

## **PROTOCOL ON THE APPROPRIATENESS OF TRANSFER BY THE NEONATAL TRANSFER SERVICE**

When a request for an ex utero transfer for a baby is made to the NTS it is very important that all the information to make the appropriate decision is passed to the transport team and an assessment is made of the appropriateness of the entire transfer.

The following questions need to be answered:

- a) Which is the correct team to undertake the transfer?
- b) Is it appropriate to transfer the baby?
- c) Is the receiving hospital the appropriate unit to take the baby to?

Where necessary the transport consultant should liaise with the referring unit to elucidate any factors which may have a bearing on the decision.

Despite taking all care there will be occasions when a transport team arrives at a referring unit to prepare the baby for transfer and it becomes apparent that the planned transfer is inappropriate. One of the following situations may have been incurred.

- i) The baby does not require transport as their clinical needs can be met by the local referring hospital.
- ii) The baby does require transport but the planned receiving hospital does not provide the appropriate level of care of type of care that the baby needs. (For example a very pre-term sick baby going to a Level II unit, a baby requiring surgery going to a neonatal intensive care unit that does not provide it or a baby requiring a cardiac unit.)
- iii) The baby is so ill, and the likelihood that the baby will survive is so low, that it would be inappropriate to transfer the baby to another unit to die.

There will be situations, particularly with suspected metabolic disease, where it may be appropriate to transfer baby, purely for diagnostic purposes, to a unit that has facilities to carry out specialised tests, even when that baby is unlikely to survive. There may also be occasions when a baby who is unlikely to survive or have any quality of life will need to be transferred to a tertiary unit for confirmation of that assessment and to let the parents come to terms with their decision to withdraw treatment.

### **Team Actions**

1. Where the team arrives and assesses the baby for transfer and feels that the baby's care could be carried out by the hospital the baby is already in, they should discuss this with the local consultant and report it to the transport consultant. The transport consultant and local consultant may wish to have further discussions before a final decision is made as to whether it is appropriate to transfer the baby.

Transfer of a baby not requiring intensive care for capacity reasons alone is a local issue and it is important not to block beds in an intensive care unit.

If a baby does not need intensive care and the referring unit has got a capacity problem, it may be appropriate to locate an alternative cot. These transfers are not the responsibility of the Neonatal Transport Services emergency transport facility.

2. Where, on assessment, it is apparent that the baby for transfer is going to an inappropriate unit this will need to be discussed with the transport consultant, the Emergency Bed Service - who should seek a bed in the appropriate unit - and the referring hospital consultant. Where a baby needs to be transferred to a specialist unit for ECMO or cardiac reasons the decision will need to be made whether the NTS team is the appropriate team to carry out the transfer and to which unit they should go. (See separate algorithms for transfer). The team needs to notify the original destination once the alternative cot has been located.
3. Babies who should not be transferred because of severe disease and are unlikely to survive the transfer or for long afterwards can be divided into three groups

- a) ***Babies who are extremely premature.***
- b) ***Babies who have hypoxic ischaemic encephalopathy.***
- c) ***Major congenital abnormality not compatible with long term survival***

a) It is possible on assessment that the baby who is extremely premature – 25 weeks gestation or less – and has been born in poor condition may be so ill that they are unlikely to survive the journey and if they do, their chances of survival with reasonable outcome is so low that it is inappropriate to move them away from their mother and the hospital of their birth. This will include babies with gross bruising, severe oedema and unsupportable blood pressure. When this situation arises you should discuss it with the transport consultant who will make a decision and, if in agreement the baby is inappropriate to transfer, will discuss it with the referring hospital consultant to reach an agreement. Good quality cranial ultrasounds may be useful in making this decision. This decision needs to take into account all the factors surrounding the baby and full discussion between all parties involved including the parents. The decision should be made on a patient by patient basis..

b) Baby is born with severe perinatal asphyxia with a prolonged documented history of fetal bradycardia, the pH of the cord blood is less than 6.7, the period till the onset of breathing is greater than 25 minutes or the Apgar is less than 3 at 10 minutes. It should be considered that the baby is likely to have severe cerebral damage and it is questionable whether the baby should be transferred. There may however be good reasons to transfer the baby:

- i) The baby is taking part in the Toby trial
- ii) It is desirable to have an assessment of the baby's condition at a Level III unit with all the facilities available.
- iii) The underlying cause of the baby's severe illness is not clear and further investigations are required which may only be available at a tertiary unit.

Appropriateness of Transfer

- c) When a baby is born with major congenital abnormalities or possible metabolic disease, all parties need to be in agreement when a decision is made not to transfer. This must include the parents. Where the diagnosis is in doubt and it will not be possible to make that diagnosis following death, it may be appropriate to transfer the baby for diagnostic reasons and genetic counselling for future births.
- d) Babies who are terminally ill, e.g. NEC.

## **Note**

It is always a difficult decision *not* to transfer a baby once the team has been activated. The referring unit has requested help in a situation it feels it is not able to adequately cope with and the parents will have been given the expectation that further assessment and possible treatment is desirable for the baby's health. The decision not to transfer will need to be discussed fully between the involved professionals and with the parents before it is agreed not to transfer the baby from the unit it is already in.

If the decision not to transfer has been made after the baby's care has been handed over to the transfer team, it should revert to the referring unit and the transfer team should give the referring unit any support that they require.