

Newborn Critical Care Center (NCCC) Clinical Guidelines

UNC PICU / NCCC Transfer Guidelines

PRIORITIES WHEN CONSIDERING TRANSFERS :

- Maintain excellent clinical care (nursing, MD, ancillary service capability)
- Maintain family-centered care (transfers generally avoided)
- Always have beds available for internal needs (surgery, L&D, floor transfers, etc) and outside referrals for subspecialty care or from important outside partner hospitals (Rex, Nash, FirstHealth/Moore, etc)

CATEGORIES OF PATIENTS MOST SUITABLE FOR PICU / NCCC TRANSFER

NCCC to PICU Transfer Eligible:

- Non-preterm neonatal patients (medical and surgical)
- Infants with neonatal disease but still needing ICU care (e.g. BPD, pre-op cardiac, ECMO)
- Preterm infants (35-36 weeks PMA) with surgical problems
- Others considered as the need arises

PICU to NCCC Transfer Eligible:

- Neonates (medical and surgical)
- Older infants with neonatal disease but still needing ICU care (e.g. BPD, post-op CHD, post-ECMO)
- Others considered as the need arises

FRAMEWORK FOR TRANSFERS

Standard: “Routine” transfer of patient with multi-level handoff

- Handoff should occur from bedside RN to bedside RN, Housestaff/NNP to Housestaff/NNP, and Fellow/Attending to Fellow/Attending

Less Frequent: Transfer with consult

Rare: Transfer with ongoing consultation (daily check-in and availability for questions)

- The specific medical issue and expected length for ongoing consultation should be clearly defined
- Logistics: providers should define which attending or fellow will be responsible for ongoing consultation and communicate this decision as part of sign-out to covering providers

Almost Never: “Cross-cover”

- Patient changes location (NCCC to PICU or vice versa) but MD coverage does not change

Questions about applying this guideline should be directed to the Medical Directors (Karen Wood or Jenny Boyd) and then to the Division Chiefs (Michael O’Shea and Benny Joyner)