60 - NEWBORN AT RISK AND CONDITIONS OF TRANSPORT TO NEONATAL REFERENCE UNITS

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INTRODUCTION

The service of efficient and well-planned transport of neonates complements the care to pregnant and newborn (NB), showing as indispensable to the newborn at risk, who were not offered an adequate perinatal care, regionalized and hierarchical. It makes possible the identification of risks in prenatal and the appropriated planning for the birth happened in tertiary centers, well-equipped in terms of human and material resources. In this scope, perinatal transport cannot be only a complement and its existence becomes vital to the newborns that need these services (MARBA; VIEIRA, 2008).

Neonatal transport is a service which must be part of an articulated net of attention points to the health of women and children from the primary attention, in which the prenatal is performed, to units of bigger technological complexity, like the Neonatal Intensive Care Unit (NICU), which assists newborns at risk. For a good functioning of this net, it is necessary a good attendance, what permits the precocious identification of risk situations, foreseeing probable intercurrences with mother and newborn. In addition, it is also necessary a previous agreement between services and municipalities.

The literature appoints to a significant correlation between neonatal transport and the reduction of neonatal morbidity and mortality. Half of all neonatal child mortality occurs due to an inadequate transport (SILVA; PEREIRA, 1995). In Brazil, it persists an access difficult of newborns and women to intermediate and intensive care due to the big deficit of beds and trained professionals to this treatment, what is more serious in the countryside and in North and Northeast regions of Brazil (FRANÇA; LANSKY, 2008).

In Paraíba, in 2007, neonatal mortality corresponded to approximately two thirds of child mortality in Brazil. This elevated proportion is due to the occurrence of obit causes of hard prevention and treatment, as affections originated in perinatal period, congenital malformations and chromosomal abnormalities (BRASIL, 2009). However, by diverse circumstances, nowadays innumerable premature newborns with or without pathologies are born in maternities destined to term birth, being necessary the transference of them to NICUs which offer better conditions of treatment to their needs.

Given the importance and individual and collective repercussions provoked by the adequate neonatal transport, it becomes necessary the availability of this service in enough quantity, and with adequate human and material resources destined to the satisfactory transport of customers cited here.

Based on the exposed, the main objective of this study was to evaluate the clinical conditions of transport of newborns admitted in the public Neonatal Intensive Care Units in João Pessoa – PB.

METHODOLOGICAL CONSIDERATIONS

This is a retrospective and documental study, with quantitative approach, based on information collected in newborn medical registers of the only three reference units in João Pessoa – PB, in the neonatal intensive care which accept newborns from João Pessoa, from other municipalities, and even other States.

The research universe considered the newborn medical registers admitted in 2008, 2009 and in the first quarter of 2010. In the Medical Records Service (MRS), all medical registers of newborns that were transported from other municipalities to receive specialized treatment were selected, constituting a sample of 36 medical registers. The information collection used a structured questionnaire with objective questions. Moreover, the descriptive analysis of data from the absolute frequency and percentage of the evaluated variables was done with the SPSS® Software (Version 17.0). The significance level adopted was 0.05.

Furthermore, all terms of the Resolution 196 form the National Health Council/ MH were fulfilled, and the present study was approved by the Research Ethics Committee of Lauro Wanderley University Hospital, according to protocol number 260/2010.

RESULTS AND DISCUSSION

The research analyzed 36 medical registers of newborns that were transported to Neonatal Units. From the total of admissions, 30.6% occurred in 2008, 55.6% in 2009 and 13.9% in the first quarter of 2010.

The kind of birth of these newborns was registered in 26 medical records, only (72.2%). From these, 61.5% were born by eutocic delivery and 38.5% from operative delivery. In 35 medical registers (97.2%), the sex of newborns was registered, indicating a masculine predominance (65.7%). Considering 35 medical registers with valid registers (91.7%), most of newborns (78.8%) was admitted in the first 24 hours after birth, and 60.6% of these ones were transported immediately after their births, 6.1% in the first six hours, 12.1% twelve hours after birth, 18.2% more than 24 hours after birth, and only one newborn (3%) was admitted with 28 days of life. The gestational age varied from 24 to 40 weeks, and this datum was registered in 28 admissions (77.8%). It was also verified that 3.6% of newborns presented extreme immaturity, 50% were premature, 42.9% were term birth and 3.6% were post-term birth.

Table 1 – Characterization of newborns according to their weight. João Pessoa – PB, 2010.

	n.	%	% valid
<800g (microp)[a]	2	5.6	5.6
<1.500g (NVUW)[b]	6	16.7	16.7
<2.500g (NUW)[c]	9	25.0	25.0
>2.500 a 4.000g (NNW)[d]	17	47.2	47.2
>4.000g (NOW)[e]	2	5.6	5.6
Total	36	100.0	100.0

aMicrop – micro-premature; bNVUW – newborn very underweight; cNUW – newborn underweight; dNNW – newborn with normal weight; eNOW – newborn overweight

In the investigated sample, more than 50% of newborns present important alterations of weight to minus. It is known that the lower the weight the greater the risk for the newborn evolutes to obit in neonatal period. Low weight at birth favors the appearing of morbid conditions like perinatal anoxia, meconium aspiration and metabolic disorders, what represents an important risk factor to respiratory and neurologic complications in prenatal, perinatal or postnatal period (ALMEIDA; MELLO JORGE, 1998). As the research is about newborns at risk, variable weight changes are expected (SALGE, et al, 2009), and therapeutic standards pertinent to each case must be promptly adopted by the team. Hence, it is necessary trained professionals and appropriate material resources to attend the specific and complex needs of newborns at risk as to modify the prognosis and survival of preterm newborns (PTN) (ROLIM, et al, 2010).

The clinical conditions of newborns, according to the systems, presented this way: Thermoregulatory – 30.6% with hypothermia, 2.8% with hyperthermia, 44.4% normothermic, and 22.2% did not reveal register on medical registers. Cardiovascular – 27.8% with tachycardia, 13.9% with bradycardia, 52.8% normocardic, and 5.6% with no registration. Respiratory – 8.3% with apnea, 47.2% with tachypnea associated to other respiratory alterations, 25% eupneic, 16.7% with dyspnea associated to other respiratory alterations, and 2.8% with no registration. Integumentary (Coloration) – 19.5% pallid, 44.6% plethoric, acyanotic and anticteric, 16.7% presented cyanosis, 5.6% jaundiced, 2.8% acrocyanotic, and 11.1% with no registration.

The frequency of hypothermia at the moment of admission of transported newborns occurred in 30.6% of cases. The finding can be explained by own neonatal characteristics, which favors the appearing of hypothermia, like limited ability in heat production, large corporal surface in relation to weight and low quantity of subcutaneous tissue (ALMEIDA; MELLO JORGE, 1998). On the other hand, factors related to the own transport, as its duration and conditions of inadequate transport to the maintenance of body temperature can have influence in this result.

In relation to cardiovascular system, fifteen newborns (41.7%) presented bradycardia or tachycardia. When these registers were analyzed, it was verified that, from total, 5 newborns (33.3%) presented gestational age inferior to 37 weeks and 6 (40%) were underweight.

Moreover, considering the respiratory system, 26 newborns (74.2%) presented disturbances, such as dyspnea, tachypnea or apnea. From this total, 12 newborns (46.1%) had gestational age inferior to 37 weeks, and 13 (50%) presented weight inferior to 2500g. These data evidenced a bigger frequency of respiratory alterations in premature newborns and underweight than cardiovascular alterations. Premature newborns are more susceptible to discomfort and respiratory insufficiency due to lung immaturity, still aggravated by physiological alterations that occurs in the cardio-circulatory system after birth, which exposes, in a precocious way, these neonates to factors that can harm their lungs which have immature structure. (SALGE, et al, 2009).

In relation to Integumentary system and, except jaundice, the other identified alterations are related to cardio-respiratory problems, which were evidenced in the transported newborns. These evidences justify the need for an equipped transport with human and material resources that enables the monitoring and an adequate cardio-respiratory support to diagnose in time critical situations, preventing complications and sequels which can emerge during transport.

Table 2 – Morbidities related to the indication of inter-hospital transport for newborns.

	n.	%
Prematurity and associations*	14	38.9
Resp. Alt. and associations**	9	25.1
Cardiovascular alterations	3	8.4
Infectious alterations	2	5.6
Hematologic alterations	2	5.6
Other disturbances***	5	14.0
Without register	1	2.8
Total	36	100.0

* Prematurity, respiratory and hematologic alterations; ** Respiratory, metabolic, cardiovascular and infectious alterations; *** Neurologic alterations, congenital malformation, surgical pathologies, serious innutrition and apparent death.

Prematurity and other respiratory disturbances associated to other changes (hematologic, metabolic, cardiovascular and infectious) constituted the main causes that led to the indication of inter-hospital transport in all years of study, an expected result because these are the main indications of admissions in the day-to-day of neonatal units (REGO, 2005).

Considering the origin of newborns, there was register on 35 medical registers (97.2%) of 36 analyzed ones. From these, 51.4% came from littoral region, 20% from brejo paraibano region, 17.1% from sertaneja region, and 11.4% were from interstate origin. The data evidenced the worrying reality of newborns from sertaneja region, once all municipalities are far more than 200 km from João Pessoa. This fact increases the risk of sequels or even death, once the transport of newborns at risk should be done by plane (ROLIM, et al, 2010). However, Paraíba does not have this kind of transport, a condition which can contribute to serious health complications for newborns.

Also, in relation to the kind of transport, it was verified that 62.5% of newborns were transported in mobile ICU, 31.3% in basic ambulance, and 6.3% in precarious conditions of transport without the correct identification of the kind of vehicle used.

Since June 24, 1999, the Ordinance n. 824/GM regulates that neonatal transport should be done in ambulance type D (Mobile ICU), aircraft or airplanes. The choice will depend on the seriousness of case, emergence transfer, need for support interventions during the route, distance/ time, transport/ personal availability, climatic conditions of access and traffic, geography, safety and costs (MARBA; VIEIRA, 2008).

Table 3 – Human and material resources to support the lives of newborns in the realization of inter-hospital transport. João Pessoa-PB, 2010.

Variables	n.	%
Physician	4	11.1
Nursing technician	2	5.6
Nursing assistant	3	8.3
Physician and nurse	1	2.8
Physician and nursing technician	2	5.6
Nurse and nursing technician	1	2.8
No registration	23	63.9
Total	36	100.0
Dispositive used by newborn during transport	n.	%
Acrylic cradle	3	8.3
Incubator for transport	11	30.6
Lap of professional	1	2.8
No registration	21	58.3
Total	36	100.0
Equipment for oxygen therapy	**n.**	**%**
Ambulance	6	16.7
Rechargeable O_2 cylinders	11	30.6
None, ambient O_2	7	19.4
No registration	12	33.3
Total	36	100.0

For the realization of transport of patients at risk, in which neonatal transport is included, it is necessary at least two people to accompany the patient, usually a nurse and a physician, besides the driver and a familiar. These professionals should be able to give advanced life support in neonatology at hospital and keep this care during the transport (MEZZACAPPA FILHO; GUISBURG, 2000). The study reveals a preoccupant datum, once from 13 (36.1%) medical registers with registration, only 2.8% of transports were accompanied by a complete transport team. Furthermore, it reveals that, in many cases, transport is done by a driver and a nursing assistant only, in opposition to the recommendations that every neonatal transport team should have at least one professional that is able to perform all the necessary procedures for assistance of critically ill newborns, including tracheal intubation, obtainment of venous and arterial access, and chest tube drainage (SBP, 2004).

The study also proved a underreporting in registries in relation to the observation of equipments used during transport. Essential equipment like transport incubator was used in 30.6% of cases only. In 26.7% of them, newborns were accommodated in the transport inadequately, increasing the risk of complications, once the combination between obsolete equipment and the lack of specialization of the team becomes the transport dangerous, what jeopardizes the health of newborn (HADLY; MASM, 2001). Moreover, the Ordinance n. 824/GM is also violated, because it orientates that all this means of transportation must contain transport incubator for newborns with battery which connects in the vehicle (12 volts), base on its own pedestal for oxygen and compressed air cylinders, and temperature control with alarm. Equipments like respirator neonatal transport and other materials, with sizes and specifications adequate to neonatal use, as well as all necessary medicines to advanced support of life.

The motif for newborn discharge from hospital was registered in 86.1% of the analyzed medical registers, in which 8.3% were sent to nursery, 22.2% to collective accommodation, 22.2% were transferred to other hospitals, 11.1% went home, 22.2% died, and 5.3% of newborns did not present the motif of discharge from hospital in medical registers. The high incidence of death among the transported newborns (22.2%), which was identical to other motifs for discharge from hospital, is worrying. This datum, if compared to the characteristics of admitted newborns, evidenced that only the death of two newborns could be considered as hard to be avoided because they were concentrated on 27 weeks of gestational age (extreme premature) and less than 1000g of weight at birth. These conditions contribute to deaths in consequence of hypovolemic shock, septic shock, aspiration pneumonia, and acid-base disturbances, serious complications and of hard reversion due to the development conditions of newborns (REGO, 2005). Nevertheless, from the obtained data in this study, it cannot consider if these were the conditions of newborns who died, or if they were, they were not properly registered.

FINAL CONSIDERATIONS

The results of the present study evidences that minimum conditions to a safe neonatal transport were not followed adequately in most of transports to reference units in João Pessoa – PB. Furthermore, they evidence a worrying diagnostic, the sub-register of information by the health teams which admit these newborns in reference units. The study emphasizes that, besides the importance of a trained team to the success of transport, it is necessary that the responsible team for newborns admission does the adequate register of information because they are extremely relevant not only to the immediate care, but also to its continuity during the permanence of newborns in neonatal ICU.

This way, the study proposes the continuing education of health professionals which work in neonatal ICUs in order to make adequate registers about the clinical and transport conditions of newborns at risk, primordial aspect to maintain the quality of transport service, as well as the realization of new studies about the theme, in the intention of helping in the establishment of protocols to transport critically ill newborns in a high level of clinical safety.

REFERENCES

ALMEIDA, M. F. de; MELLO, J. M. H. Pequenos para idade gestacional: fator de risco para mortalidade neonatal. Rev. Saúde Pública, São Paulo, v. 32, n. 3, p. 217-24, jun. 1998. Available in:
<http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89101998000300003>. Access on: May 11, 2011.

BRASIL, Ministério da Saúde. Sistema Nacional de Vigilância em Saúde. Relatório situacional Paraíba. Brasília, DF, 2009. Available in: <http://portal.saude.gov.br/portal/arquivos/pdf/002_pb_relatorio_de_situacao.pdf>. Access on: January 10, 2010.

BRASIL, Ministério da Saúde. Gabinete do Ministro. Portaria nº 824/GM, de 24 Jun. 1999. Brasília, DF, 24 jun 1999. Available in: <http://dtr2001.saude.gov.br/sas/PORTARIAS/Port99/GM/GM-0824.html>. Access on: March 9, 2011.

SOCIEDADE BRASILEIRA DE PEDIATRIA. Documento Científico do Departamento de Neonatologia da Sociedade Brasileira de Pediatria: Infraestrutura para atendimento integral ao recém-nascido. Sociedade Brasileira de Pediatria, 2004. Available in: <http://www.sbp.com.br/show_item2.cfm?id_categoria=21&id_detalhe=1636&tipo_detalhe=s>. Access on: January 10, 2011.

FRANÇA, E.; LANSKY, S. Mortalidade Infantil Neonatal no Brasil: Situação, Tendências e Perspectivas. Minas Gerais: Departamento de Medicina Preventiva e Social, UFMG, 2008. Available in:
<http://www.ims.uerj.br/downloads/funsaco/2009/bib_apoio_02.pdf>. Access on: March 20, 2011.

HADLY, G. P.; MASM, M. Improving neonatal transport in the third world: technology or teaching?. SAJS, [s.n.], v. 39, n. 4, p. 122-4, 2001.

MARBA, S. T. M.; VIEIRA, A. P. L. Transporte neonatal. In: PEREZ, J.R.S. Projeto Qualisus. Campinas: Fundação de desenvolvimento da UNICAMP, 2008. 315p. (Sistematização de Guidelines e Caracterização das Respectivas Linhas de Cuidado). Available in: http://portal.saude.gov.br/portal/arquivos/pdf/Guidelines_3.pdf. Access on: June 07, 2011.

MEZZACAPPA FILHO, F.; GUISBURG, R. Transporte Neonatal. In: Rugolo L M.S. Manual de Neonatologia. 2. ed. Rio de Janeiro: Revinter, 2000. p. 7-11.

REGO, M. A. S. Assistência Hospitalar ao Neonato. 1. ed. Belo Horizonte: Gutenberg Publicações, 2005. p. 17-66. Available in: <http://www.solucoesconsultoria.com.br/docs/Decreto%20Estadual%2040.134%20de%2026-05-1988.pdf>. Access on: March 20, 2011.

ROLIM, K. M. C. et al. Permanência da membrana semipermeável na pele do recém-nascido: um Cuidado diferenciado. Rev. Rene, Fortaleza, v. 11, n. 1, p. 144-151, Jan/Mar. 2010. Available in: < http://www.revistarene.ufc.br/>. Access on: September 10, 2011.

SALGE, A. K. M. et al. Fatores maternos e neonatais associados à prematuridade. Rev. Eletr. Enf, Goiana, v. 11, n. 3, p. 642-6, 2009. Available in: <http://www.fen.ufg.br/revista/v11/n3/v11n3a23.htm>. Access on: August 17, 2010.

SILVA, C. V.; PEREIRA, L. D. C. Transporte Neonatal em Santa Catarina. Arquivo Catarinense de Medicina, Santa Catarina, v. 24, n. 2/3, p. 11-6, abr/set. 1995.

NEWBORN AT RISK AND CONDITIONS OF TRANSPORT TO NEONATAL REFERENCE UNITS

ABSTRACT

Objectives: To evaluate the clinical and transport conditions of newborns admitted in public neonatal intensive care units in João Pessoa – PB. Methods: Documental research, retrospective, which comprehended the analysis of 36 medical registers of newborns admitted in Intensive Care Units after transport in 2008, 2009 and in the first quarter of 2010. The descriptive analysis of data was done from the absolute and percent frequency, and from the correlation among the evaluated variables. Results: From the transported newborns (61.5%) were born by eutocic delivery. The sex was notified in 97.2% of medical registers and, from these, 65.7% were masculine and 34.3% were feminine. 78.8% of newborns were admitted in the first 24 hours after birth. The prematurity and respiratory disturbances associated to other alterations constituted the main causes of indicating inter-hospital transport in all the years of study. The precedence of newborns was registered in 97.2% of the sample: 50% of them were from the littoral region, 19.4% from brejo paraibano, 16.7% from sertaneja region, and 11.4% from Pernambuco State. It was evidenced that only 2.8% of transports were accompanied by a complete transport team. Conclusions: The conditions of transport did not obey the recommendations of the Ordinance nº 824/GM. We can consider that the inexistence of protocols of transport and admission of newborns can have influenced the underreporting of information related to their clinical conditions, which are very important to the continuity of care and whose underreporting can provoke serious risks to newborns that need to be transferred to reference services.

DESCRIPTORS: Neonatal transport; Newborn; Intensive Care Units.

NOUVEAUX-NÉS DE RISQUE ET LES CONDITIONS DE TRANSPORT AUX UNITÉS NÉONATALES DE RÉFÉRENCE

RÉSUMÉ

Objectifs: évaluer les conditions cliniques et de transport des nouveaux-nés admis dans les Unités Mobiles de Soins Intensifs Néonatales Publiques de João Pessoa – PB. Méthodes: recherche documentaire, retrospective qui a compris l'analyse de 36 dossiers de nouveaux-nés (NNs) admis dans les Unités Mobiles de Soins Intensifs après transport dans les années 2008-2009 et au premier trimestre de 2010. L'analyse descriptive des données a été faite à partir de la fréquence absolue et pourcentage et de la correlation entre les variables évaluées. Résultats et des discussions: des NNs transportés, 61,5% est né d'accouchement normal. Le sexe a été notifié dans 97,2% des dossiers, dont 65,7% masculin et 34,3% féminin. Dans les premières 24 heures, après la naissance, 78,8% des NNs ont été admis. La prématurité et les troubles respiratoires associés à d'autres altérations ont constitué les principales raisons d'indication au transport inter-hospitaliaire pendant la recherche. La provenance des NNs a été notifiée dans les 97,2% de l'échantillon dont 50% venaient du littoral, 19,4% du “brejo paraibano”, 16,7% du “sertão” et 11,4% de Pernambuco. On a constaté que seulement 2,8% des déplacements ont été faits par une équipe de transport complet. Conclusions: Les conditions de transport n'ont pás été faits selon les normes du décret no824-GM. On peut considérer que l'inexistance de protocole de transport et l'admission des NNs ont, peut-être, influencé le sous-registre d'informations par rapport à leurs conditions cliniques, très important pour la suíte de l'assistance. Le sous-registre peut occasioner de sérieux risques aux NNs qui doivent être transportés aux services de référence.

DESCRIPTEURS: Transport neonatal, nouveau-né, Unité Mobile de Soins Intensifs

RIESGO DEL RECIÉN NACIDO Y CONDICIONES DE TRANSPORTE DE LAS UNIDADES DE REFERENCIA NEONATAL

RESUMEN

Objetivos: Evaluar las condiciones clínicas y el transporte de los recién nacidos ingresados en unidades neonatales de cuidados intensivos del público en João Pessoa – PB. Métodos: Esta retrospectiva, que incluyó el análisis de las historias clínicas de 36 recién nacidos (RN) ingresados en la unidad de cuidados intensivos después del transporte, en los años 2008, 2009 y el primer trimestre de 2010. Se realizó un análisis descriptivo de los datos de la frecuencia y el porcentaje y la correlación absoluta entre los parámetros. Resultados y Discusión: De los recién nacidos transportados (61,5%) nacieron de parto normal. El sexo se informó en el 97,2% de los registros de 65,7% y 34,3% hombres y mujeres. Fueron admitidos en las primeras 24 horas después del nacimiento el 78,8% de los recién nacidos. Trastornos de la prematuridad y respiratorios asociados con otras causas fueron la principal indicación del transporte inter-hospitalario en todos los años de estudio. El origen de los recién nacidos se registró en el 97,2% de la muestra, y el 50% provino de la región costera, el 19,4% de la Brejo, el 16,7% del 11,4% y la región interior del estado de Pernambuco. Mostró que sólo el 2,8% del transporte se ha visto acompañado por un completo equipo de transporte. Conclusiones: Las condiciones de transporte no cumplieron con las recomendaciones de la Ordenanza N º 824/GM. Podemos considerar que la falta de protocolos de transporte y la admisión de los recién nacidos pueden haber influido en el subregistro de información acerca de sus condiciones clínicas, que son de importancia sustancial para la continuidad de la atención y cuyo recuento incompleto puede causar graves riesgos para los recién nacidos que necesitan ser transferidos a servicios de referencia.

PALABRAS CLAVE: Transporte neonatal. Unidades de recién nacidos. Cuidados intensivos.

RECÉM-NASCIDO DE RISCO E CONDIÇÕES DE TRANSPORTE PARA UNIDADES NEONATAIS DE REFERÊNCIA

RESUMO

Objetivos: Avaliar as condições clínicas e de transporte dos recém-nascidos admitidos nas unidades de terapia intensivas neonatais públicas do município de João Pessoa-PB. Métodos: Pesquisa documental, retrospectiva, que abrangeu a análise de 36 prontuários de recém-nascidos (RNs) admitidos em Unidades de Terapia Intensiva após transporte, nos anos de 2008, 2009 e no primeiro trimestre de 2010. Foi realizada a análise descritiva dos dados a partir da frequência absoluta e percentual e da correlação entre as variáveis avaliadas. Resultados e Discussões: Dos RNs transportados (61,5%) nasceu de parto eutócico. O sexo foi notificado em 97,2% dos prontuários e destes 65,7% masculino e 34,3% feminino. Foram admitidos nas primeiras 24 horas após o nascimento 78,8% dos RNs. A prematuridade e os distúrbios respiratórios associados a outras alterações constituíram as principais causas de indicação do transporte inter-hospitalar em todos os anos do estudo. A procedência dos RNs foi registrada em 97,2% da amostra, sendo que 50% eram procedentes da região litorânea, 19,4% do brejo paraibano, 16,7% da região sertaneja e 11,4% do Estado de Pernambuco. Evidenciou-se que apenas 2,8% dos transportes foram acompanhados por uma equipe de transporte completa. Conclusões: As condições de transporte não atenderam as recomendações da Portaria Nº 824/GM. Podemos considerar que a inexistência de protocolos de transporte e admissão dos RNs pode ter influenciado o subregistro de informações relativas às suas condições clínicas, as quais são de substancial importância para continuidade da assistência e cujo subregistro pode ocasionar sérios riscos aos RNs que necessitam ser transferidos para serviços de referência.

DESCRITORES: Transporte neonatal; Recém-nascido; Unidades de terapia intensiva.