DISCHARGE OF INFANTS TO OTHER UNITS OR HOME - GCNIC - CHW

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- This document provides information on the discharge or transfer (to referring hospital or other hospital) process for neonates from Grace Centre for Newborn Intensive Care
- Discharge home or to another hospital requires a planned coordinated approach and is supported by members of the multidisciplinary team

Key Performance Indicators

- Infants are transferred or discharged at the agreed time without delay
- Transfer plan or discharge plan is documented in the electronic medical record prior to discharge
- A medical discharge summary is complete and provided to all relevant parties as part of the transfer/discharge paperwork
- For patients transferred to other health services: accepting medical and nursing staff are notified of the infants' departure
- Infants are discharged on the estimated date of discharge
- Appropriate community referrals and follow-up specialist appointments are provided
- Parents/carers receive instructions and education on specific follow up care in accordance with their child's specific health needs
- Parents are provided with information on infant safe sleeping and safe car restraint transport requirements.
- Parents throughout the discharge process will feel supported and confident in continuing care of their infant at home.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st September 2023	Review Period: 3 years
Team Leader:	Clinical Nurse Consultant	Area/Dept: GCNIC - CHW

CHANGE SUMMARY

- Input for Allied health team included
- Addition of hyperlinks to external resources to aid in ease of identification:
  - Non-Emergency NETS Inclusion Criteria (Brochure for Sydney NICUs & Level 4 Special Care Nurseries)
- Inclusion of additional resources under the 'Staff Information' section of this document's ePolicy page for this document:
  - GCNIC Nurse Practitioner-Led Acute Review Clinic (ARC) Brochure
- Removal of the term 'Discharge Nurse' and the inclusion of the Neonatal Nurse Practitioner (NNP) Service which encompasses the NNPs, transitional NNPs, and Chronic and Complex Care advanced clinical nursing roles (e.g., Chronic and Complex Care Clinical Nurse Consultant).

READ ACKNOWLEDGEMENT

- Clinicians and identified non-clinical staff involved in the discharge and transfer of neonates from GCNIC should read and acknowledge they understand the contents of this document.

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Principles of Discharge Planning

Key Components

- The patient and their family/carer/guardian are at the centre of care and are partners in care.
- Responsive, effective discharge planning starts before the patient is admitted to the hospital.
- Admission and discharge are part of a continuum of care.
- Efficient use of information technology (IT) supports effective communication practice.
- Effective discharge incorporates monitoring and evaluation components.

Estimated Discharge Date (EDD)

- All infants have an Estimated Date of Discharge (EDD) allocated on admission which is recorded in eMR by the Nurse Unit Manager/Team Leader (NUM1/TL) or Clinical Support Officer (CSO).
- The average length of stay (LOS) in the GCNIC is 12 days, this can be used initially as a rough guide until more formal data is available on LOS for more specific conditions (e.g., tracheo-oesophageal fistula).
- The discharge destination needs to be identified and a plan of care developed based on this and the EDD.

Preparation of the Family for Discharge or Transfer

Failure to prepare families for discharge is associated with increased health care utilization in the first 30 days after discharge including readmission[1&2]. Mothers who were not ready for discharge from the NICU have reported greater difficulty in coping with the care of their infant and decreased confidence in their infant care abilities. Resulting in twice as many calls to health care providers, they were more likely to place their infant in the prone sleeping position to settle, and, had a higher likelihood of re-presenting to the emergency department[1].

Parents are often anxious and afraid to leave the safety net of the NICU. Initial fear and anxiety results from their perceived inability to care for infants after discharge and the complex health needs of infants discharged from the NICU. Parental caring confidence is often noted to improve as the infants' health improves and through the provision of adequate support[6]. Discussing and validating these feelings as normal for families can help to assist parents during the post discharge adjustment phase. During their hospital stay, nursing staff can support parents to establish their role as a parent by facilitating opportunities for them to be involved in all aspects of care, offering them opportunities to take on the role of caregiver.

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Ensuring families are ready for discharge can be achieved by[3]:

- Notifying the family of the EDD and discharge destination as soon as this is apparent.
- Discussing discharge planning with parents well before the discharge is planned.
- Informing parents of the approximate date, time and method of discharge or transfer.
- Ensuring parental needs and preferences are taken into consideration for discharge; however, the demand for intensive care beds may necessitate negotiation for discharge or transfer times.
- Use of parent discharge checklist may assist to ensure parents/carers and health care providers are aware of skills and information to be mastered prior to discharge.
- Offering parents/carers opportunities to practice skills under direction and supervision repeatedly as this will increase the retention of knowledge.
- Utilisation of rooming in facilities if deemed appropriate (for patients who are being discharged home)

Discharge/Transfer Criteria

- The decision for discharge is made by the on-call Neonatologist in collaboration with members of the multidisciplinary team
- Patients requiring ongoing care will be transferred to their referring or other suitable hospitals when appropriate if specialist evaluation has been completed, or a terminal or untreated condition exists, and the infant is to be reunited with the parents (if this is their wish)
- Patients who no longer require intensive care management, but who still require paediatric specialist evaluation, surveillance or care will be transferred to a ward within the Children's Hospital at Westmead (CHW) as deemed appropriate by the discharging team in consultation with the specialist teams and Bed Manager.
- Patients are discharged home when the medical or surgical condition no longer requires active inpatient care; there is appropriate weight gain; and the levels of parental competence in infant care skills are satisfactory.

Discharge Criteria

Patients prior to discharge are required to have:	• Stable cardiopulmonary status • Thermal stability • Caffeine treatment has been discontinued with no clinically significant apnoeas or bradycardias for 5 days prior to discharge

	• A sustainable mode of enteral/or parenteral nutrition with steady weight gain or a defined follow up plan to monitor weight • Family can provide the necessary care without undue strain and with appropriate support services in place prior to discharge • A suitable home environment that is safe. If there are any concerns regarding the safety of the home, these need to be addressed so that appropriate supports can be put in place

- Support for patients discharged from the unit will be coordinated by the Neonatal Nurse Practitioner (NNP) Service, in consultation and collaboration with members of the multidisciplinary team, including (but not limited to): Neonatologist; Nursing Unit Manager/Team Leader; GCNIC Medical Officers; bedside nursing staff; Allied Health staff and the specialty teams. Sources of follow-up support may include:
  - GCNIC Nurse Practitioner-led Acute Review Clinic (ARC)
  - Hospital in the Home (HITH)
  - Kids GPS
  - Community-based support and early intervention services (e.g., child and family health nursing, multidisciplinary feeding clinic)
  - General paediatrician
  - CHW sub-specialty follow-ups
  - Grace Development clinic

Transfer of Infants to another Hospital or Department

Preparation Prior to Transfer (day before or when placed on portal)

The following documentation and components are to be undertaken prior to transfer:

- Discharge summary preparation with Staff Specialist/Neonatal Fellow review
- Baby check/discharge assessment completed and documented in Baby Blue Book (or relevant patient documentation if the Blue book has previously been filled out at other hospital)
- Blue Book checked and all relevant areas have been filled out
- Assess the need to supply stock of medications for transfer
- MRSA discharge swabs
- Review vital signs monitoring requirements (e.g., ECG, Sp02)

- Discussion with the patient's family regarding EDD, likely timeframe, and the mode of transport.

Transfer Criteria

The following transfer criteria are to be met prior to transfer to another health service location:

CHW Ward	• Medically stable • Post intensive care needs • No invasive respiratory support, inotropes, invasive monitoring • Unable to return to referring hospital/ closer to home due to specialist needs • Likely to have stay for > 48 hours in the other ward/hospital that they are transferred to • No pending surgery within the next 48 hours
Westmead Hospital	• Referral hospital • Requires post-specialist care to support growth and nutrition • Ongoing requirement for Intensive care, high dependency, or special care
Other Hospital	• Requires post-specialist care to support growth and nutrition • Ongoing requirement for Intensive care, high dependency, or special care • Location closer to home, however, still needs hospitalisation • Availability of staff to escort patient

Referral and Handover of Care

Referral and handover of care is to be discussed between relevant specialty teams to ensure a smooth transition of care. Responsibilities are outlined in the table below:

Medical Referral of care and handover	• Medical acceptance from Admitting Medical Officer obtained; from discussion with GCNIC medical staff or NNP
Nursing acceptance of care and handover	• GCNIC nursing team (NUM, T/L, or NNP Service team member) to contact accepting ward/ hospital nursing team leader regarding acceptance and bed availability
Co-consultants and Subspecialty teams notified	• GCNIC staff contact speciality teams to notify of transfer intentions
Allied Health handover	• Allied Health staff to provide handover to ward therapy team and/or referral to community early intervention services as required (e.g., NDIS)

Family Discussion

Parents require the following information:

- Likely time of transfer
- Mode of transport
- If they wish to accompany infant on transfer and if this is possible
- What happens in the event of a delay/ if bed is no longer available
- Need for ward tour, if required

Preparation of the Infant on the Day of Transfer

For all patients transferred out of the unit:

- All equipment with patient
- Discharge summary (copies for transfer site, parents, and other care teams as required)
- Copy of operation reports if appropriate
- X-rays on disc if appropriate (minimum 24 hours' notice required for CHW Medical Imaging disc request)
- Feeds completed at least 30mins prior to transfer
- Appropriate clothing for patient to maintain thermoregulation
- 2 ID bands
- Personal belongings including Blue book
- Expressed breast milk and medication (if required) in cooler bag

For transfer within CHW	Transfer external to CHW
• Allergy status documented on eMM • Chart medication on eMM • Review of Altered Calling Criteria on eMR and adjustments made as clinically indicated • Contact accepting team to inform of imminent departure from GCNIC • Nursing transfer form completed on eMR • Take all paper notes with patient as appropriate • BTF chart with at least 4 hours of observations if appropriate	• If a transport service with a nurse escort (e.g., non-emergency NETS, Patient Transport Services, Ambulance etc.) are unavailable, a GCNIC nurse can escort the patient. A Cab-charge voucher is provided to the nurse escort and must be collected from the CHW Transport Department prior to leaving CHW • Collect medication supply if needed • Syringes and NGT adapters for 24 hours' worth of feeds • Contact accepting team to inform them of imminent departure from GCNIC • Nursing transfer form printed

• Transfer patient in a white cribette or transfer to a local cribette/bed on arrival, ensuring GCNIC bed is returned to our unit	• BTF chart with at least 4 hours of observations if appropriate • Copy of Medication chart, TPN order and Fluid balance chart if appropriate

Equipment Required for Transfer

The following equipment is required for all patient transfers:

- Emergency bag
- Suction available
- Monitor for HR, RR, and/or SpO2
- Check adequate battery on monitor for length of transfer, take spare monitor if required

The monitor used for transfer has a 6-hour battery life please plug into mains power whenever available.

The type of cot/crib and staffing required for transfer is determined by the distance and patient needs. A summary of the unit requirements for safe transfer are listed in the table below:

CHW Transfer	**Westmead Hospital Transfer**	**Other Hospital Transfer**
• Cribette (white cot) • Porter	• George, Giraffe or Panda warmer bed • CHW Porter via link-way • With medical staff or NNPs if ventilated or on midline CPAP/ BiPAP	• NETS (ventilated, HHFNP, CPAP/BiPAP, UAC/UVC) – complete elective retrieval form • Non-Emergency Newborn Transport Service (please refer to the inclusion criteria featured in the service's brochure located here) • CHW transport in Ambulance or car with capsule only (no respiratory support) • Contact Patient Transport Service (PTS) to determine mode of transport. Must identify if Humidicrib and other equipment are required

Care of the Patient during Transfer

- Ensure nurse escorting patient is facing the patient and can always visualise them during transfer
- For road transport, avoid feeding the infant during transfer. If feed is required, Ambulance must stop for the infant to be fed safely to avoid aspiration
- Monitor vital signs every 30mins on SPOC chart
- Monitor temperature to maintain normothermia

On Clinical Staff Member's Return to GCNIC

- Inform the CSO of approximate time that handover was given to the receiving team. This is then recorded as the official discharge time in the patient's electronic medical record
- Clean all equipment
- Restock emergency bag if required

Supporting Documentation for transfer

- Located within the GCNIC Discharge Resource Manual
    - Additional information for nursing and medical staff

Planning for Discharge Home

Discharge planning is a collaborative team approach between the multidisciplinary team in GCNIC, it is governed by a model of individualised developmentally supportive family-centred care. Discharge planning needs to be part of handover from admission through to discharge, to maintain the flow of communication on discharge readiness.

- The Nursing Unit Manager or Team Leader, Neonatologist, GCNIC NNP Service, Allied Health team and medical officers, work collaboratively to coordinate discharge planning whilst sub-specialty teams (including consultants and CNCs) involved with the infant are kept informed of the discharge process and any anticipated problems.
- A list of the relevant CHW staff involved with the infant's care needs to be kept as part of the discharge care plan and should be updated regularly to reflect any changes.

Discharge Planning

To adhere to Responsive Standards for discharge planning, it is recommended to:

- Screen for discharge risk
- Estimate the date of discharge and establish a discharge plan
- Track patient changes

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- Communicate with the family, the GP, or Aboriginal Controlled Health Service (ACCHS), the community health & community service providers (CHP or CSP), with the paediatric specialist and specialist services within SCHN Westmead

Screen for Discharge Risk:

Screening for discharge risk occurs as part of the unit's Rounds/Handover in-consultation with the Neonatology and Nursing staff. As a guide for staff, the following categories should be considered as representing a level of risk to the patient or family.

Pre-term or Very Low Birth weight infant	Technology-Dependant Infant	Infant at risk because of social/ family issues	Infant with life-limiting condition
Infant less than 38 weeks Birth Weight less than 1500g	Special or assistive feeding techniques Apnoea monitoring Home Oxygen Complex Congenital Anomalies requiring supportive and assistive devices Infants with stomas Infants on non-invasive ventilation	Very low birth weight infants Prolonged hospital stay Congenital Conditions Lower educational level Lack of social support DCJ involvement Marital instability Fewer antenatal visits Substance abuse Narcotic abstinence syndrome	Infant discharged home with "end of life" support

The GCNIC multidisciplinary treating team need to be alerted of any discharge risks that have been identified to collaboratively plan towards a discharge with adequate support structures put in place for the family.

Documentation of risk at discharge

This information (i.e., requirement for parent education, equipment, or psychosocial support) is documented in the electronic medical record and communicated to the neonatologist on service. During the process of discharge planning, strategies to manage the risk are implemented and follow up processes identified.

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Recommended discharge teaching content includes[1]:

Technical Baby Care Skills

- Basic infant care skills (bathing, feeding, swaddling)
- Equipment or medication education

Home Environment Preparation

- Supplies and equipment required at home
- Where to acquire provisions to address specific needs (dressings, medication, equipment)
- Emergency contingency plans (who to contact e.g., GP, HITH, Kids GPS)

Car Seat/Bed Use

- Installation of car seat (referral to Occupational Therapist for individual review of car seat when medically indicated)
- SIDs and safe sleeping information
- Use of slings

Infant Behaviour information: Normal versus Abnormal

- Typical infant behaviours and cues
- Differences between term and preterm behaviours (if relevant)
- Abnormal behaviours

Anticipatory Guidance

- What to expect at home
- Parental coping strategies (support)
- Infant settling techniques

Nutrition

- Discuss home feeding plans and feeding regimes
- Involve the lactation consultant and dietician (as indicated) to offer instruction on supplementary/complementary feeding (e.g., formula milk recipes, etc)
- Provide advice on milk storage and feeding equipment cleaning practices

Parent Resources

Additional resources to provide families that will support them during, and post-discharge can be found at the following link. See the 'Staff information' section on the ePolicy webpage for this guideline.

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Medications

Component	Information
Family	• List of medications provided • Opportunity to administer medications prior to discharge • Information about why the medication is required and potential complications • Identify if medication has a shelf-life (e.g., Frusemide™ has a 21-day shelf-life)
Paediatrician, GP or CHW Clinician managing ongoing care	• Provided with copy of discharge summary listing all current medications and dosages • Appointment arranged for prior to medication stock running out
Medication specific	• Certain paediatric formulations of medications) may not be available in community pharmacies, and can only be obtained through CHW (i.e., Omeprazole Liquid and Sildenafil) • Supply provided should last to their next appointment
Bedside Clinician	• Order 24 hours prior to discharge • For community pharmacy prescriptions check the medication is available on the Pharmaceutical Benefits Schedule in a formulation that is suitable for infants.

Equipment

- The NNP Service is alerted for any infants who will be requiring equipment (including intragastric feeding) at home.
- The family is provided with written information on the use and care of the equipment.

Specific equipment training/ instruction is provided by the individual teams with continuing supervision from the GCNIC nursing staff, for example:

Care Management	Individual responsible for training/information/management
Stoma management	Stoma CNC
Airway management (Suctioning and tracheostomy)	Stoma CNC NNP Service, and ENT CNC
Apnoea monitoring/CPAP/BiPAP	Respiratory Support Services team member (Sleep/Respiratory CNC, CNS2, RN or scientific officers)

Parent Basic Life Support Training	NNP Service or other staff member who is accredited as a parent trainer in BLS
Nasogastric tube feeding and tube insertion	NNP Service and all clinical nursing staff
Wound Management	• Check with appropriate team for wound management plan and for any specific instructions (e.g., sutures for removal) • Written information on wound care and management should be provided to the family • Follow-up can be arranged through the wound clinic, or with the NNP Service or the relevant specialty CNC
Developmentally supportive care (GCNIC)	• Fact sheets and other resources can be provided during developmental rounds • Refer to the DR team if you would like a family to be reviewed prior to discharge • Referral to neurodevelopmental follow-up clinic (either at GCNIC or referring hospital) as per clinic inclusion criteria (coordinated by Medical and Allied Health clinic team)
Implementation of Primary Care (Documentation in blue book)	All staff (nursing and medical) are responsible for checking: • Immunisations • Hearing screening • Metabolic screening • Newborn examination
Discharge planning meetings	• For patients with complex needs requiring coordination of multiple teams. These are facilitated by the NNP Service or medical officers on an individual as-needed basis
Emergency plan	• Information is provided to parents regarding who to contact in the event the infant deteriorates, including how to access help (i.e., ambulance, GP, or Emergency Department presentation) • This is provided by specialty teams, Kids GPS and should be clearly documented on the discharge summary

Communicate with GP or Aboriginal Controlled Health Service (ACCHS)

- The family should be offered the opportunity to identify a General Practitioner (GP) that they would like information regarding the infant be sent to.
- This is confirmed at discharge, so that ongoing communication post discharge is maintained.
- The family should be allowed the opportunity to identify if they are linked with an ACCHS and this should be documented in their discharge plan.
- All infants discharged from GCNIC (particularly infants with complex needs or those requiring ongoing review of medications) are to be linked in with a paediatrician prior to discharge.

Communication with Community Health and Community Service Providers:

- Infants admitted from home may already have established community health providers involved in their care. Identifying the individuals already involved in their care is necessary so that communication can commence with these services regarding progress towards discharge and so that effective transfer of care and information occurs.
- If an infant is admitted to Grace requiring equipment at home (nasogastric tube, home oxygen, etc.), establish which service is facilitating the provision of equipment (most often CHW).
- All infants discharged from GCNIC are referred to the local child and family health nurses, with the permission of the family, by the GCNIC nursing team (or if none are available to complete this task, the medical officers).
- Other community health providers (i.e., neonatal/paediatric outreach services, or community support services) will be identified on an individual basis by the NNP Service and will be included in the discharge plan with appropriate referrals to be made and arranged prior to discharge occurring.
- The need for specialised early intervention services will be identified on an individual basis by the Allied Health team, in consultation with the Neonatologist. This includes referral to the NDIS (via the Early Childhood Approach), and referral to services such as the Cerebral Palsy Alliance. Referrals will be made prior to discharge and will be included on the discharge summary.
- Kids GPS (Guided Personalised Service) may be considered for infants with complex needs to coordinate their care within the community. Referrals to KIDS GPS are made by any member of the treating multidisciplinary care team through PowerChart.
- Copies of the discharge summary are sent to these services by either the NNP Service, team leader/NUM1, or the medical officer.

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Documentation

- A discharge summary is prepared by a medical officer/ NNPs and is checked by the neonatologist/fellow prior to discharge.
- The discharge physical assessment/check is performed by the medical officer/ NNPs and documented in the patient's notes, blue book, and discharge summary on the day prior to discharge.
- The discharge documentation needs to capture the important issues that could potentially impact on the infant beyond discharge, and should include:
  - Medical issues relating to the infant including primary diagnosis, principal diagnosis, perinatal history, nutrition, medications the infant is on including dosage and frequency, recent laboratory results, other investigations, and plan for follow-up.
  - Significant social issues that could impact on the infant after discharge should also be included.
  - Any significant feeding issues including:
    - If the infant needs enteral feeding
    - If the infant needs special bottles or teats
    - If the family require lactation support
    - If the mother is on motilium
    - If the infant requires additional calories
- If there is a requirement for close follow-up of growth in the immediate post-discharge period, a referral can be made to the NNP Service for the GCNIC NP Acute Review Clinic and/or to the child's local child and family health nursing service, who can provide this support. Please note: if local child and family health nursing services are being asked to complete close follow-up growth assessments, please contact the service directly to establish if they can provide this service and ensure that a clear escalation pathway and plan is established.
- The discharge summary should contain any developmental concerns, any follow-up carried out by allied health professionals during the admission, and requirement for follow-up after discharge, including Grace Development Clinic and/or early intervention.

Discharge summary distribution:

A copy of the discharge summary approved and signed by the neonatologist on call is provided to:

- Relevant co-consultants referring doctor
- GP
- Paediatrician
- Early Childhood Health Centre

- NETs (for patients transferred into the unit using NETs)
- Families receive copies only after the finalised version of the summary has been approved by the neonatologist on-call

Grace Development Clinic

The Grace Development Clinic (GDC) reviews at-risk infants who have been discharged from GCNIC, and occasionally PICU. The GDC has an eligibility criteria (not all infants discharged from GCNIC will be eligible), and a copy of the eligibility criteria list of is kept in the doctor's office on the notice board. Appointments for GDC are automatically made by the GDC secretary and the family will be notified after discharge of this appointment day and time. A note of the plan for GDC follow-up should be made in the discharge summary of any infants requiring a GDC appointment.

Criteria for Referral to GCNIC Nurse Practitioner Acute Review Clinic (ARC)

Following recovery from illness, many newborns cared for in a surgical NICU are medically safe for discharge however require ongoing close surveillance during the early post-discharge period. The GCNIC NP Acute Review Clinic is led by the NNP Service and was established to facilitate early discharge home of medically safe patients.

Newborns referred to the ARC will ideally be seen in the clinic within 72 hours of discharge.

Referrals to the clinic can be made for infants with any of the following indications:

- Growth assessment
- Feeding assessment
- Review of caloric supplementation and nutritional requirement
- Wound review
- Pathology assessment
- Cardiac assessment
- Pharmacological review

To refer an infant to ARC, please refer to the step-by-step instructions in the "Staff Information" section on the ePolicy webpage for this guideline. For referrals to the ARC occurring out of hours refer to the discharge after-hours section of this document.

Caveat

If an ARC appointment has been arranged and a member of the GCNIC NNP Service is unavailable to review the patient, the patient can be seen in ARC by a medical officer (Fellow/Career Medical Officer [CMO]). Following the completion of the appointment, the medical officer is responsible for documenting the appointment in the patient's electronic medical record and providing handover to a member of the NNP Service.

Planning for Discharge

Planning for discharge should be thought out since admission and operationalized one week prior to the proposed EDD. A three-stage approach is recommended:

One week prior to discharge	• Discuss proposed date with family • Schedule education sessions relevant to the infants needs • Utilise interpreter to communicate discharge planning if required • Provide family with GCNIC Going Home Resource and Parent Discharge Checklist • Referral to Kids GPS or HITH if indicated • **Remove nest** from bedding and provide safe sleeping guidelines • Facilitate opportunities for bathing and other parent craft activities • Identify if rooming in is required. If the infant is going home on equipment (NB: rooming in cannot be offered prior to the availability of home equipment) • Refer to lactation consultants to establish feeding plan (as indicated) • Admission > 4weeks check hip USS is booked • Check immunisations, NBST and hearing test are complete • Identify patients that require an alert documented in PowerChart if readmitted to ED/PICU • NNP or medical staff notify paediatrician and/or GP of impending discharge
Day prior to discharge	• Ensure the infant discharge check is done and documented • Check that medications have been ordered and are available • Discharge summary complete and ready for signing by the neonatologist • All follow-up appointments have been made and family aware • The family have a mode of transport for getting home • If travelling by car, a car seat for the infant that is fitted correctly (recommended that families use an authorised restraint fitting station – see Service NSW website), and that they know how to use the five-point harness • Ensure family has a dedicated sleeping area (i.e., cot) for the infant

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On the day of discharge	• All aspects of the discharge care plan have been addressed
	• All appointments have been made prior to discharge, and the family provided with a copy
	• The family have a copy of the discharge summary (the contents of which have been explained to them)
	• The family have collected any EHM that is stored in the fridge and freezer
	• The family have received a copy of the safe sleeping/ SIDS guidelines and understand the content
	• Address and telephone numbers of the family have been confirmed and, if necessary, altered on PowerChart™
	• The family understand the role of the blue book with regards ongoing care through the child and family health nurses, and other services that come into contact with the infant. The following is documented in the blue book:
	  o Results of the hearing screen
	  o Results of the newborn check done by the registrar/ NNP/ fellow
	  o Any immunisations given during the admission and any requirements for a catch-up immunisation schedule
	  o A list of phone numbers of the relevant health professionals to contact in CHW is completed under "contacts"
	  o Discharge weight, length, and head circumference

Discharges Occurring After-hours

In the event a discharge occurs out of business hours, please ensure the following:

- Infants requiring GCNIC ARC follow-up are referred using the usual referral process and an email is sent to the GCNIC NNP Service to inform them of the referral, reason for review, and tentative appointment date and time.
- For infants that require speciality follow-up appointments, the medical officer, NNP Service, or TL/NUM1 is required to notify the CSO of the appointment information so that the appointment can be arranged.
- The medical officer discharging the infant is required to provide copies of the discharge summary to:
    - The parents (if reviewed and approved by the neonatologist)
    - CHW medical records department
    - The receiving doctor (paediatrician and /or GP)
    - The referring doctor
    - NETS
    - CHW specialty teams
    - The NUM or TL is the identified primary discharge coordinator in the absence of a member of the NNP Service.

Post-discharge Home Support Services

GCNIC nursing and medical staff can provide the following support to infants following discharge:

- Linking infants with the relevant child and family health nurses once consent is obtained from the family. This is a free service to ALL new babies born across NSW, whether they are well or have required admission to a NICU or SCN.
- Support through follow-up in the GCNIC NP Acute Review Clinic
- Linking infants with complex/high medical requirements with Hospital in the Home (HITH)
- Linking infants with complex/high medical requirements with Kids GPS
- Referrals to other services that may be relevant to the individual infant and family, including:
  - CHW allied health staff
  - Lactation consultants, based in the community or consulting with the lactation consultant based in GCNIC
  - General practitioners
  - Paediatricians
  - Subspecialty consultants and CNCs within CHW
  - Department of Disability, Health and Aged Care, and other relevant early intervention services

Kids GPS (Guided Personalised Service)

Kids GPS Care Coordination Service provides an integrated model of care for children with chronic and complex conditions by interfacing with the entire continuum of care. The service aims to improve efficiency and patient outcomes by supporting families to navigate services and providers within SCHN, Local Health Districts (LHDs) and Primary Health Networks (PHNs). Care Coordination for this cohort of children intends to reduce avoidable overnight admissions and Emergency Department attendance, improve length of stay, streamline appointments, facilitate discharge, and improve the integration of care between community health providers and the hospital.

Eligibility Criteria for Care Coordination

- The child/young person is a patient of SCHN
- The patient has complex needs, involving multiple health care providers and services
- There is not a designated key person coordinating the patient's care within a multidisciplinary team

This Guideline may be varied, withdrawn or replaced at any time.

- Where there is potential to facilitate a more coordinated approach to the patient's healthcare needs, particularly for patients who frequently utilise hospital services over a twelve-month period demonstrating:
  - More than 4 Emergency Department presentations within 12 months
  - More than 14 days length of stay for hospital admission/s
  - Greater than 10 outpatient appointments within 12 months
  - OR infants identified as being at risk of significant future hospital utilisation

There may be exceptions outside of this inclusion criteria, which may be considered by KIDS GPS Care Coordination Service.

Exclusion Criteria

- Children and young persons who currently receive formalised care coordination from their speciality team, to avoid duplicity of interventions. However, Kids GPS Care Coordination may be able to assist current teams in coordinating care through a documented care plan where the need arises.

Kids GPS can be contacted via:

- Email: schn-kidsgps@health.nsw.gov.au
- Phone: 02 9845 2526 (Westmead)
- Phone: 02 9382 0529 (Randwick)

Hospital in the Home (HITH)

The Sydney Children's Hospital Network HITH is defined as a substitute for inpatient care that reduces hospital admissions or total avoidance of services.

Referral Criteria

Are undertaken in consultation with Paediatrician/Specialist Consultant on service and the CNS2 for Ambulatory Services, the involvement of the Paediatrician is to ensure the patient has been referred and accepted by a suitable paediatrician/Specialist Consultant.

Acceptance of referrals depends on:

- Geographical location
- Patient's condition i.e., clinically/medically stable
- Consent from parents/carers for CAPAC
- Carer presence during home visits
- Carer competency
- Phone access
- Mutual recognition of identified goals of care

This Guideline may be varied, withdrawn or replaced at any time.
NSW GOVERNMENT

- Medicare eligibility
- Family access to transport
- No issues identified that can compromise staff safety during home visits

Formal referral to the HITH service is done via PowerChart and contacting the Ambulatory Care CNS2.

Follow up in the Home Setting

The initial home visit from HITH occurs on the first day after discharge. Where possible, facilitating the discharge of the patient from GCNIC earlier in the week (i.e., Monday, Tuesday, or Wednesday) facilitates a stronger capacity to meet the HITH home visiting requirements so that the family can be adequately supported.

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7. CHW Practice Guideline. Transferring Paediatric Patients and Related Transport Requirements: http://chw.schn.health.nsw.gov.au/o/documents/policies/guidelines/2006-8105.pdf

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