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# NEONATAL CARE STABILIZATION GUIDE

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NEONATOLOGIST

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For Children's Minnesota education and resources, visit [cmn.education.childrensmn.org](https://cmn.education.childrensmn.org), or contact the neonatal outreach liaison, Kristen McDaniel at [kristen.mcdaniel@childrensmn.org](mailto:kristen.mcdaniel@childrensmn.org).

# NEONATAL RESUSCITATION/STABILIZATION SUPPLY AND EQUIPMENT CHECKLIST

## Thermoregulation

- Preheat warmer
- Warm blankets/hat
- Plastic wrap or bag for newborn < 1500 gms
- Chemical warming mattress if available for premature baby

## Airway/Ventilation

- Stethoscope
- Bulb syringe
- 8 F–10 F catheter attached to wall suction set at 80–100 mm/Hg
- Ventilation bag connected to oxygen with flow at 8–10 L
- Correct size mask for baby
- T-piece resuscitator checked and set: (PIP at 20–25 and Peep at 5 cm with flow at 10 L)

## Oxygenation

- Pulse oximeter probe and monitor ready
- Oxygen blender set per NRP recommendations
- Turn on gases just prior to delivery (ex. 21% for term and 21–30% oxygen for preterm newborns per NRP recommendations)
- Equipment set to deliver free flow oxygen if needed
- 100% oxygen if baby needs compressions

## Intubation

- Endotracheal tubes: 2.5, 3.0 and 3.5
- Laryngoscope with bright light and appropriate size blades
- CO<sub>2</sub> detector
- Laryngeal mask (size 1) with 5 ml syringe
- OG tube size 8 Fr with 20 ml syringe
- Suction set up

# NEONATAL RESUSCITATION/STABILIZATION SUPPLY AND EQUIPMENT CHECKLIST

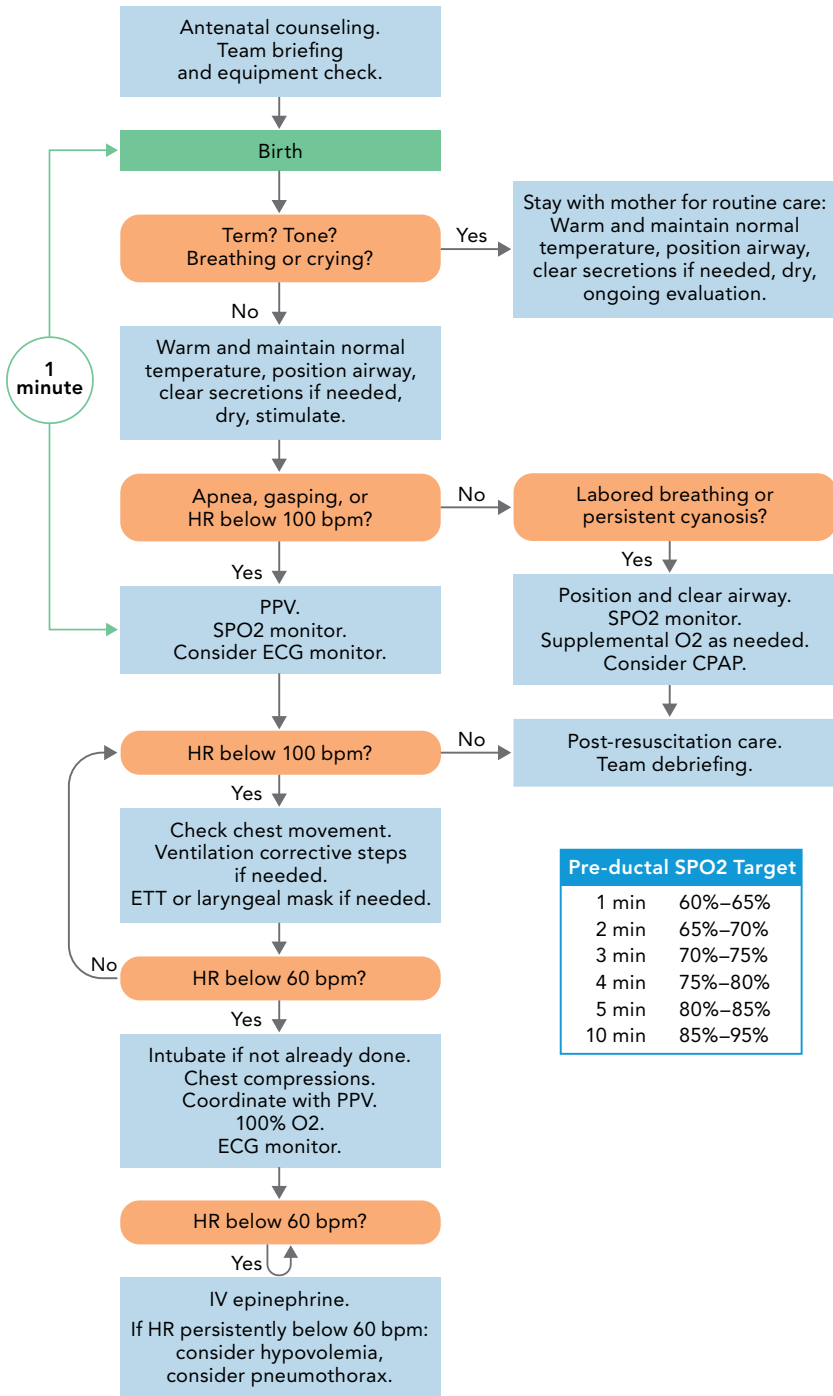
## Medications

- Normal saline
- 20 ml syringes
- Epinephrine 0.1 mg/ml concentration with 1 ml, 3 ml and 5 ml syringes
- Labels for Epinephrine ETT and UVC doses
- Umbilical line tray
- Umbilical catheters (3.5 Fr for <1500 gm and 5.0 Fr for > 1500 gm)
- Emergency medication dosing manual

## Documentation

- Code Sheet and pen

# NRP ALGORITHM



# STABILIZATION BEST PRACTICES

## Thermoregulation

- If infant < 1500 grams or < 32 weeks' gestation, place baby immediately in plastic wrap and/or use warming mattress. Monitor for hypo- or hyperthermia.
- Maintain room temperature 74–77° F for all preterm births
- Use warmer on servo mode
- Dry infant, remove wet linens for infants > 1500 grams
- Place hat on infant ASAP
- Maintain axillary temperature 97.6–99° F or 36.5–37.5° C
- For infants born late preterm with birth weights < 2500 grams, monitor temperature closely

## Glucose (refer to section on hypoglycemia)

- Check blood sugar on all infants at risk for hypoglycemia within 15–30 minutes of birth

## Respiratory

- Always use blended oxygen in resuscitation to avoid unnecessary exposure to hyperoxia
- Place oximeter on right hand or wrist of all babies requiring ventilation support
- For infants < 35 weeks gestation, begin resuscitation at 21–30% oxygen
- For infants > 35 weeks gestation, begin resuscitation at 21% and titrate to keep saturations within recommended levels
- Increase oxygen to 100% if compressions are needed
- Target saturation levels according to NRP guidelines

## Laryngeal Mask Airway (LMA)

- Consider LMA for infants who are  $\geq 2$  kg, or at least 34 weeks gestation and are:
  - » Difficult to intubate
  - » Have experienced unsuccessful face mask ventilation

# STABILIZATION BEST PRACTICES

## Positive Pressure Ventilation (PPV)

- When delivering PPV, apply electronic cardiac monitor
- Recommend initial ventilation pressure of 20–25 cm H<sub>2</sub>O and peep of 5 cm H<sub>2</sub>O

## T-Piece Resuscitator

Settings:

- < 32 weeks: PIP 20–25, PEEP 5, rate 60, flow 8 lpm of blended O<sub>2</sub>
- > 32 weeks: PIP 25–30, PEEP 5, rate 40–60, flow 10 lpm blended O<sub>2</sub>
- Use minimal inflation pressures to achieve normal chest rise and increase heart rate
- Consider CPAP if > 27 weeks and breathing spontaneously
- CPAP: Use 5 cm H<sub>2</sub>O

## Endotracheal intubation

- See NRP Algorithm for ETT sizes
- Depth of ETT: measure from middle of nasal septum to ear tragus and add 1 cm
- Obtain X-ray to verify correct placement (T2–T3)

# NEONATAL UMBILICAL VESSEL CATHETERIZATION

## Low umbilical venous catheter use

- Intravenous access for administration of fluid, medications, blood transfusion or hypertonic glucose
- Does not need X-ray confirmation

## Equipment

- Umbilical Line Tray
- Umbilical catheter: (3.5 for < 1.5 kg or 5.0 for > 1.5 kg baby)

## Patient preparation

- Apply limb restraints on newborn if active
- Use sterile technique for staff including gloves, gown, cap, mask
- Cleanse umbilical cord and abdomen with CloraPrep or betadine (per policy) while assistant holds cord clamp above newborn abdomen
- Allow cleanser to dry
- Apply sterile drapes over newborn
- Apply cord tie around stump near skin using only mild tension so that it does not restrict ability to insert catheter into vessel
- Increase tension slightly if bleeding occurs once cord is cut
- Cut umbilical cord 1 cm from skin

## Set up

- Sterilely open line tray
- Use 5 ml syringe to flush normal saline through 3 way stopcock and umbilical catheter
- After flushing catheter, turn stopcock to off position
- Place sterile instruments and catheter on drapes near baby



# NEONATAL UMBILICAL VESSEL CATHETERIZATION

## Catheter insertion and use

- Grasp stump and hold upright
- Blot with gauze to visualize vein (a single, larger, thin-walled oval vessel)
- Dilate vein and remove any clots
- Insert umbilical catheter approximately 2–4 cm until blood can be drawn through catheter
- Catheter is ready for administration of necessary fluids, medications, blood, etc.
- Flush after all medication administration since area of infusion is non-pulsatile

## RESPIRATORY DISTRESS

1. Always use blended oxygen to avoid unnecessary exposure to 100% oxygen.
2. If giving oxygen or assisting infant with breathing, place pulse oximeter on right hand or wrist.
3. At delivery, use the NRP target saturations. After 10 minutes of life and beyond, maintain saturations of 88–94% with target oxygen saturation of 92%.
4. Nasal cannula oxygen:
  - a. Set flow at 1–2 LPM (using minimal flow to achieve desired oxygen saturation)
5. T-piece resuscitator. Use whenever possible instead of bag mask ventilation.
  - a. Consider CPAP if infant > 27 weeks and breathing spontaneously
  - b. Set CPAP at 5 cm H<sub>2</sub>O
  - c. If ventilation assistance is needed, use minimal inflation pressures to achieve normal chest rise and improved heart rate
  - d. For infants < 32 weeks, set PIP 20–25, PEEP 5, rate 60, flow 8 LPM
  - e. For infants > 32 weeks, set PIP 25–30, PEEP 5, rate 40–60, flow 10 LPM

## RESPIRATORY DISTRESS

6. Intubation (if infant is stable, consult with neonatologist regarding intubation parameters) or place Laryngeal Mask Airway (LMA) and continue PPV through LMA if unable to intubate.
  - a. Infant is apneic, heart rate  $< 100$ , prolonged PPV, oxygen requirement  $> 40\%$ ,  $PCO_2 > 60$ .
  - b. ETT sizes and depth per NRP guidelines. For depth of ETT, measure distance from middle of nasal septum to ear tragus and add 1 cm.
  - c. Obtain CXR to confirm ETT placement below clavicles and above carina. If infant has a UV Line, get abdominal X-ray with chest X-ray.
7. Do not feed any infant with respiratory distress or those that are likely to be transported.
8. If moderate or severe distress, place peripheral IV (or UVL) and start D10W at 80 ml/kg/day .
9. Consider pulmonary air leak in any infant who acutely deteriorates and has received CPAP or PPV.

# HYPOGLYCEMIA

## Glucose assessment of blood sugar levels

Check blood sugar on all infants at risk for hypoglycemia within 15–30 minutes of birth.

Use own hospital policy for blood sugar targets, or see Allina protocol based on the AAP recommendation below:

0–4 hours of age:  $\geq 35^*$

4–24 hours of age:  $\geq 45$

> 24 hours of age:  $\geq 50$

> 48 hours of age:  $\geq 60$

\*Check serum glucose for any glucose  $< 35$  but do not wait for results to treat low level.

## High-risk infants

- Small for gestational age (less than 10th percentile growth for gestation).
- Large for gestational age (greater than 90th percentile growth for gestation).
- Infant of diabetic mother.
- Sick or unstable.
- Premature.
- Infant with perinatal depression.
- Symptomatic for hypoglycemia (*abnormal, weak or high-pitched cry, poor feeding, poor suck and coordination, hypothermia, diaphoresis*).

### IMPORTANT

If IV dextrose solution required is  $> D12.5W$ , solution must be administered in a centrally located venous line, such as a UVC.

# HYPOGLYCEMIA

## Intervention for low blood sugar

If baby is able to breastfeed or bottle feed within first hour of life:

- Breastfeed 10 minutes and offer formula or donor milk if mom's milk supply is not established,  
or
- Bottle feed (20 kcal/oz or higher calorie if available).
- Recheck blood glucose 30 minutes after feeding.
- Feed baby q 3 hours and continue to monitor blood sugar levels before all feedings for 12–24 hours to ensure normal blood sugar levels.

If baby's blood sugar remains low despite feedings, and/or baby is unstable, and/or unable to eat or is going to be transferred:

- Administer 40% glucose gel, 0.5 ml/kg if available, and monitor sugar levels until stable.
- If gel is unavailable or infant has symptoms of hypoglycemia, place a peripheral IV or UVC.
  - » Give baby D10W bolus of 2 ml/kg and start maintenance IVF of D10W IV at 80 ml/kg/day.
- Continue to monitor blood sugar and titrate IV to keep blood sugar normalized according to policy.

### **IMPORTANT**

**If IV dextrose solution required is > D12.5W, solution must be administered in a centrally located venous line, such as a UVC.**

## CARE OF THE BABY WITH BIRTH ASPHYXIA AND EVALUATION FOR MILD SYSTEMIC HYPOTHERMIA THERAPY

Mild systemic hypothermia (MSH) is indicated for use in infants  $\geq 36$  weeks' gestation following birth asphyxia with clinical evidence of seizures or moderate to severe hypoxic-ischemic encephalopathy (HIE). The therapy prevents or reduces the severity of neurologic injury associated with HIE.

- Establish airway, breathing and circulation.
- Consult with Children's Minnesota team and evaluate infant for eligibility to receive total body cooling therapy.

### Patient eligibility criteria

- **A** Infant is  $\geq 36$  weeks gestational age (special consideration may be given to infants 34–35 weeks gestation; consult neonatology),  $> 1,800$  grams, and at least one of the following:
  - Apgar score of  $\leq 5$  at 10 minutes after birth.
  - Continued need for resuscitation, including endotracheal or mask ventilation, at 10 minutes after birth.
  - Acidosis defined as either umbilical cord pH or any arterial pH within 60 minutes of birth  $< 7.0$ .
  - Base deficit  $\geq 16$  mmol/L from cord or other infant blood sample within 60 minutes of birth.

# CARE OF THE BABY WITH BIRTH ASPHYXIA AND EVALUATION FOR MILD SYSTEMIC HYPOTHERMIA THERAPY

- B** Infant with seizures or moderate to severe encephalopathy consisting of altered state of consciousness with at least three of the following:

Moderate to Severe Encephalopathy		
Category	Moderate Encephalopathy	Severe Encephalopathy
1. Level of consciousness	Lethargic	Stupor or coma
2. Spontaneous activity	Decreased activity	No activity
3. Posture	Distal flexion, complete extension	Decerebrate
4. Tone	Hypotonia (focal or general)	Flaccid
5. Primitive reflexes	Weak	Absent
Suck	Incomplete	Absent
Moro		
6. Autonomic system	Constricted	Deviated, dilated, or non-reactive to light
Pupils	Bradycardia	Variable/Apnea
Heart rate/respiration	Periodic breathing	

## What to do while transport team is on the way

- Turn down the radiant warmer to allow infant to cool to a goal temperature of 34°C. Use a skin probe for continuous temperature monitoring and control. This allows the infant to cool through passive means while waiting for transport team. **Do not** place ice packs on infant.
- **Turn overhead warmer to 50%, monitor infant's axillary temperature every 15 minutes with goal of maintaining temperature at 36.5°C (98°F). Avoid hyperthermia. Additional passive cooling may be recommended based on referral center distance or time to arrival of transport team.**
- Place a peripheral IV or low UVC and start antibiotics after obtaining a blood culture.
- Support blood pressure and perfusion as needed (see section on sepsis/shock).
- Monitor blood sugar and maintain euglycemia.

## SEPSIS/SHOCK

**High-risk infants:** those at risk for infection or those that have experienced significant blood volume loss during birth.

Sepsis evaluation treatment:

- Obtain blood culture.
- Place PIV or low UVC.
- Give Ampicillin 100 mg/kg IV slow push over 5 minutes.
- Give Gentamicin 4 mg/kg IV infused over 30 minutes.

Evaluate for hypoglycemia and start maintenance glucose infusion:

- If glucose < 50 mg/dl, give 2 ml/kg D10 bolus and start maintenance D10 infusion at 80 ml/kg/day.
- Recheck glucose 30 minutes after bolus given and maintenance is started.

Give 10 ml/kg of normal saline over 15 minutes if baby's perfusion is sluggish (may repeat dose if needed):

- Capillary refill > 3 seconds.
- Infant appears mottled.
- Brachial and femoral pulses are weak.
- If able to get a cuff blood pressure and the mean cuff pressure is less than the gestational age.

Give 10 ml/kg of normal saline if known blood volume loss while waiting for O negative blood to arrive from blood bank (if able to obtain).



# EXTREMELY LOW BIRTH WEIGHT INFANT (< 30 WEEKS GESTATION)

## Special equipment and pre-delivery setup

- Food grade or sterile plastic bag.
- Chemical warming mattress (if available).
- Monitor and leads (recommended if available).
- Umbilical line tray with size 3.5 umbilical catheter.
- Pulse oximeter probe.
- Skin probe for warmer.
- T-piece resuscitator PIP 20–25, PEEP 5, FiO<sub>2</sub> 21-30%.
- 2.5 ETT if infant < 28 weeks and/or < 1000 gm
- 3.0 ETT if infant > 28 weeks and/or > 1000 gm
- Suction.
- CO<sub>2</sub> detector.
- Tape for ETT.
- NS available.
- D10W available.
- Pre-warmed infant warmer.

## AT DELIVERY

### Temperature

- Place infant in bag on chemical warming mattress.
- Place temperature probe on abdominal skin.
- Monitor temperature frequently.
- Remove plastic wrap if infant temperature > 98.6°F.

### Cardio/respiratory

- Place oximeter on right hand or wrist.
- Place electrodes on chest.
- PPV if not breathing or HR < 100.

## **EXTREMELY LOW BIRTH WEIGHT INFANT (< 30 WEEKS GESTATION)**

- CPAP if infant breathing and HR > 100.
- Begin oxygen at 21–30% and titrate per NRP saturation guide by minute of age.
- Intubate if not breathing effectively, HR remains < 100, unable to maintain oxygen saturation within recommended guidelines. Ventilate at a rate of 40–60/minute.
- Use CO<sub>2</sub> detector to help assess if ETT is correctly placed.

### **Fluids/medications**

- Place low UVC (2–4 cm).
- Initiate IV fluids of D10 at 80 ml/kg/day  
(wt in kg X 80 ml ÷ 24 hr = ml/hr).
- D10W glucose bolus 2 ml/kg if glucose level is < 50.
- Start Ampicillin (100 mg/kg) and Gentamicin (4 mg/kg) after culture drawn.
- Give normal saline bolus 10 ml/kg if capillary refill time > 3 seconds or blood pressure mean is < gestational age. May repeat dose as needed.

### **Labs/X-rays**

- Chest/abdomen X-ray for ETT placement and umbilical line placement.
- Labs: CBC, differential, platelets, blood culture, VBG, glucose.

## SURGICAL EMERGENCIES

**\*\*For all surgical emergencies, keep baby NPO and start IV of D10W at 80 ml/kg/day.**

### Esophageal atresia

- Pass OG until resistance is met.
- Place OG to low intermittent suction of 20–30 cm H<sub>2</sub>O pressure to keep pouch empty.
- Abdominal and chest X-ray.
- Elevate HOB 30 degrees.
- Place infant prone to reduce reflux of stomach contents through fistula to trachea.
- Place oximeter and support oxygenation/ventilation.

### Intestinal obstruction

- Pass orogastric tube to stomach, manually remove air/contents, then place on low intermittent suction of 20–30 cm H<sub>2</sub>O pressure to decompress abdomen.

### Abdominal wall defect

- Use polyethylene baby bag.
- Position neonate on right side at 90 degree angle for gastroschisis — no tension on defect.
- Place PIV. **Avoid UVC placement.**
- Pass OG to stomach, remove contents, and place on low intermittent suction.

### Congenital diaphragmatic hernia

- Intubate immediately.
- Place OG to stomach, remove air/contents, place on low intermittent suction or manually remove air with a syringe frequently.
- Place infant on side of defect.
- Get a chest/abdominal X-ray.

## **SURGICAL EMERGENCIES**

### **Neural tube defect**

- Position neonate prone.
- Wrap defect with Telfa soaked in room temperature NS, then cover with plastic wrap bag.
- Monitor baby's temperature to maintain normal (NS wrap may cool baby).

### **Encephalocele**

- Position neonate prone.
- Wrap defect with Telfa soaked in room temperature NS, then cover with plastic wrap or poly bag.
- Monitor baby's temperature to maintain normothermia (NS wrap may cool infant). PPV if not breathing or HR < 100.

# ASSESSMENT AND STABILIZATION FOR A SUSPECTED CARDIAC LESION

## Physical assessment

In a cyanotic neonate, pulse, respiratory rate, oxygen saturation and blood pressure (measured in right arm and either leg) may be similar between neonates with congenital heart disease (CHD) and other causes.

In some cases, specific physical findings can help determine cause of cyanosis or cardio-respiratory instability.

To assess if a neonate has suspected congenital heart disease, assess for the following:

- **Murmur:** Assess for sound and location of a murmur.
- **Oximetry:** Place pulse oximeter on the right wrist and on one of the infant's feet; pre-ductal and post-ductal saturations should be within 10 points of each other.
- **Blood Pressure:** Neonates with CHD may have a significant BP gradient between arms and legs, or weakened/absent femoral pulses. A difference of 10 or more between upper and lower extremities may indicate aortic flow compromise.
- **Level of Respiratory Distress:** (Distress is most often related to respiratory causes but may also indicate a structural cardiac disease). Infants with a CHD usually present with cyanosis and mild or absent tachypnea.
- **Hepatomegaly:** Often present in patients with heart failure due to left-sided obstructive lesions (hypoplastic left heart syndrome, coarctation, critical aortic stenosis and cardiomyopathy) or total anomalous pulmonary venous connection.
- **Chest X-ray:** May help to rule out pulmonary causes of cyanosis, and assess for heart size and shape.

## Lab testing

- **Blood gas:** Obtain in any infant with cyanosis:
  - » Provides more specific data than oxygen saturation.
  - » An elevated arterial PCO<sub>2</sub> value often indicates presence of pulmonary disease but may also be increased in heart failure due to pulmonary congestion.

## ASSESSMENT AND STABILIZATION FOR A SUSPECTED CARDIAC LESION, *continued*

- » A reduced pH level raises concern about poor cardiac output and pending shock (seen in cases of severe hypoxemia and/or heart failure).
- » Patients with methemoglobinemia typically have low oxygen saturation and normal oxygen tension.
- **Complete Blood Count (CBC):** May help rule out non-cardiac disorders such as sepsis, thrombocytopenia, anemia and polycythemia.
- **Glucose:** Neonates with CHD are at increased risk for hypoglycemia.
- **Sepsis Evaluation:** Obtain blood and urine culture to rule out differential diagnosis of CHD vs. sepsis.

### Supportive care

- **NPO**
- **Cardio-respiratory monitoring and support** to ensure sufficient organ/tissue perfusion and oxygenation
- **Oximetry**
- **Establish stable/adequate airway**
- **Establish vascular access** with a PIV or low UVC as soon as possible (for blood sampling, administration of medications, monitoring of acid-base status, maintain adequate glycemic and calcium levels, blood pressure maintenance (NS, inotropic agents). Umbilical vessel catheter (UVC) is often the best option.
- **Maintain glucose in normal range:** Begin D10W at 80 ml/kg/day. If glucose level is low, bolus with 2 ml/kg of D10 and titrate IV dextrose rate/concentration to normalize glucose level. Monitor levels closely.
- **Antibiotics:** Initiate after obtaining blood and urine cultures

## NEONATAL EMERGENCY REFERENCE

Gestational Age	Estimated Weight	ETT Size	ETT Depth	Surf (4 ml/kg)	Epi – ETT (0.5-1 ml/kg)	Epi – IV (0.3 ml/kg)	NS Bolus (10 ml/kg)	D10 Bolus (2 ml/kg)	D10 Rate (GIR 6)
24 weeks	0.5 kg	2.5	5.5	2 mL	0.25–0.5 mL	0.15 mL	5 mL	1 mL	1.8 mL/hr
26 weeks	0.75 kg	2.5	6	3 mL	0.38–0.75 mL	0.25 mL	7.5 mL	1.5 mL	2.7 mL/hr
28 weeks	1 kg	2.5	6.5	4 mL	0.5–1 mL	0.3 mL	10 mL	2 mL	3.6 mL/hr
30 weeks	1.5 kg	3	7.5	6 mL	0.75–1.5 mL	0.45 mL	15 mL	3 mL	5.4 mL/hr
33 weeks	2 kg	3	8	8 mL	1–2 mL	0.6 mL	20 mL	4 mL	7.2 mL/hr
35 weeks	2.5 kg	3.5	8.5	10 mL	1.25–2.5 mL	0.75 mL	25 mL	5 mL	9 mL/hr
38 weeks	3 kg	3.5	8.5	12 mL	1.5–3 mL	0.9 mL	30 mL	6 mL	10.8 mL/hr
40 weeks	3.5 kg	3.5	9	14 mL	1.75–3.5 mL	1 mL	35 mL	7 mL	12.6 mL/hr
40 weeks	4 kg	3.5	9	16 mL	2–4 mL	1.2 mL	40 mL	8 mL	14.4 mL/hr

ETT depth = nasal septum to ear tragus + 1 cm

# NEONATAL VIRTUAL CARE PARTNERS — COMMUNICATION GUIDE

Initiate a neonatal virtual care consult with Children’s Minnesota: 651-220-5500.

Identify yourself by location, name and role to Children’s Minnesota virtual care staff.

Give a brief description of why you are calling and what you need.

- “I am calling about a \_\_\_\_ week gestation baby with \_\_\_\_.”
- “We need \_\_\_\_\_  
(help with questions/stabilization assistance/resuscitation support/help placing a UVC, etc).”
- “We do/**do not** need to initiate transport at this time.”

Children’s Minnesota staff will log on to virtual care. Once they are logged on and visible on the virtual care monitor, please give a quick introduction to your team leader and team:

- “Our team leader in the room is \_\_\_\_\_, MD/RN/RT”  
(Spell out leader last name if possible.)
- “We also have \_\_\_\_\_ RN, \_\_\_\_\_ RN,  
\_\_\_\_\_ RT” etc.

## **If the infant is not born yet:**

Children’s Minnesota team can assist you to verify that appropriate equipment is ready and that staff have assigned roles for specific jobs during the stabilization and/or resuscitation.

## **If the infant is already born:**

Children’s Minnesota staff will help to offer guidance, support and lead you to follow NRP algorithm and evidence based guidelines for care.



# NEONATAL VIRTUAL CARE PARTNERS — COMMUNICATION GUIDE

## During resuscitation

- Speak clearly and with good volume
- Verbalize your assessments of the baby out loud regarding breath sounds, heart rate, cap refill time, etc., to help Children's Minnesota team to be aware of baby's status.
- Seek clarification any time you question what you are advised to do by your lead or the Children's Minnesota team. Clear, closed-loop communication among the entire team is vital to assure accurate, safe and quality care.
- If you have difficulty hearing the Children's Minnesota team, turn up the volume or ask the Children's Minnesota team to do it for you.
- If at any time you feel that you or your team leader needs privacy with the consult, please request that the Children's Minnesota team go into "Private mode" and pick up the phone handset on the virtual care monitoring equipment.

## Your team may initiate a request for transport at any time. If transport has been initiated:

- Children's Minnesota will update you on the arrival status of the transport team. If you do not receive an update, you may ask for one.
- Feel free to ask what tests or labs are advised prior to transport arrival if you have not been prompted by Children's Minnesota team.
- Let Children's Minnesota team know whether you prefer to have them remain on the Virtual Care monitor until transport arrives, or if you feel comfortable signing off once the newborn is stable.

# CHECKLIST

## INFORMATION TO GATHER WHILE WAITING FOR TRANSPORT TEAM

- Baby's chart — admission history and physical (H&P), including reason for admission and assessment; full medication administration record (MAR), including all meds given prior to arrival of transport team; nursing notes, and pertinent vital sign flowsheets.
- Mother's chart— delivery record of operation, prenatal records, admission H&P, labor/delivery complications (if any), and MAR.
- Discharge summary from referring provider, and preferred method of communication for updates.
- Diagnostic tests (X-rays, ultrasounds, ECHO and labs).
- Collect state newborn screen if baby is > 24 hrs old and stable enough to tolerate lab draw.
- Mother's breastmilk if available.

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