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CARE OF SUBSTANCE-EXPOSED INFANTS: DISCHARGE FROM HOSPITAL TO COMMUNITY

AN INTERAGENCY GUIDELINE FOR THE VANCOUVER ISLAND HEALTH AUTHORITY (VIHA) AND MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT (MCFD)

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Goal of the guideline:

The care of newborns with prenatal alcohol and drug exposure has been widely recognized as a significant health problem in British Columbia. While all infants discharged from hospital require coordinated care during the transition to the community, infants with prenatal substance exposure may present with a unique and complex mix of medical and social needs that require a comprehensive discharge plan based on specific assessment parameters (BCRCP, 1999). The goal of this guideline is to provide all members of the interdisciplinary team caring for substance-exposed infants with the information that will facilitate discharge planning and ensure the safety and well-being of the infant and their family/caregiver in the community.

Objectives of discharge planning:

- To develop coordination with community resources to ensure continuity of care.
- To facilitate appropriate resource utilization by matching the needs of the infant and the family/caregiver with the most appropriate services.

Guideline principles:

1. Effective care for substance-exposed infants is multi-faceted and involves coordinated and collaborative teamwork between professionals and families.
2. Preparation for discharge planning should be considered part of the routine antenatal education for all expectant mothers (and families). Discharge planning, including the identification and preparation of alternate caregivers, should begin as early as possible.
3. A primary guiding principle is the safety and well-being of the infant. Health care providers share responsibility to ensure that children are protected from harm. However, the legislative authority for determining if children are in need of child protection is vested in the MCFD Director of Child Protection. Offering families help and support as early as possible requires a cooperative and integrated response from those involved with the infants and parents.
4. Preserving the mother-infant pair whenever possible is valuable. Helping to support women, children, and their families is the responsibility of all service providers and caregivers even during times when the mother and infant are separated.
5. The level of care being asked of parents and caregivers who care for infants with prenatal substance exposure is beyond that of the usual parenting role; the transfer of health care information and discharge care plans is key.
6. Substance-exposed infants should not be viewed as a homogenous group but as individual at-risk infants presenting with a broad spectrum of possible effects, ranging from healthy term newborns with no apparent effects to high-risk births with significant effects.

Confidentiality and privacy:

Although individuals who are substance-exposed or substance misusing often experience complex high risk and unstable lives, their rights to confidentiality and protection of privacy should and must be maintained in accordance with applicable legislation.

Components of the discharge plan:

1. Readiness of the infant for discharge:

The infant's discharge should occur after the following criteria are met:

Physiologic competencies:

- The infant is taking oral (bottle or breast) feeds and gaining weight satisfactorily, as evidenced by a trend of consistent weight gain (Note: this may be lower if the mother is breastfeeding).
- The infant has been tolerating the formula with which he/she will be fed at home.
- The infant is physiologically stable.

Behavioral competencies:

- The infant is showing neurobehavioral recovery from withdrawal (if this has occurred). The infant can be consoled with measures that match the ability of the parent/caregiver.
- The infant is managing an environment that can be duplicated in the home, for example able to tolerate a moderate amount of activity, light, and noise. The infant has managed this environment for at least 5 to 7 days prior to discharge.
- All necessary assessments have been completed.
- The newborn should have been off Morphine for at least 7 days prior to discharge.

2. Readiness of parent/caregiver for discharge:

Participation of parent(s) or alternate caregivers in infant care should occur as early as possible to increase confidence in handling the infant and readiness to assume full responsibility for the infant's care at home.

The infant's discharge should occur after the following criteria are met:

- Parents/alternate caregivers demonstrate the ability to provide necessary care for the infant. Besides basic baby care, components of care include providing cue-based care, managing feeding, provide handling strategies needed by the baby, provide infant safety including CPR, administer medications (if applicable), and understanding and acting on early signs of illness or symptoms specific to the infant's condition.
- The parent/caregiver teaching checklist should be completed prior to discharge.
- Parents will have been encouraged to bring family and friend supports in to the hospital to participate in teaching.
- All necessary assessments have been completed (including medical, social work, occupation and physiotherapy etc).

- If discharged to the care of parents or alternate family members, the MCFD social worker or Aboriginal Child Welfare Agency worker has reviewed safety of the home. The worker will also have arranged for home respite services as needed that will support the family as they transition from hospital to home. Parents and caregivers retain the option to request respite services at a later date even if they are not required immediately after discharge.
- If discharged to foster care, the infant will be placed in a home that meets the requirements of the MCFD Safe Babies program.

3. Length of stay:

These maternal/infant pairs are not candidates for early discharge. Maternal-infant length of stay should be flexible and may be extended as needed to provide time to meet medical, social, teaching, or environmental needs. A minimum observational stay of 3 days is recommended for infants with a history of prenatal substance exposure.

4. Laboratory studies and immunization:

If indicated from the mother, and if medically indicated for the baby, lab studies should be done with informed consent from the mother or legal guardian. If the mother cannot or will not give consent, the tests can be ordered by a pediatrician or the newborn's family physician, but only if the infant's health is at risk. The tests should be done prior to discharge and the reports should be sent to the medical practitioner following the baby in the community. These tests may include:

- Urine drug screen
- Anti-HbsAg
- Anti-HCV
- HIV

Appropriate immunizations should be administered. If indicated, the infant may have already received the following:

- Initial Hepatitis B vaccination
- Initial Hepatitis B vaccination (*see Province of BC Ministry of Health: Communicable Disease Control manual: Immunization Program 2000*).
- Hepatitis B Immune Globulin (*Post-exposure Prophylaxis – see Province of BC Ministry of Health: Communicable Disease Control manual: Immunization Program 2000*).
- Initial diphtheria/polio/tetanus/pertussis/HIB immunization if in the hospital at 2 months of age.

5. Discharge meeting:

Discharge planning will have been ongoing since the birth of the infant. Support and follow-up should be in place prior to discharge. Adequate time is needed for preparation of the

family/alternate caregivers to provide care in a home setting and for mobilization of community resources to provide support services.

Completion of a discharge plan is required prior to discharge. An interdisciplinary meeting with the parents or alternate caregivers participating must be held prior to discharge to review the plan and identify any further needs. *Parents/alternate caregivers must be present at the discharge meeting.* There are many provider participants that may be invited to attend the discharge meeting or contribute suggestions to discharge planning (refer to Appendix 1 for description of recommended roles and responsibilities). It is important to consider that having all the following members may be overwhelming and perceived as threatening by parents. It may be more effective to have only a few selected participants at the discharge meeting. Participants may include some of the following:

Key:

- Parents/alternate caregivers (family members, foster parents)
- Pediatrician
- Primary care nurse
- Public health nurse (PHN) or Aboriginal Liaison/Band nurse
- Hospital social worker
- MCFD protection social worker

Other:

- Clinical resource nurse
- MCFD Resource social worker (if discharged to foster home)
- Occupational therapist
- General practitioner and/or pediatrician who will be providing community follow-up
- Follow-up clinic representative if infant required pharmacological management
- Infant Development Program (IDP) representative
- MCFD Safe Babies caregiver advisor
- Addictions specialist
- Midwife (if previously involved)

Items to be discussed at the meeting include:

- Review of infant's health history
- Discussion of current health issues and health risks for infant
- Confirmation of readiness of home for discharge
- Need for and availability of relief support. Relief support may be required for prolonged periods of time, depending on the needs of the infant and the family/caregiver.
- Identification of specific follow-up needs and appointments, including dates, times, locations.
- Confidentiality and its limits, including consents for release of information regarding reports. Consent statements for release of information should be signed prior to discharge.
- Importance of parents/caregivers having self-awareness of their stress level and the ability to ask for assistance

- Parental visitation plans (if the infant is discharged to foster care)
- Designation of family case manager who will have the responsibility of monitoring birth parents adherence to follow-up recommendations. This will usually be the social worker but may also be another professional, especially if someone has developed an effective working rapport with the parents.
- Breastfeeding appropriateness, depending on individual context of situation.

At the completion of the discharge meeting the following documentation will be made available to the parents/caregivers and the providers participating in the discharge meeting:

- Summary of discussion
- Contact names and numbers for services and supports
- Recommended follow-up schedule (arrangements for initial appointments should be made prior to discharge)

Specific points related to discharge include:

1. Discharge on weekends (Friday to Sunday) or holidays should be strongly discouraged due to the lack of availability of community resources during these times.
2. Infants should not be discharged to a motel/hotel unless in transit.
3. The infant's caregivers must be present at discharge.
4. Telephone access in the home is recommended to assist in follow-up and in case of emergency.

For interagency collaboration and linkage to be successful, the referral process should be clear:

- When a tentative discharge date has been identified by the pediatrician, the hospital social worker is responsible for notifying members of the interdisciplinary team and planning the discharge meeting.
- On the day of discharge the hospital RN completes the public health referral form and faxes to the appropriate public health district office.
- The hospital health records department forwards a copy of the medical discharge summary to the family practitioner. The MCFD social worker or foster parents will provide the discharging physician with the name of the family physician.
- When an infant is being discharged into foster care, the resource worker is responsible for notifying the foster parent caregiver advisor.
- If the IDP consultant does not attend the discharge meeting, the case manager or therapist will forward referrals to IDP.
- Prior to discharge the parent/caregiver will have received relevant education and information related to care of the infant. If the child is discharged to a foster family, they should receive a completed Care Instructions on Discharge form plus a completed MCFD Child's Permanent Medical Record. The liaison nurse, the hospital nurse, the hospital social worker or the MCFD social worker can complete the Care form. Section 1 of the Child's Permanent Medical Record is completed by the MCFD protection social worker while Sections 2 to 4 are completed by the discharging pediatrician.

6. Community follow-up:

The care of the infant after discharge must be carefully coordinated to provide ongoing interdisciplinary support of the family. Careful balancing of infant safety and well-being with family needs and capabilities is required while giving consideration to the availability and adequacy of community resources and support services (AAP, 1998).

The following initial contacts for *birth families* are recommended:

- Appointment with pediatrician or family practitioner within 7 – 10 days of discharge. It is recommended that infants have a consistent primary care physician.
- Phone call from public health nurse within 48 – 72 hours of discharge, and a home visit within 7 days of discharge
- Phone call by hospital social worker within 24 hours of discharge
- Home visit by protection/family service social worker on the day of placement. If the infant is discharged on the same day as the discharge meeting, the visit may be in the first week.

The following initial contacts for *foster families* are recommended, as above plus:

- Phone call from resource worker within 24 – 48 hours of discharge, and a home visit within 7 days of discharge.
- Phone call from caregiver advisor within the first week of discharge.

Recommendations regarding ongoing intensity of follow-up will be determined at the discharge meeting. The intensity of follow-up will be dependent on the skill of the parent/caregiver and the needs of the baby. *The following guidelines are recommended for the infant's first year of life:*

- All infants with perinatal substance exposure will receive ongoing follow-up and support by the PHN/band nurse as indicated on the Nursing priority Screening Tool. The frequency of visits from PHN/band nurse will vary according to the needs of the infant and family and indicators from previous visits.
- Referrals to early infant development programs (ie. IDP, Child Development Centre), respite care and parent/foster parent support groups are recommended. These programs track development and promote positive growth.
- For infants in foster care, home visits should be done by MCFD social worker within 30 days following placement and at least every 90 days thereafter (MCFD practice standard for guardianship # 19, 1999). More frequent visits required for some substance-exposed infants.
- Medical follow-up by pediatrician or family practitioner as indicated by health status.
- For foster parents, monthly home visit or phone call by MCFD resource worker.
- For foster parents, monthly home visit or phone call by resource worker.

REFERENCES

American Academy of Pediatrics (1998). Hospital discharge of the high-risk neonate – proposed guidelines. Pediatrics, 102(2), 411-416.

British Columbia Ministry for Children and Families (1999). Practice standards for guardianship. Victoria, BC.

British Columbia Reproductive Care Program (1999). Discharge planning guide for substance-exposed women and newborns. Vancouver, BC.

BC Women's Hospital and Health Centre (2006). Caring for women with problematic substance use, their newborns and families: A self-directed learning module. Vancouver, BC.

APPENDIX 1
ROLES AND RESPONSIBILITIES FOR MEMBERS OF THE INTERDISCIPLINARY TEAM IN RELATION TO DISCHARGE PLANNING

All professional members of the interdisciplinary team have the personal responsibility to be knowledgeable about addiction and the effects of prenatal substance exposure on the infant. Recommended roles and responsibilities for members of the interdisciplinary team in relation to discharge planning are:

Parents or alternate caregivers

- Participate in the discharge planning process
- Participate in follow-up activities

General practitioner

- Provide follow-up medical support for infant in collaboration with pediatrician
- Provide pertinent information about mother and father's health history, and substance-using history
- Ensures the primary medical caregiver of mother, if different from baby, receives all medical reports of baby while in foster care

Pediatrician

- Provide pertinent information about the infant's health status
- Provide follow-up medical support in collaboration with general practitioner following discharge

Hospital primary nurse

- Provide pertinent information about infant's response to care and mothers ability to care for baby
- Initiate education and skill-building of parents or alternate caregivers regarding baby care, feeding, baby cues and safety.
- Assesses the effectiveness of breastfeeding and teaches mother how to assess feeding.

Clinical resource nurse

- Review infant record regularly to identify discharge planning needs
- Participate in and document weekly SCN discharge planning meetings and family conferences as needed
- Provide written copy of recommendations made at discharge meeting to parents, alternate caregivers, and discharge planning team members

Public health nurse (PHN)

- Provide prenatal and postnatal health teaching, parenting programs, and Child Health Clinics, and immunizations
- Provide screening and referral for general health issues at clinics, schools, and other community locations
- Provide general health information and consultation and communicable disease information
- Contact and provide home visits for first time parents and home visits to other parents as needed
- Provide information and support on community resources

Perinatal social worker

- Complete a psycho-social assessment of the birth family
- Assess child protection issues in collaboration with the Ministry for Children and Families (MCF)
- Support parents/alternate caregivers as needed, emotionally and financially
- Facilitate family and team meetings regarding discharge plans in collaboration with interdisciplinary team members and representatives from community support agencies

District office social worker

It is the mandate for the MCFD to provide a protection plan for children at risk under the Children and Families and Community Services Act. It is the responsibility of all professionals to report infants considered at risk, and to share information with MCF in a timely and comprehensive manner. It is the responsibility of the MCF social worker to complete a protection assessment and to ultimately make the decision about the removal of guardianship of an infant from parent(s) to MCF guardianship. The MCF social worker has a family support role along with their legislative mandate and works with the hospital social worker to incorporate supportive services into the plan for the family (BCRCP, 1999).

- Gather information on the medical condition of the infant
- Maintain contact with the natural family
- Assess the risk to the child in the discharge home
- Determine the need and method of natural family visitation
- Ensure appropriate support services are available for the needs of the mother and the infant
- Monitor the home if appropriate
- Arrange alternate care if necessary

Resource social worker (involved if foster care required)

- Collaborate with the district office worker to gather information regarding the medical needs of the infant
- Select the appropriate foster home for the infant
- Ensure that the foster home has the necessary skills, training, and support to manage the specific needs of the infant
- Ensure respite is in place prior to discharge
- Monitor directly and/or through the caregiver advisor how the placement is progressing

SCN occupational therapist/developmental consultant

- Liaise with other team members regarding assessment of infant's response to care
- Consultation regarding identification of infant cues and assessment of parent/child interaction
- Consultation regarding developmentally appropriate environment as infant progresses
- Participation in family/caregiver teaching
- Refers infants to Infant Development Program

Infant development consultant

- Provide ongoing assessment of, and information on, developmental progress
- Provide strategies to encourage growth in skills tailored to fit family style, child's temperament, and schedule
- Offer information to assist in dealing with specific management issues associated with NAS/FAS
- Connect family to variety of community supports and professional resources
- Work in partnership with family/alternate caregivers to build positive and consitent care and facilitate communication

Foster parent caregiver advisor (involved if foster care is required)

- Provide direct post-placement and ongoing support and consultation to foster parents
- Provide advice on issues of daily care of infant
- Maintain a communication link to resource social workers
- Receive information from the resource social worker about the specific needs of the infant
- Communicate any concerns regarding care of the infant to the resource worker or district office worker

APPENDIX B

DISCHARGE PLANNING WORKSHEET FOR INFANTS WITH PRENATAL SUBSTANCE EXPOSURE

Please note that this sheet is intended as a quick reference for discharge planning; it does not form part of the permanent record. All detailed information regarding teaching, resources needed etc. must be recorded on the Health Record.

1. **Caregivers on discharge:**
   Parent only ____Yes ___No
   If no complete the information below:
   Additional support: Name: _____ Phone: _____

2. **Information/education:**

DOCUMENT/SUBJECT	ACTION	DATE	INITIALS
Written information on NAS	Given:		
	Reviewed:		
Awareness of caregiver to provide means for baby to self-console			
Infant care demonstrated: • Stress cues • Calming • Feeding • Diapering • bathing			
CPR course	Discussed:		
	Taken:		
Discharge conference	Organizer:		

3. **Post discharge needs:**

ACTION	DATE	INITIALS
Pediatrician visit booked		
IDP referral sent		
PHN referral sent		
Other:		