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	Document Title:	ADMISSION AND DISCHARGE OF PATIENT TO NEONATAL INTENSIVE CARE UNIT

PURPOSE:


To discuss the processes involved in the admission and discharge of patients, to and from the NICU.

SCOPE:

Applies to all Neonatal Intensive Care Unit personnel of Dr. Pablo O. Torre Memorial Hospital.

PERSON RESPONSIBLE:


Pediatric Consultants or Neonatologist, Resident Physicians, Post-Graduate Interns, NICU Registered Nurses, Admitting Personnel, Supervisor on Duty

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PROCEDURE:

ADMISSION

1. The NICU Nurse on duty prepares the following materials and equipment for possible admission:
 - a) radiant warmer with temperature probe fully functional
 - b) pulse oximeter with probe
 - c) oxygen set (oxygen with gauge, connecting tube nasal catheter or oxygen face mask and aqua pack/humidifier
 - d) laryngoscope with blades
 - e) endotracheal tube size 2.5, 3, or 3.5 with sterile guide wire or stylet
 - f) neonatal bag valve mask
 - g) adhesive tape (micropore, leukoplast)
 - h) suction apparatus with connecting tube, inner liner and suction catheter
 - i) OGT insertion and gastric lavage (orogastric tube – feeding tube fr. 8, 10cc syringe, sterile plastic container, sodium chloride for irrigation)
 - j) umbilical catheterization set with Vygon umbilical catheter (fr. 3.5 or 5), suture, 10cc syringe, urine container, gauze swab, micropore, sterile gloves 6, 6.5 or 7, sterile iris scissors, surgical blade 15 or 20, bacticide 10% antiseptic solution
 - k) IV line materials (IV cannula g. 24 or 26, luer lock, 3 way stop-cock, perfusor, 50cc syringe, IV solution, syringe pump)
 - l) hemoglucose test (blood lancet, glu-test strips)
 - m) syringes, diapers, digital thermometer
2. The NICU Nurse on duty receives patient from Delivery Room or Surgical Complex. The Nurse or Resident Physician and takes note of the following data:
 - 2.1. Name of patient
 - 2.2. Time of delivery
 - 2.3. Type of delivery
 - 2.4. Attending physician

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- 2.5. Emergency measures done (e.g. intubation – take note of time and ET size, administration of emergency medications such as epinephrine or naloxone, etc.)
- 2.6. Indication for admission to NICU
3. The NICU Nurse calls the station where the mother is admitted (either Station 11 or 7B or any other room as the case requires) or the delivery room to ask for the father or the folks of the patient to come over to NICU for doctors' appraisal of the patient's situation and the essential intervention and to secure informed consent on the procedures to be performed or refusal thereof by signing in waiver as deemed necessary.
4. The NICU Nurse assists the Attending or Resident Physicians with procedures to be performed (endotracheal intubation, umbilical catheterization, gastric lavage, ambu bagging, IV insertion, etc.)
5. The NICU Nurse positions patient comfortably under radiant warmer.
6. The NICU Nurse ensures proper ways of identification for the baby (e.g. name tag in the bassinet, identification tags)
7. The NICU Nurse performs initial interview with the father or the folks about the patient's condition and concerns.
8. The NICU Nurse orients the relatives as to the physical set-up of the unit, call system, facilities, equipment, medicines, feeding pattern and other support services.
9. The NICU Nurse makes an initial assessment of all observations and information gathered from patient's vital signs.
10. The NICU Nurse carries out doctor's orders:
 - 10.1. Scans and requests for medications ordered
 - 10.2. Requests for radiologic and diagnostic tests needed
 - 10.3. Transcribes doctors' orders in the Kardex
 - 10.4. Transcribes medication orders in the Medication and Treatment Record and Summary of Medication and Treatment Record
 - 10.5. Makes medication cards and gives the initial dose of medicines as ordered

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once available

- 10.6. Follows up results of diagnostic exams and relays/refers to resident on duty
- 10.7. Draws a vertical line from the first line of the order up to the last line of the order, writes "NOTED" beside it and affixes complete name, signature, date and time the order was carried out under the NOTED
11. The NICU Nurse monitors vital signs every 30 minutes or hourly and records at the Flow Sheet
12. The NICU Nurse makes a Fall Assessment Tool (Humpty Dumpty Scale) upon admission.
13. The NICU Nurse completes all charges of the materials and equipment used upon patient's admission.


DISCHARGE

Once the infant reached the criteria set by their attending physician, the infant can be a candidate for discharge (example: continuous daily weight gain, can tolerate good amount of milk without complications and no signs of problem or distress in any areas the physician can determine if the child and family is ready for the discharge).

1. The Attending Physician gives the order for discharge
2. The NICU Nurse checks for final diagnosis and orders from the physician
3. Checks if the vaccines are given, and expanded newborn screening and hearing test are done.
4. The NICU Nurse notifies the family of the order and start the discharge process until the bill is done and settled and clearance is provided by the folks upon discharge.

CLAIMING OF THE BABY UPON DISCHARGE:

1. A clearance issued by the Billing Section is submitted to the NICU staff.
2. Only the legitimate mothers are allowed to claim the baby. To avoid the discharge of infants to the wrong families, be sure to use at least two (2) patient identifiers.

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Ask the mother to verify identifying information to confirm that it is correct. If the mother is still admitted, the ID band should be checked. If the mother has been discharged already, ask the mother to present a valid ID bearing her name and date of birth for verification purposes.

3. If for some reasons the mother is unable to claim the baby during discharge (e.g. mother is too sick to come back to the hospital or has passed away during or after child birth), claimants shall be required to bring the following:
 - 3.1. A letter of authority from the mother with valid ID
 - 3.2. Valid ID of father or claimant
 - 3.3. A note from the OB/Pedia Attending Physician is acceptable if a letter of authorization is not available.
 - 3.4. A confirmatory call to the mother and/ or the OB/Pedia Attending Physician is also recommended for verification purposes (to avoid unauthorized claiming of the child without the mother's permission in cases of family issues).
 - 3.5. All events should be documented and included in the nurses notes.
4. If the claimant is unable to provide the necessary documents/ proof, do not discharge the baby and inform the Charge Nurse/ Head Nurse immediately.

FOR NON-VIABLE INFANT

The general principles of special care will dictate the need for admission, unless ordered otherwise by the physician. These include:

- A) An infant of 20 weeks gestation or more with an APGAR score of one or more at any time after delivery is considered live born, regardless of whether the patient dies in the delivery room or NICU and regardless of whether the pediatric team was in attendance.
- B) An infant with an APGAR score of zero at all times after delivery is considered stillborn and is entered into labor and deliver statistics, but not admitted to the NICU.

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FOR LIVE BORN BUT NON-VIABLE INFANTS:

1. If the infant is physically admitted to the NICU:
 - 1.1. The delivery room staff will admit the patient to the NICU.
 - 1.2. The delivery room staff will assemble a chart which includes a record of labor and delivery, doctor's notes including delivery room resuscitation, if required and other pertinent information.
 - 1.3. NICU personnel will Complete the admission assessment form.
 - 1.4. NICU personnel will notify the Nursing Service Division Office and the Nurse Supervisor on duty of the infant's death.
The Resident on duty completes the physician's notes and other pertinent information.
2. If the infant is not physically admitted to the NICU (regardless of whether pediatric physicians or residents attended the infant)
 - 2.1. The delivery room staff will assemble a chart of the infant, fill out completely pertinent data.
 - 2.2. Notify Nursing Service Office and the Nurse Supervisor on duty of the infant's death.
3. If a pediatric resident provides any assessment or treatment, a note will be written for inclusion in the infant's chart.
4. The physician in attendance at the time of death, regardless of department, will be responsible for completing the chart.

REFERENCE:

Haidari, E. S. (n.d.). *Hospital variation in admissions to neonatal intensive care units by diagnosis severity and category*. PubMed. Retrieved June 18, 2021, from <https://pubmed.ncbi.nlm.nih.gov/32801351/>





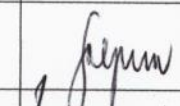
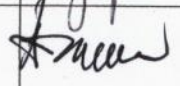
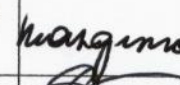



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