

## Early Discharge from the Neonatal Unit with Nasogastric Tube Feeding: Does not Mean Isolated Working

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### Introduction

Daily on the Neonatal Unit's parents are faced with the difficulty of trying to understand why their baby was born early and when they will be able to take them home. The article by Bathie and Shaw [1] provides a detailed programme that was used by their neonatal team to ensure the transition from hospital to home with a baby on nasogastric tube feeding was positive and confidence building process for the parents. In order, to achieve this successful transition, the neonatal units would need to provide a family centred approach that encourages parents to participant fully in practices and procedures within the critical care setting's [2].

### Aim

The purpose of this review began with identifying the underlying reasons why neonatal units are aiming for early discharge home with nasogastric tube feeding. Furthermore, the review aimed to gain an understanding on the pressures the neonatal units has on the cot availability and financial impact in regards to long term hospitalisation.

### Discussion

Evidently, the article discusses the programme as a form of establishing oral feeding for the preterm infant. The benefits of early discharge from the neonatal unit with the support of naso-gastric tube feeding were identified by the authors as a form of reuniting the families, providing emotional and psychological benefit to the family, beneficial for the infant's development, an opportunity to establish a more consistent approach to feeding by the parents and finally achieving successful weight gain. A study by Rosen et al. [3] based in New York, USA supports Bathie and Shaw [1] by highlighting the advantages for early discharge with nasogastric tube feeding as a form to reduce cost, shorter hospital stay and lower risks of malnutrition-associated complications. In comparison, a study by Khalil et al. [4] based in USA investigating outcomes of infants with tube feeding by comparing nasogastric vs gastrostomy tube, identified that gastrostomy complications were 8 times higher than nasogastric tube feeding, secondly gastrostomy infants attended emergency departments 3 times higher than the nasogastric tube feeding infants. Lastly, Khalil et al. [4] found in their study that infants discharged from the neonatal unit with nasogastric tube feeding, achieved full oral feeds by 6 months of discharge.

Bathie and Shaw [1] article remains very informative and relevant in this current economic climate. The programme discussed in the article has proved valuable information as the National Health Service is searching for ways to save money within the clinical and community

settings. The point highlighted by the authors of a savings of £64260 in 4 months, advocates the importance of having community neonatal nurse/family care nurse to follow up and support the families. Similarly, Dixon et al. [5] reviewed data from their community neonatal service between 2005 to 2008 of infants discharged from the neonatal unit, including nasogastric tube feeding. It can be seen from the analysis of Dixon et al. [5] that early discharge from the neonatal unit of preterm infants with the follow up of a community neonatal team has not shown any reductions in the breastfeeding rates, however improved discharge planning, reduced readmission to hospital and finally a cost saving of £860000 (if the infant had been in hospital with NGT for 2059 days) [5]. The programme discussed by Bathie and Shaw [1] identifies that early discharge home with Nasogastric tube feeding from the neonatal unit, is only successful if a multi-agency team agrees on the goals set, in order to achieve this level of success. The value of multi-agency working has been highlighted numerous times in organisational policies and procedures, as a process of sharing confidential information and a form of good practice to create a secure environment for the vulnerable preterm baby [5,6].

As a community, neonatal sister, I would have wanted to know the structure of the home visits, was it weekly or only when the parents requested. Bathie and Shaw [1] clearly state that there were no audit results about the total number of babies discharged on the programme. Importantly, data from parents about their experiences would also been beneficial, to ensure that it is not only a cost saving programme but a quality assurance process [7].

### Conclusion

Although, the article highlights the positives there are some considerations to such a programme, this would be where the parents competent to care for their baby at home with a Nasogastric tube. This point is also sustained by the work of, Uhl et al. [8] and Rowe and Jones [9] that involvement of parents needs to be joint decision making process with follow up support for as long as up to 18 months of the infants age. Bathie and Shaw [1] programme was achieved by ensuring the parents had teaching, step 1, step 2, step 3 and step 4 explained in the article. Undoubtedly, the prevalence of preterm infants in the community is increasing as a result of improved medical care and increasing birth rates [10]. The development of parent training packages and increasing community neonatal nurses/family care nurses that have expertise knowledge in this area, may reduce parents feeling anxious, insecure and unprepared to take their infants home from the neonatal unit as identified by Nicolaou et al. [10]. The conclusion would be that having an infant discharged home with nasogastric tube feeding allows the infant to integrate early with their family and social environment, importantly improving their quality of life [3,11,12].

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## Future Research

- Parental feedback on their quality of life when caring for an infant on home nasogastric tube feeding.
- Follow up support home visits vs. clinic reviews.
- Data collection from different neonatal units in different geographical areas because discharge with nasogastric tube feeding is more common in developed countries dependant on funding from their local governments.

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