Perinatal Quality Collaborative of North Carolina

Via a statewide late preterm infant (LPI) collaboration, provide the facilitation, coaching, mentorship, education and support necessary to develop guidelines within in NC hospitals for the Care of the LPI. Aim: • Create a multidisciplinary hospital based community focused on providing a standardized approach to the key clinical issues related to the care of the LPI; • 100% of hospitals will clearly designate in the medical record that an infant 35 0/7-36 6/7 weeks is a **LATE PRETERM INFANT.;** • 100% of hospitals will develop a LPI pathway to discharge that will address critical issues of feeding and breastfeeding support, guidelines for hypoglycemia evaluation and treatment, hyperbilirubinemia evaluation and treatment, safe sleep education and outpatient follow up within 48 hours.

Secondary Aim	**Primary Drivers**	**Secondary Drivers**
19.1 All nurseries will have a standardized discharge plan for the LPI regarding successful feedings, assessment and treatment of hyperbilirubinemia and safe sleep education	.	19.1.1 Consider that the LPI should not be discharged prior to 48 hours of age
	19.1.2 Ensure the LPI has had successful feedings for at least 24 hours prior to discharge	19.1.2. Successful feedings defined as: Breastfeeding: • At least eight feedings per day • Support the use of a home breast pump if needed • If weight loss from birth exceeds 3-4%/day, consider obtaining a LATCH score for breastfeeding infant • If weight loss from birth is greater than 7%, consider supplementation or fortification of feeds in addition to LATCH scoring for breastfeeding infants • Whenever possible, supplementation should be with mother's expressed breast milk • Consider delaying discharge for weight loss from birth equal to or greater than 7% prior to discharge Formula or Breast/Formula feeding: • At least eight feedings per day • If weight loss from birth is greater than 7%, consider supplementation or fortification of feeds • Consider delaying discharge for weight loss from birth equal to or greater than 10% prior to discharge • Consider utilizing the NEWT newborn weight tool • Discuss and document mother's feeding plan for infant after discharge

	19.1.3 Perform a systematic assessment of the infant prior to discharge to help determine the risk of developing severe hyperbilirubinemia and provide parent/caregiver education	19.1.3. Systematic assessment for hyperbilirubinemia and parent/caregiver education to include: • Assess and document risk factors for developing hyperbilirubinemia • Document rate of rise and bilirubin level via TcB or TSB within 48 hours of life and/or immediately prior to discharge • Assess parental understanding and recognition of newborn jaundice • Teach parents that adequate feedings and maintaining hydration are ways to prevent excessive jaundice • Provide written and verbal information on jaundice, including the process for follow-up assessment, if indicated
	19.1.4 Provide education on safe sleep recommendations	19.1.4. Ensure safe sleep education is provided to parent/caregiver prior to discharge • Consider adoption of safe sleep calculator to aid parent/caregiver education around safe sleep • Discuss and document a plan for safe sleep after discharge
	19.1.5 Ensure follow up pediatric appointment is made prior to discharge.	19.1.5 Ensure than an appointment for a follow up visit is scheduled with the primary pediatric provider within 24-48 hours of hospital discharge • If follow up for a specific issue is needed, such as weight loss or bilirubin level, consider notifying pediatrician office via telephone call in addition to discharge summary and EMR notes

	19.1.6 Discharge criteria for late preterm infants	19.1.6 Ensure the late preterm infant has demonstrated the following: • Respiratory rate is stable and less than 60 breaths per minute, and the heart rate is between 120 – 160 beats per minute • Axillary temperature is maintained at 36.5° C to 37.5° C (97.7°F – 99.5°F) while in an open crib with appropriate clothing (or while in STS contact) for 24 hours • The infant has demonstrated elimination, defined as voiding as expected for day of life, and at least one spontaneous stool • The infant is feeding well, defined by coordinated sucking, swallowing, and breathing while feeding, and weight loss does not exceed 7% of birth weight
	19.1.7 Develop a discharge feeding plan and ensure the late preterm infant has had at least 24 hours of successful feeding prior to discharge	19.1.7 Assess the following to determine feeding success for discharge: • Formally evaluate breast-or-chestfeeding and milk transfer • Ensure infant is feeding every 3 hours and at least eight times per day • Supplement with human milk, if needed whenever possible • Maintain milk supply with use of hand expression or a breast pump in the hospital and at home, once discharged
	19.1.8 Prior to discharge, perform a systematic assessment of the late preterm infant's risk of developing severe hyperbilirubinemia	19.1.8 Provide written and verbal information on jaundice, including the process for follow-up assessment, if indicated
	19.1.9 Ensure all screening tests are completed prior to discharge	19.1.9 Ensure the following tests have been completed: • Newborn blood spot screening 24 hours after initiation of feedings, and encourage parents to request results from the newborn's primary care

	19.1.10 Reinforce primary care visits	provider if not available by discharge; educate parents that additional screening may be necessary • Critical congenital heart defects (CCHD) using pulse oximetry no sooner than 24 hours of life • Car seat tolerance screening to observe for apnea, bradycardia, and oxygen desaturation • Hearing screening 19.1.10 Reinforce the potential need for frequent primary care follow-up visits, developmental evaluation, and referral to a specialist when indicated

**** Adapted from the AWHONN Assessment and Care of the Late Preterm Infant Evidence Based Clinical Practice Guideline and the CPQCC Care and Management of the Late Preterm Infant Toolkit**