Postnatal ward management of late preterm babies (35+0- 36+6 weeks gestation)

Many babies born at 35-36 weeks gestation can be safely cared for on the postnatal wards. Babies will be admitted to the Neonatal Unit if birth weight is <1800g or there are clinical concerns. Late preterm babies have different considerations during the transitional period and they should not be regarded as term infants.

All late preterm infants should be started on a newborn early warning score (NEWS) chart following delivery.

Communication with parents

It is important to manage parental expectation. Whilst the baby may be well enough to be managed on the ward, these infants do in fact differ from more mature, larger babies and require more consideration. As soon as possible after birth, give parents a copy of the parent information leaflet 'Care of the Late Preterm Infant' and prepare them for a stay of at least 3 days and sometimes as much as 10 days.

Parents should also be made aware that it is relatively common for babies born at this age to require admission to the neonatal unit.

During their stay in hospital, parents should be taught how to assess the temperature, feeding and wellbeing of their baby. On discharge, parents should know how to monitor for jaundice and who to contact if they have concerns.

Temperature

The normal axillary temperature range is 36.6 – 37.2°C

Late preterm babies are at increased risk of hypothermia. They have a larger surface area to body mass ratio and have limited strategies to reduce heat loss. They have less insulating subcutaneous fat and less brown fat for non-shivering thermogenesis.

Their physiological response to cold includes a decrease in activity, a more flexed posture and an increase in the heart rate. Glucose stores are depleted more rapidly in cold babies, increasing the risk of hypoglycaemia.

It is important to think about temperature regulation right from the point of delivery, with extra care given when moving between clinical areas.

Thermal care:

- Dry well at delivery, apply hat and swaddle with warm blankets
- Offer early skin-to-skin with an overlying blanket and hat
- Provide adequate layers of clothing: hat, vest, baby-gro, cardigan, mittens, socks
- Regular axillary temperature check recorded on NEWS chart for at least the first 8 hours

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- Ideally environmental temperature should be maintained at 22 - 24°C and draughts minimised
- Parental education to support discharge.

Hypoglycaemia (Blood glucose <2.5mmol/L)

Late preterm babies are more likely to develop hypoglycaemia than term babies. This is due to poor glycogen stores, reduced gluconeogenesis and sometimes inadequate breast milk supply.

Hypothermia further decreases the activity of gluconeogenesis enzymes, increasing the risk of hypoglycaemia in cold babies.

All late preterm babies require glucose testing after delivery, at 3 hours of age.
(See Hypoglycaemia in infants < 37 weeks)

To prevent hypoglycaemia:

- Early feeding within 1 hour of delivery
- 3 hourly feeds, for at least 48 hours
- Attention to thermal care

Signs of hypoglycaemia in a neonate include:

- CNS excitation (more common)
    - Jittery
    - Tachypnoea
    - Unsettled
    - Frantic feeding

- CNS depression
    - Not waking up for feeds
    - Poor feeding
    - Lethargy
    - Hypotonia
    - Apnoea

It is common for hypoglycaemic infants to have no symptoms. If symptoms occur, the hypoglycaemia may be severe or poorly tolerated.

If hypoglycaemia occurs, please follow the flowchart for management of babies at risk of hypoglycaemia on Labour Ward, HDU and Postnatal Wards. This provides advice on feeding, frequency of blood sugar monitoring and consideration of admission to the neonatal unit.

Hyperbilirubinaemia

Jaundice is more common in preterm babies. The bilirubin peak occurs later (5-7 days) and so if a baby is discharged with jaundice at 3 days, this will require follow-up by the community

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midwifery team or hospital. In addition, the clearing phase can be prolonged, even up to 2-4 weeks and investigation for prolonged jaundice is common in this gestational age group.

Bilirubin levels can be monitored on the postnatal ward using a Minolta Bilimeter.

Please refer to the unconjugated jaundice guidelines for bilirubin monitoring and treatment thresholds. Single light phototherapy can be used in the postnatal wards. Particular attention to thermal care is required for late preterm babies on phototherapy.

Rate of rise and timing of bilirubin measurements must be considered before discharge.

Feeding

Breastmilk is the optimal nutrition for all babies, particularly those born preterm. Well, late preterm infants should be able to suck feed, however, they can take longer to develop a good suck and feeding may take longer to establish.

Mothers should receive adequate information, encouragement and breastfeeding support as adequate milk supply may be delayed following preterm birth. If babies do not attach or suck well following delivery, mothers should start expression in the first 6 hours.

Babies of this gestation have lower fat stores and are more prone to hypoglycaemia. They should therefore be fed 3-hourly for at least 48 hours after birth. This may be required for longer if there is excessive weight loss. Routine provision of formula top-ups is not recommended.

All babies require a weight at 72 hours. This should be repeated on the day of discharge to inform planning of community care and follow-up.

As in term babies, weight loss in the week after birth is expected. However, if weight loss is ≥10%, feeding should be assessed and the large postnatal weight loss guideline followed (see also breastfeeding assessment chart and seek advice from breastfeeding support midwife).

These babies require daily neonatal team consideration until discharge.

Discharge

Preterm babies cannot be discharged home after 6 hours. The minimum recommended period of observation is 72 hours but some babies require admission for longer. The first neonatal examination needs to be done before discharge and within 72 hours. Occasionally discharge prior to 72 hours may be considered only at the discretion of the attending consultant.

The Discharge Readiness checklist should be completed on day of discharge and a **registrar/consultant should always be involved in decision-making for home**. If feeding is becoming established, milk supply is sufficient and weight loss is <10%, babies may be discharged prior to weight gain.

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A Community Midwife or Health Visitor must be informed of discharge and a follow up home visit arranged for weight check and feeding review within 24 hours.

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