NEO-SOP-003: Family information and presence in the neonatal unit

Standard operating procedure (SOP) · NEO-SOP-003 · Version 0.1 · Draft for local review

Supports: 37.3

At a glance

- Parents are told about their baby's condition in person, in a private space, at least once every day and after any significant change.
- Parents can be present and take part in care, with the unit's policy on hours and infection control explained to them in writing.
- An interpreter or accessible format is offered whenever a parent needs one. Nobody is asked to rely on a child for interpretation.
- Every important conversation, decision and consent is recorded in the notes the same day.
- Stop and get help if: a parent has not been updated as the policy requires, or a parent is excluded from the unit without a documented reason.

1. Purpose

To make sure families of neonates receive clear, regular and understandable information, and are present in and involved in their baby's care, so that they can take part in decisions and support their baby (37.3).

2. Scope

Item	Coverage
Applies to	All clinical staff in the neonatal unit, special care baby unit, maternity wards and any area caring for neonates
Families	Parents, guardians and others the parent nominates in writing to receive information
Period	From admission to the unit until discharge, transfer or bereavement follow-up

3. Definitions

Term	Meaning in this SOP
Family	The parents and any other person the infant's parents name in writing as a person to receive information or to be present
Structured update	A conversation at a set time each day, with the same key information each time: condition, plan for the next 24 hours, what the family can do, and questions
Family presence	The family being with the infant for care, feeding, holding and procedures, within the unit's rules on hours and infection control
Parental consent	Permission given by a parent after the risks, benefits, alternatives and the option to decline are explained in a way the parent understands

4. Background

Parents of a sick newborn often feel frightened, powerless and separated from their baby. Clear information and early involvement reduce distress, improve trust and support decisions made together. Parents' presence supports the infant's development, feeding and comfort, and provides a second set of eyes on the baby's wellbeing.

Information that is given differently by each member of staff, or only when a parent asks, leaves families uncertain. A set, shared approach to updates protects families and staff.

5. Responsibilities

Role	Responsibility
Consultant or senior doctor	Leads the daily structured update, agrees the plan with the family, and leads conversations about serious changes and end-of-life decisions
Registered nurse (primary nurse)	Keeps the family informed of routine care, invites them to care activities, and records the family's questions and wishes
Unit manager	Keeps the family presence policy current, provides a private room, and audits the process
Interpreter or communication lead	Arranges an interpreter, translated material or accessible format on request
Social worker or bereavement lead	Supports families with practical, emotional and bereavement needs
Chief executive or medical director	Approves the family presence policy and receives audit results

6. Materials and equipment

- A private family room or quiet space near the unit, with seating and a telephone.
- Written information about the unit, visiting rules, infection control and the baby's care, in the families' main languages.
- Daily update record in the notes, with date, time, names of people present and the family's questions.
- Access to a professional interpreter, by phone or in person, for every family who needs one.
- Breast pumps, kangaroo care chairs and skin-to-skin guidance materials where the unit provides them.

7. Safety

Families are never left without contact information for the unit, and never told that a baby is 'fine' or 'stable' without an explanation of what that means. Information about a death or serious harm is always given in person, by a senior clinician, in a private room, and never over the telephone alone, unless the family cannot attend and the senior clinician has agreed the approach with them.

> Children should not interpret for their parents or for each other. Use a professional interpreter, or a family member the parent chooses only when the parent asks for it and the conversation is not about serious harm.

8. Before you start

1. Identify the family's main language and any communication need, and record how they wish to be contacted.
2. Ask the parents who may receive information and who may be present, and record their names and relationship in the notes.
3. Confirm the baby's current condition and the plan for the next 24 hours with the senior clinician before the update.

9. Procedure

9.1 Daily structured update

1. At a set time each day, the consultant or senior doctor meets the family in the private room, with the primary nurse where possible.
2. Give the key information in the same order each time: how the baby is today, what has changed, the plan for the next 24 hours, what the family can do, and any decisions needed.
3. Use plain language, avoid abbreviations, and check understanding by asking the parent to repeat the main points.
4. Invite and answer questions. Write down any question that cannot be answered now, and give a time when it will be answered.
5. Record the update in the notes: date, time, people present, the information given, the questions asked, and the plan agreed.

9.2 Family presence

1. Explain the visiting and presence policy in writing on admission, including hours, infection control rules and how to take part in care.
2. Encourage parents to hold, feed and provide skin-to-skin contact with the baby, unless a clinical reason prevents it, which is recorded.
3. Where the unit has limited space or hours, agree a plan for presence and contact, and review it at each update.
4. Do not exclude a parent from the unit without a documented clinical or safety reason agreed with the consultant, and tell the parent the reason and how to appeal.

9.3 Serious changes and difficult conversations

1. When there is a serious change, inform the family as soon as possible, in person where safely possible, and no later than the end of the shift.
2. Explain the change, what is being done, the options, and what the next steps are. Give the family time to ask questions.
3. Arrange a follow-up conversation within 24 hours of a serious change, or sooner if the family asks.
4. For end-of-life decisions, follow the unit's end-of-life policy and offer the family a private space, support and the chance to spend time with their baby.

10. Decision points

Situation	Action
Family does not attend the daily update	Phone the family at the agreed time, offer another time within 24 hours, and record each attempt
Parent does not speak the unit's language	Book an interpreter immediately. Do not use a child or untrained person as interpreter for serious information
Parent is not able to be present because of their own illness or distance	Arrange updates by telephone or video, with a named clinician who will speak to them, and record that the parent agreed
Parent asks to be excluded from information or to restrict who receives it	Record the request in writing and check it with the senior clinician and social worker. Explain the limits of the restriction, especially where the baby's safety is involved
Family disagrees with the plan	Arrange a meeting with the consultant and, if wanted, the unit manager within two working days. Record the outcome

11. Special situations

- Families in a different country or community: check how they prefer to receive information, and whether a family member or community representative should be present, always with the parent's agreement.
- Parents with a disability or who are blind or deaf: provide information in an accessible format and in a way they can use.
- Parents under the age of 18: involve a safeguarding lead and check the arrangements for consent and support.
- Baby transferred to another unit: give the family the name and contact number of the receiving team, and explain how updates will continue.
- Bereavement: offer a bereavement follow-up under HSP-SOP-005 and a named contact for questions in the weeks after the death.

12. Escalation

- Family not updated for more than 24 hours without a documented reason: inform the unit manager the same day.
- Complaint or family distress that cannot be resolved at the bedside: refer to the consultant and, if needed, the complaints process.
- Safeguarding concern raised by a parent or staff member: follow NEO-SOP-004 immediately.

13. Monitoring

The unit manager audits 20 family records each month, or all if fewer, for the daily update, the family presence plan, interpreter use and the recording of serious-change conversations. Results go to the neonatal governance meeting each quarter, and family feedback is reviewed at the same meeting.

Measure	Target
Daily structured update recorded	100 percent of days
Interpreter offered when the family's language is not the unit's language	100 percent
Serious changes discussed with the family within the same shift	100 percent
Family satisfaction with information (survey, annual)	At least 90 percent agree they were kept informed

14. Records

- Daily update record in the notes.
- Presence and visiting plan, signed by the family and the unit manager or senior nurse.
- Consent and conversation records for serious decisions.
- Interpreter request and use record.
- Complaints and feedback records.

15. Training

All staff who speak to families complete communication training at induction and every two years. The training covers difficult conversations, use of interpreters, and how to give information in plain language. Consultants and senior nurses also complete training in breaking serious news.

16. Related documents

Code	Document
NEO-SOP-004	Child protection and safeguarding in the neonatal unit
NEO-POL-001	Neonatal level of care
NEO-FRM-001	Neonatal level of care assessment record
HSP-SOP-005	Bereavement follow-up
CRT-SOP-003	Family communication and presence

17. Evidence

This SOP is based on the reference sources listed below, the requirement of criterion 37.3 of the ASF standards, and the local family presence policy, which must be checked at each review.

E-learning for this document

- No course linked yet. Request a family communication course from the academy (see the Standard 37 request list).

References

1. World Health Organization and UNICEF. Kangaroo mother care: a practical guide. WHO, 2003.
2. UNICEF and WHO. Baby-Friendly Hospital Initiative: revised, updated and expanded for integrated care. 2018.
3. United Nations. Convention on the Rights of the Child, Article 9 and Article 12. 1989.
4. Haig KM, Sutton S, Whittington J. SBAR: A shared mental model for improving communication between clinicians. Joint Commission Journal on Quality and Patient Safety. 2006.
5. National neonatal service family-information standards and the unit's local family presence policy (to be inserted by the unit at adoption).

Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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