

# POSTNATAL WARD MANAGEMENT OF THE LATE PRETERM NEONATE (34+0 → 36+6 WEEKS' GESTATION) AT UNIVERSITY HOSPITAL WISHAW



<b>TARGET AUDIENCE</b>	Maternity and neonatal teams at University Hospital Wishaw
<b>PATIENT GROUP</b>	Neonates born at 34+0 to 36+6 weeks' gestation

## Clinical Guidelines Summary

- Late preterm neonates born at 34+0 to 36+6 weeks' are physiologically and developmentally immature compared to term infants ( $\geq 37$  weeks' gestation).
- This can lead to unique medical and developmental challenges.
- This bundle of care is designed to guide adequate thermoregulation, feeding support, and early detection of hypoglycaemia, jaundice, parental education and robust discharge planning.

## Postnatal Ward Management of the Late Preterm Neonate

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### Background

Late preterm neonates are infants born between 34 weeks and 36 weeks + 6 days of gestation, representing a cohort of preterm births that differs significantly from both term and earlier preterm neonates. Despite their relatively advanced gestational age, late preterm neonates are physiologically and developmentally immature compared to term infants ( $\geq 37$  weeks' gestation). This can lead to unique medical and developmental challenges. As a result, increased vigilance, clinical monitoring and occasionally medical intervention is recommended.

### Incidence and Significance

Late preterm births account for approximately 70–75% of all preterm deliveries, making them the largest group of preterm neonates. Risk factors contributing to late preterm births include maternal complications (e.g., preeclampsia, diabetes, preterm labour), foetal indications (e.g., growth restriction, multiple gestation), and iatrogenic causes (e.g., medically necessary early delivery).

### Physiological and Developmental Immaturity

The late preterm neonate is in the unique position of being physiologically less mature with limited compensatory responses to the extra-uterine environment compared with term neonates. This predisposes them to organ-system postnatal complications and an increased risk of initial NICU admissions, separation from their mothers and readmission post discharge. Awareness of their specific vulnerabilities is essential for providing comprehensive care and improving outcomes. Key areas of immaturity and immediate postnatal morbidity include:

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- **Respiratory immaturity:** leading to a higher risk of respiratory distress syndrome (RDS), Transient Tachypnoea of the Newborn (TTN), and neonatal apnoea. Increasing the likelihood of respiratory support after birth
- **Thermoregulation:** Reduced subcutaneous fat and immature thermoregulatory mechanisms make these neonates prone to developing hypothermia.
- **Feeding and Nutrition:** Immature suck-swallow-breathe coordination and low energy stores can lead to feeding difficulties, poor weight gain, and an increased risk of dehydration and hypoglycaemia.
- **Jaundice:** Higher levels of bilirubin production and immature liver function increase the risk of hyperbilirubinemia requiring treatment.
- **Infections:** Late preterm neonates have a less mature immune system, predisposing them to infections, including sepsis.

## Care Considerations

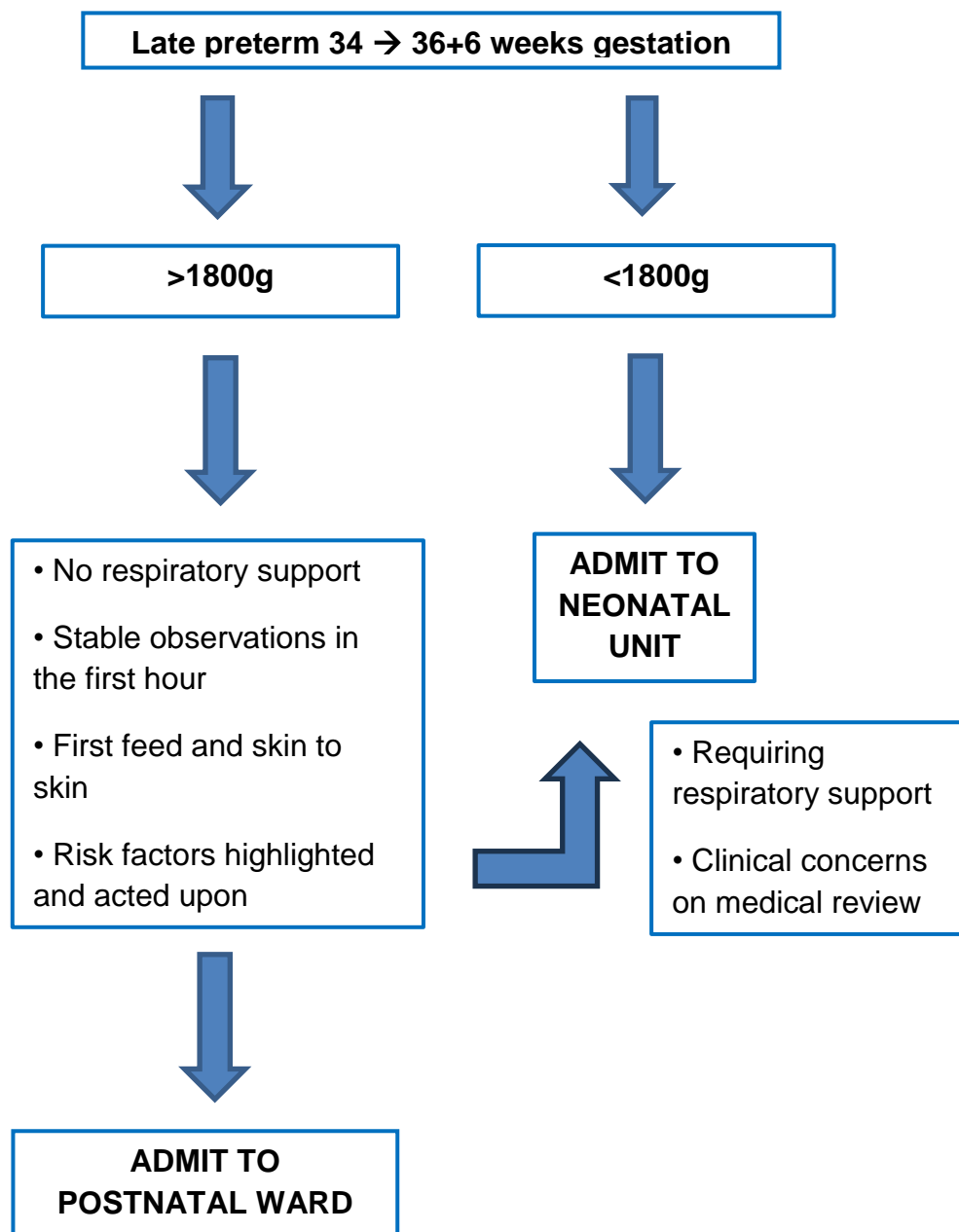
Optimal care for late preterm neonates comprising of standardised pathways in monitoring, early identification of deterioration and provision of support, will ensure that these neonates are nursed safely beside their mothers within the postnatal/transitional care areas. This bundle of care should include ensuring adequate thermoregulation, feeding support, and early detection of hypoglycaemia, jaundice, parental education and robust discharge planning. Follow-up care to monitor growth, neurodevelopment, and other potential long-term sequelae is also essential.

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### Patient Care Location



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### Postnatal Ward Management

1. Continue Skin to skin to continue for at least one-hour post birth.
2. Give first feed within an hour, and then 3 hourly feeds.
3. 3 hourly blood glucose monitoring as per preterm glucose monitoring policy.
4. Commence NEWTT2 chart monitoring, recording 4 hourly observations for 24 hours then twice daily until discharge.
6. Daily neonatal review.
7. Repeat weight, head circumference and length at 60-72 hours of life then 48 hourly thereafter

### Neonatal Medical Team Daily Preterm Review

All neonates who are preterm must be highlighted on the Neonatal Medical Team handover for team awareness. As per the local guidance (guideline '[Early Onset Sepsis Risk Assessment and Management for Infants  \$\geq\$  34 weeks' Gestation in the Postnatal Ward at University Hospital Wishaw](#)'), all preterm neonates should also have an early onset sepsis risk assessment using the KP score.

In addition to the baby's observations, the babies should be reviewed by the neonatal medical team at least every 24 hours. This should be documented as a 'Specialist Review' in Maternity Badger, and should consider:

- Parental, carer and midwifery concerns
- A review of the baby's observations including thermoregulation
- The baby's current clinical presentation including feeding and behaviour
- Microbiological results from baby and mother, if relevant
- A review of other investigations e.g. CRP trends, blood cultures
- A review of jaundice
- Documentation of the overall plan
- If being discharged, documentation of senior discussion regarding this if relevant

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### Discharge Criteria

All the below criteria to be achieved prior to discharge.

1. All observations within normal parameters.
2. Temperature maintained for more than 24 hours.
3. Feeding established for at least 24 hours (i.e. waking for feeds, sucking and completing feed volumes. If breastfeeding, attaching effectively with good suck).
4. For breast fed babies, a breast-feeding assessment to be carried out and documented prior to discharge.
5. Review weight profile and if trending downwards, discuss with Tier 2 or Consultant.
6. Ensure no active concerns regarding jaundice requiring action before discharge.
6. Family readiness for discharge.

**If the baby is still admitted on day 5 of life, please reassess and discuss with a senior member of the Neonatal team.**

### Follow Up

- If the baby is 10 days or less on day of discharge, baby should be discharged to the care of the Community Midwife.
- If baby is above 10 days on day of discharge, baby should be discharged to the care of Health Visitor.

#### 1. Governance information for Guidance document

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Date	Lead Author	Change	Version
		<i>e.g. Review, revise and update of policy in line with contemporary professional structures and practice</i>	1
			2
			3
			4
			5

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