Hypoglycaemia – Neonatal Clinical Guideline V2.0
1. **Aim/Purpose of this Guideline**

- **Definition:** Blood Glucose < 2.0mmol/l

- These guidelines are based on the BAPM guidance released May 2017.
- Blood gas machine measurement of Blood Glucose is superior to handheld glucometer measurements at low levels (<2.0mmol/l) and is the recommended standard method for bedside evaluation. Any result <2 mmol/l on a hand held machine should immediately be repeated on a blood gas machine if available.
- Samples should be taken from a warm heel or free-flowing sample.
- This guideline is based on the BAPM Guidance for detecting and treating hypoglycaemia in **term infants**. No equivalent external evidence based guideline exists for preterm infants. Having obtained expert advice on the applicability of this guideline to **preterm infants** (Appendix 4), we recommend the use of flowcharts A or B (as applicable) for preterm infants nursed on neonatal unit, but with a treatment threshold of 3mmol/l in symptomatic preterms.

**Background**

- Prolonged exposure to hypoglycaemia can cause **brain damage**.
- Neonates are known to have a **physiological fall** in their Blood Glucose levels shortly after birth and for this reason Blood Glucose levels are not recommended until pre-second feed (4hrs of age) if the baby is well.
- For the majority of babies physiological fall in Blood Glucose is not a problem if their brains have the normal substrate stores to utilise, but if they don’t they will become **neurologically symptomatic** and require Blood Glucose management sooner.
- **40% Glucose gel** has been found in multiple trials to be **effective and safe** in managing hypoglycaemia with or without a subsequent feed.
- This means that **40% Glucose gel** can now be administered and is not an indication for admission to the NNU.

2. **The Guidance**

**Routine management to prevent hypoglycaemia in all healthy babies**
- Dry and place skin-to-skin with hat on
- Maintain warm ambient room temperature and ensure free from draughts.
- Provide skin to skin and ensure this is not interrupted unless there is a medical indication to do so.
- Provide the mother with:
  - 1. Breastfeeding support
  - 2. Information about recognition of early feeding cues (rapid eye movements under the eye lids, mouth and tongue movements, body movements and sounds, sucking on a fist)
  - 3. Signs of effective attachment.
- Assess and document feeding cues and feeding effectiveness with each feed.
- Offer the breast in response to feeding cues as often as possible.
- Continue feeding support until mother and midwife are satisfied that effective feeding is established.
- If the baby is not showing signs of effective feeding encourage continuous skin-to-skin contact.

2.1 Identifying babies at risk of hypoglycaemia

The following babies are at risk of impaired metabolic adaptation and recognition of clinical signs and are at risk of neurological sequelae of neonatal hypoglycaemia, and measures should be in place to identify them at birth for early milk / energy provision and monitoring of Blood Glucose. Measure Blood Glucose before the second feed at 4 hours of age.

They should be placed on flowchart A “Management of infants (≥ 36+0 weeks) at risk of hypoglycaemia”

2.1.1 Risk factors
- IUGR (birth weight 2nd centile, Table 1), clinically wasted or premature
- Infants of diabetic mothers (gestational, IDDM or type 2)
- Maternal beta-blockers e.g. labetalol in the third trimester or at time of delivery
- Perinatal acidosis (cord arterial or infant pH <7.1 and base deficit ≥ -12mmol/l)

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<tr>
<td>42</td>
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</table>
2.2 Identifying symptomatic babies regardless of risk factors (measure Blood Glucose immediately as part of assessment)

Measurements of Blood Glucose concentration should be performed for any infant who has one or more of the following diagnoses or clinical signs:

- Hypothermia (<36.5°C) not attributed to environmental factors
- Suspected / confirmed early onset sepsis
- Cyanosis
- Apnoea
- Altered level of consciousness
- Seizures
- Hypotonia
- Lethargy
- High pitched cry

Jitteriness is not considered a sign suggestive of hypoglycaemia and not by itself an indication to measure Blood Glucose. Abnormal feeding behaviour (not waking for feeds, not sucking effectively, appearing unsettled and demanding very frequent feeds), especially after a period of feeding well may be indicative of hypoglycaemia.

If a baby has abnormal clinical signs suggestive of hypoglycaemia, Blood Glucose should be measured immediately and urgent review by a paediatrician or advanced neonatal nurse practitioner should be sought. Use flowchart A.

Large for gestational age [LGA] Infants should only be monitored if concerns about Beckwith Wiedeman, Soto’s, Prader-Willi, Turners or Costello syndrome.
Flowchart A. Management of Infants ≥36+0 weeks at risk of hypoglycaemia (Box 1)

- Dry and place baby skin-to-skin care in a warm, draught free room.
- Put hat on baby, and cover with a warm blanket.
- Encourage and support early breast feeding within the first hour after birth.
- For women who chose to formula feed give 10-15ml/kg within the first hour after birth.
- Provide verbal and written information to parents that explains how to prevent hypoglycaemia, why their baby needs blood glucose monitoring, lists signs that may indicate hypoglycaemia (see Box 2), and advises parents to inform a member of the healthcare team if they are concerned about their baby’s well-being (Appendix 1).

Check pre-feed blood glucose level prior to second feed (2-4 hours after birth):
Is the blood glucose level ≥2.0mmol/l?

- YES

- Encourage frequent feeding and ensure no longer than 3 hours between feeds.
- Assess the need for helping the mother with: ongoing help with feeding; hand expression; recognition of early feeding cues; and signs of effective attachment and feeding.
- For women who chose to formula feed; give 10-15ml/kg per feed 3 hourly over the first 24 hours after birth.
- Check blood glucose level prior to third feed (no longer than 8 hours after birth):
Is the blood glucose level ≥2.0mmol/l?

- YES

- Continue to support responsive breast feeding and ensure that mother understands how to assess effective feeding and knows how to escalate concerns.
- If formula fed give 10-15ml/kg per feed 3 hourly over the first 24 hours after birth.
- No further blood glucose monitoring required unless there are clinical signs of hypoglycaemia (Box 2).
- Observe feeding for 24 hours.
- Complete at least one recorded breastfeeding assessment using local / BFI tool prior to transfer home.

- NO

See Flowchart B

Box 1. Infants who require routine blood glucose monitoring
- Intrauterine growth restriction (≤2nd centile for gestation age and sex, refer to BAPM NEWTT thresholds) or clinically wasted
- Infants of diabetic mothers.
- Maternal beta blocker use.

Box 2. Signs that may indicate hypoglycaemia
- Lethargy
- Abnormal feeding behaviour especially after a period of feeding well
- High pitched cry
- Altered level of consciousness
- Hypotonia
- Seizures
- Hypothermia (<36.5°C)
- Cyanosis
- Apnoea

Do not forget additional risk factors
Perinatal acidosis pH <7.1 and/or base excess = >-12

All babies less than 36+0 weeks require routine Blood Glucose monitoring

- **Additional best practice for babies at risk of hypoglycaemia**
  - Dry and place skin-to-skin with hat on
  - Maintain warm ambient room temperature and ensure free from draughts
  - Ensure baby is offered breast within 60 minutes, assessment need for helping the mother with:
    1. breastfeeding support
    2. recognition of early feeding cues (rapid eye movements under the eye lids, mouth and tongue movements, body movements and sounds, sucking on a fist)
    3. Signs of effective attachment.
  - Assess and document feeding cues and feeding effectiveness with each feed.
  - Offer the breast in response to feeding cues as often as possible.
  - Do not allow more than three hours to pass between feeds, until Blood Glucose measurements have been above 2.0mmol/l on two consecutive occasions.
  - Continue feeding support until mother and midwife are satisfied that effective feeding is established.
  - If the baby is not showing signs of effective feeding encourage continuous skin-to-skin contact and teach the mother to hand express.
    Any colostrum expressed should be fed immediately to the baby, using a method that is best suited to the infant’s capabilities and parent’s preferences and consistent with local policy.

2.3 **Management of confirmed hypoglycaemia**

When Blood Glucose measurements are obtained the baby should be placed onto the appropriate flow chart.

**Flowchart B:** First pre-feed Blood Glucose 1.0-1.9mmol/l, and no abnormal signs

**Flowchart C:** First pre-feed Blood Glucose <1.0mmol/l, and / or clinical signs consistent with hypoglycaemia at higher Blood Glucose concentration
Flowchart B. Pre-feed Blood Glucose 1.0 – 1.9mmol/l and no abnormal clinical signs, on NNU, delivery suite or postnatal ward

- Does the baby have clinical signs consistent with hypoglycaemia (Box 1)?
  - NO
    - Repeat one loop, then see Box 3.
  - YES
    - See Flowchart C

- Box 1. Signs that may indicate hypoglycaemia
  - Lethargy
  - Abnormal feeding behaviour especially after a period of feeding well
  - High pitched cry
  - Altered level of consciousness
  - Hypotonia
  - Seizures
  - Hypothermia (<36.5°C)
  - Cyanosis
  - Apnoea

- Box 2. Supporting breast feeding
  - Encourage skin-to-skin contact.
  - Offer breast feed and if not feeding effectively teach mother to hand express.
  - Give colostrum obtained to baby by the method suitable to parents.
  - Continue to encourage hand expression at least 8-10 times in 24 hours and support feeding on the breast until infant is feeding effectively.

- Box 3. If more than 2 measurements 1.0-1.9mmol/l, inform neonatal team.
  - Investigate for causes of hypoglycaemia, consider sepsis.
  - Consider increased feed frequency, nasogastric tube insertion or IV infusion of 10% glucose.

- Give buccal Glucose gel 200mg/kg as part of feeding plan (Appendix 5).
- Support breast feeding (see Box 2).
- If mother is choosing to formula feed, aim to deliver 10-15ml/kg in 3 hourly feed volumes.
- Recheck blood glucose before third feed, no later than 8 hours after birth.
- Is the blood glucose level ≥2.0mmol/l?
  - YES
    - Give feed: breast feed and/or offer expressed breast milk.
    - For formula fed infants give 10-15ml/kg in 3 hourly feed volumes.
    - Recheck blood glucose before next feed. Is the blood glucose level ≥ 2.0mmol/l?
      - YES
        - Continue to support responsive breastfeeding.
        - After 2 consecutive pre-feed BG measurements ≥2.0mmol/l discontinue BG monitoring unless there are abnormal clinical signs (Box 1), in which case use Flowchart C
        - Observe feeding for 24 hours.
        - Complete at least one recorded breastfeeding assessment using local / BFI tool prior to transfer home.
      - NO
        - Repeat one loop, then see Box 3.

Flowchart C. Blood Glucose < 1.0mmol/l or 1.0 to 1.9 mmol/l with clinical signs consistent with hypoglycaemia. ADMIT TO THE NNU

Flowchart C. Blood glucose < 1.0mmol/l and, clinical signs consistent with hypoglycaemia

- Obtain intravenous (i.v.) access.
- Collect blood sample for: laboratory confirmation of blood glucose, hypoglycaemia screening tests and site a urine bag.
- Consider screening and treatment for sepsis.
- Admit to Neonatal Unit.

Unable to obtain immediate iV access

- Give i.v. 10% glucose 2.5ml/kg.
- Start IV infusion of 10% glucose at 60ml/kg/d.

- 40% Glucose gel >200mg/kg massaged into the buccal mucosa can be given while i.v. access is obtained OR intramuscular glucagon (200micrograms/kg)

- Do not stop the establishment of breast feeding unless the baby is too sick to feed or there is a clinical contraindication to enteral feeding. Support expression of breast milk.
- In formula fed infants, continue feeds if no contraindication to enteral feeding.
- Recheck blood glucose after 30 minutes.

Blood glucose < 1.0mmol/l or abnormal clinical signs.
- Give IV 10% glucose 2.5ml/kg.
- Increase glucose delivery rate by 2mg/kg/minute by increasing volume and/or concentration of glucose infusion*.
- Recheck BG after 30 minutes.
- Repeat cycle if BG < 1.0mmol/l or there are abnormal clinical signs

Blood glucose > 2.5mmol/l.
- Slow wean of i.v. infusion.
- Continue enteral feeds.
- Continue to monitor blood glucose until infant is on full enteral feeds and blood glucose values are >2.5mmol/l or 3.0mmol/l in cases of hyperinsulinism over several fast-feed cycles for at least 24 hours

*If glucose infusion rate >8mg/kg/min, test for hyperinsulinism


Note:
2 mg/kg/minute = 30 ml/kg/day
Appendix 2 Management of reluctant feeding in healthy term infants ≥ 37 weeks

Late preterm infants – see Appendix 4
Appendix 3 Treating with 40% oral Glucose gel (≥ 36 weeks)

2.4 Consideration:
Infants being managed using the pathway in Flowchart A are fed within the first 60 minutes and must have a Blood Glucose level measured prior to the 2nd feed (2 – 4 hours after birth).

If the first BG is 1.0-1.9mmol/l or there is a subsequent Blood Glucose measurement <2.0mmol/l, 40% buccal Glucose gel (200mg/kg) should be given alongside a feeding support plan.

2.5 Indications
- Blood Glucose 1.0-1.9mmol/l in infant with no abnormal clinical signs

2.6 Notes
- Must be used in conjunction with a feeding plan
- For babies with severe hypoglycaemia (Blood Glucose <1.0mmol/l) use 40% oral Glucose gel only as an interim measure while arranging for urgent medical review and treatment with Intravenous Glucose

2.7 Dose
- Use 200mg/kg Glucose gel (0.5 ml/kg of 40% Glucose gel), up to two doses given 30 minutes apart per episode of hypoglycaemia and a maximum of six doses of buccal Glucose gel in 48 hours.

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<thead>
<tr>
<th>Weight of baby (kg)</th>
<th>Volume of gel (ml)</th>
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<tbody>
<tr>
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<td>1</td>
</tr>
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<td>2.0-2.99</td>
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</tr>
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<td>3.0</td>
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<tr>
<td>6.0-6.99</td>
<td>3.5</td>
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</table>

2.8 Method of administration
- Draw up correct volume of 40% Glucose gel using an oral/enteral syringe
- Dry oral mucosa with gauze, gently squeeze in gel with syringe onto the inner cheek and massage gel into the mucosa using latex-free gloves
- Offer a feed preferably breast milk, immediately after administering 40% dextrose gel.
- Repeat Blood Glucose measurement as requested – normally 1 hour post completion of the feed.
- Repeat 40% Glucose gel if baby remains hypoglycaemic according to flow chart.
• Up to 6 doses can be given over a 48-hour period **BUT ANY MORE THAN ONE DOSE SHOULD BE DISCUSSED WITH THE NEONATAL TEAM AND IT IS ADVISABLE FOR THE BABY TO BE EXAMINED BEFORE THE 3RD DOSE IS ADMINISTERED.**

### 2.9 Once admitted to the NNU

Further investigations for hypoglycaemia should be considered:
- In the case of suspected sepsis
- If there has been >2 episodes Blood Glucose <2.0mmol/l in 48hrs
- If Blood Glucose <1.0mmol/l
- If Blood Glucose <2.5mmol/l and the baby has altered neurology
- If baby is requiring >8.0mg/kg/min dextrose to maintain sugars (think hyperinsulinism)
- If diagnosed with hyperinsulinism aim for >3.0mmol/l
- Babies with proven Hypoxic Ischemic Encephalopathy aim for Blood Glucose ≥ 3.0mmol/l. Reference is Dr J Hawdon See appendix 4

#### Hypoglycaemia screening bloods: (should only be taken if the Blood Glucose < 2.0mmol/l as results not valid)

<table>
<thead>
<tr>
<th>Fluoride (grey top)</th>
<th>Glucose and lactate if not on gas</th>
<th>1.0 mL</th>
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</thead>
<tbody>
<tr>
<td>Lithium heparin (green top) or SST (yellow)</td>
<td>U&amp;E and LFT</td>
<td>1.0 mL</td>
</tr>
<tr>
<td>EDTA (purple top)</td>
<td>Ammonia to be sent on ice to lab immediately</td>
<td>1.0 mL</td>
</tr>
<tr>
<td>EDTA (purple top)</td>
<td>Insulin</td>
<td>1.0 mL</td>
</tr>
<tr>
<td>SST (yellow top)</td>
<td>Cortisol</td>
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</table>

Discuss with consultant in regard to additional blood tests.

<table>
<thead>
<tr>
<th>Fluoride (grey top)</th>
<th>B-Hydroxybutyrate Free fatty acids</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>Plasma amino acids</td>
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</tr>
<tr>
<td>EDTA (purple top)</td>
<td>Insulin C - peptide</td>
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<tr>
<td>SST (yellow top)</td>
<td>Very long chain fatty acids 17-Hydroxyprogesterone Salicylate</td>
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<tr>
<td>EDTA (purple top)</td>
<td>ACTH sent on ice</td>
<td>1.0 mL</td>
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</table>
Ongoing care once Blood Glucose levels normalise

Transfer babies with risk factors for impaired metabolic adaptation and hypoglycaemia to community care you are satisfied that the baby is maintaining Blood Glucose levels >2.0mmol/l on at least two consecutive occasions and is feeding well.

Infants at risk of hypoglycaemia should not be transferred to the community until they are at least 24 hours old.

This clinical guideline is based on the British Association of Perinatal Medicine [BAPM] Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant – A Framework for Practice April 2017. A full version of this can be found at: [http://www.bapm.org/publications/Hypoglycaemia%20F4P%20May%202017.pdf](http://www.bapm.org/publications/Hypoglycaemia%20F4P%20May%202017.pdf)

Appendix 4
From: HAWDON, Jane (ROYAL FREE LONDON NHS FOUNDATION TRUST)
Sent: 15 June 2017 08:25
To: JONES, Steve (ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST)
Cc: SHANMUGALINGAM, shanthi (ROYAL FREE LONDON NHS FOUNDATION TRUST)
Subject: RE: guideline for screening in late preterm and preterm infants

I would say the principles are the same. For the late preterm baby cared for with mother the same thresholds and interventions apply. For the more preterm baby receiving standard neonatal unit care, it is actually quite rare to become hypoglycaemic. Even less evidence base for thresholds in this group. For a sicker baby some teams use a higher threshold e.g. 3mmol/l which would be reasonable.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Key changes to practice</th>
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<tbody>
<tr>
<td>Lead</td>
<td>Dr Paul Munyard</td>
</tr>
<tr>
<td></td>
<td>Lel George</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit</td>
</tr>
<tr>
<td>Frequency</td>
<td>As dictated by audit findings</td>
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<tr>
<td>Reporting arrangements</td>
<td>Child Health Directorate Audit and Neonatal Clinical Guidelines</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Dr Paul Munyard, consultant Paediatrician and Neonatologist</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required Changes in Practice will be identified and actioned within 3 months</td>
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4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
# Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Hypoglycaemia – Neonatal Clinical Guideline V2.0</th>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>27th November 2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>27th November 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>27th November 2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Ms Lel George ANNP, Dr Paul Munyard, Consultant Paediatrician</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872252681</td>
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<tr>
<td>Brief summary of contents</td>
<td>Definition, identification and management of neonatal hypoglycaemia</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Neonatal, hypoglycaemia, low blood sugar, glucose gel, Reluctant feeder</td>
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<td>Target Audience</td>
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<td>Medical Director</td>
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<tr>
<td>Date revised:</td>
<td>16/11/2017</td>
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<tr>
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<td>Hypoglycaemia – Neonatal Clinical Guideline V1.0</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Neonatal Guidelines Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>David Smith</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>‘Not Required’</td>
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<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed} Name: Caroline Amukusana</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and)</td>
<td>Internet &amp; Intranet [✓] Intranet Only</td>
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Ratification):

Document Library Folder/Sub Folder  Clinical / Neonatal

Links to key external standards  http://www.bapm.org/publications/Hypoglycaemia%20F4P%20May%202017.pdf

Related Documents:  Infant feeding Policy, Enteral Feeding Of Preterm Infants

Training Need Identified?  Neonatal medical and nursing staff, midwifery staff

Version Control Table

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<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>V1.0</td>
<td>Original Guideline</td>
<td>Dr Paul Munyard</td>
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<tr>
<td>November 2017</td>
<td>V 2.0</td>
<td>New National BAPM Guidance incorporated</td>
<td>Dr Paul Munyard and Lel George (ANNP)</td>
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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

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### Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

| Name of Name of the strategy / policy / proposal / service function to be assessed | Hypoglycaemia – Neonatal Clinical Guideline V2.0 |
| --- |
| Directorate and service area: |  |
| Women, Children and Sexual Health | Is this a new or existing *Policy?* |
| Existing |  |
| Name of individual completing assessment: | Dr Paul Munyard |
| Telephone: | 01872252681 |
| 1. *Policy Aim* | Aimed at clinical staff who manage newborns, (midwifery and neonatal staff) Diagnosis and management addressed |
| Who is the strategy / policy / proposal / service function aimed at? |  |
| 2. *Policy Objectives* | Prompt identification and management of neonatal hypoglycaemia |
| 3. *Policy – intended Outcomes* | Audit |
| 4. *How will you measure the outcome?* | Audit |
| 5. Who is intended to benefit from the policy? | Neonatal patients |
| 6a Who did you consult with | Workforce | Patients | Local groups | External organisations | Other |
| b). Please identify the groups who have been consulted about this procedure. | x |  |  |  |  |
| Please record specific names of groups | Neonatal guidelines group from British Association of Perinatal Medicine |
7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy **could** have differential impact on:

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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

What was the outcome of the consultation?  Localisation of national guidance
8. Please indicate if a full equality analysis is recommended. | Yes | No |
---|---|---

9. If you are **not** recommending a Full Impact assessment please explain why.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>No areas identified</td>
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<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
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</thead>
<tbody>
<tr>
<td>Dr Paul Munyard</td>
<td>16/11/2017</td>
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</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Dr Paul Munyard</td>
<td></td>
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<tr>
<td>2. Human Rights, Equality &amp; Inclusion Lead</td>
<td></td>
</tr>
</tbody>
</table>

**Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead**
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

**This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.**

A summary of the results will be published on the Trust’s web site.

Signed **Dr Paul Munyard**

Date **27/11/2017**