ADMISSION AND DISCHARGE CRITERIA TO THE GRACE CENTRE FOR NEWBORN INTENSIVE CARE - CHW

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- All babies admitted to GCNIC are admitted under the direction of the on-call Neonatologist.
- The decision to discharge babies from GCNC is that of the on-call Neonatologist in collaboration with members of the multidisciplinary team
- GCNIC has the dual role to accommodate patients from external sources as well as patients from within CHW
- GCNIC surge graph provides details of bed management and access in GCNIC

CHANGE SUMMARY

- Updated GCNIC Surge Table
- Included PICNIC transfer information

READ ACKNOWLEDGEMENT

- All medical staff admitting neonates to the Grace Centre for Newborn Intensive Care should read and acknowledge they understand the contents of this policy.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st April 2022	**Review Period**: 3 years
Team Leader:	Nurse Educator	**Area/Dept**: Grace Centre for Newborn Care

Admission Criteria

- **Neonates** under one month of age or a corrected post-conceptional age of one month, in the case of premature babies.
- **Priority** is given to:
  - Neonatal surgical emergencies
  - Neonatal cardiac lesions
  - Neonates with critical airways
  - Complex medical conditions requiring multidisciplinary care and with high dependency needs such as metabolic and genetic conditions.
- **All other babies (>28 days)** presenting to the emergency department or from other hospitals are admitted to appropriate wards in the hospital led by the respective medical leads and Bed Manager. In exceptional circumstances admissions may be negotiated with the neonatologist on call and Nurse Manager or delegate.

Admitting consultant

- All babies admitted require consultation and confirmation by on-call Neonatologist.
- All babies are to be admitted under the on-call Neonatologist, who will be the primary consultant with other relevant sub specialists becoming co-consultants.

PICU to NICU (PICNIC) Huddle

- PICNIC Huddles occur for any patient transfer between GCNIC to PICU
- Timing of the huddle and attendees is identified in the morning at Grace Team Talk and PICU Safety Huddle
- The Consultant, Fellow, NP and Team leaders from each unit are required to attend
- A repeat huddle occurs if the transfer did not occur within 12 hours of the huddle
- The completed huddle check list (see appendix) is signed, copied and placed in a designated folder in each unit

Discharge Criteria

- The decision for discharge is made by the on-call Neonatologist in collaboration with the other members of the multidisciplinary team.
- Patients may be discharged to PICU for management post by-pass surgery or for ongoing care beyond the neonatal period.
- Convalescent patients will be transferred to their referring or other suitable hospitals when they have improved to the point where they can be cared for by that hospital, specialist evaluation has been completed, or a terminal or untreated condition exists

and the infant is to be reunited with the parents (if this is their wish). Alternative arrangements in consultation with the parents may need to be implemented including transfer to an alternate site.

- Some patients requiring long-term care in CHW will be transferred internally to a ward deemed appropriate by the discharging team in consultation with the accepting medical team and Bed Manager.
- Patients will be discharged home when the medical or surgical condition has resolved; there is appropriate weight gain; parental skills in infant care and any necessary nursing procedures are satisfactory.
- Support for patients discharged from the unit will be coordinated by the Nurse Practitioner and Nurse Unit Manager in consultation with members of the multidisciplinary team. Sources of follow up support may include:
  - Nurse Practitioner led Acute Review Clinic (ARC)
  - Hospital in the Home (HITH)
  - KidsGPS
  - Community based support

Neonatal Admissions from CHW ED to Westmead Adults Hospital NICU

Westmead Hospital's (WH) Perinatal Unit has local guidelines for admission of patients to their unit. The following components should also be considered:

- Readmission timeframe is 7 days from the day of discharge from WH
- Factors influencing the capacity to readmit the patient to WH may include gestational age at discharge or an infectious/viral presentation to hospital
- CHW ED may seek support from GCNIC in the management of the patient prior to referral to WH
- Decision to request an inter-hospital transfer from CHW to WH, either from ED, wards or NICU/PICU is made only after the approval of the named consultant managing the patients care
- Request for admission to WH and clinical handover is to occur between CHW treating team and WH Neonatal Fellow or Consultant
- The mode of transport and escort required is the responsibility of the referring hospital

Babies from Westmead's Perinatal Unit presenting *to CHW Emergency Department* deemed too unwell to be transported to Westmead require admission to GCNIC for stabilisation and management.

Surge Management

The following Surge table has been developed in line with the neonatal State-wide Bed state and in collaboration with the CHW Demand Management and Escalation Plan. It is understood that the GCNIC is part of a state-wide service for the provision of neonatal beds and is also part of the CHW, and therefore has a duel role to accommodate patients from external sources as well as within the hospital. The graph is to be used in conjunction with the Bed state which is updated on numerous occasions each shift by the nurse in charge of GCNIC.

Escalation Level	Status	Trigger Points	Action Required
Level 0	Core business as usual	Sufficient nursing and medical staff, and equipment, to care for any patient needs and acuity	Ensure all standard operational procedures are functioning as efficiently as possible to maintain flow Level 0 strategies are actioned: • NUM/TL to communicate the current escalation level to the wider GCNIC team each shift at Team Talk • Maintain safe medical and nursing staffing levels and continually monitor safe nurse-to-patient ratio • NUM/TL to continually monitor essential equipment status (ventilators/pumps/specialist beds) • Continue routine ward rounds, and SCHN and GCNIC team talks • Maintain up to date discharge summaries and proactive discharge planning • Referrals to potential accepting ward teams early in admission • NUM/TL to attend Patient Flow meeting to discuss activity and staffing requirements for GCNIC o Review of PFP for potential transfers to and from GCNIC o Review prospective antenatal and postnatal admissions (including Westmead Hospital deliveries)
Level 1	Moderate Pressure	Compromised nursing and/or medical staffing levels/skill mix/acuity:	Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. De- escalate when applicable. Levels 0 & 1 strategies are actioned:

		• There is insufficient equipment available • GCNIC capacity at 20 beds occupancy and/or high acuity caseload • ICU at 10-12 beds • Multiple isolation requirements	• NUM/TL to communicate escalation level status at GCNIC and SCHN team talks • NUM/TL to collaborate with C1*/C2** to expedite discharges/transfers and prioritise admissions • C1/C2 to ensure handover/planning and accepting consultants are up to date at least 1 day prior to discharges • NUM/TL and C1 to increase nursing/medical staffing levels as appropriate to provide appropriate cover • NUM/TL to monitor and ensure that essential equipment is maintained and available
Level 2	Severe Pressure	• GCNIC at 23 beds occupancy and/or high acuity case load and/or staffing issues • ICU at 13-14 beds • Insufficient key equipment available • Compromised nursing and/or medical staffing levels/skill mix/acuity with no cover available • The number of infected patients in the unit exceeds isolation capacity	Prioritise available capacity in order to meet immediate pressures. Put contingencies into action and bring pressures back within unit control. De- escalate when applicable & ASAP Levels 0, 1 & 2 strategies are actioned: • NUM/TL and C1 to communicate status at GCNIC/SCHN team talks, and discuss measures including intra-hospital transfers • NUM/TL to collaborate with C1/C2 to expedite discharges/transfers, discharge planning and summaries, and prioritise admissions • NUM/TL & C1/C2 to negotiate potential transfers with PICU Consultant and NUM/TL • NM/NUM/TL and/or C1 to notify AHNM and Critical Care Program Directors • NUM/TL, NM and C1 to determine safe nurse-to-patient ratios, medical/nursing staffing requirements and prospective overtime • Consider fellow/NP cover for POD2 for the weekend
Level 3	Extreme pressure	• GCNIC capacity at ≥23 beds occupancy and/or high acuity case load and/or multiple isolation requirements and/or staffing issues • ICU beds 14+ • There is insufficient key equipment available	Ensure all contingencies are operational to recover the situation. De-escalate when applicable and ASAP Level 3: Level 1,2 & 3 strategies actioned • Cancel elective surgery • Escalation to SCHN CPD and AHNM • C2 on site as directed by C1 • C1 to notify HODs and coordinate extra medical staff help as required via HOD and CRMO

		• Severely compromised nursing and/or medical staffing levels/skill mix/acuity with no cover available • The number of infected patients in the unit exceeds isolation capacity	• NUM/TL and C1 to review prospective admissions, to be triaged and diverted if possible • C1 to alert Westmead Hospital Co-directors of escalation level
Level 4	Exceptional Pathway	Level 3 trigger points and any of the following: • All surge beds are open • No capacity to admit any patients from other hospitals or wards (complete bed block) • Hospital at full capacity • Code Brown and/or other applicable codes (Code Red, Code Black, Code Purple etc)	This may result due to unexpected internal influx or as a result of an external matter which has placed unprecedented pressure on the department • Level 1, 2 and 3 strategies actioned • Escalation to Disaster Protocol • NM/NUM/T/L to notify CPD and AHNM • C1 to contact HODs • C1 and NM/NUM/TL to call disaster if necessary • HODs to source additional medical help via a dial list and liaise as per disaster protocol

*C1= consultant pod 1, **C2= consultant pod 2, ***HOD = Heads of department

Appendix: PICNIC Huddle Checklist

PICNIC HUDDLE CHECKLIST

Patient identification label

Date:

Time:

Location: **Bed number:**

Staff members present:

Proposed transfer date/time:

Instructions:
- *Time & attendees of huddle identified in morning (Grace Team Talk and PICU Safe Start)*
- *PICNIC Consultant/Fellow, PICNIC team leaders to be present for huddle*
- *Huddle to be attended at patient bedside at designated time (default time 11:30am)*
- *Repeat huddle if transfer not occurred within 12 hrs*
- *Completed sheet to be signed, copied and placed in designated folder on each unit*

Handover Checklist (to be read in conjugation with the patient discharge summary):

Completion of ISBAR	Yes / no
Clinical management plan discussed	Yes / no
Infection risk/isolation requirements	Yes / no
Subspecialty team aware/agreed	Yes / no
Is the discharge summary template complete?	Yes / no
Medications transcribed	Yes / no
Potential Incidents/Risks identified	Yes / no
Has newborn screening been completed?	Yes / no
Parents aware	Yes / no
Social alerts acknowledged	Yes / no
Allow a Natural Death Plan in situ	Yes / no

Hardware in situ

ETT/tracheostomy	Yes / no	IAL	Yes / no
CVL	Yes / no	Drains	Yes / no
PD Catheter	Yes / no	Pacing wires	Yes / no

Is an out of hours transfer occurring? Yes / No

If 'Yes' to above, what is the reason for this -

Factors contraindicating transfer

Open chest	Yes / no	Replogle tube in situ	Yes / no
Active pacing	Yes / no	Weight <1.5kg	Yes / no
Ongoing Peritoneal dialysis	Yes / no		

Are there any outstanding issues that needs follow-up?

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Date and time for huddle re-review if transfer has not occurred within 12 hrs:

Attendee name and Sign off:

PICU consultant/fellow..... **PICU Team Leader**.....

NICU consultant/fellow..... **NICU Team Leader**.....