TRUST POLICY

NEONATAL UNIT and TRANSITIONAL CARE UNIT ADMISSIONS POLICY
A0097

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All document profile details are recorded on the last page.

All documents must be reviewed by the last day of the month shown under "review date", or before this if changes occur in the meantime.

FAST FIND: NNU, NICU, Inutero transfer, Transitional care, neonatal admission

DOCUMENT OVERVIEW:
This document provides guidance as to which babies ought to be admitted to the Neonatal Unit or Transitional Care Units at Gloucestershire Royal Hospital, and applies to all Maternity and Neonatal staff.

This document may be made available to the public and persons outside of the Trust as part of the Trust's compliance with the Freedom of Information Act 2000
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1. **INTRODUCTION**
1.1 The vast majority of babies remain with their mothers after birth and are not admitted to the Neonatal unit. However, there are occasions when a baby will need care over and above that which can be given by the mother or on the post-natal ward. In some instances it is clear to all involved that admission to the Neonatal Unit is needed, whilst in others the decision is less easy to make. This guideline has been drawn up by maternity and neonatal staff to act as guidance to those making the decisions of whether a baby needs admission to the Neonatal or Transitional care units or not.

2. **DEFINITIONS**
2.1 Neonatal Unit: refers to the Neonatal Intensive Care Unit (NICU) at Gloucestershire Royal Hospital
2.2 Transitional Care Unit: a 4-bedded unit for mothers and their baby co-located within the Neonatal Unit at Gloucestershire Royal Hospital.
2.3 The Transitional Care Unit provides care for those babies who require more than normal postnatal care, but do not require admission to the neonatal unit. The aim of transitional care is to support mothers and babies staying together where possible.
2.4 Unanticipated admissions to NICU are defined as those babies admitted to NICU who are 35 weeks (or 1.8kgs) or more, or greater than 1.8kg, for whom there are no clear antenatal plan to admit to NICU. Unanticipated admissions will be used as a process from which to learn lessons; see section 8 (below).

3. **PURPOSE**
3.1 This guideline aims to ensure that admission to the Neonatal or Transitional Care unit is limited to those who need it for medical or other reasons, whilst giving guidance to those who are in the often difficult position of making a decision about the best place for a baby to be cared for.
3.2 It is hoped that by consulting this guideline, conflict will be avoided between the various different teams involved in the care of the newborn baby including the parents, with regard to the best and safest place for the baby to be cared for.

4. **ROLES AND RESPONSIBILITIES**
4.1 It is the responsibility of all staff to ensure that parents are kept fully aware of any plans regarding their baby.
4.2 All groups should be aware of the admission criteria outlined below:

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
<th>Resources</th>
<th>Planning</th>
<th>Monitoring</th>
<th>Implementation</th>
<th>Records</th>
<th>Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician (Cons/ST 3-6)</td>
<td>• To liaise with the NNU regarding the birth of any baby known or thought to fulfill the criteria for admission to the unit, regarding availability of cots and staff to be present at the delivery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>
| Midwives       | • To identify babies needing admission to the NNU and to contact the unit in a timely fashion.  
  • Midwives may have to initiate treatment for sick babies, whilst requesting help from NNU staff, or if in a midwifery-led unit or patient’s home, whilst waiting for an ambulance to transfer them and the baby to hospital.  
  • They should therefore have training in newborn life support through annual mandatory training. | X         | X        | X          | X              |         |           |
| Consultant     | • To liaise with Obstetric and Neonatal Unit staff regarding cot-availability | X         | X        | X          | X              |         |           |
### Post/Group Details

<table>
<thead>
<tr>
<th>Neonatologist:</th>
<th>and the optimum time and place of delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• To bear responsibility for deciding which babies are admitted.</td>
</tr>
<tr>
<td></td>
<td>• To be available to attend in emergencies.</td>
</tr>
<tr>
<td>Neonatal FT2/ST1-8/ANNP:</td>
<td>To identify any baby requiring admission to the NNU and to ask for senior help, if needed.</td>
</tr>
<tr>
<td></td>
<td>• To anticipate the need for extra help, and ensure that the NNU is aware of an impending admission; e.g. with extreme prematurity; babies with known perinatal compromise/anomalies.</td>
</tr>
<tr>
<td></td>
<td>• All staff at these grades to be trained in resuscitation of the newborn.</td>
</tr>
<tr>
<td>Neonatal nurses</td>
<td>To liaise with labour ward regarding any babies likely to require admission post-partum.</td>
</tr>
<tr>
<td></td>
<td>• To discuss any possible transfers with the Neonatal Consultant covering the unit, especially when there is a paucity of cots.</td>
</tr>
<tr>
<td></td>
<td>• To be available to attend for high-risk deliveries and emergency cases.</td>
</tr>
</tbody>
</table>

### 5. NEONATAL UNIT ADMISSIONS

#### 5.1 The following newborn infants should *always* be admitted to the Neonatal Unit:

a. Gestation below 35 completed weeks (ie 34⁺⁶ weeks and below)

b. Birth weight less than 1.8kgs

c. Signs of respiratory distress (tachypnoea greater than 70/min, grunting, recession) still present at 4 hours, or earlier if more than one sign of distress present. **Any baby requiring oxygen** should be admitted

d. Infants requiring advanced resuscitation (apgar's less than 5 at 5 mins, or equal to 5 at 10 mins) including those who needed intubation following birth

e. Known or suspected fetal/neonatal anomaly requiring treatment or investigation.

f. Symptomatic hypoglycaemia

g. Hypoglycaemia not responding to feeding (see GHNHSFT Neonatal hypoglycaemia [http://glnt313/sites/ghnhsft_policy_library/WPP/A1095.aspx](http://glnt313/sites/ghnhsft_policy_library/WPP/A1095.aspx))

h. Symptomatic polycythaemia, symptomatic anaemia and bleeding disorders

i. Significant haemolytic disease of the newborn

j. Jaundiced babies with an Serum Billirubin (SBR) above the ‘exchange’ level

k. Major trauma to the infant

l. Convulsions

m. Social reasons for admission, e.g. adoption

n. Any infant who requires more than the normal care provided on the postnatal or labour ward e.g. nasogastric feeding, observations more than 2 hourly

o. Infants admitted from other units, after discussion with nursing staff and neonatal registrar or consultant on call
5.2 The following infants may need admission to the Neonatal Unit:
Consideration for admission should be given for the following babies who have been examined by a
Neonatologist after birth, and a decision taken about the need for admission:

a. Infants with a cord pH of less than 7.00. Not all these babies will require admission: if they have not
required resuscitation and are otherwise completely well, they can safely be left with the mother.
They must be examined by the neonatal doctor / ANNP. However, if they needed resuscitation or
are symptomatic, these babies should be admitted to the neonatal unit.

b. Birthweight less than 2kg

c. Gestation between 35\(^{16}\) and 36\(^{16}\) weeks

d. Jaundice not responding to phototherapy on the post-natal wards

e. Any maternal condition known to pose a risk to the baby, including:
   - diabetes mellitus with poor control
   - maternal thyroid disease
   - substance misuse or maternal medication
   - maternal SLE

f. Babies readmitted from the community with severe jaundice, dehydration, weight loss or poor
feeding up to 28 days of age. Always discuss babies readmitted to the hospital from home with a
consultant before admitting to the neonatal units (there is a theoretical risk of importing infection to
the unit when a baby has been out of the hospital).

g. Neonatal abstinence: In most instances, a pre-birth planning meeting will have taken place, where
the postnatal care of the baby will have been discussed and a plan made. In most cases the baby
will be cared for on the postnatal ward and observed for signs of withdrawal. Admission to the
neonatal unit will be necessary if:
   - A plan has been made and agreed antenataly for the baby to be admitted to the neonatal unit
     immediately after birth.
   - The baby shows significant signs of withdrawal (scoring greater than 5 on the modified Finnigan
     withdrawal chart).
   - Any infant causing concern who does not fit into any of the above

If in doubt as to whether a baby needs admission, always discuss with senior members of the
midwifery and neonatal staff

5.3 Admission from other neonatal units

Babies from other neonatal units should ordinarily be admitted to NICU or TC according to their clinical
need. They should have a MRSA screen taken on admission, and until this result becomes available
they should be isolated as far as practicable to reduce the potential risk of cross-infection.

Prior to accepting admissions from other units, always consider whether they would be better going to
the General Paediatric ward, rather than NICU. This may particularly be the case for babies with
chronic conditions likely to need on-going paediatric specialist consultant or nurse input, or open-
access to the ward after ultimate discharge from hospital.

5.4 Readmissions

The worry of admitting a baby who has been home or on a general paediatric ward is that they may
have an infectious (viral) illness, which may then spread within the NICU. Babies should not normally
be admitted to NICU from other general paediatric wards.

The need for a baby who has been at home to be admitted to the Neonatal Unit or Transitional Care
must be considered on an individual basis, and discussed with the nurse in charge of NICU and the on-
call consultant. However, it is reasonable for babies less than 7 days of age in whom there is no
clinical suspicion of infection to be admitted, providing reasonable infection-control measures
are taken. Most babies are initially admitted from home to the Maternity ward for assessment, with some then needing transfer to NICU. Reasons for readmission may include:

- Poor feeding and weight loss
- Jaundice
- Other non-infectious condition where specialist neonatal nursing or medical care is preferred to admission to the paediatric ward.

Most babies with feeding problems or Jaundice can be managed on the maternity ward, but those babies requiring NG feeds or IV fluids will require admission to the Neonatal Unit.

6. TRANSITIONAL CARE UNIT ADMISSIONS

6.1 The transitional care unit (TCU) provides care for those babies who require more than normal postnatal care, but do not require admission to the neonatal unit. The aim of transitional care is to support mothers and babies staying together where possible.

6.2 The criteria for admission to the TCU are more difficult to define than those to the NICU; generally, the mother must not need in-patient midwifery or obstetric care, but the baby needs more care than can be provided on the Postnatal Ward.

6.3 Admission criteria to TCU:

a. Babies between 34+0 and 34+6 weeks gestation at birth who are otherwise well; they may be admitted directly from delivery suite depending on the mother's condition.

b. Babies with a birthweight of less than 2.0kg, unless requiring admission to the neonatal unit

c. Babies who require regular tube feeding but are otherwise well.

d. Babies requiring treatment for neonatal abstinence syndrome due to maternal substance use

e. Babies of insulin dependent diabetic mothers requiring increased monitoring or management of low blood sugars

f. Babies on low flow oxygen establishing feeding prior to discharge

g. Babies requiring double phototherapy

6.4 In addition, there are specific exclusion criteria for TCU:

a. Babies who require admission to the NICU (see above)

b. Babies requiring intravenous fluid

c. The following (otherwise well) babies should be managed on the postnatal ward:
   - Gestation 35 completed weeks or more; birthweight over 2.0kg and not fulfilling criteria above.
   - Babies only requiring phototherapy
   - Babies requiring a hot cot or incubator to maintain temperature only.
   - Mothers and babies requiring breastfeeding support or babies requiring cup feeds
   - Well babies on intravenous antibiotics
   - Babies only requiring blood sugar monitoring, other than infants of insulin dependent diabetic mothers
   - Babies requiring physiological observations only (e.g. as per meconium aspiration policy, risk of group B streptococcus policy etc)

7.0 TRANSPORT AND TRANSFER OF BABIES

7.1 Transport and Transfer of babies within GRH
7.1.1 All babies must be discussed with the paediatric Registrar / ANNP prior to transfer, and they should be asked to review the baby prior to transfer where possible.

7.1.2 For babies born within the maternity unit at GRH
7.1.2.1 Preterm babies less than 32 weeks will be transferred from the delivery room to NICU in the transport incubator, under the supervision of the neonatal team of nurse and doctor / ANNP. In some cases it may be appropriate to transfer on the resuscitare, but this will be a clinical decision and depend on the clinical situation.

7.1.2.2 Staff undertaking transfers of babies in the transport incubator must be familiar with the equipment and have received appropriate training on its use. The baby should be stabilised before transfer.

7.1.2.3 For babies being transferred between the delivery room and NICU on the resuscitare, this must be carried out safely and with appropriate supervision by the neonatal doctor / ANNP. Resuscitation equipment and adequate medical gases must be available, and the baby must receive adequate thermal care.

7.1.2.4 Staff transferring babies between wards must have appropriate resuscitation training.

7.2 Transfer of Babies to other hospitals
7.2.1 For babies born at a stand-alone Midwife Led Unit (Stroud, Cheltenham)
7.2.1.1 Urgent transfers must be made using an emergency ambulance, see GHNHSFT Transfer and Discharge Policy. The midwife is responsible for arranging the transfer, and for managing the baby until arrival at GRH and handing over to the neonatal team at GRH.

7.2.2 For babies born at home or before arrival at the hospital
7.2.2.1 Those attending the delivery (ambulance staff, midwife) are responsible for arranging the transfer of the baby to the maternity Unit at GRH. See GHNHSFT Transfer and Discharge Policy.

7.2.3 For babies requiring transfer from NICU to other hospitals:

7.2.3.1 The need for transfer will be the decision of the on-call neonatal consultant.

7.2.3.2 The transfer must be discussed in the first instance with the regional transport team, NEST: telephone 0117 342 5050. This team was established in 2008 to carry out all transfers for the region. Advice and information, including documentation and policies are available on their website www.nestteam.org. The NEST nurse or doctor will take the details, liaise with the tertiary unit consultant, and can arrange a transfer and give advice.

7.2.3.3 Only if NEST are unavailable will the transfer be undertaken by GHT staff; this must be agreed in advance with the NEST team and the on-call GHT consultant, and is likely to be a rare occurrence. In this instance, the transfer must only be undertaken by staff trained and experienced in the transport of unwell neonates; the equipment must be appropriate and checked; there must be adequate resident cover for NICU during the time the team is carrying out the transfer.

8. INFORMATION SHARING
8.1 The Sister in charge on the NICU at GRH phones the delivery suite and the Maternity ward at GRH daily to discuss possible admissions and cot-availability. This information is recorded and shared with the relevant staff during shift changes. The neonatal sister is responsible for arranging appropriate staffing, and informing the medical team as appropriate.

8.2 In addition, there is often direct contact at consultant level regarding possible complex cases, or in times of limited cot-availability.
9. INCIDENT REPORTING

9.1 Monthly case reports are drawn from the ‘Badger’ system of all unanticipated admissions, and they will be reviewed and discussed at the multi-professional Perinatal Mortality / Morbidity Meeting.

9.2 All lessons learned from the incident reviews are disseminated to all staff via meeting minutes and unit newsletters. Action plans may be developed and reviewed as required by the instigating body.

10. TRAINING

<table>
<thead>
<tr>
<th>*Level of training required</th>
<th>Staff Group / s</th>
<th>Division / Department</th>
<th>Frequency of training / update</th>
<th>Method of training delivery</th>
<th>Lead and department responsible for provision of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Midwives, Obstetricians, Neonatal staff, Neonatal Nurses</td>
<td>Women and Children’s Division</td>
<td>Once</td>
<td>Policy familiarisation</td>
<td>Practice Development midwife and Lead Neonatologist</td>
</tr>
</tbody>
</table>

*Levels of Training

<table>
<thead>
<tr>
<th>A = Awareness</th>
<th>B = ½ day (2.5 – 3 hours)</th>
<th>C = Full day (5-6 hours)</th>
<th>D = Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Micro-teach, drop in session, e-learning)</td>
<td>(workshop, training event, e-learning)</td>
<td>(workshop, training event)</td>
<td>(more than one day training)</td>
</tr>
</tbody>
</table>

11. MONITORING OF COMPLIANCE

11.1 This list is not exhaustive and additional criteria may be included at the Trust discretion

11.2 The audit will include the current CNST level 3 Maternity standards and sample size if related

11.3 Sample sizes selected will be dependent on the cohort size. The data collection period will be identified by the Maternity CNST Lead

11.4 Action plans will be developed and reviewed as required by the instigating body

11.5 The audit will be carried out using the standardised audit tool and methodology as agreed by the maternity audit team and in line with the audit process.

11.6 The audit results will be presented to the multidisciplinary Obstetrics and Gynaecology Audit presentation meeting.

11.7 Where deficiencies are identified, an action plan will be developed by the author, following the Multidisciplinary Obstetrics and Gynaecology Audit presentation meeting. These action plans are implemented and monitored by the Associated Forum.

11.8 Audits are undertaken as routine triennially, however if deficiencies are identified or changes implemented, audit will be undertaken sooner.

12. REFERENCES


EQUALITY IMPACT ASSESSMENT

INITIAL SCREENING

1. Lead Name: Miles Wagstaff
   Job Title: Paediatric Medical Director

2. Is this a new or existing policy, service strategy, procedure or function?
   New x Existing

3. Who is the policy/service strategy, procedure or function aimed at?
   Patients x Carers x Staff x Visitors
   Any other Please specify:

4. Are any of the following groups adversely affected by this policy?
   If yes is this high, medium or low impact (see attached notes):
   - Disabled people: No x Yes
   - Race, ethnicity & nationality: No x Yes
   - Male/Female/transgender: No x Yes
   - Age, young or older people: No x Yes
   - Sexual orientation: No x Yes
   - Religion, belief & faith: No x Yes

   If the answer is yes to any of these proceed to full assessment.
   If the answer is no to all categories, the assessment is now complete.

   Date of assessment: 5.9.11
   Completed by: miles wagstaff
   Signature: Job title: paediatric specialty director
   Director: Signature:

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIAs are completed in accordance with this procedure.