Neonatal Intensive Care Unit - Admission - Paediatric Full Clinical Guideline

Reference no: NEONATE/09:16/N3

Integrated Care

Joint Maternity & Children's Guideline

Contents

1. Introduction

A number of newborn infants will need referral for specialist medical treatment and continuing specialist care in a Neonatal intensive care unit. The need for this service cannot always be anticipated, but the risks surrounding this can be reduced if robust evidence based arrangements are in place. We are primed to expect the unexpected and as such always have an ITU cot prepared.

2. Purpose and Outcome

The aim of this guideline is to ensure that all staff can identify and ensure that newborn infants are admitted to the Neonatal Unit (NICU) appropriately. This clinical guideline cannot cover all eventualities. As with all guidelines the application remains the responsibility of the individual clinician

3. Abbreviations

ANNP – Advanced Neonatal Nurse Practitioner

NICU – Neonatal Intensive Care Unit

4. Key Responsibilities and Duties

Advice should be sought from either the Neonatal Registrar or Consultant if doubt exists about the appropriateness of an admission.

The Neonatal doctor/ANNP on duty and the Nurse in Charge for the Neonatal Unit (NICU) should be contacted prior to transferring any baby to the Neonatal Unit. The midwife co-ordinator or obstetrician will take responsibility for this. Paediatricians, ANNPs and midwives will be involved in moving the baby to NICU within the maternity unit.

The status of the availability of neonatal cots on the unit is updated daily by the neonatal staff and communicated to the labour ward co-ordinator, who will ensure the labour ward white board is updated. The postnatal ward co-ordinator liaises with the labour ward co-ordinator to ascertain NICU status. This is updated on the white board.

5. Documentation

Please ensure all assessments and individual plans of care are documented clearly in the appropriate records which may include some or all of those listed below

- medical records
- maternity hand held records
- maternity clinical system special instructions page
- Baby notes

6. Indications for Admission

6.1 Labour Ward or Immediately after birth

Babies requiring **direct admission** to the Neonatal Unit include:

- Babies <1800g or <34 weeks gestation
    - Some babies who are <1800g but who are relatively mature may require only a short period of assessment (<12 hours) before transfer to the postnatal ward.
    - Babies 1800-2500g and 34-35 weeks may be admitted to the postnatal ward but there may be times where flexibility and individualised discussions are necessary e.g. staffing/workload restraints.
- Babies who appear unstable and cause concern/require intensive care.
- Suspected significant perinatal asphyxia.
- Respiratory problems
  Any baby with signs of respiratory distress should be reviewed by the Neonatal doctor.
    - Where oxygen saturations are <92% or the baby is clearly unwell, admit to NICU for further assessment.
    - If a baby is well but has a respiratory sign e.g. grunting or recession or tachypnoea >70bpm reassess between 1 and 4 hours of age. If there are 2 or more signs consider direct admission to NICU.
    - A single sign persisting or developing after 4 hours requires admission.
- Congenital abnormalities where intensive care is anticipated or diagnosis of multiple anomalies.
- Haemolytic disease where exchange transfusion is likely.

- Chorioamnionitis i.e. presence of maternal pyrexia, purulent liquor and prolonged rupture of membranes. It may be possible to manage the well term infant on Ward 314 after septic screen and antibiotics started.

6.2 Postnatal Wards

Babies requiring admission include:

- Convulsions, apnoeic or cyanotic attacks.
- Respiratory distress (including grunting) at or beyond 4 hours of age.
- Hypoglycaemia not responding to regular 3 hourly feeds of breast milk or formula milk (see hypoglycaemia guideline).
- Spontaneous bleeding.
- Severe jaundice that may require exchange transfusion.
- Major feeding problem and/or vomiting.
- Neonatal abstinence syndrome where treatment is required
- Any bile stained vomit.
- Low temperature (<36°C) not responding to measures available on postnatal ward.

7. Moving a baby to NICU

All babies of 32 weeks gestation and below should be transferred to NICU in occlusion wrapping, i.e., the body of the baby is wrapped in a plastic bag to prevent heat loss by evaporation plus a hat and blankets if appropriate**.**

Moving the sick newborn baby the short distance from the labour ward area or from ward 314 to NICU will usually be done on the resuscitaire with radiant heater.

If moving from other areas, especially a baby who is intubated / ventilated, then the transport incubator should be used to ensure the necessary equipment is available and heat loss is minimised.

For the stable baby it is usually appropriate to move them in their cot with due attention paid to keeping them warm.

7.1Transfer from Home

If a baby, who is born at home, requires admission within the first 24 hours after birth, the attending midwife will organise this in liaison with the Neonatal registrar / Consultant and NICU co-ordinator. The baby will be transferred by ambulance with the mother if possible. If the baby needs to be transported via an incubator the mother will go in a separate ambulance. The midwife should contact the NICU co-ordinator to give an estimated time of arrival. NICU staff should be waiting at the maternity entrance of the hospital to transport the baby to NICU.

7.2Readmissions from home

It is unusual for babies beyond this time period to be admitted to NICU but there may be times when it should be considered because of the particular nature of the problem e.g. exchange transfusion.

A decision must be made after discussion with the Neonatal Consultant, Paediatric Consultant, Senior Neonatal Nurse in Charge and the Paediatric Ward Sister.

Babies, who have 'graduated' from the Neonatal Unit and need hospitalisation, are re-admitted to the Paediatric Ward.

8. Risk Process for reporting & learning the lessons for unanticipated admissions

There is a daily communication between NICU and labour ward as to the status of NICU bed availability
Multi disciplinary team meetings are held on NICU at the start of the service week when all the babies are discussed and any untoward problems are raised by staff.
The senior midwife from the postnatal ward, as the link person, attends this meeting and then feeds back the discussions to the Labour ward risk meeting.

Unanticipated admissions are recorded on a Clinical Risk Event Form and sent for review by the Risk Co-ordinator. Any serious issues will be actioned as necessary following the Trust Policy and Procedures for Incident Reporting, Analysing, Investigating and Learning (RKM 020). Evidence to demonstrate learning from these events maybe through different portals. These can include open meetings to discuss incidents or multidisciplinary case reviews or through the directorate newsletters.

9. Monitoring Compliance and effectiveness

Monitoring requirement	Review of case notes where admission to the NICU has been required Demonstration of implementation of the process for reporting and learning the lessons from unanticipated admissions to NICU
Monitoring method	Retrospective case note review Audit & Risk trail
Report prepared by	Clinical Lead Neonatologist
Monitoring report sent to:	Directorate Management Team
Frequency of report	Biannual

10 References

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