Clinical Practice Policy:	Nurse Calling Physician Support to the Special Care Nursery (SCN)
Approval:	CWN Practice Council March 31, 2017, BWH CPP Steering Committee April 3rd, 2017, NEB: April 4th, 2017
Effective Date:	April 4th, 2017

1. Purpose

The purpose of this policy is to outline the process for nursing staff to call physician support to the Special Care Nursery (SCN).

This policy presumes knowledge of:

- NICU/SCN T.6 T(transferring level of care within NICU)
- NICU/SCN Nursing Standards of Care
- Target O2 saturations in the Neonatal Intensive Care Unit
- WNH C.4 Resolution of Clinical Discord (forthcoming policy)

2. Policies, Procedures, General Principle:

There is on-site physician coverage available to the SCN 24 hours per day, seven days per week. Should the clinical acuity of a SCN patient be such that the nurse requires physician support, then the SCN nurse or his/her designee will page the primary LIP (Nurse Practitioner/Neonatologist) Monday through Friday from 8:30am- 5:00pm to attend the SCN and evaluate the relevant patient(s). If the primary LIP is unavailable, or it is during the night/weekend, the SCN Nurse or his/her designee will page the on-call Neonatal Fellow for infant concerns in the SCN. If the fellow is unavailable, then the SCN nurse or his/her designee will page the in-house attending neonatologist. If the in-house attending neonatologist is unavailable, then, at the guidance of the on-call neonatologist, the nurse or his/her designee will page the back-up attending to provide additional clinical coverage.

CRITERIA FOR CALLING PHYSICIAN TO SCN BEDSIDE

This list is inclusive but not limited to:

- **Unresolved parental concern re: a physiologic system, eg., neuro, cardiac, etc.**
- **Any staff concern about an infant**

Respiratory:

- Respiratory rate persistently above baseline
- Increasing oxygen requirement to maintain oxygen saturation within target saturation guidelines
- Dusky spell(s)
- Increased incidence of apnea/bradycardia
- Worsening respiratory distress

<u>Neurologic:</u>

- Seizures or seizure like activity
- Lethargy/hypotonia/floppiness
- New/unexplained focal weakness

<u>Cardiovascular:</u>

- Heart rate (HR) persistently <75 or >210

<u>Other:</u>

- Any fall/drop event
- Unexplained bleeding
- Bilious emesis with distended abdomen
- Diffuse petechiae/vesicular eruptions
- Unexplained pain, e.g. irritable persistent cry

Procedure for calling assistance to bedside

1. **Call button/ call cord**: *Located on the headwall of each bed space.* Press once to call Unit Coordinator (UC). A white light illuminates outside the room and the corridor dome light is illuminated to indicate that assistance is needed. This is used by staff or parents.
2. **Emergency Button**: *Located on the headwall of each bed space, on the call cord at each bedside, and in the family space of each room*. Press once to call UC for staff emergency. A **red flashing light** illuminates outside the room and activates a call to the UC and an automatic page to Respiratory Therapist. The UC overhead pages "RN assist to Neighborhood_ Room_". This can only be cancelled at the headwall in the patient's room (referred to as the "Patient Station.")
3. **Code Blue Lever**: *Located on the headwall of each bed space.* Pulling lever down activates a call to the UC and an automatic page to the multidisciplinary NICU Code Response Team (NICU staff with code beepers). The UC will also overhead page "Staff assist to Neighborhood_ Room_". A **blue flashing light** is illuminated outside the room and the corridor dome light is illuminated to indicate that assistance is needed. The **Code Blue Lever** may be used for any type of code, (i.e. code blue, code grey, code pink, code red). This can only be reset by pushing the level back up at the headwall in the patient's room (referred to as the "Code Blue Station.") resetting the Code Blue Station.