Mid Essex Hospital Services NHS Trust

CARE OF PRETERM AND SMALL FOR GESTATIONAL AGE INFANTS ON THE POSTNATAL WARD	CLINICAL GUIDELINES Register No: 08013 Status: Public

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Policy to be followed by (target staff)	**Midwives, Obstetricians, Paediatricians**
Distribution Method	Intranet & Website. Notified on Staff Focus
Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 09128 Prevention and Management of Neonatal Hypothermia 09111 Management of Breast Feeding in the Postnatal Period 08094 Premature Neonatal Feeding 12025 Treatment of Neonatal Hypoglycaemia in the high risk infant 08055 Passing a shot term naso-gastric tube/orogastric tube on an infant 04225A Admission to the Neonatal Unit

Document History Review:

Review No:	Reviewed by:	Issue Date:
1.0	Julie Bishop	July 2005
2.0	Sharon Pilgrim	January 2008
3.0	Sharon Pilgrim	January 2012
4.0	Sharon Pilgrim	28 April 2015
5.0	Sharon Pilgrim – Full review	28th August 2018

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1.0 Purpose

1.1 To give guidance to midwives to care for infants between 35 - 37 weeks gestation nursed on the Postnatal Ward.

1.2 To give guidance to midwives who care for IUGR (intra-uterine growth restricted) infants whose weight is on the 3rd centile or below for gestations that are being nursed on the postnatal ward.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Aims of Management and Care

3.1 To allow mother and baby to be nursed together in the Postnatal Ward and to monitor the following:

- Prevent hypoglycaemia
  (Refer to guideline Treatment of Neonatal hypoglycaemia in the High risk infants register number 125025)

- Prevent hypothermia
  (Refer to the guideline for the 'Prevention and management of neonatal hypothermia'; register number 09128)

- Establish and maintain optimal weight gain of 15g/kg/day

- Establish enteral feeding as required

4.0 Management of Feeding for Preterm and Small for Gestational Age Infants

(Refer to the guideline for the 'Management of breast feeding in the postnatal period'; register number 09111; 'Premature neonatal feeding'; register number 08094)
(Refer to Appendix A)

4.1 Evidence suggests that the use of breast milk in preterm and small for gestational age infant, provides protection from infection particularly necrotising enterocolitis. Therefore parents need to have an understanding of the health benefits of breast milk. Mothers should be encouraged to hand express as soon as possible (within 4 hours) and should continue to express at regular intervals in order to maximise milk supply.

4.2 3 hourly feeds should be commenced within 4 hours of birth following a pre-feed blood glucose reading.
(Refer to guideline Treatment of Neonatal hypoglycaemia in the High risk infants register number 125025)

4.3 Feed volume should be calculated as per postnatal feeding protocol and re-calculated daily. (Appendix A.)

4.5 A nasogastric tube (NG) should be passed if the infant is unable to complete a bottle feed, is not fixing to the breast or is not waking for feeds. Alternate sucking and tube feeds may be required for several days. NG top-ups may be required following breast feeds.

4.6 Weigh the baby on the third day and every 3rd day following thereafter. Weight and head circumference should be plotted on a centile chart weekly.

4.7 Consult neonatal unit staff daily for advice if required.

4.8 Small infants should be nursed in a warm environment. Aids such as the heated cot should be used to minimise heat loss. Mothers should be encouraged to do Kangaroo mother care for periods with the infant placed directly on the mothers chest dressed only in a nappy. When in a cot Infants should be warmly dressed at all times. (Refer to guideline prevention and management of neonatal hypothermia No. 09128)

4.9 Minimal handling by visitors should be encouraged to help promote rest and reduce energy requirements.

4.10 Each infant should be reviewed by the midwife each shift and seen by the paediatrician daily.

4.11 Any infant who is not tolerating feeds, has unstable blood glucose levels or temperature, has lost a significant amount of weight (>10%) or is handling poorly must be referred to the paediatric registrar.
(Refer to guideline Treatment of Neonatal hypoglycaemia in the High risk infants register number 125025 and Guideline for admission to the Neonatal unit register number 04225A)

4.12 Infants may be discharged home when they are established on enteral feeds and maintaining their temperature. They may be discharged home with a nasogastric tube in situ as long as they are completing 2 sucking feeds within 24 hours. A referral to the community paediatric service should be made prior to discharge and supplies of feeding syringes given to parents to take home.

4.13 If there are concerns regarding feed intake or weight refer to a paediatrician. Early post discharge weight checks should be arranged in the community to establish adequate weight gain is being achieved (i.e. ≥ 15/g/Kg/day).

5.0 Staff and Training

5.1 All staff caring for intra-uterine growth restricted (IUGR) and pre-term infants on the postnatal ward should be aware of the relevant MEHT guidelines cross referenced in this guideline.

5.2 All qualified midwifery staff should be fully trained to pass a nasogastric tube and also be able to assist midwifery students in acquiring skills to complete this procedure effectively.

6.0 Infection Prevention

6.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively ‘decontaminate their hands’ before and after each procedure and when undertaking the passing of a nasogastric tube the Aseptic Non-Touch Technique (ANTT) should be utilised.

7.0 Audit and Monitoring

7.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

7.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

7.3 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

7.4 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

7.5 Key findings and learning points will be disseminated to relevant staff.

8.0 Guideline Management

8.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

8.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

8.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

8.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

9.0 Communication

9.1 A quarterly 'maternity newsletter' is issued to all staff with embedded icons to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

9.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

9.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

9.4 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

10.0 References

Rosie Hospital (2013) The Neonatal handbook

Boxwell G (2010) Neonatal Intensive Care Nursing. London: Routledge

Lars Hanson, Immunobiology of Human milk: How breast feeding protects babies: www.ibreastfeeding.com/larrs-hanson-phd

Meeks M (Ed), Hallsworth M (Ed), Yeo H (Ed) (2009) Nursing the Neonate (2nd Edition) Wiley Blackwell

Gomella T (Ed), Cunningham M (Ed), Eyal F (Ed), Tuttle D J (Ed) (2013) Neonatology management, procedures, On-Call problems, Diseases and Drugs. (7th Edititon) New York Lange McGraw Hill.

Feeding Regime for Postnatal Ward

Day of Age	Term SGA	GA <37 weeks
1	**40mls/kg/day**	**60mls/kg/day**
2	**60mls/kg/day**	**90mls/kg/day**
3	**90mls/kg/day**	**120mls/kg/day**
4	**120mls/kg/day**	**150mls/kg/day**
5	**150mls/kg/day**	**150mls/kg/day**

From day 5 feeds may be increased by 10mls/kg/day to a maximum of 160mls/kg/day for preterm formula or 200mls/kg/day for EBM or term formula.

- Feed every 3 hours at correct mls/kg/day this may be increased to the next day on the neonatal feeding regime i.e. from 40ml/kg day 1, to 60mls/kg to maintain blood sugars
- Should not be increased by more than one day ahead without consulting a paediatric registrar.