Introduction

In the POPPY Project (Parents of Premature babies Project) Aug 2009, which looked at the provision of Family Centred Care in Neonatal units, one of the Indicators that parents wanted to provide family centred care at its optimum was the provision of outreach support by trained neonatal staff. This was highlighted as support at times of transition, including going home.

The home visiting programme for Continuing Care is conducted by the Continuing Care Team to provide continuing support for babies after hospital transfer of care to the family at home in the critical period that immediately follows discharge.

The Continuing Care Team consists of both registered nurses and clinical support workers.

The continuing care registered nurse will follow up all babies who were born less than 27+6 weeks gestation who may or may not have complex needs on discharge i.e. oxygen dependant babies.

The continuing care support worker will follow up all babies who were born over 28 week’s gestation.

These criteria are discretionary following consultation with the Continuing Care Team.
Security/Risk Assessment
All Continuing Care Team members must carry a hospital issued mobile phone to be used during their working day to facilitate their safety and adhere to the lone worker NUH Trust policy. (See appendix 1 of Aggression, Violence and Harassment Policy reference HS/SP/012 located on the NUH intranet)

The daily log of community visits must be completed by all continuing care team members and placed for access in the continuing care office in the relevant neonatal unit.

Patient Group
The home visiting programme for continuing care will be offered to appropriate babies of all mothers who reside within the Nottingham and Nottinghamshire area, or who are primarily booked at CHN or QMC.

For babies residing outside the area, the home visiting programme of the Continuing Care Team will be negotiated with the local Family Care Team/ Paediatric community service.

The criteria for receiving the home visiting programme of family care incorporates those risk factors associated with a high incidence of infant mortality, morbidity and child abuse or neglect.

The criteria includes:

(a) Prematurity <34 weeks
(b) Birth weight less than 2000 grams
(c) Babies admitted to the Neonatal Unit who are assessed by the low dependency care team as high risk.
(d) Babies who are symptomatic of withdrawal for maternal alcohol or drug misuse and the baby required admission to NNU.
(e) Babies that are establishing adequate nutrition including the establishment of Breastfeeding.
(f) Babies with poor growth patterns.
(g) Babies assessed to have medical problems by the Consultant.
(h) Babies requiring short term nasogastric feeding.

There will be certain babies who will be discharged home with needs that require other specialist teams to support them at home and this care is referred to as “shared care”.

Teams who will share care are:
- Community paediatric team based at QMC
- Dietetic team
- Stoma care nurses
- Social care teams
- Cleft palate team
- Children’s development centre community team

The criteria of babies who will receive shared care are as follows:
(a) Long term nasogastric tube feeding in the community.
(b) Oxygen dependent babies. These babies should have been referred before discharge to the Children’s community team at 36 weeks corrected age.
(c) Babies who have a life threatening or life limiting (Palliative) condition.

Babies who fit these criteria on admission to the NICU should be offered the home visiting programme of continuing care even if they subsequently receive transitional care on the postnatal ward.
Management

1. The Neonatal Service will assure that all babies (who fulfil the stated criteria) receive access to the home visiting programme of the Continuing Care Team after discharge.

1.1. The Continuing Care Team will participate in the discussion around discharge planning with the parents, the medical team and low dependency team. Formal discharge planning meetings will be arranged for babies with extra needs eg Home oxygen babies. The outcome will be documented in the home for care plan.

1.2. The low dependency team will notify the Continuing Care Team of impending discharge usually at least 48 hours prior to discharge by telephone or direct contact. The home care plan is given to the continuing care team prior to discharge.

1.3. The Continuing Care Team member will refer babies who do not fit the criteria to the appropriate local agency.

1.4. A risk assessment must be done by the Continuing Care Team member to ascertain their personal safety when visiting families at home and the necessary precautions must be put in place if required. (see Appendix 2: Lone worker assessment tool)

1.5. The Continuing Care Team member will negotiate the first contact with the parent before the baby is discharged from the Neonatal Unit. This contact may be by telephone or a home visit and will usually be undertaken within 24-72 hours. Oxygen dependant babies will be visited within 24 hours of discharge.

1.6. If the Continuing Care Team member is unable to schedule the visit, the Continuing Care Team member will arrange for another team member to visit.

1.7. If the parents of the baby are not at home when the Continuing Care Team member arrives for the planned visit, the Continuing Care Team member will leave a written notice of appointment or leave a telephone message. The Continuing Care Team member will continue to attempt to see the baby based on any additional information that the hospital or primary health care team can provide for two further visits.

1.8. The Continuing Care Team member will document all ‘no access’ visits. Where the Continuing Care Team member is unable to gain access, the family nurse specialist for family centred care, the baby’s Neonatal Consultant and the primary health care team need to be notified.

1.9. After three ‘no access’ visits, the Continuing Care Team member should refer the family to the relevant agency and should write to the family to inform them that the service is withdrawn.

The home visiting programme for continuing care

- The first contact after discharge will be agreed before discharge from the Neonatal Unit and will usually be completed within 24-72 hours. **This contact may be by telephone or a home visit.**

- At this and every subsequent visit the Continuing Care Team member will:
  a) Assess parent-baby attachment and interaction
  b) Identify potential or existing health need.
  c) Review the parent’s care of the baby
  d) Review the baby’s growth and development.
  e) Reinforce the need for immunisations and follow-up visits
  f) Inform the family of community support and assist them in referrals
g) Determine the need for additional care e.g. community children’s team, social services or others.
h) Support the parent with issues around preterm birth/grief-loss of expected baby.

- The following paperwork should be completed:
  - Plan of Care in Child Health Record
  - Continuing Care Nursing Record

- Two to six follow up visits is recommended and will be performed according to the Care Plan. The number of visits can be adjusted according to the needs of the baby and family.

- All babies must be visited weekly or more frequently if required. If this is not possible by the Continuing Care Team member then they must arrange for their colleague to visit in their absence.

- If the Programme of care is not completed by the fourth visit, the Continuing Care Team member must review the care plan with their line manager and if deemed necessary with the baby's Neonatal Consultant.

**Discharge to Primary Health Care Team Criteria**

Babies will be discharged from the home visiting programme for continuing care when:

- The programme of care is successfully completed and the family are confident in the care of their baby.

- Readmitted to hospital. The baby has been admitted to the paediatric ward for two weeks or longer. (Babies readmitted to the Neonatal Unit should be reassessed for follow up by the criteria)

- Transferred to the care of the Community Children’s Team.

- Unable to find the family: After repeated attempts the family cannot be found.

- Moved out of the area.

- Refused visits: The family will not accept the service.

**Follow Up Care Post Discharge from Continuing Care Team**

- The Continuing Care Team member must notify the health visitor when they have discharged a baby from neonatal continuing care by telephone. A message can be left if the Health Visitor is unavailable.

- This should be followed up with a letter to the Health Visitor highlighting any concerns.

- The Continuing Care Team member must complete all paperwork:
  1. Continuing care evaluation
  2. Home care plan details

- All paperwork must then be given to the relevant person for filing into baby’s medical notes. Where the baby has medical records from both campuses of Nottingham University Hospitals NHS Trust, these will be filed in the medical notes from the hospital of discharge home.
Audit points:
Family Care Team Members' Annual Caseload Report.

Allied guidelines
Clinical Guideline: ‘Discharge of infants from the Neonatal Unit’ (Guideline No. 21.3)
‘Home in Oxygen Guidelines.’

Reference
Poppy Steering Group. Family-centred care in neonatal units. A summary of research results and recommendations from the POPPY project. London: NCT; 2009

APPENDIX
1. Trust Guideline: 'Aggression, Violence and Harassment Policy' (including lone working guidance) Reference HS/SP/012 (see NUH Intranet)
2. Nottingham Neonatal unit Lone workers assessment tool
**NEONATAL CONTINUING CARE TEAM**

**LONE WORKERS ASSESSMENT TOOL**

Name of Mother

Name of father

Telephone numbers

**ACTION TO BE TAKEN FOLLOWING ASSESSMENT**

**GREEN:** Lone visits acceptable. Colleague must be aware of location and times of visit.

**AMBER:** Visits must be taken with caution. Colleague must be aware of location and times of visit. If risk factors score 4 or more in amber column then a joint visit must be considered. This is discretionary dependant on each individual case.

**RED:** If any risk factor scores red first home visit **MUST** be a joint visit. Thereafter visits are at the discretion of the nurse/clinical support worker.

Please tick each box as applicable and then make assessment

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>GREEN</th>
<th>AMBER</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection</td>
<td>Child not on register</td>
<td>Child on register for emotional abuse of</td>
<td>Child on register for sexual of physical</td>
</tr>
<tr>
<td>Register</td>
<td></td>
<td>neglect</td>
<td>abuse</td>
</tr>
<tr>
<td>Verbal Aggression</td>
<td>No known or suspected</td>
<td>Know aggressive behaviour/anxiety due to</td>
<td>Irrational aggression displayed and difficult</td>
</tr>
<tr>
<td></td>
<td>aggression</td>
<td>situation</td>
<td>not diffused with explanation</td>
</tr>
<tr>
<td>Physical violence</td>
<td>No known or suspected</td>
<td>Suspected violent behaviour voiced by</td>
<td>Known violent behaviour within household</td>
</tr>
<tr>
<td></td>
<td>violence</td>
<td>professional</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>No known history</td>
<td>Professional concerns voiced regarding</td>
<td>Carer with extreme disorientation, impaired</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mild mental health issues</td>
<td>judgement or impulsive disorder</td>
</tr>
<tr>
<td>Location of Property</td>
<td>Parking in front of house in</td>
<td>Rural address. No mobile phone reception,</td>
<td>Rural address with no mobile phone reception</td>
</tr>
<tr>
<td></td>
<td>well lit road. Land line phone</td>
<td>but land line phone available.</td>
<td>or landline phone.</td>
</tr>
<tr>
<td></td>
<td>available. Daylight visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol or Drugs</td>
<td>No known evidence of abuse</td>
<td>Suspcion of abuse</td>
<td>Known abuse within household</td>
</tr>
<tr>
<td>Pets</td>
<td>No Pets</td>
<td>Family agree to lock away pets for duration</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>No smokers in the house</td>
<td>1 parent/carer smokes</td>
<td>Both parents/carers smoke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lone Working Guidance for Staff and Managers

1. Introduction

It is inevitable and necessary that at certain times, staff and students will find themselves working alone. These occasions happen, for example, at the beginning and end of flexible working periods, during holidays, during the night and at weekends.

There is no legal prohibition on working alone, but the general duties of the Health & Safety at Work Etc Act and the specific duties of the Management of Health & Safety at Work Regulations apply. These require the identification of the hazards associated with the work, the assessment of any significant risks and the devising and implementation of risk control measures to ensure that the risks are eliminated, avoided or adequately controlled.

Many staff and students work alone at some time during the working periods at the hospital and in the majority of the cases they do so without significant risk. For example, persons working alone in offices carrying out typical office activities outside normal working hours are unlikely to be at significant risk, provided the appropriate fire precautions are in place and the building is secure against unauthorised access. However, there are occasions when it is not possible to devise arrangements for work to be done safely by one person. In these cases, alternative arrangements involving help or back up have to be put into place.

Establishing safe working arrangements for lone workers is no different from organising the health & safety of other staff or students.

This guidance lays down guidelines for areas for managers to assess which tasks may be carried out safely by lone workers.

The guidance should be used in conjunction with other health & safety procedures – in particular those covering risk assessment.
2. Aims of the Guidance

- To ensure that Trust staff and students working alone/community workers are at no significantly greater risk from their work activities than when accompanied.
- To provide guidance covering all lone working situations.
- To incorporate all identified lone working activities within one section of the Workplace Safety Management Toolkit.

3. Definitions
Persons are considered to be working alone if they have neither visual nor audible communication with someone who can summon assistance in the event of an accident, illness or other emergency. In other words, without the close and immediate support of colleagues or without close or direct supervision.

Examples include staff working outside of the ‘normal’ working hours when no one else is within close proximity. Peripatetic workers/Community Workers, those working in remote parts of their recognised place of work and those working away from such a base – during or outside normal working hours i.e. 9-5 Monday to Friday.

4. Application of Guidance
All Trust staff and students.

5. Principles
Lone workers must not be exposed to significantly higher risks than those who work accompanied.

Precautions should take into account normal working conditions and foreseeable emergency situations e.g. fire, equipment failure, illness and accidents – including pre-existing conditions.

Safe systems for lone working must ensure that:

- All health & safety risks are identified, assessed and – where necessary – controlled.
- The person is medically fit to work alone.
- Instruction, information and training are provided.
- Arrangements are in place for emergencies and other unplanned events.
- A monitoring system is in place.

6. Responsibility for Implementation
6.1 All Line Managers

Risk Assessment Process

Where a person may have to, or chooses to, work alone it is the responsibility of the Line Manager to ensure that a risk assessment is carried out in accordance with existing health & safety guidance.

Subject to the finds of the risk assessment, suitable control measures must be devised and implemented to ensure that:

**An individual working alone is not exposed to significantly greater risks than when working accompanied.**

Lone working must not be undertaken where there is a reasonably foreseeable risk that there may be an incident sufficiently serious to require a second person to be available to summon assistance. Those tasks, which are deemed unacceptable to be performed by a lone worker under any circumstances, must be documented in the written risk assessment and within any safe working practices, together with the local arrangements for health & safety for those tasks, which are deemed acceptable.

During risk assessment, all situations where staff and students may be working alone must be identified and the following questions asked:

<table>
<thead>
<tr>
<th>Questions to be asked?</th>
<th>Areas to consider/ What’s the risk?</th>
</tr>
</thead>
</table>
| **Is the work legally prohibited?** | There is no general legal prohibition on lone working, but there is certain specific activities. Examples include:  
• Entry into confined spaces – these include voids, tanks, pipes, ducts, enclosed basement rooms etc.  
• Use of ladders which cannot be secured and require “footing” by a second person  
• Erection of scaffolding.  
• Use of certain dangerous machines without sufficient training  
• Work on or near live electrical conductors. |
| **Is the work subject to a permit to work?** | Permits specify strict requirements on how work is carried out, including:  
• Agreed check in and out arrangements  
• Testing of emergency communications equipment  
• Estimated duration of the work  
• Provision of first aid materials  
• Inspection of tools/equipment before use and |
### Questions to be asked?

<table>
<thead>
<tr>
<th>Areas to consider/ What’s the risk?</th>
</tr>
</thead>
<tbody>
<tr>
<td>establishment of electrical safety</td>
</tr>
<tr>
<td>- Checklist of personal protective equipment and clothing</td>
</tr>
<tr>
<td>- Exit to safety established</td>
</tr>
<tr>
<td>- Manual handling suitable for a single person</td>
</tr>
<tr>
<td>- There is an inspection of Fire and Safety equipment as applicable to work being undertaken.</td>
</tr>
</tbody>
</table>

### Can one person adequately control the risks?

As lone workers must not be exposed to a greater risk than if part of a group, the following questions must be answered:

- Can one person carry out all reasonably foreseeable activities?
- Does the workplace present a special risk to lone workers? (consider normal, expected work and foreseeable emergencies).
- Is there safe access and egress for that person? (For example, in the evenings and at weekends some doors that provide an exit from buildings in normal working hours may be locked for security reasons. All means of escape required during normal working hours must be available wherever a person works in the building outside normal working hours. However, the mechanism for opening doors on exit routes may be different outside normal working hours and the lone worker must be aware that aspects of the route out of the building in an emergency may be different. Lone workers must not be expected to traverse routes in the darkness).
- Can any temporary access equipment – such as portable ladders, scaffolds, trestles, be safely handled and used by one person?
- Is the correct PPE available?
- Can all plant, equipment, tools, loads, substances etc. be handled/operated by one person?
- Will cash be handled?
- Is there a risk of violence?
- Are women or young persons especially at risk alone?

### What training is required to ensure competence in safety matters?

It is particularly important where there is limited supervision to control, guide and help in situations of uncertainty. It may be necessary so as to avoid panic reactions in unusual situations. Lone workers must have:

- Adequate information, instruction and training, so they can recognise hazards and appreciate the risk of lone
work and deal with foreseeable problems
- Sufficient experience and be able to fully understand the risks and control measures.
- Knowledge of the limits and procedures established as to what can be done alone.
- Knowledge of all safe working procedures.
- Competence to deal with circumstances new, unusual or beyond the scope of their training e.g. when to stop work and seek advice from a supervisor and how to handle aggression.

<table>
<thead>
<tr>
<th>How will the worker be supervised?</th>
</tr>
</thead>
</table>
| Although lone workers cannot be subject to constant supervision, there is still a duty to provide some. Persons new to a job, undergoing training, doing a job that presents special risks, dealing with new situations and young people may need to be accompanied at first. The extent of the supervision required is a management decision; it should not be left to individuals to decide if they do or do not require assistance. Supervision complements information, instruction and training and helps to ensure staff and students understand the risks associated with their work and that the necessary safety precautions are carried out. It can also provide guidance in situations of uncertainty. The higher the risk the higher the requirement for supervision. The following are necessary:
- Employers must arrange adequate supervision (the extent and level depends on worker skill, proficiency, competence etc and needs to be determined via risk assessment.
- Suitable systems should be devised to monitor conditions of lone workers and include at least a check at the end of the working period. In addition, it may be necessary to consider:
  - Procedures where a member of supervisory staff periodically visits and visually monitors lone workers
  - Procedures where regular contact between the lone worker and a member of supervisory staff or security staff is maintained.
  - Use of signing in/out systems
  - Manual/automatic alarms
  - Checks worker has returned to base or home
  - Automatic warning devices that raise the alarm in an emergency and are activated by the absence of activity from the lone worker. |
**Does the workplace present a special risk to the lone worker?**

For example, it is not generally reasonable for staff or students to work alone in workshops because there is usually dangerous machinery about. However, if just low risk work such as assembly or some cleaning were planned, then provided other risks were minimised and a system of checking or communication established, then it would be reasonable for a person to work alone.

**What happens if a person becomes ill, has an accident, or there is an emergency?**

A lone worker is more vulnerable when the unexpected happens, so consider both routine and foreseeable emergencies:

- Lone workers must be capable of responding correctly in emergencies and must have adequate first aid facilities available to them, also first aid training.
- Emergency procedures should be established in areas and the appropriate persons given clear and concise training and instructions on how to implement them.
- Similar information should be given to contractors or service engineers who may be working alone.

**Is the person medically fit and suitable to work alone?**

Medical fitness should be considered when assessing whether a person is medically fit to work alone. Emergencies may also impose additional physical and mental burden on the individual.

- Is there a medical condition that makes a person unsuitable for lone work?

**Communications**

Communications between lone worker and base/contact point is essential. There are many methods but it is necessary to allow vulnerable individuals to raise instant alarm or be precisely located, via:

- Diaries
- Pre-arranged call in times
- Calls from base to worker
- Arrangements in place for contacting police, rescue services, families
- Log out/in procedures ~ Buddy System
- Mobile phone, radio, personal alarm, panic button etc.

**NOTE:** It should be recognised that measures put in place should be practical. For instance a “Buddy System” may only be feasible within working hours therefore when the office closes that measure is invalid and a different measure should be put in place.
Further Information:

Confined Spaces Regulations 1997. Approved Code of Practice L101
Electricity at Work Regulations 1989 SI 1989/635
Violence at work INDG69(rev) 1997
Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance L21
HSE leaflet 5 steps to risk assessment INDG163(rev1)

*All available to download free of charge at [www.hse.gov.uk](http://www.hse.gov.uk)*

Additional information and advice is available from your local HSE Office and Employment Medical Advisory Service, your trade association or employers’ organisation, trade unions and some charities, e.g. The Suzy Lamplugh Trust

[www.suzylamplugh.org.uk](http://www.suzylamplugh.org.uk)