Health Authority – Abu Dhabi			
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1. PURPOSE

The purpose of this policy is to outline the standards for the Healthcare Facilities (HCFs) providing maternity care including labor, delivery and postnatal care in the Emirate of Abu Dhabi, so as to ensure safe neonatal care after delivery.

2. POLICY STATEMENT

Healthcare Facilities offering intrapartum (labor and delivery) maternity services must satisfy and comply with the following requirements (minimum standards) which are mandated by the Health Authority Abu Dhabi (HAAD):

2.1. NRP (Neonatal Resuscitation Program) trained staff (medical or nursing) must be in attendance for every delivery;

2.2. Medical staff trained with current neonatal resuscitation certification must be available on-call, to deal with **unexpected** neonatal emergencies (imminent preterm birth, severe birth asphyxia, unavoidable delivery of high risk patients). Each HCF must have, or have access to appropriately staffed and equipped transport for the transfer of newborns to other facilities;

2.3. Level 1 HCFs will manage low risk obstetric cases, but moderate to high risk cases must be referred in a timely fashion for confinement, to a healthcare facility that has level 2/3 neonatal care capabilities (Appendix 1). The HCF must ensure that the hospital at which confinement is ultimately planned has the opportunity to review the patient and put in place a management plan. This shared care model is well established as a good clinical practice. Should the facility intend to manage the delivery of a moderate to high risk woman (Appendix 2) they must have a minimum of level 2 neonatal care capabilities (see 2.5);

2.4. All HCFs providing intrapartum maternity care must have full time consultant obstetrician available;

2.5. HCFs planning level 2/3 neonatal services:

2.5.1. Each level 2/3 neonatal unit must be staffed with a designated on-call Consultant Neonatologist, responsible for the clinical care and management of the newborn babies 24 hours per day;

2.5.2. In addition, a Resident doctor having specialized in pediatrics/ neonatology (or equivalent academic degree) with at least two years' experience in the specialty must be available around the clock;

2.5.3. All HCFs providing neonatal care (level 2/3) must be able to demonstrate the availability of the required number of appropriately trained and qualified nurses in accordance with recognized international standards;

2.5.4. Each HCF providing neonatal care above level 1 must have 24 hrs. access to the

following services:

2.5.4.1. Radiology (including ultrasound, CT and MRI); and

2.5.4.2. Laboratory: including clinical chemistry, microbiology, hematology & transfusion.

2.5.5. Each HCF providing neonatal care above level 1 must have following range of equipment:

2.5.5.1. Incubators

2.5.5.2. Neonatal Ventilator

2.5.5.3. Syringe/infusion pumps (0.1 ml/hour)

2.5.5.4. Bag and mask ventilation equipment for Positive pressure ventilation

2.5.5.5. Resuscitation trolley: (with a list of equipment and medication regularly checked for availability and expiration date including medication for emergency management of newborn such as epinephrine, normal saline PGE1 for IV infusion…)

2.5.5.6. Micro blood gas analysis

2.5.5.7. Phototherapy units

2.5.5.8. Neonatal Monitors that can measure HR, RR, Sio2, NIBP, CRG, ETPco2

2.5.5.9. Transillumination by cold light

2.5.5.10. Portable X-Rays

2.5.5.11. Portable Ultrasound scanning

2.5.5.12. Breast pump machine

2.5.5.13. Oxygen analyzer

2.5.6. Each neonatal care unit must have written standardised clinical protocols for medical and nursing staff, which also contain details of evidence-based practical procedures (as per best practice). These must be regularly reviewed through discussion and audit, and must be made available to HAAD inspectors when requested;

2.6. A lead in time of 12 months will be permitted for newly licensed healthcare facilities in order that the appropriate staffing levels can be achieved and that staff can be trained and certified to NRP standards. It is a requirement that HCFs develop an action plan to achieve adequate staffing numbers and to facilitate their training, demonstrating a commitment to the initiative. It is also a requirement that a significant proportion of the clinical staff will have been trained by six months from new facility licence issuance;

2.7. All HCFs providing intrapartum (labor and delivery) maternity services must have policies and procedures to support all the services provided at the facility, and must demonstrate their implementation, professionals' compliance with them and ongoing monitoring and review to ensure they continue to support safe and quality services.

3. SCOPE

All HAAD licensed HCFs which provide intrapartum (labor and delivery) maternity services in the Emirate of Abu Dhabi.

4. TARGET AUDIENCE

All HCF and healthcare professionals licensed by HAAD in the Emirate of Abu Dhabi who are providing maternity services.

5. RESPONSIBILITY

The administration/management of all those healthcare facilities that are providing the maternity care services are responsible to ensure implementation of and compliance with this policy throughout their facilities. HAAD will monitor, inspect and audit the compliance of HCF and professionals.

APPENDIX 1

DESIGNATION OF NEONATAL UNITS

Level 1 Units provide Special Care but do not aim to provide any continuing High Dependency or Intensive Care.

Level 2 Units provide High Dependency Care and some short-term Intensive Care.

Level 3 Units provide the whole range of medical neonatal care, including intensive care services, but not necessarily all specialist services such as neonatal surgery.

Personnel and Category

A. Intensive Care (level 3)

These babies have the most complex problems. They need 1:1 care by a nurse with a neonatal qualification. The possibility of acute deterioration is such that there should be the constant availability of a Resident doctor having specialized in pediatrics, in addition on-call Consultant Neonatologist, 24 hours per day.

Intensive care patients (Level 3) are those:

- Receiving respiratory support via a tracheal tube and for 24hrs after its withdrawal
- Below 1000g weight and receiving NCPAP and for 24hrs after its withdrawal
- Less than 29 weeks gestational age and less than 48 hours old
- Requiring major emergency surgery, and post-operatively for 24 hours
- Requiring complex clinical procedures:
    - Peritoneal dialysis
    - Infusion of an inotrope, pulmonary vasodilator or prostaglandin and for 24hrs afterwards
- Any other very unstable baby considered by the nurse-in-charge to need 1:1 nursing: *for audit, a register should be kept of the clinical details of babies recorded in this category*
- A baby on the day of death

B. High Dependency Care (level 2)

A nurse should not be responsible for the care of more than two babies in this category and must have constant availability of a Resident doctor having specialized in pediatrics, in addition on-call Consultant Neonatologist, 24 hours per day.

High dependency patients are those:

- Receiving NCPAP but not fulfilling any of the criteria above, for intensive care
- Below 1000g current weight but not fulfilling any of the criteria above, for intensive care
- Receiving parenteral nutrition
- Having convulsions
- Receiving oxygen therapy and below 1500g current weight
- Requiring treatment for neonatal abstinence syndrome
- Requiring specified procedures that do not fulfill any criteria for intensive care:

- Care of an intra-arterial catheter or chest drain
- Exchange transfusion
- Tracheostomy care until supervised by a parent

- Requiring frequent stimulation for severe apnea.

C. Feed and Grow (Special /minimal Care, level 1)

A nurse should not be responsible for the care of more than four babies receiving NG feeding, cup feeding, not oxygen dependent until they reach to discharge weight. Neonatal resuscitation Program trained staff should be in attendance for every deliver in HCF providing Level I care.

This kind of care is provided for all other babies who could not reasonably be expected to be looked after at home by their mother.

D. Normal Care

Is provided for babies who have no medical indication to be in hospital.

APPENDIX 2

HIGH RISK PREGNANCIES

These are essentially situations in which the potential for maternal and/or neonatal compromise is predictable and delivery can be planned appropriately. The list is not exhaustive but includes:

Maternal conditions

Insulin dependent diabetes or poorly controlled gestational diabetics
Hypertensive states – pre-eclampsia, unstable essential hypertension
Unstable epilepsy
Cardiac disease
Thyrotoxicosis
Morbid obesity (BMI > 35)

Obstetric conditions

Multiple pregnancy
Acute fatty liver, haemolytic uraemic syndrome
Placenta previa
Suspected placenta accreta or percreta
Previous caesarean sections =/> 3

Fetal conditions

Congenital anomaly requiring surgery or ICU support at delivery
Prematurity – preterm labour <37 weeks
Pre-term rupture of membranes, chorioamnionitis
Fetal hydrops
RH isoimmunisation
Significant IUGR (estimated birth weight <5th centile)
Other evidence fetal compromise – severe oligohydramnios
Absent/reverse diastolic flow on umbilical Dopplers