Clinical Practice Guideline
Guideline coverage includes NICU KEMH, NICU PMH and NETS WA

Admission to NICU: Level of Care

This document should be read in conjunction with the Disclaimer

Aim

Infants may be admitted the Special Care Nurseries when there is any medical concern. This is only a guide to the level of care and the types of conditions a neonate may present with.

The following infants post-delivery who are slow to transition to extra-uterine should be admitted for ongoing observation:

- Infants with poor muscle tone at 10 minutes of age.
- Infants who respond slowly to significant resuscitation.
- Infants who require support to transition post maternal general anaesthesia (LUSCS).
- Infants with signs of respiratory distress/grunting.
- Infants who have required cardiac massage.

Infants who have significant birth trauma such as subgaleal haemorrhage where there is a potential for sudden deterioration and require close monitoring.

LEVEL 2 CARE INDICATED FOR	LEVEL 3 CARE INDICATED FOR
• Transient problems requiring cardiorespiratory monitoring / frequent laboratory investigations in neonates > 32 weeks, > 1500 grams, not requiring level 3 care. • Need for peripheral IV fluid therapy. • Convalescing infants recovering from acute problems. • Assessment for poor feeding. • Jaundice infants requiring peripheral IV fluid therapy and closer monitoring. • Assessment of NAS, until stable.	• Sustained assisted ventilation (intermittent positive pressure ventilation or continuous positive airway pressure). • Preterm < 32 weeks until stable. • Cardiorespiratory monitoring for recurrent apnoea or seizures. • Exchange transfusion. • Severe systemic illness. • Parenteral nutrition via central line. • Oxygen requirement for assessment. • Complex multi-system life support.

Clinical Handover

Medical and midwifery/nursing staff that accompany a baby into the SCN or NICU must handover to the receiving medical and nursing staff. The handover must take place using the ISOBAR format.

Identity	Confirm identity, check name bands against accompanying paperwork
Situation	Describe current clinical scenario
Observations	Of the baby
Background	Maternal history, labour and resuscitation history
Assessment	Of clinical status
Recommendations	Current treatment plan, possible ongoing management and procedures to be completed
Readback	Confirm information handed over

The receiving team must make a management plan for the baby and allocated staff accordingly.

Medical Responsibility on Admission to NICU or SCN2

- The order and priority of procedures will depend on the condition and initial assessment of the infant on admission to the unit.
- Provide immediate care as necessary to stabilise.
- Ensure completed documentation of the Neonatal History Sheet MR410, including relevant clinical details of the baby's birth, clinical assessment and status.
- Full clinical examination and patient assessment.
- Full documentation in the inpatient progress notes MR420 (in addition to checking complete records of the Neonatal History Sheet MR410) of:
  - Maternal history.
  - Perinatal and birth history.
  - Clinical reason for admission and focused problem list.
  - Clinical examination and assessment.
  - Investigations and management plan.
  - Completion of NCCU problem list MR485.03.
  - Documentation of communication with parents, including details provided of clinical diagnosis and management.
  - Documentation of discussion with senior medical staff (Senior Registrar/Consultant).

Admitting Nurse

- Admission nurse is responsible for checking the resuscitation equipment/admission set-up prior to admitting an infant. Ascertain if there is a need to isolate the infant.
- When taking clinical handover on admission check for Vitamin K and Hepatitis B vaccine consent form.
- Check whether the infant has voided or passed meconium since birth.
- Check cord clamp in place, no ooze and skin intact.
- Check preferred method of feeding. Obtain written consent for the use of formula milk if applicable.

Equipment

- A warmer, pre-warmed incubator or open cot.
- Ventilator / nasal CPAP if applicable.
- Stethoscope.
- Cardiopulmonary monitoring, Non-invasive blood pressure (Invasive BP/TCM/CVP - if applicable).
- Thermometer.
- Nappy (pre-weighed for NICU babies).
- Hat and appropriate clothing.
- Scales / Measuring tape.
- Admission paperwork / Name bands.
- X1 Infusion pump and syringe pump (L3 need 2-3 syringe pumps + infusion pump).
- Equipment for peripheral access and/or central access.
- Equipment for septic screen.

Procedure

- The order and priority of procedures will depend on the condition and initial assessment of the infant on admission to the unit.
- Stabilisation and maintenance of airway, admission weight and baseline vital signs are initial priorities.
- Further procedures and care are then prioritised in conjunction with medical staff and shift coordinator.
- Place the infant on a pre-warmed radiant warmer or incubator - see Admission of Infants onto a Radiant Warmer < 32 Weeks Gestation or < 1500 Grams Birth Weight.
- Complete full physical assessment (may be done later if condition warrants). If there is excessive moulding or caput, the HC should be repeated daily until this has resolved.
- Document observations hourly for the first 3 hours then reassess the need for continuous monitoring - see Monitoring Guideline.

- If there is a suspicion of sepsis, a septic screen should be performed - see Septic Screening Procedures.
- Routine bloods - see Ordering Blood Tests Guideline.
- Medications: Administer prescribed medications after obtaining specimens for laboratory investigations. Administer Vitamin K and Hepatitis B (if BW > 1000 grams and no pyrexia or coagulopathy). Antibiotic administration is a priority in the unwell neonate.
- CXR/AXR for ETT/Line placement and further management if applicable.
- Commence fluids or feeds as early as possible. Respiratory compromised infants should only be fed enterally if their condition allows.
- Blood glucose should be tested with the blood gas machine as soon as lines are in situ. Repeat within 2 hours or as ordered. If feeding is by enteral route, do a pre 2nd feed blood glucose - see Hypoglycaemia.
- Initially weigh all nappies to assess urine output. Carry out a ward urinalysis.

When Stabilized

- Complete and document full physical examination within the first 24 hours. If there is excessive moulding or caput, the HC should be repeated when this has resolved.
- If there is excessive amounts of bodily fluids i.e. Meconium or blood the neonate can be minimally cleansed with a cloth whilst under the warmer. Don't bath for 24 hours.
- Anti-staph on day 1 then alternate days - see Anti-Staphylococcal Procedure.
- Determine whether an open cot or incubator is required.
- Use appropriate positioning aids to enhance physiological stability, promote energy conservation and to reduce physiological and behavioural stress.
- Complete necessary documentation plus the Birth Register, Fireboard and Handover file.
- When the parents visit make sure that they are welcomed and shown the layout of the unit and understand NICU hand washing and visiting guidelines.
- Monitor fluid balance until condition no longer warrants it. Review daily.

Related WNHS policies, procedures and guidelines

WNHS Clinical Handover Policy W076

WNHS Clinical Deterioration Policy W124

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