Policy Directive

Women and Babies: Late Preterm Infants (34^{+0} - 36^{+6}) on the Postnatal Ward

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Functional Sub-Group: Clinical Governance
Corporate Governance
Summary: Direction on the management of preterm newborns on the postnatal ward.

National Standard: 
- Standard 1 Governance for Safety and Quality in Health Care
- Standard 9: Recognising & Responding to Clinical Deterioration in Acute Health Care

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Approved by: HOD Low Risk Obstetrics
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Note: Sydney Local Health District (LHD) and South Western Sydney LHD were established on 1 July 2011, with the dissolution of the former Sydney South West Area Health Service (SSWAHS) in January 2011. The former SSWAHS was established on 1 January 2005 with the amalgamation of the former Central Sydney Area Health Service (CSAHS) and the former South Western Sydney Area Health Service (SWSAHS).

In the interim period between 1 January 2011 and the release of specific LHN policies (dated after 1 January 2011) and SLHD (dated after July 2011), the former SSWAHS, CSAHS and SWSAHS policies are applicable to the LHDs as follows:

Where there is a relevant SSWAHS policy, that policy will apply.

Where there is no relevant SSWAHS policy, relevant CSAHS policies will apply to Sydney LHD; and relevant SWSAHS policies will apply to South Western Sydney LHD.

Compliance with this policy directive is mandatory
Late Preterm Infants (34\textsuperscript{0}-36\textsuperscript{6}) on the Postnatal Ward

Contents

1 Introduction ........................................................................................................................ 3
2 Policy Statement ................................................................................................................ 3
3 Procedure .......................................................................................................................... 3
  3.1 Parent education ......................................................................................................... 4
  3.2 Breastfeeding .............................................................................................................. 4
  3.3 Thermal Stability ........................................................................................................ 5
  3.4 Jaundice ...................................................................................................................... 5
  3.5 Observations ............................................................................................................... 5
  3.6 Blood sugar levels ....................................................................................................... 5
  3.7 Weight ......................................................................................................................... 6
  3.8 Transfer to NICU if the baby ........................................................................................ 6
  3.9 Discharge planning .................................................................................................... 6
4 Performance measures ...................................................................................................... 8
5 Definitions ........................................................................................................................ 8
6 References ........................................................................................................................ 8
7 Late Preterm Infant Management on the Postnatal Ward Flowchart................................... 9
Late Preterm Infants (34^{+0}-36^{+6}) on the Postnatal Ward

1 Introduction

*NB: Babies born <2200gms are not to be admitted to the postnatal ward from Delivery Ward or Operating Theatre but are to be assessed in NICU first*

The risks addressed by this policy:

| Babies born between 34 and 37 weeks are more at risk of thermal instability, breastfeeding problems, hypoglycaemia, dehydration and jaundice. 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. |

The aims:

| 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 |

2 Policy Statement

This policy provides direction on the management of preterm newborns on the postnatal ward.

3 Procedure

Background

- 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\(^{1,2,3}\)
- 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.\(^{1,2,3}\)
- 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.\(^2\)
• 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.

3.1 Parent education
• Parents are to be given the Late preterm Infants pamphlet upon arrival to the ward
• 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

3.2 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 pc 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 intragastic 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

<table>
<thead>
<tr>
<th>First 24 hours</th>
<th>24 – 48 hours</th>
<th>48 – 72 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 10 mls per feed EBM / formula Encourage 8 feeds /day Must have at least 6</td>
<td>10 - 20mls per feed EBM/formula Encourage 8 feeds/day Must have at least 6</td>
<td>20 – 30 mls per feed EBM/formula Encourage 8 feeds/day Must have at least 6</td>
</tr>
</tbody>
</table>

• 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 / sucking.

- 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

### 3.3 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 ≥ 37.2°C.
- If baby’s temperature is 36.3°C - 36.5°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 > 36.5°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.

### 3.4 Jaundice
- Ongoing observation of the baby for clinical signs of jaundice on clinical examination and if any concerns then consult with the neonatal team regarding an SBR. Note: the transcutaneousbilimeter (TCB) should not be used on a baby less than 35 weeks
- 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 careplan.
- If baby ≤ 35 weeks consult with neonatal team to ascertain if an SBR is necessary at 72 hours

### 3.5 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

### 3.6 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 BSLs attended 30 mins after a feed to maintain BSL>2mmol/L.
- BSLs 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 BSLs 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
3.7 Weight
- Baby is to be weighed at 72 hours of age
- If 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 pc amount to be calculated by birth weight x 90mls divided by 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

3.8 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 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

3.9 Discharge planning
- Readiness for discharge is to be assessed by the midwife caring for the mother and baby and the baby is ready for discharge if :
  - maintaining temperature > 24hours
  - weight loss no more than 7 %
  - If previous weight loss ≥ 7% baby to show increasing weight
  - Taking all sucking feeds for 48 hours in line with NICU policy
- Ensure Child and Family Health Nurse (CFHN) referral via the psycho-social referral form for follow up at 48-72 hours.
- Educate parents that the baby requires weekly weight and monitoring until 40 weeks corrected 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

Compliance with this policy directive is mandatory
• Ensure parents have information on breastpump hire, storage of breastmilk, sterilisation and formula preparation if appropriate

• 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

• 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:
  o Discussion with the Fellow who is on for the day
  o A discharge summary or referral letter from the neonatal staff placed in the pink jaundice folder in the nursery
  o An appointment made with the receptionist on 58760. The lactation consultants can be available at this clinic if required – page 80354.
  o Parents are to be given an appointment card with date and time
  o As the clinic on Saturday 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.

4 Performance measures

Incident Information Management System

Audits
5 Definitions

Nil

6 References

1 Academy of Breastfeeding Medicine (2011). ABM Clinical Protocol #10: Breastfeeding the Late Preterm infant (34\textsuperscript{07} to 36\textsuperscript{07} Weeks Gestation) (First revision June 2011)
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 **5mls- 10mls**
  - A maximum of 2 X IG tube feeds per 24 hours is acceptable on the postnatal ward
- Encourage skin to skin time in accordance with safe sleeping guidelines.
  - Double Wrap all infants when not skin to skin unless ≥ 37.2C
  - Refer to thermoregulation policy if temperature falls below 36.5C
- 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
  - Refer to Hypoglycaemia Policy if:
    - **Infant <35 weeks and BSL <2.5 mmol/L OR > 35 weeks and BSL <2.0 mmol/L**
- Give Parents the ‘Late preterm Infants Brochure’.

24-48 Hours

- 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

48-72 hrs

- 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.
- Observe infants daily for early signs of Jaundice.
  - TCB may not be used on infants <35 weeks.
  - Inform neonatal SRMO if concerned

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.