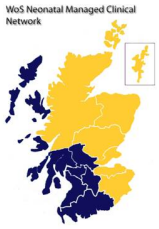
MCN for Neonatology

West of Scotland

Neonatal Guideline



Criteria for attendance at delivery by neonatal staff

This guideline is applicable to all medical, nursing and midwifery staff working in maternity units in the West of Scotland. Staff using this guideline are responsible for maintaining their skills in neonatal resuscitation and for seeking appropriate help where required. Staff should also refer to appropriate guidelines for the management of specific medical and surgical conditions which may require urgent intervention during the resuscitation of the infant.

Introduction

The following are intended as guidance, judgement should be exercised in individual cases. **Labour ward staff have primary responsibility for assessing the degree of risk anticipated and communicating their concerns effectively to the neonatal team.** The earlier the neonatal team is given notice of a potential problem the better, allowing decisions to be made around the appropriate staffing and management at delivery.

If in doubt, call and discuss

In turn the neonatal team should make every effort to attend promptly and ensure that they have adequate information to make management decisions.

Definitions

- For the rest of this document the term "First attender" will be used when referring to anyone on a "first on" rota, ie ST1-2, FY2s, ANNPs etc.
- "Registrar" will refer to anyone on "middle grade" rotas, i.e ST3+, SpRs and ANNPs.

Training and competence

- It is expected that trainees acting as "First Attenders" will be accompanied to deliveries until they and an experienced member of middle grade staff (or consultant) feel that they are capable of attending independently. By this time the trainee should have demonstrated the ability to assess wellbeing and institute appropriate management up to and including supporting respiration with face mask ventilation.
- Trainees should be assessed as being competent for this procedure and the evidence logged on ePortfolio as a directly observed procedure (DOP)
- Once trainees are attending independently they should continue to ask for assistance from middle grade staff early in resuscitation if a rapid improvement is not being made in the baby's condition.
- In smaller units trainees may not obtain sufficient experience during their post to attend independently, so should be supervised at all times.

Communication

Communication around an emerging situation where there may be both neonatal and maternal concerns is a challenge, however every effort should be made to ensure that adequate information is accurately passed to the neonatal team when they are called for resuscitation. Ideally the call should be made by a member of staff with a good working knowledge of the situation- if the midwife looking after the mother or midwife in charge is not able to make the call to the neonatal team, they should ensure that when delegating this adequate information is passed on.

When calling for neonatal assistance, the SBAR format should be used:

S Situation

e.g. - I've got a baby about to deliver with meconium and a non reassuring CTG

B Background

e.g. - The baby is at term, mum has gestational diabetes, and there have been no other concerns in pregnancy. The obstetric registar is setting up for a vacuum extraction in the room

A Assessment

e.g. The CTG trace is concerning, with late dips

R Recommendation

e.g. I need you to come to room 4 straight away- will you need the registrar too?

Response

e.g. I'll come straight down, my registrar is with me- I'll bring them along

Guidelines for neonatal attendance at deliveries:

Deliveries not routinely requiring the presence of neonatal staff:

- Elective caesarean sections under regional anaesthesia with no concerns re fetal wellbeing
- Low/mid cavity instrumental deliveries with no concerns re fetal wellbeing

First Attender only (Doctor or ANNP carrying the first-on page)

- 33-36 weeks gestation
- Where a fetal blood sample (FBS) has been done with a pH <7.25
- Intrapartum haemorrhage prompting delivery*****
- Fresh meconium in the amniotic fluid, with an abnormal CTG or FBS*
- Vaginal breech delivery*
- Instrumental deliveries in theatre
- Sustained Fetal tachycardia > 160
- Non-reassuring CTG *

All those marked with a * require assessment by labour ward staff of the degree of concern and whether middle grade staff should be requested to attend in addition to the first attender. This should be communicated using standard SBAR procedures

First Attender and Middle Grade (Doctor or ANNP carrying the second-on page)

- Caesarean Section under general anaesthesia
- All criteria above marked * where labour ward staff have sufficient concerns
- All emergency calls (2222 calls)
- 29-32 weeks' gestation
- Major concerns re intrapartum fetal wellbeing, e.g.:
  - Significant abruption
  - Any case of suspected fetal haemorrhage (specify this concern to neonatal team)
  - Acute fetal bradycardia
  - Cord prolapse
  - Shoulder dystocia
  - FBS with pH <7.2
- Multiple births <37 weeks
- Fetal anomalies with potential need for immediate resuscitation/stabilisation, e.g.
  - Duct dependent cardiac anomalies
  - Cleft lip/palate
  - Abdominal wall defects
  - Open Spinal defects

} ***NB.*** *A delivery plan should be agreed antenatally. This should include a decision about the staff* } required at delivery. This may included the need } the presence of a consultant or other specialist.

First Attender, Middle grade and Consultant

(A sufficiently experienced neonatal trainee may act up in the role of the Consultant by agreement with the attending consultant)

- <29 weeks' gestation
- Diaphragmatic hernia
- Hydrops fetalis
- Fetal anomalies with potentially immediate life threatening consequences.
- CTG trace suggestive of **fetal asystole** or **severe bradycardia**

It should be borne in mind that consultant staff are not resident out of hours in all units, and are not ordinarily part of the paediatric emergency team. It is the responsibility of the middle grade on call to have accurate contact information for the on call consultant. This may be in the form of a "baton" page or a list of contact numbers.

Local Contact Arrangements - PRM SHO page 12201 Registrar page 12200 Neonatal Nurse page 12202	Consultant Baton page 12210 NB – The baton page is carried by the Neonatal Nurse coordinator when the consultant is not resident. If required, they will contact the on-call consultant at home
Local Contact Arrangements - QEUH SHO } & } - use Red phone 62262 Neonatal Nurse } Registrar page 17690	Consultant Dect phone 82114 The Baton page is carried by the resident consultant who is on site 24/7
Local Arrangements - RAH Neonatal FY2 page 56018 Neonatal FY2 should be accompanied for all deliveries by either: ANNP page 56547 (day time) **OR** Neonatal registrar page 56017	Consultant contact – Contact via Switchboard

There are also a number of circumstances where a team including specialists other than neonatologists should attend delivery, e.g. ENT support for congenital upper airway anomalies. This should be clearly documented in the maternal notes, and the on call neonatal team should be informed as soon as a mother presents in labour.

Attendance by neonatal nursing staff

- Attendance by neonatal nursing staff is determined in part by local arrangements for cover with labour ward.

- In all cases requiring a registrar or consultant a member of the neonatal nursing team should also attend as admission to the neonatal unit would be expected.

- Where nurses/midwives "taking the baby" at a caesarean section will be impinging upon the sterile field (e.g if baby going into a plastic bag, having delayed cord clamping etc), they should scrub and gown in the same way as those at the operating table.

Early neonatal review

A number of fetal/neonatal issues require prompt review by a member of the neonatal team after delivery, but do not require them to be present at delivery. This is primarily to ensure that an investigation/treatment plan is put in place. The neonatal team should be informed of these situations before delivery, and should review the babies ***before they leave labour ward***.

Requiring prompt review:
- Maternal HIV infection – See Neonatal HIV guideline
- Maternal Hepatitis B infection – See Neonatal Immunisation guideline
- Known blood group sensitisation with haemolytic antibodies present (e.g. rhesus incompatibility) – See Neonatal transfusion guideline
- Risk factors for Early Onset Neonatal Sepsis – See Early Onset Sepsis guideline
- Infants at risk of hypoglycaemia – See Neonatal Hypoglycaemia guideline
- Infants at risk of bleeding, e.g. maternal haemophilia carrier, ITP or NAIT
- Other situations where an urgent neonatal review has been requested in the special features section of the maternal notes.

There are a number of situations outwith this that merit review by the neonatal team in the postnatal period, but where there is no need for any intervention immediately, e.g. an infant with antenatally diagnosed renal pelvis dilatation. In these circumstances it is most appropriate that the baby is reviewed on the postnatal ward, and many can wait for normal working hours. As before if there is any doubt about the timing of a review please contact the neonatal team to discuss.

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Other professionals consulted

Title
WoS_AttendanceDeliveries_Neonates

Implementation / review Dates
Implementation - 01/08/2017 Reviewed – 24/04/2024 Next Review – 24/04/2027