MODULE 3:

COUNSEL, DISCHARGE AND FOLLOW UP

SICK & SMALL NEWBORNS

INTRODUCTION

Deciding when a baby is ready for discharge requires an assessment of the baby, the mother and the home circumstances. Babies who are term, are feeding well and have had no serious illness can be discharged earlier than babies who are pre-term, low-birth weight, feeding poorly or have had serious illness. This module describes the full assessment of the baby's condition, feeding, growth and the assessment of the mother's condition and ability to cope and handle the baby and feeding well in order to be discharged. Many babies who have been low birth weight will be discharged from the KMC unit and a KMC score is useful in knowing when the baby is ready for discharge.

Before discharge, immunizations need to be given and all details about the birth and post natal period need to be recorded in the baby's discharge papers and a Road To Health Card, as well as dates for routine follow up visits.

Mothers should be counselled on the babies condition, feeding, when to bring back her baby in case of emergency or signs of illness, and should know when to return with her baby for routine follow up visits. During all visits, babies should be assessed for priority signs, for weight gain and growth as well as checking their developmental progress.

OBJECTIVES

At the end of the module you will be able to

- Understand which babies can be discharged and when
- Counsel mother on babies condition and care, when to return with the baby for routine and emergency care
- Assess returning ill babies for review at the PHC or hospital
- Assess and treat babies returning for routine care over the first few months of follow up, and counsel the mother appropriately at each visit

3. COUNSEL, DISCHARGE AND FOLLOW UP

Counsel

Counsel the mother as well as the father and grandparents, about the condition of the baby, how to care for the baby, how to feed the baby, when to come back immediately, when to come back for review, as well as the routine child health visits.
Counselling requires using good skills in communication, listening and learning, and building the family's confidence in caring for the child. These skills are covered in the Routine care of the newborn, and can be found in section E, or page 14 of the chart book.

Communication

- Be respectful and understanding
- Listen to the family's concerns and encourage them to ask questions and express their emotions
- Use simple and clear language
- Ensure that the family understands any instructions and give them written information
- If a baby needs to be transferred, explain the reason for the transfer and how the baby will be transferred
- If a baby has a poor prognosis, is not improving or has had a sudden deterioration, discuss this with the mother and explain the current management
- Respect the family's right to privacy and confidentiality
- Respect the family's cultural beliefs and customs, and accommodate the family's needs as much as possible
- Remember that health care providers may feel anger, guilt, sorrow, pain and frustration.
- Obtain informed consent before doing any procedures

Listening and learning skills

- Use helpful non-verbal behaviour.
- Ask open-ended questions.
- Use responses and gestures that show interest.
- Reflect back what the mother says.
- Avoid judging words.

Confidence building skills

- Accept what the mother says, how she thinks and feels.
- Recognise and praise what the mother is doing right.
- Give practical help.
- Give relevant information according to the mother's needs and check her understanding.
- Use simple language.
- Make suggestions rather than giving commands
- Reach an agreement with thee mother about the way forward

Steps in Counselling

Assess	Assess knowledge and practise
Advise	Give advice
Ask Checking questions	Check her understanding by asking checking questions
Agree	Agree on a management plan
Assist	Give practical help and suggestions to achieve the plan
Arrange	Follow up sessions as required

3.1 DISCHARGE

When to discharge

- Low birth weight baby: When baby is at least 1,8kg and KMC score is more than 20
- Baby with serious infections: Completed course of treatment and feeding well
- Baby with encephalopathy and seizures: Completed treatment, seizures controlled and breatfeeding well
- Other babies: Once treatment is completed, baby is breastfeeding well, and mom is able to provide home care

Give Immunisations before discharge

- Give BCG and OPV0 on discharge if less than 6 weeks of age.
- If more than 6 weeks and baby has not received OPV0 and BCG yet
    - Give BCG, OPV0, DaPT-Hib-IPV1, HepB1, PCV1, and RV1 – then give OPV1 in 4 weeks with 10 week immunisations.
- If 6 weeks and has received BCG and OPV0
    - OPV1, DaPT-Hib-IPV1, HepB1, PCV1, and RV1

Document information in the road to health booklet

Document information on the Road to health booklet on the following pages** note that the page numbers may change in the future

- Page 2: well child visit summary at 3 days, 6 weeks and 10 weeks if applicable
- Page 4: Details of child and family
- Page 5: Neonatal information
- Page 6: Immunisation
- Page 7: PMTCT/HIV information

Counsel

- Counsel on any special care the child may require e.g. for HIV or other condition
- Counsel on exclusive breastfeeding: Refer to page 10, Health Promotion messages in babies up to 6 months

Counsel on when to return immediately

- Bleeding
- Diarrhoea
- Feeding poorly
- Convulsions
- Fever
- Cough with fast breathing
- Yellow hands and feet
- Pus draining from the eyes
- Skin pustules
- Cord stump red or draining pus

Counsel on when to return for follow up

All babies

- Return to the PHC Clinic
    - 3 – 6 days of age then 6 weeks and normal routine

HIV exposed babies

- Return to the PHC Clinic or PMTCT follow up clinic
    - 3 – 6 days after discharge
    - 6 weeks of age and monthly for first year

Babies who weighed < 2 kg at birth

- Return to the High risk Neonatal follow-up
    - 3 days after discharge then weekly until 2.5 kg

HIGH RISK: Babies who had the following problems

- Birth weight < 1.5 kg
- Meningitis or sepsis
- Moderate or severe neonatal encephalopathy
- Severe hypoglycaemia
- Required CPAP or IPPV
- Major congenital abnormalities
- Necrotising enterocolitis
- Severe jaundice

Return to the High-risk neonatal follow-up clinic

- 3 days after discharge
- Weekly until 2.5 kg
- 4 months
- 9 months
- OR as required by the condition of the baby
- Babies < 1.5kg or who required CPAP or IPPV to have ophthalmological assessment for Retinopathy of prematurity

3.2 NEONATAL FOLLOW UP

Visit	Assess	Treat, Counsel, Follow up
3 days after discharge	• Assess and classify weight gain 2.2.2.4 (p.60) • Assess and classify for priority signs 1.2 (p. 26)	Counsel on feeding **Low birth weight** Gaining well: follow up in 2 weeks Not gaining: follow up in 3 days Losing weight: readmit Multivitamin drops 0.6 ml / day Ferrous lactate 0.6 ml / day
Low birth weight visits until 2500g	• Assess and classify weight gain 2.2.2.4 (p.60) • Assess and classify for priority signs 1.2 (p. 26) • Measure and record head circumference	Multivitamin drops 0.6 ml daily for 6 months Ferrous lactate 0.6 ml daily for 6 months Counsel on feeding If well at 2500g, for routine PHC clinic follow up • Birth weight less than 1500g, and / or • Serious illness (see p.85) • Follow up at 18 weeks corrected age and 9 months for developmental screen
6 weeks of age HIV exposed	• Assess and classify weight gain 2.2.2.4 (p.60) • Do HIV DNA PCR • Give Immunisations • Initiate co-trimoxazole syrup • Discontinue NVP syrup unless extended course indicated (p.79)	• Counsel on feeding • Get PCR result in 2 weeks. If PCR positive initiate on ART and confirm HIV status with a repeat PCR.(P.80-81) • PCR negative: routine follow up at clinic and repeat PCR if baby shows signs of HIV • PCR negative, and breast feeding: repeat PCR 6 weeks after stopping breast feeding. • Repeat HIV antibody test at 18 months
18 weeks corrected age	• Assess and classify weight gain 2.2.2.4 (p.60) • Measure and record head circumference • Assess development 3.3.	• According to problems identified • If delayed motor development, start physiotherapy • If delayed communication, assess hearing

	p.87	
9 months	• Assess growth and feeding • Measure and record head circumference • Assess development 3.3. p.87	• According to problems identified • If delayed motor development, start physiotherapy • If delayed communication, assess hearing
Retinal Assessment	• Specialised assessment by ophthalmologist	• A decision on when this is done and an appointment to be made when the baby is in hospital.

📖 **Now see Exercise Module 3: Do Exercise 3A and 3B (p.45-46)**

3.3 DEVELOPMENT CHART (0–18 MONTHS)

Use this development chart as a guide to assess the baby's development on all routine and non-routine follow up visits (see p. 87 in Newborn Care Chart booklet)

Months	Gross-motor	Fine-motor-adaptive	Communication	Personal-social
18	Walks well, arms down Pulls a toy Throws a ball Climbs on a chair	Completes simple form board with reversal (trial and error)* 3 - 4 cube tower	2 word utterances. 6-20 words Points to one body part Points to one picture	Indicates wet / dirty nappy Pulls up pants Handles spoon and cup well
15	Walks alone – uneven steps, arms out for balance	2 cube tower Simple form board - replaces both circles*	Jabbers with expression Uses 5 words (other than mama, dada)	Pulls off socks Holds and drinks from a cup Attempts to feed with a spoon - spills most
12	Bear walks, walks around furniture lifting one foot and stepping sideways, may walk alone	Pincer grasp, releases object on request Simple form board (one circle in)*	Knows own name 2 – 3 words with meaning	Finger feeds Pushes arm into sleeve
10	Pulls to stand, walks with assistance	Picks up small object between finger and thumb Clicks two cubes together	Shakes head for no Waves bye bye	Plays peek-a-boo with mother
9	Sits without support Crawls on hands and knees Pulls up to stand	Immediately reaches out and holds a cube in each hand Exploratory mouthing	Vocalizes deliberately Babbles	Stranger anxiety Holds cup
6	Pulls to sit: braces shoulders and pulls to sit Prone: Lifts head and chest up Supports on extended arm Rolls from supine to prone	Reaches for and grasps toy Transfers toy from one hand to the other	Initiates conversation	Takes everything to the mouth Pats mirror image
3	Pulls to sit: little or no head lag Prone: supports on forearms, lifts head, buttocks flat Rolls from prone to supine	Follows through 180^0 Holds rattle when placed in hand	Coos, chuckles and squeals	Excited when sees mother Obvious pleasure at being handled
6 weeks	Pull to sit: some head control Prone: head to side, buttocks moderately high Moro reflex	Stares Follows horizontally to 90^0	Startle response	Smiles at mother
Newborn	Ventral suspension: head drops, hips flexed, limbs hang Moro reflex, palmar & plantar grasp reflexes	Hands fisted Closes eyes to sudden bright light	Stills to sound Startles to sudden loud noises	Alternates between drowsiness and alert wakefulness