Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Care of Late Preterm & Low Birth Weight Newborns

Preterm infant born at YKHC

Unstable or GA <35 weeks → Transfer to NICU. See **Pediatric Medevac: Bethel to Anchorage** Guideline.

35 – 36.6 weeks AND stable → BW <2200 grams?**

Yes → Transfer to NICU. See **Pediatric Medevac: Bethel to Anchorage** Guideline.

No

- Encourage mother to express breastmilk.
- If infant is stable, encourage bonding and breastfeeding while awaiting medevac.

NOTE: If infant of any GA is unstable at any time, please contact the pediatric hospitalist (Tiger Connect Peds Wards on Duty) and prepare for transfer.

- Admit patient to OB using the Late Preterm Power Plan.
- Infant is observed in the mother's room or in the Newborn Treatment Room for at least four hours to ensure stability.
- VS Q4h, including temperature, throughout entire stay.
- Weigh baby Qshift.
- Blood glucose screening per **protocol** for full first 24 hours of life.
- Establish feeding plan with parents (see box).
- Ensure parents are educated (see box).
- Follow Late Preterm Goals of Care worksheet (to be placed on baby's hard chart).
- On day of birth, schedule outpatient appointment for DOL 4-5 to ensure appointment availability.

Parent Education

- Educate parents regarding vulnerability of late preterm neonate and late preterm protocol.
- Attach completed Late Preterm Crib Card to crib.
- Ensure parents have received the Late Preterm Handout and use as a resource.
- Emphasize need for follow-up with outpatient appointment prior to return to village.
- Ensure and encourage proper pediatric follow-up.
- Education regarding feeding plan and follow-up resources.

Huddle at 24 hours of Life

(to include bedside nurse, charge nurse, family medicine hospitalist, and pediatric hospitalist if needed)

- Points to discuss: how the baby is feeding, %weight loss, can we safely manage the baby's needs, unit acuity/staffing ratios, does the baby need to be transferred at this time, time for next huddle (if needed).
- If infant receives three "strikes" on the Late Preterm Goals of Care worksheet, there must be a huddle to discuss if the infant should be transferred. (See Strike box.)

Infant Stability

- Temperature ≥97.7 (axillary) for 6 hours in open crib.
- Cardiovascular and respiratory stability as determined by the medical team.
- Able to tolerate oral feeds without color change or increased WOB: breastfeeding or tolerating 5-10 ml EBM or formula at a minimum of every 3 hours.

Strikes

- Any temperature <97.7
- Any weight <2200 grams
- Any blood glucose level below target for age

**NOTE: Term babies with BW <2200 grams do not need to be automatically transferred if stable. For these infants, this guideline should be applied, with the BW counting as one strike. There should be a huddle at 24 hours of life or sooner if infant receives two more strikes.

Goals for Discharge

- All late preterm babies are admitted for at least 72 hours.
- Weight loss <8% below BW.
- Temperature ≥97.7°F x24 hours in an open crib.
- Well-established feeding plan.
- Follow-up appointment scheduled in outpatient clinic in Bethel in 24-48 hours. If weekend, may have this follow-up on OB by pediatric hospitalist.
- Must have warm handoff with message sent to provider seeing patient for follow-up that includes minimal requirements to be met for discharge back to village.
- Follow-up weekly in village or outpatient clinic until corrected GA of 40 weeks.
- Prescribe Poly-Vi-Sol WITH Iron at discharge.

Definitions

- GA: gestational age at birth
- Late preterm: GA 34 weeks 0 days to 36 weeks 6 days
- Early term: GA 37 weeks 0 days to 38 weeks 6 days
- Term: GA 39 weeks 0 days to 40 weeks 6 days
- Low birth weight is any baby born <2500 grams

Characteristics of Late Preterm Infants

- Low birth weight
- Low body fat
- Poor thermoregulation
- Low glycogen stores
- Low tone
- Poor state regulation
- Immature immune system
- Immature suck and swallow
- Delay in bilirubin metabolism

Late Preterm Infants Are at Risk For:

- Hypothermia
- Hypoglycemia
- Sepsis
- Poor feeding and infrequent feeds can lead to inadequate maternal milk supply/breast feeding failure
- Poor suck and swallow may lead to inadequate milk intake
- Excessive weight loss, failure to thrive
- Hyperbilirubinemia with late rise (expect peak on DOL 5)
- Increased readmission rate (5-13 times that of term infants)
- Respiratory instability in upright car safety seats or other upright infant devices
- Hospital readmission

Feeding Plan

Infants meeting any of the following criteria should be assessed for the need for supplementation:

- Birth weight <2500 grams
- Poor reserve (evidenced by temperature instability or hypoglycemia)
- Poor feeding (LATCH <7 or <10 minutes at breast)
- Weight loss >3% per day or >8% total
- Minimum volumes for both bottlefed and breastfed babies:
  - 0-24 hours: 5-10 mL
  - 25-48 hours: 10-20 mL
  - 49-96 hours: 20-30 mL
- If bottlefeeding, advance feeds as tolerated.

If Breastfeeding

- Lactation evaluation within 24 hours of birth.
- **LATCH score** documented at least Qshift.
- Infant should be put to breast at least Q3h.
- Use Supplemental Nursing System (SNS) **to ensure measurable amounts each feed with the above minimum volumes.**

Supplementation

- Supplementation should be given by SNS (preferred), cup, or finger feeds rather than nipple and bottle. May receive formula if milk volume not meeting fluid needs.
- Mother to pump every 3 hours after nursing unless infant nursing vigorously.
- Bedside nurse and medical team should re-evaluate feeding plan daily.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by Clinical Guideline Committee 7/14/23.
Click **here** to see the supplemental resources for this guideline.
If comments about this guideline, please contact Amy_Carson-Strnad@ykhc.org.