Neonatal Transitional Care

Introduction and Background:

“Keeping mothers and babies together should be the cornerstone of newborn care. Neonatal Transitional Care (NTC) supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require to be in a neonatal unit (NNU). Provision of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and also to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.”

-BAPM 2017

“NTC can be delivered under several different service models, including within a dedicated transitional care ward and on a postnatal ward, but the primary carer must be resident with the baby and providing care. Whatever the location, NTC should be considered a service, rather than a place in which care is delivered.”

-BAPM 2017
Patient requirements:

UHL NHS Trust does not have a physical NTC unit. The NTC service is delivered on the postnatal wards at both the LRI and LGH with collaboration between both the maternity and neonatal service. NTC activity is captured on BadgerNet.

To be eligible for NTC, the primary carer must be resident with the baby. There are two routes whereby a neonatal patient can be admitted to the NTC service.

Route 1 – From delivery suite having been born between 34+0 and 36+6 weeks of gestation with a weight of ≥1.6kg meeting at least one of the following criteria:

- Cardiorespiratory observations required but not more frequently than 4 hourly (after 12 hours of age)
- Temperature monitoring as required +/- radiant heater or ‘hot cot’
- Establishing feeds by breast or bottle +/- nasogastric tube insitu
- Blood sugar monitoring in line with UHL Prevention and Management of Symptomatic or Significant Hypoglycaemia in Neonates (Yadav 2018) guideline is considered ‘normal newborn care’. Babies that require treatment or additional medical review in line with this policy would be categorised as NTC.
- Risk factors for sepsis requiring intravenous (IV) antibiotics as per Antibiotic Guideline for Early-onset & Late-onset neonatal infection (Kairamkonda et al. 2018), but remains clinically well. Baby will remain resident on postnatal ward and will attend the neonatal unit for initial septic screen, cannulation and for each dose of IV antibiotics
- Drug treatment for neonatal abstinence syndrome, and requiring 4 hourly (or more frequent) monitoring
- Hyperbilirubinaemia requiring single phototherapy and regular bilirubin monitoring in line with NICE (2016) guidance (If an NTC patient’s bilirubin level requires double phototherapy treatment or greater, the patient should be admitted to the neonatal unit)
- Non-life threatening anomaly/condition requiring investigations until plans are made for outpatient review and follow up e.g. Non-concerning heart murmurs with ECG or ECHO already reviewed by cardiology

Route 2 – Step-down from neonatal unit meeting the following criteria:

- Any of the above criteria with a gestation of ≥33 weeks

Workforce and resource requirements

NTC patients are admitted under the care of a neonatal consultant and reviewed at least once per day by either the neonatal doctor or ANNP allocated to the postnatal wards. Any concerns are escalated initially to the registrar allocated to special care on the neonatal unit. Each baby requiring a septic screen and IV antibiotics will be reviewed by the registrar as part of the admission process. Further escalation, if required, should be directed to the consultant neonatologist on service for either special care or intensive care.
At both the LGH and LRI there is a baby care assistant on duty between the hours of 09:00-17:00 to support the medical and maternity teams in caring for NTC patients. There is a cross-site band 8a ANNP lead allocated for developing transitional care services.

Monitoring activity:

Currently, the only NTC babies from route 1 that are recorded on BadgerNet are those that have received a septic screen and are receiving IV antibiotics. These babies will trigger a ‘special care’ level of care on the day of their screen and will subsequently be recorded as ‘transitional care’. Of the babies from route 2, only those who remain on IV antibiotics will be recorded on BadgerNet as transitional care. On discharge these patients will have a discharge summary generated from within BadgerNet and sent to their GPs.

All other babies on the postnatal wards from route 1 and 2 will not be admitted onto BadgerNet but are still described as NTC patients. Any notes or appointments required for these patients will be made by either the baby care assistant or postnatal ward SHO/ANNP. On discharge an ‘ICE’ discharge letter is generated for these patients and sent to their GP to handover the care and describe any plans for the future.

References to other standards, alerts and procedures:


