european standards of care for newborn health

Topic Expert Group: **Infant- and family-centred developmental care**

Case management and transition to home

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Target group
Infants, parents, and families

User group
Healthcare professionals, neonatal units, hospitals, and health services

Statement of standard
An individual case management plan for each newborn infant is established, in collaboration with parents, to plan and coordinate needed investigations and procedures, ensure the acquisition of needed parental competences prior to discharge and to plan follow-up and continuing care.

Rationale
An early appraisal of the expected clinical course during and after the hospital stay of each admitted infant and corresponding planning, collaboratively with parents, will safeguard effective provision of care. (see TEG Follow-up & continuing care) It will also support informed and empowered parental involvement, that subsequently will ensure adequate preparation for discharge. (1–7) (see TEG Follow-up & continuing care) Parents can best assess their infant's needs (8), and are expected to assume full responsibility for their child's care including feeding, medication and treatment regimens (9) as well as recognising signs and symptoms of infection or developmental issues. (8) Supporting and involving parents during the hospital stay and in the discharge process from the NICU can reduce the risk of readmission and also give the parents the confidence in caring for their preterm infant at home. (10–14) (see TEG Follow-up & continuing care) Providing domiciliary care when some medical care still is needed but feasible at home, is an example of how to support a smooth transition from hospital to home. Home care provided by NICU affiliated staff can facilitate discharge from hospital even if the infant still needs some medical care, and ensures the access to the unit after discharge if readmission is needed. The safety of the infants is ensured by regular home visits by healthcare professionals from the home care team. Parental skills are enhanced and hospital stay is reduced. (15–22) It is important that the hospital can ensure parental access and involvement if the infant needs readmission after discharge.

Benefits

Short-term benefits

- Improved preparedness for discharge and reduced length of hospital stay (3–5,7,12,22)
- Improved parental confidence and bonding (14)
- Improved recognition and management of potential infant medical issues (11)
- Improved management of developmental issues through linking in with the community-based intervention services prior to discharge

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Long-term benefits

- Reduced rate of readmissions and emergency department visits (11–13)
- Improved parent experience leading to reduction in parental anxiety issues (7,23,24)

Components of the standard

Component	Grading of evidence	Indicator of meeting the standard
For parents and family		
1. Parents and family are informed by healthcare professionals about the importance of their involvement in planning the care and in the discharge process of the infant. (12)	A (High quality) B (High quality)	Patient information sheet
2. Parents are guided to participate in creating and regularly updating a case management plan in collaboration with responsible healthcare professional. (3–6,12)	A (High quality)	Parent feedback
For healthcare professionals		
3. A unit guideline on case management is adhered to by all healthcare professionals. (3–6,12)	A (High quality)	Guideline
4. Training on case management is attended by all responsible healthcare professionals.	B (Moderate quality)	Training documentation
5. The individual case management plans are implemented in collaboration with parents by all healthcare professionals. (3–6,12)	A (High quality)	Clinical records, guideline
6. Support of families throughout their stay with ongoing structured conversations about the care of their infant, infant feeding, information about health management and infant development is ensured. (4–7,13)	A (High quality)	Clinical records, parent feedback
For neonatal unit		
7. A unit guideline on case management is available and regularly updated. (3–6,12)	A (High quality)	Guideline

8. A unit guideline ensuring family access and parental involvement in case of readmission after discharge is available and regularly updated.	B (Moderate quality)	Guideline
For hospital		
9. Training on case management is ensured. (4–7)	A (High quality)	Training documentation
10. A hospital guideline ensuring family access and parental involvement in case of readmission after discharge is available and regularly updated.	B (Moderate quality)	Guideline
For health service		
11. A national guideline on implementation of case management and transition to home programmes is available and regularly updated. (4–7)	A (High quality)	Guideline

Where to go – further development of care

Further development	**Grading of evidence**
For parents and family	
• Parents and family are offered peer-to-peer support whilst in the unit. (25)	A (Moderate quality)
• Every family has access to a post-discharge family support unit including 24-hour telephone support. (26)	A (Moderate quality)
• Every family has access to home care. (16)	A (Moderate quality)
For healthcare professionals	
• Coordinate peer-to-peer support activities. (25)	A (Moderate quality)
For neonatal unit	
• Provide rooming facilities for all families.	A (Moderate quality)
• Supervise, train and authorise the peer-to-peer family support. (25)	A (Moderate quality)
• Provide a post discharge family support group including 24-hour telephone support. (26)	A (Moderate quality)
• Provide a home care programme. (7,15,22,26)	A (Moderate quality)
For hospital	
N/A	
For health service	
N/A	

Getting started

Initial steps
For parents and family
• Parents and family are verbally informed by healthcare professionals about the discharge planning process.
For healthcare professionals
• Attend training on case management. • Establish a Discharge Planning Group with an aim also to develop a structured discharge planning education programme for families.
For neonatal unit
• Develop and implement a unit guideline on case management. • Develop information material on case management for parents. • Authorise and approve the establishment of a designated discharge planning nurse and a unit discharge planning group to develop a structured discharge planning education programme for families.
For hospital
• Support healthcare professionals to participate in training on case management.

- Make preparations for creating a discharge planning education programme for families.
- Make preparations for creating a home care programme.

For health service

- Develop and implement a national guideline on implementation of case management and transition to home programmes.

Description

Planning for discharge for very preterm infants begins around the time of birth. During the clinical course, various disciplines and departments are involved according to the individual needs of the infant and their family. The role of case management is to plan and monitor the entire care pathway and prepare parents for the next phase. Coordination between needed investigations, treatment and services, and adequate communication with families, is best ensured by providing a specific unit case manager, who is usually a specialist neonatal nurse or a nurse practitioner. The case manager, in close collaboration with parents, makes a case management plan that is regularly updated according to the interventions needed by the infant and training and support services needed by their family, e.g., in breastfeeding and practical caregiving (see TEG Care procedures, Nutrition, and Infant- & family-centred developmental care). The transition to home is enhanced by organising follow-up and continuing care on an individual basis.

Source

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