AUDIT OF TERM ADMISSIONS TO NEONATAL AND TRANSITIONAL CARE SERVICES DURING COVID 19 PANDEMIC

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Avoiding Terms Admissions into Neonatal Units is a key programme in the National Maternity Safety Transformation for several reasons:

- Over 60% of admissions to neonatal services are term babies of which 20-30% are avoidable
- Overwhelming evidence that separation of mother and baby shortly after birth has an enormous impact on bonding, long term morbidity impact on women and babies, lasting effect on maternal mental health
- Important for the physiological stability of the baby
• Year 3 Maternity Incentive Scheme incorporates ATAIN in Safety Action Three of which includes the following:
  • Monthly Audit of the Transitional Care Pathway
  • Review of all Term admissions into the neonatal unit
  • Review of Term admissions to NICU and Transitional Care Unit during the COVID 19 pandemic
• To audit that all terms admissions to the Neonatal Unit are reviewed
• To audit that all admissions to the Transitional Care Unit meet the admission criteria.
• To audit that all the criteria outlined in the Transitional Care Guideline is implemented.
• To the review the impact of COVID 19 on term admissions including readmissions.
AUDIT CRITERIA

- Avoidable Admission to NICU
- Meeting the Transitional Care admissions criteria
- Was the baby admitted through the neonatal readmission pathway
- Full set of neonatal admissions completed on admissions
- Seen by a paediatrician on admission if acute concerns
- Daily review by Midwife undertaken
- Baby seen or discussed with Registrar or Consultant within 24 hours of admission
- Baby seen daily by paediatric doctor/ ANNP
- Has the baby had observations recorded at least four hourly until they are discharged from paediatric care
- Has the baby met the discharge/ transfer criteria
- Fit for discharge
- Discharge Delays
METHODOLOGY

• All term admissions to the Neonatal Unit are reviewed by a Multi-professional team on a weekly basis using case review methodology
• Monthly audit of Transitional Care activity
• Datix was reviewed in terms of readmissions, staffing issues
• Complaint data was reviewed to ascertain if any issues raised by families regarding visiting or other restrictions implemented during Wave 1 COVID 19 Pandemic
There was multi-professional representation from both maternity and neonatal services at all meetings

All cases are documented on a ATAIN tracker

66 Babies met the criteria for a multi-professional ATAIN review between March and August 2020 of which 16 were deemed as avoidable. One case was deemed as a Serious Incident

39 babies were admitted due to respiratory needs of which one baby is documented to be COVID Positive and a further nine were recorded as Sepsis

Themes identified as part of the ATAIN reviews include CTG monitoring, Intermittent Fetal Monitoring, correct use of neonatal O2 sats review. Action taken against all themes.
RESULTS-ATAIN AT HH

• ATAIN review meetings were held and recording of attendance is becoming more robust
• A tracker is in place to document the findings of all cases reviewed
• 23 babies met the ATAIN Criteria between March and August 2020 of which 3 were deemed avoidable
• 14 of the cases were admitted due to respiratory issues and 3 related to hypoglycaemia
• Themes identified include staffing, management of the diabetic mother
The summary is of monthly audits undertaken at PCH Transitional care from February to September 2020 which included a review of 140 babies.

139 babies met the admission criteria.

73% of babies had a full set of observations undertaken on admission between February and June 2020 against a standard of 100%. In August and September 2020, this had improved to 100%.

There is evidence that all babies with clinical concerns except one were reviewed on admission. (1 set of notes missing)

Named Paediatrician was only documented in 43%. This had improved to 100% in the August and September audit.

98% of babies had a daily examination by a midwife.

71% of babies had observations undertaken four hourly which improved to 100% in August and September 2020 (7 charts missing).

98% of babies met the criteria for discharge. 12 babies experienced a delayed discharge due to requiring additional feeding support. No delays were reported in either August or September.

Monthly Audits recommenced in August and full compliance against all criteria was reported for both August and September 2020.
RESULTS- SUMMARY OF MONTHLY TRANSITIONAL CARE - HH

- The summary is of monthly audits undertaken at Lilac Transitional care from February to October 2020 which included a review of 125 babies
- All 125 babies met the admission criteria
- 100% of babies had a full set of observations undertaken on admission against a standard of 100%
- 100% of babies reviewed by a paediatrician on admission if acute concerns were present
- There were clinical concerns for 20 babies out of the 80 of which 19 saw a paediatrician within 24 hours of admission. (1 set of notes missing)
- Named Paediatrician was documented for 99 babies during the audit period
- All but 2 babies had a daily examination by a midwife
- 100% of babies had observations undertaken four hourly
- All babies except nine met the criteria for discharge. For these nine babies, details were not documented.
RESULTS - COVID19

Visiting

- Only Mothers were permitted to visit their baby on Neonatal Unit and Special Care Baby Unit during Wave One until June when visiting was extended to partners
- 1 informal complaint was received on the SCBU at Hinchingbrooke but resolved locally
- 0 formal complaints received regarding NICU
- No visitors were permitted to the maternity services on both sites
- The Service received feedback from many different routes regarding how difficult families found the restrictive visiting arrangements.
Readmissions PCH

- For PCH there were 49 reported readmissions to Transitional Care between March and August 2020 which were categorised as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding Support</td>
<td>4</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>6</td>
</tr>
<tr>
<td>Jaundice requiring feeding support</td>
<td>9</td>
</tr>
<tr>
<td>Jaundice requiring phototherapy</td>
<td>30</td>
</tr>
</tbody>
</table>
Neonatal Readmissions to Hinchingbrooke

- No readmissions were accepted onto Lilac Ward during the COVID 19 pandemic. The babies were admitted to Holly Children’s Ward
- There were 5 babies admitted due to Jaundice and 6 for poor feeding
- There were also a further babies who required attendance at the hospital for review and treatment which included 5 for jaundice, 2 for weight loss and 6 for poor feeding
RESULTS – COVID 19

Staffing at PCH

There were 4 reported incidents of "inadequate levels" relating to Transitional Care between March and August 2020 one of which relates to paediatrics and the other three related to midwifery.

Of the three midwifery incidents, two relate to the volume of work requiring staff to stay late and one relates to a midwife being pulled to DS to provide 1:1 care, leaving one midwife on the ward.

Sickness levels averaged at 5.59% between March and August 2000 but peaked in March at 18.33%

These incidents are in the context of an actual 1:34 midwife to birth ratio. The Unit closed on three occasions once in July and twice in August 2020
RESULTS – COVID 19

Staffing on Lilac Ward

- Transitional Care is part of the postnatal ward Lilac so the data is for the whole ward.
- In total, 20 clinical incidents regarding “inadequate staffing” were reported between March and August 2020. Of which six related to staffing levels specifically on Lilac Ward, 3 relating to Unit staffing levels impacting on Lilac ward and 6 related to Lilac ward staff being redeployed to assist with Labour Ward.
- The average sickness rates in 11.97% between March and August 2020 peaking in March at 17.13%
- The actual in post midwife to birth ratio is 1:27 at Hinchingbrooke
- The Unit closed on 2 occasions once in July and once in August 2020
RECOMMENDATIONS

• The ATAIN action plan should be updated to include greater improvement actions regarding:
  • Reducing respiratory distress
  • Management of the diabetic mother
  • Management of the deteriorating neonate
  • Monitoring compliance of neonatal observations
  • Review the staffing model/levels for Transitional Care
• Quarterly reports of ATAIN and TC audits to be generated for future Maternity Safety Champion Meetings
• To improve rigour of TC monthly audits
SUMMARY

• There is no evidence that capacity was adversely impacted by COVID 19 and staffing whilst low due to higher sickness rates appears to have been mitigated
• Visiting arrangements have been changed for Wave 2 in response to feedback from women and the introduction of the national framework
• Only one case referred to a positive COVID 19 test
• Lessons identified have been added to the ATAIN action plan