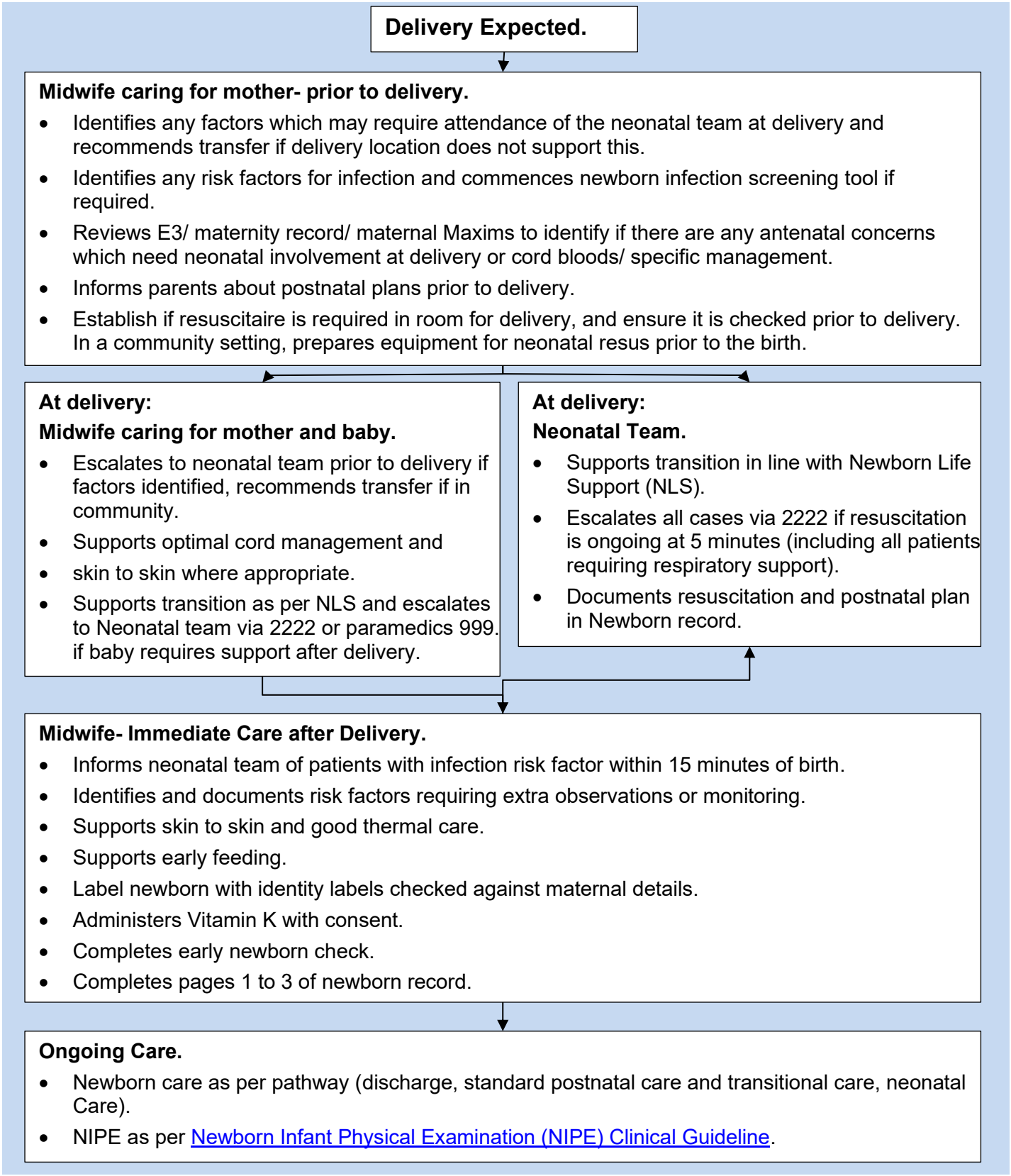
Royal Cornwall Hospitals
NHS Trust

Care of the Newborn Clinical Guideline

V4.1

December 2025

Summary


Delivery Expected.
Midwife caring for mother- prior to delivery.
• Identifies any factors which may require attendance of the neonatal team at delivery and recommends transfer if delivery location does not support this.
• Identifies any risk factors for infection and commences newborn infection screening tool if required.
• Reviews E3/ maternity record/ maternal Maxims to identify if there are any antenatal concerns which need neonatal involvement at delivery or cord bloods/ specific management.
• Informs parents about postnatal plans prior to delivery.
• Establish if resuscitaire is required in room for delivery, and ensure it is checked prior to delivery. In a community setting, prepares equipment for neonatal resus prior to the birth.
At delivery:
Midwife caring for mother and baby.
• Escalates to neonatal team prior to delivery if factors identified, recommends transfer if in community.
• Supports optimal cord management and
• skin to skin where appropriate.
• Supports transition as per NLS and escalates to Neonatal team via 2222 or paramedics 999. if baby requires support after delivery.
At delivery:
Neonatal Team.
• Supports transition in line with Newborn Life Support (NLS).
• Escalates all cases via 2222 if resuscitation is ongoing at 5 minutes (including all patients requiring respiratory support).
• Documents resuscitation and postnatal plan in Newborn record.
Midwife- Immediate Care after Delivery.
• Informs neonatal team of patients with infection risk factor within 15 minutes of birth.
• Identifies and documents risk factors requiring extra observations or monitoring.
• Supports skin to skin and good thermal care.
• Supports early feeding.
• Label newborn with identity labels checked against maternal details.
• Administers Vitamin K with consent.
• Completes early newborn check.
• Completes pages 1 to 3 of newborn record.
Ongoing Care.
• Newborn care as per pathway (discharge, standard postnatal care and transitional care, neonatal Care).
• NIPE as per Newborn Infant Physical Examination (NIPE) Clinical Guideline.

1. Aim/Purpose of this Guideline

1.1. This guideline applies to:

1.1.1. The midwife providing care to a woman in labour, or when delivery is expected.

1.1.2. The midwife providing care to a neonate post delivery.

1.1.3. Any members of the neonatal or midwifery team reviewing a neonate within a maternity, postnatal or neonatal setting.

1.2. This version supersedes any previous versions of this document.

1.3. The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Newborn infants at term gestation usually require no more than adequate drying, a clear airway and warmth to support adaptation to extra uterine life.

2.2. Risk factors for infection or impaired perinatal adaptation should be identified and documented in the newborn record. If these may affect normal transition at delivery (e.g., presence of meconium-stained liquor or prematurity) then the neonatal team should be informed prior to delivery.

2.3. Any antenatal concerns which have been identified should have a plan of care in the mother's Maxims record under "patient documents" by the clinician instigating the alert and inform the relevant community midwife/ hospital midwife to upload to E3 from the Neonatal Consultant. This should be checked on the woman's arrival and any plan of care placed in the baby notes and the Neonatal team contacted, as necessary.

2.4. **Delivery**

2.4.1. Ensure the room is warm and draught free before delivery of the baby.

2.4.2. Ensure delivery is taking place in an appropriate location, if in community with risk factors present or concerns, recommend transfer and call 999.

2.4.3. Ensure that a resuscitation equipment is prepared including a resuscitaire in the room in hospital settings if there are any risk factors for impaired transition/ perinatal adaptation.

2.4.4. Supporting transition/ resuscitation of the newborn should be in line with newborn life support (NLS) guidance.

2.4.5. Immediate cord clamping is only indicated where there is evidence of significant fetal compromise and resuscitation with cord intact is not possible.

2.4.6. Towel dry baby's skin then cover with a dry towel whilst assessing the baby's tone, colour, respiratory effort, and heart rate.

2.4.7. If babies require support post delivery and the neonatal team are not in attendance, or if resuscitation is ongoing at 5 minutes (including face mask PEEP (positive end expiratory pressure)), then a 2222 neonatal emergency call should be called out (in hospital) or via 999 paramedic call (in community).

2.4.8. Support skin to skin as soon as possible.

2.4.9. Apply two Identity labels, cross checked for accuracy with a parent as per Trust patient identification policy. For hospital deliveries- initially this should be handwritten with the mother's name, baby's date of birth and the mothers CR number and once a printed label is available this should be applied to one ankle and the mothers CR remain on the second ankle. Put a hat on baby.

2.5. Initial feeding and thermal care

2.5.1. Allow baby to remain in warm contact with mother to optimise early breastfeeding as per Baby Friendly Initiative (BFI) standard seven, RCHT (Royal Cornwall Hospitals NHS Trust) Enteral feeding policy, and RCHT Neonatal Hypoglycaemia Management Guideline or offer milk feed of mother's choice within first hour of life.

2.5.2. A transwarmer should be used for any babies requiring resuscitation in the community setting to optimise thermoregulation.

2.5.3. Check baby's temperature and record on infant record. If baby's temperature is below 36.5° centigrade warm the baby under a radiant heater, and when they are 37.0˚C, then put skin to skin if possible, cover the baby with a warm blanket and hat, encourage a breast/ warm feed. If temperature not ≥36.5°C within one hour or if in community transfer into RCHT, maintaining skin to skin. Use a transwarmer during transfer if

skin to skin not possible or appropriate.

2.5.4. Administer Vitamin K with parental consent (see Vitamin K Administration Neonatal Clinical Guideline).

2.6. Additional observations for infants (NEWTT (Newborn Early Warning Trigger and Track))

2.6.1. Single infection risk factor:

12 hours minimum - one hour, second hour then two hourly.

2.6.2. Thick, particulate meconium or babies who have received newborn life support at delivery in the presence of meconium stained liquor:

12 hours minimum- one hour, second hour then two hourly.

2.6.3. All other newborns where meconium is present observe for two hours minimum, one hour, second hour.

2.6.4. Infants requiring IV (intra venous) antibiotics or phototherapy:

Four hourly for duration of treatment.

2.6.5. Infants requiring NAS (neonatal abstinence syndrome) observations:

One hour post feed for 72 hours.

2.6.6. Infants requiring SSRI (selective serotonin reuptake inhibitor) observations:

One hour post feed for 48 hours (see Maternal Use of SSRI's Neonatal Clinical Guideline for more detail).

2.6.7. Infants defined as requiring additional observations as per BAPM (British Association of Perinatal Medicine) NEWTT framework for practice (see below)- **12 hours minimum- One hour, second hour then four hourly.**

2.6.7.1. Requiring NIPPV (nasal intermittent positive pressure ventilation) at 5 minutes.

2.6.7.2. Cord pH ≤7.1.

2.6.7.3. APGAR ≤7 at five minutes.

2.6.7.4. BE ≤-12.

2.6.7.5. Maternal beta blocker use.

2.6.7.6. Maternal diabetes.

2.6.7.7. Growth restriction (any of <2nd centile or <2.5kg or clinically wasted) or prematurity (34-36+6 weeks).

2.6.7.8. Hypothermia unresponsive to thermal care.

2.6.7.9. Feeding concerns.

2.6.7.10. Elective LSCS (lower uterine segment caesarean section) <39 weeks of gestation

2.6.7.11. If resuscitation has been required at birth in a community setting, transfer should be recommended for neonatal review and ongoing observation.

2.7. Examination of the newborn

2.7.1. Examine baby in front of parents in a warm environment. Explain this initial check is the first of a series of child health checks to monitor baby's progress. Any suspected abnormalities should be escalated to a senior midwife/ the neonatal team.

2.7.2. Review the mother's notes and medical history, progress during pregnancy, labour and delivery details and condition of the baby at birth. Babies who require additional observations should have these documented on a NEWTT chart.

2.7.3. Weigh baby and record weight in the appropriate midwifery and neonatal records. All babies born less than 2.5kg should be managed as per the Birth Weight Less Than 2.5kg (Neonates) Standard Operating Procedure. A plan for discharge or ongoing admission should be discussed with the Neonatal Registrar after 12 hours of NEWS (national early warning score) observations are complete.

2.7.4. The midwife needs to employ a systematic method of examining the whole baby looking for any skin problems, dysmorphic features, and congenital abnormalities, circumnavigating the midline.

2.7.5. The baby's colour, breathing pattern, behaviour, activity, and posture should be noted.

2.7.6. Examine the head, including fontanelles, palpate sutures; observe face, nose, philtrum, mouth including palate for clefts and tongue for size or ankyloglossia, natal teeth. Check ear position, shape, report any pits or tags. Check general symmetry of head and facial features. Note any bruising, caput or moulding of the head and any iatrogenic marks e.g., forceps marks, ventouse chignon. Check the eyes for any subconjunctival haemorrhages (document on NIPE), exudate, movement, and opacities. Palpate the neck and clavicles.

2.7.7. Chest: observe chest shape, presence of nipples, respiratory effort, respiratory rate any inspiratory or expiratory sounds. Check central capillary refill time (2-3 seconds to refill normal) Check pulse oximetry as per Newborn Infant Physical Examination (NIPE) Clinical Guideline.

2.7.8. Abdomen: check for abnormality and condition of umbilical cord.

2.7.9. Genitalia and anus: check for normal position of urethral and anal openings.

2.7.10. Spine: inspect and palpate bony structures and check integrity of the skin.

2.7.11. Skin: note colour and texture as well as any birthmarks or rashes.

2.7.12. Central nervous system: observe tone, behaviour, movements, and posture.

2.7.13. Limbs: Examine arms, hands, legs, feet, and digits; assess proportions, symmetry and movement of the limbs and skin folds.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	• Is the baby's temperature documented in the immediate care after birth page. • If temperature below normal limits, was the appropriate action taken. • The audit will be registered with the Trust' audit department. • This guideline will be included in the audit programme. The audit lead will identify an appropriate health professional to review 10 random sets of babies' notes with any associated Datix record.
Lead	Audit Midwives.
Tool	• Was a temperature detected? • Was there clear documentation of the concern? • Was a timely referral made to the ANNP (Advanced Neonatal Nurse Practitioner)/ SHO (Senior House Officer)/ SPR (Specialty Registrar) • Was the review documented? • Was a clear plan of care documented? • Was it documented that the parents were kept informed throughout the process? Adherence to guidelines will be monitored as part of the ongoing audit process within the department on a Word or Excel template specific to the topic.

Information Category	Detail of process and methodology for monitoring compliance
Frequency	1% or 10 sets, whichever is the greatest, of all health records of women who have delivered, will be audited over the life time of this guideline.
Reporting arrangements	A formal report of the results will be received at the maternity risk management forum.
Acting on recommendations and Lead(s)	Any deficiencies identified will be discussed at maternity risk management forum and an action plan developed.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

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 And Inclusion 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

Information Category	Detailed Information
Document Title:	Care of the Newborn Clinical Guideline V4.1
This document replaces (exact title of previous version):	Care of the Newborn Clinical Guideline V4.0
Date Issued/Approved:	December 2025
Date Valid From:	December 2025
Date Valid To:	July 2028
Directorate / Department responsible (author/owner):	Dr Chris Bell; Neonatal Consultant
Contact details:	01872 252667
Brief summary of contents:	To provide guidance for the immediate care and examination of newborn infants for all clinical staff working in the Women, Children and HIV Care Group.
Suggested Keywords:	Care, Examination, Newborn, Neonate, NIPE, hot cot, weaning.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Meeting
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Michael Cross

Information Category	Detailed Information
Links to key external standards:	None required
Related Documents:	1. Newborn Life Support. Resuscitation Council UK https://www.resus.org.uk/resuscitation-guidelines/ 2. Early onset neonatal bacterial infection prevention, diagnosis, and Treatment RCHT guideline. 3. Rupture of Membranes at Term (Term PROM) – RCHT Guideline. 4. Meconium Stained Liquor in Labour and Management of the Newborn – RCHT Clinical Guideline. 5. Newborn Life Support guideline, Transfer and Admission of the Sick Newborn to the Neonatal Unit and Support for Parents – RCHT 6. Baby Friendly Initiative 2010 www.babyfriendly.org.uk 7. NICE Clinical Guideline https://www.nice.org.uk/guidance/qs37 Postnatal Care July 2013 8. RCHT Identification Policy. 9. RCHT Breastfeeding Policy. 10. RCHT Guideline for management of newborn hypoglycaemia. 11. RCHT Guideline for neonatal temperature management. 12. Newborn and infant physical examination NIPE: clinical guidance NHS Health England 2014: https://www.gov.uk/government/collections/newborn-and-infant-physical-examination-clinical-guidance
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Newborn Care

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
April 2016	V1.0	Updated pathways and references.	Judith Clegg, ANNP
February 2019	V2.0	Updated flowchart to include care pathway for respiratory concerns. RAG rating for hat colour and ongoing NEWS observations.	Judith Clegg, ANNP
March 2021	V2.1	Addition of 2.6.3. All babies less than 2.5kg should have 12 hours of NEWS observations completed, discuss a plan with the registrar when observations are complete, any concerns prior to completion of observations should be escalated to neonatal team.	Chris Warren, Neonatal Consultant
May 2022	V3.0	Full review and formatting update. Appendix 3 added- “Supporting Newborn Care”. Wording changed in section 2.4.7 and 2.4.8. Vitamin K policy referral updated.	Chris Bell; Neonatal Consultant
July 2022	V3.1	Amendments to appendix 3. Added bottle feeding support. Added 35 and 36 week infants to the blood glucose 2nd centile/birth weight table. Added wet nappy and stool output table.	Lesley George: ANNP

Date	Version Number	Summary of Changes	Changes Made by
September 2023	V3.2	Updated to new Trust format. Section 2.5.2. amended. Appendix 4 added. Hot cot flowchart in appendix 3 updated.	Charlotte Lea; Neonatal Consultant
October 2024	V3.3	2.6.1 Single infection risk factor or Meconium requiring observation - 12 hours minimum - one hour, second hour then two hourly. 2.6.3 Infants requiring NAS observations - 1-hour post feed for 72 hours. 2.6.4 Infants requiring SSRI observations- 1 hour post feed for 48 hours (see SSRI guidance for more detail) due to change, Chris Warren updating guideline. 2.5.3. If baby's temperature is below 36.5° centigrade warm the baby under a radiant heater, and when they are 37.0˚C. Remove as no longer available - Refer to RCHT neonatal temperature management guideline. 2.7.6 Check the eyes for subconjunctival haemorrhages (document on NIPE). 2.5.2. section added. Full review and update as required from Community Midwifery perspective.	Lel George; Advanced Neonatal Nurse Practitioner
May 2025	V4.0	Key words updated. Reference to hot cot guideline removed. Appendix 3, supporting thermoregulation in at risk infants actions amended.	Charlotte Lea; Neonatal Consultant.
December 2025	V4.1	Guidance regarding additional observations for infants with risk factors amended at section 2.6 and appendix 3.	Ellie Lawes; Neonatal Consultant

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Care of the Newborn Clinical Guideline V4.1
Directorate and service area:	Neonatal
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines group
Contact details:	01872 252667

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To assist staff caring for newborn infants.
2. Policy Objectives	To ensure a systematic approach of immediate care and examination of the newborn.
3. Policy Intended Outcomes	To ensure a systematic approach of immediate care and examination of the newborn.
4. How will you measure each outcome?	Auditing tool.
5. Who is intended to benefit from the policy?	All Neonatal infants.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Neonatal Audit and Guidelines Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer needs- i.e., available in different languages if required/access to an interpreter if required.
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Supporting Newborn Care- Routine care for all infants and those at risk of impaired perinatal adaptation.

First Hour of Care for all Babies

Babies at risk of impaired perinatal adaptation should be identified and managed in line with the appropriate guidelines as outlined within the newborn care guideline. These can be found within the newborn and neonatal care guidelines pages and include:

- Jaundice in the First Two Weeks Of Life Clinical Guideline.
- Birth Weight Less Than 2.5kg Standard Operating Procedure.
- Hypoglycaemia Neonatal Clinical Guideline.
- Infection In Neonates Early and Late Onset Clinical Guideline.
- Maternal Use of SSRIs Neonatal Clinical Guideline.
- Neonatal Abstinence Syndrome (NAS).
- Prematurity SOP for infants born 34+0 to 36+6 weeks.

All babies	Care	Action
Skin to skin	Where possible mothers will be offered the opportunity to have uninterrupted skin contact with their baby at least until after the first feed and for as long as they want. Birth partner to do skin to skin only if mother unable to.	• Dry baby. • Place baby naked directly on mother's chest. • Cover baby and mother with a blanket- ensuring babies airway is correctly positioned and that they remain visible and observed. • Put hat on baby's head.
First feed	Support first feed (breast/ formula)- ensure it is effective: **Effective feed** • 5- 45 minutes. • Full, round cheeks. • Rhythmical sucking and swallowing. • Comfortable for mother.	• Continue skin to skin. • Support the mother to hand express (if breastfeeding). • Document the feed in the Newborn Record- page 2 under "Feeding".
Thermoregulation	• Ensure baby is fully dried. • Measure axilla temperature • Put a hat on the baby. • Ensure the room temperature is >22°C and windows closed/turn off fans. • Babies not having skin to skin should be dressed.	• If <36.5 (degrees c) see appropriate flow chart below.

Observations for “at risk” infants

Single infection risk factor:

12 hours minimum - 1 hour, second hour then 2 hourly.

Thick, particulate meconium or babies who have received newborn life support at delivery in the presence of meconium stained liquor:

12 hours minimum- 1 hour, second hour then 2 hourly.

All other newborns where meconium is present

Observe for 2 hours minimum, 1 hour, second hour.

Infants requiring IV antibiotics or phototherapy:

4 hourly for duration of treatment.

Infants requiring NAS observations:

1 hour post feed for 48 hours.

Infants requiring SSRI observations:

1 hour post feed for 72 hours* (see SSRI guidance for more detail).

Infants defined as requiring additional observations as per BAPM NEWTT framework for practice:

- **Requiring NIPPV at 5 minutes.**
- **cord pH ≤7.1.**
- **APGAR ≤7 at 5 minutes.**
- **BE ≤-12.**
- Maternal beta blocker use.
- Maternal diabetes.
- Growth restriction <2.5kg or <2nd centile.
- Prematurity (34-36+6 weeks).

12 hours minimum- First hour, second hour then 4 hourly.

Routine Hypoglycaemia monitoring

Routine monitoring of blood sugar should occur in the following infants:

- Intrauterine growth restriction (birth weight 2nd centile, see table below) or clinically wasted.

Birthweight on 2nd centile/Kg		
Gestational age in weeks	Boys	Girls
35	1.70 admit to Neonatal Unit (NNU)	<1.8 admit to NNU
36	1.90	1.8 admit to NNU
37	2.10	2.00
38	2.30	2.20
39	2.50	2.45
40	2.65	2.60
41	2.80	2.75
42	2.90	2.85

- Infants of diabetic mothers.
- Infants of mothers taking beta-blockers in the third trimester and/ or at time of delivery.
- Preterm infants <37 weeks.
- Perinatal acidosis pH <7.1 or base deficit ≥ -12.
- Symptomatic babies regardless of risk factors, any 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.

Supporting infants at risk of hypoglycaemia:

- Maintain a warm room, free from draughts.
- Ensure baby's dry and place skin to skin with hat on.
- Ensure the baby is warm, axilla temperature ≥36.5℃.
- Ensure an effective feed within the first hour following delivery.
- Monitor blood glucose (on blood gas machine) pre second feed AND encourage second feed within 4 hours following delivery.

Escalation for abnormal blood sugar results:

- If blood glucose 1.0-1.9mmol/L for babies ≥37 weeks or 1.5-2.6mmol/L for babies ≤36+6 weeks with no abnormal clinical signs give buccal glucogel see Appendix 3 for dosage AND an effective breast feed or 10-15ml/kg formula.
- If the next blood glucose 1.0-1.9mmol/L for babies ≥37 weeks or 1.5-2.6mmol/L for babies ≤36+6 weeks with no abnormal clinical signs repeat step above.
- If < 1.0mmol/l for or more than 2 measurements 1.0-1.9mmol/l for babies ≥37 weeks or 1.5-2.6 for babies ≤36+6 weeks - **Inform Neonatal ANNP/SHO IMMEDIATELY.**

Supporting thermoregulation in "at risk infants"

For all babies:

- Measure axilla temperature (as per guideline).
- Put a hat on the baby, for the first 12 hours.
- Appropriate warm and dry clothing and bedding.
- Ensure the room temperature is >22°C and close windows and turn off fans.
- Encourage skin to skin.
- If <36.5 (degrees c) see appropriate flow chart below.

Hot Cot Guidance

Discuss any infant with persistent low temperature with the neonatal team.

Hot cot can be initiated and weaned as per the following protocol:

Commence Hot Cot at 38°C

Cover the mattress with a thin sheet.

Dress the baby in one thin baby grow.

Use two layers of blanket only (1 x purple thermal blanket + 1 x thin knitted blanket OR 1 x purple blanket folded).

Check the infant's temperature 30 minutes after starting.

If the infant's temperature is above 37.5°C, reduce mattress temperature by 0.5°C until within normal parameters.

Check temperature every 30 minutes until a stable normo-thermic temperature is achieved, then at least 4 hourly, adjusting the mattress accordingly.

Keep the infant in the hot cot turned off until you are happy the heat source is no longer needed.

Dress the baby in a vest and baby grow and cover with 2 blankets.

Weaning a Hot Cot

Reduce by 0.5°C if the infant's temperature >36.9°C.

Repeat until the Hot Cot is set to 36.5°C.

Criteria for Hot Cot

- ≥ 34 weeks gestation.
- ≥1.6kg.
- Medically stable.
- Tolerating feeds.
- Stable in incubator ≥32°C.

If the axilla temperature is below 36.6°C the mattress can be increased to a maximum of 39.0°C. If the infant is still unable to maintain a normo- thermic temperature, consider using a radiant heater and inform the Nurse in Charge and the medical team.

Jaundice - Infants at increased risk of jaundice

- Known antibodies.
- Rhesus negative mothers.
- Babies with bruising.
- IUGR/Premature <38/40.
- Babies with sepsis.
- Previous sibling treated for jaundice.
- Poor feeding.
- Exclusively breastfeeding.
- Ethnicity – Asian, African, Mediterranean (G6PD risk).
- Family history of spherocytosis.

Management of infants with jaundice, or those with increased risk of jaundice

- If baby appears clinically jaundiced at < 24 hours – baby needs urgent neonatal review.
- Commence **appropriate gestational age phototherapy chart** – ask an independent member of staff to check that the phototherapy chart and time of birth are correct– both sign the chart.
- Any preterm infants should be **closely monitored** for jaundice and considered whether an SBR (serum bilirubin) is indicated within their first 24 hours since birth.
- Monitor babies >35 weeks' and over 24 hours old, that have **not received** phototherapy with TCB's (transcutaneous bilirubin) 6 hourly (as per guideline). If TCB > 250 or > the treatment line, take an SBR.
- Babies requiring phototherapy monitor SBR (as per guideline).
- Ensure bloods are sent for FBC (full blood count) and DAT (direct antiglobulin test) for babies starting phototherapy for their first time.
- Ensure effective feeding (may need a nasogastric tube if not effectively feeding).
- Ensure baby only comes out of phototherapy for 30 minutes for feeds.
- Monitor 4 hourly observations, especially temperature, if ≤36.5℃ inform Dr/ ANNP.

N.B. Please **double sign all** SBR/ TCB measurements on the phototherapy chart.

Supporting breast feeding

- Encourage skin to skin.
- Continue to observe and document feed (if concerns about effective feeding/ latch), talk about baby's feeding behaviour and signs to look out for.
- Consider if glucose monitoring is indicated (maternal medical history), see hypoglycaemia care plan.
- Ensure feeds are supported at least 3 hourly.
- If reluctant to feed refer to the 'reluctant feeding guideline'.
- If supplementing feeds refer to "alternative methods of giving formula or breast milk guideline" where appropriate.
- If not managing to latch and feed effectively, consider the need for a nasogastric tube, discuss with ANNP/ SHO/ IFT.
- If latching and managing effective feeds aim for responsive feeding.
- Monitor wet nappies and stools.
- Weigh on day 3 and 5, review weight loss with "management of weight loss guideline".

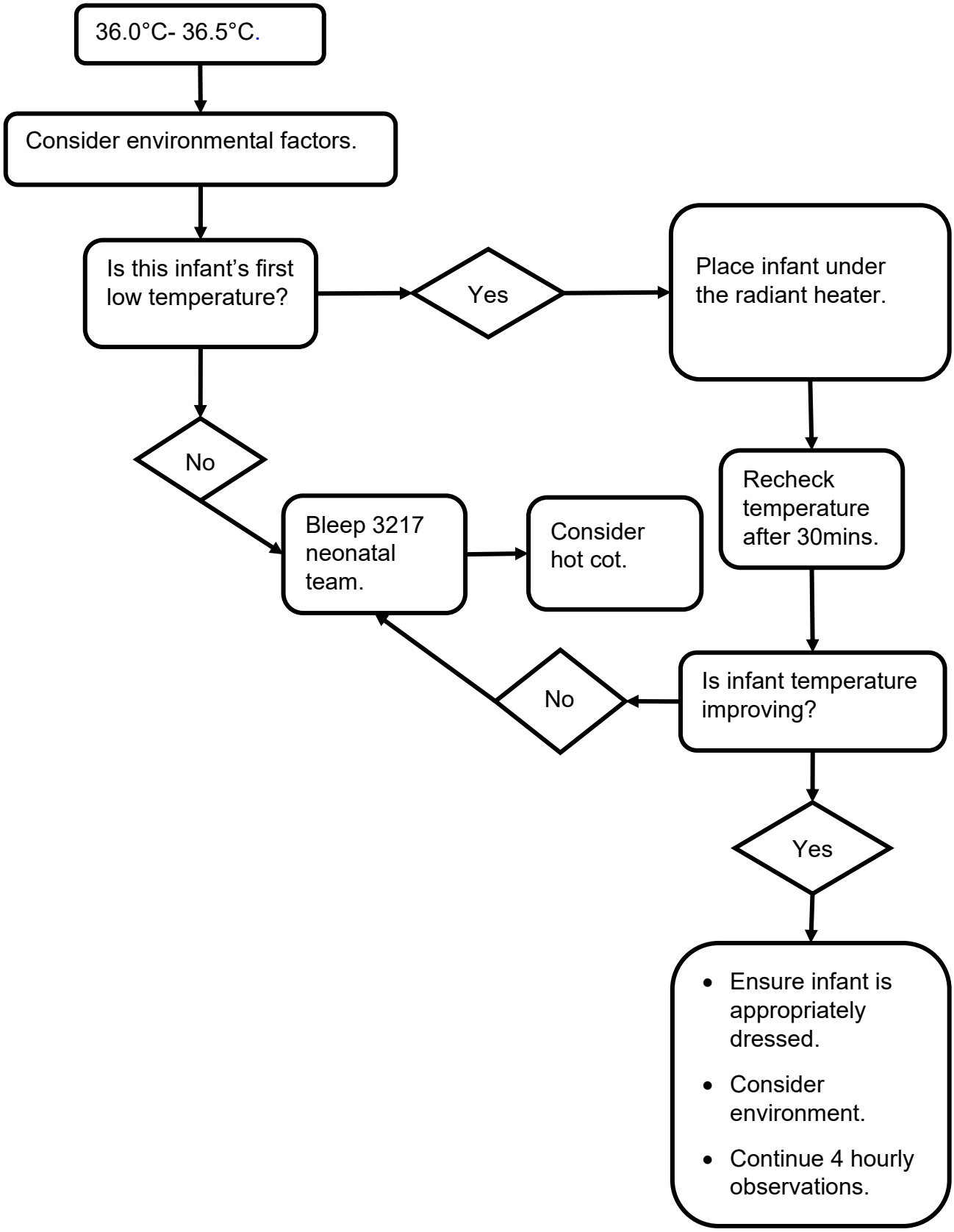
Supporting bottle feeding

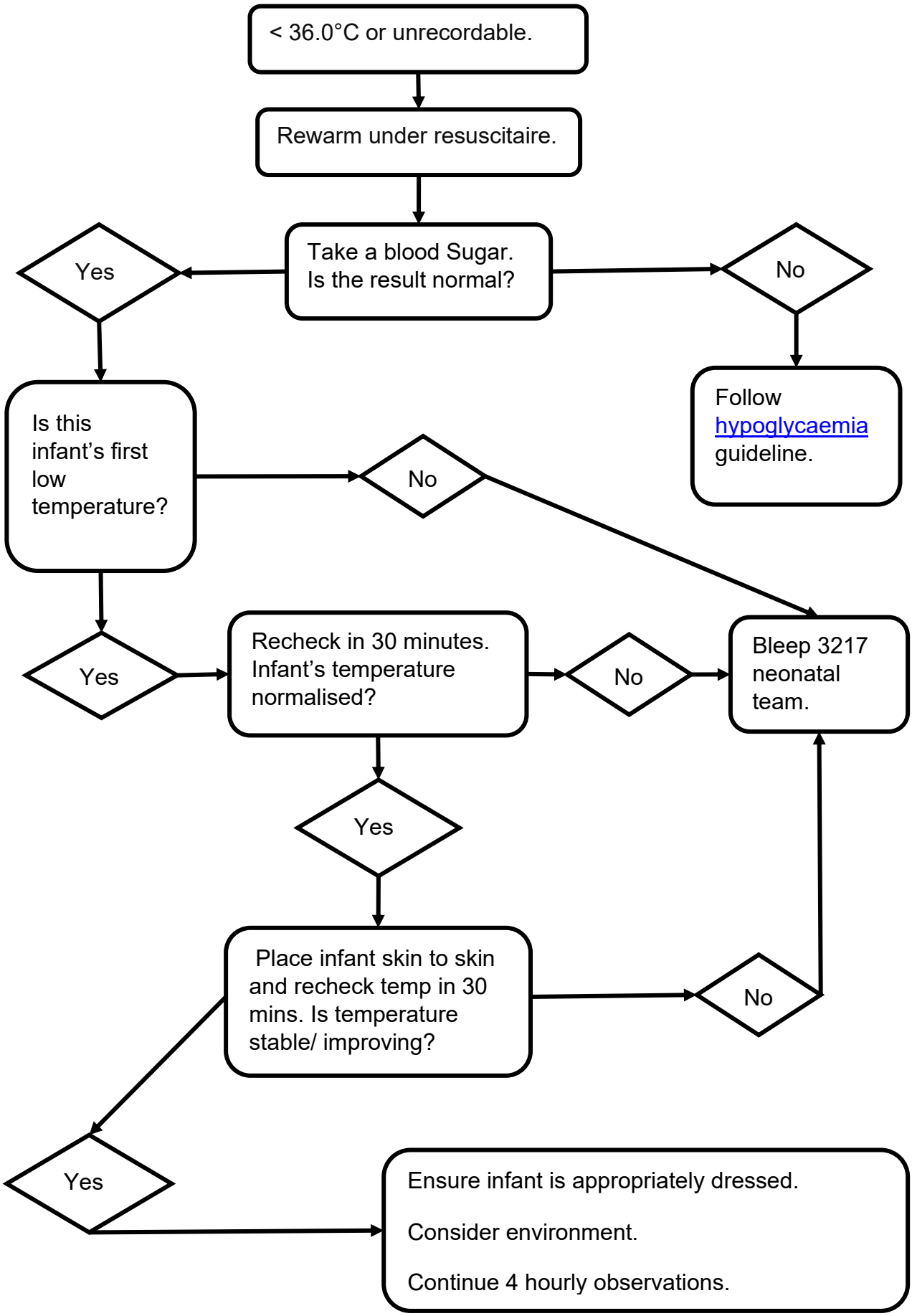
- Encourage skin to skin.
- Offer feeds 3 hourly.
- Consider if glucose monitoring is indicated (maternal medical history), see hypoglycaemia care plan.
- If not managing to take volumes consider the need for a nasogastric tube, discuss with ANNP/ SHO and refer to IFT (Infant Feeding Team).
- First 24 hours feed at 60ml/kg/day.
- Second day increase feed volume to 90ml/ kg/ day.
- Third day increase feed volume to 120ml/ kg/ day.
- Fourth day increase feed volume to 150ml/ kg/ day or if taking the volumes consistently aim for responsive feeding (if no concerns about the baby).
- Document feeds on the feeding chart and monitor wet nappies and stools. See table on the following page:

Age	Day 1-2	Day 3-4	Day 5-6	Day 7 and beyond
Urine. Number of wet nappies per day.	1-2 wet nappies, urates may be present.	3 or more wet nappies, nappies becoming heavier.	5 or more.	6 per day, heavier.
Stools. Number per day, colour and consistency.	1 or more, dark, green/black tar like meconium.	2 or more, changing in colour and consistency, brown/ green/ yellow, becoming looser (changing stool).	2 or more, yellow, may be quite watery.	2 or more, least size of £2 coin, yellow and watery, seedy appearance.

- Weigh on day 3 and day 5, if > 12% weight loss inform Neonatal ANNP/ SHO.

Appendix 4. Management of Hypothermia for an Infant ≥ 37weeks and ≥ 2.5kg.




< 36.0°C or unrecordable.
Rewarm under resuscitaire.
Take a blood Sugar. Is the result normal?
Yes
No
Follow hypoglycaemia guideline.
Is this infant's first low temperature?
No
Yes
Recheck in 30 minutes. Infant's temperature normalised?
No
Bleep 3217 neonatal team.
Yes
Place infant skin to skin and recheck temp in 30 mins. Is temperature stable/ improving?
No
Yes
Ensure infant is appropriately dressed.
Consider environment.
Continue 4 hourly observations.