

MNO-Neonatal Missed Opportunities Debrief Form

Use this form to review missed opportunities in caring for Mothers and Newborns affected by Opioids with the clinical care team. This form will facilitate review of:

- prenatal consult
- non-pharmacologic care
- breastfeeding
- coordinated discharge

1a. Was a neonatal/pediatric consult provided prenatally?

- Yes
- No

1b. If no, discuss the possible reasons why not?

- Opioid exposure unknown prior to delivery and discovered after newborn's birth
- Opioid exposure discovered on delivery admission, but mother delivered precipitously so unable to provide consult
- Mother declined consult
- Neonatal/Pediatric consult not requested
- Other: _____

1c. What could your team/hospital do to address these barriers?

2a. Which non-pharmacologic bundle components were implemented?

- Optimal feeding at early hunger cues
- Safe swaddling
- Quiet, low-light environment
- Non-nutritive sucking
- Clustered care
- Limited visitors
- Safe sleep/fall prevention
- ILPQC Newborn Care Diary
- Rooming-in
- Breastfeeding
- Other: _____

2b. For components that were not implemented, what steps could the clinical team have taken to ensure implementation? Possible elements to consider for discussion, include:

- Review hospital policies to support non-pharmacologic care
- Obtain provider / staff buy-in
- Electronic Medical Record barriers
- Identify appropriate facilities for rooming in, considering:
 - Impact on other departments within hospital
 - Room availability
 - Census/volume for learning and maintaining competency
 - Access to pediatricians
 - Access to volunteers
 - Birthing unit/ facility set up
 - Staffing availability
 - Policies

2c. How did the team engage the mother in the non-pharmacologic care of the newborn?

2d. What steps could the team have taken to better support, engage, and empower her?

- Establishing a trustful and respectful relationship
- Reviewing prenatal neonatal/pediatric consult education
- Demonstrating and modeling non-pharmacologic care strategies
- Ongoing support from staff
- Other: _____

3a. If mother was eligible to breastfeed, was newborn receiving breastmilk at infant discharge? (Please see eligibility criteria in the ILPQC MNO-Neonatal Toolkit)

- Yes
- No

3b. If no, please select all items that were not documented or completed

- Mother received a Neonatal/Pediatric consult prenatally
- Mother received NAS and maternal engagement education prenatally
- Mother received breastfeeding patient education prenatally
- Mother received NAS and maternal engagement education during delivery admission or during newborn hospital admission
- Mother received breastfeeding patient education during delivery admission or during newborn hospital admission
- Lactation or breastfeeding support offered
- Documentation of maternal decision to not breastfeed

3c. If items were not documented or completed discuss what role they might have played in newborn receiving breastmilk at infant discharge? What could your team/hospital do to address these barriers to breastfeeding for eligible mothers?

4a. What elements of the MNO-Neo Coordinated Discharge Worksheet did the team feel successful in completing in partnership with the care team, mother, family, and community pediatrician during the infant discharge process?

- Pediatrician appointment scheduled within 48-72 hours of discharge
- Warm hand off provided to Pediatrician
- Discharge coordinated in partnership with hospital care team, mother, and community Pediatrician
- Care team submitted an APORS report within 7 days of newborn discharge
- Care team coordinated discharge planning with IL DCFS (if applicable)
- Early Intervention referral completed
- Additional Community Resource mapped/identified and documented (i.e. WIC, Local Health Department services, Home Visiting)

4b. For elements not successfully completed, did any of the following barriers/limitations apply? What could your team/hospital do to address these barriers or limitations?

- Providers/staff did not have access to MNO-Neo Coordinated Discharge worksheet
- Provider/staff did not know they needed to complete MNO-Neo Coordinated Discharge worksheet for infants with NAS
- Providers/staff did not document discharge components received
- Checklist was in chart but not completed
- Mother/Family unavailable
- Foster family identified day of discharge
- Unable to directly speak to community Pediatrician to coordinate hand off and discharge plan