Nottingham Neonatal Service – Clinical Guidelines Guideline F11

**TITLE – THE HOME VISITING PROGRAMME OF NEONATAL CONTINUING CARE**
Version: 3 (Version 1: October 2001)
Ratification: July 2016
Review Date: July 2021
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Distribution: Nottingham Neonatal Service, Neonatal Intensive Care Units, Postnatal Wards of the Nottingham University Hospital NHS Trust
Target audience: Staff of the Nottingham Neonatal Service and Midwives in Transitional care area of post-natal wards
Patients to whom this applies: Patients of the Nottingham Neonatal Service and Transitional care areas of post-natal wards, who fit the inclusion criteria of the guideline below
Key Words: Home visiting, family care team
Risk Managed: Sub-optimal or inappropriate provision of the home visiting programme of family care
Evidence used: The contemporary evidence base has been used to develop this guideline. References to studies utilised in the preparation of this guideline are given at its end.

Clinical guidelines are guidelines only. The interpretation and application of clinical guidelines remain the responsibility of the individual clinician. If in doubt, contact a senior colleague. Caution is advised when using guidelines after the review date. This guideline has been registered with the Nottingham University Hospitals NHS Trust.

**Introduction**
In the POPPY Project (Parents of Premature babies Project) Aug 2009, which looked at the provision of Family Centred Care in Neonatal units, one of the Indicators that parents wanted to provide family centred care at its optimum was the provision of outreach support by trained neonatal staff. This was highlighted as support at times of transition, including going home.

The home visiting programme for Continuing Care is conducted by the Continuing Care Team to provide continuing support for babies after hospital transfer of care to the family at home in the critical period that immediately follows discharge.

The Continuing Care Team consists of both registered nurses and support workers.

The continuing care registered nurse will follow up all babies who were born less than 27+6 weeks gestation who may or may not have complex needs on discharge i.e. oxygen dependant babies.

The continuing care support worker will follow up all babies who were born over 28 week’s gestation.

These criteria are discretionary following consultation with the Continuing Care Team.

**Security/Risk Assessment**
All Continuing Care Team members must carry a hospital issued mobile phone to be used during their working day and a hospital issued GPS security ID card with alarm to facilitate their safety and adhere to the lone worker NUH Trust policy is advised. (See appendix 1 of Aggression, Violence and Harassment Policy reference HS/SP/012 located on the NUH intranet)
The daily log of community visits must be completed by all continuing care team members and placed for access in the continuing care office in the relevant neonatal unit.

**Patient Group**
The home visiting programme for continuing care will be offered to appropriate babies of all mothers who reside within the Nottingham and Nottinghamshire area, or who are primarily booked at CHN or QMC. For babies residing outside the area, the home visiting programme of the Continuing Care Team will be negotiated with the local Continuing Care Team or equivalent Paediatric community service.

The criteria for receiving the home visiting programme of continuing care incorporates those risk factors associated with a high incidence of infant mortality, morbidity and child abuse or neglect.

**The criteria includes:**
(a) Prematurity <34 weeks
(b) Birth weight < 2000 grams
(c) Babies admitted to the Neonatal Unit who are assessed by the low dependency care team as high risk.
(d) Babies who are symptomatic of withdrawal for maternal alcohol or drug misuse and the baby required admission to NNU.
(e) Babies that are establishing adequate nutrition including the establishment of Breastfeeding.
(f) Babies with poor growth patterns.
(g) Babies assessed to have medical problems by the Consultant.
(h) Babies requiring short term nasogastric feeding.

There will be certain babies who will be discharged home with needs that require other specialist teams to support them at home and this care is referred to as “shared care”. Teams who will share care are:
- Community paediatric team based at QMC
- Dietetic team
- Stoma care nurses
- Cleft palate team
- Children’s development centre community team
- Social Care teams – The Continuing Care Team will become involved with babies with social care issues where the above criteria are met, however in the absence of the above criteria, the presence of social care issues alone, does not qualify an automatic referral to the Continuing Care team.

The criteria of babies who will receive shared care are as follows:
(a) Long term nasogastric tube feeding in the community.
(b) Oxygen dependent babies. These babies should have been referred before discharge to the Children's community team at 36 weeks corrected age.
(c) Babies who have a life threatening or life limiting (Palliative) condition.

**Babies who fit these criteria on admission to the NICU should be offered the home visiting programme of continuing care even if they subsequently receive transitional care on the postnatal ward.**
Management
1. The Neonatal Service will ensure that all babies (who fulfil the stated criteria) receive access to the home visiting programme of the Continuing Care Team after discharge. A member of the continuing care team will meet with the family whose baby they will be overseeing at home within 2-3 weeks of admission of baby to the neonatal unit and the family will be given information on continuing care after discharge.

1.1. The Continuing Care Team will participate in the discussion around discharge planning with the parents, the medical team and low dependency team. Formal discharge planning meetings will be arranged for babies with extra needs e.g. Babies requiring oxygen at home. The outcome will be documented in the home for care plan.

1.2. The low dependency team will notify the Continuing Care Team of impending discharge usually at least 48 hours prior to discharge by telephone or direct contact. The home care plan is given to the continuing care team prior to discharge.

1.3. The Continuing Care Team member will refer babies who do not fit the criteria to the appropriate local agency.

1.4. The risk assessment tool must be initiated and completed prior to discharge by nursing staff that work with the family on a daily basis. This will allow the Continuing care team member to ascertain their personal safety when visiting families at home and the necessary precautions put in place if required. (see Appendix 2 : Lone worker assessment tool)

1.5. The Continuing Care Team member will negotiate the first contact at home with the parent before the baby is discharged from the Neonatal Unit. This contact may be by telephone or a home visit and will usually be undertaken within 24-72 hours. Oxygen dependant babies will be visited within 2 to 4 hours of discharge.

1.6. If the Continuing Care Team member is unable to schedule the visit, the Continuing Care Team member will arrange for another team member to visit.

1.7. If the parents of the baby are not at home when the Continuing Care Team member arrives for the planned visit, the Continuing Care Team member will leave a written notice of appointment or leave a telephone message. The Continuing Care Team member will continue to attempt to see the baby based on any additional information that the hospital or primary health care team can provide for two further visits.

1.8. The Continuing Care Team member will document all ‘no access’ visits. Where the Continuing Care Team member is unable to gain access, the family Care Coordinator, the baby’s Neonatal Consultant and the primary health care team will be notified.

1.9. After three ‘no access’ visits, the Continuing Care Team member should refer the family to the relevant agency and should write to the family to inform them that the service is withdrawn.

The home visiting programme for continuing care
The first contact after discharge will be agreed before discharge from the Neonatal Unit and will usually be completed within 24-72 hours. This contact may be by telephone or a home visit.

At this and every subsequent visit the Continuing Care Team member will:

a) Assess parent-baby attachment and interaction
b) Identify potential or existing health need.
c) Review the parent’s care of the baby
d) Review the baby’s growth and development.
e) Reinforce the need for immunisations and follow-up visits
f) Inform the family of community support and assist them in referrals
g) Determine the need for additional care e.g. community children’s team, social services or others.
h) Support the parent with issues around preterm birth/grief-loss of expected baby.

The following paperwork should be completed:
• Plan of Care in Child Health Record copies of which are placed into medical notes of baby

Two to six follow up visits is recommended and will be performed according to the Care Plan.
The number of visits can be adjusted according to the needs of the baby and family.
All babies must be visited weekly or more frequently if required. If this is not possible by the Continuing Care Team member then they must arrange for a colleague to visit in their absence.
Consultation with Neonatal Consultant and/or Family Care Coordinator may be necessary if programme of visiting baby in the home is extended due to problems arising with the baby.
The Continuing Care team member must complete a weekly continuing care report to be sent to Neonatal consultants and senior nursing team to update them on baby’s progress at home.

Discharge to Primary Health Care Team:
A joint visit at the home of the baby will be arranged with the health visitor and family to hand over care of the baby to primary care to facilitate discharge from the home visiting programme for neonatal continuing care when:
• The programme of neonatal continuing care is successfully completed and the family are confident in the care of their baby.
A baby will be also discharged from neonatal continuing care when:
• Readmitted to hospital. The baby has been admitted to the paediatric ward for two weeks or longer. The health visitor must be notified to ensure continuity of care.
• Transferred to the care of the Community Children’s Team for babies with long term needs. This is facilitated with a pre-arranged joint visit in the home of the baby between the neonatal continuing care team, health visitor, family of baby and community paediatric team
• Unable to find the family: After repeated attempts the family cannot be found and the necessary actions have been taken within primary care to ensure baby is followed up to ensure that appropriate care is facilitated.
• Moved out of the area.
• Refused visits: The family will not accept the service. Notification of this refusal must be documented and primary care (health visitor) will be notified to ensure continuity of care within the community setting.

The Neonatal Continuing Care Team member must complete all paperwork:

• Continuing care evaluation
• Home care plan details
• Input data re discharge from neonatal continuing care details on to the Badger database.

All documentation with regards to the home visiting programme for the baby must then be given to the relevant person for filing into baby’s medical notes.
Where the baby has medical records from both campuses of Nottingham University Hospitals NHS Trust, these will be filed in the medical notes from the hospital of discharge home.
Audit points:
Family Care Team Members' Annual Caseload Report.

Allied guidelines
Clinical Guideline: 'Discharge of infants from the Neonatal Unit' (Guideline No. 21.3)
‘Home in Oxygen Guidelines.’

Reference
Poppy Steering Group. Family-centred care in neonatal units. A summary of research results and recommendations from the POPPY project. London: NCT; 2009

APPENDIX
1. Trust Guideline: ‘Aggression, Violence and Harassment Policy’ (including lone working guidance) Reference HS/SP/012 (see NUH Intranet)

2. Nottingham Neonatal unit Lone workers assessment tool

3. NUH Trust Risk Assessment for neonatal service: home visiting.