Escalation Pathway and Contact Numbers - Neonatal Intensive Care Unit (NICU)

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Child Health - Neonatal Intensive Care Unit
Document Facilitator Name	Dr Jutta van den Boom
Document Facilitator Title	Neonatologist (SMO)
Document Owner Name	Dr Jutta van den Boom
Document Owner Title	Head of Department, NICU
Target Audience	Clinical Staff, NICU
Disclaimer: This document has been developed for use specifically by staff at the former Waikato District Health Board. Caution should be exercised before use outside this district. Any reliance on the information contained herein by any third party is at their own risk and Health New Zealand | Te Whatu Ora assumes no responsibility whatsoever for any issues arising as a result of such reliance.	

Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
01	David Graham	18-10-2019	New protocol
02	Jutta van den Boom	April 2022	Inclusion of phone allocations and roles, title change
03	Jutta van den Boom	June 2024	Change of title SMO afterhours call and attendance criteria

Escalation Pathway and Contact Numbers - Neonatal Intensive Care Unit (NICU)

1 Overview

1.1 Purpose

This document contains information when neonatal service assistance is required

- Phone and role allocations for NICU
- Medical Escalation Pathway
- Nursing Demand Escalation Pathway

1.2 Staff group

All NICU clinical staff, paediatric medical staff, anaesthetic staff.

1.3 Patient / client group

Infants in the care of the Neonatal Intensive Care Unit at Waiora Waikato hospital.

1.4 Definitions

ACNM	Associate Charge Nurse Manager
DM	Duty Manager
Neonatal Medical Escalation	SMO is required to attend immediately to medical emergencies, clinical deterioration and high acuity/demand
NICU	Neonatal Intensive Care Unit
Paeds Reg	Paediatric Registrar
Resident	Registrar, Neonatal Nurse Practitioner, Neonatal Nurse Specialist, Fellow
SHO	Senior House Officer
SMO	Senior Medical Officer

2 NICU Roles and Phone Allocations

- Resident and ACNM cover in NICU is 24 hours every day
- SMO cover on site is 8.00am to 5.00pm, then on call back
- Neonatal Community Service is available Monday to Friday, 8.00am to 5.00pm

The table below outlines phone allocations and roles, which will be reflected in Whoison accordingly (https://www.whoison.net/cgi-bin/ocs?Lo=waikato&Enote)..

Phone Name/Duty	Number	Time Held	Function/Role
Neonatal emergency	**99777**	24 hrs	• NICU arrest pager 20630 *If no response:* *Call Level 1 NICU Acute Calls (021 488 194, 23863)* *If NICU Resident unavailable:* *Call Paed Reg (ext 26142)* • Delivery Suite Coordinator -20908 • Duty Manager - 27003 or 021 504 638 • L3 Coordinator - 23703 or 021 240 8955
NICU arrest pager	**20630**	24 hrs	For all emergencies Level 2 Resident
Level 1 NICU Acute Calls	**021 488 194 Ext 23863**	24 hrs	Held by Level 1 Resident All acute phone calls / postnatal ward
Level 2 NICU Second on Call	**027 254 7312 Ext 20724**	24 hrs	Held by Level 2 Resident In case 'Level 1- Acute calls' unavailable
Level 3 NICU Third on Call	**027 242 4401 Ext 20164**	0800-1700	Held by Level 3 Resident (admission space) Backup for Level 1/2 Internal communication for level 3
SHO	**021 919 248 Ext 23002**	0800-2200	Held by SHO, 0800-2130 (handover to NICU at 2130) Charged overnight (while turned off) in NICU
SMO	**Own phones (whoison/operator)**	24 hrs	Any requests All transport calls
Coordinator L3	**021 240 8955 ext 23703**	24 hrs	Held by ACNM Level 3
Coordinator L2	**021 701 634 ext 23412**	0700-2300-	Held by ACNM Level 2
Community Nurses NICU	**0800 667 882 ext 23571**	0800-1700 (Mon-Fri)	Community nurses NICU for community contact

3 NICU Medical Escalation

3.1 Decision to trigger "Medical Escalation".

Decision to trigger "Medical Escalation" is taken by the Registrar/NNP or ACNM on duty. This includes medical emergencies, clinical deterioration and high acuity/demand needing the attendance of the Neonatal SMO.

This is also to be used in conjunction with the 'Safety Code'

Escalate to the on-call Neonatal SMO	**state "Neonatal Medical Escalation"**
If they are uncontactable:	
In hours	
Call another neonatal SMO who is on-site in the hospital	state "**Neonatal Medical Escalation**"
After hours	
Call another neonatal SMO moving down the list of Neonatal SMOs until successful response	state "**Neonatal Medical Escalation**"
Call the acute Paediatric Registrar (ext 26142) (They must attend, and also call their on-call medical SMO to come in to cover their duties)	state "**Neonatal Medical Escalation**"
Call the Duty Anaesthetist (ext 23322) If specifically an airway issue - they will coordinate support from an anaesthetic perspective	state "**Neonatal Medical Escalation**"
If the on call Neonatal SMO was initially not contactable, further attempts should continue until a response is gained, in order to inform the Neonatal SMO of the current clinical situation.	
Activation of a "Neonatal Medical Escalation" should be documented in the clinical notes as soon as practicable; and a timely debrief and Datix should be considered - Critical Incident Debriefing – Neonatal Intensive Care Unit (NICU) guideline (Ref. 6349)	

For neonatal emergencies refer to the Neonatal Emergency Response procedure (Ref. 0192)

For neonatal attendance at births refer to Attendance of Neonatal Staff for Births at Waikato Hospital guideline (Ref. 2293)

3.2 SMO After-hours Call and Attendance Expectations

Medico legally, SMOs remain responsible for decisions made in their absence. Appropriately timed discussion can ensure alternative perspectives and differentials are considered and aid in balanced decision making. On call SMO should be consulted and informed in the situations outlined below. The list is not comprehensive – **staff are encouraged to call SMO for help and advice if in doubt**.

3.2.1 SMO afterhours call expectations

Please start your call with: '**I do / do not need you to come in**', then use SBARR for pertinent information.

- All deliveries <28/40 (see section 3.2.2 below)
- Babies who meet therapeutic hypothermia criteria or are considered borderline
- Severely unwell babies
- If you
  - plan on instrumenting an airway (ETT or LISA)
  - plan on giving blood products (except for RBC as per threshold guideline)
  - plan on initiating inotropes or changing inotropes (outside what was discussed during handover rounds)
  - consider introducing nitric oxide or changing mode of invasive ventilation (unless discussed at handover rounds as planned)
  - have concerns that may warrant surgical review
  - unsuccessful IV access attempts (same expectations as during daytime)

In addition, there should be no impact on your ability to "Speak Up for Safety". If there are concerns around acute decision making, please proportionally speak up e.g. suggest a second opinion be sought. If declined and still thought necessary, suggest you yourself may call for a second opinion. Any SMO who receives a call for a second opinion will confer with the on call SMO and discuss appropriately. Feedback will then be provided to the person who initiated the request for a second opinion. ACNMs are also empowered and encouraged to have these discussions with medical staff or escalate to SMO if they have concerns.

3.2.2 SMO after-hours attendance expectations

In emergencies, all that needs to be said is e.g. "24 week delivery imminent, please come"

There is a standard expectation of attendance in the following scenarios

- Deliveries at ≤26/40 gestation
- Multiples <28/40 (i.e. twins/triplets)

Continued over page

- Deliveries <28/40 (dependent on mid-level staff experience)
- Profoundly unwell neonate
- Terminally unwell neonate (i.e. dying baby; unless expected and ACP in place)
- Whenever requested to attend.

3.3 NICU Nursing Demand Escalation

This guideline is to be read in conjunction with the Care Capacity Demand Management guideline.

Decision to trigger Demand Escalation is taken by ACNM on duty.

- Basic criteria should be patient centred, and should reflect clinical demand vs available service capacity.
- Demand Escalation is the usual expected response to very high demand.
- Demand Escalation is distinct from discussion with more senior staff re patient management.
- Escalation implies new resource (usually more hands, more expertise, more seniority) being urgently sought on-site.
- Staff must respond to an escalation request.

Demand includes - volume of work to be done, and acuity of work to be done i.e.

	Acuity		
Volume	Low	Medium	High
Low	-	-	-
Medium	-	-	-
High	-	-	-

In the usual setting, escalation is ***mandatory*** in the setting of high volume and high acuity, and may be necessary in the setting of a combination of medium or high acuity and volume.

Acuity for an individual patient is derived from standard clinical assessment. If there are several patients with elevated acuity individually below the threshold for escalation (i.e. high volume, medium acuity), this may in itself require escalation. Demand may also be escalated if there is insufficient staff. The duty manager must be informed of this situation, and will support the demand escalation pathway.

4 Evidence base

4.1 Associated Health New Zealand Waikato Documents

- Attendance of Neonatal Staff for Births at Waikato Hospital guideline (Ref. 2293)
- Care Capacity Demand Management guideline (Ref. 5916)
- Code Red Major Trauma Response W0342HWF
- Critical Incident Debriefing – Neonatal Intensive Care Unit (NICU) guideline (Ref. 6349)
- Early Warning Scoring System for the Deteriorating Patient procedure (Ref. 1541)
- Neonatal Emergency Response procedure (Ref. 0192)
- SBARR Communication Tool protocol (Ref. 5038)
- SMO Responsibilities and Limits of Delegation to RMOs policy (Ref. 2561)
- Speaking up for Safety