Neonatal Presentations to the Emergency Department
Clinical Practice Guideline

Section 1: Babies < 28 days: Criteria for involving neonatal or paediatric department

a) Neonatology
   • The Neonatal Service is primarily responsible for the management of all babies born pre-hospital or in ED.

b) Paediatrics
   • The Paediatric Service is primarily responsible for all other babies presenting to ED
   • The Paediatric AMO on call should be consulted first and will be expected to attend babies requiring resuscitation.
   • The Paediatric AMO on call should contact the Neonatal AMO on call to formally request their involvement to assist management, or take over care if clinically indicated.

c) Cases where Neonatal Service involvement should be considered
   • Common problems usually managed in a neonatal service (e.g. jaundice, feeding problems, seizures)
   • Babies who have recently been discharged from the neonatal unit
   • Babies requiring or likely to require ventilator support and need admission to intensive care (whether this is in NICU or NETS transfer to Paediatric Tertiary Hospital)

Section 2: Neonatal Emergency Response

a. Neonatal Emergencies may include the following:
   i. Babies born pre-hospital or in ED (gestation suspected or actual greater than 20 weeks)
   ii. Any infant recently discharged from NICU who presents acutely unwell
   iii. Any baby <28 days old who presents to the ED acutely unwell
   iv. Any baby whatever age needing immediate critical care or resuscitation that will not wait for the arrival of the NETS service, including:
      • Babies being managed in ED.
      • Babies already admitted to the Paediatric ward under the care of a Paediatrician who have a sudden deterioration requiring transfer to the ED Resuscitation room.

b. Activation
   The neonatal emergency call is activated by any member of the ED team when there is a neonatal emergency. This is done by calling 222 and stating "Neonatal Emergency to Emergency Department Resusc".

c. Staff Notified by neonatal emergency page activation
   When activating a neonatal emergency call the following staff will attend:
   • Neonatal Intensive Care Unit (NICU) registrar, fellow or nurse practitioner
   • NICU registered nurse who will bring a bag with equipment required for a pre-term baby

d. Extra Staff required to be contacted
   i. The Paediatric Consultant on call should be contacted as early as possible for every case
   ii. The following staff are not contacted automatically by the Neonatal Emergency page and need to be contacted directly:
      • Obstetric registrar
      • The paediatric consultant on-call
      • The neonatal consultant on-call
      • The paediatric registrar if in hours
      • The paediatric, NICU or on-call social worker

e. Core responsibilities in the resuscitation of neonates and young infants.
   i. Resuscitation team leadership
      • It is critical that a team leader is identified early in each resuscitation.
      • Usually this role will be taken by the most senior ED consultant or registrar present, given that ED staff are most familiar with the ED resuscitation room environment.
      • Airway management and ventilation should be the responsibility of the most experienced clinician and this will usually be the Neonatal Fellow or consultant in this patient group.

   ii. Definitive care and disposition
      • Ultimate responsibility for admission or transfer lies with the Paediatric Department and on call Paediatrician.
      • Involvement of the neonatal service is also appropriate reflecting the fact that within RPA Hospital, the neonatal department will have the most appropriate skills and equipment for infant critical care

   iii. Neonatal Consultant
      • Should be involved in the care of all babies less than 28 days old who need critical care in ED or the Paediatric Ward.
• May consider short term care in NICU for babies less than 28 days old who need ventilation prior to NETS transfer

Section 3: Triage and assessment of all babies <28 days old

a) Background:
• Children less than 4 weeks of age may present with severe illness that may be difficult to identify particularly to inexperienced medical and nursing staff.
• These children are particularly prone to the effects of hypothermia, hypoglycaemia, sepsis and respiratory compromise.
• Neonates should be kept “warm, pink and sweet”. This reminds us to look for and manage hypothermia, hypoxia and hypoglycaemia.
• As a result of the low presentation rates of these babies and skill mix variations, it may be that many emergency nursing and medical staff have very little professional experience of assessing small babies.

b) Triage and initial assessment
• All children less than 4 weeks of age will be given a triage category 2 by default and notified to the orange consultant or registrar immediately
• These babies will, where possible, be initially assessed in the resuscitation bay. The newborn resuscitaire should be utilised for this purpose.
• A full set of observations including temperature, respirations, heart rate and pulse oximetry and rapid clinical assessment will be completed as soon as possible.
• Babies may then be moved to the paediatric area for further assessment of that the baby’s condition when staff levels and skill mix allows.
• Any such baby that requires prolonged exposure for examination or procedures including cannulation should have this done to the resuscitaire to avoid the risk of hypothermia.

Early involvement of the paediatric or neonatal department may be appropriate depending on the result of the initial assessment.

Section 4: Role of Neonatal medical and nursing staff in ED and Paediatric Ward

a) Situations where neonatal JMO attendance of paediatric patients is mandatory:
   i. Any “Neonatal emergency to ED activation”
   ii. Any patient who is the subject of a paediatric arrest or paediatric assist call:

b) Situations where neonatal JMO attendance of paediatric patients is discretionary:
   i. Calls for help with paediatric procedures to ED: There is no mandated responsibility for the neonatal department to provide assistance with paediatric procedures in the ED in non-critical situations.
   ii. A Neonatal JMO may (but is not required) to agree to provide assistance with paediatric procedures as long as workload in the Neonatal Department is such that they can be spared for a period of time (usually no more than 30 minutes)
   iii. If Neonatal JMO is unable to attend ED staff should call the Paediatric or Emergency Consultant on call.

c) Situations where neonatal JMO attendance of paediatric patients should not occur.
   i. Calls to review non-critical patients older than 14 days of age: Neonatal JMOs should not get involved in these patients unless specifically requested by the paediatrician.

d) Neonatal Nurse Practitioners
   i. There are occasions after hours where there are two Neonatal Nurse Practitioners rostered on, without any onsite doctors.
   ii. Outside of a true neonatal emergency these nurse practitioners have no general credentialing to see patients in ED or Paediatric Ward.
   iii. In rare circumstances where a neonatal opinion is required the on call neonatologist should be contacted by the paediatrician on call or emergency physician on duty or on call.

Authors: Tim Green, Phil Coote, Ingrid Rieger
Authorised: Tim Green
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