NEONATAL ADMISSION AND DISCHARGE CRITERIA
(<1 MONTH CORRECTED AGE)

PLACES OF CARE

- **Mother-** this is the preferred place for all well stable babies

- **Well baby nursery** (postnatal ward) - for babies requiring closer observation and simple care.
  - Well term babies with sick or absent mothers
  - Well term babies (>1.7 kg) for phototherapy that for some reason cannot be given at the mother's bedside.
  - At risk babies eg LGA, IDM, PROM as per list below

- **24 hour KMC-** For stable, growing premature babies on full feeds.
  The baby should not be on IV fluids but IV cannulas for antibiotics are acceptable

- **Neonatal unit-** For sick and very low birth weight babies

WHERE TO ADMIT A NEONATE?

- **Well babies with well moms** - Room in with their mothers.

- **Well babies with sick moms** - Should be nursed with the mother in a side ward if possible (particularly if breast feeding) or sent home with the relatives. If this is not possible they should be admitted in the well-baby nursery for a maximum of 1 week while the social worker organises a place of safety.

- **Well babies with no moms** (mother demised or baby abandoned) - admit in the well-baby nursery for a maximum of 1 week while the social worker organises a place of safety.

- **At risk babies** - Do not routinely admit to the neonatal unit. They are at risk for complications and must be assessed in the labour ward for possible admission to the neonatal unit. If no immediate problems are identified transfer the baby with mother to postnatal unit. The baby should be observed for 24 hours with mother or in the well-baby nursery in order to detect any problems that may develop. If symptomatic admit to neonatal unit.

  - **Pregnancy complications**
    - ✓ Babies with Rh negative mothers
    - ✓ Oligo/polyhydramnios
    - ✓ Intrauterine growth restriction (IUGR)
    - ✓ Large for gestational age (LGA)
    - ✓ Eclampsia or pregnancy induced hypertension (PIH)
    - ✓ Maternal medical condition eg cardiac or renal disease
    - ✓ Ante partum haemorrhage
    - ✓ Babies between 2000-2500g

  - **Labour / birth complications**
    - ✓ Birth asphyxia
    - ✓ Meconium stained liquor Grade 3
    - ✓ Obstructive labour with fetal distress
    - ✓ Birth injuries
    - ✓ Assisted deliveries
    - ✓ Prolonged rupture of membranes > 18 hours
    - ✓ Maternal infections – chorioamnionitis, urinary tract infection (UTI) or vaginitis, WR positive
    - ✓ Baby Born Before Arrival (BBA)

- **Small babies-** All babies <2 kg and/or <35 weeks gestation must be admitted initially to the neonatal unit. When able to feed and maintain sugar and temperature, transfer to mum for 24 hours KMC or rooming-in.

- **Sick babies-** Admit to appropriate level neonatal unit as per table below. Any difficult/complicated cases must be discussed with referral centre.

NB. Outside admissions: Babies who have been home and require admission and are < 14 days of age with a neonatal problem should be admitted to the neonatal nursery. Those over 14 days of age or with a non-neonatal illness should be admitted to the children's ward.

ADMISSION / TRANSFER CRITERIA FOR SICK NEWBORNS	**LEVEL 1** Managed by MO	**LEVEL 2** Managed by Paediatrician	**LEVEL 3** Managed by Neonatologist
RESPIRATORY SYSTEM:			
Respiratory Distress from any cause	X		
Nasal CPAP < 40% (refer if unavailable)	X		
Respiratory distress > 60% Headbox Oxygen, > 40% nCPAP or requiring ventilation		X	X
Persistent Apnoea		X	X
Congenital Abnormalities including: ✓ Choanal atresia (severe distress with cyanosis, deep sternal recessions and suprasternal/tracheal tug, no breath sounds with stethoscope over nares, failure to pass feeding tube via nostrils); ✓ Oesophageal atresia or tracheoesophageal fistula (respiratory distress with bubbling saliva from mouth, choking on saliva or feed, failure to pass NG tube into stomach); ✓ Diaphragmatic Hernia (respiratory distress, cyanosis, decreased breath sounds on one side [usually left side] dullness to percussion [before gas enters bowel] scaphoid abdomen [only pre-bag and mask resuscitation, after which air enters bowel and results in distension].			X
CARDIOVASCULAR SYSTEM: Discuss all with referral centre first			
Congenital cyanotic heart disease (cyanosis with/without resp. disease despite 100% O_2, cardiomegally, murmur, hepatomegally)			X
Cardiac failure unresponsive to treatment		X	X
Congenital Acyanotic Heart Disease (post assessment at cardiac clinic)	X (stable)	X	X
CENTRAL NERVOUS SYSTEM: Discuss all with referral centre first			
Congenital Abnormalities (if stable can be assessed as outpatient at neonatal clinic)	X (stable)	X	X
Lethargic and/or hypothermic babies that do not respond to routine management	X	X	
Convulsions (refer if unable to fully investigate)	X (simple)	X	X
Hypoxic ischaemic encephalopathy (HIE) NB exclude other causes. If confirmed hypoxic damage manage at as low a level as possible.	X	X	
GASTROINTESTINAL TRACT: Discuss all with referral centre first			
Congenital abnormalities including abdominal wall defects, intestinal obstructions and anorectal malformations ✓ Oesophageal atresia/ tracheoesophageal fistula ✓ Bowel atresias and stenoses, malrotation, volvulus, anorectal malformation: (early vomiting, passage of little or no stool, abdominal distension); ✓ Gastroschisis- Herniation of abdominal contents lateral to cord. Not contained in a sac ✓ Exomphalos-Hernaition of abdominal contents into the cord. Covered by membrane sac. Discuss all cases with referral centre		X (if small)	X X X X X
Necrotising Enterocolitis (abdominal distension, abdominal wall erythaema/ discoloration/ oedema, abdominal mass, vomiting, bloody stools, general signs of sepsis/shock/collapse). ✓ Surgical ✓ Medical	X (stable)	X	X X
Persistent vomiting		X	X
Persistent GIT bleeding			X
GENITOURINARY SYSTEM: Discuss all with referral centre first			
Severe congenital abnormalities of kidney, bladder or genitalia ✓ Including multicystic/dysplastic kidneys, renal agenesis, posterior urethral valves (in male: weak or no urinary stream, bladder distension), severe hydronephrosis, bladder extrophy, cloacal malformation, ambiguous genitalia. (*If stable* discuss telephonically or arrange booking for outpatient assessment at Neonatal Clinic in tertiary POPD)		X	X
Reversible Acute renal failure (Including: pre-renal and ATN)	X	X	
Severe or persistent renal failure		X	X
METABOLIC:			
Neonatal jaundice – Phototherapy	X		
- Onset within 24hrs		X	X
- If associated with pos. coomb's test with or without Hydrops Fetalis		X	X
- For exchange		X	X
Hypoglycaemia - reversible/transient	X		
- persistent or recurrent		X	X
- Infant of a diabetic mother	X		
Inborn errors of metabolism (acidosis/ hypoglycaemia/ neurological signs)			X
GENETIC:			
Stable- following discussion with / assessment at referral centre	X		
Unstable or complicated			X
OTHER: Discuss all with referral centre first			
Haemorrhage eg subaponeurotic or haemorrhagic disease of the newborn	X	X	
Congenital/nosocomial sepsis	X (stable)	X	
Overwhelming sepsis (multi organ failure)			X
Large Wounds e.g. burns, skin conditions, necrosis (requiring plastic/surgical consult)			X

REFERRAL

If a baby's condition deteriorates and can no longer be managed at your level contact your regional/tertiary hospital for advice or possible transfer. NB Resuscitation and stabilisation are essential prior to transfer.

DISCHARGE CRITERIA

- From Regional/tertiary unit to level one hospital:
  - ✓ Weight preferably >1,2 kg
  - ✓ IUGR >1kg
  - ✓ Stable medically
  - ✓ Needing no more than 30% oxygen
  - ✓ Tolerating feeds
  - ✓ Preferably off IVI fluids and antibiotics

- From neonatal unit to 24 hour KMC (See KMC admission criteria)

- Home from 24 hr KMC according to KMC score and home circumstances

- Home from neonatal unit. Must fulfil all the following:
  - ✓ Weight 1.7kg or more
  - ✓ Gaining weight
  - ✓ Breast feeding (or cup feeding if medically unable to breast feed)
  - ✓ Medically fit.

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