

## CARE OF LOW-RISK BABIES IN POST-NATAL WARD

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### SUMMARY

A facility was developed in postnatal ward to look after low risk babies which included babies weighing between 2-2.5 kg, babies recovering after special care and those with perinatal risk factors requiring supervisory care. The interventions included provision of warmth, supervised feeding and simple monitoring of the well-being of the babies by examination of the soles. Mothers participated in the care with supervision of nurses and pediatrician. Out of 662 babies receiving this care, only 16 required transfer to special care unit of which 2 babies died of non-preventable causes.

### INTRODUCTION

There is always a category of newborns which is too low risk to be admitted to a special care unit (SCU) and too high a risk to be admitted to a normal post-natal ward (PNW). Similarly, babies who are admitted to a special care unit at birth but have recovered from their illness, need not be exposed to the risk of nosocomial infection any more by their continued stay

in such units. Thus, there is a need for an area where intermediate care can be offered to the babies who need more than average attention. We describe our one year experience of care of such babies in post-natal ward.

### MATERIAL AND METHODS

As per the unit's policy, low-risk babies (LRB); e.g. babies with birth weight between 2-2.5 kg, breech presentation without perinatal asphyxia, forceps application, thin meconium passage in utero, prolonged rupture of membranes for more than 24 hours and those with severe placental dysfunction are

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observed in a warm room in labour ward for 5-6 hours. Asymptomatic babies are transferred subsequently to PNW for intermediate care and symptomatic ones to special care unit. Similarly, recovering babies (RB) from SCU are transferred to intermediate care nursery (ICN) once they start taking nipple feeds. In fact, most of the SCU discharges are routed via ICN.

The intermediate care has been delivered through a room made of wooden partition and kept warm by an electric room heater. The room accommodates 10 babies. An oxygen outlet point and resuscitation tray are available in the room. LRB receives 100 ml 10% dextrose by spoon over 24 hours for first 2 days of life in addition to breast feeds. RB is exclusively breast fed. Nursing care is mainly a responsibility of mothers. Minimal supervision by nursing staff, common for obstetric and newborns is required. Monitoring is restricted to examination of the soles of feet for colour and warmth (Daga et al 1995). In case of problem, doctor's advice is sought. We found out number of live births, admissions for intermediate care and babies requiring transfer to SCU for one year.

#### **OBSERVATIONS**

Out of 1821 live births, 395 babies required special care and 220 required intermediate care. Total number of admissions to SCU were 518, 395 inborn and 123 outborn. Total number of babies requiring intermediate care were 662 of which 220 were LRB and 442 were RB.

LRB included borderline LBW, 2-2.5 kg (107), placental dysfunction (52), thin meconium passage (29), PROM (26),

uncomplicated breech presentation (6), uncomplicated forceps application (4).

16 intermediate care babies required transfer to special care unit. The reasons for transfer were : probable sepsis (5), hyperbilirubinemia (1), transitional circulation (3), poor feeding/vomiting (6), and apparent life threatening event (1). Two babies died.

#### **DISCUSSION**

Advantages of establishing intermediate care are obvious. It can be offered through, (i) a separate postnatal ward staffed by midwives, supervised by pediatrician and senior nurse/midwife, (ii) special care unit's mother and baby rooms or on an adjacent postnatal ward and supervised by neonatal staff, and (iii) normal postnatal wards. We preferred to deliver intermediate care through a warm room in normal postnatal ward with minimal supervision of nurses from postnatal ward and of pediatrician.

Risks involved in managing babies in ICN were negligible. Only 16 out of 662 babies required transfer to SCU for observation/active treatment. Two babies died. One of them was a severely asphyxiated term baby transferred to PNW after 14 days of SCU stay. The baby had an apparent life threatening event, recovered from it but had a sudden infant death a week later. The other baby was born at term, with no risk factors. On day 4, the baby was found blue and limp. She soon convulsed and died of convulsive apnea.

Antibiotics, anticonvulsants and supportive therapy were of no avail. Autopsy did not help in establishing the cause of death. The outcome may not have been different in these cases if

they were still in SCU.

The concept of having an intermediate care area is well accepted (Dear & McLain 1987, DeCates et al 1982). It is expected to provide warmth, supervised feeds and monitoring for respiratory distress, colour change and feeding problems. The equipment, staffing, location and criteria for admission may differ in different situations. A room made of wooden partitions, kept warm by electric heater was the basic input in our ICN. No addition has been made to the nursing staff for ICN. With mother's participation in newborn care at our centre, (Daga & Shinde 1987) especially in feeding and temperature maintenance it was not difficult to cope up with extra work. Intermediate care on these lines is easily affordable. Some of the benefits

were obvious but were difficult to quantify. They include avoidance of mother-child separation and promotion of breast feeding. The mothers are more confident of looking after their babies after discharge. Compartmentalization of baby care and maternal care is prevented and communication between obstetricians and pediatricians improved.

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