Western Health

Joan Kirner Women's and Children's (JKWC)

Division of Women's and Children's Services

Newborn Services

Operating Guideline

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Western Health

Newborn Services

Operating Guideline

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Abbreviations and Acronyms

AHA	After Hours Administrator
ANTT	Aseptic Non-touch Technique
ANUM	Associate Nurse Unit Manager
BLS	Basic Life Support
BLSD	Basic Life Support and Defibrillation
CNS	Clinical Nurse Specialist
CPIS	Clinical Practice Improvement Specialist
DHHS	Department of Health and Human Services
DMR	Digital Medical Record
ED	Emergency Department
ESD	Environmental Services Department
EMR	Electronic Medical Record
EN	Enrolled Nurse
GP	General Practitioner
HDU	High Dependency Unit – a sub-space in Newborn Services
HMO	Hospital Medical Officer
ISBAR	Identity Situation Background Assessment Request communication Framework
JKWC	Joan Kirner Women's and Children's
JMS	Junior Medical Staff
MDT	Multi-disciplinary Team
NHITH	Neonatal Hospital In the Home
NIC	Nurse in Charge of a shift
NICU	Neonatal Intensive Care Unit – a sub-space in Newborn Services
NLS	Neonatal Life Support
NUM	Nurse Unit Manager
PAHS	Paediatric Allied Health Service
PIPER	Paediatric, Infant and Perinatal Retrieval Service
PPG	Policy, Procedure and Guidelines
PSA	Patient Services Assistant
SC	Special Care – a sub-space in Newborn Services
SH	Sunshine Hospital
W&C	Women's And Children's
WH	Western Health
WHMI	Western Health Medical Imaging

1. Introduction

1.1 Purpose

The purpose of this Operating Guideline is to profile Newborn Services, and to provide details of the day to day operation of the service.

The Operating Guideline describes the various components and associated processes of the patient journey, staffing requirements, governance structures, clinical and non-clinical support requirements, equipment and capital requirements and communications procedures.

1.2 Intended Audience

This Operating Guideline is intended for the following audience:

Who	Utilisation
• W&C Leadership & Management Team • W&C Services Operational Projects Team • Allied Health Leadership and Management Team	• To be used as a baseline plan and overall tool to define what and how Newborn Services operates.
• Frontline staff	• To provide frontline staff with a detailed understanding of the day to day operation of the Newborn Services. This Operating Guideline will be used ongoing for new staff to JKWC to assist with orientating to Newborn Services.

Table 1: Intended audience

1.3 Related Documents

This document forms part of a suite of documentation outlining the provision of Newborn Services delivery across various phases of care at Western Health (WH).

As such, it should be considered in conjunction with the following:

- *Children's Ward Operating Guideline (2019)*
- *Neonatal Hospital in the Home Operating Guideline (2019)*
- *Newborn Services Model of Care (2019)*
- *Paediatric and Neonatal Specialist Clinics and Paediatric Allied Health Operating Guideline (2019)*

2. Service Overview

Newborn Services will continue to provide a Level 5 service at opening in May 2019, with a phased opening model implemented from mid-2019, in order for the service to uplift and provide Level 6A services.

Newborn Services provide inpatient care for neonates, including those requiring continuous life support and comprehensive multidisciplinary care for extremely preterm newborns and those with non-surgical critical illness, as well as neonates requiring less intensive care (Defining levels of care for Victorian newborn services, 2015, © State of Victoria, Department of Health and Human Services).

Newborn Services provide a consultative service to neonates with their mothers in the maternity clinical areas, in addition to outpatient services for the follow-up of high risk neonates post-discharge.

In mid-2019, Newborn Services capacity will include two neonatal intensive care unit (NICU) cots and 28 special care cots which can include provision for up to four high dependency unit (HDU) cots; providing a total of 30 neonatal cots. With ongoing provision of funding it is anticipated that NICU cot uplift will progress to a total of four NIC cots in 2020, then six NICU cots in 2021 along with a further five special care cots to reach total capacity at 39 cots by 2021.

Inclusion criteria for neonatal admission **at opening** will continue to be neonates ≥ 31 weeks gestation and who require care within the Level 5 capability framework.

Inclusion criteria for admission of neonates to Newborn Services **after phased uplift** include neonates ≥ 28 weeks gestation and ≥ 1000 grams and who may require:

- Ventilation
- Management of pneumothorax
- Surfactant administration
- Intravenous nutrition
- Inotropic circulatory support and invasive blood pressure monitoring
- Other less invasive interventions/support due to prematurity, low birth weight or other problems

Exclusion Criteria **following uplift** of the JKWC (indicating that neonates require alternate Level 6A or 6B NICU facilities) include:

- Birth weight under 1000 grams
- Gestation less than 28 completed weeks
- Requirement for ongoing therapeutic hypothermia
- Requirement for neonatal surgery
- Requirement for high frequency oscillatory ventilation
- Requirement for inhaled nitric oxide therapy (iNO)

2.1 Location and Operating Hours

Newborn Services is located on Level Five of the JKWC at Sunshine Hospital (SH). Figure 1 provides detail of the Level Five floor plan.

Newborn Services operates 24-hours per day, seven days per week.

There are no visitation restrictions for parents and siblings. All other visitors are welcome between 08:00 – 12:00 and 14:00 – 20:00 (12:00-14:00 is allocated 'quiet time', during which bedside visiting is limited to parents only). Currently, no children under the age of twelve are allowed to visit Newborn Services unless they are siblings of the patient due to infection prevention strategies. Parents must escort their visitors into Newborn Services or must complete a visitors list. If visitors are not on the visitors list they are not allowed into Newborn Services.

On arrival to the Level Five, all parents and visitors must ring the entry video intercom to be given access through to the unit. Clerical support to gain entry to Newborn Services will be directly available from 07:00 – 15:30 and, from 15:30 – 07:00; access will be managed via video intercom call with remote release diverted to the staff bases on Newborn Services.

Parents/caregivers of neonates admitted to Newborn Services have the option for one adult to stay with their neonate overnight. To support parents/caregivers to stay overnight, each cot has an adjacent inbuilt day bed. Women who have recently given birth must be discharged from their Maternity Ward to be deemed safe/appropriate to stay by the bedside overnight. The WH **Visitor Management - General Public** Procedure outlines some expectations for visitors, including the need for security in JKWC to be aware of the names and number of people in the building after hours in case of emergencies overnight, and the method of identifying approved overnight stay individuals.

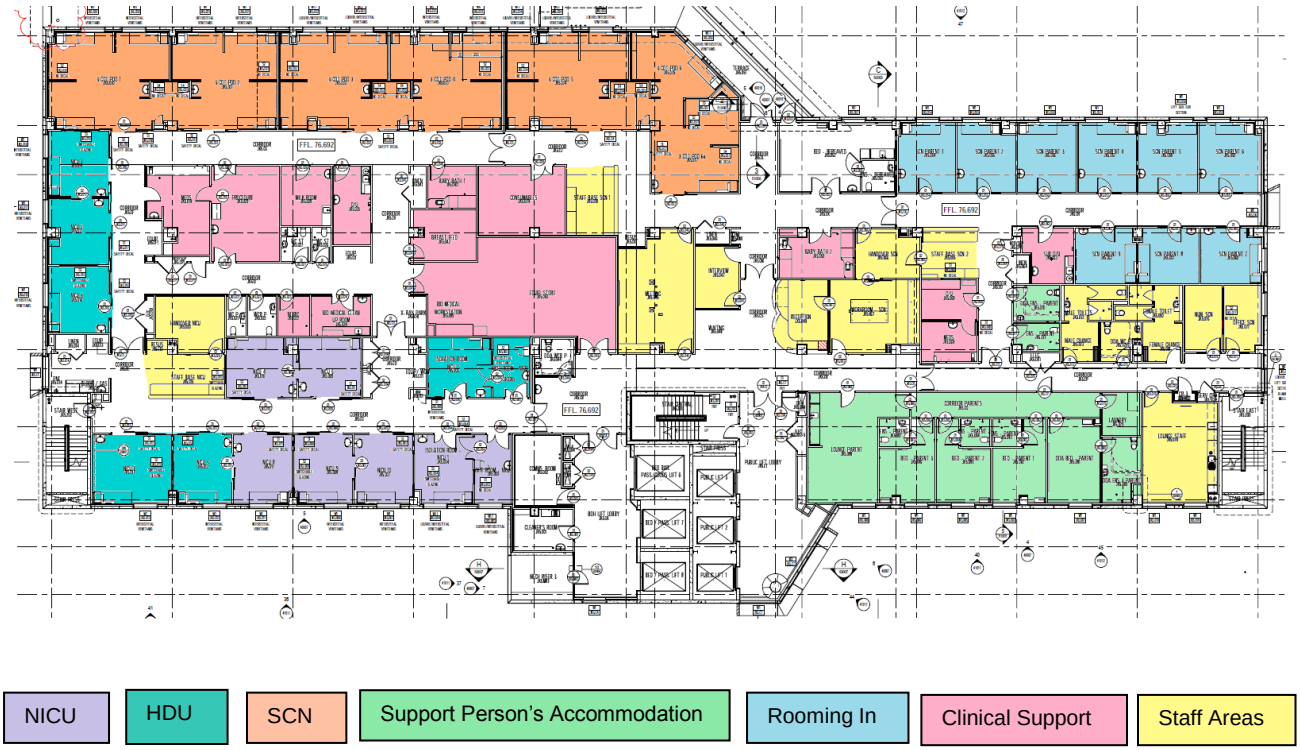


Figure 1: Floor plan of JKWC Level Five, Newborn Services

2.2 Patient Profile

Neonates are defined as term infants born at ≥ 37 weeks gestation and ≤ 28 days of age, or pre-term infants born at < 37 weeks gestation and < 44 weeks corrected age.

Newborn Services in JKWC is a designated Level 6A Neonatal Service. A phased opening model will be implemented from mid-2019, in order for the service to provide care for neonates born all gestations ≥ 28 weeks – 44 weeks and who may require continuous life support for non-surgical, critical illness and comprehensive multidisciplinary care. The service also provides care to growing and convalescing preterm or term neonates.

On opening of the JKWC in 2019, a staged plan for increasing neonatal acuity and service provision is underway for the first 24 months in the new facility. This plan will be reviewed and revised in liaison with DHHS, to ensure a safe transition from provision of Level 5 Neonatal Services, which have been the capability at WH Sunshine, to the increase in complexity and acuity that neonates cared for in Level 6A services may require.

3. Referral

3.1 Referral Sources

Referrals to Newborn Services come from internal and external sources to WH and fall into two main categories: admissions and transfers.

3.1.1 Admissions

An admission occurs when the referral source is from either a WH Sunshine or JKWC inpatient area, direct from the community, or from an external hospital, including:

- Birth Episode
- Maternity Wards
- Unplanned admissions from the community via the SH Emergency Department (ED)
- Planned admissions from the community
- Planned admissions from external health services via PIPER

Admissions from Birth episodes

Direct admission to Newborn Services following birth occurs for the following babies:

- Babies requiring extensive resuscitation at birth
- Gestation ≥ 28 weeks at birth ≤ 35 weeks
- Birth weight ≥ 1000 grams or < 2000 grams
- Prenatal indication for Newborn Services admission following birth
- Respiratory distress that persists for more than 1 hour or hypoxia requiring oxygen
- Apgar < 7 at 5 minutes of age and where clinical condition indicates admission
- Sepsis or suspected sepsis
- Newborn whose mother is unable to care for them e.g. mother admitted to ICU, baby awaiting adoption, child protection order and newborn services is deemed the most appropriate location to provide care.
- Other indications as per medical staff.
- Information about admission criteria is contained within the WH Procedure DP-CC1.1.1 Paediatric Referrals and Admission to Special Care Nursery (SCN)

Admissions from Maternity Wards

Babies on the Maternity Wards with the following problems MUST be referred to the birthing/postnatal registrar or neonatal consultant for review and potential admission to Newborn Services:

- All late preterm or low birth weight infants (Late Preterm or Low Birth Weight Neonates on Postnatal Wards DP-CC2.1.11)
- Newborns with signs and symptoms of subgaleal haemorrhage or deterioration in hourly observations for those at risk of subgaleal haemorrhage (Diagnosis and Management of Subgaleal Haemorrhage in At Risk Infants DP-CC2.1.10)
- At risk of hypoglycaemia (maternal gestational diabetes, Labetalol, intrauterine growth restriction, large for gestational age) or hypoglycaemic (Neonatal Hypoglycaemia DP–CC2.1.7)
- No urine or meconium passed in the first 24 hours of life

- Jaundice in the first 24 hours or jaundice requiring phototherapy (Jaundice in Newborn Babies < 35 Weeks Gestation DG – CC2.6.3, and Jaundice in Newborn Babies > 35 Weeks Gestation DG – CC2.6.2)
- Bile-stained vomiting or projectile vomiting
- Cyanosis
- Discharge post-ductal SpO_2 screening < 95% (Oxygen Saturation Screening of Newborns DP – CC2.1.16)
- Pallor, poor perfusion, tachycardia
- Poor muscle tone
- Signs of sepsis or suspected sepsis (Management of Early Onset Group B Streptococcus Sepsis in Newborns DG – CC2.6.6)
- Abnormality identified on newborn examination (Discharge Examination of the Newborn DG-CC5.1.1
- Poor feeding and/or weight loss of more than 10%;
- Neonate with symptoms of Neonatal Abstinence Syndrome (NAS) requiring pharmacological intervention
- Seizures or suspected seizures
- Antenatal diagnosis of congenital abnormalities or congenital abnormalities discovered on newborn examination

Following this medical review, the birthing/post-natal registrar or neonatal consultant will determine whether the neonate can remain on the Maternity Ward with an appropriate management plan or requires an admission to Newborn Services.

Admissions via ED

Admissions of neonates from the SH Emergency Department (SH ED) may occur following emergency, unplanned presentations of babies born before arrival to hospital, obstetric presentations to SH ED that progress rapidly to birth, or emergency admissions of unwell neonates.

In all instances the SH ED team will triage, assess and begin stabilisation of these neonates, and consult/liaise/request assistance from neonatal and paediatric services as appropriate. Admission to Newborn Services, the Maternity Wards or the Children's Ward will be decided on collaboratively as clinically indicated.

Neonates may also present to SH ED from the community after discharge from a health service with an acute illness, or with clinical issues flagged by community health providers and referred into SH ED. In these instances the following is proposed:

- Readmission of neonates from the community with non-infectious conditions (e.g. jaundice, failure to thrive, feeding issues) will be to Newborn Services JKWC
- Readmission of neonates from the community with possible sepsis should be to Newborn Services, particularly if unwell as Children's Ward is not set up to manage complex monitoring or respiratory support
- Readmission of neonates from the community with infectious (or suspected infectious) respiratory illness should be into a single room in Newborn Services, where they will be nursed in an incubator and with contact precautions implemented as per Infection Control

WH. Neonates with suspected or proven Influenza, measles, pertussis or TB should be nursed in the negative pressure Isolation Rooms. If this group of neonates require respiratory support that escalates to intubation and ventilation, PIPER will be consulted with the preference being to move these babies to a facility with PICU capacity

Admissions via the community

Neonates who have been discharged to the community but who remain active as part of either the Neonatal HITH or Maternity @ Home Programs, will be discussed with and triaged by the Rapid Review Clinic registrar in the Paediatrics and Neonatal Specialist Clinics, available in-hours. This is usually in the setting of persisting feeding issues, or jaundice requiring treatment.

If re-admission is deemed appropriate, the Registrar will liaise with the Newborn Services Associate Nurse Unit Manager (ANUM)/Nurse in Charge (NIC) and neonatal consultant on service regarding admission and bed availability. Refer to the *Neonatal Hospital in the Home (HITH) Operating Guideline (2019)* for details about Neonatal HITH Readmissions.

Planned Admissions from External Health Services

Referrals from external health services are received from both higher and lower capability health services where newborns require either Level 6A or Level 5 ongoing Care. These admissions are co-ordinated between PIPER, the neonatology team and the ANUM/NIC of Newborn Services. The Access Coordinator/After-Hours Administrator (AHA) is to be informed of accepted admissions so updated bed/patient numbers are available.

3.1.2 Transfers

An intra-hospital transfer occurs when the neonate is being referred from a WH inpatient area to another WH inpatient area for the purposes of an investigation or procedure, or for ongoing care in another clinical area, and is accompanied by a registered nurse or midwife, including:

- Birthing
- Maternity Assessment Centre (MAC)
- Maternity Wards
- Children's Ward

Transfers may involve neonates being transported to radiology or newborn services for investigations, assessment or procedures or from outpatients for admission or investigations.

4. Admission

4.1 Clerical Admission

All neonates who are admitted to the Newborn Services will undergo a clerical admission or transfer on iPM. Responsibility for completing this clerical admission varies according to the referral source as listed in Table 2.

Neonates whose mothers have had their antenatal care conducted via WH will be pre-registered at 36 weeks gestation, whereby an individual UR number and a generic date of birth (DOB) (01/01/1900) is generated and linked to the Mother's iPM profile. Following the woman's admission to birthing, the birthing ward clerk confirms the neonate is pre-registered and prints the pre-registration labels.

Circumstances where pre-registration may not have occurred include if a woman was booked for antenatal care with another organisation or if the woman is < 36 weeks gestation. In the event that the unborn neonate is not pre-registered, the ward clerk will need to complete the pre-registration.

Following birth, a 'Newborn Registration & Admission' form is completed with maternal and neonatal pre-registration labels and emailed to BabyAdmissions@wh.org.au . Following registration of the neonate's birth, the neonatal pre-registered ID label is replaced with an updated ID label with the correct DOB. Table 2 details the clerical admission responsibility for patients admitted to Newborn Services.

Referral Source	Clerical Admission/Transfer completed by
Birthing	• Birthing Ward Clerk
Maternity Wards	• Maternity Ward Clerks
ED	• ED Clerical Staff
Planned Community Admissions	• Direct admissions by the Newborn Services Ward Clerk
Planned Admissions from External Health Services	• Newborn Services Ward Clerk
Transfers	• Newborn Services Ward Clerk 07:00– 15:30 • 15:30 – 07:00 shared Ward Clerk with Level Six Children's Ward (to be based on Level Six, Children's Ward)

Table 2: Clerical registration responsibility for Newborn Services admissions and transfers

4.2 Bed allocation:

Newborn Services comprises a total of 39 inpatient cots and includes a designated NICU area – single rooms with central cardiorespiratory monitoring and invasive ventilation capability, a designated HDU area (single rooms) with non-invasive ventilation capability and central cardiorespiratory monitoring, a designated Special Care area (three- bed bays with 18 beds in total) and nine single rooms for parental rooming in with their baby prior to discharge. Two negative pressure isolation rooms are included in these numbers, one of which is configured to enable neonatal intensive care of a neonate if required. Refer to Figure 1 for a floor plan of JKWC Level Five, Newborn Services.

Allocation of rooms by the Newborn services ANUM/NIC will be guided by the level of care and technology a neonate requires and workflow of the unit. Neonates will be progressively moved to appropriate care areas as their condition dictates.

Provision for acceptance of admission will be co-ordinated between the ANUM/NIC, neonatal medical team and the Access Coordinator/AHA.

4.3 Clinical Handover – Admission

Clinical handover for admissions/transfers from internal sources is provided verbally, either in person or over the phone, and follows the ISBAR Framework in accordance with WH's Clinical Handover Procedure.

Clinical handover for admissions from external health services is provided verbally over the phone from the referring hospital, verbally in person from the PIPER Transport Team (who also use the ISBAR Framework) and in written form via patient record and transport documentation.

5. Service Provision

5.1 Medical Allocation, Admission and Care

Patients admitted to Newborn Services are under the care of the neonatal medical team. A neonatologist oversees and directs care for inpatients, and leads a daily ward round review of all inpatients.

Junior medical staff (Registrars and HMO's) undertake roles based on their level of training and experience. HMO's generally will work with a registrar and have activities allocated depending on their capability. Neonatal registrars undertake documentation, procedural and patient reviews at least daily and as patient conditions dictates.

Neonatal registrars will undertake different roles depending on the location within the service they are allocated to (Newborn Services, postnatal wards, outpatients, birthing or theatre). Roles will broadly include acute care such as evaluation and resuscitation as well as ongoing clinical management throughout admission and discharge preparation and documentation. Registrars will also attend when newborns are identified at risk, or are experiencing problems listed in section 3.1.1.

5.2 Nursing Allocation

Shift	Area	Nurse & patient allocation	Additional supernumerary
Morning 07:00 – 15:30	NICU HDU SCN & Rooming in	1:1 ventilated neonates 1:2 neonates on CPAP Other nurses allocated a number of patients based on acuity	ANUM/NIC Admissions Nurse (attends code Blue and deliveries) Team Support Nurse (Rapid Admission / short stay neonates and general assistance)
Afternoon 13:00 – 21:30	NICU HDU SCN & Rooming in	1:1 ventilated neonates 1:2 neonates on CPAP Other nurses allocated a number of patients based on acuity	ANUM/NIC Admissions Nurse (attends code Blue and deliveries) Team Support Nurse (Rapid Admission / short stay neonates and general assistance)
Night 21:00 – 07:30	NICU HDU SCN & Rooming in	1:1 ventilated neonates 1:2 neonates on CPAP Other nurses allocated a number of patients based on acuity	ANUM/NIC Admissions Nurse (attends code Blue and deliveries) Team Support Nurse (Rapid Admission / short stay neonates and general assistance)

Table 3: Nursing Allocation Newborn Services

Enterprise Agreement Nurse: Patient ratios are guided by the acuity of the in-patient population and anticipated needs of the unit.

The ANUM/Nurse in charge of the shift does not have a patient load and is responsible for managing the shift which involves:

- Allocation of patients to oncoming nursing staff
- Attending medical ward rounds; communicate ongoing management plans to staff as required
- Attending the morning access meeting
- Ensuring staff vacancies are filled for oncoming shifts as the need arises
- Facilitating discharges in a timely manner. Planned discharges should aim to occur between 10:00 – 11:00
- Handover to oncoming shift in brief, then to oncoming ANUM/NIC in more detail
- Monitoring and facilitating patient admissions and transfers
- Providing necessary support during high acuity/deteriorating patient situations

The bedside nurse is responsible for:

- Providing nursing care to patients
- Recording patient vital signs
- Communicating with medical staff regarding the neonate's condition and ongoing management plan
- Escalation of patient/family concerns to the Neonatal medical team and ANUM/NIC
- Trigger Neonatal MET or Code Blue process in a deteriorating neonate
- Performing treatments as required
- Administering medications
- Documentation of care delivered in the EMR and on paper charting as required
- Educating, engaging with and empowering parents and primary caregivers to participate fully in the family centred care model and their neonate's care
- Educating parents in relation to ongoing management and care of their neonate
- Escorting patients to other departments
- Making referrals to Allied Health, Lactation consultant when required or discussing with the medical team potential referrals required

5.3 Nursing Admission and Documentation

- The primary nurse is responsible for completing a nursing admission and developing a comprehensive *Nursing Care Plan* in the EMR as soon as possible after the patient has been admitted to the ward. This is updated regularly throughout the admission and at each nursing shift to reflect real time care needs and care plan
- In addition to the *Nursing Care Plan*, the *Neonatal & Paediatric Risk Screening Assessment Tool* is to be completed by the primary nurse in the EMR within four hours of admission, and is updated daily until discharge
- A shift check is completed in EMR by the oncoming nurse/midwife at each handover.
- Updating the neonate's day of life (age) and corrected gestational age in the EMR needs to be manually entered after midnight by the night duty nursing team

- The primary nurse in conjunction with medical staff will identify the need for allied health involvement during their admission, in accordance with the indications for referral detailed in Table 6, and will complete referrals to allied health via EMR
- Additional assessment and documentation tools to be completed by the primary nurse are listed in Table 4.

Name	Use	Documentation
• Victorian Children's Tool for Observation and Response (ViCTOR): • Special Care Nursery VSCN010	• Documentation of clinical observations including temperature, heart rate, respiration rate, blood pressure and oxygen saturation	• Paper-based
• Neonatal Intensive Care Observation Chart (number to be determined)	• Documentation of vital signs, ventilation parameters (document under development)	• Paper-based
• Neonatal Unit Fluid Balance and Treatment Orders AD157.8	• For all neonates regardless of IV fluids only, IV plus enteral fluids or enteral only fluids	• Paper-based

Table 4: Additional documentation to be completed by the primary nurse

5.4 Nursing & Medical Handover

The Clinical Handover Procedure provides details regarding the ISBAR Framework used at WH to ensure safe, effective clinical handover is applied in all clinical situations and with all clinical staff.

Medical Handover in JKWC Newborn Services will take place at 08:00, 16:30 and 22:00 to enable information exchange and updates at shift change-over. At 08:00, a Neonatal Medical Handover will take place in the Newborn Services meeting room, attended by the Night and Day Duty Paediatric Junior Medical Staff allocated to Newborn Services, Neonatal trainees, and the Consultant Neonatologist on service. Another handover will be conducted at around 16:30 attended by the Neonatologist on service and providing on-call cover during the evening and overnight. The evening to Night Duty Medical handover will be attended by the Paediatric JMS trainee allocated to Newborn Services. Issues, concerns, admissions, evaluations and referrals that have occurred during the previous shift will be reviewed as well as provisional plans made for any anticipated admissions.

Nursing clinical bedside handover is completed three times per day at each nursing shift change. Prior to commencing clinical bedside handover, a short group brief is facilitated by the Newborn Services NIC/ANUM in the Handover Room to the staff commencing their shift and, which entails a general overview of the ward in relation to:

- Medically unstable neonates
- Expected admissions and discharges
- Any social issues that cannot be discussed at the bedside

Following this short brief, a more detailed clinical handover, that includes the neonate's family if present and both the incoming and outgoing nurse in the transfer of information, occurs at the bedside using the Identity Situation Background Assessment Request (ISBAR) Framework as described in Table 5.

I	**IDENTITY**	Identify yourself, (name and role) and your patient
S	**SITUATION**	State the patient's diagnosis or reason for admission and current problem
B	**BACKGROUND**	Patient History – clinical background or context
A	**ASSESSMENT**	Current problems, observations and treatments
R	**REQUEST**	What you want from them/ what the plan is

Table 5: ISBAR framework for handover

The outgoing ANUM/NIC of the shift also provides a more detailed handover to the incoming ANUM/NIC.

5.5 Diagnostic Services

5.5.1 Medical Imaging

Medical Imaging modalities located within JKWC to support Newborn Services include a general X-ray room, located on the Ground Floor JKWC, and ultrasound rooms, located on Level One JKWC. In addition, there is a mobile X-ray machine located on Level 5 and a mobile ultrasound machine, also located on Level Five. All other medical imaging modalities are located within the main SH Medical Imaging department, located on the Ground Floor of Building A. 24 hour emergency X-ray services are available for all neonatal inpatients in Newborn Services. MRI facilities are available in the radiology department SH. Refer to the *Newborn Services Model of Care (2019)* Table 7 for further medical imaging details.

All neonates require nursing escort to and from Medical Imaging.

A weekly medical imaging meeting led by one of the paediatric radiologists is held to review abnormal imaging from the paediatric and neonatal services over the previous week.

5.5.2 Pathology

There are currently no routine pathology blood collection rounds scheduled for Newborn Services. Bloods and other specimens required are collected by the ward nursing or medical staff and are sent to the pathology laboratory via pneumatic tube. Samples which cannot /should not be transported via the pneumatic tube system are samples in formalin, samples affected by agitation such as CSF and samples too large for the tube system.

5.6 Clinical Support Services

5.6.1 Pharmacy

Pharmacy technicians are responsible for restocking ward imprest on a weekly basis. Outside of dedicated imprest top-up times, a Pharmacy Requisition Form is to be completed by nursing staff for any imprest medications which are not available. The Pharmacy Requisition Form for imprest medications is to be sent via pneumatic tube system or faxed to JKWC Pharmacy on 9055 2055 during weekdays (Monday-Friday). On weekends, all medication requests are to be faxed down to Sunshine Main Pharmacy on Ext 51532. All non- imprest medications can be ordered through the MAR (EMR).

Clinical ward pharmacist(s) can be contacted for queries regarding medicines especially sourcing non-standard/urgent medications requests.

Pharmacist(s) also collaborate to support the development of policies, procedures, guidelines and processes applicable to Newborn Services. If a policy, procedure or guideline mentions medication, Pharmacy is a mandatory stakeholder.

Discharge prescriptions are generated from the EMR, printed and signed by the treating medical team. Nursing staff contact the ward pharmacist to review the scripts. Once prescriptions are profiled, ward pharmacist(s) then facilitate the dispensing process. The ward pharmacist(s) provide the discharge medications and counselling to the patient and their family prior to discharge.

The after-hours drug cupboard is located adjacent to the Sunshine Main Pharmacy on the Ground Floor of Building B+ and is accessed by the AHA. If the required drug is unavailable in the after-hours drug cupboard and cannot wait until the regular pharmacy hours, the AHA will contact the on-call pharmacist.

The satellite pharmacy, situated on the ground floor of the JKWC, provides clinical pharmacy services to the Children's Ward as detailed in Table 9. The satellite pharmacy is open between 08:15 – 17:00 Monday to Friday. It is closed on public holidays and weekends.

5.6.2 Allied Health

On admission to the ward, nursing and/or medical staff will identify if a referral to allied health is indicated and will complete referrals accordingly. Indication for referral to allied health may also be identified at any stage throughout the admission by medical, nursing or by other allied health disciplines.

Referrals to allied health are made using an electronic referral via the EMR and at a minimum should state the reason for referral, anticipated discharge date and discharge destination. Allied health staff aim to respond to all inpatient referrals within 24 hours of receipt of referral, within the limits of a Monday to Friday service. Please refer to DP-CC2.4.1 Inpatient Referral to Allied Health for further details.

An Allied Health Flow and Interdisciplinary Referral Management (AHFIRM) Lead is allocated to Newborn Services and will liaise daily with the ANUM/NIC in regard to any allied health referrals or issues. The AHFIRM lead will enhance Allied Health ward based leadership through communication and assisting in the areas of access and flow. Allied Health services are available 08:00 – 16:30 Monday to Friday. Table 6 outlines the Allied Health services available for patients in the Neonatal

Unit, including indications for referral and contact details.

Discipline	Service Description	Indications for Referral	Contact

Audiology	Assessment and management of patients presenting with hearing issues or risk factors for hearing loss.	• Failed VIHSP screen.
		• Risk factors for hearing loss
		  • Family history hearing loss
		  • Parental concern
		  • Aminoglycoside antibiotics 3 or more days
		  • Severe jaundice
		  • Meningitis/encephalitis
		  • Congenital abnormality of head/neck, e.g. cleft lip/palate
		  • Syndromes associated with hearing loss, e.g. Down syndrome
		  • Maternal infection during pregnancy, e.g. CMV
		  • Ventilation > 5 days
		  • Significant head injury
			Ext: 52054 or 52056

Nutrition & Dietetics	Provide dietary advice, intervention and appropriate monitoring of neonates on all aspects of nutrition as referred. Additionally dietitians work with the family to provide education on nutritional needs for the home and any modifications that may be needed including TPN and parenteral feeding.	• Nasogastric tube or parenteral nutrition, or education required • Consideration of elemental formula • Dietary support for conditions with likely growth impairment e.g. Congenital heart disease, chronic lung disease, Gastrointestinal anomaly, Renal Failure, Suspected Metabolic disorder or osteopenia • Poor feeding/Poor feed tolerance • Requiring nasogastric feeding upon discharge	Pager 409/836
Occupational Therapy	Provide early assessment and intervention for infants at risk of developmental delay and poor health outcomes. May include supporting developmentally appropriate occupations of the infant, education, developmental care plans, splints to support upper limb positioning and function, prescription of equipment for inpatient stay and home environment e.g. car seat/capsule; bath equipment, positioning equipment for early play	Referral indicators currently under development.	TBA

Pastoral Care	Pastoral Care is concerned with the well-being of the human spirit. Pastoral Care staff offer confidential emotional and spiritual support during times of change and challenge that is sensitive to and respectful of each person's individual needs (including all faith traditions, or none).	• Emotional and spiritual support for patients and relatives/carers, especially around fear, anxiety and emotional and existential crises. • Provision of non-religious and/or traditional blessings if/when required • For referrals/links to external faith communities or representatives when necessary	Ext.51307
Physiotherapy	Assessment and management, including education and support, of neonates who have or are at increased risk of neurodevelopmental disorders or musculoskeletal concerns or issues.	• Gestational age ≤32 weeks • Birth weight ≤1500g • Infants with Neurological Complications (e.g. PVL, HIE, Seizures, Stroke, IVH, Congenital Syndromes) • Altered Tone • Difficulties with Positioning and Handling • Musculoskeletal concerns (e.g. Plagiocephaly, Torticollis, Hip Instability, Positional Talipes)	Pager 768
Psychology	Clinical & Health Psychologists provide assessment and therapeutic intervention for parents presenting with significant psychological distress regarding their infant	• Parents experiencing significant psychological distress	TBA
Social Work	Provide a range of services through statutory, therapeutic, welfare and education interventions. A Psychosocial Assessment of patient's needs is completed during hospitalisation; this includes identification of immediate needs, Child at Risk and Family Violence assessments and safety planning. Social Workers actively risk screen infants with the purpose of identifying infants at risk and providing early interventions to ensure the safety and wellbeing of children.	• Child at risk • DHHS-CP involvement • Family Violence • Readmission to Inpatient Newborn Services • Babies born to imprisoned mothers • Babies with Neonatal Abstinence Syndrome • Bonding and attachment concerns • Adjustment to parenting • Emotional support with adjustment to illness/diagnosis • Grief and loss support • Unattended infants, parents absent from ward • Accommodation and transport issues • Refugee/immigration issues • Discharge planning	Pager 395 Duty Pager 401 Mob:0466531855

Speech Pathology	Services provided include assessment and assistance with complex, developmental feeding problems	• Signs of possible aspiration • Neurological complication with poor oro-motor or sucking skills • Anatomical abnormalities impacting on feeding • Poor feeding secondary to illness • Feeding refusal/long term tube dependency	Pager 985/911/922

Table 6: Allied Health Services for Newborn Services

5.6.3 Victorian Infant Hearing Screening Program (VIHSP)

The Victorian Infant Hearing Screening Program (VIHSP) screens the hearing of newborn babies in their first weeks of life. The results of the screen are provided to the mother immediately. Neonates who do not pass the screen will be referred to Diagnostic Audiology for further testing by the VIHSP team

The results of the screen are recorded in the Child Health and Development Record book. The VIHSP are located in JKWC and are available Monday to Saturday 08:30 – 17:00. Referrals are automatically generated via BOS when the neonate is born.

5.7 Non- Clinical Support Services

5.7.1 Food Services

Breakfast items only will be provided to those parents/guardians who have been requested to stay overnight in the Rooming-in bed spaces prior to their neonate's discharge, as this group of parents are being supported in the care-giver role. All other parents who elect to stay with their neonates will source their own meals.

5.7.2 Patient Services Assistant (PSA)

Management of the Environmental Services Department (ESD) workforce in JKWC will be under the direction of the ESD Co-ordinator, ESD Manager and Operations Manager - Environmental Services. 24 hour a day cover will be provided as detailed in Table 7.

	Weekday		Weekends	
	Shift Time	**Hrs**	**Shift Time**	**Hrs**
PSA	06:30 – 15:00	40	06:30 – 15:00	16
PSA	15:00 – 23:00	37.5	15:00 – 23:00	15
PSA	23:00 – 06:30	35	23:00 – 06:30	14

Table 7: PSA allocation for Newborn Services

5.7.3 Ward Clerks

The Division of Health Support Services manages the clerical workforce (ward clerk) that supports Newborn Services

The ward clerk on Newborn Services is available between 07:00 – 15:30 seven days per week, with a ward clerk shared between Newborn Services and the Children's Ward between 15:30 – 07:00 as per Table 8.

	Weekday		Weekends	
	Shift Time	**Hrs**	**Shift Time**	**Hrs**
Ward Clerk	07:00 – 15:30	40	07:00 – 15:30	16
PM – Shared Lv 5&6	15:30 – 22:30	32.5	15:30 – 22:30	13
Nights – Shared Lv 5&6	23:30 – 07:00	40	22:30 – 07:30	16

Table 8: Ward Clerk allocation for Newborn Services

5.7.4 Language Services

Interpreters should be used for patients and their families whenever key information is being communicated or discussed. On-site interpreting services are provided by in-house interpreters between the hours of 08:30 – 17:00, Monday to Friday. Outside these hours, and for languages not provided by in-house interpreting services, telephone interpreting services can be used. When a face to face interpreter is essential out of hours, such as in an emergency, an interpreter can be requested through the same number as the telephone interpreting services.

The Language Services page on the WH Intranet provides details on how to book interpreting services both in and out of hours.

6. Discharge

6.1.1 Transfers Out

If a neonate's condition exceeds the capability of Newborn Services, requires a surgical procedure, or if neonatal bed capacity in Newborn Services is at total capacity, PIPER will be consulted to source a neonatal bed in another health facility. Refer to Figure 2 for process of consultation and retrieval. Back-transfers from JKWC Newborn Services to other neonatal facilities may also occur in the context of moving neonates closer to home to a near-by health service once they meet level of care lower level neonatal service. Refer to Fig. 3 for process of consultation and referral.

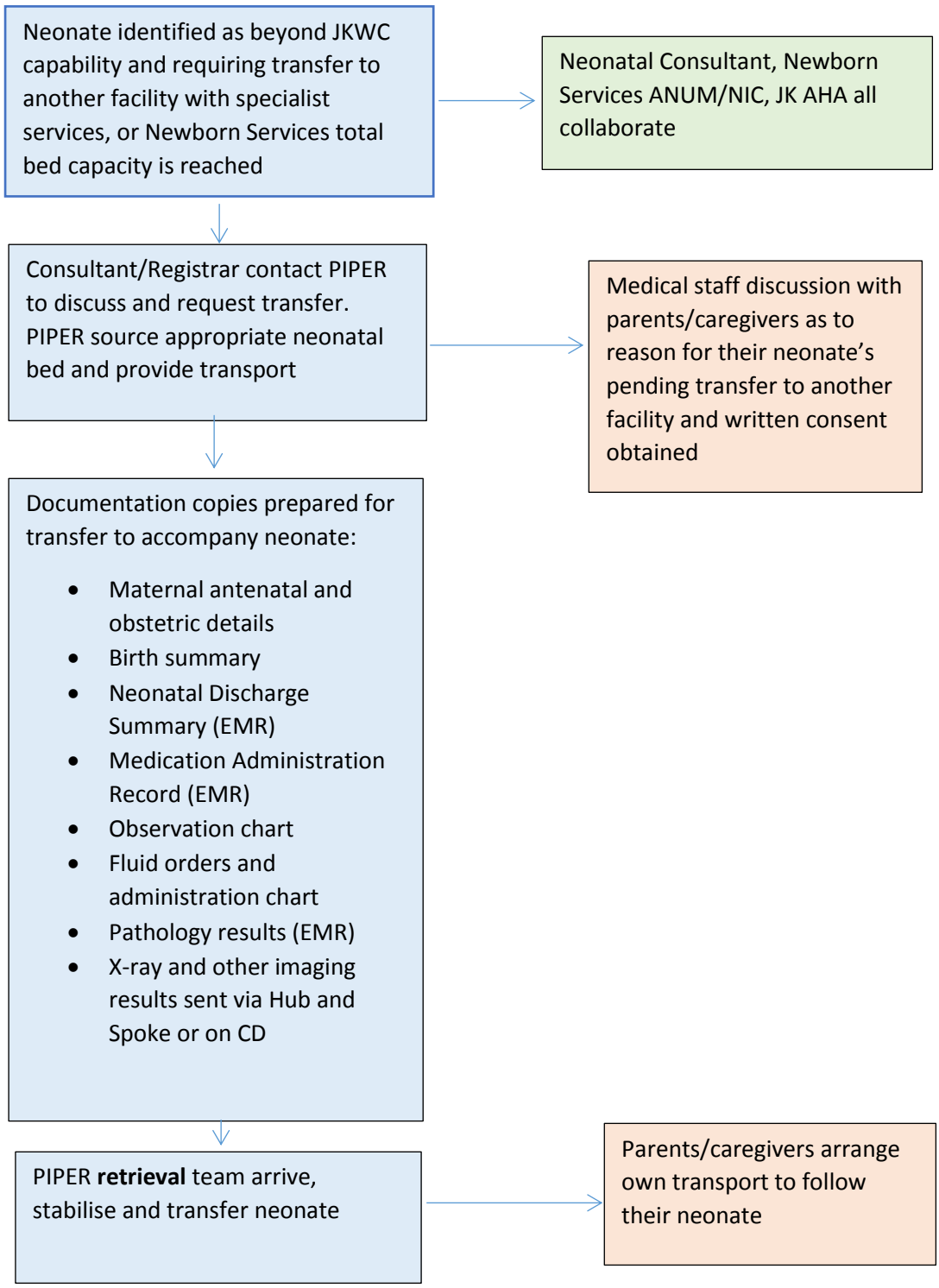


Figure 2: Process for neonatal transfer when specialist services required or bed capacity is reached

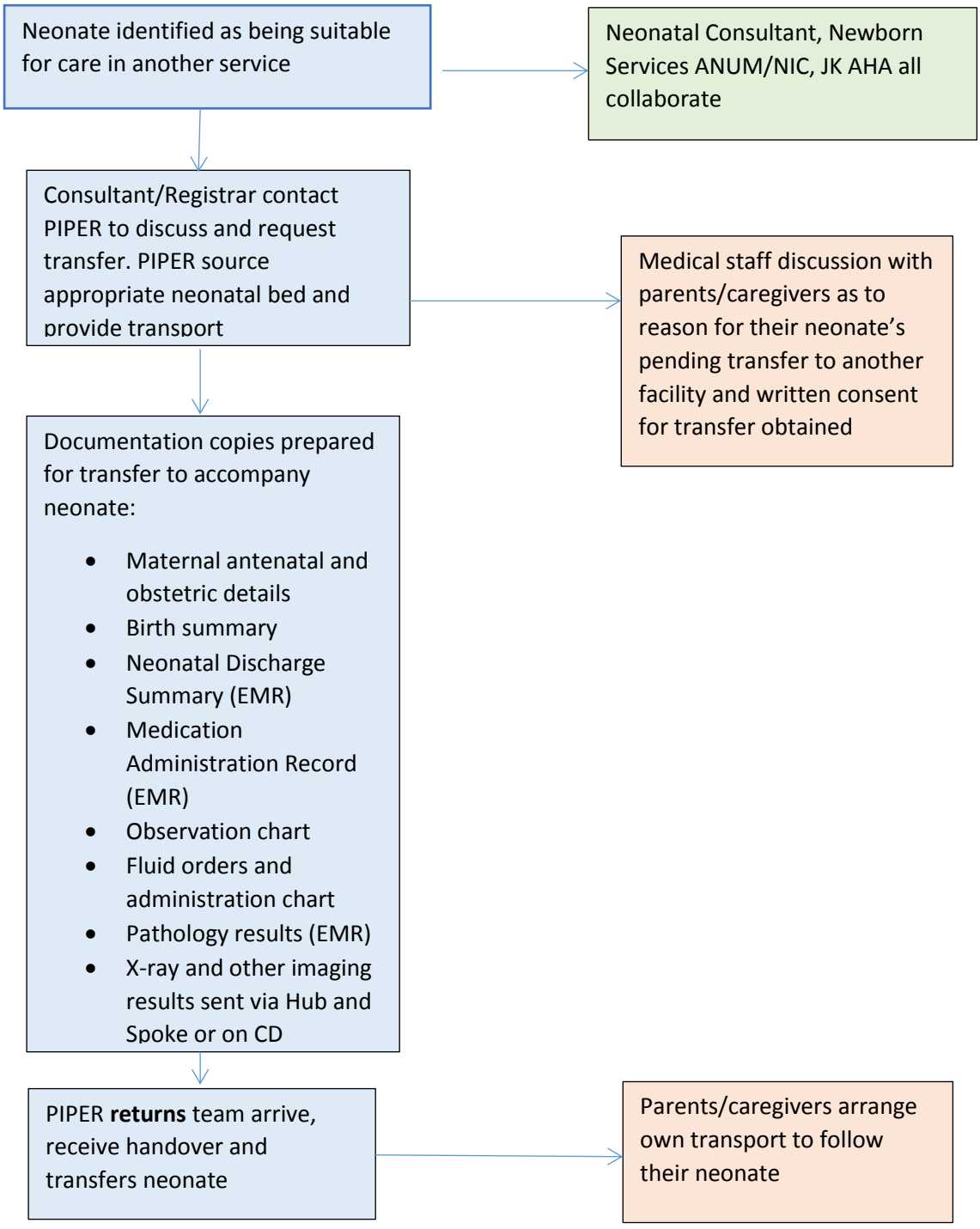


Figure 3: Process for non-urgent transfer of neonate to another health service

6.1.2 Discharge to HITH

If a neonate is suitable for discharge home but requires close monitoring of weight gain, feeding, nasogastric tube feeding or ongoing home oxygen therapy, transfer to Neonatal HITH is arranged as per the *Neonatal Hospital in the Home (HITH) Operating Guideline (2019).*

6.1.3 Discharge home

Discharge planning will commence soon after admission for all Newborn Services in-patients. Parent assistance and education is a focus throughout the admission. When rooming-in facilities are available prior to discharge, parents/caregivers are encouraged to room in for a minimum of one night. The aim is to ensure that parents are able to take over the care of their child in a supported environment. In some situations a longer period may be required and further nights may be arranged dependent on the neonate and family's individual circumstances. Once the patient has been deemed suitable for discharge by the Neonatal medical team, a discharge summary is generated from the EMR as well as a discharge prescription if required. These documents are required for discharge to Neonatal HITH or for discharge home from Newborn Services. Planned discharge is scheduled to occur between 10:00 – 11:00 regardless of destination (HITH/Home).

7. Follow-Up

Neonatal patients can be followed up by the Neonatal Consultants in the Neonatal Services Specialist Clinic, JKWC, Ground Floor, Children's Clinic A, and by Allied Health professionals in Neonatal and Paediatric Allied Health Clinics, JKWC, Ground Floor, Children's Clinic A or B as appropriate. Neonatal Outpatient referrals are made via BOSSnet at discharge; guidance on eligibility criteria and the anticipated interval to appointments can be found in the *Access Referral Guidelines, Paediatric Medicine Specialist Clinic - Neonatology* which will be available on the WH intranet.

If a more urgent medical review is required, this can be arranged to occur within one day to two weeks of discharge (Tuesday – Friday) in a registrar-run Rapid Review clinic, with Neonatologist oversight. An internal referral via BOSSnet will be the referral path.

8. Infrastructure

8.1 Patient Care Environment

Newborn Services is located on Level Five of the JKWC at SH. The ward has physical capacity of six single NIC rooms, six single HDU rooms, 18 SCN beds configured in three-bed areas, and nine single rooms for parent rooming in prior to discharge. One each of the NIC and HDU rooms are negative pressure isolation rooms. Each bed space is divided into three zones; clinical, patient, parent/support zone. The parent/support zone has a day bed to enable one parent/guardian to stay overnight.

8.2 Clinical areas

The following areas will support neonates and parents during admission:

- Baby bath room x two
- Breastfeeding/expressing room
- Milk room
- Special care procedure room
- Bereavement room
- Medication room x two

8.3 Non-Clinical Areas

The following non-clinical support areas are located within Newborn Services

- Consumable store room
- Equipment store
- Biomedical workstation
- Biomedical clean-up room
- X-ray park
- Nitric store
- Clean utility room
- Dirty utility room

8.4 Staff Facilities

Staff working in Newborn Services can access the Level Five staff lounge, meeting room, lockers and toilets and change rooms as required. These facilities are available via swipe card access. Dedicated offices and shared office and workstation facilities are available for use by Newborn Services staff on Level Five.

9. Workforce

Clinical care in Newborn Services is co-ordinated and delivered by a multidisciplinary workforce that is staffed from both within and external to the Division of W&C Services as listed in Table 9.

Discipline/s	Division/Directorate	Role/s
Nursing	W&C Services	• Operations Manager for Paediatric, Neonates and Gynaecology. • Nurse Unit Manager(NUM) • Neonatal Services Development Manager (NSDM) • Associate Nurse Unit Managers (ANUM) • Clinical Nurse Specialists (CNS) • Clinical Midwife Specialists (CMS) • Clinical Practice Improvement Specialist (CPIS) • Clinical Nurse Educators (CNE) • Registered Midwives (RM) • Registered Nurses (RN) • Enrolled Nurse (EN) • Lactation Consultant (LC)
Medical	W&C Services	• Head of Unit – Neonatology • Head of Unit – Paediatrics • Consultant – Neonatology • Consultant – Paediatrics • Registrars/HMOs – Paediatrics & Neonatology
Other Medical		• Consultant – Cardiology • Consultant - Endocrinology • Consultant – Perinatal Genetics • Consultant - Paediatric Surgery • Consultant and JMS – Plastic Surgery, ENT, Orthopaedics, Ophthalmology • Perinatal Mental Health - Psychiatry

Discipline/s	Division/Directorate	Role/s
Allied Health	Allied Health, Community Services and Service Planning	• Audiology • Nutrition & Dietetics • Occupational Therapy • Pastoral Care • Physiotherapy • Psychology (limited service) • Speech Pathology • Social Work
Clinical Support	Clinical Support & Specialist Clinics	• Pharmacy • Victorian Infant Hearing Screen (external provider)

Table 9: Newborn Services Clinical Workforce

9.1 Mandatory Competencies

All WH staff are required to undertake annual mandatory training as outlined in the Mandatory Training Procedure. Table 10 outlines the annual mandatory competencies for staff working in Newborn Services.

	Nursing	Senior Medical Staff	Registrars & HMOs	Allied Health
Fire and Emergency Procedures	✓	✓	✓	✓
General Manual Handling	✓	✓	✓	✓
Back 4 Life Patient Handling	✓	✖	✖	✓
Therapeutic Handling	x	x	x	✓*
Hand Hygiene	✓	✓	✓	✓
Aseptic and No Touch Technique (ANTT)	✓	✓	✓	✖
Basic Life Support and Defibrillation (BLSD) or ALS	✓	*2 yearly*	✓	✓
Neonatal and Pediatric Life Support (NLS and PLS)	✓	NLS	✓	✖
Online Neonatal Life Support	✓	✓	✓	x
Blood Components and Blood Transfusion Practice	✓	✖	x	✖
Prevention and Management of Occupational Violence	✓	✓	x	✖
Breastfeeding	✓	✓	x	x

Table 10: Mandatory competencies for clinical staff working in Newborn Services

*The therapeutic handling competency applies only to physiotherapists, occupational therapists and allied health assistants

10. Education & Training

10.1.1 Service-Based Education - Nursing

Newborn Services in JKWC has Clinical Nurse Educator positions to assist new, existing, undergraduate and postgraduate nurses and midwives to become more knowledgeable and proficient in delivering care to unwell, preterm and term babies.

An in-service program which utilises a variety of education formats is available for all staff to attend, with sessions run at 14:15 Monday – Friday. Occasional night duty sessions occur on an ad-hoc basis and a once-a-month ND opportunity with a designated later shift start –time for afternoon staff facilitates education provision for Night Duty staff. An Education Calendar for the current month is displayed in the staff room on Level Five of the JKWC and emailed to all the nurses and midwives at the start of each month by the Clinical Nurse Educator of Newborn Services.

Western Health WeLearn modules on the Neonatal portal via Women's and Children's Division are continually being developed. Once topics have been presented at face-to-face sessions, resources are uploaded onto WeLearn so that they can be accessed by all staff for continuing professional development.

10.1.2 Service-based Education - Medical

Trainee medical staff are employed on three to twelve month contracts. A component of their orientation is neonatal education. HMOs participate in hospital-wide generic medical education. Registrars and HMOs participate in a neonatal education program that includes tutorials, journal club, procedural simulation and resuscitation and stabilisation scenarios (usually multidisciplinary including nursing, midwifery and anaesthetic trainees).

10.1.3 Multidisciplinary and Interdisciplinary Service-based Education

Opportunities for multi and interdisciplinary education exist and are communicated via the Education Leads in Nursing and Midwifery. The Simulation Centre in the Western Centre for Health Research and Education host a number of programs that involve staff from different disciplines and clinical areas, including several neoResus programs annually.

10.2 Research

Western Health participates in the data collection program facilitated by the Perinatal Society of Australia and New Zealand. This provides opportunities for research. In addition, Newborn Services often participates in multicentre trials – such as comparing High Flow with CPAP, and the management of neonatal CMV infection. Future provision for FTE to be utilised by a data nurse to assist with data collection and reporting has been proposed.

11. Policies, Procedures & Guidelines

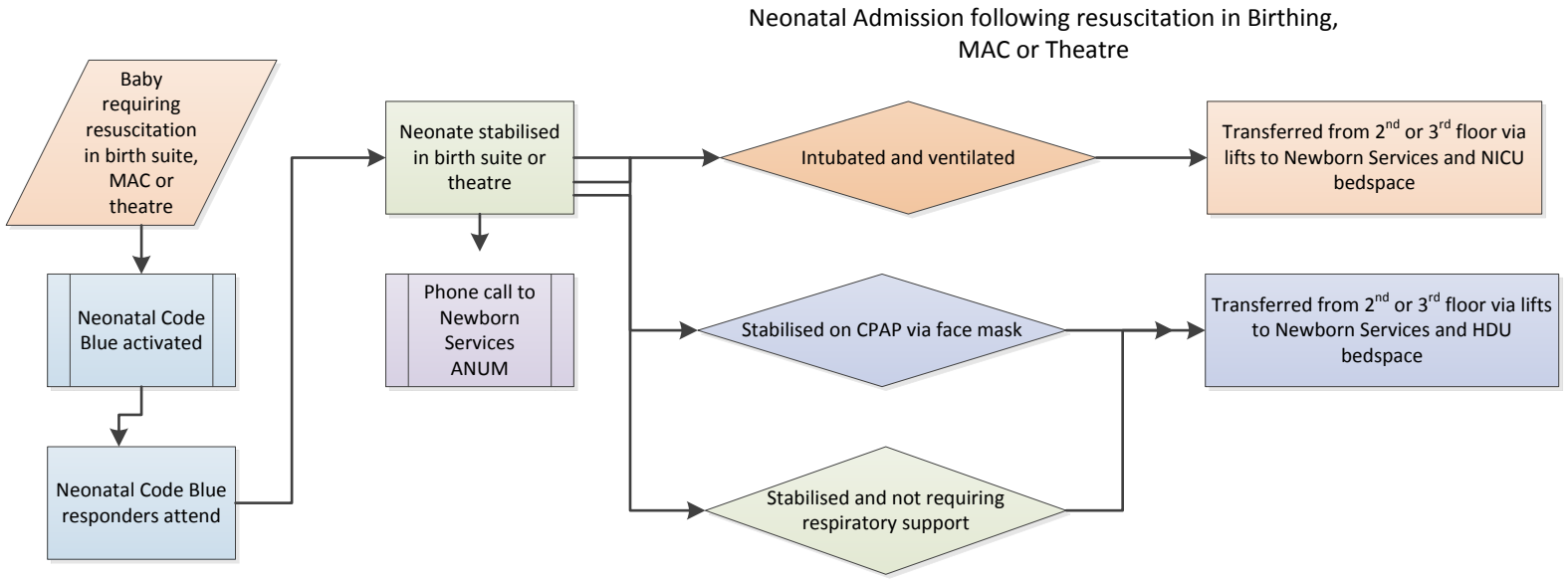
Table 11 lists the WH policies, procedures and guidelines (PPGs) that are specific to Newborn Services.

DG-CC2.6.6	Management of Early Onset Group B Streptococcus(EOGBS) Sepsis in Newborns
OP-PS1.1.G3	Gentamicin Administration in the Neonate and Child
	Neonatal and Paediatric Peripherally Inserted Central Catheters- Parent Information Form
DP-CC2.1.7	Neonatal Hypoglycaemia
DG-PS1.3.1	Vitamin D - Antenatal, Postnatal and Neonatal Management
DG-PS1.3.2	Metabolic Bone Disease (Osteopenia in Preterm Infants)
DP-CC2.1.10	Diagnosis and Management of Subgaleal Haemorrhage in At Risk Infants.
DG-PS1.3.3	Premedication for Neonatal Intubation
DP-PS1.1.S1	Surfactant Administration
DP-CC2.1.5	Rooming-in in Special Care Nursery
DP-CC2.1.1	Investigation and Management of Babies born to Mothers with Thyroid Disorders
DP-CC2.1.4	Neonatal Nasal Continuous Positive Airway Pressure (CPAP)
DP-CC1.1.1	Paediatric Referrals and Admission to Special Care Nursery (SCN)
DP-CC2.2.1	Neonatal Tension Pneumothorax
DP-CC2.1.9	Inguinal Masses in Infants
OP-PS1.1.S3	Administration Of Sucrose as an Analgesic in Infants
DP-CC2.1.12	Extravasation Injury Management - Paediatric Neonatal
DP-CC	Kangaroo Care and Skin to Skin Contact in the Special Care Nursery
DP-CC2.1.13	Neonatal Intravenous Nutrition (IVN)
DP-CC2.1.15	Enteral feeding in SCN
DG-CC7.2.1	Paediatric Palliative Care
DP-CC2.1.17	Oxygen Saturation Monitoring in Special Care Nursery
DG-CC2.6.3	Jaundice in Newborn Babies less than 35 Weeks Gestation
DP-CC2.1.8	Developmental Dysplasia of the Hip (DDH)
DG-CC2.6.5	Management of Suspected Imperforate Anus in Newborns
DP-CC2.1.2	Management of PICC in Neonatal and Paediatric Patients
DP-PS1.1.P1	Palivizumab in Neonates and Infants
DP-CC2.1.19	Neonatal Umbilical Arterial Catheter (UAC)
DP-CC2.1.20	Neonatal Umbilical Venous Catheter (UVC)
OP-CC2.1.3	Paediatric and Neonatal Code Blue
DP-PS1.2.1	Use of Western Health Neomed Medication Resource
OP-CC2.1.11	Vulnerable Babies, Children and Young Persons at Risk of Harm and Placement of a Child at Western Health by Child Protection or Court Order Procedure

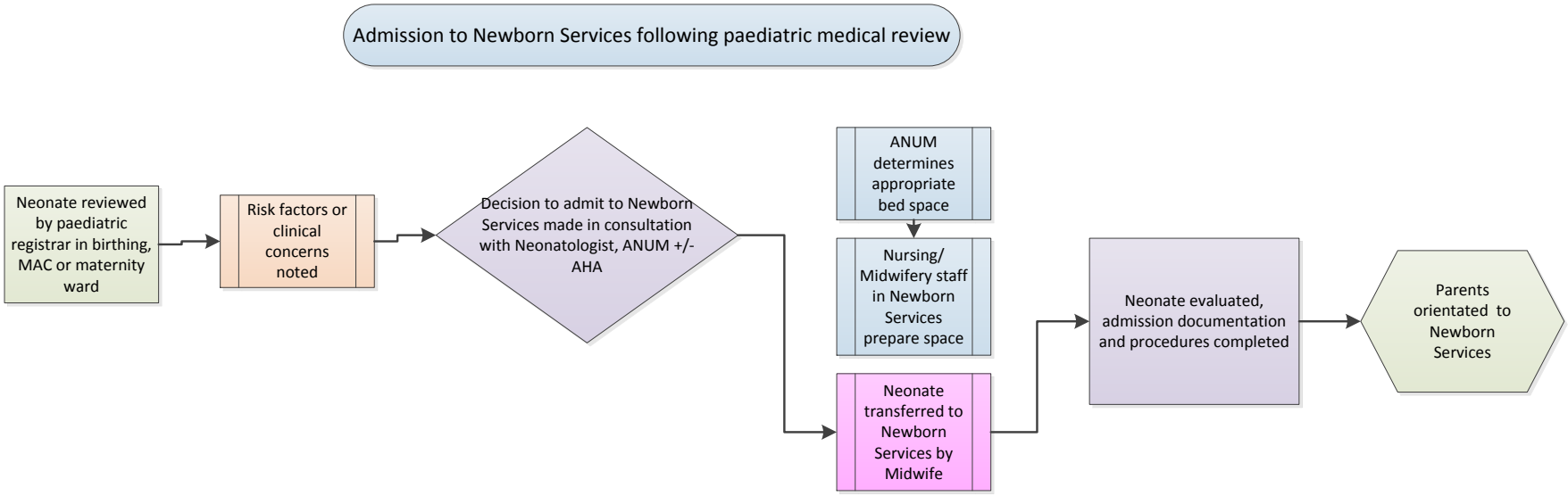
Table 11: Newborn Services specific PPGs

12. Appendix 1 – Patient Flow Diagrams

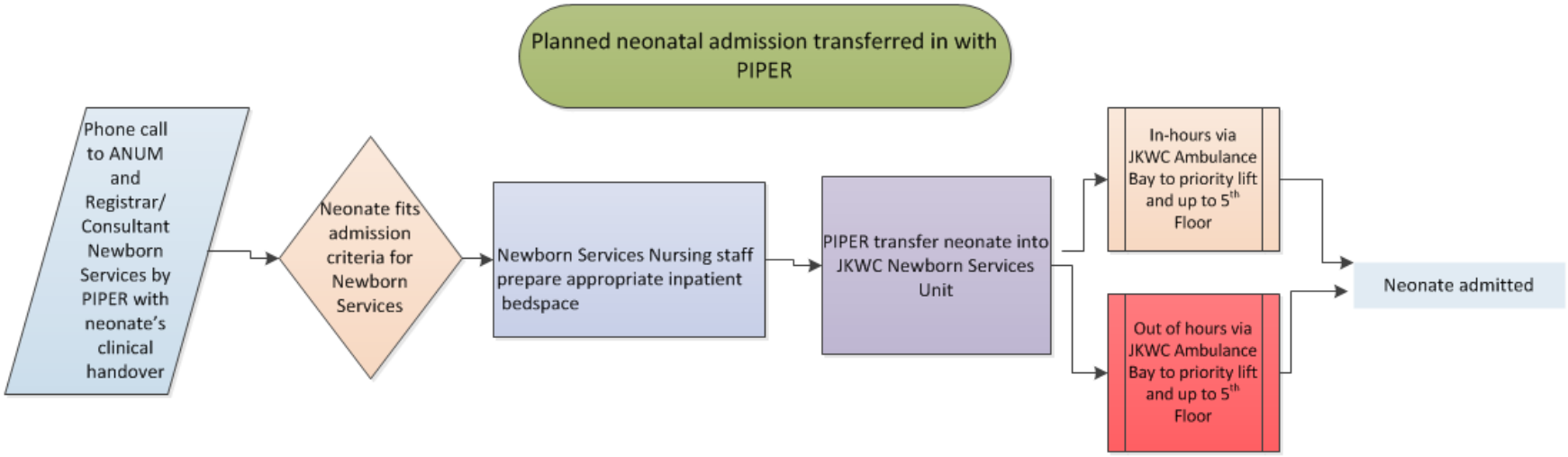
12.1 Neonatal Admission Following Resuscitation in Birthing, MAC or Theatre



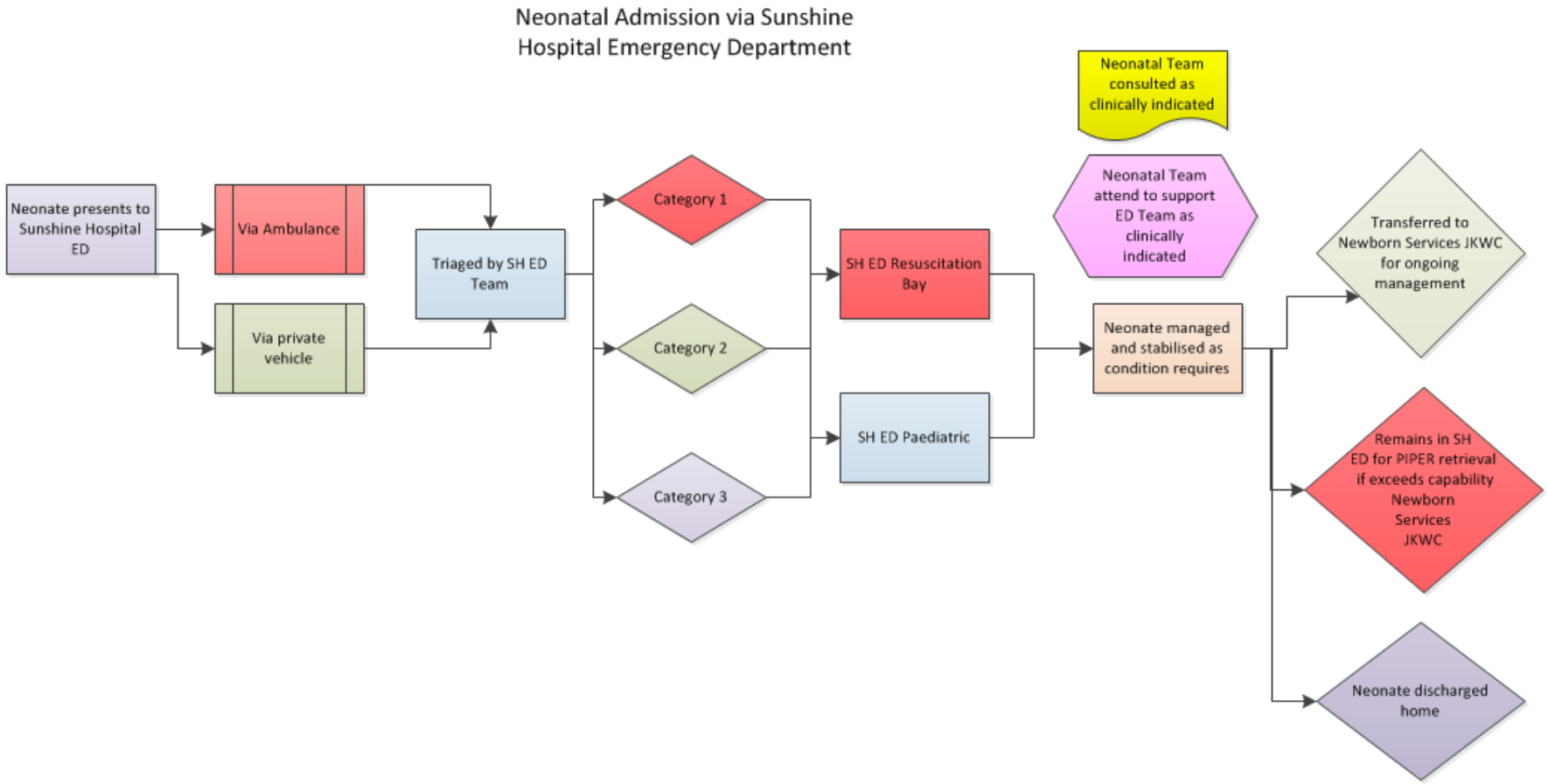
12.2 Admission to Newborn Services following paediatric medical review



12.3 Planned Neonatal Admission transferred in with PIPER

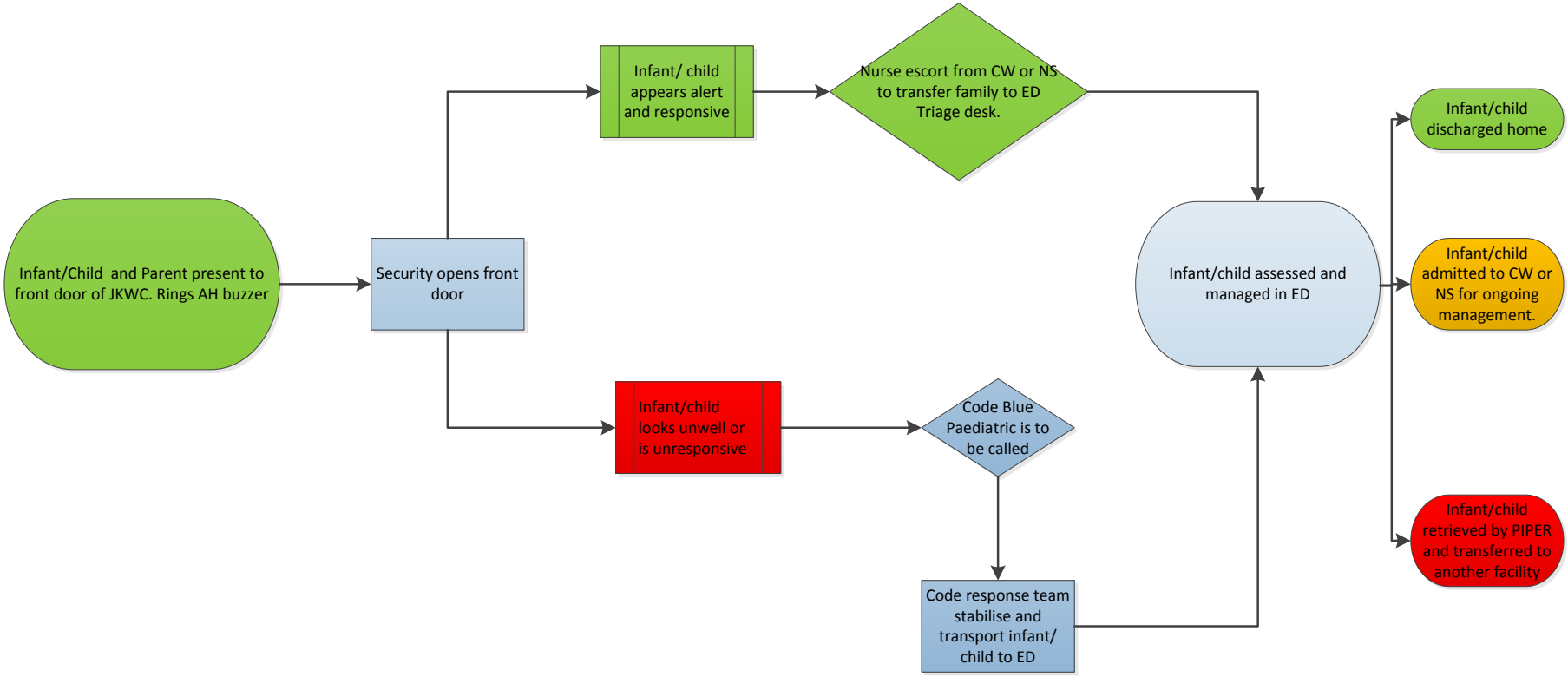


12.4 Neonatal Admission via Sunshine Hospital ED



12.5 After-hours unplanned presentation of infant/child to JKWC

After Hours Unplanned Presentation of Infant/Child to JKWCH



13. Appendix 2 – Stakeholders Consulted

Stakeholder Name	Title	v1.0 Feedback	v2.0 Feedback
Adele Mollo	Divisional Director, W&C Services	No	Yes
Glyn Teale	Clinical Services Director, W&C Services	Yes	Yes
Maree Comeadow	Operations Manager – Gynaecology, Paediatrics and Neonates	Yes	Yes
Melissa Dodsworth	Unit Manager, Newborn Services	Yes	Yes
Martin Wright	Head of Paediatrics	Yes	Yes
Thao Lu	Neonatologist	Yes	Yes
Rosalyn Pszczola	Neonatologist	Yes	Yes
Gregory Woodhead	Neonatologist	Yes	Yes
Penny Kee	Neonatologist	Yes	Yes
Julia Firth	Operations Manager, Medical Imaging & Pathology Contract	No	Yes
Angus Campbell	Allied Health JKWC Project Officer	Yes	Yes
Nicole Keogh	Quality Improvement Partner, W&C Services	No	No
Marieta Pring	Lactation Consultant	Yes	No
Phuong Nguyen	Pharmacy JKWC Project Officer	Yes	Yes
Tim Henderson	JKWC Logistics Support Manager, Health Support Services	Yes	Yes
Wendy Watson	Director of Nursing & Midwifery, Sunshine Hospital	Yes	Yes
Janelle Parsons	Clinical Practice Improvement Specialist	N/A	Yes
Kathy Macdonald	Chief Radiographer, Sunshine Hospital	Yes	Yes
Julia Blackshaw	Allied Health Director	No	Yes
Grace Crowe	Maternity Services Development Lead	Yes	Yes
Dianne Pattison	Paediatric Services Development Lead	Yes	Yes
Erin Casey	JKWC Operational Support Manager	Yes	Yes
Seona Emanuelli	Clinical Nurse Educator Special Care Nursery	N/A	No