RECEIVING A NEONATAL CARDIAC PATIENT FROM THEATRE

PRIOR TO ARRIVAL

- Two neonatal nurses should set up the bed space with appropriate monitoring equipment: invasive pressure monitoring (BP and CVP), infusion pumps and infusions that are expected to be needed written up and ready to go.

- The ventilator should be set up and settings checked by the senior registrar/ registrar.

- The OT staff should forward documentation (information on drains, lines, infusions) to NICU 10-30 minutes prior to transfer of the patient. A verbal handover between nursing staff will occur at that time.

- NICU should be notified as the patient leaves theatre.

- Babies are transferred from OT under the supervision of the cardiac anaesthetist who should remain present until adequate verbal handover has occurred, all current infusions have been identified and all monitoring equipment has been transferred.

ON ARRIVAL IN NICU

- The cardiac anaesthetist, allocated neonatal nurses, NICU consultant, NICU registrar and/or senior registrar should be present. All non-essential staff should move away and everyone should keep quiet until handover is completed.

- Patient should be transferred onto ventilator with assessment of adequate chest movement/air entry and SpO2.

- Chest drains should be connected to suction (15-20cmH2O) immediately.

- Transport monitoring should be retained until after handover.

HANDOVER

1) Pre-op status
   - Brief clinical background and status.

2) Anaesthesia
   - Any issues with airway/ vascular access.
3) **Surgery**
   - Pre-op trans-oesophageal echo (if done).
   - Details of procedure.
   - Intra-operative problems/ complications.
   - Post-op echo (if done).

4) **Other details**
   - Any ventilation problems/ PHT and latest gas.
   - Myocardial function – pressures, peripheral perfusion, inotropes/ dilators required, residual defects. Any arrhythmias.
   - Amount and type of fluid received.
   - Blood loss/ drain losses and latest Hb.
   - Analgesia/ neuro-muscular blockade given – type and time.
   - Other drugs/ infusions.
   - Temperature.
   - Identify lines/ drains.

5) **Draft plan**
   - Made with NICU consultant.

Brief surgical handover (from consultant cardiothoracic surgeon).

**FOLLOWING HANDOVER**

**Change to NICU monitoring.**
   - All patients to be monitored with ECG, pulse oximetry and non-invasive BP.
   - All cardiac patients should also have an invasive systemic arterial pressure and most central venous pressure (CVP) monitoring.

**Change to NICU pumps.**
   - Infusions should be changed to NICU concentrations at the earliest convenience to avoid confusion as most anaesthetic/ PICU infusions are of a different concentration
   - When changing inotrope infusions, they should be ‘double pumped’. The original infusion should only be stopped once the new infusion has ‘hit’. You will be able to tell this when the BP rises.

**Medical staff should examine patient thoroughly.**

**Bloods/gas**
   - ABG should be taken within 10-15 mins of admission.
   - FBC/ U+E/ Ca/ Mg/ coags should be sent.

**ECG** - A rhythm strip should be recorded/ printed as soon as possible.

**CXR** - Should be done as soon as possible to confirm ETT length, line, NGT and drain positions and any immediate complications eg. pneumothorax/ lung collapse/ collections.
Parents - Once surgeon has spoken to the parents and if patient is stable enough parents should be encouraged to see their child as soon as possible.

Registrar or senior registrar should write all the above details in notes.