PRE-DELIVERY

Delivery RN

- ❑ Communicate with OB team
- ❑ Ask L&D to PEND baby chart
- ❑ Prepare Delivery Room (see *Standard Preterm Delivery Setup Checklist*)
- ❑ Bring Code Cart to hallway outside DR (consider staging shuttle here too)

WHEN CALLED FOR DELIVERY

- ➢ Vocera "Broadcast to High-Risk Delivery Team"
- ➢ Pause briefly before stating "NICU Team to Room [Room Number] for [Type of Delivery]" and keep broadcast channel open
- ❑ Bring IntelliVue portable monitor to DR

NICU RN

- ❑ Ensure bedspace is prepared
  - ○ Procedure masks/hats
  - ○ 2 fluid pumps, 2 syringe pumps
  - ○ Suction x 2
  - ○ 3.5 Fr UVC/UAC lines
- ❑ Call Neonatal Pharmacist to alert to pending ELBW delivery

WHEN CALLED FOR DELIVERY

- ❑ Release Admission Orders in Pended Chart
- ❑ Sign out starter PN from Pyxis and prime fluids
- ❑ Call x3-2125 to alert x-ray tech of potential need for Priority1 x-ray

RT

- ❑ Ensure bedspace is set up
  - ○ Blended flowmeter with T-piece/mask/flow-inflating bag
  - ○ Jet ventilator (for all infants < 24 weeks) and/or CPAP
- ❑ Set up and check respiratory equipment in DR
  - ○ Two Hamilton T1 vents should be available, one set up in invasive mode and one set up in non-invasive mode
  - ○ Check tanks on Hamilton vents
  - ○ Neopuff: PIP 20, PEEP 5-6
  - ○ Set blender to 50% for infants < 24 weeks, 30% for infants 24-28 6/7 weeks

Provider

- ❑ Place and SIGN (NOT pend) admission orders in pended chart (see *Small Baby Admission Guideline*)
  - ➢ Include orders for starter PN, UAC fluids, eyes/thighs, and surfactant (use EFW as DW)
  - ➢ Do not include orders for weight-based meds (e.g., antibiotics, caffeine)
  - ➢ Include order for Priority1 chest x-ray PRN x 1 (for ETT placement)
  - ➢ Consider including orders for prn RSI medications
- ❑ Make sure intubation equipment is ready (Neoview, 2.0 ETT with stylet if < 24 weeks)
- ❑ Prep umbilical lines in unit

WHEN CALLED FOR DELIVERY

- ➢ Use Vocera walkie-talkie feature (hold button down) to notify that delivery team is on the way

Updated: ESS, 1/2024

DELIVERY ROOM

Goal: Out of DR by 15 minutes of life

Delivery RN

WHEN BABY ARRIVES

- ❑ Catch baby in plastic wrap (use chemical warmer if in OR)
- ❑ Bring wrapped baby to Giraffe bed (leave chemical warmer behind)
- ❑ Place limb leads, temp probe, pulse ox ON PATIENT
- ❑ THEN connect pulse ox to monitor
- ❑ Check temp WITHIN 10 MINUTES
- ❑ Place OG tube, if needed

WHEN READY TO LEAVE DR

- ❑ Weigh patient
- ❑ Call NICU Charge – report weight, type of resp support*

***If intubated, CHARGE RN should tell bedside RN to:**

- ❑ Release order for PRN Priority1 chest x-ray
- ❑ Call radiology (x32125) and give room number for chest x-ray
- ❑ Remove surfactant from fridge

CUB RN/Scribe

- ➢ Scribe
- ➢ Guide team in neuroprotective strategies (avoid excessive neck rotation, avoid Trendelenburg position)

RT

- ❑ Start Apgar timer when baby delivers
- ❑ Confirm ventilation and/or ETT placement with CO_2 detector

➢ **INTUBATED PATIENTS:**

- ❑ Ensure ETT is properly secured
- ❑ Place on Hamilton T1 vent (set up for invasive mode) in VG mode for transfer to NICU
- ❑ Set max PIP on vent

➢ **NON-INTUBATED PATIENTS:**

- ❑ Get head measurement and secure CPAP hat/mask
- ❑ Place on Hamilton T1 vent (set up for non-invasive mode) for transport to NICU

Provider

- ❑ Confirm DCC plan with OB team
- ❑ Oversee/direct DCC

- ❑ Proceed with Airway/HOB or Team Leader duties

- ➢ HOB should be a provider with experience in intubating small babies (see *NICU Intubation Guideline*)

If < 24 weeks GA:

- ➢ Intubate (no trial of CPAP)
- ➢ ETT depth 5.5-6.0 cm

If ≥ 24 weeks GA:

- ➢ Can consider trial of CPAP (start at 5-6 cm H_2O)

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CUB ROOM

Goal: Isolette closed by 1 hour of life

NICU RN (can circulate)

- ❑ Call HUSC with admit time & weight
- ❑ Obtain first set of vital signs
- ❑ Calculate IV fluid rates
- ❑ Check temp (q 5-10 min)
- ❑ Mepitel One under temp probe
- ❑ Secure OG tube

➢ Take this time to assist Admitting RN, retrieve medications, etc.

❑ <u>Position patient for babygram</u>

- Remove chemical warmer or have x-ray tech notate presence of warmer
- Keep infant wrapped in plastic
- Use x-ray tray
- Move leads/lines out of field

❑ Give meds (*NOTE: Can be done before or after isolette is closed*):

1. Vitamin K
2. Gentamicin*
3. Ampicillin*
4. Caffeine load
5. Erythromycin eye ointment

❖ <u>CLOSE ISOLETTE</u>

❑ Add water and initiate humidity

*Give after blood culture is sent

CUB/Admit RN (remains at bedside)

- ❑ Secure isolette in bedspace
- ❑ Transition to bedside monitor
- ❑ Weigh patient (if not already done)

➢ If intubated, pause for chest x-ray, if tech is present or approaching

❑ Check BG (*Goal: within 10' of admission & q30' until dextrose fluid is running*)

➢ If BG < 40: place PIV, start D5W, and re-check BG in 15 min

➢ If BG ≥ 40: provider can proceed with line placement

❖ *Attempt PIV if umbilical line placement will be delayed*

❑ Secure infant for line placement

❑ Release lab slips

❑ Run sPN in UVC, if directed to do so by provider

❑ Call for babygram

❑ Secure lines

❖ <u>CLOSE ISOLETTE</u>

❑ Get OFC & length w/next hands-on

RT

Stabilize the patient on respiratory support

<u>NON-INTUBATED PATIENTS</u>

➢ Place on CPAP

<u>INTUBATED PATIENTS</u>

Starting HFJV settings:

➢ PIP 22-24 (check wiggle)

➢ PEEP 5 (measured)

➢ Rate:

- <24w (<600g) → 300
- 24-26w (600-1000g) → 360
- ≥27w (≥1000g) → 420

❑ Prep surfactant catheter

❑ Assist RN in positioning patient for chest x-ray

❑ Give surfactant (*Goal: within 10 min of chest x-ray*) and document time

Provider

- ❑ Order STAT weight-based meds (antibiotics, caffeine, indomethacin)
- ❑ Calculate desired depth for umbilical lines
- ❑ Scrub and prep lines

❑ Place UVC first (can start fluids prior to x-ray)

❑ Place UAC

❑ Tell RN to call for babygram when suturing lines

➢ NOTE: Minimize fluctuations in BP by slowly flushing/ withdrawing from lines (1 ml per 40 sec)

❖ <u>CLOSE ISOLETTE</u>

❑ Update family and give Lactation Welcome Letter

❑ Obtain assent for DBM (and transfusion/PICC consents, if applicable)

Updated: ESS, 1/2024

FASTTT Preemie Pause at 60 minutes

Fluids	What fluids are running?	What is our IV access? Central line?	Do we need to bridge with PIV?
Airway	Is airway and WOB stable? Need surf?	If ETT, is position confirmed?	If CPAP, prioritize caffeine
Sugar	What was the last blood glucose?	Checked within last 30 minutes?	Ensure proper GIR
Temp	What was most recent temp?	Checked within last 30 minutes?	Ensure slow wean out of thermal bag
Tests	Have we sent blood for labs/cultures?		
Treatment	Which meds have been given?	Which meds still need to be given?	

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