of equal clinical level within your network		*			yes we have similar visiting to other level 2 units in the network, ie. Open visiting for parents and set times for grandparentson weekdays and friends and family at weekends.

3.4C	Your unit follows network-wide guidelines on procedures on breastfeeding, day-to-day cares, developmental care etc.		*			we follow network guidelines and have representatives that attend network groups and updates. New and junior staff attend the network run Foundation course together as well as those doing the intensive care course and staff are encouraged to attened all network study days provided

PRINCIPL E 4

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
Standard 4.1 Monitoring and benchmarking						
4.1A	Benchmarking activity is routinely included in your units' quality improvement programme	QF ref: 3.4.5	*			We are involved in regular auditing, ie. Infection control, CQC within the network.
4.1B	Feedback from parents is regularly sought, collated and fed into decision-making processes	NHS Service Spec. 3.2.15	*			Parents area sked to complete parent satisfaction surveys and feedback in parents passport as well as being told about the parent app. Surveys escalated and collated by ward manager.
4.1C	Your unit works together with other units within your network on agreed benchmarking/audit programmes	QF ref: 3.4.5	*			Unit partakes in agreed benchmarking and auditing programmmes as agreed at network meetings. Unit represntation involved in network groups for education, developmental care.
4.1D	Your unit participates in the national neonatal audit programme	QF ref: 3.4.5	*			unit participates in the use of badger system for inputting all patient dta and information. This is audited and completed by the ANNP'S.
Standard 4.2 Service improvement						
4.2A	There is a continuous process for involving parents in improving your delivery of family-centred care	NHS Service Spec. 3.2.15	*			We use the parent satisfaction surveys that are given to parents at the end of their stay and this information is then collated by the ward manager, we have no parental representatives at the moment but have x2 bliss champions starting on the unit.
4.2B	Parents are included in the planning and development of services improvements throughout the network	NHS Service Spec. 3.2.15	*			Service improvement following feedback from the network and parents, this can also be looked at with the addition of Bliss volunteers when they start.
4..2C	Benchmarking and audit inform future service improvement activities and action plans		*			From Network feedback information locally benchmarked to plan services
4.2D	Improvements are introduced to the unit in response to feedback	NHS Service Spec. 3.2.15	*			Improvements introduced from network feedback, senior management and staff groups.

PRINCIPLE 5

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
Standard 5.1 Introduction to the unit						
5.1A	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	*			Whenever possible parents are shown around the unit if a predicted or possible admission is imminent and we liaise with antenatal clinic. This is more difficult if transferring to or from another hospital as ususally occurs at short notice.
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 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	*			on admission to unit a welcome and admission pack is given to all parents , with visiting information, bliss booklets etc and the admitting Nursing staff will orientate parents to the ward and discuss equipment and plan of care etc.
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	NICE 5a and 5b; QF ref: 3.1.1 and criteria review	*			we liaise with the midwives to get mums to the unit as soon as possible depending on their condition. Allocated Nurse will go speak to mum or give update via midwife and if baby is transferred to another hospital transfer for mum will be arranged as soon as condition allows. if parents are unable to visit
5.1D	Parents are given a named contact for practical queries and advice	NHS Service Spec. 3.2.14.3	*			Parents are given a direct line phone number on admission and the allocated nurses name for the shift is written on the cot card and all enquiries will be directed to them.
5.1E	Staff inform parents about relevant policy and procedures on the unit, i.e. 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	*			This is included in admission pack and the Nurses also will go through on first visit to the unit.
5.1F	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	*			staff introduce themselves to parents when they visit each shift or they will speak over the telephone. All staff are indentifyable via their name badges and Nurse incharge will also introduce themselves each shift.

5.1G	Parents are provided with a 'welcome pack' (ideally provided in languages and formats relevant to 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		*		Admission/welcome pack have been recently updated to provide all relevant information and we also have parent information boards and leaflets. Bliss family books also provided but only in English, Hindu and polish so researching into other languages.
5.1H	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		*		we have a dedicated neonatal transfer team that we use and they have their own specific leaflets that they give to parents, we can obtain information online if parents request and are currentlly looking to develop our own information folder for other hospitals. parents can also access the ssbc newborn network app that provides relevant information.
5.1I	The unit has staff photo boards at the entrance to the unit which are kept up to date				*	These boards were discontinued years ago by the trust who felt that they could be a security issue.
Standard 5.2 Facilities						
5.2A	Babies are safe and secure while on the unit and parents are informed of security arrangements	DH Toolkit 3.11	*			we have the electronic tagging system in place, all babies have a tag on their leg and parents are informed of this . We have a security door and camera at entrance and all visitors have to buzz and vetted before they are allowed onto the unit.
5.2B	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		*		we have 2 parent flats that have recently been redecorated, both double beds with a shared bathroom and kitchen area with microwave, fridge and tea/coffee making facilities. Mothers are not able to access this unless they are discahrge from maternity ward. parents can use the hospital canteen/shops or bring their own food, tea, coffe, juice, toast and cereals are provided free of charge if staying overnight. hopefully more accomodation will be available when planned expansion of unit goes ahead.
5.2C	Easily accessible facilities are made available for parents to store their personal belongings safely and securely	QF ref: 3.1.4			*	no facilities available at present but discussion with ward manager to provide lockers has taken place and awaiting decision.

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	QF ref: 3.1.4; NHS Service Spec. 1.2 and 3.2.14.6		*		Due to a increase in deleiveries and increased admissions the unit is often over capacity and therefore facilities to not meet the need of the unit. This should be better when the planned expansion has been finished with more facilities.
5.2E	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		*		we have a parent kitchen that has a kettle, fridge and microwave and tea and coffee is provided. We don't have a specific parent/family sitting room but the 2 flats can be used to facilitate this if they are not in use.
5.2F	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		*		we no longer have a designated family room or play area for siblings, but if the flats are free they can be used as a sitting room for families visiting and we have a selection of age appropriate toys and colouring sheets etc to keep them occupied.
5.2G	Families are informed on 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	*			on admission parents are given a leaflet advising them of canteen , costa and shop opening times. We provide cereals, toast and tea and coffee for parents staying over night and are looking into meal subsidories for breast feeding mums at present.
5.2H	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	*			most of the side rooms only accommodate 1 or 2 babies so often easy to have private discussions. We also have other rooms on the unit that we use if privacy is needed.
Standard 5.3 Support networks						
5.3A	Parents are given information on how to contact national and local support groups (e.g. Bliss)	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	*			All parents are given Bliss family handbooks on admission and are told about the website and network parent information app. When the allocated Bliss champion starts on the unit they can also help to facilitate this.
5.3B	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	*			All parents are entitled to free hospital car parking throughout the babys stay on the unit and provisions can be made with general office with reguards to travel costs, if parents are having difficulty.

5.3C	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	*			Parents are given information on support groups such as TAMBA and condition specific via Birmingham Childrens Hospital and we also have our own parent support group which runs once a month by the community team and unit staff which has been very successful.
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	QF ref: 3.1.2; NHS Service Spec. 3.2.14.4	*			Parents are updated daily by the nurse caring for their baby and are invited and encouraged to attend the daily ward rounds with the consultants, medical staff,ANNP and sister in charge so that care and progress can be discussed. All conversations between parents and the team are documented in nursing and medical notes for auditing.
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)	NICE 5a and 5b; DH Toolkit 3.4 and 3.9; QF ref: 3.1.2; NHS Service Spec. 3.2.14.4	*			parents are informed prior to treatments and procedures and documented in medical notes. Following any emergency treatment/procedure parents are informed as soon as possible. All consultations documented and audited.
5.4C	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	*			we have a team of link workers/translators available in the hospital and we can arrange appointments in advance when necessary.
5.4D	Health professionals understand the potential difficulties parents may face in taking in complex information and there are unit strategies to overcome this		*			Staff are aware of such difficulties and parents may require information repeating or given either written, printed or verbal. They may also require another family member to be present, but we don't have any specific strategies that we follow. Many nursing staff and all medical staff have attended the advanced
Standard 5.5 Use of data						
5.5A	Staff understand data protection principles and inform parents how data about their baby is used		*			All satff attend manadtory training sessions and complete competencies annually.
5.5B	Parents are fully informed about clinical trials and the consent process and value of research		*			Trials are not instigated here specifically but babies may transfer from other hospitals on a trial which we would continue to support whilst liaising with the trial team.
5.5C	Staff are taught how to transmit information to third parties securely and confidentially		*			This forms part of trust mandatory training on data protection.
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	NICE 5b; DH Toolkit 3.5; BAPM 6.1; QF ref: 3.1.2; NHS Service	*			Both parents are encouraged to handle and participate in their babys care if they are well enough to do so. The nursing staff support this fully and documentaion is completed in the parent passport, which gives parents the opportunity to identify learning needs before discharge.
5.6B	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	*			Care by parents increases towards discharge, and parents are encouraged to room in the flats where possible especially for first time parents, mums wishing to breast feed or if the baby has been on the

PRINCIPLE 6

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
Standard 6.1 Promote and support breast milk expression						
6.1A	Your unit has a breastfeeding policy adhered to by staff		*			**we have maternity and network policies which staff are able to refer to.**
6.1B	Following the birth of any preterm or sick baby, 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.		*			**we do take this factors into consideration and liaise with breast buddies support team to provide help and support.**
6.1C	Mothers receive practical support to enable them to establish lactation in the first six hours after birth		*			Midwives on delivery suite and postnatal wards often have the initial contact and skin to skin is encouraged as soson as possible after birth if condition allows. Staff on the unit liaise with the wards to encourage early lactation if mums condition prevents her from visisting the unit and breast buddies support team is contacted.
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 double pumping and skin-to-skin		*			Skin to skin encouraged as soon as possible, we also recommend double pumping , taking babies bedding/ clothing home prior to expressing, expressing by the cotside or following skin to skin contact. We also give each mum and baby bonding hearts on admission.
6.1E	Parents are given clear and consistent information on the benefits of breastfeeding and the importance of frequent expression is explained		*			yes information is given both verbally and via leaflets.
6.1G	The unit has a dedicated professional to support mothers in establishing lactation and increasing milk production in the following days		*			The hospital has a dedicated breast feeding taem - breast buddies to support mums and the nursing staff are also supportive to mums.

6.1H	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	*			All staff receive annual updates and training and are required to complete E-learning module, training is also given to new starters to the trust.
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		*		we no longer have our own stock of breast pumps and equipment, we now access this through the breast buddies, we do provide storage bottles, syringes and lables and sterilizing unit on ward and pump if required for mums whilst visiting.
6.1J	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	*			yes and this adheres to the breast feeding policy
6.1K	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	*			yes we encourage expression at the cot side where possible and if mums feel comfortable with a screen. We also have a dedicated room for feeding or expessing if mums prefer privacy.
6.1L	Your unit has a policy for and consistent practice guidelines on the fortification of breast milk		*			yes we do follow a policy with reguards to fortifying breast milk.
Standard 6.2 Breastfeeding						
6.2A	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		*			Parents are given support from nursing staff and breast buddies
6.2B	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;	*			We have the breast feeding/expressing room, also the 2 flats are especially useful for mums wishing to room in and establish breast feeding.
6.2C	Mothers are consistently supported to establish breastfeeding on the unit, before going home		*			Whenever possible mums are encouraged to room in to establish breastfeeding in the unit flats prior to discharge.
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/expression once at home	NHS Service Spec. 2.1.11	*			Breast feeding buddies available for support and are notified on discharge to give support at home, also community nurse can provide advise whilst visiting baby.

6.2E	Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding and encourage a supportive culture		*			the consultants and medical staff will request expressed breast milk especially for the most vulnerable or at risk babies, if mum unable to provide the milk they will discuss the benefit of donor milk if parents are happy.
Standard 6.3 Alternative to maternal breast milk						
6.3A	Parents are informed on how to donate any surplus milk, if the meet donor criteria		*			we do not do this at our hospital, but Birmingham womens has a milk bank and we would refer any mums wishinh to donate breast milk to them.
6.3B	Both mothers and father are supported and are shown how to make feeds and sterilise bottle and teats	BAPM 6.1; RCOG 15.6	*			we go through this with parents as part of parent craft in preparation for discahrge and passports.
6.3C	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			*		We do not collect donor breast milk, any mothers wishing to donate will be given relevant information. Any milk we purchase from the milk bank is stored and documented with reguards to the policy.
6.3D	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).		*			We have access to donor breast milk from birmingham womens Hospital.
6.3E	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	*			yes we use a policy regarding the use of pretem formula and follow on milks that we adhere to.

PRINCIPLE 7

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or requirements
Standard 7.1 Coordinated discharge planning						
7.1A	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	*			Yes we have a discharge policy and tick list that is adhered too and all staff are fully aware of, we also use the parent passports inconjuction with this to help facillitate a smooth discharge.we also have a discharge planning team.
7.1B	Your unit demonstrates a multidisciplinary approach in 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	*			Yes we liase and work closely with social services, health visitors and GP'S aswell as informing them when baby is discharged. We also arrange multidisciplinary meetings when planning discharge for babies with complex needs and this will include dieticians, physios, childrens community team and possibly Acorns. We also have a discharge planning team on the unit that is headed up by the community
7.1C	Discharge plans are established from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team	NICE 7a and 7b; DH Toolkit 3.15; BAPM 6.4; NHS Service Spec. 23.2.17 and 3.2.19	*			We have the parent passports that are started on admission and follow the baby throughout their stay on the unit. Parent craft is ongoing during stay on the unit and planning meetings for complex need babys are arranged before discharge.
7.1D	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	*			There is the discharge planning team that is made up of both senior and junior staff and over sen by the Community Sister, who also participates in ward rounds or is updated by the team leader on inimment discharges.
7.1E	Parents have access to a health professional who can provide emotional/psychological support during and post discharge	QF ref: 3.1.3		*		Parents are supported by staff as allocated per shift and continuity of care is achieved if possible, also we have the community neonatal Nurses x1 fulltime and x1 who works 1 day a week. We also seek support for parents from community childrens team and the multi faith chaplaincy team.
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	NICE 1e, 1f and 7b; DH Toolkit 3.15; QF ref: 3.1.4; NHS Service Spec.		*		At present we only have X 2 parent flats both doubles that have been newly refurbished and can also be used as sitting areas if not in use. These are used for rooming in for preparation for discharge and are especially useful to establish breast feeding.

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	NICE 1e, 1f and 7b; DH Toolkit 3.15; QF ref: 3.1.2; NHS Service Spec.	*			Preparation for discahrge is ongoing throughout the stay on the unit. Use of the parent passport and the discharge tick list an d policy helps facilitate this and parents are kept upto date throughout their saty.
7.3B	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	*			All families are taught basic life support and watch a video before discharge , they are aslo offered the opportunity to have a practise on the resus doll if the want to and this is documented in the resus book and in the discharge tick list.
7.3C	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		*		We have 1 WTE community neonatal sister and a band 6 who works 1 day a week, due to this we are unable to visist babies who live out of the local area, but will refer them to local teams and we also refer to the childrens community team if babies have complex needs. This is something that we constantly want to expand as we feel its a very benificial service to parents being discharged home.
7.3D	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	*			Yes the community team will introduce theirselves and discuss the prospect of going home to parents very early on in the families stay, so they are able to build up a repore.
7.3E	Community health teams are given up-todate information about baby and any home care arrangements from care plan, as well as the opportunity to meet neonatal staff and parents	DH Health visitor implementation Plan 2011-15 NHS Service Spec.	*			We contact GP, health visitors and community midwives either on day of discharge or prior if baby requires folow up care. We aslo make referrals to other health professionals eg., Dietician, Physiotherapist and set up discharge planning meetings if required.
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 to hospital.		*			We go through all appointments, medication, contact numbers prior to discharge, this is also documented in their red books and also forms part of the community nurses initial visit.