ADMISSION TO NEONATAL UNIT, TRANSITIONAL CARE UNIT AND POST NATAL WARDS AT WORCESTERSHIRE ROYAL HOSPITAL ● 1/2

INTRODUCTION

There are three areas of postnatal care for neonates born at Worcestershire Royal Hospital. These are the Neonatal Unit, the Transitional Care Unit and the Postnatal Ward. The following guideline seeks to inform staff of the admission criteria for each area thus providing the appropriate level of care for individual patients.

Any baby requiring admission to the neonatal or transitional care unit should be transferred as soon as possible following delivery. Weighing of the baby does not need to be done on delivery suite

- There should be good clinical reasons for admission to the Neonatal unit
- Avoid unnecessary separation of mother and baby as it affects maternal bonding

Ensure that all eligible babies have newborn infant physical examination (NIPE) between 6–72 hr of birth

CRITERIA FOR ADMISSION FROM LABOUR WARD OR POSTNATAL WARD TO NEONATAL UNIT

Discuss need for admission with senior medical staff, make arrangements for transfer and liaise with midwife and neonatal staff.

- <34+0 weeks' gestation and/or birth weight <1700 g
- Babies delivered in LNU/SCBU <27 weeks (<28 if multiples) or < 800g need transfer to a NICU, they should follow IUT pathway to avoid being born outside a NICU.
- Clinical condition requiring constant monitoring
- Baby with significant illness requiring intensive/ HDU care:
  - poor condition at birth requiring prolonged resuscitation for >10 min and/or cord pH <7.0 (a low cord pH may not in itself necessitate admission)
  - respiratory distress or cyanosis
  - apnoeic or cyanotic attacks
  - signs of encephalopathy
  - jaundice needing intensive phototherapy or exchange transfusion
  - major congenital abnormality likely to threaten immediate survival
  - seizures
  - inability to tolerate enteral feeds with vomiting and/or abdominal distension and/or repeated hypoglycaemia (blood glucose <2.0 mmol/L for ≥37 weeks/<2.6 mmol/L for <37 weeks' gestation)
  - symptomatic hypoglycaemia or hypoglycaemia not responding to treatment (see **Hypoglycaemia** guideline)
- Neonatal abstinence syndrome requiring treatment (see **Abstinence syndrome** guideline)
- Short-term care while mother admitted to ITU

Procedure

- Manage immediate life-threatening clinical problems (e.g. airway, breathing, circulation and seizures)

- Show baby to parents, offer delivery room cuddles if possible and explain reason for admission to neonatal unit
- Ensure baby name labels present
- Document relevant history and examination
- Complete birth record sheet
- Measure and plot birth weight and head circumference on growth chart
- Measure admission temperature
- Measure blood pressure using non-invasive cuff
- Institute appropriate monitoring and treatment in conjunction with nursing and senior medical colleagues

Investigations

For babies admitted to NNU, obtain 1 bloodspot on newborn bloodspot screening (Guthrie) card

Babies <32 weeks/1500 g weight/unwell/ventilated

- FBC
- Blood glucose
- Blood gases
- Clotting screen if clinically indicated (see **Coagulopathy** guideline)
- routine clotting screen in all babies <30 weeks' gestation is not recommended
- If respiratory symptoms or support given, chest X-ray
- If umbilical lines in place, abdominal X-ray
- If suspicion of sepsis, blood culture and CRP before starting antibiotics and consider lumbar puncture (see **Infection in first 72 hours of life** guideline)

Other babies

- Decision depends on initial assessment and suspected clinical problem (e.g. infection, jaundice, hypoglycaemia etc.) see relevant guidelines

IMMEDIATE MANAGEMENT

- Evaluation of baby, including full clinical examination
- Define appropriate management plan and procedures in consultation with middle grade doctor and perform as efficiently as possible to ensure baby is not disturbed unnecessarily
- Aim for examination and procedures to be completed within ≤1 hr of admission
- If no contraindications, unless already administered, give vitamin K (see **Vitamin K** guideline)
- If antibiotics indicated, give within 1 hr
- Senior clinician to update parents as soon as possible (**certainly within 24 hr**) and document discussion on Badger.

Respiratory support

- If required, this takes priority over other procedures
- includes incubator oxygen, high-flow humidified oxygen, continuous positive airway pressure (CPAP) or mechanical ventilation

IV access

- If required, IV cannulation and/or umbilical venous catheterisation (UVC) – see appropriate guidelines in **Practical procedures** section

MONITORING

Use minimal handling

- Cardiorespiratory monitoring through skin electrodes. **Do not use** in babies <26 weeks' gestation
- Pulse oximetry. Maintain SpO_2 as per gestation target values (see **Oxygen saturation targets** guideline)
- Temperature
- Blood glucose (see **Hypoglycaemia** guideline)
- If ventilated, umbilical arterial catheterisation (UAC)/peripheral arterial line for monitoring arterial blood pressure and arterial blood gas – see appropriate guidelines in **Practical procedures** section

CRITERIA FOR ADMISSION TO TRANSITIONAL CARE UNIT

The aim of transitional care is to keep mothers and babies together where ever possible. Therefore, if a baby fulfils the criteria for admission to TCU every attempt should be made to arrange this admission from delivery suite.

The following babies **may** be admitted from the delivery suite or the wards by a midwife; following discussion with the midwife on TCU. The paediatric team should be informed of all new admissions to TCU.

- Babies who require regular tube feeding or significant feeding support.
- Babies of 34+0 to 36+0 weeks gestation at delivery, who are otherwise well
- In **exceptional** circumstances, babies over 33/40 who are well may be assessed on an individual basis by consultant/senior nurse as to suitability for TCU
- Babies between 1.50 and 2.0 kg birth weight who do not require admission to the neonatal unit occasionally >1.2kg + >34/40, if no significant illness
- Babies of mothers who are known substance abusers
- Unaccompanied babies e.g babies for adoption, babies of mothers who are on intensive care, providing an appropriate level of observation can be maintained
- Babies with an agreed hospital birth plan which identifies the need for additional support or observation of parenting capacity (this will be for a maximum of 7 days)
- Readmission from home if previous NICU/TCU patient, with feeding or jaundice issue. No suspected infected baby to be readmitted to this area.

If a bed is not available on TCU, these babies will need to be admitted to the Neonatal Unit. Babies will be admitted straight from labour ward with their mothers, without delay, including caesarean sections on day 0 (if mother's condition allows).

The following babies may be admitted to TCU following discussion with the paediatrician;

- Babies who no longer require care on the neonatal unit but are not ready for home or postnatal ward
- Babies requiring low flow oxygen prior to discharge home
- Babies receiving IV glucose for hypoglycaemia or awaiting production of MEBM
- Observations including saturation monitoring for babies with mild respiratory distress, who do not require oxygen

CRITERIA FOR ADMISSION TO THE POSTNATAL WARD

All babies of 36 + 1 weeks gestation or greater and greater than 2.0kg who do not fulfil the criteria for admission to the neonatal unit or transitional care. This will include the following:

- Babies requiring intravenous antibiotics
- Babies requiring phototherapy
- Babies requiring nursing in an incubator or hot cot to correct hypothermia

- Babies whose mothers need support with breast feeding or parenting skills, including those with a hospital birth plan which does not identify any risk of significant harm to the baby.
- Babies who require monitoring of blood sugars, e.g. babies of diabetic mothers
- Low birth weight infants weighing more than 2.0 kg

Nursing staff on TCU and the neonatal unit will try to offer advice and support for such babies if required.
The above admission criteria are not exclusive and other cases may be discussed on an individual basis with both medical and nursing staff