TRANSFER AND ADMISSION OF THE SICK NEWBORN TO THE NEONATAL UNIT (NNU) AND SUPPORT FOR PARENTS - CLINICAL GUIDELINE

Summary. Flow chart for transfer and admission to NNU and parental support

Criteria for routine NNU admission:

- Birth weight under 1800g
- Gestational age under 35 weeks
- Need for respiratory support/monitoring
- Significant cardiac compromise/need for cardiac monitoring
- IV fluids or feeds more often than 3 hourly
- GI concerns/surgical
- Major Congenital Anomalies or significant antenatal scan concerns eg Doppler flow abnormalities
- Hypoglycaemia not responding to appropriate management
- Requiring treatment for neonatal abstinence syndrome (NAS)
- Jaundice requiring IV fluids/exchange transfusion/close monitoring
- Any baby considered unwell/ in need of investigation/monitoring by neonatal staff after review
- Midwife to COMPLETE TRANSFER SHEET FOR ALL ADMISSIONS (app.3)

Baby identified before birth as likely to need NNU admission; inform NNU and check cot availability

Daily communication between neonatal and obstetric Consultants for known potential admissions

<26+6 singleton, <27+6 multiple, <800g arrange delivery in Regional NICU

<34+6 weeks give MgS04, <34 weeks give steroids
arrange neonatal senior team member update for parents for any known likely admission baby

Emergency community admissions needing ongoing resuscitation contact ambulance and Delivery Suite coordinator for ambulance transfer destination point Coordinator will then contact Emergency Neonatal Resuscitation team via 2222 bleep

Community baby 0-5 days requiring admission to be discussed with on call SHO/ANNP/Registrar via switchboard

Over 5 days old, baby to be discussed with Paediatric Registrar/on call Consultant re appropriate admission ward. Consultant decision for community readmission to NNU

Parent update by senior neonatal team member within 24 hours of admission
1. **Aim/Purpose of this Guideline**

   1.1. This guideline applies to Obstetric and Midwifery, paediatric and neonatal staff and Community Midwives/GPs wishing to arrange admission of a sick new-born to Royal Cornwall Hospitals (RCH) Neonatal Unit. The Guideline does not cover admission from other acute hospitals. This gives guidance on providing support for parents for babies admitted to neonatal unit where there is a suspected or poor outcome.

2. **The Guidance**

2.1. **Neonatal Unit Status**: RCHT has Local Neonatal Unit (LNU) status. Any baby that is expected to be born < 26+6 weeks gestation or multiple pregnancy <27+6 or estimated birth weight under 800g must be offered care in a regional NNU. This guideline should be used in conjunction with both the Network Neonatal Transport and local transfer guidelines for in utero and ex utero transfers and the status of Neonatal Intensive Care Unit (NICU) cot and specialist neonatal nursing levels available.

2.2. **Neonatal unit capacity**

   RCHT NNU has 20 cots and for safe service provision the following system is in use regarding admissions:
   - Green: open to admissions
   - Amber: high activity, discuss cot availability
   - Red: closed due to high activity e.g. 20 babies or inadequate staffing levels

2.3. **Source of admissions**.

   - Immediately following birth from Delivery Suite
   - RCHT Maternity Ward
   - RCHT Emergency Department
   - RCHT Community Midwife - between 1-5 days of age after direct discussion with the Duty Neonatal Consultant and Senior Nurse or Shift Leader for NNU
   - The Paediatric Ward should be the clinical area for admission of babies who do not meet direct NNU admission criteria but require special care or observation. Consider Transitional Care cot availability on the Postnatal Ward

2.4. **Neonatal Unit Admission Criteria**

   - Day 0 < 35 completed week’s gestation
   - Day 0 < 1.8 kg
   - Ventilated during resuscitation with an on-going need for respiratory support
   - Signs of respiratory distress significant, or worsening after review
   - Significant cardiac compromise
   - Major Congenital Anomalies
   - Hypoglycaemia not responding to appropriate management
   - Requiring treatment for neonatal abstinence syndrome (NAS)
   - Exchange transfusion, blood transfusion or with significant rhesus disease or risk of high jaundice levels
   - Any baby considered unwell/ in need of investigation by Paediatric staff after review
2.5. **Communication**
Communication between Delivery Suite, NNU and Maternity Services should occur each morning to liaise and plan for any baby likely to need NNU admission. This includes direct liaison regarding inductions, pending preterm or sick baby deliveries. The NNU shift leader will liaise regarding the Unit status for available cots and plans for deliveries/transfers made, updating as necessary as changes occur. Delivery Suite co-ordinator to alert NNU immediately of any pending delivery likely to need NNU admission.

2.6. **Staff Roles and Responsibilities**
It is the responsibility of all staff to ensure that parents are kept fully aware of any plans regarding their baby

2.6.1. **Obstetricians:** (consultants/ST 3-6): It is the responsibility of this staff group to liaise with the NNU regarding the possible or expected birth of any baby known or thought to fulfill the criteria for admission to the NNU, in relation to, availability of cots/resources, plan for delivery and staff requirements at delivery.

2.6.2. **Midwives:** It is the responsibility of this staff group to identify any women in labour whose babies may meet the criteria for admission to NNU and to contact the on call SHO/ANNP in a timely fashion. Midwives may have to initiate treatment for sick babies whilst awaiting support from the neonatal team or if in a community setting, whilst waiting for an ambulance. They should therefore have training in newborn life support through annual mandatory training.

2.6.3. **Neonatologists:** (FT2/ST1-8/ANNP). It is the responsibility of this staff group to identify a baby requiring admission to NNU and to ask for senior help if needed. To inform the NNU of an impending admission. To anticipate the need for extra help e.g. extreme prematurity, babies with known perinatal compromise/anomalies. All staff at these grades should be trained in resuscitation of the newborn.

2.6.4. **Consultant Neonatologists:**
- Liaise with obstetric and midwifery staff regarding cot availability
- Advise optimum time and place of delivery for known fetal compromise/anomalies
- To be available via an on call rota, to attend emergencies or give advice as required

2.7. **On Call Neonatal Team**
In an Emergency call 2222, ask for Emergency Neonatal Team and state location

| **SHO/ ANNP:** Available on site 24hrs a day | Bleep via Baton Bleep: number displayed on delivery suite white board 3217 |
| **Neonatal Registrar:** Available on site 09.00 hours - 17.00 On-call. | Both neonatal and paediatric registrars are contacted via Baton Bleep: number displayed on delivery suite white board 3216 |
| **Paediatric registrar:** Available on site 17.00 hours – 09.00 hrs | |
2.8. Transfer of the sick newborn to the Neonatal Unit From Delivery Suite
The transfer of a baby to the Neonatal Unit is the attending Senior Neonatologist’s decision. It is their responsibility to inform the Neonatal Unit of the decision to transfer and the clinical details. If the paediatrician is continuing to provide resuscitation and unable to leave the baby then another health professional should be given the task to inform the neonatal unit. The baby should be transferred direct to the neonatal unit on the resuscitaire once stabilised. Following a transfer of a baby to the Neonatal unit it is the attending midwife’s responsibly to complete a Neonatal Unit transfer form as soon as possible. This form should remain on Neonatal Unit with the baby.

2.9. Neonatal Unit Tel: Extension 2667 Nurses station/ 5961 ITU Nursery
Babies who do not need immediate life support, but need transfer to the Neonatal Unit for observation/investigations, should be reviewed by the Neonatal SHO/ANNP and they should liaise with the Neonatal unit and the midwife caring for the mother and baby to arrange the transfer. The baby should be transferred in a cot. Following a transfer of a baby to the Neonatal unit it is the attending midwife’s responsibly to complete a Neonatal Unit transfer form (Appendix 2) as soon as possible. This form should remain on Neonatal Unit with the baby.

2.10. Transfer from Wheal Fortune/Wheal Rose
If a baby becomes compromised they should be taken to the resuscitaire on the ward, neonatal help should be called for via the baton bleep system to attend urgently. Once at the resuscitaire a midwife should initiate newborn life support and continue until neonatal assistance arrives.

The baby should be resuscitated and stabilised on the ward before transfer to the Neonatal Unit is considered, this may require senior paediatric assistance, notified via the baton bleep 2222 system. The baby will be transferred either on the resuscitaire or by cot depending on baby’s condition. Parents must be fully updated as soon as possible dependent on baby’s condition and treatment.

2.11. Transfer of the Sick Newborn to the Neonatal Unit from the Community Setting
In a full resuscitation situation communication after calling for an ambulance should be directly with the Delivery Suite Coordinator who will liaise with the on call
Neonatal/Paediatric Registrar and NNU to agree the most appropriate place for admission, this could be direct to NNU or delivery suite for ongoing resuscitation/stabilisation.

If the woman is newly delivered or third stage incomplete or there are concerns about the maternal condition, a midwife should remain with the woman and either transfer mother and baby together or ask the ambulance service to take over the care and transfer of the baby.

If two midwives are present the midwife undertaking the resuscitation should escort the baby with the ambulance crew.

For other babies meeting NNU admission criteria, the midwife should bleep the on call for Delivery Suite Neonatal SHO/ANNP to arrange admission.

2.12. Transfer from Emergency Department or other areas of the hospital
The on call paediatric resuscitation team will be contacted via hospital switchboard, the baby will be stabilised and then transferred to neonatal unit using the transport incubator.

2.13. Unexpected Admissions to the NNU
Delivery Suite Co-coordinator will ensure NNU is alerted immediately of any pending delivery likely to need paediatric support or NNU admission. Any baby whose admission to NNU has not been anticipated during the intrapartum period and there has been no prior communication between Delivery Suite and NNU team should be reported as a clinical incident via the electronic online reporting system (Datix).

2.14. Support for parents in the case of an actual or suspected poor outcome
The majority of term babies who are admitted to the neonatal unit will have a short stay and be quickly reunited with their parents. For a small number of babies the long term outcome may be poor or uncertain.

2.15. Involvement of Consultant Neonatologist
Parents of babies admitted to NNU are invited to join the daily Consultant Ward round (7 days per week) and are included in the discussion of their baby. Parents can request a meeting with a senior doctor/ANNP to be updated on the medical progress of their baby at any time. The meeting will usually occur same day at a mutually convenient time. The timing of the first parental update by senior staff is recorded on the Badger neonatal database for all babies admitted to NNU. A parent of any baby who is very unwell/ likely to have a poor outcome is seen by the duty Consultant with attending nurse as soon as possible after admission. These meetings are repeated as often as necessary for the family’s needs.

2.16. Breaking bad news
Parents of any baby whose condition is likely to result in poor outcome will be seen by the Duty Consultant as soon as possible after the diagnosis is made, the nurse caring for the family should also be present to support the parents. Bedrooms are available on the NNU for parents to spend time with their baby and, if intensive care is withdrawn they can care for their baby, with nurse support, in their room both before and after death. The British Association of Perinatal Medicine (BAPM) guidelines and neonatal bereavement support group (SANDS, BLISS, etc) guidance is followed regarding best practice including taking baby home if they wish.

2.17. Emotional support whilst in hospital
Parents are supported by trained nursing and medical staff with continuity of care where possible. Extended family members are also included if the family wish. Pastoral support is offered according to family preferences and is available out of hours. If a baby has a syndrome/ genetically life limiting disorder families are offered contact with other parents where available.

2.18. Support Groups Information
A checklist is completed for any baby who has died or has an actual or suspected poor outcome; the check list is completed as an ongoing process and is filed in the baby’s health records. Bereavement packs are pre-prepared with full information of bereavement support groups to be given to parents as part of the checklist. Babies diagnosed with a recognised disorder eg. Trisomy 21, also have packs of information ready for parents. Consultants will give parents additional information regarding diagnosed disorders with support group details where available.

2.19. Follow up and Community Services
- Inform Community Midwife/Health Visitor and GP at discharge
- Arrange follow up with Consultant, as per Consultant request
- Referred to the Neonatal Outreach Service, Neonatal Neurological Physiotherapist, Occupational Therapist and Diana Team member as appropriate for babies requiring additional support at home
- Outreach teams meet with the family before discharge
- Arrange a discharge planning meeting approximately 1 week pre discharge. This may include Parents, HV, GP, Outreach nurse, Paediatric Physio/OT, Social worker, Community Paediatrician, NNU nurse representative, Neonatal Consultant. The meeting is minuted with any plan for Open door access to Polkerris Ward if readmission needed, resuscitation wishes and plan reviewed and documented.
- Arrange follow up with RCHT Neonatal Consultant after assessment by Community Paediatrician and additional services if required
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>• The audit will take into account record keeping by health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>• Maternity Risk Management Midwife</td>
</tr>
</tbody>
</table>
| Tool                     | • Admission to NNU  
  • Did the baby meet the criteria for admission to the NNU  
  • If appropriate was it documented that the neonatal team were informed prior to delivery  
  • If the admission was not anticipated and there was no prior communication with the neonatal team, was a Datix completed  
  • Was the Datix reviewed at a Clinical Incident Review meeting  
  • Support for parents NNU  
  • Was the timing of the first parental update by senior staff recorded on the badger neonatal database  
  • Was a check list completed and filed in the baby’s health records  
  • Was it documented that parents were given bereavement/support group packs  
  • If the baby required additional support at home was it documented that a referral was made to the neonatal outreach service. |
| Frequency                | • 1% or 10 sets, whichever is the greater, of all health records of all new-borns admitted to the neonatal unit within an agreed time frame  
  • Within 3 years of this guideline being uploaded onto the RCHT Document Library |
| Reporting arrangements   | • A formal report of the results will be received at the Maternity Risk Management Forum or Clinical Audit Forum |
| Acting on recommendations and Lead(s) | • Any deficiencies identified will be discussed at the Maternity Risk Management Forum or Clinical Audit Forum and an action plan developed  
  • The action plan will be monitored by the Maternity Risk Manager until all actions complete |
| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within a time frame agreed on the action plan  
  • A lead member of the forum will be identified to take each change forward where appropriate  
  • Risk Management Newsletter |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>TRANSFER OF THE SICK NEWBORN TO THE NEONATAL UNIT (NNU) AND SUPPORT FOR PARENTS – CLINICAL GUIDELINE</th>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; December 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; December 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; December 2018</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Judith Clegg  
Advanced Neonatal Nurse Practitioner  
Neonatal Unit |
| Contact details: | 01872 252667 |
| Brief summary of contents | This guideline applies to Obstetric, Midwifery, Paediatric, Neonatal staff and General Practitioners (GPs) wishing to arrange admission of a sick newborn to Royal Cornwall Hospitals NHS Trust (RCHT) Neonatal Unit. The Guideline does not cover admission from other acute hospitals. |
| Suggested Keywords: | Admission, neonatal, unit, hospital, admission, sick, new-born, baby |
| Target Audience | RCHT | PCT | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 17<sup>th</sup> December 2015 |
| This document replaces (exact title of previous version): | CLINICAL GUIDELINE FOR TRANSFER AND ADMISSION OF THE SICK NEWBORN TO THE NEONATAL UNIT AND SUPPORT FOR PARENTS |
| Approval route (names of committees)/consultation: | Maternity Guideline Group  
Obs & Gynae Directorate  
Divisional Board for noting |
| Divisional Manager confirming approval processes | Head of Midwifery |
| Name and Post Title of additional signatories | Not Required |
### Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings

{Original Copy Signed}

Name: Helen Ross-McGill

### Signature of Executive Director giving approval

{Original Copy Signed}

### Publication Location (refer to Policy on Policies – Approvals and Ratification):

- Internet & Intranet
- Intranet Only

### Document Library Folder/Sub Folder

Clinical/Midwifery and Obstetrics

### Links to key external standards

- MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. [https://www.npeu.ox.ac.uk/mbrrace-uk](https://www.npeu.ox.ac.uk/mbrrace-uk) 2015
- BAPM Framework for palliative care (2011) Palliative Care Report
- BAPM Guideline for Sudden and Unexpected Postnatal Collapse in the first week of life (2011)
- BLISS Counselling and other support [www.bliss.org.uk/help-for-families](http://www.bliss.org.uk/help-for-families) Reference and Associated documents

### Related Documents:

- BLISS Counselling and other support [www.bliss.org.uk/help-for-families](http://www.bliss.org.uk/help-for-families)

### Training Need Identified?

No
### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2010</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Jane Pascoe Delivery Suite Coordinator</td>
</tr>
<tr>
<td>September 2012</td>
<td>V2.0</td>
<td>Previous guideline included neonatal resuscitation, separated in to two separate guidelines Changes to compliance monitoring and addition of Monitoring Compliance Table.</td>
<td>Judith Clegg Advanced Neonatal Nurse Practitioner</td>
</tr>
<tr>
<td>15 Jan 12</td>
<td>V2.1</td>
<td>Governance information moved to an appendix. EIA updated. Governance information amended to align with format of Document Manager Upload Form.</td>
<td>Judith Clegg Advanced Neonatal Nurse Practitioner</td>
</tr>
<tr>
<td>5 Aug 13</td>
<td>V2.2</td>
<td>Updated governance information table to include KCCG.</td>
<td>Judith Clegg Advanced Neonatal Nurse Practitioner</td>
</tr>
<tr>
<td>17th December 2015</td>
<td>V2.3</td>
<td>Updated contact numbers. Paediatricians are now referred to as Neonatologists. Addition of Summary flowchart of admission process</td>
<td>Judith Clegg Advanced Neonatal Nurse Practitioner</td>
</tr>
</tbody>
</table>

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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)</th>
<th>(Provide brief description): TRANSFER OF THE SICK NEWBORN TO THE NEONATAL UNIT (NNU) AND SUPPORT FOR PARENTS – CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Elizabeth Anderson</td>
</tr>
<tr>
<td>1. Policy Aim*</td>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
<td>Safe and seamless transfer of a sick newborn to the neonatal unit</td>
</tr>
<tr>
<td>3. Policy – intended Outcomes*</td>
<td>Best possible outcome for a sick new-born baby being transferred to RCHT NNU and improved experience for the parents</td>
</tr>
<tr>
<td>4. *How will you measure the outcome?</td>
<td>Compliance Monitoring Tool</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy?</td>
<td>All sick babies and their parents</td>
</tr>
<tr>
<td>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</td>
<td>No</td>
</tr>
<tr>
<td>b) If yes, have these *groups been consulted?</td>
<td>N/A</td>
</tr>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
<td>N/A</td>
</tr>
<tr>
<td>7. The Impact</td>
<td>Please complete the following table.</td>
</tr>
</tbody>
</table>

<p>| Are there concerns that the policy could have differential impact on: |
|----------------|----------------|
| Equality Strands: | Yes | No |
| Age | X | All sick new-born babies |
| Sex (male, female, transgender / gender reassignment) | X | All sick new-born babies |</p>
<table>
<thead>
<tr>
<th>Race / Ethnic communities /groups</th>
<th>X</th>
<th>All sick new-born babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td>All sick new-born babies</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td>All sick new-born babies</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
<td>All sick new-born babies</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td>All sick new-born babies</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td>All sick new-born babies</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | X |

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director Judith Clegg

Date of completion and submission

20th October 2015

Names and signatures of members carrying out the Screening Assessment

1. Elizabeth Anderson

2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Elizabeth Anderson

Date: 17th December 2015