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Interdisciplinary Recommendations for Psychosocial Support of NICU Parents

Developed by

The Workgroup for Psychosocial Support of NICU Parents

(Convened by the National Perinatal Association)

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Recommendations for NICU discharge planning and beyond

A. Emotional support:

1. Parents should be Involved in their baby's care in the NICU and this should be continued into the home as a crucial first step toward empowering and enabling their competence and confidence as caregivers.
2. Screening parents for emotional distress should be a high priority in the NICU along with providing parents access to resources, handouts and contact information for parent support organizations and mental health care providers.
3. All pre- and postnatal healthcare inpatient and outpatient settings should have staff trained to identify families at economic, social and psychological risk, as well as to provide the appropriate referrals.
4. Support for breastfeeding should be provided. To sustain breastmilk feeding from NICU admission through infancy, professionals should help parents develop pre- and post-discharge plans to overcome breastfeeding obstacles, to craft a breastmilk feeding plan, access breast pumps and gain support from their family.

B. Parenting education:

1. Hospitals need to have designated NICU staff to provide individualized training to prepare parents to assume the parenting role and feel capable of providing home medications, special

feeds, changing tubes, ordering additional supplies and initiating cardiopulmonary resuscitation if needed.

2. Healthcare teams in NICU, outpatient and at-home visits should be skilled at observing and assessing parent-infant interactions so they can teach parents to respond to their baby's cues to support bonding.
3. One to two parents and/or members of the family should receive individualized teaching with checklists and outlines to cover all necessary care and education. Parents should be given a discharge folder or notebook that includes all teaching handouts, medication sheets, growth charts, supplies, follow-up appointment dates with phone contacts and a copy of the discharge summary.
4. The primary care provider and subspecialists involved in a baby's care should receive a copy of relevant information or be able to access it via the electronic medical record. High Risk Infant Follow-up (HRIF) clinics and home visitors (HV) should also be included in these communications.
5. To facilitate the transition process to home, a staff member from the primary care provider's office should meet with the family to gain familiarity with their needs and to establish a supportive relationship.
6. Parental teaching should be provided in a culturally and linguistically appropriate manner so that parents will be able to show competence in infant caregiving prior to transition to home. NICUs should establish policies that include members of the discharge team serving as "parent champions" to educate and guide the family through the maze of referrals and to pre-schedule initial appointments.

C. Medical Follow-up:

1. Transition planning involves NICU discharge (DC) preparation by teams beginning at admission and continuing beyond discharge. The team should identify the degree of medical, psychosocial, environmental and financial readiness of the infant-family unit.
2. A NICU point person needs to communicate information regarding parental emotional distress to alert other providers and assure documentation in the discharge plan.
3. The DC team should assist the parents with establishing post-discharge plans and referrals to lactation and feeding specialists, mental health providers, social workers, PCP, HRIF clinics, specialists, visiting nurses, and other community resources.
4. Healthcare teams in NICU and outpatient settings should observe evidence-based recommendations from literature reviews, policy statements and statewide quality improvement projects for pre- and post-discharge and follow-up during early childhood.

D. Home Visiting Services

1. During NICU admission, if a family is already involved with a home visiting program, their continued involvement should be encouraged. If peer mentors developed supportive relationships with families, it is desirable for them to continue their involvement after discharge,

if both parties are willing. If not, home visits can be provided by NICU nurses or therapists, or other appropriate referrals can be made.

2. Nurses or others conducting home visits may augment other services by including screening for depression and anxiety and providing an additional level of emotional support to families via techniques such as 'listening visits.'

*The comprehensive document covering all recommendations is "Interdisciplinary Recommendations for Psychosocial Support of NICU Parents," available elsewhere on this website (www.support4NICUparents.org).