# Document Control

| | | | |
|---|---|---|---|
| **Title** | | | |
| **Transfer of Neonates Standard Operating Procedure** | | | |
| **Author** | | | **Author's job title**<br>Lead Nurse Neonatal and Paediatric Services |
| **Directorate**<br>Women and Children's | | | **Department**<br>SCU |
| **Version** | **Date Issued** | **Status** | **Comment / Changes / Approval** |
| 0.1 | Oct 2011 | Draft | Initial version for consultation. |
| 0.2 | Jan 2013 | Revision | Additions by Paediatric Consultant |
| 0.3 | Feb 2013 | Revision | By Lead Nurse Neonatal and Paediatric Services |
| 0.4 | April 2013 | Draft | Additions by Paediatric Consultant / Lead Nurse Neonatal and Paediatric Services |
| 1.0 | May 2013 | Final | Approved by Paediatric Specialty Team on 31st May. |
| 1.1 | Sep 2013 | Revision | Amendments by Corporate Governance to document control report, headers and footers, hyperlinks to appendices and formatting for bookmark navigation and semi-automatic table of contents.<br>Addition of PNTS referral log and the PNTS parent leaflet as Appendices 3 and 4. |
| 1.2 | July 2016 | Reviewed | Revised and sent out to stakeholders for discussion |
| 1.3 | Sept 2016 | Revision | Revised following comments from the Patient Safety Team |
| 2.0 | Dec 2016 | Final | Approved at Paediatric Speciality Team on 23rd Dec 2016 |
| 2.1 | Jan 17 | Revision | Small amendments in response to SIRI investigation 2016 10053 |
| **Main Contact**<br>SCU<br>North Devon District Hospital<br>Raleigh Park<br>Barnstaple, EX31 4JB | | | **Tel: Direct Dial** – 01271 322610 |
| **Lead Director**<br>Director of Nursing | | | |
| **Superseded Documents**<br>Transfer of Neonates SOP V2.0 | | | |
| **Issue Date** | **Review Date** | | **Review Cycle** |

| | | |
|---|---|---|
| December 2016 | December 2019 | Three years |
| **Consulted with the following stakeholders: (list all)**<br>• Neonatal staff<br>• Midwifery services<br>• Paediatric staff<br>• Trust Patient Safety Team | | |
| **Approval and Review Process**<br>• Paediatric Specialty Team | | |
| **Local Archive Reference**<br>G:\Paediatric Resources\Neonates\Neonatal guidelines\Old versions of guidelines<br>**Local Path**<br>G:\Paediatric Resources\Neonates\Neonatal guidelines\Transfer of Neonates<br>**Filename**<br>Transfer of Neonates Policy v2.0 23.12.16 | | |
| **Policy categories for Trust's internal website (Bob)**<br>Paediatrics, Neonatal | **Tags for Trust's internal website (Bob)**<br>Transfer, Transport, SCU, Neonates, Ambulance, Stabilisation, Repatriation, giraffe, docking station, baby pod. | |

# CONTENTS

# 1. Introduction

**1.1.** The safe transfer of premature and sick babies is an essential component of neonatal care enabling all babies to be looked after in the right level of neonatal unit, as close to home as possible, (BLISS 2016).

**1.2.** Problems related to the transport of newborns are frequent. The transfer environment is potentially "hostile" and it is essential that neonates are not exposed to a greater risk of adverse events as a result of transfer processes.

**1.3.** This document describes the situations when transfers should be arranged to facilitate enhanced care of the neonate.

**1.4.** North Devon District Hospital Special Care Unit (SCU) provides care for the sick and premature newborn infant.

**1.5.** Neonates are potentially at risk whenever they are moved out of areas of relative clinical safety. These procedures should be adhered to when an infant requires transfer either within the hospital or to another neonatal unit.

**1.6.** When transfer is deemed to be necessary this should be in-utero unless there is an appreciable risk to the mother of moving her or delivery is so imminent that it is likely to take place before arrival at destination. In these cases delivery should be followed as soon as possible after stabilisation by ex-utero transfer.

**1.7.** Barnstaple SCU is part of the South West Neonatal Network. The Peninsula Neonatal Transfer Team (PNTS) offers a 24/7 retrieval and repatriation service for Neonatal units in the Southern parts of the Network (Exeter, Barnstaple, Torbay, Plymouth and Truro). Transfer is prioritised according to priority of need for the above units across Network.

# 2. Purpose

**2.1.** The policy has been written to:

- Enable the safe uninterrupted transport of the neonate by developing procedures that minimise thermal, physiologic, and developmental stress while maintaining uninterrupted care to the neonate.
- To enable the safe transfer of the infant within the hospital or to / from other neonatal units that can provide appropriate levels of care.
- To minimise the risk of healthcare acquired infections through adherence to Trust Infection and Prevention Control Policies (http://www.northdevonhealth.nhs.uk/2014/08/standard-infection-control-precautions-policy/)
- To maintain privacy and dignity of the patient during transfer (http://ndht.ndevon.swest.nhs.uk/confidentiality-policy/ )
- To maintain patient safety and security of the patient during transfer (http://www.northdevonhealth.nhs.uk/2015/10/patient-identification-policy/ )
- To enable the safe transfer of the parent / mother and the welfare of any member of staff involved in escort duties

- To ensure good communication and documentation throughout the transfer process with all parties involved and that informed consent with parents has been obtained and documented (http://ndht.ndevon.swest.nhs.uk/consent-policy/ )

## 3. Scope

**3.1.** The policy applies to:-

- All Trust staff, professional, administrative, bank, agency and locum who may be involved in the transfer of neonates either in-utero or ex-utero, internally or externally.
- Peninsula Neonatal Transfer Service, (PNTS).
- Newborn Emergency Stabilisation Team, (NEST).
- Parents and the neonate.

## 4. Definitions

| | | |
|---|---|---|
| **4.1.** | A+E – | Accident and Emergency |
| **4.2.** | Baby PAC- | Neonatal transport ventilator |
| **4.3.** | CDS – | Central Delivery Suite |
| **4.4.** | CFM- | Cerebral Function Monitor |
| **4.5.** | CPAP – | Continuous Positive Airway Pressure |
| **4.6.** | External transfer- | From SCU to another neonatal unit. |
| **4.7.** | Ex-utero transfer– | Infant is transferred following birth. |
| **4.8.** | HCA – | Health Care Assistant |
| **4.9.** | HD – | High Dependency |
| **4.10.** | HIE – | Hypoxic Ischaemic Encephalopathy |
| **4.11.** | IC – | Intensive Care |
| **4.12.** | Internal transfer- | From one clinical area within NDDH to another within NDDH. |
| **4.13.** | In-utero transfer– | expectant mother is transferred prior to birth of infant. |
| **4.14.** | IV - | Intravenous |
| **4.15.** | LNU – | Local Neonatal Unit |
| **4.16.** | MCA – | Midwifery Care Assistant |

| | | |
|---|---|---|
| 4.17. | MRSA – | Methycillin Resistant Staphylococcus Aureus |
| 4.18. | NC – | Normal Care |
| 4.19. | NEST – | Newborn Emergency Stabilisation Team |
| 4.20. | NICU – | Neonatal Intensive Care Unit |
| 4.21. | NN – | Neonatal Nurse |
| 4.22. | PICU – | Paediatric Intensive Care Unit |
| 4.23. | PNTS - | Peninsula Neonatal Transfer Service |
| 4.24. | QIS – | Qualified In Specialty |
| 4.25. | RDS – | Respiratory Distress Syndrome |
| 4.26. | SC | Special care |
| 4.27. | SCU – | Special Care Unit |
| 4.28. | WNN – | Western Neonatal Network |

# 5. Responsibilities

## Role of the Referring consultant

5.1. It is the responsibility of the referring consultant:

- To assess and initiate the need for transfer
- To have discussion between referring centre, receiving centre and the PNTS, prior to move being agreed and undertaken
- Access the time scale for transfer

## Role of the Nursing/Midwifery staff

5.2. It is the responsibility of the SCU staff/midwifery team in the referring unit to:

- Arrange and support the retrieval/transfer process according to policy
- Support the transfer by escort if necessary

# 6. Neonatal Cot Bureau

The Neonatal cot bureau provides a real time view of the neonatal cot capacity across the SW region. All neonatal units within the Southwest Neonatal Network update the cot bureaux with their activity twice daily.

http://www.swneonatalnetwork.co.uk/health-professionals/neonatal-cot-bureau/

# 7. Criteria for transfer to and from other neonatal units

**As a Level One unit, the agreed network thresholds for transfer out in-utero or ex-utero are:**

| **Agreed network thresholds for transfer from NDDH to a level 2 or 3 Unit** |
|---|
| • Under 30 week gestation (29 weeks and 6 days<br>• Under 32 week gestation twins (31 weeks and 6 days)<br>• Under 1000g<br>• Intensive care and some high dependency infants<br>• Infants requiring invasive procedures (e.g. exchange transfusion)<br>Infants requiring cardiac/surgical/specialist services<br>(2015 service specification) |

**Babies may also require transfer out if:**

- Current level of activity and acuity on SCU would make conditions unsafe if the infant was to stay on the unit, (see SCU Ward Closure Escalation Policy).
- The SCU staffing levels/experience are not at the appropriate levels
- An infant is receiving care on the SCU where the mother had not originally booked to deliver (repatriation).
- The parent of the infant moves out of the area and the infant is still in need of continuing care.

  These babies should be electively transferred out to another unit where the appropriate level of care can be provided (see Appendix 1) e.g.
- Local Neonatal Unit (LNU) - Exeter or Truro (Level 2 unit).
- Network Neonatal Intensive Care Unit (NICU) –Plymouth, Derriford Hospital (Level 3 unit).
- Bristol St Michaels NICU (Level 3 unit) or Paediatric Intensive Care Unit (PICU) for surgical/cardiac/intensive care infants and Bristol Southmead NICU (Level 3 unit).
- Wherever possible all mothers at risk of delivering the above infants should be transferred for delivery at the above hospitals.

# 8. General principles applicable to all transfers

During a transfer babies/parents should be treated and cared for in such a way as to maintain:

**8.1.** **Privacy and dignity** – An incubator should be covered when travelling through public areas (yet allow full observation of infant by clinical team).

8.2. **Health and safety** – According to health and safety guidance a minimum of 2 persons are required to move the transport incubator. All monitoring equipment, IV pumps and emergency bags should be well secured prior to moving incubator.

8.3. **Infection control** - Prior to transfer porters, escorts, receiving neonatal units, hospital wards or departments should be informed of any infection issues.

8.4. **Patient safety and security** – Follow Trust Patient Identification Policy.

8.5. **Necessary treatment and care** - All staff undertaking transfers of infants should be competent:

- To deliver the level of care the baby requires
- In the use of transport equipment

8.6. **Respect for individual needs.**

8.7. **Good communication:**

- With parents. There should be discussion with parents/carers who should be given full information and kept updated on events. Informed consent from parents/carers throughout all the processes of neonatal transfer should be obtained.
- Between CDS, SCU, Paediatric and Obstetric teams with regular updates on progress
- Between the referral, receiving areas, (wards and other units) and transport teams. To handover the condition of the infant and ascertain capacity and ability to safely transfer, receive and care for the mother and, or baby.

8.8. **Confidentiality of infant's information.**

8.9. **Documentation.** The process of transfer and retrieval of infants is documented in the baby's medical notes. This includes:

- Details of all discussions between referring and receiving areas and transfer teams.
- Recording by both the referring and receiving unit for all requested transfers, accepted or declined.
- All episodes of communication and consent with the parents.

# 9. Areas Involved in Neonatal Transfer

## For in-utero transfer

9.1. **From:**

- Postnatal ward or Central Delivery Suite (CDS) to another obstetric unit with an appropriate neonatal unit, to deliver expected level of neonatal care.

### For ex-utero transfers

- Ex-utero transfers and repatriation of babies may occur from and to SCU from other neonatal and paediatric units within and outside of the SW Neonatal Network.
- Neonatal transfers also occur to and from SCU within the Trust e.g. delivery suite, postnatal ward, A+E, paediatric ward, other departments (including mortuary) and home

## 10. Peninsula Neonatal Transfer Service

**10.1.** All transfers and decision-making are co-ordinated by the Peninsula Neonatal Transfer Service (PNTS).

**10.2.** PNTS contacts SCU on a daily basis to identify at risk infants and potential need for transfers

Direct line 01752 432346

Alternative contact numbers:

Neonatal Unit: 0845 1558138 / 01752 432333
Mobile: 07788416248 (primary)
07795591178 (secondary)

**10.3.** PNTS will determine priority for move, confirm/identify appropriate unit and cot for infant; if needed, will liaise with other units to confirm cot and arrange transfer team to move infant.

## 11. Transfers for infants that require cardiac/surgical/specialist services

**11.1.** It is likely that SCBU will have made prior contact with surgical/cardiac/other centre will have confirmed appropriateness of transfer and identified cot.

**11.2.** SCU staff will then contact PNTS transport co-ordinator via Derriford Neonatal Unit - if not already involved in discussions.

**11.3.** PNTS will liaise with referring and receiving centre and arrange appropriate transfer team and time if it is deemed appropriate that the PNTS carry out the move.

## 12. Procedures when PNTS Cannot Co-ordinate Transfers

**12.1.** On some occasions PNTS are unable to facilitate a transfer.

**12.2.** In this instance the paediatric consultant on SCU may identify a cot and organise a retrieval. The neonatal cot bureau or PNTS may help with this. The receiving consultant/team must accept the baby before arrangements for transport are booked. The infant's diagnosis and level of care must be communicated via receiving hospital referral form.

**12.3.** The transfer may be by:

**12.1 Newborn Emergency Stabilisation Team (NEST)** – this is the other transport team that operates for the upper neonatal units in the South West Neonatal Network. NEST is located in St Michael's Hospital, Bristol.

| | |
|---|---|
| To contact NEST ring | 0117 342 5050 |
| or St Michael's NICU | 0117 342 5232 ext 5275 |

Information and paperwork can be downloaded from www.nestteam.org

This includes referral forms, observation charts, drug guidelines and parent information.

**12.2 WATCh**

WATCh is the paediatric critical care transport service for Southwest England and South Wales, responsible for co-ordinating the transfer of all referrals to the PICUs in Bristol and Cardiff

WATCh Transport for Children Follow link on home page on Trust intranet

Or ring 0300 0300 789 -

Note:-Follow point 1 for procedures for preparation prior to retrieval.

**12.3 NDDH SCU team**

**(see below point 15)**

## 13. In- utero transfer procedures for unborn infants

**13.1.** This applies to mothers that may deliver infants that fall into criteria for transfer (point 7 above). They should be transferred to an obstetric unit whose neonatal unit can provide the appropriate level of care for the expected baby. The obstetric team will discuss case with the paediatrician and identify appropriate maternal bed and neonatal cot arranging safe transfer of mother. PNTS or the cot bureau may be used to help identify a cot. For in depth procedure see PNTS Guideline.

**13.2.** Obstetric staff to contact PNTS transport co-ordinator.

**13.3.** Transport co-ordinator will review Peninsula capacity to identify appropriate centre for infant, ascertain cot and labour ward operational capacity, identify cot and communicate with referring centre to permit liaison between relevant obstetric/labour ward teams. In the absence of a location of a local centre with cot/bed space, then the PNTS will undertake to contact other network centres in order to identify a cot in an alternative centre.

**13.4.** The PNTS transport co-ordinator should be made aware of any request for an in-utero transfer into the network from elsewhere. This permits the proposed move to be aligned with current network capacity, other network operational pressures and potential transfers.

## 14. Ex-utero transfer procedures

(for criteria see point 7)

| Steps | Procedures for preparation prior to retrieval |
|---|---|
| | PNTS must be contacted as soon as it is known a move may be required. |
| | There should be consultant to consultant discussion involving the Tertiary NICU at Derriford or the proposed receiving centre, the PNTS, and the parents prior to any move being agreed and undertaken.<br>The decision to transfer lies with the SCU senior nurse and consultant in discussion with the teams identified above and the parents.<br>See Appendix 2 for contact numbers. |
| | Give parents information on their baby's condition and need for transfer.<br>Gain informed consent for transfer and procedures required. (see Trust consent policy http://ndht.ndevon.swest.nhs.uk/consent-policy/). |
| | Give parents information on PNTS (or other transport service) and their receiving unit (Appendix 4).<br>http://www.swneonatalnetwork.co.uk/transport-services/transport-information-for-parents/ |
| | Ascertain parent wishes regarding accompanying baby and move to another unit. Make plan for parents liaising with midwives, transfer team and receiving hospital (post-natal ward and neonatal unit). |
| | Keep parents updates throughout included expected time of arrival of retrieval team |
| | Complete PNTS referral form (Appendix 3). |

| Steps | Stabilise infant for transfer |
|---|---|
| 1 | Follow recommendations for care to stabilise and prepare infant for retrieval as discussed with tertiary unit and PNTS. |

| | |
|---|---|
| 2 | Use PNTS/NEST guidelines for drug preparation and Alaris Asena syringe drivers |
| 3 | Insert 2nd IV cannula (if infant is receiving continuous parenteral therapy) and consider NBM status |
| 4 | Place labelled expressed breast milk into a cool bag with ice packs just prior to departure. Send with the infant |
| 5 | The care of the infant continues to be the responsibility of SCU until the retrieval team have put the infant in their transport incubator or they have formally taken over care |
| 6 | Consider sending maternal blood sample with baby |
| 7 | |
| **Steps** | **Complete Clinical Records - Documentation** |
| 1 | Document all discussions and decision-making between the referring centre, receiving centre and the PNTS |
| 2 | Record all discussions/information given to parents and consent gained throughout transfer process |
| 3 | Record all care of the infant until the retrieval team have formally taken over care and document the time this occurred. |
| 4 | Record Arrival/departure times of retrieval team |
| 5 | Complete Badger referral/discharge letter and have ready to finish and print when retrieval team depart. Print 2 copies – one for transport team and one for medical records |
| 6 | Print out 2 snapshots from CFM Print– one for transport team and one for medical notes. |
| 7 | Photocopy medical notes/results/blood gases/prescriptions charts and nursing documentation to send with baby. Add Badger discharge letter |
| 8 | Send neonatal blood spot with baby and check if retrieval team need sample of maternal blood |
| 9 | Ensure all documentation accompanies the infant |
| 10 | Record all any transfers (in-utero and ex-utero) and requests for repatriation etc on to the ward bed state. |
| **Steps** | **Procedure once baby is transferred** |
| 1 | File all medical/nursing documentation. |
| 2 | Complete Trust discharge processes |
| 3 | Send notes for coding. |
| 4 | Complete Peninsula Perinatal Transport (PEPT) data form. Completed PEPT forms are sent to Dr John Madar, Neonatal Unit, Level 5, Derriford Hospital, |

| | |
|---|---|
| | Plymouth. PL6 8DH. |

## 15. Procedures when NDDH SCU team transfers a baby to another neonatal unit

**15.1.** On occasions when PNTS cannot co-ordinate and provide transport SCU staff may undertake this role

| Steps | Procedure when SCU team provides transfer |
|---|---|
| 1 | Follow point 14 procedures for preparation prior to retrieval by PNTS. |
| 2 | Determine if the baby is medically stable for transfer.<br>• If the baby is having enteral feeds a cannula may be inserted for the journey. Infant may require parenteral fluid/nutrition and/or need to be nil by mouth.<br>A second cannula will be required if the infant is receiving continuous parenteral therapy |
| 3 | Choose escorts appropriate to the level of care required, by use of risk assessment tool (see Appendix 6) |
| 4 | Determine equipment required<br>• Choice of mode of transfer is guided by the risk assessment tool, (see Appendix 6). See Appendix 7 for criteria for use of transport incubator.<br>• Calculate amount of medical gases required for length of journey. (See guidelines for use of the transport incubator).<br>• Appropriate equipment to be used for transfer may be guided by the risk assessment tool (Appendix 6). |
| 5 | Identify type of vehicle for transfer (see Appendix 6).e.g.<br>• Emergency ambulance.<br>• Non-urgent ambulance.<br>• Private ambulance.<br>• Parent's car. (They will need to use their baby seat). |
| 6 | Book mode of transfer.<br>• For **urgent transfers**: ring 999/122 and ask for an ambulance with a **240 volt power supply and state that it must not be the bariatric ambulance** (the transport incubator will not fit into this vehicle).<br>If the transport pod is being used it will fit to any stretcher in any ambulance.<br>Out of hours transfers are always classed as urgent. Ambulance |

| | |
|---|---|
| | is then requested as above through bleep 500.<br><br>• For **non-urgent transfers**: ring 3281 to book ambulance or ask operator to connect. Or Bleep 289/500 out of hours. (However booked ambulances cannot be guaranteed. Other cases may take priority). |
| 7 | Arrange staff cover for transfer/escort. |
| 8 | Follow check list on PNTS documentation |
| 9 | Place infant in mode of equipment chosen for transfer and secure by straps and nesting. |
| 10 | For Booked transfers - on the day of transfer:<br>▪ Confirm that infant's condition is suitable for the transfer.<br>▪ Confirm that an appropriate level cot is available on the receiving unit. |
| **Steps** | **Action and safety during transfer** |
| 1 | Prior to departure a set of clinical observations will be performed and documented, PNTS transfer documentation may be used. |
| 2 | Contact the receiving unit once transfer has left and give them expected time of arrival. |
| 3 | During the transfer the infant will be continually observed and clinical observations documented every 30 minutes or more frequently according to clinical need |
| 4 | Medical gases, battery life etc. will be constantly monitored. |
| 5 | It is good practice for an escort to carry a mobile phone during the transfer for use in emergencies. |
| 6 | If the baby needs attention which requires escorts to undo their seatbelt during transportation the ambulance must be requested to stop in the most appropriate and safe area. |
| 7 | If staff need to leave the vehicle at all then a High Visibility jacket must be worn. |
| 8 | Lights and sirens should be used with discretion and mainly to expedite the way through busy traffic. Progress should be made with sensible speed. |
| 9 | Avoid direct sunlight on the incubator (it may overheat). |
| 10 | En route between ward and ambulance the incubator may be covered while leaving direct view of infant and monitors (This provides privacy and dignity and prevents incubator from cooling). |
| 11 | All equipment, intravenous lines, drains and tubes must be secured to prevent them from becoming dislodged or disconnected. |
| 12 | Safe manual handling procedures should be used when moving equipment. 2 |

| | |
|---|---|
| | people are required to move the transport incubator/pod. |
| 13 | Equipment manuals for trouble shooting and transfer bags containing emergency items and drugs will be taken with baby. |
| 14 | Any care that is given during the transfer should be clearly documented in the patient's records as soon as practical. This may be on arrival at the receiving area. |
| **Steps** | **Actions on arrival at transfer destination** |
| 1 | The escort team will hand over the baby and documentation to the receiving team. |
| 2 | Once baby has been formally accepted by the receiving unit the transfer team will check they have all their equipment prior to departure |
| 3 | The parents/carers will be informed of baby's safe arrival on receiving unit. |
| **Steps** | **Actions on completion of transfer** |
| 1 | Ensure that all equipment is cleaned and gases replenished before it is returned to storage areas. |
| 2 | Ensure relevant equipment is left charging. |
| 3 | heck and replenish transfer bag as necessary. |
| 4 | Return and replenish medicines. |
| 5 | Dispose of disposable equipment following Trust protocol. |
| 6 | Document any events or problems encountered during the transfer. |
| 7 | Complete incident forms if any untoward events took place. |
| 8 | It is the responsibility of NDDH to ensure that staff and equipment are enabled to return to their base unit. The ambulance may be called out to an emergency during return to SCU. If this occurs ring bleep 500 NDDH and a taxi will be arranged to bring you back. |

## 16. Parent Information

(see appendix 4 for PNTS information and appendix 5 for PNTS Policy for parental travel arrrangements)

For information about the transport teams see websites :-

- http://www.swneonatalnetwork.co.uk/transport-services/transport-information-for-parents/
- http://www.nestteam.org/
- http://www.watch.nhs.uk/

For information about the SW Neonatal Network and individual neonatal units see:-

- http://www.swneonatalnetwork.co.uk/transport-services/transport-information-for-parents/

For information about NDDH SCU see:-

- http://www.northdevonhealth.nhs.uk/barnstaple-special-care-unit/

## 17. Procedure for all internal hospital transfers

| Steps | Procedures for internal hospital transfers |
|---|---|
| 1 | Decision to transfer baby will be made by attending paediatric doctor and following discussion between transferring and receiving department and after gaining informed consent from parents. |
| 2 | Safest route is chosen according to general principles (point 8) e.g. the transfer from CDS to SCU may be through day surgery or the main entrance. |
| 3 | For mode of transfer and choice of escort use Neonatal Transfer Assessment Tool (Appendix 6) according to level of care required for baby and gestational age. |
| 4 | Admission to SCU should be according to admission indications (Appendix 8). |
| 5 | If a member of SCU staff supports transfer he/she may be backfilled by a member of staff from the paediatric ward. |
| 6 | Relevant documentation will be completed by the transferring ward and sent with the baby |
| 7 | There will be handover between departments on condition and plan of care |
| | Parents will accompany baby whenever possible. (Midwives will bring mother to visit baby prior to her transfer from CDS to postnatal ward if her condition allows). |

## 18. Transfer from home to hospital

**18.1.** The infant will come to hospital brought in by parents own transport or ambulance (according to condition) following discussion with midwife, health visitor, GP and liaison with the Paediatric Medical team.

**18.2.** The newborn infant's admission would be organised by the midwife who calls for an ambulance (999/112).

## 19. Transfer from SCU to the mortuary following an infant's death

Please follow guidelines for the death of an infant in SCU.
(http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2013/11/Death-of-a-Neonate-V1.0-11Nov131.pdf)

# 20. Procedure for repatriation to SCU

## Babies may be repatriated into SCU from other neonatal units because:

- The infant, transferred out in-utero, is now delivered and returning home.
- The infant, transferred out for LNU/tertiary/specialist level of care, is now returning to the unit near their home.
- The booking unit is unable to provide appropriate level of care.
- Parents move into the area and the infant is still in need of continuing care.
- Network activity is high so infants are transferred to units with low occupancy to make cot spaces available in tertiary units. (See below for thresholds for repatriation criteria)

## Threshold Criteria for Repatriation/transfer back to SCU

| | **Threshold Criteria for Transfer back to SCU** |
|---|---|
| Corrected gestation | >30/40 (32/40 multiples) |
| Weight | >1000g |
| Ventilation | • Stable enough to be transferred.<br>• No indwelling arterial line and<br>• Off ventilation for 48 hours<br>• On low flow oxygen<br>• Vapotherm / Optiflow /CPAP (will require discussion) |
| Feeding | • Tolerating full feeds (150mls/kg) for 48 hours, stable on current feed regime<br>• Do not accept if risk of feed intolerance<br>• NG/OG acceptable<br>• No TPN |
| Exceptions / wider consideration | |
| 1. Infants under the care of surgical or cardiology teams will be reviewed on a case by case basis | |
| 2. Infants with confirmed diagnoses with infection control implications may require a cubicle at base unit. Where colonisation status with regard to pathogenic organism isunknown, a cubicle is not essential. | |
| 3. Once a baby fulfils step down criteria it is the responsibility of the receiving unit to find an appropriate cot space as soon as possible and facilitate repatriation to avoid tertiary cot blocking. This may include needing to arrange additional staffing, or arranging discharge or transfer of other babies. | |

**20.1.** Discussions should include the PNTS co-ordinating consultant. Contact the PNTS as soon as such a move is identified as being required.

**20.2.** Any such transfer must have been discussed and sanctioned by the responsible consultants in the referring unit and NDDH Barnstaple. Discussions should include the PNTS co-ordinator if moving between units other than Plymouth.

**20.3.** SCU must have sufficient capacity to accept the transfer without compromise to the current in-patient population or make plans to accommodate infant safely.

**20.4.** All babies repatriated from another unit will be swabbed for MRSA culture and barrier nursed until confirmed negative. (see Trust infection control policy http://www.northdevonhealth.nhs.uk/2014/08/standard-infection-control-precautions-policy/)

They should be managed:-

- In a cubicle, if available
- Colonised babies should be nursed in an incubator (if clinically indicated)
- In a cot on the open ward with augmented infection control practices to prevent cross-transfer of multi-resistant alert organisms

## 21. Standards / Key Performance Indicators

Key Performance indicators on which to base care in the Special Care Unit are:

- Nice Neonatal Quality Standards
- NHS England's service specification for Neonatal Intensive Care Transport
- NHS Toolkit for High Quality Neonatal Services
- National Neonatal Audit Programme
- NHS Standard Contract for Neonatal Critical Care

## 22. Monitoring Compliance and Effectiveness

- Staff are informed of new documentation. There is an expectation that staff are responsible to keep updated on any revisions/improvements to practice and deliver care accordingly.
- All babies admitted will be entered onto the BADGER system. This is the national reporting system for all neonatal units. Reports from this system will be reviewed annually for lessons learned.
- All requested transfers, accepted or declined, are recorded by the Peninsula Neonatal Transfer Service and both the referring and receiving areas.
- Incidents concerning transfers are discussed in SCU governance meetings and reported and monitored via DATIX.
- Incidents concerning external transfers and repatriation are reported to the Southwest Neonatal Network. In addition exception reporting occurs when units care for babies that are out of their designation criteria due to lack of availability of transfer services.
- Learning/actions from all incidents are discussed locally in ward meetings, SCU Governance and Paediatric Team meetings and externally by the Neonatal Roadshow, SW Neonatal Network Transport Team working group and reported to Network board.

# 23. References


- BAPM (2008). [on-line]. The Management of Babies born Extremely Preterm at less than 26 weeks of gestation: A Framework for Practice at Time of Birth. (Accessed 20/11/11) http://www.bapm.org/media/documents/publications/Approved%20manuscript%20preterm%20final.pdf
- BAPM (2008). [on-line]. Management of Acute In-Utero Transfers: A Framework for Practice. http://www.bapm.org/media/documents/publications/IUTs%20Jun08%20final.pdf
- BAPM (2010). [on-line]. Service standards for hospitals providing neonatal care. 3rd edition. (Accessed 20/11/11). http://www.neonatal.org.uk/documents/4819.pdf
- BLISS (2016). Transfer of premature and sick babies. http://www.bliss.org.uk/News/transport-services-for-uks-sickest-babies-severely-under-resourced
- Clinical Resource Efficiency Resource Team (CREST). (2006). Protocol for the Inter Hospital Transfer of Patients and Their Records.
- Department of Health (2009). [on-line].Toolkit for high quality neonatal services. (Accessed 20/11/11). http://www.neonatal.org.uk/documents/4650.pdf
- Loersch. F, Schindler. M, Starr. K, Moore. J, and Lynam Bayne. L. (2011). Risk factors for intra-hospital transport of newborn patients: A new solution to an old problem. Journal of Neonatal Nursing. 17 (6) p203-214.
- NHS England (2013) Neonatal Intensive Care Transport
- NHS Service Specification for Neonatal Critical Care E08/S/a (2014/15)
- Nice (2010) Nice Neonatal Transfer Services Quality Statement [on-line] accessed 18/11/11 http://www.nice.org.uk/guidance/qualitystandards/specialistneonatalcare/neonataltransferservices.jsp
- Peninsula Neonatal Network (2011) Peninsula Neonatal Transfer Service guidelines for In-utero and Ex-utero Referral Guidance.
- Moss. S, Embleton. N, and Fenton. A. (2005). Towards safer neonatal transfer: the importance of critical incident review. Arch Dis Child 90. p729-732


# 24. Associated Documentation

- Admission of a baby to SCU Guidelines
- Communication, Escalation and Transfer Protocol for SW Neonatal Units during infection status of a NICU.
- Death of a Baby in SCU
- Escalation to SCU ward closure SOP
- Guideline for Repatriation Thresholds for Babies in SW Neonatal Units (draft Network guideline
- Infection Prevention and Control Operational Policy
- Neonatal and Paediatric Ward Operational Policy

- Patient Identification Policy
- Patient Isolation and Staff Exclusion Policy
- Peninsula Neonatal Transfer Service guideline
- 'Transfer of Patients' policy
- Standard Infections Control Precautions Policy

## Appendix 1 - South West Neonatal Network Unit levels of care

**24.2.** The tables below outline the current agreed recommendations on elective transfer of babies between neonatal units in the Peninsula. It covers the stratification by gestational age of babies moved in- and ex- utero. Babies requiring surgical, cardiac or other specialist care not available within the network units are subject to different arrangements independent of maturity.

| EX-UTERO TRANSFERS | |
|---|---|
| Treliske | Babies under 27 weeks (26 weeks 6 days) to be transferred to the Network NICU – Derriford |
| RD&E | Babies under 27 weeks (26 weeks 6 days) to be transferred to the Network NICU – Derriford |
| Torbay | Singleton under 30 weeks (29 weeks 6 days) and Twins under 32 weeks (31 weeks 6 days) to be transferred to either a Local Neonatal Unit - Exeter or Treliske or the Network NICU – Derriford |
| North Devon | Singleton under 30 weeks (29 weeks 6 days) and Twins under 32 weeks (31 weeks 6 days) to be transferred to either a Local Neonatal Unit - Exeter or Treliske or the Network NICU – Derriford |

| IN-UTERO TRANSFERS | |
|---|---|
| Treliske | All mothers at risk of delivering before 27 weeks (26 weeks 6 days) to be transferred to Network NICU – Derriford |
| RD&E | All mothers at risk of delivering before 27 weeks (26 weeks 6 days) to be transferred to Network NICU – Derriford |
| Torbay | All mothers at risk of delivering singleton babies before 30 weeks (29 weeks 6 days) and twins under 32 weeks (31 weeks 6 days) to be transferred to either a Local Neonatal Unit - Exeter or Treliske or the Network NICU – Derriford |
| North Devon | All mothers at risk of delivering singleton babies before 30 weeks (29 weeks 6 days) and twins under 32 weeks (31 weeks 6 days) to be transferred to either a Local Neonatal Unit - Exeter or Treliske or the Network NICU – Derriford |

**24.3.** All in-utero and ex-utero data should be sent on the current PEPT form to Derriford who will collate and disseminate for the Peninsula.

## Appendix 2 - Contact phone numbers

| | | |
|---|---|---|
| **PNTS Co-ordinator** | **01792 432346 direct line** | **01752 432333/0845 1558138 NICU** |

| | | |
|---|---|---|
| **NEST Co-ordinator** | **0117 342 5050 direct line** | **0117 342 5252** |

| | | |
|---|---|---|
| **WATch** | **0300 0300 789** | |

| **Hospitals** | **Neonatal Unit** | **Delivery suite** |
|---|---|---|
| **SW Neonatal Network** | | |
| Derriford | **01752 432333** | 01752 763611 |
| Exeter | 01392 406623 ext 6621 | 01392 406651 |
| Truro | 01872 252667 | 01872 252361 |
| Barnstaple | 01271 322610 | 01271 322605 |
| Torbay | 01803 654605 | 01803 654631 |
| Bristol (SMH) | 0117 342 5252 ext 5275 | 0117 342 7869 |
| Bristol (Southmead) | 0117 3235312 | 0117 3235320 |
| Bristol Children's | | 0117 342 5213 |
| 0117 3428332 ward 32 | | |
| | | |
| Bath | 01225 824833 | 01225 824847 |
| Taunton | 01823 342575 | 01823 342059 |
| Gloucester | 0300 422 5529 | 0300 422 2324 |
| Swindon | 01793 605174 | 01793 604575 |
| Yeovil | 01935 384539 | 01935 384530 |
| **South Central** | | |
| Southampton (Princess Anne) | 023 8120 6001 | 023 8103 6002 |
| Portsmouth | 02392 283232 | 023 9228 6000 ext 4500/4547 |
| Oxford (John Radcliffe) | 01865 223205 | 01865 221987 |
| Dorchester | 01305 254234 | 01305 254267 |
| Poole | 01202 442330 | 01202 442319 |
| Salisbury | 01722 425180 | 01722 425183 |
| **Other Units** | | |
| Cardiff (University) | 029 2074 7747 x 2684/2680 | 029 2074 2686/42679 |
| Royal Gwent Newport | 01633 234599/234600 | 01633 234948 |
| Merthyr Tydfil | | 01685 721721 switch |
| GOS | | 020 7405 9200 switch |
| Kings | | 020 3299 9000 switch |
| Birmingham (Women's) | 0121 627 2686 | 0121 472 1377 Ext 4085 |
| Leicester (ECMO) | | 0300 303 1573 switch |

## Appendix 3 - PNTS referral form

### Peninsula Neonatal Transport Service

Referral log / Booking form

(tel: 01752 432346, mobile 07788 416248, fax 01752 517965)

| **Referral details:** | |
|---|---|
| Date: | Referring hospital: |
| **Start time of referring phone call**: | Referring name: |
| Call taken by: | Contact number: |
| Location of patient (ward) | In utero ☐ ex utero ☐ |

| **Patient details:** | | |
|---|---|---|
| Name: (Mother's if in utero) | | Sex |
| D.O.B.: | Gestation: /40 | Current age: |
| Birth weight: | Current weight: | |
| Booking Unit: | | |

**Clinical information**: (continue overleaf if required)

☐ Gastroschisis ☐ Ventilated TOF ☐ Intestinal Perf ☐ Suspected Cardiac Lesion **not** responding to prostin

☐ Bilious Vomit ☐ Unstable respiratory or cardiac failure (refer to additional info – referral log folder)

**These moves are deemed TIME CRITICAL- please initiate team ASAP please.**

Reason for transfer

History and management:

| **Apgars:** | 1 min | 5 mins | 10 mins | |
|---|---|---|---|---|
| **Cord gases:** Arterial: | | Venous: | | Vit K given yes ☐ no ☐ |

**Respiratory support:** intubated: **yes** ☐ **no** ☐ **ETT size**: length: oral: ☐ nasal: ☐

SIMV ☐ TTV ☐ CMV ☐ PTV ☐ HFOV ☐ CPAP ☐ BiPAP ☐ Other:

| | | | | | | |
|---|---|---|---|---|---|---|
| Ventilator settings: | PIP | | Rate | | MAP | |
| | PEEP | | FiO2 | % | ∆ P | |
| | Ti | | SaO2 | % | | |
| | VG/TTV | ml/kg | | | | |
| Nitric oxide: yes ☐ no ☐ if yes, _____ppm. Date/time started: | | | | | | |

| **Clinical observations:** | | | | | |
|---|---|---|---|---|---|
| Heart rate: | /bpm | Temperature: | °C | Respiratory rate: | /bpm |
| BP (mean): | mmHg | Urine output: | ml/kg/hr | CRT | |
| | | | | | |
| Seizures yes ☐ no ☐ | | Cooling yes ☐ no ☐ date/time started: | | | |
| **Vascular access:** peripheral cannula x ☐ UAC ☐ UVC ☐ Long line ☐ Peripheral art line ☐ | | | | | |
| **Other tubes:** NGT: ☐ OGT: ☐ Urinary catheter : ☐ Chest drain: ☐ | | | | | |

| **Infusions and drugs:** | | | |
|---|---|---|---|
| 10% Dextrose | ml/kg/day | ml/hr | Dextrose additives |
| Morphine | mg/kg/hr | ml/hr | other drug |
| Dopamine | mcg/kg/min | ml/hr | other drug |
| Dobutamine | mcg/kg/min | ml/hr | other drug |

| **Blood gas** | | | | | **Blood results:** | | | |
|---|---|---|---|---|---|---|---|---|
| Date | | | | | Date | | | |
| Time | | | | | Time | | | |
| Art/cap/ven | | | | | $Na^+$ | | Hb | |
| pH | | | | | $K^+$ | | WCC | |
| $pCO_2$ | | | | | Urea | | Plt | |
| $pO_2$ | | | | | Creatinine | | Hct | |
| $HCO_3$ | | | | | $Ca^+$ | | Blood group | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| BE | | | | | SBR | | DCT | |
| Glucose | | | | | Blood culture | | | |
| Lactate | | | | | CRP | | | |

**Priority:** Time critical: ☐ Early urgent: ☐ Early non urgent: ☐ Planned: ☐

| | |
|---|---|
| Destination: | Accepting Consultant: |
| Contact Details | |
| **Ambulance ordered @ what time**: | |

Other information / advice given:

**(Please document start time of each phone call to avoid omission of essential data – thank you)**

For all communications please record name, date, time and sign entry

## Appendix 4 - PNTS Parent Information

**Frequently Asked Questions:**

**Where will my baby be moved?**

Some babies need more care than local units can provide and need to move to another unit in the Peninsula. Some specialist care and therapies (such as surgery) are only available elsewhere. If so, then transfer is arranged to hospitals such as Bristol, Southampton or London who are able to offer the best care for your baby. Usually the Peninsula Transport Team will take the baby but sometimes, another team will help.

**What are 'back transfers' or 'repatriations'?** Ideally babies are cared for close to their parents' home. If transferred elsewhere, then every effort will be made to get the baby back to your home hospital as soon as he/she is well enough and a cot is available. Once your baby is transferred back, the staff in the home unit will work with you and your baby to get ready for going home when the time is right.

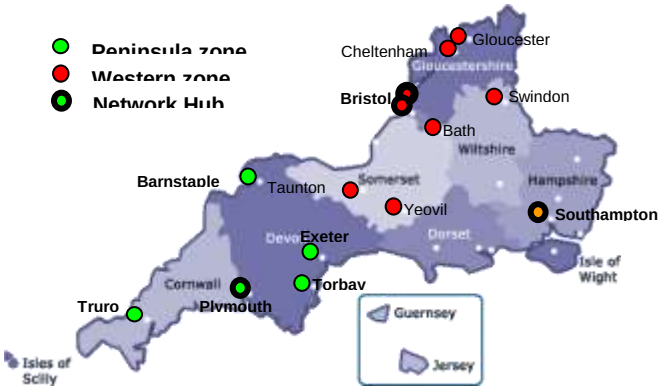
**I booked my obstetric care at my local unit but my baby is being transferred elsewhere - why is this?**

Some babies need more complex care than the home unit can provide. Plans are then made for transfer to the nearest unit able to provide the right care—sometimes before birth. Transfer may take place because he/she (a) has been born very early or is sick and needs more help or (b) cannot safely be looked after locally because the unit (as occasionally happens) is too full. Moves are only made if really necessary. You can have confidence that your local team is ensuring the best care for you and your baby.

**Who will accompany my baby when he/she is taken back to my local hospital?**

A doctor and nurse will accompany your baby in the ambulance if a lot of breathing support is required. If your baby is stable and does not need such support, your baby may be accompanied by the transport nurse alone.

**South West Neonatal Services**




www.swneonatalnetwork.co.uk

Plymouth Hospitals NHS
NHS Trust

Neonatal Intensive Care Unit

Level 05

Derriford Hospital

Plymouth

PL6 8DH

Tel: 01752 432333

Fax 01752 517965

**South West Specialised Commissioning Group**

# South West Neonatal Network

## Peninsula Neonatal Transport Service

**Information Leaflet for Parents**

Director of Service

Dr. John Madar

Transport Co-ordinator

Sister Helen Darby

Tel: 01752 432346

Mob: 07788416248

07795591178

**Background Information**

The SW Neonatal Network provides care for babies born in SW region including Devon & Cornwall, (the Peninsula). Babies occasionally need to move to a unit other than where they were born for specialist care, not provided in the home unit. This may be to another unit in the Peninsula or one further away such as Bristol or Southampton for surgery or cardiac care.

The Peninsula Neonatal Transport Service (PNTS) is the service which moves babies between hospitals when this is required. It has provided support for emergency and pre-planned moves of babies since 2005 and undertakes around 350 moves a year.

The PNTS is based on the neonatal unit at Derriford Hospital, which is the designated centre for intensive care for the sickest and most vulnerable babies in the Peninsula. The service works closely with the nursing and medical staff in the other units in the Peninsula (Barnstaple, Exeter, Torbay and Truro) to ensure the safe transfer of any baby that needs to be moved to the unit best able to provide the care required.

**Who are we?**

We are a team of specialist senior nurses and doctors with specific training and experience of moving babies. We work together with our ambulance colleagues to make sure moves run smoothly and provide the best care for your baby.

**How do we do it?**

The transport team use equipment that is essentially the same as that used on the neonatal unit except that it has been specially designed for transport and can provide for all the needs of your baby on the move.

The equipment can fit into ambulances and even aircraft which have been specially modified.

We aim to provide a service whenever it is needed – sometimes this is a challenge, but if a baby needs to move, then the service undertake to do the move, or make alternative arrangements.

**Frequently Asked Questions:**

**Why is my baby moving?** The doctors and nurses looking after your baby feel this is the best way to provide the care needed. Your baby may require specialist treatment not available locally, or because local facilities are so busy there is no room; or possibly because having had treatment, they are returning nearer home.

**What is an 'emergency transfer'?**

These are moves not planned in advance where an unwell baby needs to be transferred from one hospital to another for specialist care. The transport team travel by ambulance to the baby. The aim is to get to where the baby is as soon as possible and ensure the baby is in the best condition before moving to the specialist unit.

**Will my baby be safe during the transfer?**
Babies are only moved when the team are satisfied that they are well enough for the journey. The emphasis is on safety and stability. On arrival the transport team will ensure staff in the receiving hospital have all of the information needed to take over care.

**Will I be transferred to be with my baby?**
Ideally mother and baby should be in the same place. Every effort is made to ensure this. Delays can occur. Mothers who have just delivered will be transferred to be with their baby as soon as they are well enough and a bed is available.

**Can I travel with my baby in the ambulance?**
Where possible we encourage parents to travel with their baby but it is not always possible to do so. The transfer teams are in a position to make a judgment based on many factors including whether there is room in the ambulance, the clinical condition of the baby, support staff available, distance and facilities at the other end.

## Appendix 5 - PNTS policy on parental travel arrangements for ex utero transfers

**PNTS policy on parental travel arrangements for ex-utero transfers.**

- Parents should be offered the opportunity to see their baby prior to transfer.
- Where possible parents should be given the opportunity to accompany their baby.
- Where this is not possible alternative travel arrangements for parents should be made.
- The PNTS team are the arbiters of whether parents can travel with their baby. Where the decision not to permit parents to travel in the ambulance is made, the reason for this decision must be documented and parents made aware of the rationale for any decision.
- In most circumstances one parent is able to accompany the child. Parents and relatives told **not** to follow ambulance.
- Situations where it may not be felt appropriate include:
    - Inadequate room within ambulance for safe travel.
    - Inability to provide support to parent and baby given condition of baby and/or staff available on journey.
    - Condition of parent (e.g. mother post-delivery).

- It is the responsibility of the local obstetric team to liaise with the obstetric department in the receiving hospital to arrange a bed and transfer the mother if she is still an in-patient on the post natal ward. Where this is not possible the midwives may arrange transfer of mother and admission to post natal ward alongside neonatal unit.
- If parents are travelling themselves they should be given a route map to the hospital and told not to follow the ambulance.
- Parents in receipt of certain benefits should be advised that transport payments to travel to another unit may be re-claimed. They should apply for information from NDDH office about this.

## Appendix 6 - Neonatal Transfer Risk Assessment Tool

### Neonatal Transfer Risk Assessment Tool

**Prior to start of transfer clinicians decide the route according to general principles for transfer (point 8) .**

| *Patient* | Minimum Personnel | Equipment | Monitoring |
|---|---|---|---|
| **NC** | • Parent or guardian<br>• RN/Nursery nurse / health care assistant/midwifery care assistant, Nursing student / midwife<br>• Porter / any other for help with moving mother's bed/wheelchair | **Internal Transfer**<br>• Pram, Parents pram<br>• Baby's cot<br>• Transport pod/resuscitaire or giraffe incubator with docking station<br>• With mother on bed or in wheelchair<br>**External Transfer:**<br>• Parents own transport<br>• Hospital/Ambulance / car | None |
| **SC** | • RN Childrens / Neonatal Nurse >37 weeks gestation<br>• Neonatal Nurse <37 weeks gestation<br>• Porter / any other for help with moving transport of incubator | **Internal Transfer:**<br>• Pram, parents pram,<br>• Baby's cot<br>• Transport pod<br>• Transport incubator/resuscitaire or giraffe incubator with docking station<br>**External Transfer :**<br>• Transport pod<br>• Transport incubator<br>• Neonatal transfer bags<br>• Suction<br>• Syringe drivers<br>• Oxygen cylinder with adequate O2 as per calculation | **Internal Transfer:**<br>• O2 saturation<br>• Document observations on observation chart pre-transfer and on arrival at destination/return<br>**External Transfer:**<br>• O2 Sats or Welch Allyn monitor<br>• Continuous skin temp<br>• Document regular observations on PNTS obs chart |
| **HD** | • Neonatal nurse QIS (or competent in transfers) for all transfers with Medical staff see below<br>• Doctor may be required for escort. Decision to be made by senior nurse and Paediatric consultant<br>• Porter / any other for help with moving transport of incubator | **Internal and External Transfers:**<br>• Transport pod with baby pac and gases<br>• Transport incubator<br>• Resuscitaire or giraffe incubator with docking station (internal only)<br>• Neonatal transfer bags<br>• Emergency drugs<br>• Suction<br>• Syringe drivers<br>• Oxygen cylinder with adequate O2 as per calculation<br>• Air cylinder with adequate air as per calculation if in use<br>• Mobile phone, (external only) | **Internal Transfer:**<br>• O2 sats/Welch Allyn monitor<br>• Continuous skin temp<br>• Document observations on observation chart pre-transfer and on arrival at destination/return<br>**External Transfer:**<br>• O2 sats/Welch Allyn monitor<br>• Continuous skin temp<br>• Document regular observations on PNTS obs chart |
| **IC** | • Internal and External Transfers<br>• Neonatal nurse (QIS)<br>• Doctor will be required for escort, Decision to be made by senior nurse and Paediatric consultant. May be ST3 and above or Paediatric Consultant<br>• Porter / any other for help with moving transport of incubator | • As above for HD Equipment | • As above for HD monitoring |

Note – During transfer adequate equipment should be taken to manage potential infant deterioration or delay, e.g. lift breakdown.

(Adapted from Transferring children to and from theatre...*RCN position statement and guidance for good practice July 2011)*

## Appendix 7 - Criteria for modes of transport

### Criteria for use of Transport Incubator

- Consider if < 1500grams and, or <32 week
- Intubated baby needing ventilation
- Babies requiring CPAP
- Babies requiring oxygen
- Sick unstable baby of any gestation
- When deemed necessary by attending staff

It may also be appropriate for these babies to be transported on the resuscitaire (see below)

### Criteria for use of Baby Pod

- Should be used where possible in place of transport incubator
- It may be heated by use of gel mattress
- The baby pod can take babies up to 7 kg. It should be used with consideration to the baby at risk of hypothermia
- May be used with Babypac ventilator to give ambient oxygen, CPAP or ventilate the infant

### Criteria for use of Resuscitaire

- Resuscitaire should only be used for transfer when attached to the docking station for power.
- Gas levels should be checked and replace if required
- Babies with low birth weight or gestation should be transferred in a plastic bag with heater on. (Consider use of transport incubator)
- Babies suspected to develop HIE should be transferred on resuscitaire, loosely covered with the heater switched OFF
- The attending physician may decide it to be appropriate for a baby to be transferred on the resuscitaire with continued heating (internal transfers only).
- Resuscitaire may be used with Babypac Ventilator to give CPAP or ventilate the infant
- Babies may be transferred in giraffe incubator with docking station. Thus they can be transferred in an open or closed incubator.

Note- Check all equipment prior to start of transfer. Equipment should be in working order, batteries should be charged and there should be more than adequate gases for the journey

## Appendix 8 - Indications for Admission to SCU from Delivery/Postnatal Ward

- Birth weight <1800g or gestational age <35weeks
- Requiring oxygen
- Signs of RDS (including grunting, recessions and tachypnoea)
- Signs of infection with symptoms
- Congenital abnormalities requiring assessment and or transportation for surgery. (Simple anomaly such as cleft lip is not a reason to admit)
- HIE
- needing intensive resuscitation
- Apgar scores<6 at 5 minutes
- Meconium aspiration syndrome
- Hypoglycaemia requiring dextrose infusion or baby symptomatic.
- Babies from diabetic mothers exhibiting complications
- Severe jaundice/ haemolytic disease
- Convulsions
- Apnoeas
- Hyperthermia / hypothermia
- Unsupervised home delivery requiring assessment and observation
- Feeding difficulties (with clinical concern i.e.dehydration)
- Signs of drug withdrawal/substance abuse requiring pharmacological therapy. (Usually following a period on the postnatal ward)