



Bliss Baby Charter

Helping to make family-centred care
a reality on your neonatal unit

Bliss
for babies born
premature or sick



Foreword

The Bliss Baby Charter Standards are based on the UN Convention on the Rights of the Child and align with the UK's Human Rights Act. The Standards evolved from the Bliss Baby Charter, originally published in 2005, which was an aspirational document aiming to inspire staff to continually deliver the highest quality of family-centred care (FCC).

This second edition of the Bliss Baby Charter has been updated with statements outlined in *All Wales Neonatal Standards*, 3rd Edition (2017) and *Best Start* (2017).

It is a practical guide to help hospitals provide the best possible family-centred care for premature and sick babies, an approach which places the family at the centre of their baby's care.

The Bliss Baby Charter is acknowledged as a quality standard that serves as a meaningful and effective benchmark for assessing performance, rewarding achievement and driving improvement.

Acknowledgements

Bliss would like to thank the following people, without whom the development of this booklet would not have been possible:

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Introduction

The Bliss Baby Charter provides a practical framework for neonatal units to self-assess the quality of family-centred care they deliver. It aims to improve outcomes for babies by changing the culture and practice in neonatal care to:

- ensure parents are at the centre of their baby's care
- improve consistency of care and support to babies and families
- improve (developmental) care for babies
- ensure all babies in neonatal care receive the correct clinical support /care.

Bliss developed the Bliss Baby Charter for neonatal units across the UK with the goal of standardising high-quality services that focus on the needs of babies and their families. We know that clinical and family-centred care must work hand in hand to provide babies with the best opportunity to survive and thrive.

The Bliss Baby Charter is a practical framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles. It enables units to audit their practices and develop meaningful plans to achieve changes that benefit babies and their families.

What is family-centred care?

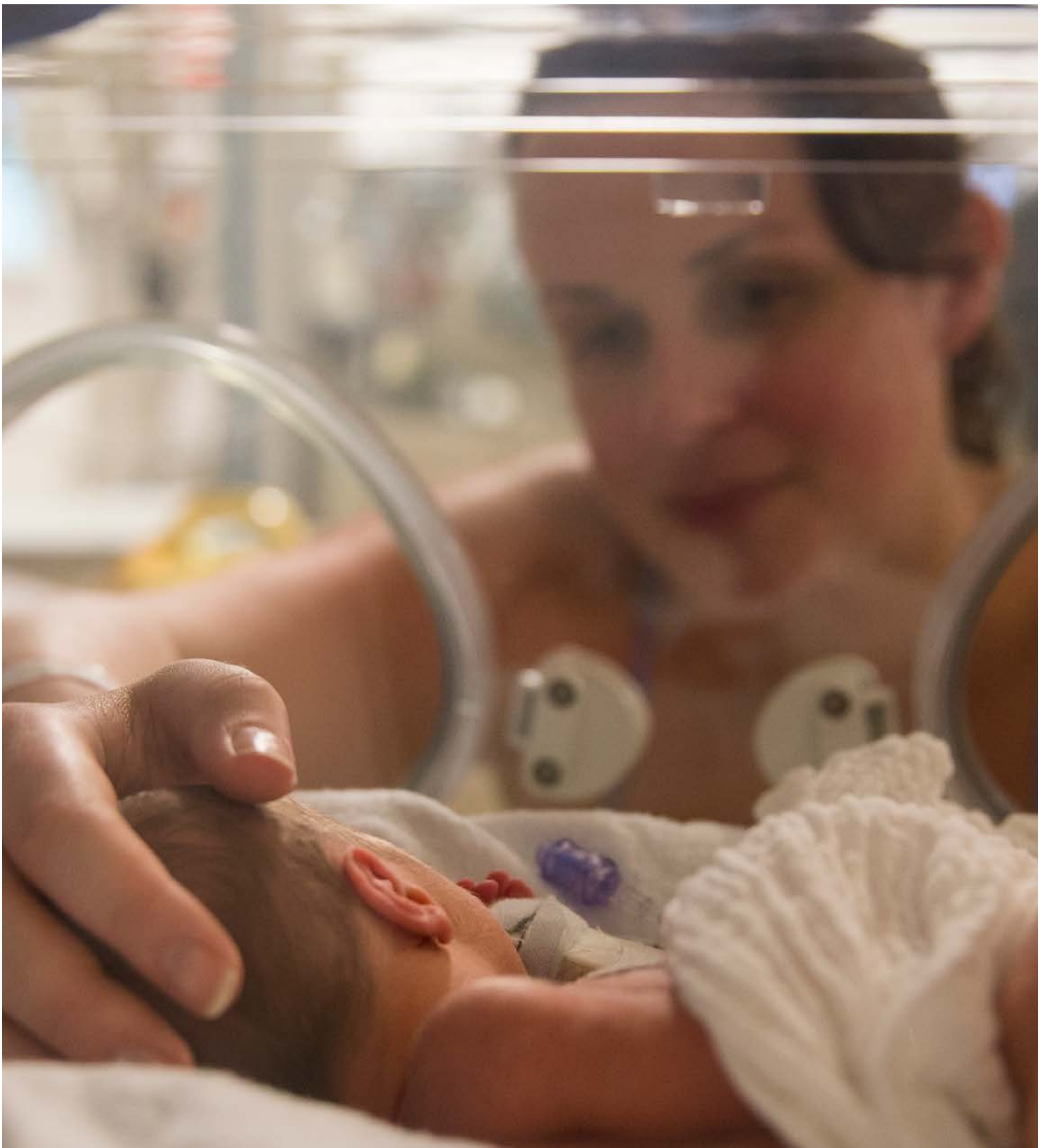
Family-centred care places the baby firmly in the context of the family, acknowledging that the family is the most constant and consistent influence on a baby's development.

It is a philosophy of care that help families who baby is in hospital to cope with the stress, anxiety and altered parenting roles that accompany their baby's condition.

It puts the physical, psychological and social needs of both baby and their family at the heart of all care given. Parents' care is essential for their baby's development. Evidence has shown when they are able to be full involved in their baby's care, it can improve their chances of a healthier future.

Family Integrated Care

Family-centred care is the foundation of Family Integrated Care. Some units in the UK are working towards taking parental involvement one step further by embedding Family Integrated Care. Family Integrated Care is a model of neonatal care that facilitates partnership and collaboration between parents and the neonatal healthcare team in order to promote the parent-infant relationships and build parental confidence further through a process of education, mentoring and coaching. The Bliss Baby Charter is a practical tool that enable neonatal units to start their journey towards this philosophy of care.



Bliss Baby Charter audit tool



Principle 1

Social, Developmental and Emotional Needs

Every baby should be treated as an individual and with dignity, respecting their social developmental and emotional needs as well as their medical and surgical needs

Rationale

Respecting the baby's individual rights – including private time for the baby and the family, and providing care that maximises the comfort of baby and family, can have a positive impact on the baby's health and development, and the wellbeing of baby and family

Standard 1.1 - Dignity and Privacy

1.1A All babies are referred to by their given name and parents/care givers are referred to by their preferred name.

1.1B All parents have unrestricted access to their baby, unless individual restrictions can be justified in the baby's best interest.

1.1C Parents are offered privacy when feeding their baby, during skin-to-skin care and when clinical procedures are taking place.

1.1D Parents and visitors are encouraged to respect other babies' and families' privacy on the unit e.g. not approaching other cots or accessing other babies' medical information.

1.1E Parents have the opportunity for private time with their baby in a separate room or cot side with screens, as their baby's condition allows.

1.1F Parents are involved in the choice of clothing for their baby as their clinical condition permits.

Standard 1.2 - Comfort

1.2Ai Your unit has a guideline for reducing baby's stress and a process for implementation.

1.2Aii Your unit uses a range of techniques to minimise pain and distress for baby during and after interventions.

1.2B Staff are expected to observe and respond appropriately to the baby's behavioural cues. The baby's responses to care giving and to their parents are documented in their records.

1.2C Timing and pacing of care takes into account the availability of parents, the individual baby's sleeping pattern, stress thresholds and tolerance of handling.

Standard 1.3 - Touch

1.3A Close contact between parents and their babies is integral to the unit philosophy. Whenever possible, comforting touch should be baby-led and individualised by interpreting the baby's cues.

1.3B Information about 'touch' and their baby is shared in active partnership with parents.

Standard 1.4 - Positioning

1.4A Your unit implements evidence-based guidelines for positioning that are readily available.

1.4B The baby's position is changed according to individual needs and cues and responses are recorded.

1.4C Staff discuss with parents optimal positioning strategies for their baby.

Standard 1.5 - Light

1.5A The unit has evidence-based guidelines for lighting that are safe and comfortable for babies, parents and staff, and these are readily available.

1.5B The unit uses a range of mechanisms to minimise stress from bright or continuous light.

Standard 1.6 - Sound

1.6A The unit has evidence-based guidelines to create a safe and comfortable sound environment for babies, parents, and staff, and these are readily available.

1.6B Your unit uses a range of mechanisms to minimise baby's stress from loud and continuous noise.

1.6C Your unit promotes a quiet and restful environment e.g. scheduling specific periods for baby and the parents with no clinical cares.

Standard 1.7 - Taste and Smell

1.7A Your unit has evidence-based guidelines for optimising the olfactory environment for infants.

1.7B Your unit uses a range of strategies to optimise the olfactory environment for infants.

Principle 2

Decision Making

Neonatal care decisions are based on the baby's best interest, with parents actively involved in their baby's care. Decisions on the baby's best interest are based on evidence and best practice, and are informed by parents, who are encouraged and supported in the decision-making process and actively participate in providing comfort and emotional support to their baby.

Rationale

Parents have a right to be involved in decisions about their baby's treatment. Involving parents into the care of their baby on the neonatal unit has benefits for both baby and parents.

Standard 2.1 - Decision making

- 2.1A** On admission, all parents are effectively signposted to Bliss information.
- 2.1B** Parents receive sensitive, honest and timely communication regarding their baby's condition.
- 2.1C** Clear guidelines on consent are followed and parents are sufficiently informed and understand when consent is needed.
- 2.1D** For routinely anticipated care, explanations are given in advance and parents are signposted to appropriate written information.
- 2.1E** For immediate interventions, an explanation is given as soon as possible and any discussion is documented.
- 2.1F** All significant changes in baby's condition requiring new interventions or care are discussed with parents as soon as possible. Where necessary, signed consent is obtained and filed.
- 2.1G** Decisions/changes in care where parents may express a preference should always involve them.

2.1H Parents have regular access to their baby's named consultant or senior medical staff, are invited to be present at ward rounds and encouraged to participate in them.

2.1I Parents are provided with information about how to access their baby's notes and records.

Standard 2.2 - Care plans

- 2.2A** Staff follow pathways and use the prompts within the pathway to direct or anticipate care.
- 2.2B** Care plans are reviewed regularly and kept up to date.
- 2.2C** Parents have an identified individual, who proactively provides regular information on the care pathway and provides support during transition and discharge.
- 2.2D** Parents are provided with information about who to contact on the unit with queries or advice regarding their baby's condition and treatment and know where to go for further information, including useful websites.
- 2.2E** Parents are provided with ongoing information, by trained staff, about their baby's long-term outcomes.
- 2.2F** Health visitors are informed of a new admission as soon after birth as possible and mechanisms are in place to facilitate appropriate contact with the family on the unit, particularly in preparation for discharge.

Standard 2.3 - Psychosocial support

- 2.3A** Families, including siblings, are offered social and psychological support while on the unit.
- 2.3B** Families, including siblings, have access to support from community neonatal teams while on the unit.
- 2.3C** Staff provide families with written information about local social and psychological support and advice services, organisations and networks, including relevant literature and information on how to contact them when they are ready.

Standard 2.4 Sensitive news

2.4A Your unit provides comfortably furnished private rooms for parents to have confidential, sensitive or difficult discussions.

2.4B Staff have received specific training on how to communicate difficult news (as appropriate).

2.4C When breaking sensitive or difficult news to parents, staff ask the parent/s whether they would like a support person present.

2.4D Families are offered psychological/emotional support after receiving sensitive news.

2.4E Staff help families to access bereavement counselling and support if their baby has died on the unit.

2.4F Parents have access to or are offered faith/spiritual support within the hospital.

Standard 2.5 - Palliative and end of life care

2.5A Units have clear criteria for assessing which babies require palliative care, taking into account diagnosis and prognosis.

2.5B Palliative care decisions are made following discussion between parents and senior/suitably trained clinicians.

2.5C Palliative care is coordinated by a named lead professional and involves a multi-agency, multi-disciplinary team.

2.5D The baby's documented care plan is agreed with parents and based on a multidisciplinary assessment. There is an ongoing discussion with parents about personal faith or spiritual wishes and place of death.

2.5E Units have links with children's hospices to support parents and their choices on baby's place of death.

2.5F Staff working in this area are experienced in supporting palliative care and have received appropriate training.

2.5G A lead clinician talks through making critical decisions with parents and notes the conversation in the baby's record.

2.5H Bereavement support is made available and is coordinated by a dedicated professional.

2.5I Staff support the rapid discharge of a dying baby to home if the parents wish it. They are competent in involving a GP in this process and can provide a discrete level of support to the family during this period.

Principle 3

Specialist Services and Staff

Babies receive the nationally recommended level of specialist care in the nearest specialist unit to the baby's family home. Parents actively participate in providing comfort and emotional support to their baby.

Rationale

Parents have a right to be involved in decisions about their baby's treatment. Involving parents into the care of their baby on the neonatal unit has benefits for both baby and parents

Standard 3.1 - Trained specialist staff

3.1A Medical and nursing staff establishments and training meet nationally agreed minimum standards. Medical rotas and nurse staffing levels meet nationally agreed requirements in all levels of neonatal care.

3.1B All health professionals providing care should be competent in basic life support and stabilisation of the newborn baby.

3.1C The unit has identified competency frameworks including developmental care, breastfeeding and discharge planning that staff are regularly assessed against.

3.1D Staff training included components that develop knowledge and skills in baby and family-centred care.

3.1E Staff are trained to the appropriate level in mandatory safeguarding procedures.

Standard 3.2 - Multidisciplinary team

3.2A Babies have time-sensitive access to allied health professionals with specific neonatal or paediatric training.

3.2B Families have access to social workers for assessment and provision of support services or are signposted to the relevant local agencies.

3.2C Care plans reflect a multi-disciplinary approach to supporting family-centred neonatal care.

Standard 3.3 - Near to home

3.3A Your unit follows network transfer guidelines for admission to appropriate specialist services or return to an appropriate local service.

3.3B Parents are informed about and have the chance to visit a new unit in advance of a transfer.

3.3C If transferred, parents are given detailed information (by staff on their current unit,) on the new unit in advance.

3.3D Parents are given an explanation and involved in discussions on transfers, with the choice to accompany their baby if safe to do so.

Standard 3.4 - Consistency across the neonatal network

3.4A The unit has a visiting policy that is flexible to optimise family-centred care and is consistent with other units in the network.

3.4B The unit follows network-wide guidelines for procedures on breastfeeding, day-to-day cares, developmental care etc where available.

Principle 4

Benchmarking

Units encourage parents to be involved in plans and processes for continuous service improvement, and outcomes of care and benchmarked against local and national standards.

Rationale

Monitoring outcomes of care enables local trends to be observed and compared to local, national and international benchmarks. A culture of continuous improvement, that involves and is informed by parents, promotes high quality care and is responsive to the needs of each baby and family. A commitment to delivering national standards ensures local levels of excellence.

Standard 4.1 - Monitoring and benchmarking

4.1A Benchmarking activity is routinely included in the units' quality improvement programme.

4.1B Feedback from parents is regularly sought, collated and fed into decision-making processes.

4.1C Your unit works together with other units within your network on agreed benchmarking/audit programmes.

4.1D Your unit participates in the National Neonatal Audit Programme.

Standard 4.2 - Service improvement

4.2A There is a continuous process for involving parents in improving the unit's delivery of family-centred care.

4.2B Parents are included in the planning and development of service improvements at unit and network level.

4.2C Benchmarking and audit inform future service improvement activities and action plans.

4.2D Improvements are introduced to the unit in response to feedback from both staff and parents.

Principle 5

Unit Information and Facilities

Parents are informed, guided and supported, so that they understand their baby's care processes and become confident in caring for them. Parents should have access to information about clinical conditions, tests and treatment, infant development, as well as practical issues such as breastfeeding, financial support, transferring between units, local facilities and support services. Information needs to be available in different formats, different media and different languages (according to local population).

Rationale

It is important that parents have equal opportunities for information as it can help to alleviate stress and anxiety. Parents need to know how they can care for their baby on the unit so that they have opportunities to develop parenting roles and feel confident about taking their baby home.

Standard 5.1 - Introduction to the unit

5.1A Parents with a predicted need for neonatal care should be offered a visit to the unit and an opportunity to meet staff before their baby is born.

5.1B All parents are fully inducted to the unit as soon as appropriate so they can orient themselves and are aware of the different equipment, noises and alarms within the unit.

5.1C Provision is made for parents who have not been able to access the unit straight away, either due to their own health or having one or more babies in a different unit.

5.1D Parents are given a named contact for practical queries and advice.

5.1E Staff inform parents about relevant policy and procedures on the unit, e.g. infection control.

5.1F Unit staff introduce themselves to parents and explain their role in relation to baby's care and the running of the unit.

5.1G There are staff photo boards at the entrance to the unit that are kept up to date.

5.1H Parents are provided with a 'welcome pack' (accessible and in formats relevant to local community) giving practical information about the unit. Parents should also receive information about local amenities, such as local public transport, taxi service, free or reduced parking, meal vouchers, restaurants – particularly if they have not been admitted to their local unit.

5.1I Written information explaining the local neonatal network and how it operates should be accessible and in a format appropriate to the local community. This should include basic information about each unit and an explanation of the transfer service.

Standard 5.2 - Facilities

5.2A Babies are safe and secure while on the unit and parents are informed of security arrangements.

5.2B Parents are able to access overnight accommodation with bathroom facilities, as close as possible to their baby and without cost.

5.2C Parents and families have easily accessible facilities available to store their personal and baby's belongings safely and securely.

5.2D Unit facilities for families are clean and comfortable, free of a charge and of an appropriate size to the scale of the unit.

5.2E Families have easy access to a parent/family sitting room, and a small kitchen to make hot drinks and snacks.

5.2F Child-friendly areas for siblings are available, easy to access and safe.

5.2G Families are informed of the whereabouts and opening hours of the hospital canteen and other facilities for having meals within the hospital.

Standard 5.3 - Support networks

5.3A Parents are given information on how to contact national and local support groups.

5.3B Parents are informed on where to get further information, including advice on financial support and useful websites.

5.3C The unit facilitates contact with local parents, as appropriate, for peer support.

Standard 5.4 - Consistent information

5.4A Parents are fully involved in discussions about their baby's care and receive consistent information from staff caring for their baby.

5.4B Verbal and written information is provided at appropriate times to help parents' understanding of neonatal care (including clinical conditions, procedures, risks, complications, tests, investigations etc).

5.4C Translation services and/or professional interpreters are accessible and secured as soon as possible.

5.4D Health professionals understand the potential difficulties parents may face in taking in complex information and a multi-disciplinary team is available to support parents in their decision making.

Standard 5.5 - Use of data

5.5A Staff understand data protection principles and inform parents how data about their baby is used.

5.5B Parents are fully informed about clinical trials, the consent process and value of research.

5.5C Staff are taught how to transmit information to third parties securely and confidentially.

Standard 5.6 - Daily cares

5.6A Both parents are supported to learn to carry out their baby's day-to-day cares and are actively encouraged to do so.

5.6B Parents should be educated and supported to become a central carer in their baby's care from admission in line with family-centred care principles.

Principle 6

Feeding

Breast milk expression and breastfeeding are actively promoted, and mothers receive appropriate information and practical support to achieve successful lactation. Relevant health professionals are equipped with appropriate knowledge and skills to facilitate and support lactation following a preterm birth.

Rationale

Nutrition is an important part of neonatal care and the benefits of colostrum and breast milk, particularly for preterm babies, are scientifically established. Lactation and breastfeeding outcomes are influenced by the quality of support mothers receive.

Standard 6.1 - Promote and support breast milk expression

6.1 Unit is undertaking Unicef Baby Friendly Initiative

6.1A Unit has an infant feeding policy/guideline adhered to by staff.

6.1B Your unit provides an individualised and considered approach to support the baby's mother.

6.1C Mothers receive practical support to enable them to establish lactation in the first two to six hours after birth and throughout their neonatal stay.

6.1D To ensure good milk production in the following 10 to 14 days, mothers are shown how to make the best use of techniques such as double pumping and skin-to-skin.

6.1E Parents are given clear and consistent information on the benefits of breastfeeding and the importance of frequent expression is explained.

6.1F The unit considers feeding a multi-disciplinary team issue with a dedicated lead professional responsible for maintaining profile, teaching and supporting mothers in establishing lactation and increasing milk production in the following days.

6.1G Staff receive training on the benefits of breast milk, physiology of lactation and how to provide practical support to parents.

6.1H The unit has adequate stock of equipment for all mothers wishing to express their breast milk, including breast pumps, different sized funnels and storage bottles etc.

6.1I The unit promotes safe and hygienic handling, storage and transport of breast milk and ensures parents are informed of these measures.

6.1J Private and comfortable facilities are provided for mothers to express their milk and expression at the baby's cot side is encouraged.

6.1K Your unit has a policy for and consistent practice guidelines on the fortification of breast milk.

Standard 6.2 - Breastfeeding

6.2A Parents receive adequate and timely support to aid transition from tube feeding to breastfeeding, for example, with recognition of feeding cues, help with attachment and positioning, and signs that baby is feeding well.

6.2B Mothers are consistently supported to establish breastfeeding on the unit before going home.

6.2C Breastfeeding is a discrete part of a discharge planning process in which mothers are provided with the support and motivation necessary to continue breastfeeding/expression once at home.

6.2D Senior nursing and medical staff provide leadership in promoting the practice of breastfeeding and encourage a supportive culture.

Standard 6.3 - Alternative to maternal breast milk

6.3A Parents are informed on the procedure of breast milk donation and how to contact the appropriate milk bank if they have surplus milk they may wish to donate.

6.3B Parents are supported and shown how to make feeds and sterilise bottle and teats.

6.3C The unit follows the British Dietetic Association and the NICE Clinical Guideline 93 (Donor milk banks: Service Operation) recommendations on the storage and use of donor human milk on the neonatal unit.

6.3D The unit has assured access and procedures for obtaining milk from a milk bank that adheres to the NICE guideline (CG93). An agreed protocol is in place determining which babies will receive donor human milk and the duration of its use in the event of insufficient maternal milk being available.

6.3E The unit has a policy on using preterm formulae (appropriate formula, follow-on milk, nutritional supplements etc) which is adhered to by staff.

Principle 7

Discharge

Discharge should be a seamless and supported transition from the neonatal unit to home. Discharge planning is facilitated and coordinated from admission to discharge to ensure both baby and the family receive the appropriate care and access to resources.

Rationale

Good discharge planning facilitates safe, early discharge to home; it reduces the risk of future hospital admissions and ensures that any ongoing health or social care needs are met in a timely way.

Standard 7.1 - Coordinated discharge planning

7.1A Your unit has an established discharge planning policy which is adhered to by staff.

7.1B The unit demonstrates a multi-disciplinary approach to discharge planning, which incorporates parents, and includes facilitating access to social services and other support professionals.

7.1C Discharge plans are established from the point of admission and are continually reviewed, involving both parents and a multi-disciplinary team.

Standard 7.2 - Rooming in

7.2A Sufficient rooms are available on or adjacent to the unit for rooming in (with space and resources for any oxygen equipment) to help the family prepare for the discharge.

Standard 7.3 - Meeting the baby's needs at home

7.3A Before discharge, the family is given relevant and appropriate information to make sure they are able to meet their baby's ongoing needs at home.

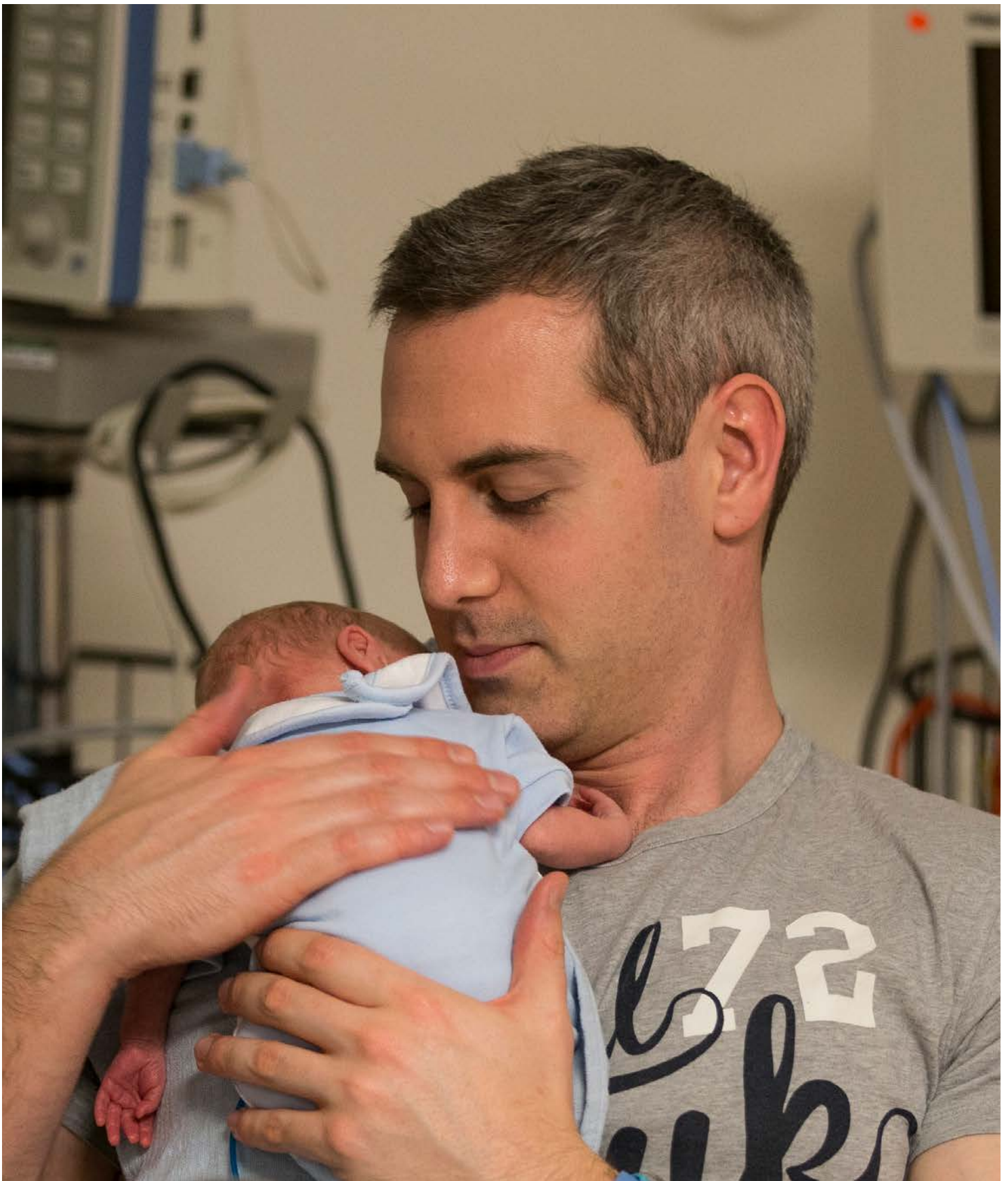
7.3B The family is supported through appropriate training to deliver all aspects of their baby's care at home (including basic life support).

7.3C Comprehensive community support is provided by neonatal teams and community staff in line with local and national guidance as appropriate to the needs of the individual baby and family.

7.3D Before discharge, parents are given the opportunity to meet with the community team supporting them at home.

7.3E Community health teams are given up-to date information about baby and any home care arrangements from care plan, as well as the opportunity to meet neonatal staff and parents before discharge.

7.3F Parents are informed and understand who to contact should the baby become unwell at home, and when they may need to take them to hospital.



Bliss' vision is that every baby born premature or sick in the UK has the best chance of survival and quality of life.

We rely on the generosity of our supporters and partners to help us make this a reality. To find out more about what we do and how you can get involved, please get in touch.

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Registered charity no. 1002973 Scottish registered charity SC040878