

Dear friends, On this webinar, we will learn about triaging sick newborn babies and the essential components of neonatal transport..

Slide 2

1. The word “triage” means sorting.
2. Triage is the process of rapidly screening sick neonates when they arrive at the hospital and categorizing them in one of the groups depending on the urgency of the care needed
3. The site at the facility where a neonate is first brought to the hospital such as a emergency area or the reception and resuscitation corner in the casualty should be the triaging area.
4. All the staff involved should be trained in the triaging process. The most experienced doctor present who is trained in neonatal care should undertake the responsibility of emergency treatment and management of the neonate.

Slide 3

1. By triaging, we classify the babies into the following three categories:
 - a. Those needing emergency care. These babies require urgent intervention and emergency treatment and need to be admitted in the SNCU
 - b. Those needing priority care. These babies need immediate assessment and priority treatment and need to be admitted in the SNCU
 - c. Those neonates whose underlying medical conditions do not merit immediate management or are “non urgent”

Slide 4

1. Some of the examples of babies needing emergency care include babies with moderate to severe hypothermia (temp<36⁰ C), apnea or gasping respiration, Severe respiratory distress, Central cyanosis, Shock, Coma, convulsions or encephalopathy

2. Babies with priority signs include ~~tiny~~ babies weighing less than (<1800gms), babies in cold stress (temp 36.4°C - 36°C), babies with Respiratory distress, those who are Irritable/restless/jittery, babies presenting with Refusal to feed, Abdominal distension, those with Severe jaundice or Severe pallor or Bleeding from any sites, and babies with Major congenital malformations

3. All cases **not** categorized as Emergency or Priority such as those with superficial infections, minor trauma, neurodevelopmental delay_etc would be examples of non urgent cases

Slide 5

The process of triaging involves assessment of emergency signs

- **Assess temperature and look for hypothermia.**

And assess if baby is hypothermic

Assess airway and breathing

Is the child apnoeic or has gasping respiration. It could be due to apnoeic spells or aspiration or blockage of airway.

Assess if the baby has ~~severe~~ respiratory distress such as RR more than 60/min, retractions or grunting.

Is there central cyanosis? This is said to be present if the lips and tongue are blue or the mucosa in and around the mouth is blue.

[Connect a pulse oximeter and check oxygen saturations.](#)

- **Assess circulation**

Look for evidence of shock. Are the hands and feet cold? Look for Capillary Filling Time by pressing the front of chest and blanching the area not the hands and feet. If the area takes more than 3 seconds to become pink again, it is suggestive of prolonged CFT. Check for the pulse. If the child has tachycardia and the pulse is weak and rapid, it is suggestive of shock.

- **Assess for sensorium.**

Assess for response to stimulus and evaluate if the baby is awake, responds to pain or is unresponsive. Evaluate if the baby has convulsions, which may be generalized or localized.

[Perform blood sugar to check for hypoglycemia.](#)

Slide 6

Having assessed the vital signs...In the emergency treatment we need to firstly

Manage temperature:

If the baby's temperature is less than 34 [Cdegree celsius](#), then do rapid re-warming till temperature of 34 [degree celsius](#) is reached. Subsequently, maintain the baby's temperature between 36.5⁰ C - 37.5⁰C.

Keep the baby dry and the head, hands and feet covered.

To Maintain the airway;

Place the child in sniffing position, Place a shoulder roll under the shoulder to position the child. Clear the airway of secretions by suctioning if indicated

Slide 7

To Assist breathing;

Support the child's respiration by using nasal cannula which can be placed just inside the nostrils and secured with a tape. The flow rate can maintained be around 1-2 litres/min. The child could also be placed under an oxygen hood with an oxygen flow rate of 5-8 litres /min. Positive pressure ventilation will be required if the baby is apenic or having gasping respiration. The oxygen should be monitored by a pulse oximeter for monitoring oxygen saturation.

To Support circulation;

If the child is in shock;

Give an IV bolus of normal saline at the rate of 10ml/kg over 20-30 mins. Repeat bolus iv fluid if features of shock persist. Give blood transfusion if bleeding is the cause of shock.

Initiate Dopamine or dobutamine as the condition demands if the neonate remains in shock despite fluid boluses.

For a baby having convulsions.

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Manage airway, correct hypoglycemia if present and give anticonvulsant

Slide 8

Its important to recognize that **Baby may have more than one underlying condition to treat, so we need to look for all underlying conditions and treat them**

Slide 9

So to summarize, the key messages are

- 1. Assess sick babies in a systematic manner**
- 2. Categorize them into groups depending on urgency of treatment required**
- 3. Manage the underlying condition**
- 4. Look for all possible underlying conditions causing sickness in the baby**

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