PROTOCOL FOR: **Discharge Planning: Neonatal**

POLICY:

1. All individuals on the health care team are responsible for discharge planning for nursery patients.

2. A primary care physician must be identified by the family prior to the infant's discharge.

3. Discharge to home requires MD/AP order.

4. All infants born at less then 37 weeks gestation or under 2500 grams, and those with chronic lung disease, O_2 requirement at discharge or neurologic issues will have a period of observation and monitoring in a car seat prior to discharge. Refer to procedure for: Car Seat Monitoring.

5. "At risk" infants will be referred for Neonatal Follow-Up. "At risk" is defined as those infants with:

   a. Gestational age < 32 weeks/birth weight less than 1500 gms

   b. Hypoxic-ischemic encephalopathy

   c. Intraventricular hemorrhage

   d. SGA/IUGR infants

   e. Neurological compromise

   f. Any other infant designated by the Discharge Planning Team

   g. Substance exposed infant

   h. Severe hypoglycemia

   i. Severe hyperbilirubiemia

6. Weekly discharge planning rounds are held to provide a forum for communication about discharge plans and needs.

7. The discharging nurse will verify the identity of the persons to whom the infant is discharged (unless this identity is known to her/him). Verification of identity may occur by examination of delivery room identification bracelets (which are on the person and have not been cut) or by a picture ID. Validation of identity should be included in the discharge note.

8. CPR teaching is required by families and caregivers of infants who, at discharge:

   a. Require a cardiac monitor

   b. Are receiving supplemental oxygen

   c. Have a tracheostomy

   d. Require a ventilator

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CPR teaching is strongly recommended for parents of all infants, especially those with GE reflux and BPD.

DESIRED PATIENT OUTCOMES:

1. All parents/legal guardians will be included in the discharge/transfer plan.
2. For infants discharged home, parents/legal guardian/family will verbalize/demonstrate adequate knowledge and skills to meet caretaking needs.
3. Parents/care takers will have appropriate referrals generated to support services.

CLINICAL ASSESSMENT AND CARE:

1. On admission and throughout hospitalization, the following criteria will be used to help assess discharge planning needs.
   a. Maternal prenatal history and perinatal course.
   b. Family unit: extended family, supportive friends.
   c. Parent visitation, telephone calls, interaction with infant and staff.
   d. Parent level of education, employment, culture.
   e. Home environment and support of caretaking.
   f. Parent/guardian's knowledge of disease process and potential care needs.
   g. Parent/guardian's emotional, intellectual and physical ability to learn and carry out infant care needs, treatments and procedures.
   h. Services, supplies and equipment required after discharge.
   i. Services utilized by family prior to infant's discharge.
2. The primary nursing team and discharge coordinator/case manager collaborate in implementing the discharge plan. Discharge planning involves collaboration with:
   a. Infant's family/guardian
   b. Attending physician
   c. House officers
   d. Advanced practitioners
   e. Primary care physician
   f. Developmental therapist

PROTOCOL FOR: Discharge Planning: Neonatal

g. Social worker

h. Dietitian

i. Consulting specialty physicians

j. Nursing staff at receiving hospitals

3. The infant's primary care team and other assigned RN staff will initiate and implement the teaching plans that are needed.

PROCEDURE:

ACTION	POINTS OF EMPHASIS
1. When discharge is anticipated, the health care team will communicate with the case manager so that discharge plans can be finalized.	1. Sufficient time is required to plan for care at home: a. Referrals for home nursing visits must be made prior to the infant's discharge. b. For complex cases, several weeks may be needed to arrange durable medical equipment and/or extended nursing care.
2. The health care team is responsible for ensuring that required screenings/procedures are completed, including, but not limited to: a. Newborn hearing screen b. Immunizations c. Metabolic screens d. Ophthalmology screens e. Follow-up ultrasounds f. Prescriptions obtained by families g. Circumcision h. Car seat monitoring (if meets criteria) i. Arranging CPR teaching	2. Planning is required so that all items are not completed on the day of discharge; this may cause the family to feel overwhelmed.
3. RN staff are responsible for: a. Completing and documenting teaching according to relevant teaching plans. This should include plan for follow-up teaching or reinforcement by visiting	a. Documentation of teaching and family's response should occur on the patient and family teaching record.

nurses.

b. Completing the neonatal transfer summary (if back transported to home hospital).

c. Completing relevant areas of the clinical resume/nursery discharge sheet.

d. Reviewing content of the clinical resume/nursery discharge sheet with the family to ensure understanding of discharge instructions.

e. Communicating with families about services needed post-discharge, such as WIC, home nursing visits.

e. RN staff may initiate paperwork for WIC referral. RN staff should communicate with case manager about parents' desires for home nursing visits as soon as this information is known.

f. Communicating with the case manager regarding:

1) Timing of discharge

2) Parental or guardian competence in caregiving

3) Planning for needs post-discharge

4) Other issues identified that may affect discharge plans (such as illness among other family members)

g. Collaborating with case manager as needed or directed to assist with coordinating plans for post-hospital care. This may include:

1) Assisting with communication with families about preferred home care agencies.

2) Assisting with completion of interagency referral forms for home care.

3) Communicating with home care agencies about infant's care needs and care plan.

4) Assisting with making follow-up appointments.

h. Educating home care RNs (in complex cases) of plan of care (as needed on a case-by-case basis).

i. The discharging RN will instruct and reemphasize dates and times of follow-up appointments. These should be documented in the electronic discharge instructions/nursery discharge sheet.

i. NICU patients should have an appointment with the primary care physician within one week of discharge.

j. The discharge nurse will close out the standard care plans/carepaths and summarize infant's status at discharge (unless this can clearly be delineated from the flowsheets).

k. The discharging nurse will write a discharge note indicating date, time, mode of discharge, and individuals to whom the infant is discharged.

4. The case manager will:

a. Collaborate with the health care team in coordinating post-discharge care, including, but not limited to:

1) Making follow-up appointments with specialty physicians.
2) Arranging for durable medical equipment for the home.

3) Communicating with payors to pre-certify payment for discharge supplies, equipment and home care visits.

4) Communicating with families about available home care nursing agencies and their wishes.

4) Familial choice of home care agencies and options presented must be documented.

5) Educating families about infant's care needs (to supplement information from care team, if applicable).

6) Communicating with home care agencies to arrange services and confer regarding the infant's needs.

7) Completing needed discharge paperwork, such as interagency referral form.

8) Communicating with primary care provider and specialty physicians (at the direction of the attending physician).

5. MD/AP is responsible for:

a. Writing discharge prescriptions and giving to family in a timely manner.

a. Medication is obtained prior to discharge so that accuracy can be verified.

b. Writing the prescriptions in the discharge medication reconciliation nursery discharge sheet.

c. Ensuring accuracy and timeliness of documentation so that accurate discharge summary can be completed in a timely fashion.

d. Entering a discharge order that is dated, timed and signed.

e. Completing and signing discharge instructions as required.

e. These forms indicate orders for post-discharge care. Attending physician signature may be needed on some forms.

6. Discharging the infant:

a. Security system sensor are removed and placed in designated area for cleansing.

b. Well newborn:

1) Remove infant’s ID band in presence of mother.

2) Compare ID band number with mother’s band and the number on the newborn.

3) Have mother sign identification sheet.

4) Tape infant’s ID band to sheet.

5) Infant will be discharged with mother.

c. NICU/SCN/Boarder Infants:

1) Verify identity of person to whom infant is discharged (if not known to discharging nurse).

2) Document identification check in

the discharge progress note.

3) Infant will be escorted to the lobby by a member of the nursery staff.

3) Car seat should be installed in the care by the parents. Literature and other educational material is available to parents about car seat use for healthy and pre-term infants.

d. Time of discharge will be documented (by unit clerk or charge nurse) on a daily census log and in the log book.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/90

REVISION DATES: 6/91, 6/92, 8/93, 1/95, 4/97, 1/00, 10/00, 6/08, 12/12

REVIEWED DATES: 11/06, 11/07, 10/09, 12/10, 3/29/11