

# The Bliss Baby Charter Standards



**Bliss**

for babies born too soon,  
too small, too sick

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BAPM: 'The British Association of Perinatal Medicine (BAPM) has had the opportunity to review the new Bliss baby charter. BAPM wishes to fully support this charter and, in addition, to congratulate Bliss on setting a high standard of care for babies and families'

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## Foreword

When Bliss launched the Baby Charter in 2005, it was the first time that the rights of a preterm or sick baby had been clearly set down. Seven simple statements encapsulated the care, respect and support that the most vulnerable babies should receive.

It was always our intention to publish a fuller set of standards that set out how the Baby Charter's principles could be made a reality on neonatal units. These standards are published now, when there is unprecedented attention on neonatal care services in every country in the UK.

Much focus has been put on improving the clinical care that babies receive, especially increasing the appropriate number of specialist staff to be able to provide high quality care. The Baby Charter standards complement this by highlighting the importance, to both the baby and their whole family, of many other facets of care. Each of these plays an essential part in a vulnerable baby's journey.

Clinical and family-centred care must work hand in hand to provide these babies with the very best opportunity to survive and thrive.



Andy Cole

Chief Executive

## Executive summary

Bliss believes that every baby should be treated as an individual and with dignity, respecting their social, developmental and emotional needs, and that babies should receive the nationally recommended level of specialist care in the nearest specialist unit to their family home.

We trust this charter will give staff delivering neonatal care the support and direction they need to encourage parents to be actively involved as partners in their baby's care, with neonatal care decisions based on the baby's best interest and made together by clinicians and parents.

This Charter aims to ensure mothers receive practical support to express breast milk and achieve successful lactation from health professionals with appropriate knowledge, and that discharge planning is facilitated and coordinated from admission, to ensure both the baby and the family have the appropriate care and resources they need.

The Charter also aims to help parents become more involved in the planning and development of services to ensure improvements for the future, and that parents are also able to feedback their experiences to the units and networks through national and local surveys.

We want to make sure that through these seven principles parents are informed, guided and supported, so they can feel confident in caring for their baby and to ensure both the baby and the family have a smooth journey, from admission to discharge and beyond. We believe this Charter is a very valuable tool for making family-centred care a reality on neonatal units across the country.

## **Charter principle 1**

**Every baby should be treated as an individual and with dignity, respecting their social, developmental and emotional needs, as well as their clinical needs. This includes respecting the baby and family's right to privacy, time to make attachments and referring to the baby by name.**

**Rationale:** Respecting the baby's individual rights – including private time for the baby and the family, and the provision of cares to minimise the stress of the NICU environment – can enhance a preterm baby's long-term developmental outcomes, and also support attachment between the baby and the family.

### **Standard 1.1 Dignity and privacy**

**Neonatal units respect the baby and parents' right to dignity and privacy.**

#### **Criteria for achieving standard**

- The baby is referred to by their given name.
- All parents have unrestricted access to their baby, unless individual restrictions can be justified in the baby's best interest.
- Parents are offered privacy appropriate to the baby's condition, particularly during feeding, skin-to-skin care and during clinical procedures.
- Visitors are expected to respect other babies' and families' privacy on the unit:
  - by not approaching other cots unless the babies' family are present
  - by not accessing other babies' medical information.
- 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.
- The unit makes provision for private consultation with health professionals in an appropriate environment.
- Parents are involved in the choice of appropriate clothing for their baby as and when the baby's clinical condition permits.

### **Standard 1.2 Comfort**

**Clinical interventions and care-giving respect the baby's needs, and are timed and paced to minimise stress, avoid pain and conserve energy.**

#### **Criteria for achieving standard**

- The unit follows a guideline for promoting comfort, based on evidence and best practice, and puts strategies in place to minimise pain and distress during and after interventions, including:
  - touching the baby or practising comfort holding
  - talking to the baby very quietly.
- Staff are trained to observe and interpret each baby's cues and respond appropriately. Information is shared in active partnership with parents.
- Timing, pacing and clustering of care/interventions takes into account the individual babies' stress thresholds and tolerance for handling.
- The baby's responses to interventions are documented.

### **Standard 1.3 Touch**

**Parents are supported and feel confident in providing gentle comforting touch that is responsive to their baby's needs and behavioural cues.**

#### **Criteria for achieving standard**

- The unit follows a guideline for social interaction and touch, based on evidence and best practice. This is practised by staff and promoted and shared with parents, and includes:
  - comfort holding (containment holding)
  - regular skin-to-skin care
  - non-nutritive sucking.
- Whenever possible, comforting touch should be baby-led and individualised by interpreting the baby's cues.
- Responses to touch/social interaction should be documented in clinical notes/care pathway documentation.
- The unit recommends and uses soft natural fibres next to the baby's skin.

### **Standard 1.4 Positioning**

**Early correct positioning is promoted and encouraged to ensure body alignment and influence posture and movement.**

#### **Criteria for achieving standard**

- The unit has a guideline on positioning, based on evidence and best practice, that is regularly referred and adhered to by staff, which includes:
  - a position that helps the baby's self organisation
  - a position that helps promote good posture and development
  - the correct use of positioning aids.
- The baby's position is changed according to individual needs and cues, using positioning aids as appropriate.
- Staff inform parents about placing babies in the most appropriate and comfortable positions to regulate babies' comfort and stability.
- The baby's responses to position changes are recorded.

### **Standard 1.5 Light**

**Units protect babies from the effects of bright or continuous light.**

#### **Criteria for achieving standard**

- The unit has a guideline, adhered to by staff, to regulate environmental light.
- The unit puts in place strategies to minimise stress from bright or continuous light, for example:
  - creating day/night light patterns by switching off lights, using incubator covers and canopies, and using curtains or blinds appropriately
  - controlling lighting with dimmer switches
  - individual and adjustable lighting for each cot
  - shielding the baby's eyes and any neighbouring baby's eyes from any bright light during procedures, particularly phototherapy.

## **Standard 1.6 Sound**

**Units care for babies in a comfortable auditory environment that protects them from loud or continuous sounds (below 50 decibels).**

### **Criteria for achieving standard**

- The unit has a guideline, adhered to by staff, to consistently regulate and monitor the sound environment.
- The unit puts in place strategies to minimise stress from loud and continuous noise, such as:
  - opening/closing incubator ports, bins and doors with care and if possible, padding them to muffle noise
  - using soft close bins
  - mopping nursery floors, not vacuuming
  - informing staff/parents not to tap or knock on incubator cots
  - keeping conversations at a low level and, where possible, outside of the babies' rooms
  - setting telephones and monitor alarms to the lowest audible level
  - staff responding to alarms and telephones promptly
  - encouraging staff/visitors to wear soft-soled shoes.
- All staff and parents respect the need for a quiet environment that avoids unnecessary distress and allows the baby to sleep.
- A quiet and restful environment may be further enhanced by scheduling specific periods for the baby and the parents, with no interruptions from clinical interventions.
- The unit has a mechanism and process for monitoring sound levels on the unit, for example sound monitoring devices.

## Charter principle 2

**Neonatal care decisions are based on the baby's best interest, with parents actively involved in their baby's care. Decisions on the baby's best interest are based on evidence and best practice, and are informed by parents who are encouraged and supported in the decision-making process and actively participate in providing comfort and emotional support to their baby.**

**Rationale:** Multidisciplinary neonatal care is responsive to the clinical and psychosocial needs of babies, and decisions are based on the baby's best interest. Treating parents as partners in their baby's care provides the balance between baby- and family-centred care.

### Standard 2.1 Decision making

**The baby's best interests are paramount in clinical decision making, and are based on a partnership between clinicians and parents, who are involved on an equal basis in the decision-making process.**

#### Criteria for achieving standard

- Parents should receive adequate and timely information, regarding the following (see also principle 5):
  - their baby's condition/diagnosis
  - treatment options available
  - likely outcomes/benefits of treatment
  - possible complications/risks
  - possible tests/interventions.
- Clear guidelines on consent are followed, and parents are sufficiently informed and understand when consent is needed.
- For routinely anticipated care (for example, routine blood tests and regular endo-tracheal suction) explanations are given in advance, and parents are referred to local leaflets or the *Bliss Parent Information Guide*.
- For those immediate interventions in the baby's best interests that need to proceed (for example, an emergency chest drain) when there is no prior opportunity to discuss with parents or gain consent, an explanation is given as soon as possible, and any face to face/telephone discussion is documented.
- A significant change in the baby's condition, requiring new intervention or care, is discussed with parents (for example, elective inguinal hernia repair or planned transfers) as soon as possible. Where necessary, signed consent is obtained and filed in the baby's notes.
- Decisions/changes in care where parents may express a preference should always involve them, for example moving the baby from incubator to cot, or the clothes the baby wears.
- Parents have regular access to their baby's named consultant/senior medical staff and are invited to be present at ward rounds.
- Parents have open access to their baby's records.

## **Standard 2.2 Care plans**

**Up-to-date and documented care plans are used to direct care and are formulated in discussion with parents.**

### **Criteria for achieving standard**

- Staff follow pathways and use the prompts within the pathway to direct or anticipate care.
- Care plans are reviewed regularly and kept up to date.
- Parents of babies with complex needs are allocated an identified individual, who provides proactive and regular information on the care pathway.
- Parents are provided with information about who to contact with queries or advice and where to go for further information, including useful websites regarding their baby's condition and treatment (for example Bliss).
- Parents are provided with adequate information by trained clinical staff about their baby's developmental needs, long-term outcomes and quality of life.
- The primary care team is informed of a new admission as soon after birth as possible, and is given any relevant information from the care plan, particularly in preparation for discharge (see also principle 7).
- Care pathways are used throughout the baby's time in neonatal care, and cover admission, discharge, surgery, neonatal transfer, withholding care and end of life/palliative care.

## **Standard 2.3 Psychosocial support**

**Psychological and social aspects of care for the whole family (including siblings) are recognised and included throughout the baby's care pathway, and especially at critical times, for example when receiving sensitive news and at end of life (see standards 2.4 and 2.5).**

### **Criteria for achieving standard**

- Families, including siblings, are offered social and/or psychological support while on the unit, and are monitored by community neonatal teams.
- Written information on local services and organisations, which may be of assistance when family are ready to make contact, are made available.
- Parents are advised about lay support networks or websites and provided with relevant literature to help them understand and to support them.

## **Standard 2.4 Sensitive news**

**Sensitive or difficult news relating to the baby should be given to parents by appropriately trained staff and in a private environment where support is immediately available.**

### **Criteria for achieving standard**

- Neonatal units provide comfortably furnished private rooms for parents to have confidential, sensitive or difficult discussions.
- Professionals caring for babies have received specific training on how to communicate difficult news.
- When staff break sensitive and difficult news to parents, they should try to have at least two members of the family present, so that they can support each other.
- Parents have access to psychological/emotional support.
- If needed, help to access bereavement counselling is made available for families whose babies die in the unit, including siblings.
- Parents have access to faith/spiritual support within the hospital.

## **Standard 2.5 Palliative/end of life care**

**Supportive and sensitive end of life care is provided by a multidisciplinary team in partnership with parents.**

### **Criteria for achieving standard**

- Units have clear criteria for assessing those babies for whom palliative care will be provided, taking into account diagnosis and prognosis.
- End of life/palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.
- Palliative care should be coordinated by a named lead professional, but involve a multi-agency, multidisciplinary team.
- The documented care plan is based on a multidisciplinary assessment and ongoing discussion with parents, including personal, faith or spiritual wishes, and place of death.
- Units have links with children's hospices to support parents and their choices on their baby's place of death.
- Staff are experienced in supportive end of life care and receive appropriate training.
- Bereavement support coordinated by a named professional is made available if needed.
- Staff support the rapid discharge of a dying baby to home if the parents wish it. Neonatal staff will involve the GP in this process and will provide a discreet level of support to the family over this period of time.

## **Charter principle 3**

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

**Rationale:** Within each unit, trained health professionals with sufficient specialist skills and competencies are available to work with babies. This will provide parents with the confidence that their baby is in expert hands. Units also need to have transparent arrangements for transfers to the most appropriate unit, as determined by the baby's condition. Babies and families should have access to the neonatal services their baby needs as close to home as possible.

### **Standard 3.1 Trained specialist staff**

**Babies receive care appropriate to their clinical need, in a neonatal unit that is appropriately staffed to deliver the required level of care, in line with national targets and recommendations.**

#### **Criteria for achieving standard**

- Adequate numbers of staff are specifically trained to meet nationally agreed minimum clinical standards in maternity and all levels of neonatal care.
- The unit employs competent staff able to stabilise the baby, assess them and initiate an action plan.
- The unit has an identified competency framework that staff is regularly assessed against, and staff training includes components to develop knowledge and skills in baby- and family-centred care, including:
  - developmental care
  - breastfeeding
  - discharge planning.
- Staff are trained in safeguarding procedures for babies in their care, and are aware of indications that will prompt the necessary interventions.

### **Standard 3.2 Multidisciplinary team**

**Staff adopts a multidisciplinary approach to care that draws on generalist and specialist neonatal health professionals to best meet the baby's and family's clinical, psychosocial and developmental needs.**

#### **Criteria for achieving standard**

- Timely access to allied health professionals (dietitians, SLTs, physios, OTs, psychological therapies) with specific neonatal or paediatric training.
- Timely access to social workers for assessment and provision of support services.
- Care plans reflect a multidisciplinary approach to neonatal care, both within primary care and community teams.

### **Standard 3.3 Near to home**

**Where possible, both mother and baby are cared for in the same hospital and neonatal unit as close to the family's home as the baby's condition allows.**

#### **Criteria for achieving standard**

- Units follow consistent transfer guidelines for admission to appropriate specialist services, or return to an appropriate local service.
- Where possible, parents are encouraged and have the opportunity to visit the new unit in advance of the transfer (see also Standard 5.1).
- If transferred, parents are given information on the new unit, a contact name and number in advance.
- Parents are given an explanation and are involved in discussions on transfers, with the choice to accompany their baby (where there is space in the ambulance and with agreement of the local ambulance service).
- Parents who have had a long-distance transfer are offered support, including an agreed financial support package.
- In the case of multiple births, both/all babies and their mother are kept in the same hospital, as far as the babies' condition allows.

### **Standard 3.4 Consistency across the neonatal network**

**When babies are transferred within the network or beyond, families are entitled to a consistent level of care from each of the hospitals they stay at.**

#### **Criteria for achieving standard**

- The unit follows network guidelines.
- Each unit of equal clinical level within the same network has the same visiting policy.
- The unit follows network-wide guidelines on procedures, including breastfeeding, day-to-day cares, developmental care, etc.

## **Charter principle 4**

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

**Rationale:** Monitoring outcomes of care enables local trends to be observed and compared to local, national and even international benchmarks. Developing a culture of continuous improvement, that involves and is informed by parents, maintains high quality care for babies and their families and encourages units to continually raise the bar in provision of family-centred care. A commitment to delivering national standards ensures local levels of excellence.

### **Standard 4.1 Monitoring and benchmarking**

**The unit is committed to and supports the monitoring of outcomes, and regularly benchmarks its performance against local, national and even international standards, particularly with reference to family-centred care.**

#### **Criteria for achieving standard**

- Benchmarking activity is routinely included in the units' quality improvement programme.
- Feedback from parents is regularly sought, collated and fed into decision-making processes.
- Units work together within their network to agree a benchmarking/audit programme, and contribute to the neonatal care minimum data set.
- Units are able to participate in the national neonatal audit programme and other longitudinal outcome assessments/studies.
- There is a local audit programme, with a lead clinician overseeing planning and coordination.
- There is a commitment towards progress and adopting agreed national standards.

### **Standard 4.2 Service improvement**

**There is an ongoing commitment to continuous improvement in family-centred care.**

#### **Criteria for achieving standard**

- There is a continuous process for involving parents in improving family-centred care processes on the unit.
- Parents are included in the planning and development of service improvements throughout the network.
- Benchmarking and audit inform future service improvement activities and action plans.
- Improvements are introduced to the unit in response to feedback from both staff and parents.

## Charter principle 5

**Parents are informed, guided and supported, so they understand their baby's care processes and feel confident in caring for them. Information provided to parents should cover clinical conditions, tests and treatment, as well as practical issues such as breastfeeding, financial support, transferring between units and local facilities.**

**Rationale:** Taking time to inform parents and provide written information (in a range of formats and languages relevant to the local community) helps to alleviate the stress and anxiety experienced by parents on the neonatal unit. Informing parents on how they can help to care for their baby while on the unit and in preparation for discharge aids development of the parental relationship, helping the baby and their family to achieve the best quality of life. Attention is paid in particular to Black and Minority Ethnic groups and groups where English is not the first language. In addition, particular attention is paid to those groups that are at higher risk to having preterm babies, as well as young parents.

### Standard 5.1 Introduction to the unit

**All parents are adequately introduced to facilities, routines, staff and equipment on admission to the neonatal unit.**

#### Criteria for achieving standard

- A prior visit to the unit and an opportunity to meet staff should be offered to parents with a predicted need for neonatal care, or a transfer to another unit for ongoing care.
- All parents are fully inducted on entry to the neonatal unit, so they can orient themselves, are aware of the different equipment and noises or alarms within the unit, and understand the importance of hand hygiene.
- 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 to having one or more other babies in a different unit.
- Parents are given a named contact for practical queries and advice.
- Staff inform parents about relevant policy and procedures on the unit, for example regarding infection control, training for parents and how to support their baby.
- Unit staff introduce themselves to parents and explain their role in relation to their baby's care and the running of the unit.
- Parents are provided with a 'welcome pack' – ideally provided in languages and formats appropriate to the local community – giving practical information about the unit. For example, the *Bliss Parent Information Guide*. Parents should also receive information about local amenities, such as taxi services, restaurants, etc, particularly if they have not been admitted to their local unit.
- Written information should be available (in languages and formats appropriate to the local community) about their neonatal network if relevant. This information should cover:
  - transfer service and repatriation
  - services to which a baby is being transferred, including a named contact and telephone number.
- The unit has staff photo boards at the entrance, which are kept up to date.

## **Standard 5.2 Facilities**

**Safe and private facilities are available to parents, making visiting and staying with their babies as comfortable as possible.**

### **Criteria for achieving standard**

- Babies are safe and secure while on the unit, and parents are informed of the security arrangements.
- Parents of babies in intensive care are able to access accommodation with bathroom facilities, as close as possible to their baby (within 'dressing-gown' distance) and without cost. One bed per intensive care cot should be available.
- Easily accessible facilities are made available for parents to store their personal belongings safely and securely, with more informal storage at cot side.
- All family-centred facilities are clean and comfortable for parents and siblings, free of charge and of an appropriate size to the scale of the unit.
- Families have easy access to a parent/family sitting room, and a small kitchen to make hot drinks and snacks.
- Child-friendly areas for siblings are available, and are easy to access and safe.
- Families are informed on the whereabouts and opening hours of the hospital canteen or any other facilities for having their meals within the hospital.
- Parents have access to a dedicated separate room for counselling and/or to have private conversations with staff.

## **Standard 5.3 Support networks**

**Parents are made aware of national and local support networks and sources of information on the care of their babies.**

### **Criteria for achieving standard**

- Parents are given information on how to contact national and local support groups – for example, through Bliss.
- Parents are informed on where to get further information, including advice on financial support and useful websites.
- Parents are made aware of local parent representatives for peer support, and contact is facilitated as appropriate.

## **Standard 5.4 Consistent information**

**Consistent and clear information – covering clinical conditions, tests, treatment, risks and outcomes, and practical support – is provided to parents.**

### **Criteria for achieving standard**

- Parents are fully involved in discussing their baby's care and receive consistent information from staff caring for their baby.
- Verbal and written information is provided at suitable times to help parents' understanding (provided in languages and formats appropriate to the local community). This covers:

- clinical conditions
  - procedures, risks and complications
  - diagnostic tests and investigations
  - care pathways (including discharge, palliative care and end of life care)
  - consent
  - breastfeeding
  - help with transport
  - financial support/maternity leave
  - unit transfers.
- The baby is always referred to by their given name.
  - Translation services and/or professional interpreters are available, and are contacted promptly.
  - Health professionals understand the potential difficulties that parents may face in taking in complex information, and have strategies to overcome these difficulties.
  - Staff are competent in a range of communication skills (including choice of words, body language, timing and environment).

#### **Standard 5.5 Use of data**

**Parents understand the need for data collection and are clear on how their baby's data may be used.**

##### **Criteria for achieving standard**

- Staff understand data protection principles and informs parents as early as possible about how data are used in the process of caring for their baby.
- Parents are fully informed about clinical trials and the consent process, and the value of research to future neonatal care is discussed with them.
- Staff transmit information to third parties and/or external professionals securely and confidentially.

#### **Standard 5.6 Daily cares**

**Parents are supported to participate in their baby's daily routine.**

##### **Criteria for achieving standard**

- Parents are supported to learn how to carry out their baby's day-to-day cares, including:
  - changing their nappy
  - bathing them
  - talking to them
  - feeding them.
- The level of involvement of the parents in the baby's daily cares increases prior to discharge.
- Fathers are actively encouraged by staff on the unit to be involved in their baby's daily cares.

## Charter principle 6

**Breast milk expression and breastfeeding are actively promoted, and mothers receive practical support to achieve successful lactation. Relevant health professionals are equipped with appropriate knowledge and skills to facilitate and support lactation following a preterm birth.**

**Rationale:** Nutritional support of the preterm baby is an important component of care; the benefits of breast milk for nutritional management are becoming more widely recognised. Breast milk helps with tolerance of enteral nutrition, promotes growth and reduces infections and related complications such as necrotising enterocolitis. Breastfeeding also helps to promote the role of the mother and improves her self esteem.

### Standard 6.1 Promote and support breast milk expression

**The unit promotes and actively supports breastfeeding by encouraging mothers to express breast milk as soon as her condition allows.**

#### Criteria for achieving standard

- The unit has a breastfeeding policy and a supportive culture towards breastfeeding.
- In the case of multiple births, the following should be taken into consideration:
  - status of the mother's recovery from the birth
  - the mother's level of energy
  - any previous breastfeeding experience she might have
  - any antenatal breastfeeding preparation
  - the mother's feelings about breastfeeding
  - the mother's support network (for example, her family and friends)
  - the mother's general health and any medication she might be taking.
- Practical support and techniques to establish breastfeeding take place in the first six hours after birth, to provide baby with colostrum and to increase milk production in the following ten to 14 days – this includes frequent expression, double pumping and skin-to-skin.
- Parents are given clear and consistent information on the benefits of breastfeeding and how to express breast milk. There also is recognition of different cultural and religious attitudes and perspectives towards breast milk and breast expression.
- The unit has a dedicated professional to support mothers in establishing breastfeeding and increasing milk production in the following days.
- Staff receive training on the benefits of breast milk, physiology of lactation and how to provide practical support to mothers.
- The unit has adequate stock of equipment for all mothers wishing to express their breast milk, including breast pumps (pump hire or loan programmes are available), breast funnels of different sizes, storage bottles, etc.
- The unit promotes safe and hygienic handling and storage of breast milk and ensures parents are informed of these measures.
- Private and comfortable facilities are provided for mothers to express their milk, and expression at the baby's cot side is encouraged.
- The unit has a policy and consistent practice guidelines on the fortification of breast milk (ideally, this will be a network-wide approach.)

## **Standard 6.2 Breastfeeding**

**Mothers are supported to breastfeed or to make the transition from tube feeding to breastfeeding, and to continue breastfeeding when their baby is discharged.**

### **Criteria for achieving standard**

- Time and support are given to aid the transition from tube feeding to breastfeeding, for example with recognition of feeding cues, help with attachment and positioning, and signs that the baby is feeding well.
- Mothers are provided with a private and comfortable space for breastfeeding.
- Mothers are consistently supported in establishing breastfeeding on the unit, in preparation for going home.
- Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding, and encourage a supportive culture around it.
- Parents and especially mothers are informed on how to donate any surplus milk, if they meet donor criteria.
- Breastfeeding is a discrete part of the discharge planning process, and whenever possible, the aim is to encourage and support exclusive breastfeeding.

## **Standard 6.3 Alternatives to maternal breast milk**

**Where maternal breast milk is unavailable, mothers are given appropriate advice and support.**

### **Criteria for achieving standard**

- Mothers are supported and are shown how to make feeds and sterilise bottles and teats.
- The unit follows the policy on the collection and use of donor breast milk, in line with the United Kingdom Association for Milk Banking (UKAMB).
- The unit has access to donor breast milk for those preterm babies who would benefit from it and where a baby does not have access to their own mother's expressed milk.
- A policy on using preterm formulae (appropriate formulae, follow-on milk, nutritional supplements, etc.) is in place.

## **Charter principle 7**

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

**Rationale:** Discharge should be a seamless and supported journey from the unit to home. Coordinated discharge plans enable a baby's safe, appropriate and effective discharge home, and provide for any ongoing health and social care needs. Discharge planning begins at admission and continues throughout a baby's stay in neonatal care.

### **Standard 7.1 Coordinated discharge plan**

**Discharge planning uses a multidisciplinary approach, and is coordinated from admission by a dedicated member of staff with the skills to identify and assess the baby's and family's ongoing needs.**

#### **Criteria for achieving standard**

- The unit has an established discharge planning policy.
- The unit demonstrates a multidisciplinary approach in its discharge planning, which includes access to social services and other support professionals.
- Discharge plans are established from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team.
- The unit identifies a dedicated individual to coordinate a baby's discharge plan from the moment of admission.
- Parents have access to a health professional who can provide emotional/psychological support.

### **Standard 7.2 Rooming in**

**Units should offer rooming-in accommodation to support discharge and help parents develop confidence in the day-to-day and clinical care of their baby.**

#### **Criteria for achieving standard**

- The unit provides access to free accommodation when parents need to be with their baby in preparation for their discharge.
- At least two 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.

### Standard 7.3 Meeting the baby's needs at home

**The baby and family have their ongoing needs at home met by health professionals, who are appropriately skilled in delivering care in the community, and can support the family to care for their baby at home.**

#### Criteria for achieving standard

- Before discharge, the family is given appropriate information and training to make sure they are able to meet their baby's ongoing needs at home. The topics covered include:
  - sleeping and positioning (FSID's *Back to sleep* leaflet)
  - immunisations
  - continuation of breastfeeding
  - developmental milestones
  - follow-up appointments
  - basic life support training.
  
- The family is empowered and supported to deliver all aspects of their baby's care at home.
- Access to community support is provided by an integrated hospital-community neonatal team or an identifiable team of community health professionals.
- Parents are given the opportunity to meet with the community team supporting them at home before the baby is discharged from the unit.
- Primary care teams are given timely information about the baby and any home care arrangements, as well as the opportunity to meet neonatal staff and parents before discharge.
- Parents are informed and understand who to contact should their baby become unwell at home, and when they may need to take them back to hospital. (The FSID publication *Baby Check reborn – Helping parents decide when their baby is ill* is very useful.)

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**www.babyfriendly.org.uk/pdfs/Liz\_Jones\_article\_full.pdf** – "Principles to promote the initiation and establishment of lactation in the mother of a preterm or sick infant"

**www.ukamb.org** – The United Kingdom Association for Milk Banking

## Bliss Family Support publications

- Breastfeeding your premature baby
  - Comfort holding poster
  - Facts for fathers
  - Financial advice for families
  - Going home – The next big step
  - Going home on oxygen
  - Kangaroo Care poster
  - *Little bliss* magazine \*\*
  - Look at me – I'm talking to you!\*
  - Parent Information Guide – also available in Polish, French\*, Urdu\*, Portuguese\*, and Bengali\*
  - RSV (Respiratory Syncytial Virus)
  - The next pregnancy
  - Ventilation and Chronic Lung Disease – your questions answered
  - Weaning your premature baby
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# Bliss

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