POLICY STATEMENT:

1. Definition of late preterm infant: neonate 34 0/7 to 36 6/7 weeks gestation. IUGR/SGA infants who are term but less than 2500 grams may also need special observation. Twins or triplets who are late preterm may be at even greater risk for problems.

2. Characteristics of the late preterm infant include:
   - low birth weight
   - low body fat
   - poor thermoregulation
   - low glycogen stores
   - low tone
   - poor state regulation
   - immature immune system
   - immature suck and swallow
   - delay in bilirubin metabolism

3. These infants are at risk for:
   - hypothermia
   - hypoglycemia
   - sepsis
   - poor feeding and infrequent feeds may lead to inadequate maternal milk supply
   - breast feeding failure
   - poor suck and swallow may lead to inadequate milk intake
   - excessive weight loss
   - failure to thrive
   - hyperbilirubinemia
   - increased readmission rate (5-13 times that of term infants)
   - respiratory instability in upright car safety seats or other upright infant devices
   - hospital readmission

4. All infants should be assessed for documented gestational age consistent with LMP and prenatal ultrasound. All infants will also have a Dubowitz gestational age assessment done by either the Pediatric HO or NP. Infants born to mothers with late or no prenatal care should have more emphasis placed on the Dubowitz score rather than prenatal assessment of gestational age.
RESPONSIBLE PARTY:
Nursing staff from L&D, ISCC, FMCC, Birth Center and Newborn Care Center

PROCEDURE:

1. **Where does the baby go?:**
   - Infants less than 35 weeks are admitted to the ISCC
   - Infants 35-36 6/7 weeks or less than 2500 grams, regardless of gestational age, are transitioned in the ISCC for a minimum of 12 hours observation
   - Stable infants greater than 37 weeks remain in couplet care with their mother

2. **12 hour minimum observation in the ISCC:**
   - Infant is monitored for cardio/respiratory stability, temperature and feeding
   - Infants less than 37 0/7 weeks receive sepsis screen per protocol
   - LBW infants have glucose screening per protocol
   - When the 12 hour observation is completed, infant is stable and family is able to care for infant they are transferred to FMCC with mother
   - Infant stability is defined by:
     - Temp > 97.6 ax for 6 hours in open crib
     - Cardiovascular and respiratory stability as determined by the medical team
     - Able to tolerate oral feeds without desaturation: breastfeeding or tolerating 10-15 ml EBM or ABM at a minimum of every 3 hours

3. **PCIS:** Late Preterm orders (CPOE order set) should be initiated.

4. **Lactation:**
   - Lactation evaluation within 24 hours of delivery
   - Infant put to breast at least every 3 hours, LATCH score documented at least every shift.
   - Supplementation after breastfeeding with EBM if wt loss > 3% per day, poor feeding, wt < 2500gms:
     - Supplementation should be given by SNS (preferred), cup or finger feeds rather than nipple and bottle.
     - Supplemented breastfeed: generally EBM 5-10 cc on dol 1, then increased to 15-30cc by dol 2.
       - May receive ABM if milk volume not meeting fluid needs.
   - Mother to pump every 3 hours after nursing unless infant nursing vigorously
   - Lactation nurse and medical team should re-evaluate feeding plan each day

5. **Thermoregulation:**
   - Infant should be placed skin to skin with mother (preferred) or wearing hat, T-shirt and double wrapped
   - Temperature should be taken every 3 hours prior to feeding
   - If infant has low temperatures (and baby deemed not sick or septic), and/or baby not gaining weight consider placing baby in incubator when not skin to skin with mother

8. **Monitor for Jaundice:** Additional bilirubin testing as needed, expected peak bilirubin on day of life 5.
9. **Car Seat Challenge:** Infants < 37 weeks will require a car seat test prior to discharge (W&IS P&P: Car Seat Testing of Premature and Low Birth Weight Infants). Car Beds are available for infants who do not pass the test; parents are given handout with precautions for other upright devices.

10. **Discharge:** Late Preterm Infant will ready for discharge if meeting the following requirements:
- Baby must be gaining wt (10-30 gms per day)
- Thermal stability for >24 hours
- Well established feeding plan
- Car seat testing completed if necessary
- Follow up day after discharge, home visit if possible
- Recommended primary care follow-up weekly until corrected gestational age of 40 weeks

11. **Parent Education:**
- Educate parents regarding vulnerability of late preterm neonate and late preterm protocol
- Attach completed Late Preterm Crib Card to crib
- Ensure parents have received the Late Preterm Booklet and use as a resource
- Emphasize possible prolonged hospitalization until infant meets criteria for discharge
- Encourage parents to bring in car seat early in order to ensure it is appropriate for infant
- Ensure and encourage proper pediatric follow-up
- Education regarding feeding plan and follow-up resources

REFERENCES:


(2006). *Seminars in Perinatalogy* 30(1): Special on Late Preterm Infants including: Introduction, Drug Disposition in the Late Preterm Newborn, Physiology of Fetal Lung Fluid Clearance and the Effect of Labor, A Recommendation for the Definition of Late Preterm and the Birth Weight-Gestational Age Classification System, Changes in the Gestational Age Distribution among US Singelton Births: Impact on Rates of Late Preterm Birth, Cold Stress and Hypoglycemia in the Late Preterm Infant: Impact on Nursery Admission, Short-Term Outcomes of Infants Born at 35 and 36 Weeks Gestation: We Need to Ask More Questions, and The Role of Stillbirth Prevention and Late Preterm Births.
