TIPQC Late Preterm Infant (LPI) Key Driver Diagram

AIM

Improve care and outcomes for infants 34 0/7 to 36 6/7 by systematically implementing evidence-based practices to improve consistency across the state to ensure stability at the time of discharge by achieving completion of an appropriate readiness checklist for 90-100% of discharged LPI by June 2027.

Primary Drivers

Interventions and Potentially Better Practices

- **Infection Prevention**
  - Assess maternal & infant risk factors for infection
  - Assess for signs of sepsis and consider using the EOS Risk Calculator and follow the calculator's recommendation for care
- **Parental/Caregiver Support & Discharge Readiness**
  - Empower & engage parent/caregiver of LPI through STS, family-centered medical rounds, education, beads of encouragement, home feeding plan, etc.
  - Provide a detailed discharge feeding plan and ensure parents understand this plan
  - Ensure family has chosen a follow up provider and that the family understands the plan for follow up
- **Nutrition**
  - Facilitate early and frequent feedings, with the initial feeding taking place within the first hour of birth
  - Ensure successful feeding for >24 H prior to discharge (applies to both breast and bottle-feeding newborns)
  - If breastfeeding, complete formal assessment by lactation specialist and prescribe breast pump, if indicated
  - Facilitate skin-to-skin immediately after birth and frequently during hospital stay
- **Assessment & Stabilization**
  - Review the maternal and neonatal history for risk factors of respiratory distress
  - Examine newborn for any signs of respiratory distress and manage these signs appropriately
- **Physiologic Jaundice/Unconjugated Hyperbilirubinemia**
  - Review maternal and newborn Rh, type and DAT
  - Monitor for risk factors for hyperbilirubinemia & neurotoxicity
  - Obtain TcB or TsB prior to discharge and plot on a hour-specific nomogram – follow recommendations provided for follow up care

Global AIM: Improve the care and outcomes for all infants born in Tennessee by implementing evidence-based practices of best newborn care by June 2031.

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Primary Drivers

Thermoregulation

Interventions and Potentially Better Practices

- Assess for hypothermia risk factors
- Thermostats in DR, OR, mother-baby room, transitional care nursery, and/or NiCU should be between 22° C (72° F) and 26° C (78° F)
- Avoid evaporative, convective, conductive, and radiant heat loss
- Initiate STS as soon as possible, perform continuous STS as much as possible, & Promote & facilitate STS for all caregivers
- Use hats and dress/swaddle the infant, in accordance with safe sleep guidelines
- Delay the time of first bath depending on thermal stability
- Carefully observe and monitor axillary temperatures of infant during STS

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