THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Framework for Repatriation of Neonates within TV & Wessex Neonatal ODN	
Approved by/on:	**Thames Valley & Wessex Neonatal ODN Governance Group June 2022 Governance**
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Related documents	TV & Wessex Policy for Transfer of Infants to a NICU/LNU BAPM Categories of Care August 2011 BAPM Service Standards for Hospitals providing Neonatal Care (3rd edition) 2010 Neonatal Service Specification: Neonatal Critical Care 2013/2014 NHS England Toolkit for High Quality Neonatal Services DOH 2009 BAPM Family Integrated Care Framework 2021 Neonatal Critical Care Transformation Review December 2019
Implications of race, equality & other diversity duties for this document	**This guideline must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation or religion.**

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Appendices

1.0 Executive Summary

This guidance provides a framework for the repatriation of neonates within TV & Wessex Neonatal ODN to their local neonatal unit; this includes the repatriation from a NICU to local LNU / SCU or LNU to local SCU within the Network. There is clear guidance and specifications on levels of care that can be provided in different levels of units i.e.: NICU, LNU & SCU with recommendations and care pathways indicating where babies should receive intensive care, high dependency care and special care (Neonatal Service Specification 2013/2014).

There is currently no clear guidance or recommendation on repatriation to local LNU & SCUs for on going care when NICU/ LNU care is no longer required. It is important to ensure that babies and their families receive the highest quality of care as close to home as possible (Toolkit High Quality Neonatal Services DOH 2009).

The decision to repatriate for local care in some situations can be complex and can depend on several different factors, and should only be considered when:

- appropriate level of care can be provided in the local unit and regular input of tertiary specialist advice is no longer required
- the baby's condition is stable and safe transport can be undertaken

It should be agreed by the clinical team responsible for the care of the baby in the NICU/LNU in conjunction with the family and the local team. The timing of repatriation to the local LNU/SCU should be regularly considered and reviewed. The local LNU /SCU clinical team should be notified of the birth of the baby (i.e. delivery after in utero transfer (IUT)) and regularly updated on the infant's progress and readiness for local repatriation for ongoing care.

Parents and carers should be made aware of the pathways for ongoing local neonatal care, provided with local unit parent level information, and opportunities to visit / video tour and meet the local neonatal team and unit. The Repatriation/Family Liaison Link Nurse Role has been created to ensure families have contact from their local LNU/SCU's by an appointed member of staff who can have regular contact with them and arrange visits to their local units, answering any questions they may have.

There may be specific situations that will influence a decision to transfer a baby no longer needing intensive care e.g., practical difficulties of parents accessing their local SCU, presence of close family relatives near to the NICU/LNU. Equally there may be occasions when the transfer of a baby still requiring ongoing high dependency support is appropriate i.e. when the pathway of care is towards palliative care.
(Appendix 1: Overview Framework for Repatriation from NICU/LNU to LNU/SCU)

2.0 Aim of Guideline

The aim of this guidance is to provide a clear framework and guidance to:

Ensure safe effective clinical decision making and communication in repatriation for local neonatal care within network governance protocols, including handover of clinical information and care provision between the different neonatal units and clinical teams involved.

Define the minimum thresholds for repatriation to the local unit of booking following an episode of uplift in care for any baby who receives neonatal care following delivery outside of its local unit of booking i.e. following IUT for foetal medicine care, maternal medicine or in utero transfer for delivery and neonatal care.

Ensure that the needs of the baby and family are considered and assessed to determine the best location of care as close to home as possible.

To facilitate repatriation and safe transfer for ongoing care in their local unit.

Ensure that parents remain informed and involved in the care of their baby in the different neonatal units with seamless transition following repatriation for ongoing care.

3.0 Scope of Guidelines

Thames Valley		
TRUST	**Hospital**	**Designation**
Oxford University Hospitals NHS Foundation Trust	John Radcliffe Hospital, Oxford	NICU
Buckinghamshire Healthcare NHS Trust	Stoke Mandeville Hospital, Aylesbury	LNU
Frimley Health NHS Foundation Trust	Wexham Park Hospital, Slough	LNU
Milton Keynes University Hospital NHS Foundation Trust	Milton Keynes General Hospital	LNU
Royal Berkshire NHS Foundation Trust	Reading	LNU

Wessex		
TRUST	**Hospital**	**Designation**
University Hospital Southampton NHS Foundation Trust	Princess Anne Hospital	NICU
Portsmouth University Hospitals NHS Trust	Queen Alexandra Hospital	NICU
Hampshire Hospitals Foundation Trust	Basingstoke	LNU
Hampshire Hospitals Foundation Trust	Winchester	LNU
University Hospital Dorset NHS Foundation Trust	Poole Hospital	LNU
Salisbury NHS Foundation Trust	Salisbury	LNU
Dorset County Hospital NHS Foundation Trust	Dorchester	SCU
Isle of Wight NHS Trust	St Mary's Hospital	SCU
University Hospital Sussex NHS Foundation Trust	St Richard's Hospital, Chichester	SCU

4.0 Guideline Summary

Babies should receive the highest quality of care as close to home as possible (Toolkit for High Quality Neonatal Services DOH 2009). In general babies should be repatriated from a NICU to LNU or if relevant to their SCU of booking and LNU to SCU within 48 hours of meeting repatriation criteria. Receiving units have a responsibility to provide capacity to care for the babies being repatriated within 48 hours of the request being made.

Additional measures may need to be undertaken to create adequate capacity within LNU's and SCUs and these may include the following:

- Putting in place additional staffing including bank or agency staffing
- Reviewing all babies suitable for discharge home or ongoing care on paediatric unit

5.0 Guideline Framework

Repatriation responsibilities

All units should engage with the processes of notification and communication of outlier babies within their unit and follow the repatriation guidance.

Referral units should ensure that local units are notified of the birth of a local baby within their unit and engage with the local LNU /SCU with regular communication updates.

Referral units have a joint responsibility for preparing families for repatriation to their local unit with the receiving local LNU/SCU. The Repatriation/Family Liaison Link Nurse Roles within LNU's/SCU's has been created as a point of contact for families to build relationships prior to transfer.

Referral units are responsible for the clinical care and safety of the baby, that the minimum criteria for repatriation have been met and that the patient is safe for transfer and ongoing local care.

Receiving units should prioritise assessing capacity for acceptance of the baby for repatriation early in the day to enable timely transfer and referral to SONeT service.

Clinical teams involved in the care of a baby including subspeciality teams i.e. surgical, cardiac teams and allied health professionals are responsible for ensuring an ongoing management plan and handover of care information has been provided.

Process of repatriation

Planned delivery in NICU / in utero transfers to NICU /LNU

- Antenatal counselling of women in local services prior to IUT should be an opportunity to explain pathways of neonatal care including transfer of care back to the local neonatal service when this is appropriate

- Women booked for delivery with onsite NICU services under the care of foetal medicine / maternal medicine should be counselled antenatally to explain neonatal pathways of care within the Network including transfer of care back to local neonatal services

After birth and admission to an NICU/LNU

- Local LNU/SCUs units should be notified of the admission of their local baby by the NICU/LNU following delivery by the clinical team i.e. Nurse in charge / Neonatal Coordinator. Local teams may

not be aware of the birth of a baby following the IUT of the mother or women who were booked for delivery in a specialist centre

- Parents should be made aware that their baby will be transferred back to their local LNU /SCU for on-going care when it is appropriate for their baby. They should be provided with written generic information on repatriation for ongoing care to their local unit.
  (Appendix 2: Repatriation Parent Information Leaflet)

- Parents to be offered the opportunity to co-produce a Parent passport in the NICU/LNU as a record of their journey whilst on the Neonatal unit. The Parent passport is a record of the care parents have been giving their baby and will be transferred by the parents to be continued in the receiving unit. This will enable parents to continue providing the same care for their baby in their local unit. Parents will only need local orientation to the unit and should not need retraining i.e. in care and feeding their baby.

- There should be regular weekly communication between the NICU/LNU and the local unit to share information on the clinical condition and where appropriate, provide an anticipated or estimate of expected length of stay in NICU/LNU, this can be carried out by the Unit's Coordinator. It may not always be possible to anticipate the duration of the expected NICU/LNU stay. Information shared should be recorded using the Network Repatriation Communication Record (Appendix 3) to support effective communication.

- Local LNU/SCU should ensure up-to-date records of outlying baby communications between the units are maintained and should be widely available to the local team i.e. local unit repatriation folder. This can be done by using a Network Repatriation Communication Record or via an EPR white board system. All documented communication records should be included in the baby's medical record once transferred to the local unit.

- Local Units to allocate their Repatriation/Family Liaison Link Nurse to contact the family on a regular basis i.e. weekly, to form a relationship with them, prior to repatriation. A record of communication should be completed and kept in the patients notes. (Appendix 4: Family Communication Record)

- Parents to be offered the opportunity to visit the local LNU /SCU during their babies stay in NICU/LNU prior to repatriation. This could be facilitated virtually, i.e. via V Create/ Padlet or an in person visit to the neonatal unit, this will be arranged by the Link Nurse.

- For complex babies with multidisciplinary team (MDT) input i.e., specialist medical / surgical teams / allied health professional, involvement of the multidisciplinary teams across sites should consider holding a meeting involving the referring and receiving clinical teams as well as parents. This can be facilitated by a Teams meeting with the health care professionals and parents and should occur prior to transfer as it offer families the opportunity to meet teams and ask questions, prior to transfer. A record of the MDT should be shared and included in the patient record.

- When a baby meets the minimum criteria for transfer back to an LNU/SCU and is no longer requiring intensive or high dependency care, surgical, cardiac and subspecialist care in a NICU/LNU it may be considered for repatriation to the local LNU/SCU. The baby must be stable and receiving high dependency or special care and be suitable for transfer. (See Criteria for Repatriation section).

- It is an NICU/LNU Consultant responsibility to ensure that a baby meets criteria for repatriation and is fit for transfer and repatriation to its local LNU/SCU for ongoing care.

- Parents to be provided with up-to-date information about their local LNU/SCU during their stay in NICU in preparation for repatriation and ongoing care. This should include written Parent Information Leaflet on their local unit from the SONeT PIL on SONeT website and given the opportunity to view a virtual tour/ web-based information.

Transfer back for ongoing local LNU/SCU care

- An MDT Teams meeting with the NICU /LNU team and the local LNU/SCU team should be considered in planned repatriations to their local service of complex babies i.e.: specialist medical / surgical team / allied health professional involvement. A record of the MDT should be shared and included in the patient record. It may not be necessary for those transfers that have had a short period of stay in a NICU/LNU

- The Nurse Coordinator should contact the local LNU/SCU to arrange repatriation and ensure that a cot is available. Once agreed the NICU/LNU should contact the Neonatal Transfer Service SONeT to arrange the repatriation to the local SCU

- The NICU/LNU medical team should contact the LNU/ SCU medical team to communicate the clinical details of the baby prior to transfer. The local team should be provided with an update of clinical information. If an MDT Teams meeting for complex patients between the referring and local unit to plan repatriation to the local unit has been undertaken this may not be necessary. All babies should have a completed neonatal discharge summary on Badgernet, with printed copy outlining the care episode, current and on-going clinical issues. The baby should be recorded as transferred on Badgernet discharge.

- Break glass function on Badgernet for information sharing should be considered (see Appendix 5). This enables the Badgernet records to be visible to the local team. This function only needs to be activated for those baby's that were not born in their local unit. The records of those babies transferred to an NICU/LNU after birth should already be available to their local unit.

Criteria for repatriation to a Local Neonatal Unit LNU / Special Care Unit SCU

Minimum threshold for Repatriation to a Local Neonatal Unit (LNU)

- Considered clinically stable for transfer
- Corrected gestational > 27 weeks and current weight > 1000gms
- Respiratory support: Off invasive ventilation for 48 hours, stable on continuous Positive Airway Pressure (CPAP) ≤ 6 cm H2) , or High Flow ≤ 8L/min or Low Flow ≤ 0.3 L /min
  FiO2 should be ≤ 30 % for most babies or ≤ 40% in stable established chronic lung disease (CLD)
- No significant apnoea's or desaturations
- Cardiovascular support: Stable with no inotropic support needed. Stable on cardiovascular medications i.e., Beta blockers/ Sildenafil, doses stable for a minimum of 5 days and a clear plan from the specialist team
- Nutrition: Babies should be tolerating a minimum of 60mls/kg/day of enteral feeds for at least 24 hours prior to transfer. Babies can be receiving Total parental nutrition (may be unit exceptions)

Babies transferred from local units or born in an onsite NICU i.e. term/ moderate or late preterm infants may not need to meet all these criteria

Clinical judgement should be used in considering the readiness for repatriation and may require further clinical discussion prior to repatriation for local care. Examples include Extreme preterm infant 22/40 to 26 +6 / 40, post-surgical, infants with congenital cardiac disease, infants with complex needs i.e. subspecialist involvement.

Consideration points include the following:

- Feeding pattern and adequate growth
- Medical and nursing intensity for specialist needs
- Subspecialist face to face review or investigations

Consultant discussion / MDT cross site meeting should take place in these situations where the minimum criteria is met, and repatriation is not considered safe or appropriate or in situations where higher level of support is needed i.e., palliative care or non-invasive ventilation (NIV) for CLD and local care is deemed preferable.

Minimum threshold for repatriation to a Special Care Unit SCU

- Considered clinically stable for transfer
- Gestation > 32 weeks and over 1250 gms (with sustained growth)
- Respiratory support: Stable on High Flow ≤ 6L/min with Fio2 < 30% or Low Flow ≤ 0.3 L /min. Babies would usually have been off invasive respiratory support for minimum of 72 hours, off CPAP for minimum of 48 hours. Stable CPAP may be considered with discussion
- Nutrition: Babies can be on intravenous fluids or some enteral feeds with no specific need for TPN. Babies born at ELBW would usually be tolerating 120mls/kg /day enteral feeds

Babies transferred from local units or born in an onsite NICU/LNU i.e. term/ moderate or late preterm infants may not need to meet all these criteria

Consultant discussion / MDT cross site meeting should take place in these situations where the minimum criteria is met, and repatriation is not considered safe or appropriate or in situations where higher level of support is needed i.e. palliative care or NIV for CLD and local care is deemed preferable.

Variation Notes:

Variation for LNUs within the region may occur for weight and TPN. This may depend on access to TPN / nutritional support.

Repatriation transfers requiring higher levels of support may be appropriate i.e., palliative care close to home or where stable infants are receiving substantially higher levels of respiratory support which are likely to continue in the medium to longer term.

The thresholds for consideration of repatriation detailed are triggers, at which point active plans for repatriation should be considered and discussed between the referring and receiving units. The final decision should take into consideration the specific clinical needs of the baby, the needs of the baby's' family, social factors and wider overall best place of care. Safety and best care should be considered in these decisions.

Repatriation delays

All units have a responsibility for documenting (Appendix 3: Network Repatriation Communication Record) when a repatriation transfer is delayed: the reason, estimated timeframe and specific requirements needed i.e. clinical parameters or local unit's measures i.e. staffing needed to support repatriation to the local unit not adequate.

Colonisation or local practise need for an isolation cubicle is not an indication for repatriation refusal and measures within the TV & W Neonatal ODN Health Care Associated Infection HCAI Colonisation Transfer Guidance 2021 should be followed. Babies identified to need isolation as per local Trust Infection guidance can be cared for:

- In an incubator
- In a cubicle or side room
- In an open ward with augmented local infection control practices to prevent cross transfer of multi resistant organisms.

References

- BAPM Categories of Care August 2011
- BAPM Service Standards for Hospitals providing Neonatal Care (3rd edition) 2010
- Neonatal Service Specification: Neonatal Critical Care 2013/2014 NHS England
- Toolkit for High Quality Neonatal Services DOH 2009
- BAPM Family Integrated Care Framework 2021
- Neonatal Critical Care Transformation Review December 2019

Appendix 1: Overview Framework for repatriation from NICU/LNU to SCU

Timeline

Pre delivery / transfer
Antenatal preparation pre delivery

After birth
Notification of delivery to local LNU/SCU
Regular review of care with consideration to repatriation to local LNU/ SCU
Weekly NICU/LNU/SCU updates of outlier status
Communication with family and local LNU/SCU
Use of Network Communication record
Parental support link care coordinators
MDT repatriation meeting via Teams for complex patients

Repatriation
Notify Parents, LNU/SCU, Neonatal Transport service of planned repatriation
Communication and Handover of care between clinical teams

Transfer criteria

Transfer to NICU from SCU
< 27 wks, multiples <28 wks

BW < 800gms

< 30 weeks Triplets

Any neonate needing Intensive care

Therapeutic hypothermia

Complex specialist care *

Transfer to NICU from LNU
Singleton <27 weeks

Multiples <28 weeks

Triplets <30 weeks

BW < 800gms

Any neonate needing short term intensive care

Therapeutic hypothermia

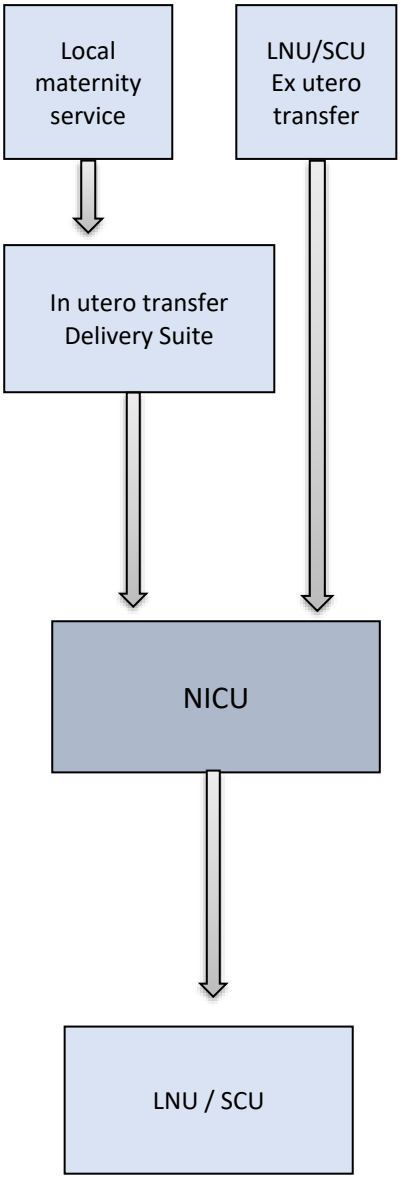
Complex specialist care *

Transfer to LNU from SCU
<32 weeks, multiples**
>34 weeks where a significant need for interventional care after birth is anticipated

BW <1250 gm

>32 weeks high dependency care over 48 hrs *** or condition deteriorating

Transfer pathway



Repatriation

Repatriation to LNU SCU
Clinically stable

Stable high dependency care

Minimum repatriation criteria met

No longer require surgical, cardiac or subspecialist care in NICU

Suitable for transfer

NICU/LNU/SCU clinical team agree repatriation to local LNU/SCU as appropriate

Repatriation within 48 – 72 hours

Parent Carer preparation for repatriation to local care

Parent information on local unit care

Parent local unit visit/tour

Parent passport completion

*Complex specialist care: with support of >1 organ, e.g. ventilation via a tracheal tube plus any of the following: inotropes, insulin infusion, presence of a chest drain, exchange transfusion, prostaglandin infusion, Neonatal surgical, cardiac or subspecialist care

****Multiples < 34 weeks for agreed SCU *** Discussion with NICU /SONeT Consultant**

Appendix 2A : Repatriation Parent Information Leaflet

NEONATAL UNITS

Neonatal Intensive Care Units

Oxford
Portsmouth
Southampton

Local Neonatal Units

Milton Keynes
Wexham Park
Reading
Stoke Mandeville
Basingstoke
Winchester
Salisbury
Poole

Special Care Baby Units

Chichester
Dorchester
Isle of Wight

GET IN TOUCH

Website
Neonatal South ODN
www.southodns.nhs.uk/our-networks/neonatal/

Mail
england.tv-w-neonatalnetwork@nhs.net

QR code for VCreate video

REPATRIATION OF YOUR BABY TO YOUR LOCAL NEONATAL UNIT

THAMES VALLEY & WESSEX
NEONATAL NETWORK

In the UK neonatal units are designated by the level of care they deliver. Neonatal Intensive Care Units (NICU's) look after preterm babies from 22 weeks, sick term babies and babies who need therapeutic hypothermia or have complex specialist care. Local Neonatal Units (LNU's) look after babies from 27 weeks gestation and Special Care Units (SBCU's) from 32- 34 weeks gestation.

Within the Thames Valley & Wessex Neonatal Network there are 14 different neonatal units. All the units have specially qualified neonatal staff, who can care for your baby at each stage of their neonatal journey.

Babies admitted to neonatal units receive their care at the hospital where the most appropriate level of neonatal care can be given. For some babies this may not always be provided at the local booked hospital closest to their home. Mothers may be transferred for the most appropriate maternity care and delivery, or babies may be transferred after birth to hospitals where additional neonatal care can be provided. The location of care for your baby may change throughout their neonatal journey and whilst this may not be close to your home initially, the aim is to transfer your baby back to your local unit as soon as they are well enough, and it is safe to do so.

When possible, if you require hospital care after delivery, you will be transferred to a maternity unit in the same hospital as your baby.

You may have met the neonatal team in your local unit before your baby is transferred for specialist care, but this may not have happened if you were transferred before your baby was born. Throughout your baby's stay you are encouraged to be with them and care for their needs. As well as this your local unit will receive regular updates on your baby's progress and will be aware of your family needs prior to repatriation.

The transfer of your baby for ongoing care in your local unit, will be planned between the referring unit, the local unit and yourselves. We encourage you to visit your local unit or have contact with the local team, prior to your baby's transfer. Please ask a member of the nursing team how to get in contact with your local neonatal Repatriation Link/Liaison Nurses or Senior Coordinators within each unit.

We would never transfer your baby without discussion with yourselves. However, the unit may need to contact you at short notice if the neonatal unit becomes full and your baby's care needs can be safely met by a local unit closer to home.

Moving units can be very daunting for parents but we will make every effort to support you throughout your baby's transfer.

The local team will have had regular updates about your baby's progress and your family's needs throughout your neonatal journey. This should help with the transition from one unit to another and any questions you may have. We will be able to provide you with general information about your local unit before transfer and the local team will orientate you to the unit once you arrive.

It may take several days for you to settle in and feel comfortable in a unit. This is a very normal feeling to have, but your new setting will soon become more familiar. Your local unit will be ready to help you to continue to develop your relationship with your baby, and to flourish and grow with the additional support of close friends and family around you.

We are always willing to answer any questions you have. Please contact a member of the nursing or medical team, who will be happy to help you.

Appendix 2B: Repatriation Parent Information Leaflet (A5 format)

Draft example of how this leaflet might look when Parent Passport is developed:

Appendix 3: Network Repatriation Communication Record

THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK Repatriation Communication Record

To be completed by the referring and receiving unit, copies to kept in the Unit's Repatriation Folder.
The referring unit should keep a copy in the medical record once discharged and send the completed record with the patient.

PATIENT INFORMATION			
Infant's name:		D.O.B:	Gestation:
Birth weight:		NHS Number:	
Booking hospital:		Telephone number:	
Birth hospital/ Referring hospital:		Telephone number:	
Consultant:		GP:	
Home Address:		Postcode	
Parents / carers name:		Contact number:	
Parents / carers name:		Contact number:	
Siblings:			
Immediate medical concerns:			
Any social/safeguarding concerns or other agencies involved:			
Parents informed of Network pathways/ transfer to local hospital when appropriate	Y/N	Badgernet Record Sharing (Breakglass function for neonates born in referral hospital)	Y/N Date:
Parents provided with Repatriation PIL and receiving Unit specific PIL	Y/N Date:	Parents offered Local unit visit / meet the team i.e. virtual unit tour, met Unit coordinator	Y/N Date:

REPATRIATION TO LOCAL UNIT			
Date Baby accepted to Local Unit:		Local Unit:	
Name of accepting Consultant:			
Name of accepting Nurse in charge:			
HANDOVER If cross site MDT discharge meeting occurred this may not be applicable/update only		Date:	
Medical handover	Y/N	Referring clinician	
Date:		Receiving clinician	
Nursing handover	Y/N	Referring clinician	
Date:		Receiving clinician	
Specialist team /AHP handover	Y/N	Referring clinician	
Date:		Receiving clinician	
Reason for refusal/deferral (if applicable)			
Name of Consultant / Nurse in charge responsible for decision to refuse/defer transfer			
Follow up call log / expected date of acceptance Further information/ plan			

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Ventilation
HFNC/CPAP
Low flow oxygen
Other</td><td colspan="2">CVS:
Inotropes
PDA management</td></tr>
<tr><td colspan="2">CNS:</td><td colspan="2">Medications:</td></tr>
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PN
Feeds / volume
Feed type/ BMF
Central line Y/N</td><td colspan="2">Investigations:
ROP
CrUSS
Hearing
MRI</td></tr>
<tr><td></td><td colspan="2">Sepsis:
Include colonisations
Barrier nursing Y/N</td><td colspan="2">Specialist input:
Subspecialist
AHP i.e. Physio/OT/SALT/Dietetics</td></tr>
<tr><td rowspan="3">Parents / carers interaction

What support are they receiving / do they need?</td><td colspan="2" rowspan="3">FiCare
e.g., are they…
NGT feeding
Taking temperatures
Kangaroo cares
Visiting
Resident
Present on ward rounds</td><td colspan="2">Additional comments:</td></tr>
<tr><td colspan="2">Expected date discharge/repatriation:</td></tr>
<tr><td colspan="2">MDT Teams discharge meeting Y/N
Date:
Circle as appropriate
For complex cases</td></tr>
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<tr><td colspan="2">MDT Teams discharge meeting Y/N
Date:
Circle as appropriate
For complex cases</td></tr>
</table>

Family Communication Record

Baby's name:	**DOB:**	**Gest:**
Type of delivery:	**Birth weight:**	
Parent/carer email address:		
Transport:	**Accommodation:**	
Referral for travel/accommodation expenses:	**Other information/notes:**	

Date:	☐ **Phone** ☐ **Email** ☐ **Facetime** ☐ **In Person**
Participants:	
What was discussed?	
Action/Follow up/Support	
Additional comments	
Next contact date:	

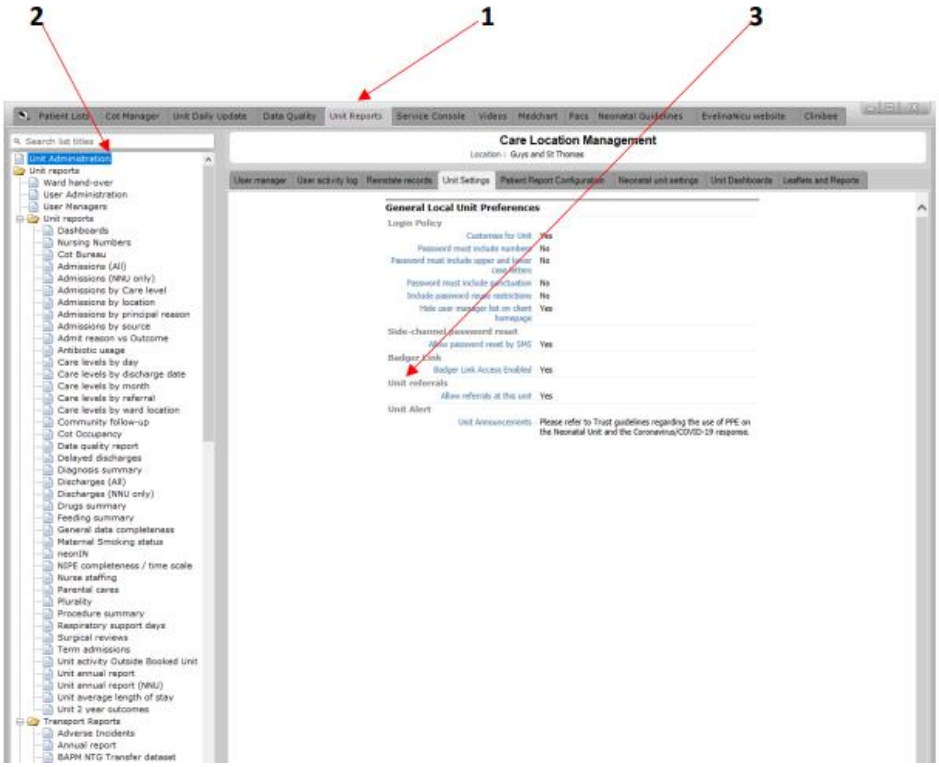
Family Communication Record

Date:	☐ Phone ☐ Email ☐ Facetime ☐ In Person
Participants:	
What was discussed?	
Action/Follow up/Support	
Additional comments	
Next contact date:	

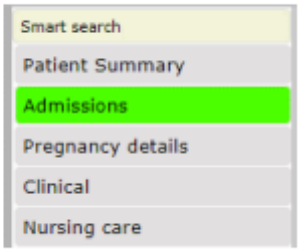
Appendix 5: BadgerNet Break glass function for record sharing prior to transfer

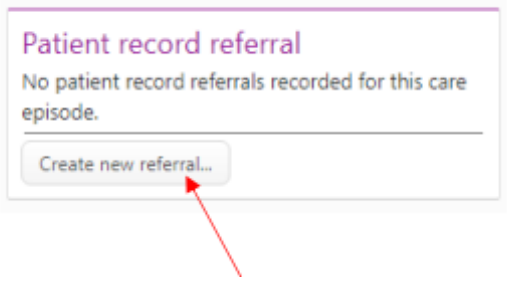
Remember any baby admitted to BadgerNet on your Unit will have all their BadgerNet records visible so this 'break glass' process is not required for a baby you transferred out that is now getting ready for repatriation. It is useful when repatriating babies born elsewhere, or when referring for ex utero transfer for uplift of care or specialist reviews

• First check your Unit settings: this needs to be done by a Local Administrator. You need to make sure your Unit settings allow Unit referrals

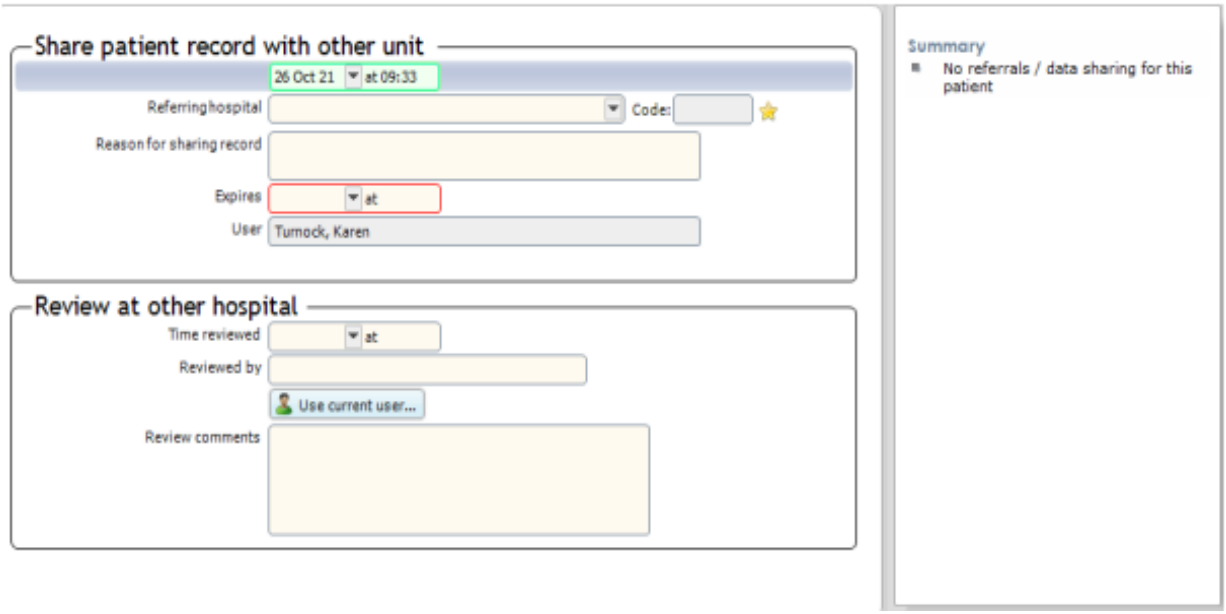


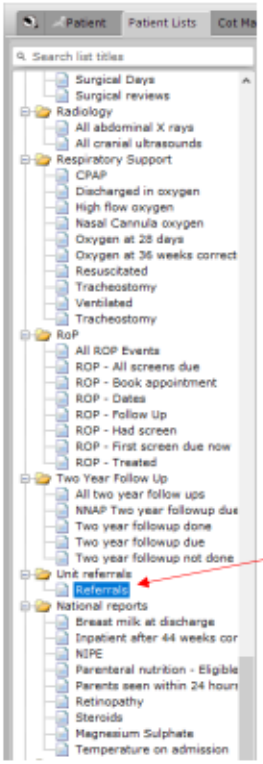
- Once that is done, on the admissions page (left hand side tab) you should now see this on the right:



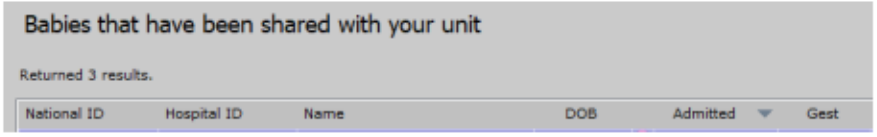


- Hit create new referral and complete. You need to state which unit can see the record ('referring hospital') and for how long.





• To find these records, scroll down the options in the 'patient lists' until you find 'Unit referrals' and click on 'Referrals' to open a list of the records shared with your unit. You can add comments by finding the patient record referral on the admission page.



Appendix 6: BAPM Categories of Care August 2011

INTENSIVE CARE

General principle: This is care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios.

Definition of Intensive Care Day:

- Any day where a baby receives any form of mechanical respiratory support via a tracheal tube
- BOTH non-invasive ventilation (e.g., nasal CPAP, SIPAP, BIPAP, vapotherm) and PN
- Day of surgery (including laser therapy for ROP)
- Day of death

Any day receiving any of the following:

- Presence of an umbilical arterial line
- Presence of an umbilical venous line
- Presence of a peripheral arterial line
- Insulin infusion
- Presence of a chest drain
- Exchange transfusion
- Therapeutic hypothermia
- Prostaglandin infusion
- Presence of replogle tube
- Presence of epidural catheter
- Presence of silo for gastroschisis
- Presence of external ventricular drain
- Dialysis (any type)

HIGH DEPENDENCY CARE

General principle: This is care provided for babies who require highly skilled staff but where the ratio of nurse to patient is less than intensive care.

Definition of High Dependency Care Day: Any day where a baby does not fulfil the criteria for intensive care where any of the following apply:

- Any day where a baby receives any form of non-invasive respiratory support
- (e.g., nasal CPAP, SIPAP, BIPAP, HHFNC)

Any day receiving any of the following:

- parenteral nutrition
- continuous infusion of drugs (except prostaglandin &/or insulin)
- presence of a central venous or long line (PICC)
- presence of a tracheostomy
- presence of a urethral or suprapubic catheter
- presence of trans-anastomotic tube following oesophageal atresia
- repair
- presence of NP airway/nasal stent
- observation of seizures / CF monitoring
- barrier nursing
- ventricular tap

SPECIAL CARE
General principle: Special care is provided for babies who require additional care delivered by the neonatal service but do not require either Intensive or High Dependency care.

Definition of Special Care Day: Any day where a baby does not fulfil the criteria for intensive or high dependency care and requires any of the following:

- oxygen by nasal cannula
- feeding by nasogastric, jejunal tube or gastrostomy
- continuous physiological monitoring (excluding apnoea monitors only)
- care of a stoma
- presence of IV cannula
- baby receiving phototherapy
- special observation of physiological variables at least 4 hourly

TRANSITIONAL CARE
General principle: Transitional care can be delivered in two service models, within a dedicated transitional care ward or within a postnatal ward. In either case the mother must be resident with her baby and providing care. Care above that needed normally is provided by the mother with support from a midwife/healthcare professional who needs no specialist neonatal training. Examples include low birth-weight babies, babies who are on a stable reducing programme of opiate withdrawal for Neonatal Abstinence Syndrome and babies requiring a specific treatment that can be administered on a post-natal ward, such as antibiotics or phototherapy.

Version Control (add when final draft agreed and ready for ratification):

Version	Date	Details	Author(s)	Comments
1	2014	Written		
2	2018	Reviewed		
3	2022	Reviewed and updated	Repatriation Group	Reviewed ready for Governance Meeting June 2022
4	2022	Ratified	Repatriation Group	Ratified at Governance Meeting June 2022
Review Date:	**June 2025**			