HUTTmaternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Care of Stable Baby 35-37 Weeks Gestation on the Postnatal Ward Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Policy statement

To ensure the safe care of newborn infants between 35-37 weeks gestation on the Postnatal ward. Early and frequent feeding is initiated to reduce the risk of hypoglycaemia, jaundice and hypothermia in these babies. There is a wide variation in ability amongst these babies. They have immature "state regulation" and may stop breastfeeding before they have taken adequate nutrition. They may also not wake for feeds. Lower muscle tone can lead to inadequate latch and milk transfer. Suck-swallow-breathe patterns may be uncoordinated and thus inefficient.

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff
- Neonatal staff

Aims

- To safely care for these babies on the postnatal ward
- To adequately feed the baby
- To establish and maintain mother's breast milk supply

Definitions

Preterm infant

Any infant less than 37 week's gestation

Late Preterm infant (LPT)

An infant between 34-37 weeks gestation

Risks and precautions

Common problems facing these infants include:

- Respiratory distress- tachypnoea, flaring, in-drawing, grunting, cyanosis, apnoea
- Hypothermia
- Hypoglycaemia
- Jaundice
- Sepsis
- Establishing independent feeding

Therefore these infants require frequent, regular monitoring of:

- Temperature
- Blood sugar levels
- Feeding attempts until efficient feeding is established
- Weight gain/loss after 48 hours
- Urine output
- Jaundice

Procedure

Temperature control

- Pre-warm linen and surfaces the infant makes contact with to avoid heat loss via conduction
- Ensure birthing rooms are warm, and avoid draughts where possible to avoid heat loss via convection
- A paediatric RMO may be required to attend the birth. Referral Guidelines see appendix 2 consultation
- Dry and examine the baby quickly then place baby skin to skin.
- The initial examination should be by the LMC or a Paediatric RMO, who will make a management plan and record this on the “Initial infant examination form”. Take the axillary temperature within an hour of birth, and then 3 hourly pre-feeds until maintained at or above 36.6 C for 24 hours. Encourage skin to skin contact for periods of **at least** 60 minutes, preferably longer.
- When not in skin to skin contact baby needs to be dressed in woollen garments.

Feeding

- Offer the first breastfeed / feed within an hour of birth, following baby’s feeding cues if present. If baby does not latch and feed well give all expressed breast milk and/or formula at a medical indicated volume for that age/size baby
- These babies are at risk of hypoglycaemia, so follow the protocol (Neonatal hypoglycaemia- prevention and management of)
- Feed 3 hourly, or sooner if baby shows feeding cues
- Place Breastfeeding Alert magnet on allocation board and refer to Lactation Consultant.
- Each feeding attempt must be observed until efficient feeding is established. Pay particular attention to respiratory difficulties such as cyanosis or

increased work of breathing during feeding. Inform mother of the need to wake baby for feeds
- Encourage the mother to use the infant feed chart
- Give mother a copy of the breastfeeding care plan for these infants (Appendix 1), after adapting it to her individual needs if required. Ensure the mother and the on coming staff understand the plan.
- Show and teach the Mother how to hand express her breast. Advise the mother to express after each feed until the baby's ability to transfer milk appears adequate, and the mother's breast milk supply is sufficient to meet baby's needs
- If supplementation is required, always prioritise expressed breast milk. Offer supplements via tube to breast if the baby is able to latch at the breast. If unable to latch, a syringe, cup, finger feed or spoon may be used.
- Discuss with Lactation Consultant

Documentation

Ongoing documentation includes:
- Mothers and baby's clinical progress notes
- Breastfeeding management form
- Baby feeding chart
- Observation chart

References

ABM Clinical Protocol #10: Breastfeeding the Late Preterm Infant (34 to 37 weeks Gestation) (Second revision 2016). *Breastfeeding Med*; vol 11, issue 10

Breastfeeding and the use of human milk. American Academy of Paediatrics Policy Statement. Paediatrics, volume 129, issues March 2012

CCDHB Policy: Management of babies 35-37 week's gestation or 2.0 – 2.5 kg on the postnatal ward. GA PN-04

Hypoglycaemia of the Newborn. WHO Report. 1997

Hutt Valley DHB: Neonatal Hypoglycaemia: Prevention and Management.

Ludwig SM. (2007) oral feeding and the late preterm infant. Newborn & Infant Nursing Reviews.7:2, p72-75

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix 1

Breastfeeding careplan:
Stable baby 35 - 37 weeks in postnatal.

Date:	
Problem:	Baby 35 - 37 weeks gestation
Consultation:	Midwife / Nurse / Lactation Consultant / LMC / Paediatric staff
Plan:	1. Skin to skin contact with baby **for at least** 60 minutes at a time but preferably longer. 2. Pre-feed Blood Sugar Levels and temperature until stable (as per Hypoglycaemia policy) 3. Offer first feed within an hour then feed baby 3 hourly or sooner if baby shows interest. Midwife or Lactation Consultant to observe feeds until baby is feeding efficiently. If feed effective offer top-ups of any expressed breast milk available. If feed not effective offer expressed breast milk/formula at a volume medically indicated for that size and age baby. See volume chart for Medical Indications. Give top up via cup, syringe or tube to breast. 4. Commence a feed chart/ or skin to skin. 5. Express after feeds to increase milk supply. Massage breasts Hand express to collect as much as possible. Express using electric pump for stimulation **after** hand expressing. Double Pump for 10mins for stimulation. 6. Weigh first approx 48 hours of age, then daily. 7. Refer to Paediatrician if parametre's are not in normal range 8. Daily review of careplan
Follow up:	
Discharge plan:	