Name of Unit	New Cross Hospital
Unit Level	3
Trust	Royal Wolverhampton Hospitals NHS Trust
Network	SSBC Neonatal ODN
Audit Lead	Erica Smith
Job Title	
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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	X			Named card with christian name on.
1.1B	All parents have unrestricted access to their baby, unless individual restrictions can be	NICU 5b: DH Toolkit 3.3: BAPM 6.1	x			screens for privacy during procedures.
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	x			Breast feeding room and screens. Promote expressing at the bedside.
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.		x			parents leave for ward round. Screens ion place and asked not to look at other babies. Charts kept in drawers.
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	x			screens available. Can go to the breast feeding room if baby's condition is stable. Side rooms used for reorientation of care.
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	x			Starlight room used.
1.1G	Parents are involved in the choice of clothing for their baby as their clinical condition permits.		x			Can bring own clothes from home. Label on cot/incubator.
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	x			
1.2Aii	Unit uses a range of techniques to minimise pain and distress for baby during and after interventions.		x			Sucrose. Breast milk. Current pain assessment tool being updated.
1.2B	Staff are expected to observe and respond appropriately to the baby's behavioural cues in line with established models of			x		More education on cues for staff and parents.
1.2B	Information about 'touch' and their baby is shared in active partnership with parents			x		More education needed for stress
1.2C	Timing, pacing and clustering of care takes into account the individual baby's stress thresholds and tolerance for handling		x			Care is clustered with activities. Cares spaced according to condition.
1.2D	The baby's responses to care giving, positive or negative, are documented in their records.		x			not specific to each care episode. General overview of handling on care plan.
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		x		room for improvement, but encourage to tube feed and partake in cares. More kangaroo care needed.
1.3C	Responses to contact between parent and baby are documented in clinical notes/care pathway documentation.		x			Badger and care plan.
Standard 1.4 - Positioning						
1.4A	Your unit implements evidence based guidelines for positioning that are readily available.	NPS F2	x			regular position change. More developmental care aids needed.
1.4B	The baby's position is changed according to individual needs and cues as appropriate		x			
1.4C	Staff inform parents about placing babies in the most comfortable positions to regulate babies' comfort and stability	QF ref: 3.1.2	x			Training for new staff.

1.4D	The baby's responses to position changes are recorded		x			documented on care plan if not tolerated, and why.
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	x			
1.5B	The unit uses a range of mechanisms to minimise stress from bright or continuous light		x			incubator covers, night lights and blinds. Cot hoods.
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		x			posters about noise. Quiet time, noise detector.
1.6B	Your unit uses a range of mechanisms to minimise a baby's stress from loud and continuous noise		x			
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		x			Cares spaced, quiet time, doctors advised regarding appropriate time for procedure.
Standard 1.7 Taste and Smell						
1.7A	Your unit has evidencebased guidelines for optimising the olfactory environment for infants.		x			
1.7B	Your unit uses a range of strategies to optimise the olfactory environment for infants.		x			Cleaning products for incubator. Blankets for mom and baby.

PRINCIPLE 2

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or

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	x			in admission box.
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	x			updated on arrival.updated on ward rounds, handovers and throughout shift by nurses and doctors.
2.1C	Clear guidelines on consent are followed and parents are sufficiently informed and understand when consent is needed.	QF ref: 3.1.1	x			trust guidelines, procedure and consent forms. Leaflets given.
2.1D	For routinely anticipated care,	QF ref: 3.1.1	x			
2.1E	For immediate interventions, an explanation is given as soon as possible and any discussion is documented.	QF ref: 3.1.1	x			information leaflets
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	x			Communication section on Badger.
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	x			

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	x			24/7 cover by registrar, junior doctors and nurses. Information book states time of ward round.
2.1I	Parents are provided with information about how to access their baby's records	BAPM 6.1	x			Access to care plans and blood chart forms. Informed if asked how to access medical records.
Standard 2.2 Care plans						
2.2A	Staff follow pathways and use the prompts within the pathway to direct or anticipate		x			
2.2B	Care plans are reviewed regularly and kept up to date.		x			
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	x			Community nurses liase prior to discharge. Complex care cases has specialist link nurses involved.
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	x			Unit information blooklet and BLISS handbook/leaflets given.
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	x			

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 implementation Plan 2011-15; NHS Service Spec. 3.2.17.2	x			Digital information. informed on discharge.
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		x		Not enough support at present. Query
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		x		Could be introduced to parents earlier
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	x			Available in leaflets.
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	x			Starlight room.

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		x		study stays available but need utilising
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.		x			
2.4D	Families are offered psychological/emotional support after receiving sensitive news	BAPM 6.1; NHS Service Spec. 3.2.14	x			By the ward staff.
2.4E	Staff help families to access bereavement counselling if their baby has died on the unit.	QF ref: 3.1.3	x			
2.4F	Parents have access to or are offered faith/spiritual support within the hospital.	QF ref: 3.1.3	x			
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	x			
2.5B	End of life/palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.	QF ref: 3.1.2	x			
2.5C	Palliative care should be coordinated by a named lead professional and involve a multiagency, multidisciplinary team.	QF ref: 3.4.1	x			

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	x			
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	x			
2.5F	Staff are experienced in supportive end of life care and have received appropriate training.		x			Study days available. Experience in pra
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	x			
2.5H	Bereavement support coordinated by a named professional is made available if needed	QF ref: 3.4.1	x			Family support liason and staff support
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.		x			When circumstances allow, depending

PRINCIPLE 3

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or
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		x		Not always meeting BAPM standards.
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	x			Relevent staff have NLS.
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		x		Not regularly assessed. Breast feeding baby friendly assessment done.
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	x			
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	x			Annual updates
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	x			
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	x			when reffered
3.2C	Care plans reflect a multidisciplinary approach to neonatal care, both within primary care and community teams.	QF ref: 3.1.2	x			
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	x			
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; BAPM 6.1;			x	Need to arrange times for baby's parents to look around if they want to.
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	x			Transport team. App available.
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	x			
3.3E	Parents who have had a long-distance transfer are offered support, including an agreed financial support package	QF ref: 3.1.3			x	No financial support package available.
Standard 3.4 Consistency across the neonatal network						

3.4A and 3.4B	Your unit has the same visiting policy as other units of equal clinical level within your network	x				
3.4C	Your unit follows network-wide guidelines on procedures on breastfeeding, day-to-day cares, developmental care etc.	x				

PRINCIPL E 4

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or
Standard 4.1 Monitoring and benchmarking						
4.1A	Benchmarking activity is routinely included in your units' quality improvement programme	QF ref: 3.4.5	x			
4.1B	Feedback from parents is regularly sought, collated and fed into decision-making processes	NHS Service Spec. 3.2.15	x			
4.1C	Your unit works together with other units within your network on agreed benchmarking/audit programmes	QF ref: 3.4.5		x		Network guidelines
4.1D	Your unit participates in the national neonatal audit programme	QF ref: 3.4.5	x			
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	x			
4.2B	Parents are included in the planning and development of services improvements throughout the network	NHS Service Spec. 3.2.15		x		

4..2C	Benchmarking and audit inform future service improvement activities and action plans		x			
4.2D	Improvements are introduced to the unit in response to feedback	NHS Service Spec. 3.2.15	x			

PRINCIPLE 5

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or
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	**x**			
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	**x**			
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	**x**			Pictures for parents who can't visit.
5.1D	Parents are given a named contact for practical queries and advice	NHS Service Spec. 3.2.14.3	**x**			Ward manager gos around daily speaking to parents.

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	**x**			
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	**x**			
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		**x**		Not provided in different languages or formats.
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		**x**		As above

5.1l	The unit has staff photo boards at the entrance to the unit which are kept up to date				x	No photo board.
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	x			security doors and baby tagging system in SCBU.
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	x			5 flats available in total. Priority given to sick babies or parents from out of area.
5.2C	Easily accessible facilities are made available for parents to store their personal belongings safely and securely	QF ref: 3.1.4			x	No lockers available.
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		x		Room small, under 10 seats available.
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	x			

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		x		Facilities are available, but very basic. Needs improvement.
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	x			
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	x			
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	x			
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	x			
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	x			Baby buddy app, best beginnings and coffee mornings at the GEM centre.
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	**x**			
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	**x**			
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	**x**			
5.4D	Health professionals understand the potential difficulties parents may face in taking in complex information and there are unit strategies to overcome this		**x**			
Standard 5.5 Use of data						
5.5A	Staff understand data protection principles and inform parents how data about their baby is used		**x**			Admission pack
5.5B	Parents are fully informed about clinical trials and the consent process and value of research		**x**			Research nurses visit unit.
5.5C	Staff are taught how to transmit information to third parties securely and confidentially		**x**			
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 Spec. 3.2.14.5	**x**			Tube feeds and all cares.
5.6B	The level of involvement of the parents in the baby's daily care is facilitated and	NICE 5b; DH Toolkit 3.5; QF ref: 3.1.2	**x**			Parent passport and tube feeding compentency.

PRINCIPLE 6

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or
Standard 6.1 Promote and support breast milk expression						
6.1A	Your unit has a breastfeeding policy adhered to by staff		x			**Breast feeding nurse**
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.		x			
6.1C	Mothers receive practical support to enable them to establish lactation in the first six hours after birth			x		Barriers from midwifery side.
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		x			

6.1E	Parents are given clear and consistent information on the benefits of breastfeeding and the importance of frequent expression is explained		x			
6.1G	The unit has a dedicated professional to support mothers in establishing lactation and increasing milk production in the following days		x			
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	x			
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	x			Mechanical pumps, hand pumps for out of area.
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	x			Cool bags/ice packs
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	x			
6.1L	Your unit has a policy for and consistent practice guidelines on the fortification of breast milk		x			

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		x			
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; NHS Service Spec. 3.2.14.6	x			If at cot side screens are available.
6.2C	Mothers are consistently supported to establish breastfeeding on the unit, before going home		x			
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	x			Flats available for establishing feeds. Transitional care also available.
6.2E	Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding and encourage a supportive culture		x			
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		**x**			

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	x			
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		x			
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).		x			
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	x			

PRINCIPLE 7

Ref	Summary of criteria	Ref	G	A	R	Outline of current practice and/or
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	x			
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	x			

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	**x**			
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	**x**			
7.1E	Parents have access to a health professional who can provide emotional/psychological support during and post discharge	QF ref: 3.1.3	**x**			Community support 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. 1.2	**x**			Flats and transitional care ward
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. 3.2.17	**x**			stork programme
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	**x**			As above

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	**x**			
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		**x**		Dependent upon if parents are on unit when community team visit.
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. 3.2.20 mentation Plan	**x**			Dependent if they are available when parents visit.
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.		**x**			