CLINICAL GUIDELINE	
Handover and Transition to the Neonatal Unit	
Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

The Child and Adolescent Health Service (CAHS) commits to being a child safe organisation by meeting the National Child Safe Principles and National Child Safe Standards. This is a commitment to a strong culture supported by robust policies and procedures to ensure the safety and wellbeing of children at CAHS.

This document should be read in conjunction with this DISCLAIMER and Neonatology Clinical Handover and Admission Documents

Aim

This clinical guideline describes the pathway for the transition and handover of neonates being admitted to all areas of the neonatal unit.

Principles / Key Points

- Preparedness

The admitting team needs to prepare the bed space in anticipation of the neonate's arrival. The specifics of this will depend of the individual patient requirements.

- Communication

Communication prior to arrival, between the resuscitation/transport team and admitting team, is essential.

- Leadership

The admission process needs to be coordinated and should be led by the most senior person present (or their delegate). The team leader needs to prioritise the admission steps.

- Handover

There needs to be a single formal handover to which all the necessary staff pay due attention. Follow the ISOBAR approach; Stop, Look and Listen. The timing of this handover is at the discretion of the team leader. It should occur once the priorities of stabilisation have been established and all key staff members are able to pay attention. At this point in time identification of the neonate is checked against maternal labels. The physical transfer of the neonate and the formal handover may occur at any stage deemed appropriate by the lead.

- Parents

Parents should be offered the option to accompany their newborn and the team to the admission area.

Process

Steps	Additional Information
Delegation of the Team Leader. The team leader then coordinates the progression of the admission.	• Determine level of respiratory support, vascular access, initial investigations and treatment. • Determine the timing of physical transfer of the baby to the admission bed • The single formal handover may occur at any stage deemed appropriate by the lead. Adopt a stop, listen, and look approach and use the ISOBAR method, inclusive of Obstetric background history of pregnancy and labour (midwife) or after birth resuscitation (birthing/transport team). • Identification of baby with maternal identification x2 labels • NETSWA retrieval handover • ED handover: ISOBAR
Secure airway and continuous respiratory support with mask IPPV, CPAP or ETT ventilation during transfer and early admission process.	• Maintain a secure airway on arrival in the NICU or SCN whilst assessed by team lead. • One member of team to support and observe continual airway during transfer to the admission bed. ETT and CPAP not disconnected for transfer • Assessment of respiratory status and management plan considered [i.e. CPAP or Ventilator]
Appropriate and continuous monitoring	• Monitoring with SPO_2 should be continuous throughout the transfer and admission phase. • Monitoring with ECG leads if used at birth/or on retrieval to remain in situ during the transfer
Thermoregulation Considerations	• Consider plugging in resuscitaire to maintain heater output during handover if transfer to admission bed is delayed, Likewise, NETSWA cot to be plugged in on arrival of retrieval area. • Neohelp™ and blankets to be left covering the neonate when transferred to admission bed with plastic coverings to remain insitu during the admission process • Attach temperature probe on abdomen in an exposed area with Sil-Flex fixation tape underneath to prevent

Steps	Additional Information
	lifting. • Switch the admission manual mode to baby servo control (ISC) and observe skin temperature is closely correlating with per axilla temperature • Check per axilla temperature reading and confirm close correlation with skin temperature probe, noting <0.5C difference is acceptable. • Consider the use of additional humidification if exposed during procedures according to thermoregulation policy
Venous access, blood gas analysis, fluids	• Venous /arterial access, early blood gas analysis, cultures and CRP as ordered by Team Leader • Fluids/nutrition according to gestational age and birthweight of baby
Measurements - Weight - NIBP - Head Circumference - Length	• Weight measurement, in order to calculate fluids and antibiotics, at a time deemed appropriate by the TL • Take weight measurement with continuous monitoring (CPAP prongs/hats, SPO_2, ECG leads then deduct weight of these post weigh as will vary for each admission NICU or SCN) [see Appendix 1] • NIBP may be attended at any time but not to delay procedures such as intubation/ventilation administration of surfactant or necessary venous access/blood gas analysis to assess respiratory status. • HC and Length when neonate considered stable and normothermic

Related CAHS internal policies, procedures and guidelines
CAHS Communicating for Safety Neonatology Cardiac: Post-Operative Handover Clinical Handover Identification of the Infant NETS WA: Communication Guidelines Post-Operative Handover

References and related external legislation, policies, and guidelines
WA Health Clinical Handover Guideline

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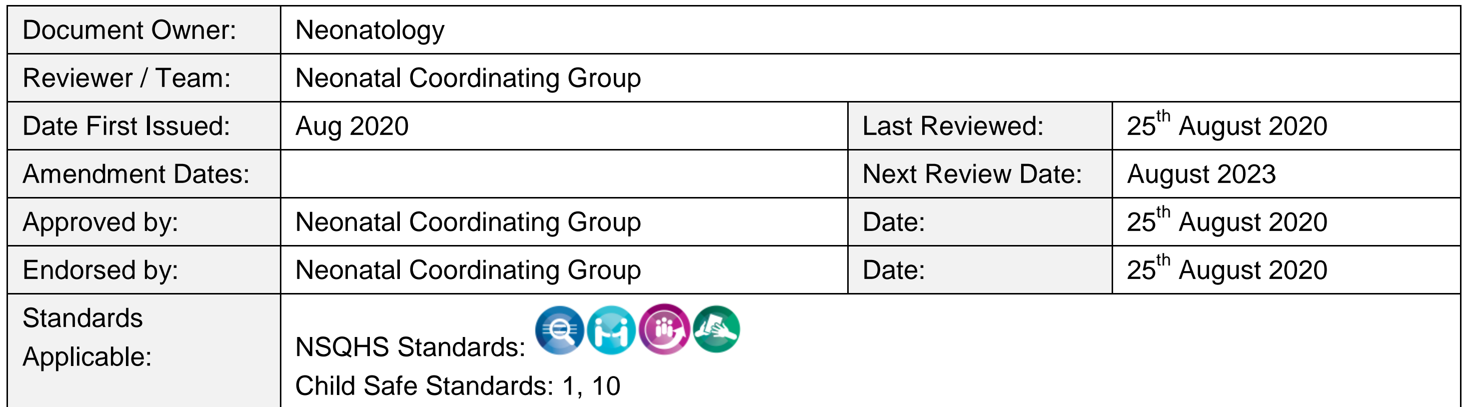

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Appendix 1: List of Equipment Weight

Item	Size	Weight
CPAP Hats	XS	24g
	S	28g
	M	31g
	L	35g
	XL	40g
CPAP Prongs	XS	5g (with bolsters)
	0	3g
	1	3g(with bolsters +2g)
	2	3g
	3	4g
	4	4g
CPAP Knit Hat	-	11g
Woollen Hat	-	10g
Biliband	S	3g
	L	5g
ECG Leads	-	12g
Saturation Probe & Strappit	S	5g
	L	18g (with cables)
Neowrap	-	20g
Neohelp	S	30g
	L	32g
Neobar	-	3g
Endotracheal Tube	2.5	7g (with Neobar)
	3 - 4	5g
PIV Splint	S	2g
	M	8g
	L	10g
PIV extension & Bung	-	6g
NIBP Cuffs	S	8g
	M	10g
	L	12g