

Learning from underlying trends of Avoidable Term Admissions Into Neonatal unit (ATAIN)

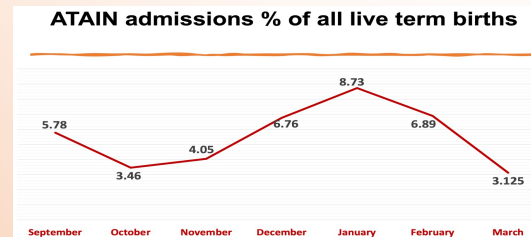
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**atain**
Admission Trends into Neonatal unit

Introduction

**NHS**
Improvement

- To prevent and reduce the Avoidable Term Admissions Into Neonatal unit (ATAIN) is NHS England initiative within maternity transformation programme, which was introduced in 2017 to improve safety of maternity services.
 - Unexpected admission of full-term baby is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.
 - Separation of mother and baby soon after birth interrupts the bonding process which in turn impacts breastfeeding uptake. The financial burden of ATAIN to NHS and families further makes it vital to find innovative ways to prevent and reduce it.
- Hypoglycemia, jaundice, respiratory distress, infection, and perinatal asphyxia are thought to be key clinical issues contributing to ATAIN.



Workstreams

Five multi-disciplinary focus groups are set up to promote education, learning and implementation of these recommendations.

Helping hand and support is received from divisional directorate, trust board level and regional networks.

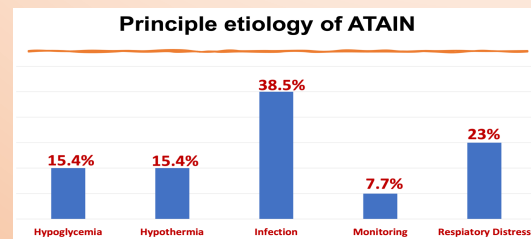
"Every new beginning comes from some other beginning's end"

Objectives

Undertaking of ATAIN meetings and audits are integral part of governance processes in our hospital. We aim to share the snapshot summary of our ATAIN project whereby we are identifying underlying themes of ATAIN, recognizing the gaps in services, and developing the improvement plans.

Method

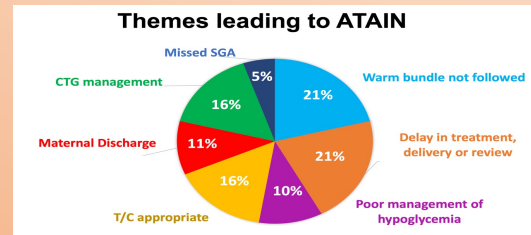
Retrospective data analysis of the audit conducted over a 7-month period from September 2020 to March 2021. Total births in our unit were 3176 over this period.



Conclusion

This analysis helped us in addressing the issues which were quick fix such as

- ✓ improving awareness via education forums
- ✓ updating guidelines
- ✓ better understanding of using warm bundle tool
- ✓ encouraging fresh eyes/ buddy system for CTG interpretation
- ✓ identifying CTG clinical leads
- ✓ auditing sepsis risk calculator
- ✓ offering counselling regarding birth choices
- ✓ improving documentation
- ✓ making risk assessments more robust



Objective	Hypothermia
90% have warm bundle tool completed at birth	Actions Audit 20 sets of notes across Trust on current use of warm bundle tool Email staff re audit results & aim Posters for staff re audit results & aim Introduce incentivise scheme for MW -prize draw
Publish guideline for prevention & management of hypothermia in the newborn	Recruit MW, ANNP and Neonatology Reg to write Literature search for best methods for management of hypothermia of newborn & Review NICE & BAPM guidelines
Introduce blanket warming cabinets onto labour ward and embed into prevention and management of hypothermia	Awaiting delivery to LWs following safety checks Develop poster to attach to warming cabinets to inform staff of appropriate use Include directions for use in guideline Audit use via the low temp admission audit
Investigate practicalities of offering hot cot care to babies on maternity wards	Research criteria for hot cot use on maternity Research costs and funding Research staff support strategies (guidelines, education, posters)

Objective	CTG Monitoring
Align with Ockendon Recommendations for FM leads	Actions Appoint Obstetric FM Lead Ensure FM leads are given protected time to carry out duties Publish FM lead Job responsibilities
Review introduction of physiological interpretation of CTG at ULHT	Benchmark HIE numbers against other Trusts using physiological interpretation. Identify barriers

Objective	Hypoglycemia
>90% completed hypoglycaemia risk assessment completed following birth	Actions Audit 20 sets of notes across Trust on Email staff re audit results & aim Posters for staff re audit results & aim Introduce incentivise scheme for MW with prize draw
Provide up to date, evidence based education to Midwives regarding hypoglycaemia	Review current hypoglycaemia education Arrange meeting to plan education strategy for hypoglycaemia management

Objective	Delays in T/t / Obstetric Review
Introduce traffic light escalation communication	Actions Present QI at LW forum Step 1: Introduce QI to co-ordinators and role out to LW pan trust only Step 2: Role out to AAU and PN & AN wards
Audit the time of decision made to deliver	20 notes audit for CS pan trust

Objective	Transitional Care
Review criteria for use of prophylactic IVABX in newborns	Actions Prospective audit for sepsis risk calculator

First Hour Care Implementing BFI standards
Human Factors Responsive Attitudes