## 1 PATIENT INFORMATION

### 1 PATIENT DETAILS

NAME
Baby Boy Ezekiel Adeyemi-Prasad

DOB
07/09/2026, 03:12

AGE
27 days chronological

CORRECTED GESTATIONAL AGE
31 weeks 5 days

GESTATIONAL AGE AT BIRTH
28 weeks 0 days

BIRTH WEIGHT
1,010 g (32nd centile, appropriate for gestational age)

CURRENT WEIGHT
1,384 g (08/05, 06:00)

MRN / PATIENT ID
NEO-77213

DATE OF SERVICE
08/05/2026 — NICU day 27

PROVIDER
Camille Beauchêne, MD

CREDENTIALS
MD, FAAP (Neonatal-Perinatal Medicine)

PARENT / GUARDIAN PRESENT
Both parents at bedside 09:20–11:00

VISIT TYPE
NICU Progress Note — daily attending round

CARE SETTING
Level III NICU, incubator, bed 7

INFORMANT / COLLATERAL SOURCE
Bedside nurse (12-hour handover), respiratory therapist, lactation consultant, parents

REFERRING PROVIDER
Delivered in-house — maternal-fetal medicine service

PRIMARY CARE PROVIDER
Not yet established — discharge pediatrician to be identified this week

## CC CHIEF COMPLAINT

### 2 PRIMARY NEONATAL CONCERN

Day 27 of care for a 28-week preterm infant, now 31+5 corrected. Active problems today: **CPAP wean in progress with persistent apnea of prematurity**, enteral feed advancement after a 5-day interruption for suspected necrotising enterocolitis that did not progress, and completion of treatment for late-onset coagulase-negative staphylococcal bacteraemia. Mother asks when he can come out of the incubator and whether she can breastfeed rather than express.

## S SUBJECTIVE

### 3 INTERVAL HISTORY & NEONATAL COURSE

### 3a REASON FOR EVALUATION & BIRTH HISTORY

#### Reason for Neonatology Evaluation

Daily attending assessment of an extremely preterm infant on a respiratory and nutritional wean, 48 hours after completing antibiotics, with a coordinated plan required for feeding advancement, thermoregulation, retinopathy screening, and the beginning of discharge planning.

#### Birth History

Born at 28+0 by emergency caesarean section for **severe pre-eclampsia with absent end-diastolic flow** on umbilical artery Doppler. Membranes ruptured at delivery; clear fluid. Apgars 4 at 1 minute and 7 at 5 minutes. Delayed cord clamping 60 seconds achieved. Required mask CPAP and one dose of surfactant via less-invasive administration at 40 minutes for respiratory distress syndrome; never intubated. Antenatal betamethasone completed 36 hours before delivery and magnesium sulphate given for neuroprotection. No maternal fever, no chorioamnionitis. Umbilical arterial gas pH 7.26, base excess −4.

#### Maternal / Pregnancy History

Mother 34, primigravida, booked at 9 weeks with regular care. Pre-eclampsia diagnosed at 26 weeks, escalating despite labetalol. Gestational diabetes on diet control only. Group B streptococcus unknown at delivery. Blood group O positive, antibody negative. Serology: rubella immune, hepatitis B and C negative, HIV negative, syphilis non-reactive. Anomaly scan normal. No substance use, no smoking. Non-invasive prenatal testing low risk.

### 3b INTERVAL SYSTEMS STATUS

#### Respiratory Status

**Day 27 on non-invasive support.** Weaned from CPAP 6 to CPAP 5 cmH&sub2;O yesterday at 14:00; FiO&sub2; has held at 0.21–0.24 through the night. Work of breathing settled with mild subcostal recession only. **Six apnea, bradycardia, and desaturation events in the last 24 hours**, down from 11 the previous day: five self-resolving, one requiring brief tactile stimulation, none requiring positive pressure. Caffeine citrate continues at 5 mg/kg/day maintenance, last dose reweighted 08/03. No surfactant since day 0. No high-flow trial yet.

#### Feeding / Nutrition

**Feeds restarted 08/01 after a 5-day nil-by-mouth period** for abdominal distension and two bilious-tinged aspirates on 07/27 that raised suspicion of necrotising enterocolitis; radiographs never showed pneumatosis and the episode settled. Now on expressed maternal breast milk 18 mL every 3 hours by nasogastric bolus (145 mL/kg/day), advanced by 20 mL/kg/day and tolerated. Human milk fortifier added 08/03 at 22 kcal/oz. Aspirates minimal and non-bilious. No emesis for 4 days. Abdomen soft with active bowel sounds and normal girth. Parenteral nutrition discontinued 08/04 and the central line remains in situ pending confirmation of tolerance. Mother expressing 8 times daily with a supply of roughly 620 mL/day — ample; three days of frozen stock held.

#### Growth / Weight Trend

Birth weight 1,010 g. Nadir 912 g on day 6 (9.7% loss, physiological). Regained birth weight day 14. Current 1,384 g, a gain of **21 g/day averaged over the past 7 days (15.2 g/kg/day)** — at target. Length 39.5 cm, head circumference 28.4 cm on 08/03; head growth 0.9 cm/week, appropriate and not accelerated. Weight remains between the 20th and 25th centile on the Fenton chart, having fallen from the 32nd during the feed interruption.

#### Cardiovascular Status

Patent ductus arteriosus identified day 3, moderate with left-to-right shunt; treated with a single course of paracetamol and **closed spontaneously by the 07/24 echocardiogram**. No murmur since. Normotensive throughout with no inotrope requirement at any point. Perfusion good, no cyanosis. No hemodynamic instability during the sepsis episode.

#### Infectious Concerns

**Late-onset sepsis day 19** — presented with temperature instability, increased apnea, and a rising CRP. Blood culture grew coagulase-negative *Staphylococcus* from the central line and a peripheral draw. Treated with vancomycin for 7 days, completed 08/03. Afebrile since day 21, CRP fallen from 48 to 4 mg/L, apnea count improving in parallel. Repeat culture at 48 hours sterile. Line was retained as the organism cleared on therapy; removal is now planned. No fungal cover required.

#### Jaundice / Bilirubin History

Peak total bilirubin 11.2 mg/dL on day 4, treated with double phototherapy for 72 hours. Blood group O positive, direct antiglobulin test negative, no hemolysis. Phototherapy discontinued day 7 with a rebound level of 6.1 mg/dL. Clinically anicteric since day 10; no conjugated hyperbilirubinemia despite the parenteral nutrition course — last direct bilirubin 0.4 mg/dL.

#### Glucose / Metabolic Status

Early hypoglycemia on day 1 (lowest 38 mg/dL) managed with a 10% dextrose infusion, resolved within 12 hours. Normoglycemic since day 3 and off all intravenous dextrose since 08/04. Sodium, potassium, calcium, and phosphate stable on the current fortification. **Metabolic bone disease surveillance** ongoing: alkaline phosphatase 412 U/L and phosphate 5.1 mg/dL on 08/03 — acceptable, trending monitored weekly.

#### Neurologic Status

Cranial ultrasound day 3: **bilateral grade I germinal matrix hemorrhage**, no extension. Repeat day 10 and day 24 both stable with no ventricular dilatation, no periventricular echogenicity, and no cystic change. Tone appropriate for 31 weeks corrected, symmetrical movements, no seizures or abnormal movements, no need for therapeutic cooling at any point. Alert wakeful periods lengthening over the past week.

#### GI / Elimination

Meconium passed day 1. Stooling 3–4 times daily, soft, no blood. Voiding well at 3.4 mL/kg/hr. Abdomen soft with no distension since 07/30, girth stable at 22 cm. No reflux symptoms requiring intervention, no inguinal hernia, no anomaly.

### 3c FAMILY CONTEXT & PERTINENT NEGATIVES

#### Family / Social Context

Both parents highly engaged and present daily; mother present most of the day, father on alternate evenings around shift work. Kangaroo care performed daily for 60–90 minutes since day 12, tolerated with improved saturations during holds. Mother's stated goal is direct breastfeeding, currently non-nutritive suckling at the breast only. Both parents completed the parent education module on safe sleep; **CPR training booked 08/12**. Live 40 minutes away with a car; no transport barrier. No social work concerns identified. Maternal blood pressure now controlled and she has been discharged from the postnatal ward.

#### Pertinent Negatives

No fever or hypothermia in 6 days. No bilious emesis, no abdominal distension, no blood in stool. No respiratory distress requiring escalation, no event needing positive pressure. Urine output adequate. No seizure-like activity, no lethargy, no cyanosis, and no return of jaundice. No new murmur. No signs of line-site infection.

## ROS NEONATAL REVIEW OF SYSTEMS

### 4 PERTINENT POSITIVES & NEGATIVES

| | |
|---|---|
| Respiratory | **Positive — 6 apnea/bradycardia/desaturation events in 24 h, mild recession, CPAP 5 at FiO&sub2; 0.21–0.24. Negative for cyanosis, escalation, positive-pressure need** |
| Feeding / GI | **Positive — feed advancement in progress after 5-day interruption. Negative for emesis, bilious aspirates, distension, blood in stool for 4–6 days** |
| Growth | **Positive — 21 g/day gain, back on trajectory. Negative for** |

| | |
|---|---|
| | weight loss or dehydration |
| Skin | Negative for jaundice, pallor, petechiae, rash, or breakdown; CPAP interface pressure area intact |
| Infection | **Recently positive** — treated CoNS bacteraemia, completed 08/03. Negative for fever, hypothermia, lethargy since day 21 |
| Metabolic | Negative for hypoglycemia since day 3; newborn screen normal; alkaline phosphatase monitored for metabolic bone disease |
| Neurologic | Negative for seizures, tremor, abnormal movements, or asymmetry. Stable grade I germinal matrix hemorrhage on serial imaging |
| Renal / elimination | Negative — urine output 3.4 mL/kg/hr, stooling 3–4× daily, meconium passed day 1 |

## O OBJECTIVE

### 5 OBSERVED FINDINGS

#### V VITALS

**TEMPERATURE**
36.8°C axillary (range 36.6–37.1 over 24 h)

**HEART RATE**
154 bpm (range 138–172; 6 bradycardic dips to 78–92)

**RESPIRATORY RATE**
54 / min

**BLOOD PRESSURE**
58/32 mmHg, mean 41 — appropriate for corrected age

**OXYGEN SATURATION**
93–97% on CPAP 5, FiO&sub2; 0.21–0.24

**WEIGHT**
1,384 g (+26 g in 24 h)

**LENGTH**
39.5 cm (08/03)

**HEAD CIRCUMFERENCE**
28.4 cm (08/03) — +0.9 cm/week

**WEIGHT CHANGE**
+374 g from birth weight; +472 g from day-6 nadir

**GROWTH PERCENTILES**
Fenton: weight 20th–25th, length 25th, head circumference 30th

**PAIN / NEONATAL COMFORT SCORE**
N-PASS 1 at rest, 3 during cares — comfortable

#### 5a RESPIRATORY SUPPORT

**MODE OF SUPPORT**
Nasal CPAP via short binasal prongs, interface rotated 4-hourly

**FIO2**
0.21–0.24

**FLOW / PRESSURE SETTINGS**
CPAP 5 cmH&sub2;O (weaned from 6 on 08/04 at 14:00)

PEEP / PIP / RATE

**Not applicable — no invasive or bilevel ventilation**

RECENT EVENTS

**6 apnea/bradycardia/desaturation events in 24 h (11 the prior day); 1 required tactile stimulation, 0 required positive pressure**

## 5b NEONATAL PHYSICAL EXAMINATION

### General Appearance

Pink, warm, and well perfused in a servo-controlled incubator at 30.4°C ambient. Alert during handling with a 20-minute quiet-alert period observed. Normal flexor tone for 31 weeks corrected with symmetrical spontaneous movement. Consolable with containment holding. No distress at rest.

### Head / Eyes / Ears / Nose / Throat

Anterior fontanelle soft and flat, sutures apposed, no molding or cephalohematoma. Red reflex present bilaterally. No eye discharge. Ears normally positioned and formed with recoil appropriate for gestation. Nares patent with mild pressure erythema from the CPAP prongs, skin intact and barrier dressing in place. Palate intact. Suck present but not yet coordinated for full oral feeding. Mucous membranes moist.

### Neck / Clavicles

Full passive range of motion, no masses or webbing. Clavicles intact with no crepitus or tenderness.

### Cardiovascular

Rate 154, regular. **No murmur** — consistent with the documented ductal closure. Femoral pulses present and symmetrical. Capillary refill under 2 seconds centrally and peripherally. No cyanosis or oedema. Blood pressure appropriate with no inotrope support.

### Pulmonary

Mild subcostal recession only, no intercostal recession, no grunting or nasal flaring. Air entry equal and adequate bilaterally with no crackles, wheeze, or stridor. Chest shape normal. Six brief self-limiting events documented overnight as above.

### Abdomen

Soft and non-distended, girth 22 cm and unchanged for 6 days. Active bowel sounds in all quadrants. Non-tender with no guarding. No hepatosplenomegaly, no palpable mass, no abdominal wall defect. Umbilical stump separated day 11, base dry and clean. No inguinal hernia.

### Genitourinary

Normal male external genitalia. **Both testes descended into the scrotum** — a change from the day-14 examination when the left was in the inguinal canal. No hydrocele, no hypospadias. Anus patent and normally positioned. Nappy area skin intact with no candidal rash.

### Musculoskeletal / Hips

Flexor tone appropriate for 31+5 with symmetrical antigravity movement of all four limbs. No deformity. Spine straight with no sacral dimple or cutaneous marker. **Hip examination deferred** — Ortolani and Barlow not reliable at this corrected age and are scheduled at term-corrected examination. Extremities warm and well perfused.

### Skin

No jaundice clinically. No pallor, mottling, cyanosis, petechiae, or bruising. Skin now mature with no fragility or excoriation. **Central line exit site clean with no erythema, discharge, or tenderness.** Two healed heel-prick sites. Pressure areas at the nares and occiput intact.

### Neurologic

Alert and responsive to voice and touch during the examination. Tone symmetrical and appropriate. Suck present, root and grasp present, Moro complete and symmetrical. Deep tendon reflexes 2+ and equal. No tremor, jitteriness, clonus, or seizure activity. Lengthening awake periods with emerging self-regulation.

## SL NICU / NEWBORN SUPPORT AND LINES

### 6 CURRENT SUPPORT & DEVICES

RESPIRATORY SUPPORT

Nasal CPAP 5 cmH&sub2;O, FiO&sub2; 0.21–0.24; caffeine citrate 5 mg/kg/day maintenance

VASCULAR ACCESS

PICC line, right basilic, day 21 in situ — parenteral nutrition stopped 08/04; removal planned today after the 12:00 feed is tolerated. No peripheral cannula. UVC and UAC removed day 6 and day 4 respectively

FEEDING TUBE

6 Fr nasogastric tube, right naris, resited 08/04, position confirmed

TPN / LIPID USE

Discontinued 08/04 after 24 days — enteral intake now 145 mL/kg/day

PHOTOTHERAPY

Off since day 7; no rebound requiring retreatment

THERMAL CARE

Servo-controlled incubator at 30.4°C; open-crib trial planned at 1,600 g with stable temperature

TEMPERATURE STABILITY

Stable 6 days, range 36.6–37.1°C, no cold stress episode

MONITORS AND ALARMS

Continuous cardiorespiratory and saturation monitoring; alarm limits 88–95% saturation, heart rate 100–200

WOUND / SURGICAL SITE / OSTOMY

None — no surgical intervention at any point in this admission

## FG FEEDING / GROWTH ASSESSMENT

### 7 NEONATAL NUTRITION & GROWTH

FEEDING ROUTE

Nasogastric bolus over 30 minutes, 3-hourly; non-nutritive suckling at the breast during kangaroo care

MILK TYPE

Expressed maternal breast milk with human milk fortifier since 08/03; donor milk not required — maternal supply ample

FEEDING VOLUME AND FREQUENCY

18 mL every 3 hours (8 feeds/day) = 144 mL/day = 145 mL/kg/day

TOTAL FLUIDS

145 mL/kg/day, all enteral since 08/04

CALORIES

22 kcal/oz fortified — approximately 106 kcal/kg/day, protein 3.6 g/kg/day

FEEDING TOLERANCE

Tolerating — minimal non-bilious aspirates, no emesis 4 days, girth stable

EMESIS / RESIDUAL CONCERNS

None since 08/01. The 07/27 bilious-tinged aspirates did not recur

STOOLING AND URINE OUTPUT

Stool 3–4× daily, soft, no blood; urine 3.4 mL/kg/hr

BREASTFEEDING LATCH AND TRANSFER

ORAL FEEDING READINESS

**Non-nutritive suckling only; no measured transfer yet. Latch attempts brief and disorganised — expected at 31+5**

**Rooting and suck present; suck-swallow-breathe coordination not yet established — first oral feed trial planned at 33 weeks corrected**

WEIGHT TREND

**+21 g/day over 7 days (15.2 g/kg/day) — at target for corrected age**

NUTRITION BARRIERS AND DISCHARGE FEEDING PLAN

**No barriers. Plan: advance to 165–170 mL/kg/day, begin cue-based oral feeds at 33 weeks corrected, transition to breast with fortified top-ups, and discharge on breastfeeding with a post-discharge fortification plan and vitamin D and iron supplementation**

## DN DEVELOPMENTAL / NEUROBEHAVIORAL ASSESSMENT

### 8 NEUROBEHAVIORAL STATUS

#### Tone, activity and state regulation

Flexor tone appropriate for 31+5 with symmetrical movement. State regulation improving — achieved and maintained a 20-minute quiet-alert state today, up from brief and fragmented alertness a week ago. Self-calms with containment and a hand to the face.

#### Feeding cues and oral coordination

Roots and brings hands to mouth reliably before feeds. Suck present and rhythmic on a pacifier. **Suck-swallow-breathe coordination not yet established**, consistent with corrected age; no aspiration signs during non-nutritive suckling.

#### Response to handling and sleep-wake pattern

Tolerates clustered cares with only mild transient desaturation, recovering without intervention. Sleep-wake cycling now discernible with longer consolidated sleep between cares. N-PASS 1 at rest.

#### Parent-infant bonding and supportive care

Excellent. Daily kangaroo care 60–90 minutes with measurably improved saturation and temperature stability during holds. Both parents perform cares, nappy changes, and mouth care with breast milk. Nested positioning, cycled lighting, and noise reduction in place.

#### Therapy involvement and follow-up needs

Occupational therapy reviewing weekly for positioning and oral readiness; speech and feeding therapy to join at 33 weeks corrected. **High-risk infant follow-up clinic referral generated today** given 28-week gestation and grade I germinal matrix hemorrhage — neurodevelopmental assessment at 4, 12, and 24 months corrected.

## L LABORATORY AND DIAGNOSTIC RESULTS

### 9 RESULTS REVIEWED OR ORDERED

#### Laboratory Studies — 08/03 and 08/05

08/05: hemoglobin 9.4 g/dL (from 10.8 on 07/29), hematocrit 28%, reticulocytes 3.2% — anemia of prematurity, appropriate reticulocyte response, **no transfusion indicated** as he is asymptomatic with no increase in oxygen or apnea. White cells 9.8 with a normal differential, platelets 288. CRP 4 mg/L (peak 48 on day 19). Sodium 138, potassium 4.6, calcium 9.8 mg/dL, phosphate 5.1 mg/dL, alkaline phosphatase 412 U/L, albumin 3.1 g/dL. Total bilirubin 2.8 mg/dL with direct 0.4 — no cholestasis. Capillary gas: pH 7.35, pCO&sub2; 46 mmHg, base excess −1 — compensated, no permissive hypercapnia concern.

### Microbiology

Blood culture day 19: coagulase-negative *Staphylococcus* from both PICC and peripheral samples — treated. **Repeat culture day 21 and day 24 both sterile.** Urine culture day 19 negative. No lumbar puncture performed — infant was hemodynamically stable with a typical organism and cleared promptly; discussed and documented at the time. No respiratory culture indicated. MRSA screen negative on admission and weekly.

### Newborn Screening

State newborn screen day 5 with repeat day 19 (preterm protocol): **both normal** — no metabolic, endocrine, hemoglobinopathy, or cystic fibrosis flag. Automated auditory brainstem response hearing screen **pending — scheduled at 34 weeks corrected**. Congenital heart disease pulse oximetry screen not applicable in a monitored NICU infant; echocardiography supersedes it. Car seat tolerance test to be arranged before discharge.

### Imaging

Cranial ultrasound 07/12, 07/19, and 08/02: **bilateral grade I germinal matrix hemorrhage, stable, with no ventricular dilatation, no periventricular leukomalacia, and no cystic change.** Next scan at term-corrected age. Abdominal radiographs 07/27 and 07/28 during the feed interruption: dilated loops without pneumatosis, portal venous gas, or free air — necrotising enterocolitis never radiologically confirmed. Chest radiograph 07/09 showed classic respiratory distress syndrome; none since day 3. Renal ultrasound not indicated.

### Respiratory / Cardiac Testing

Serial capillary gases stable with pCO&sub2; 44–48 through the CPAP wean. Event download reviewed with the respiratory therapist: 6 events in 24 h, all brief, **none associated with a desaturation below 80% for more than 10 seconds**. Echocardiogram 07/24: patent ductus arteriosus closed, normal biventricular function, no pulmonary hypertension. No EKG indicated.

### Prior Records Reviewed

Maternal antenatal record including Doppler studies and the pre-eclampsia course; delivery and resuscitation record; the full 27-day NICU chart including the sepsis episode and the necrotising enterocolitis work-up; pharmacy record confirming a 7-day vancomycin course with two trough levels in range; lactation consultant notes; occupational therapy notes.

## A ASSESSMENT

### 10 NEONATOLOGY CLINICAL INTERPRETATION

- **28-week preterm male, now 31 weeks 5 days corrected, day 27, clinically stable and progressing on all fronts.** The three problems that dominated the past two weeks — suspected necrotising enterocolitis, late-onset bacteraemia, and CPAP dependence — are each resolving, and today's work is consolidation rather than rescue.
- **Respiratory: resolving respiratory distress syndrome with apnea of prematurity, tolerating the CPAP wean.** FiO&sub2; has stayed at or near air through a pressure reduction, and the event count has almost halved in 24 hours. The apnea is maturational, not infective — the timing tracks the resolution of the sepsis episode and the CRP fall. **He is not ready for a high-flow trial today:** six events, one requiring stimulation, argues for another 24–48 hours of stability at CPAP 5 first. Weaning too fast in a 31-week infant buys a reintubation, not an earlier discharge.
- **Nutrition and growth: back on trajectory after the feed interruption.** Weight gain of 15.2 g/kg/day on fortified maternal milk at 145 mL/kg/day is at target, and head growth of 0.9 cm/week is appropriate without being alarming. The centile fall from the 32nd to the 20th–25th happened during the 5-day nil-by-mouth period; recovering it will take weeks, and the plan should aim for steady catch-up rather than aggressive fortification, which risks feed intolerance in an infant who has already declared a sensitive gut.
- **The 07/27 episode was suspected but never confirmed necrotising enterocolitis** — no pneumatosis, no portal gas, no free air, resolution with rest alone. Retrospectively this reads as feed intolerance of prematurity, possibly related to the ductal shunt physiology at the time. That said, the 5-day rest and antibiotic cover were the correct

decisions on the information available: the cost of over-treating suspected necrotising enterocolitis is small and the cost of under-treating it is catastrophic.

- **Late-onset coagulase-negative staphylococcal bacteraemia, treated and resolved.** Two sterile follow-up cultures, CRP down from 48 to 4, afebrile 6 days. **The line is now the only remaining risk and its indication has gone** — parenteral nutrition stopped yesterday and enteral intake is full. Retaining a PICC in an infant who has already had a line-associated bacteraemia, purely for convenience, is the single most avoidable risk on this chart today.
- **Anemia of prematurity, hemoglobin 9.4 g/dL with an appropriate reticulocyte response of 3.2%.** Asymptomatic with no increase in oxygen requirement, no tachycardia, and normal growth — **transfusion is not indicated.** Restrictive thresholds are appropriate here; iron supplementation and observation are the correct response to a physiological nadir.
- **Neurologically reassuring:** stable bilateral grade I germinal matrix hemorrhage on three serial scans with no ventricular dilatation and no white matter injury. Grade I carries a substantially better prognosis than higher grades, but 28-week gestation alone mandates structured neurodevelopmental follow-up, and the family should hear both parts of that message.
- **Thermoregulation and disposition:** temperature stable for 6 days in a servo incubator. At 1,384 g he is close to but not yet at a reasonable open-crib weight; a trial at 1,600 g with continued stability is realistic within 7–10 days.
- **Family readiness is a strength in this case, not a barrier.** Daily kangaroo care, an ample maternal milk supply, both parents competent with cares, and CPR training booked. The mother's question about breastfeeding is well-timed but the answer is corrected age, not motivation — oral feeding trials belong at 33 weeks. **Anticipated discharge at 36–37 weeks corrected, so early-to-mid September**, contingent on full oral feeding, thermal stability in an open crib, and 5–7 days free of significant events off caffeine.
- **Outstanding surveillance items to be tracked, not forgotten:** first retinopathy of prematurity screening is due this week at 31–32 weeks corrected and must not slip; hearing screen at 34 weeks; hip examination at term-corrected; car seat tolerance test before discharge; hepatitis B second dose by weight; RSV prophylaxis planning for the season; and identification of a community pediatrician, which has not yet been done at day 27.

## P PLAN

### 11 NEONATAL MANAGEMENT BY PROBLEM

- **Respiratory:** hold at CPAP 5 cmH&sub2;O for a further 24–48 hours; **do not wean today.** Reassess for a high-flow trial when events fall below 4 per 24 hours with none requiring stimulation. Continue caffeine citrate 5 mg/kg/day, reweighted twice weekly; no discontinuation before 34 weeks corrected. Continue 4-hourly interface rotation and barrier dressing for the nares. Capillary gas only if clinically indicated — no routine daily gas. Escalate for any event requiring positive pressure, a rise in FiO&sub2; above 0.30, or an event count above 12 in 24 hours.
- **Central line — today's priority action: remove the PICC after the 12:00 feed is tolerated.** Its indication ended when parenteral nutrition stopped, and this infant has already had a line-associated bacteraemia. Tip to be sent for culture. No replacement line; peripheral access only if required.
- **Feeding and nutrition:** continue expressed maternal breast milk with human milk fortifier at 22 kcal/oz, advancing by 20 mL/kg/day to a target of 165–170 mL/kg/day, guided by tolerance rather than the calendar. Monitor girth and aspirate character each feed; hold and review for bilious aspirate, a girth rise above 2 cm, or blood in stool. **Do not increase fortification further this week** — growth is already at target and the gut has been sensitive. Weekly length and head circumference; daily weight.

- **Oral feeding progression:** continue non-nutritive suckling at the breast during kangaroo care. **First cue-based oral feed trial at 33 weeks corrected (approximately 08/19)**, not before, with speech and feeding therapy present. Lactation to continue supporting expression and to begin pre-feed breast emptying practice so early latches are lower-flow. Mother's question about direct breastfeeding answered explicitly with this timeline and the reasoning.
- **Hematology:** no transfusion. Start oral iron 2 mg/kg/day now that enteral feeds are established and parenteral nutrition has stopped. Recheck hemoglobin and reticulocytes in 7 days. Continue vitamin D 400 IU daily.
- **Metabolic bone disease surveillance:** weekly alkaline phosphatase, phosphate, and calcium. Current values acceptable; escalate calcium and phosphate supplementation if alkaline phosphatase exceeds 500 U/L or phosphate falls below 4.0 mg/dL.
- **Infection:** antibiotics complete, none to restart. No further routine CRP or cultures. Weekly MRSA screen continues. Low threshold to re-culture for temperature instability, a rise in apnea, or feed intolerance — but avoid reflex antibiotics in a well infant, which is how the next resistant organism is selected.
- **Neurologic and developmental:** next cranial ultrasound at term-corrected age; no interim scan needed given three stable studies. Continue developmental positioning, cycled lighting, clustered cares, and daily kangaroo care. Occupational therapy weekly; speech and feeding therapy from 33 weeks. **High-risk infant follow-up referral sent today** for assessment at 4, 12, and 24 months corrected.
- **Thermoregulation:** continue servo-controlled incubator. **Open-crib trial at 1,600 g** with 4-hourly temperatures and a defined return-to-incubator threshold of two consecutive temperatures below 36.4°C.
- **Screening and preventive care — all booked today so nothing slips:** first retinopathy of prematurity examination **08/07** (31–32 weeks corrected, ophthalmology confirmed), then per schedule. Automated auditory brainstem response hearing screen at 34 weeks. Hip examination at term-corrected. **Hepatitis B second dose** due at 1 month and now above 2 kg threshold consideration — scheduled at 1,500 g or 1 month, whichever later. Routine 2-month immunisations to be given by chronological age, in-unit, not deferred for prematurity. RSV immunoprophylaxis planned for the season, eligibility documented. Car seat tolerance test in the week before discharge.
- **Family and discharge planning:** parent CPR course 08/12 confirmed. Safe sleep education reinforced — supine, flat, no bedding — and a home sleep environment check discussed. **Identify a community pediatrician this week** and send a copy of the discharge summary once identified; this is overdue at day 27. Discharge target 36–37 weeks corrected communicated to the parents with the three explicit criteria (full oral feeds, open crib with stable temperature, 5–7 event-free days off caffeine) so the goalposts are transparent. Social work not required. Home oxygen not anticipated.
- **Escalation criteria documented at the bedside:** any apnea requiring positive pressure, FiO&sub2; above 0.30, bilious aspirate or emesis, girth increase above 2 cm, blood in stool, temperature instability, urine output below 1 mL/kg/hr, new murmur with poor perfusion, seizure activity, or a sudden fall in tone or responsiveness.

## F FOLLOW-UP

### 12 REASSESSMENT PLAN

#### Follow-up timeframe and purpose

**Continuous:** cardiorespiratory monitoring and 3-hourly nursing assessment with event count reviewed each shift. **Attending reassessment tomorrow 08/06** for the CPAP wean decision and confirmation of feed tolerance after line removal. **08/07** retinopathy of prematurity screening. Daily weight; weekly length, head circumference, and metabolic bone panel. Hemoglobin and reticulocytes 08/12. **Approximately 08/19 (33 weeks corrected)** first cue-based oral feed trial with speech and feeding therapy. Hearing screen at 34 weeks. Cranial ultrasound and hip examination at term-corrected. Parent CPR course 08/12. Family meeting 08/10 to review the discharge pathway and criteria. High-risk infant follow-up clinic at 4, 12, and 24 months corrected. Community pediatrician to be identified within 7 days.

## TB TIME DOCUMENTATION & BILLING

**TOTAL TIME SPENT**

52 minutes at the bedside and on the chart

**PARENT / CAREGIVER COUNSELING TIME**

18 minutes — breastfeeding timeline, discharge criteria, retinopathy screening, developmental follow-up

**CARE COORDINATION TIME**

14 minutes — ophthalmology booking, high-risk follow-up referral, feeding therapy, community pediatrician search

**RECORDS REVIEW TIME**

11 minutes — event download, culture and pharmacy records, serial imaging, growth chart

**NICU CRITICAL CARE TIME**

Not billed as critical care — the infant is no longer critically ill; intensive care service is the appropriate level today

**PROCEDURE TIME**

8 minutes — PICC removal performed at 12:40 after feed tolerance confirmed

**E/M LEVEL**

99478 — subsequent intensive care, per day, for the evaluation and management of a recovering very low birth weight infant, present body weight 1,000–1,499 g

**NICU CRITICAL CARE CODE(S)**

None — 99469 not applicable; criteria for critical care not met today

**PROCEDURE CODE(S)**

36589 — removal of tunnelled central venous catheter without subcutaneous port or pump (PICC removal)

**SCREENING / PREVENTIVE CODE(S)**

Retinopathy of prematurity screening arranged (ophthalmology to bill); hearing screen pending

**BASIS FOR BILLING**

Newborn care — per-day intensive care service for a recovering very low birth weight infant, with a separately identifiable procedure

**PRIMARY ICD-10**

P07.31 preterm newborn, gestational age 28 completed weeks, with P07.15 other low birth weight newborn, 1,000–1,249 g

**SECONDARY ICD-10**

P28.4 other apnea of newborn; P22.0 respiratory distress syndrome of newborn (resolving); P36.30 sepsis of newborn due to staphylococcus, unspecified (resolved); P52.0 intraventricular hemorrhage grade 1 of newborn; P61.2 anemia of prematurity; P59.0 neonatal jaundice associated with preterm delivery (resolved); Z13.5 encounter for screening for eye disorder

## SO PROVIDER SIGN-OFF

| PROVIDER NAME | CREDENTIALS | SPECIALTY | DATE | TIME |
|---|---|---|---|---|
| Camille Beauchêne, MD | MD, FAAP | Neonatal-Perinatal Medicine | 08/05/2026 | 1:06 PM |