Plymouth Hospitals NHS
NHS Trust

Intrapartum Guidelines

No 32: Admissions to the Neonatal Unit

1. Introduction/Purpose of the guideline

Good communication is essential in the process of admitting to the neonatal unit.

2. Criteria for Admission

- **Prematurity:** Infants < 34 weeks
- **Low birth weight:** Infants < 1.5 kg
- **Respiratory problems:**
  - Requirement for any form of respiratory support
  - Apnoea or cyanotic episodes
  - Persisting signs of respiratory distress for more than 4 hours
- **Infection:** Suspicion of infection together with clinical concern
- **Gastrointestinal problem:**
  - Feeding problems severe enough to cause clinical concern
  - Bile stained vomiting
  - Any signs suggesting bowel obstruction
- **Metabolic problems:**
  - Inability to maintain serum glucose greater than or equal to 2.6mmol/l despite adequate feeding
- **Cardiovascular:** Problems likely to require intervention or monitoring
- **Malformations**: Congenital anomalies that may require intervention unavailable on the transitional care ward, or an initial period of observation e.g. Pierre Robin Syndrome
- **Miscellaneous**: Any infant that is causing concern such that the attending medical or nursing staff feel that the infant requires careful observation and monitoring.
- **Central Nervous System problems:**
  - Seizure
  - Moderate perinatal hypoxia which may require monitoring for an initial period to ensure that problems do not arise
  - Infants that meet the criteria for total body cooling

3. Sources of Transfer

- Central delivery suite
- Post natal wards
- Via ambulance from home births
- Transfer from another Unit
- Via the emergency department

4. Transfer Arrangements and Admission to NICU

- An infant may be transferred in the transport incubator (in which case the admission nurse should be informed and present) or a cot. Never in arms.
- No infant should be transferred until stabilised
- Parents must be kept fully informed and when ever possible given the opportunity to see and touch their infant
- Appropriate medical staff should assess the infant and accompany him/her to the Unit and when appropriate ensure a thorough handover of the infant
- In the case of an expected delivery the labour ward staff should inform the Unit when a mother is admitted and when the delivery is imminent.
- For transfers out of area, a peninsula transport NICU team is available.

In the event of an unexpected admission to NICU please complete an incident report form on Datix. Incidents are then reviewed via the incident reporting and risk Management process.

5. Responsibilities of all staff groups

- Neonatal registrar and SHO team carry a bleep for emergency calls via 2222
- A neonatal consultant is always identified to deal with emergencies and is available via a personal pager/ bleep
- On each shift a neonatal nurse is identified to deal with admissions and is available to be called to resuscitations

Labour ward coordinator

- The Labour ward Coordinator is responsible for being aware of any delivery that may give rise to a potentially sick neonate and ensuring that appropriate referral, review and discussion with the senior Nurse/Ward manager on NICU/TCW together with neonatal and obstetric team has taken place.
- All potential /expected neonatal problems should be communicated between the postnatal ward, labour ward and TCW/NICU during shift handovers.
- The labour ward Co-ordinator is responsible for ensuring that transfer to NICU is being arranged if appropriate.

Allocated postnatal midwife

- As soon as an infant is identified that will require admission to the unit the person making that assessment must inform the nurse in charge of NICU.
- The Midwife/Nurse caring for a neonate is responsible for taking and recording observations in the postnatal care plan.
- All abnormal observations should be discussed with a Neonatologist and documented in the postnatal notes.
- All reviews undertaken must be documented in the baby's hospital record.
- All Neonates that meet NICU admission criteria should be seen by a member of the neonatal team, discussed with the Nurse in charge of NICU and then transferred in a timely fashion. (See page 3 of guideline).
- Handover to other members of staff including SCBU should take place in the format of an SBAR handover (**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation), in order to improve effective communication.

Neonatal Registrar

- The neonatal team are responsible for reviewing any neonate who meets the NICU criteria as well as any other neonate giving a midwife concern. Calls regarding most patients will be initially made to the junior trainee, the neonatal middle grade (speciality doctor/registrar) will be contacted if the junior trainee is unable to attend or if the patient is in need of urgent attention. If they are not available and if the patient's condition gives cause for concern, then the Consultant Neonatologist on-call must be contacted. Reviews must take place in a timely fashion and should be documented within the infant's medical notes, as must any plan of care.
- Following review, if the neonatal Registrar is concerned about the condition of the neonate they must inform the neonatal Consultant on call and transfer to NICU.

Consultant Neonatologist

- Reviews must take place in a timely fashion and must be documented within the neonate's medical notes, as must any plan of care**.**

NICU nurses

- The nurse in charge of NICU must inform the service consultant of any admission to the unit who is causing concern to either the medical or nursing staff
- The neonatal team should attend labour ward / Maternity theatre / postnatal ward for cases requiring admission to NICU. It is their responsibility to ensure transport incubator is available (if required) and that NICU is prepared to receive the infant

6. Daily coordination

- On each nursing shift a ring around the hospital is done to identify deliveries where the infant is likely to need an admission to the neonatal unit.
- An up to date record of possible admissions is kept on the white board on the neonatal unit
- The neonatal unit should be informed of all relevant admissions to the antenatal wards and delivery suite by the admitting midwife or the unit co-ordinator
- Each day a consultant neonatologist contacts each unit within the peninsula and identifies any infant or delivery that may need a transfer into Derriford

7. Emergency equipment

- A cot should always be set up for an emergency admission to the Unit
- There is a resuscitation room always available to admit and stabilise infants admitted via an ambulance
- Emergency transfer equipment is checked during each shift

8. Unit Communication

It is the responsibility of NICU to phone all clinical areas at the change of every shift to ascertain clinical activity in order to plan workload and capacity to maximise patient safety.
This information is recorded on the white board in NICU reception area and updated as required.

9. Home Deliveries

The neonatal unit should be informed prior to admission of all infants being brought from home that may need neonatal input. Minimum information required is:

- Clinical condition of infant
- Gestation
- Expected time of arrival

The admissions nurse together with appropriate medical staff should collect the infant from the maternity entrance using the transport incubator.
If resuscitation or stabilisation is required the infant should be reported directly to resuscitation room on the neonatal unit.

10. Documentation and record keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature and printed name.**

Monitoring and Audit

Auditable standards:

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Frequency of audit:
Annual

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Responsible person:
NICU clinician

Cross references

Maternity Risk Management Framework

Antenatal Guideline 26 – Homebirth and Waterbirth at Home Guideline
Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
Antenatal Guideline 44 - Guideline development within Maternity Services

Neonatal Guideline: Admissions criteria 10

References

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health 2007. **Safer Childbirth: Minimum standards for the organisation and delivery of care in labour.** RCOG, London.

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Work Address	Maternity Unit, Derriford Hospital		
Version	3		
Changes	New Weight of Admission reduced to 1.5 kg		
Date Ratified	Aug 13 Reviewed Dec 16	**Valid Until Date**	Dec 19