Maternity and Neonatal Unit

SCOPE: All midwives and nurses working in the maternity unit

GUIDELINE: **Referral of inpatient neonates to the paediatric service**

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PURPOSE:
To identify which babies and which conditions necessitate referral to the paediatric team, in order to provide a safe and effective service.

DEFINITIONS:
Neonate – An infant during its first 28 days of life.
This guideline incorporates all births in the maternity unit at Hauora Tairāwhiti or born at home or before arrival and brought into the maternity unit.

GUIDELINE:

- The mother's medical/maternity records including antenatal information and risk factors and the baby's birth details are available to the paediatrician via MCIS. If MCIS is unavailable an infant summary sheet will be provided
- When accessing the labour and birth summaries please look at alerts in the bottom tab on MCIS for information.

The paediatrician may be requested to attend the delivery in the case of:

1. An emergency caesarean section being performed for fetal compromise. The LMC, core midwife or the obstetrician should call the paediatrician, and *discuss the reason for the requested attendance*.
2. The delivery of a pre-term infant (<34 weeks gestation).
3. Any other indications (e.g. instrumental deliveries in theatre) – discuss concerns directly with a paediatrician preferably prior to the birth, or during the labour.

Primary resuscitation:
It is recommended that at every birth there is a professional able to initiate neonatal resuscitation if required.

The midwife on delivery unit must communicate with the neonatal staff at the beginning of each shift to ascertain the situation in the neonatal unit and inform staff of any possible impending admissions as soon as possible (see Appendix 1 flow chart for further details).

The following categories should come under the neonatal team following the birth:
(Referral Guidelines 2012)

1. Infants of less than 35 completed week's gestation.
2. Birth weight less than 2000g.
3. Any severe abnormalities.
4. Suspected oesophageal atresia
5. Heart murmur with symptoms.
6. Persistent or recurrent cyanosis.
7. Apnoea
8. Convulsions or unresponsiveness.
9. Severe depression (e.g. apgar of 6 or less at 5 minutes with little improvement by 10 minutes).
10. Persistent bile stained vomiting or fresh blood in stools.
11. Evidence of a bleeding tendency, haematemesis, melena, haematuria, purpura, generalised petechia.
12. Haemorrhage from cord or other site.
13. Maternal isoimmunisation: rhesus or other antibodies. Refer prior to delivery, preferably in the antenatal period.
14. Maternal chorio-amnionitis: fetal tachycardia, maternal pyrexia, offensive liquor.
15. Prolonged rupture of the membranes (>24 hours) if any suggestion of infection present (e.g. respiratory distress, fever, etc).
16. Any jaundice in the first 24 hours.
17. Respiratory distress - any cyanosis , persistent grunting and/or pallor
18. Persistent tachypnoea with respiratory rate greater than 60/min for greater than one hour from birth
19. Infants with symptoms of withdrawal syndrome (e.g. mother on narcotic drugs)
20. Infants with symptomatic or asymptomatic hypoglycaemia *(see guidelines for management of babies at risk of hypoglycaemia or infants of diabetic mothers).*

The following infants should be considered for referral to the neonatal team:

- Low birth weight infants of less than 10th customised or population birthweight centile.

Other neonates may be referred to the neonatal team for assessment:
All babies should have identification labels on before being transferred
Urgent referral

- Infant to go directly to the neonatal unit. The neonatal team will call the paediatrician as necessary.
- The core midwife may make this referral, and does not need to wait for the LMC to attend if they are not present, but should communicate the referral and reasons for it to the LMC as soon as possible.
- The initial neonatal check may not have been completed prior to the referral, but the maternal and infant details on the Neonatal Summary sheet should be completed as far as possible.
- The maternity staff should admit the baby as soon as possible in order to obtain an NHI number as soon as possible in order for any tests to be ordered.

Non-urgent referral

- For paediatric opinion on well babies not thought to require admission to the neonatal unit (i.e. unstable hips, heart murmurs, etc).
- The correct referral paperwork must be completed stating the reason for the referral; this must be signed, timed and dated (either manually complete a referral form – appendix 2, or complete a referral in MCIS/BadgerNet and print it out)
- The referral should ordinarily occur on the morning round.
- **The initial neonatal check should still be completed and documented by the LMC within 24 hours.**

Transitional care: (see separate guideline)

- Transitional care is when a baby is cared for temporarily by nurses/midwives in the Neonatal Unit following a request for transitional care by an Obstetrician/LMC/core midwife, but the baby has **not** been referred to the Paediatrician and the management of care for the baby has **not** been taken over by a Paediatrician for a period of up to 4 hours during the first 12 hours of life.
- Breast feeding will be supported and the period of separation of mother and baby should be minimised.

If there is any need for active intervention, or if the baby does not maintain normal vital signs or shows any sign of illness during transitional care, there must be prompt referral to the on call Paediatrician by the LMC/Core Midwife/Obstetrician/NNU nurse/midwife for ongoing management.

The initial neonatal check should still be completed and documented by the LMC within 24 hours, even if the baby is or has been in transitional care.

Documentation:

It is vital that accurate information and documentation is completed, by the appropriate health professional, for all referrals.

If a baby is requested to be seen in the neonatal unit for any reason, the following should be available to the neonatal team:

- Referral for paediatric assessment form (see appendix 2) or printed referral from MCIS
- Clinical notes are accessible to all NNU staff and paediatricians via MCIS records
- A "Prenatal Neonatal" report from the mother's MCIS records can be attached to the referral form for easier access to the information required by the paediatrician.

ASSOCIATED DOCUMENTS

Maternity Unit Guideline - Treatment of narcotic depression in the newborn
Maternity Unit Guideline - Infants of Diabetic Mothers
Maternity Unit Guideline – Management of infants at risk of hypoglycaemia
Maternity Unit Guideline – Neonatal resuscitation
Maternity Unit Guideline – Emergency obstetric or neonatal
Maternity Unit Guideline – Transitional care

REFERENCES

Ministry of Health (2012). Guidelines for consultation with Obstetric and Related Medical Services (Referral Guidelines)

Approved by:

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Consultant Peadiatrician
Head of Department

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Director of Midwifery/Clinical Midwife Manager

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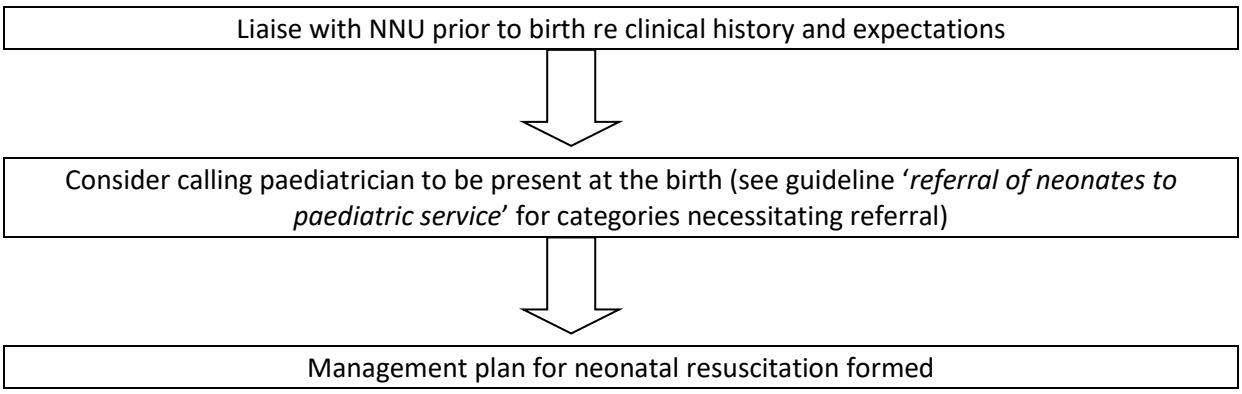
Appendix 1

NEONATAL RESUSCITATION FLOW CHART OF ACTIONS

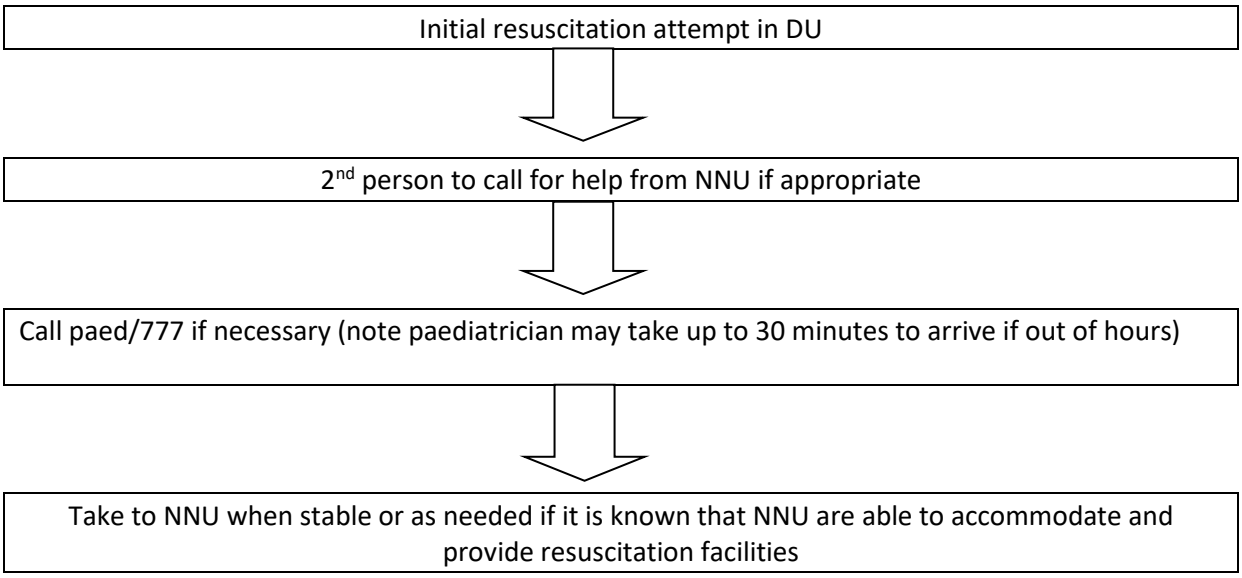
- Shift coordinator in maternity to liaise with NNU staff at the commencement of duty re staffing and bed occupancy in NNU and maternity unit

- The recommendation is that 2 staff are present for every birth (preferably 2 midwives)

1/ EXPECTED/POTENTIAL RESUSCITATION NEEDED



2/ UNEXPECTED RESUSCITATION NEEDED



Appendix 2

Referral for Paediatric Assessment.

Patient Label

History:

Examination Findings:

Reason for referral:

Referrals will not be accepted unless accompanied by a completed birth summary sheet.

Referrer:

Signed:

Paediatrician Assessment:

Outcome:

- ☐ Referred to:
- ☐ Back to LMC care

Paediatric Followup required?

- ☐ Yes
- ☐ No