THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Repatriation from NICU/LNU to SCU for TV & Wessex Network Neonates Framework to support clinical decision making

This guidance is aimed at supporting decision making for repatriation of neonates from NICU/LNU to the local SCU within the Network. There is clear guidance and specifications on levels of care that can be provided in different levels of units ie: NICU, LNU & SCU and recommendations and care pathways indicating where babies should receive intensive care , high dependency and special care . (Neonatal Service Specification 2013/2014)

There is no clear guidance or recommendation on repatriation to local SCUs for on-going care when NICU/ LNU care is no longer required. It is important to ensure that babies and their families receive the highest quality of care as close to home as possible (Toolkit High Quality Neonatal Services DOH 2009).

The decision to repatriate for local care can be complex and can depend on a number of different factors and should only be considered when appropriate medical care is available at the local unit, the baby's condition is stable, the regular input of tertiary specialist advice is no longer required and safe transport can be undertaken. It should be agreed by the clinical team responsible for the care of the baby in the NICU/LNU in conjunction with the family. The timing of repatriation to the local SCU should be regularly considered and reviewed. The local SCU clinical team should be updated on the infant's progress.

There may be specific situations that will influence a decision to transfer a baby no longer needing intensive care e.g. practical difficulties of parents accessing their local SCU, presence of close family relatives near to the NICU/LNU. Equally there may be occasions when the transfer of a baby still requiring ongoing high dependency support is appropriate ie-: when the pathway of care is towards palliative care.

Related documents

The TV & Wessex Neonatal Network Transfer Policy provides guidance on transfer of neonates to NICU and LNU: https://southodns.nhs.uk/projects/?nid=49&sub=2

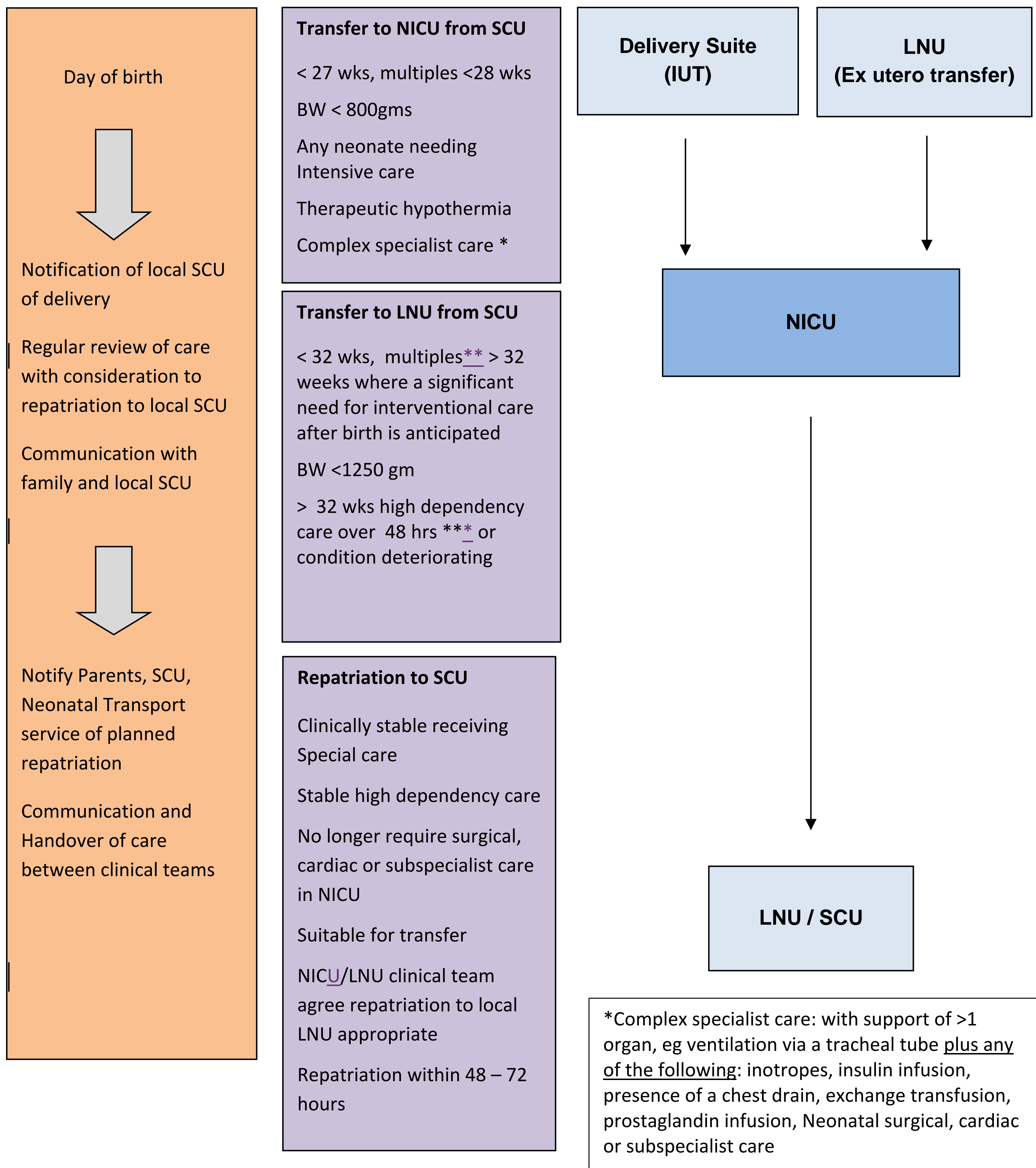
Appendix 1: Framework for repatriation from NICU/LNU to SCU

Appendix 2: BAPM Categories of Care August 2011

References

1. BAPM Categories of Care August 2011
2. BAPM Service Standards for Hospitals providing Neonatal Care (3rd edition) 2010
3. Neonatal Service Specification: Neonatal Critical Care 2013/2014 NHS England
4. Toolkit for High Quality Neonatal Services DOH 2009

Appendix 2: Framework for Repatriation from NICU/LNU to SCU



**** Multiples < 34 weeks for agreed SCU   *** Discussion with NICU /SONeT Consultant**

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Transfer back to local SCU

1. The local SCU should be notified of the admission of a local baby to NICU/LNU for care following delivery.

2. Parents should be made aware that their baby would be transferred back to their local SCU for on-going care when it is appropriate for their baby.

3. Parents should be offered the opportunity to visit the local SCU during their babies stay in NICU/LNU prior to repatriation.

4. The Nurse Coordinator from the NICU/LNU should communicate each week with the Nurse in charge in the local SCU's to update on the clinical condition, and where appropriate, provide an anticipated or estimate of expected length of stay in NICU/LNU. It may not always be possible to anticipate the duration of the expected NICU/LNU stay.

5. When a baby is no longer requiring high dependency care or surgical, cardiac and subspecialist care in a NICU/LNU it may be considered for repatriation to the local SCU. The baby may be stable receiving high dependency or special and be suitable for transfer.

6. It is an NICU/LNU Consultant decision that a baby is fit for transfer and repatriation to its local SCU.

7. The Nurse Coordinator will contact the local SCU to arrange repatriation and ensure that a cot in the SCU is available. Once agreed the NICU/LNU should contact the Neonatal Transfer Service SONeT to arrange the repatriation to the local SCU.

8. The NICU/LNU medical team should contact the SCU medical team to communicate the clinical details of the baby prior to transfer. All babies should have a completed neonatal discharge summary on Badgernet, with printed copy outlining the care episode, current and on-going clinical issues. The baby should be recorded as transferred on Badgernet discharge.

9. In situations where a baby would have been expected to be suitable to repatriate to their local SCU, it is expected that the NICU/LNU clinicians would contact the SCU clinicians and update on the clinical condition of the baby.

Neonatal Critical Care HRGs 2016

HRG XA01Z Data Item

Any day where a baby receives any form of mechanical respiratory support via a tracheal tube

BOTH non-invasive respiratory support(e.g. nasal CPAP, SIPAP, BIPAP, duoPAP, HHHFT) **AND** Parenteral Nutrition (amino acids +/- lipids)

Day of surgery (including laser therapy for ROP, but excluding intraocular injections eg. Bevacizumab)

Day of Death

Any day with Umbilical Venous Catheter Present

Any day with Umbilical Arterial Catheter or Peripheral Arterial Catheter Present

Any day with a chest drain in situ

Any day on which Insulin infusion is given

Any day on which Prostaglandin infusion is given

Any day on which inotrope or vasodilator (including pulmonary vasodilator) is given

Day on which exchange transfusion occurs (includes dilutional exchange)

Any day on which Therapeutic Hypothermia is given (hypothermia treatment given during the initial assessment period should not be counted if ongoing cooling is not required)

Any day on which a replogle tube is present

Any day on which an epidural catheter if present

Any day on which an abdominal silo is present (for anterior abdominal wall defects)

Presence of External Ventricular drain or intraventricular catheter

Dialysis (any type)

HRG XA02Z

Does not fulfill criteria for XA01Z where one of the following applies: **Data Item**

Any day where a baby receives any form of non-invasive respiratory support (e.g. nasal CPAP, SIPAP, BIPAP, HHHFT)

Any day a baby receives Parenteral Nutrition (amino acids +/- lipids)

Any day a baby receives an infusion of blood products (red cells, fresh frozen plasma, platelets, cryoprecipitate, intravenous immunoglobulin). It does not include infusion of albumin

Any day on which a central venous or long line (PICC) is present

Any day on which a tracheostomy is present

Any day with a trans-anastomotic (TAT) tube present following oesophageal atresia repair

Any day with NP airway/nasal stent present

Confirmed Clinical Seizure(s) today and/or continuous CFM recording

Ventricular tap (including via reservoir)

HRG XA03Z/HRG XA04Z

Does not fulfil the criteria for XA01Z/XA02Z and requires any of the following: **Data Item**

Presence of an indwelling urethral or suprapubic catheter

Oxygen by low flow nasal cannula

Feeding by orogastric, nasogastric, jejunal tube or gastrostomy*

Care of a Stoma

Intravenous medication not otherwise specified elsewhere**

Receiving Intravenous Sugar +/- electrolyte solutions

Receiving drug treatment for neonatal abstinence AND on an observations scoring regimen 4 hourly or more frequently

Birth weight ≤2kg for first 48 hours after birth

Gestation at birth 35 weeks for first 48 hours after birth

Gestation at birth 34 weeks for first 7 days (168 hours) after birth

Gestation at birth <34 weeks until discharge from hospital

HRG XA05Z

Does not fulfil the criteria for XA01Z/XA02Z/XA03Z/XA04Z and requires any of the following: **Data Item**

Any baby receiving care in a neonatal facility (neonatal unit or transitional care ward) who does not fulfill the criteria for HRG codes XA01Z-XA04Z

Babies receiving phototherapy

Normal Maternity Care

These babies should generally not receive neonatal payments unless they fulfil additional criteria as specified above: Gestational age at birth ≥36+0 weeks AND birth weight > 2kg

Birth weight <2kg AND/OR gestational age 35 weeks, after first 48 hours of life

Babies Gestational Age 34 weeks, after first 7 days (168 hours) of life

Any baby who has been discharged home who requires readmission in the first 14 days of life for any of the care activities considered to be part of normal care (see below)

The following care activities for babies described in the above 3 sections are considered to be part of normal care:

- PROM/GBS observations (12 hrs)
- Meconium observations (12 hrs)
- Thermoregulatory management
- Babies of diabetic mothers who are well and following a Management & Prevention of Hypoglycaemia policy
- Supporting establishment of infant feeding
- Investigation and support for infants with congenital abnormalities who do not otherwise fulfill criteria for higher category of care
- Support for babies with social care needs