SLHD: Royal Prince Alfred Hospital Guideline

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Women and Babies: Late Preterm Guideline

Contents

SLHD - RPA Women and Babies: Late Preterm Guideline ................................................................. 3
1. Introduction .................................................................................................................................. 3
2. The Aims / Expected Outcome of this Guideline ........................................................................ 3
3. Risk Statement ............................................................................................................................. 3
4. Scope ........................................................................................................................................... 3
5. Key Performance Indicators and Service Measures ................................................................. 3
6. Guidelines .................................................................................................................................... 3
7. Definitions .................................................................................................................................... 9
8. References .................................................................................................................................... 9
9. Appendix 1 Flowchart- Late Preterm Infant Management on the Postnatal Ward ........ 11

8.1 National Safety and Quality Health Service (NSQHS) Standards, Version 2 .......................... 10
SLHD - RPA Women and Babies: Late Preterm Guideline

1. Introduction

In 2017 there were 932 admissions to the neonatal intensive care unit. 209 of these were between 34 and 36 weeks gestation (22.4%). The late preterm infant (35 and 36 week infants’) that gets admitted directly to the postnatal ward needs close monitoring and evaluation due to the risk of hypoglycaemia, hypothermia and jaundice.

2. The Aims / Expected Outcome of this Guideline

- Close monitoring, evaluation and management in order to promote optimal physiological stability in the early neonatal period and therefore improve the outcomes for these babies.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 106 - Recognising and Responding to Clinical Deterioration in Acute Health Care

- Babies born between 34 and 37 weeks are more at risk of thermal instability, breastfeeding problems, hypoglycaemia, dehydration and jaundice. All babies at RPAH <35 weeks and less than 2200g require admission directly to NICU.
- Due to immaturity, the late preterm baby may be more sleepy, have more difficulty with attachment and sucking, and have less stamina with feeding than term babies.

4. Scope

- Neonatal medical and nursing staff
- Postnatal medical and nursing staff

5. Key Performance Indicators and Service Measures

- Incident Information Management System
- Audits

6. Guidelines

- Babies born between 34 and 37 weeks are more at risk of thermal instability, breastfeeding problems, hypoglycaemia, dehydration and jaundice.\(^{1,2,3}\)
- Due to immaturity, the late preterm baby may be more sleepy, have more difficulty with attachment and sucking, and have less stamina with feeding than term babies.\(^{1,2,3}\)
The late preterm baby may appear deceptively vigorous and settled after a short feed and may demonstrate less cues to feed. Furthermore, these infants are at risk for extended supplementation with formula as they frequently often do not suck effectively in the early days and as a result do not adequately stimulate breast milk production.

Increasing stimulation immediately after birth by hand expressing after each feed and giving this extra colostrum to the baby will minimise the need for formula and stimulate the mother’s milk supply.

To assist the parents understand the needs of their baby ensure they receive the pamphlet, “Late Preterm babies: Information for parents”.

Babies born at less than 37 weeks gestation are at significant risk for hypoglycaemia and therefore require blood glucose screening as per the Prevention and Management of Neonatal Hypoglycaemia policy.

5.1 Parent education

- Parents are to be given the Late preterm Infants pamphlet upon arrival to the ward or NICU
- Explain differences of the term baby and the late preterm baby to parents and reassure and support them but set realistic expectations for the postnatal period and first few weeks until baby is at corrected 40 weeks gestation

5.2 Breastfeeding

- Encourage frequent and extended periods of skin to skin contact with the mother – see Safe Sleeping Guidelines
- Feed the baby whenever there are cues to feed. It is normal to feed the baby at least 8 times a day. These feeds may be short but there should be nutritive sucking.
- Educate and assist the mother to hand express and give EBM after all breastfeeds or feeding attempts in the first few days.
- Express post feed to have EBM ready to give after next feed
- Consider encouraging the mother to use breast compression while the baby is feeding to assist with milk transfer.
- Resist tiring the baby with prolonged feeding attempts. If the baby is having difficulty attaching and sucking do not assist the mother in trying to attach for more than 10 – 15 mins.
- Do not use a dummy.
The baby can be given 2 intragastric tube (IG) feeds by orogastric route per 24 hours on the postnatal ward if unable to suck.

If the baby does not breastfeed code 5 or 6 then the baby should be comped with EBM or formula as per the chart below:

Guidelines for complementary feeds for babies not having code 5 - 6 feeds

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<tr>
<th>First 24 hours</th>
<th>24-48 hours</th>
<th>48-72 hours</th>
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<tr>
<td>5 – 10 mls per feed</td>
<td>10 - 20 mls per feed</td>
<td>20 – 30 mls per feed</td>
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<td>EBM/formula</td>
<td>EBM/formula</td>
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<tr>
<td>Encourage 8 feeds/day</td>
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<td>Must have at least 6</td>
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After the first 24 hours consider encouraging the mother to double pump with the breast pump in addition to hand expressing after feeds and continue to give EBM after all breastfeeds or feeding attempts. If the mother’s milk supply is rapidly increasing then reduce to single pumping or hand expressing to get EBM to top up her baby.

Once the baby is consistently feeding code 5 or 6 at all feeds, the baby’s output increases and weight loss is ≤ 7 % then the post feed expressing and complementary feeding can be reduced. Continue to monitor maternal supply and infant attachment.

Discuss concerns with the Lactation team at any time.

A summary of the management of Late Preterm Infants on the postnatal ward is available on page 9: Late Preterm Infant Flowchart

5.3 Thermal Stability

While skin to skin or breastfeeding ensure that the baby is draped with wraps around the outside of the baby to prevent heat loss.

When not breastfeeding or skin to skin the baby should be wrapped with extra blankets (double wrapped) unless the baby’s temperature reaches ≥ 37.20 C.

If baby’s temperature is 36.30 - 36.50 C - place baby skin to skin with mother ensuring the baby has a bonnet (refer to the Sudden Infant Death (SIDS) and Safe Sleeping Policy, RPA online) and double wraps around the outside of the baby’s body. Check the baby’s temperature in 1 hour. If not > 36.50 C then escalate to senior midwife or neonatal staff for advice.

If Temperature falls below 36.1 call a neonatal review as per baby observation chart.
5.4 Jaundice
- Ongoing observation of the baby for clinical signs of jaundice. If any concerns then consult with the neonatal team regarding an SBR.
- Use TcB to check jaundice at 72 hours and any reading over 200 micromol/L indicates the need for a formal SBR and neonatal review. Ensure the level is documented on newborn care plan.
- If baby ≤ 35 weeks consult with neonatal team to ascertain if an SBR is necessary at 72 hours.

5.5 Observations
- Respiration, temperature and apex beat 4th hourly for 48 hours and then BD if temperature stable for next 48 hours, then daily if stable and in normal range.

5.6 Blood sugar levels
As per Prevention and Management of Neonatal Hypoglycaemia policy
- Commencing with the second feed, within 6 hours of birth, the baby should have BSL’s attended 30 mins after a feed to maintain BSL>2mmol/L.
- BSL’s can be ceased if the first 3 BSLs are above 2.5 mmol/L.
- If BSL less than 2.0mmol/L in first 24 hours then BSL’s are to continue for 36 hours.
- If the baby is less than 35 weeks the BSL should be maintained at >2.5mmol/L including the first 24 hours.

5.7 Weight
Baby is to be weighed at 72 hours of age. If the weight loss ≥7% at 72 hours
- Notify lactation team
- Assess breastfeeds for nutritive sucking
- Ensure mother is expressing and giving EBM post feeds.
- If poor sucking give EBM/formula (birth weightX90) /8
- Ensure parents are not trying for extended periods to get baby to attach
- Ensure parents are not trying to settle baby instead of feeding baby
- Encourage more frequent feeds taking less time
- Ensure that the parents are not using a dummy

5.8 Transfer to NICU if the baby
- Requires more than 2 IG tube feeds per 24 hours
- Unable to maintain BSL as per Prevention and Management of Neonatal Hypoglycaemia policy
• Temperature not able to be maintained above 36.0 on 2 consecutive readings at least 1 hour apart.

• For phototherapy – the Registrar / Fellow may consider the use of phototherapy on the Postnatal ward if the infant is over 72 hours of age, is feeding well (no intra gastric feeds), has less than 7% weight loss and there are no significant risk factors.

• Other concerns after discussion with neonatal staff

5.9 Discharge planning

5.9.1 Management of the late preterm when discharged from the postnatal ward

• Readiness for discharge is to be assessed by the midwife caring for the mother and the baby. The baby is ready for discharge if:
  ▪ He/she is maintaining temperature > 24hours
  ▪ Weight loss no more than 7 % or If previous weight loss ≥ 7% then the baby needs to show increasing weight
  ▪ Taking all sucking feeds for 48 hours in line with NICU policy

• On discharge the post-natal ward midwife will inform the early childhood liaison officer who will complete the data entry on Cerner that will flag the baby to central intake for a priority Child & Family Health Nurse (C&FHN) visit. Families should expect a C&FHN phone call within 48 hours to arrange a priority home visit. Families should be advised that there needs to be the ability to leave a message on their contact phone number. Check that families are aware that if the family does not receive a home visit by C&FHN within 3 days of discharge the baby should be reviewed by the family’s general practitioner. If the family do not have a general practitioner then they can be given a list of the GP Shared Care doctors to choose their own and the GP is to be informed

• Educate parents that the baby requires weekly weight and monitoring until 40 weeks corrected (via early discharge program or GP) and that they have the ‘Late-preterm pamphlet’ with care after discharge information

• Ensure BF support group flyer is in baby’s blue book

• If the lactation team have been involved then a pink lactation sticker is to be placed inside the front cover of the baby’s blue book to indicate there is a written feeding plan in the progress notes of blue book

• Ensure parents have information on breast pump hire, storage of breastmilk, sterilisation and formula preparation if appropriate
• Newborn Family Support (NFST) may be able to provide follow up for infants who have been admitted to the post-natal ward after at least a 5 day nursery stay. This should be discussed on a case by case basis after consultation with NFST and the postnatal ward neonatologist.

• If the baby has been admitted to the NICU before the postnatal ward a full discharge summary should accompany the baby on discharge from the NICU to the postnatal ward. This summary should be printed off for the baby’s personal health record (blue book) and any relevant details regarding the postnatal ward stay to be written in the Birth details and newborn check section of the baby’s blue book.

• If weight gain and/or jaundice are of concern then the infant should be reviewed in the jaundice clinic which is run daily from 10 am in the Newborn Care follow up clinic. Booking a baby into this clinic requires:
  - Discussion with the Fellow who is on for the day
  - A discharge summary or referral letter from the neonatal staff placed in the pink jaundice folder in the nursery
  - An appointment made with the receptionist on 58760. The lactation consultants can be available at this clinic if required – page 80354.
  - Parents are to be given an appointment card with date and time
  - As the clinic on Saturday and Sunday is a “drop in” clinic the family will need to be at the nursery by 10 am. Once they have arrived in the nursery to be reviewed the Fellow on will be informed, on weekdays they should report to Newborn Care reception.
5.9.2 The management of the Late Preterm Infant when discharged from Newborn Care

• NFST will provide follow up within the first 1 – 2 weeks of discharge if the family live within area.
• Families should expect a call from NFST the day after discharge.
• NFST will complete the perinatal psychosocial referral form that will flag the baby to Early Childhood Liaison officer and central intake.
• If outside area and unable to be visited by NFST, NFST will still coordinate the C&FHN referral. C&FHN will contact families within 48 hours of referral.
• If discharged on a weekend and weight gain and/or jaundice of concern then the infant can be reviewed in the jaundice clinic which is run daily from 10 am in the newborn follow up clinic as above. An early GP appointment should be organised. If the family do not have a general practitioner they need to be assigned one prior to discharge and the GP informed.

NB: For all infants – if there is concern after discharge about the baby being unwell the family need to contact the general practitioner or for greater concerns present at the hospital emergency department.

7. Definitions

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<tr>
<td>NFST</td>
<td>Newborn Family Support Team</td>
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8. References

1. Academy of Breastfeeding Medicine(2011). ABM Clinical Protocol #10: Breastfeeding the Late Preterm infant (340/7 to 366/7 Weeks Gestation) (First revision June 2011)

8.1 National Safety and Quality Health Service (NSQHS) Standards, Version 2

- Standard 1, Clinical Governance Standard
- Standard 4, Medication Safety
- Standard 8, Recognising and Responding to Acute Deterioration Standard
9. **Appendix 1 Flowchart- Late Preterm Infant Management on the Postnatal Ward**

### First 24 Hours
- Encourage a minimum of 8 feeds per 24 hrs
- Attempts to attach babies should last for no more than 10 – 15 mins if not sucking well.
- Express PC after every feed/feed attempt and give EBM (if any) after the next feed even if code 5/6 feed
- If a code 5/6 is not achieved then give a comp of EBM/Formula of 6mls-10mls
- A maximum of 2 X IG tube feeds per 24 hours is acceptable on the postnatal ward

### 24-48 Hours
- Encourage skin to skin time in accordance with safe sleeping guidelines.
- Double Wrap all infants when not skin to skin unless ≥ 37.2°C
- Refer to thermoregulation policy if temperature falls below 36.5°C
- BSL’s to commence 30 minutes after the second feed as per Hypoglycaemic policy.
- If the first 3 BSL’s >2.5, BSL’s may cease

### 48-72 hrs
- Continue same management with addition:
  - If a Code 5/6 not achieved then comp with 10-20mls per feed of EBM/Formula.
  - Hand Express/Double pump after each feed
- Inform lactation and refer to policy if weight loss at 72 hrs > 7%.
- If a code 5/6 not achieved then comp with 20-30mls per feed EBM/Formula
- Double pump P/C
- Review post 72 Hr weight as per policy.

### DISCHARGE PLANNING ONCE…..
- Temp maintained for 48 Hrs
- Taking all sucking feeds for 48 Hrs
- If weight loss was >7% must now be showing weight gain

Refer to Policy for discharge procedures.

Give Parents the ‘Late preterm Infants Brochure’.