Standard in brief

Follow-up & continuing care

Transition from hospital to home

Hüning BM, Härtel C, Wolke D, Leemhuis AG

Statement of the standard

Families receive a **comprehensive discharge management plan** to facilitate transition from the hospital to home.

For parents and family

- Parents are informed and assisted by healthcare professionals in order to participate in care procedures and decision-making from admission to discharge management.
- Parents are informed by healthcare professionals about:
  - symptoms and signs of illness of their infant and how to respond
  - the importance of vaccination of infants and their household contacts
  - breastfeeding
  - safe sleeping environment
  - car seat safety
  - no smoking environment
  - follow-up visits for ongoing medical problems, growth, and neurodevelopment
  - post-discharge positive parenting intervention programmes
- Parents receive ongoing psychosocial support that is adapted to their individual needs and resources.
- Discharge planning includes training and resuscitation for high-risk infants.

Benefits

Short-term benefits:

- Reduced length of hospital stay and costs
- Reduced risk of hospital-acquired mortality and morbidity

Long-term benefits:

- Seamless care
- Minimised separation of parents and infant
- Continued family support
- Reduced healthcare visits after discharge
- Reduced infant mortality and morbidity
- Reduced rate of readmissions
- Increased rate of complete vaccination
- Improved parental competence and confidence
- Reduced stress for parents and family
- Improved parental mental health and resilience
- Improved interdisciplinary cooperation and cross-sectoral collaboration for the benefit of the families
- Reduced healthcare costs and costs for the family

For healthcare professionals

- A unit guideline on the management of the transition from hospital to home is adhered to by all healthcare professionals.
- Training on the assessment of discharge readiness using a standard guideline as well as on current national vaccination guidelines, including safety and efficacy data of vaccines related to preterm infants is attended by all responsible healthcare professionals.
- Healthcare professionals communicate with the primary care physician and provide a written discharge summary.

For neonatal unit, hospital, and follow-up team

- A unit guideline on the management of the transition from hospital to home is available and regularly updated.
- A multidisciplinary meeting is arranged for each high-risk infant prior to discharge.
- Discharge planning is continuously assessed from admission.
- Regular meetings to discuss parental participation and competencies, family, and social issues are organised.
- Training on the assessment of discharge readiness using a standard guideline as well as on current national vaccination guidelines, including safety and efficacy data of vaccines related to preterm infants is ensured.
- Rooms and equipment for counselling/training of parents are available.

For health service

- A national guideline on the management of the transition from hospital to home is available and regularly updated.

european standards of care for newborn health

Here you can access the full standard:
https://newborn-health-standards.org/transition-from-hospital-to-home/

EFCNI european foundation for the care of newborn infants