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Guidelines for Transfer of Infants to Level IB Community-based Maternal and Newborn Services with a Continuing Care Nursery

Purpose of the Guidelines

The Department of Public Health, with the advice of its Perinatal Advisory Committee, developed guidelines for the transfer of infants who no longer require the complex medical management provided by a Level III Maternal and Newborn Service or a Freestanding Pediatric Hospital with Neonatal Subspecialty Services (Level III/NICU), and may be transferred for continuing care to a Level IB Community-based Maternal and Newborn Service with a Continuing Care Nursery (Level IB).

The decision to transfer an infant and the determination that the appropriate staff, services and resources are available at the Level IB hospital remain with the clinical staff of the transferring and receiving hospitals. Appropriate medical and nursing staff from each hospital should confer and agree that the transfer is appropriate. The determination should be made after an assessment of an infant's needs and anticipated course of treatment, development of a plan of care, and confirmation that the level of services available at the Level IB can meet the needs of the infant. Management of infant transfers should be consistent with interfacility hospital transfer protocols.

Prior to the transfer of a newborn from a Level III/NICU to a Level IB, clinicians at the transferring Level III/NICU and the receiving Level IB should consider the following:

Gestational Age
The infant should be at a corrected gestational age of *at least 33 weeks and determined to be stable.*

Weight
The infant should be *at least 1600 g and determined to be stable.*

Respiratory

The infant should have a stable respiratory status as defined by the following:

- Acute respiratory conditions have been determined to have resolved and, in the judgment of the Level III/NICU team, have a very low probability of recurring. Such conditions would include, but not be limited to acute respiratory distress syndrome, pneumothorax, pneumonia, and pleural effusion.
- An infant requiring supplemental oxygen via nasal cannula, such as those with chronic lung disease, should be determined to have a stable clinical status on low flow oxygen support (< 200 ml/min) that is stable or decreasing as the infant matures.
- To determine stability for an infant with apnea of prematurity, the Level III/NICU should examine the number of apneic episodes, the quality of the episodes (self-limited, requiring mild, moderate or vigorous stimulation), as well as a stable need and response to pharmacologic therapy. As a guide, the infant should have no more than an average of eight events per day that do not require more than mild stimulation. If treated with methylxanthine, the infant should have a period of observation at the Level III/NICU for a minimum of 48 hours after starting medication (prior to transfer).

Cardiovascular

The infant should have a stable cardiovascular status as defined by the following:

- The infant should have normal vital signs inclusive of blood pressure for at least 24 hours prior to transfer.
- The infant with a cardiac condition (e.g., septal defect, patent ductus arteriosis) does not require a specific therapy and is very unlikely to develop congestive heart failure. The infant should be assessed for stability and approved for transfer by the Level III/NICU cardiologist with a clear plan for follow-up. A record of the cardiologist or cardiac surgeon consultation and relevant studies and imaging reports should be included with the medical documentation sent from the Level III/NICU.

Nutrition

- The infant should be on full volume enteral feedings for at least 48 hours prior to transfer without signs of feeding intolerance.
- An infant with a history of hypoglycemia should have stable blood glucose levels while off all intravenous fluid for at least 24 -48 hours.
- Lactation support from an International Board Certified Lactation Consultant (IBCLC) or equivalent should be available to mothers who plan to breastfeed. The IBCLC or equivalent should formulate a written plan for maintaining or increasing milk production as well as for transitioning the infant to feedings at the breast.

Jaundice

An infant with jaundice requiring continued phototherapy should meet the following conditions:

- The clinical cause of jaundice has been determined.
- The infant has demonstrated a positive response to phototherapy.
- The Level III/NICU attending physician has determined that the infant is unlikely to have a condition that may require an exchange transfusion.

Neurological

An infant with a neurological disorder should be approved for transfer by the consulting neurologist, as applicable. A clear plan for follow-up should be established prior to discharge for an infant with condition(s) that will require continued management as an outpatient. A record of the neurologist's consultation and reports from any relevant imaging studies should be included with the medical documentation sent from the Level III/NICU.

Special considerations

- To determine the stability of an infant with a seizure disorder the Level III/NICU should at a minimum assess the type and severity of the infant's seizures and the likelihood of the occurrence of a medical emergency requiring onsite physician availability and management. An infant with a seizure disorder who receives anticonvulsant therapy should have a therapeutic level of medication established, if such medication is dosed according to therapeutic range. The Level III/NICU confirms the availability of the anticonvulsant medication at the Level IB in the correct form/preparation prior to transport.

- An infant with neonatal abstinence syndrome should have a narcotic dose determined and have tolerated one weaning at least 48 hours before transfer. The Level III/NICU confirms the availability of the narcotic medication at the Level IB in the correct form/preparation and the availability of continuous cardio-respiratory monitoring prior to infant transport to a Level IB.

- An infant with a history of intraventricular hemorrhage should have a stable head circumference and be determined to be at low risk for post-hemorrhagic hydrocephalus. A record of the infant's head circumferences should be included with the medical documentation sent from the Level III/NICU. If further head ultrasounds are required, the Level III/NICU confirms that the Level IB has the capability of performing and interpreting head ultrasounds.

The medical record of the transferred infant shall include documentation of assessments as described above and justification for any exceptions.

The Level IB Service must meet all applicable licensure regulations under 105 CMR 130.600 – 130.630, including but not limited to the following:

Administrative Policies

According to 105 CMR 130.616(C)(6)(a)(b)(c) each maternal and newborn service shall develop and implement written administrative policies that include provisions for admission of the previously discharged (to home), or retrotransferred recovery stable-growing infant under the following circumstances:

- The infant previously discharged to home may be readmitted to the newborn nursery provided that the infant is within two weeks of discharge from that nursery, has a noninfectious condition and is approved for readmission by the medical director of the newborn service and the maternal and newborn nursing administrator or their designee(s).
- The retrotransferred recovery infant may be admitted to the newborn nursery upon written order of the attending physician and approval of the medical director of the newborn service and the maternal and newborn nursing administrator or their designee(s).

- The newborn service may admit a retrotransferred recovery infant who was not born at that hospital, providing the hospital offers the level of service required by the infant and is geographically close to the parents.

Infection Prevention and Control

According to 105 CMR 130.616(C)(6)(d) each maternal and newborn service shall develop and implement written administrative policies that include provisions for admission of the previously-discharged (to home), or retrotransferred recovery stable-growing infant under the following circumstances:

- The retrotransferred infant, who is transferred from a hospital unit with known multi-drug-organism colonization or infection, including methicillin-resistant Staphylococcus aureus, shall be managed with contact precautions in accordance with the Centers for Disease Control and Prevention guidance until the presence of infection or colonization with an antibiotic-resistant organism has been ruled out.
- Infants should be evaluated for signs and symptoms of infection prior to transfer.
- See also 105 CMR 130.626 - Infection Control

Medical and Nursing Staff

- Staff meet applicable licensure regulations under 105 CMR 130.630(E).
- The hospital designates a medical director and ensures the medical director or his/her designee is available on-call 24 hours a day.
- The hospital ensures that the conditions/situations that require a physician to be on-site are defined in writing.
- The hospital ensures that each physician in a Level IB maintains current Continuing Care Nursery skills and privileges, and such skills and privileges are documented in the physician's credential file.
- The hospital ensures that each nurse in a Level IB maintains current Continuing Care Nursery skills and competencies, and such skills and competencies are documented in staff education records.

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