Royal Cornwall Hospitals
NHS Trust

Weighing and Care Planning for Newborn Babies with Weight Loss
Clinical Guideline

V3.0

November 2023

1. Aim/ Purpose of this Guideline

1.1. This guideline gives guidance for care planning in the event of significant neonatal weight loss.

1.2. This guideline will:

1.2.1. Identify best practice in the weighing of newborn babies.

1.2.2. Identify actions for management of babies with weight loss.

1.2.3. Identify practice for review of babies with significant weight loss.

1.2.4. Identify actions for management of new born babies with slow weight gain.

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

1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women or mother in place but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

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2. The Guidance

It has generally been accepted that newborn babies lose up to 10% of their birth weight. There is continuing professional debate concerning what constitutes normal weight loss. Neonatal weight loss is brief with few babies remaining more than 10% below their birth weight after 5 days.

2.1. Recommended Practice for assessing babies

2.1.1. Assessment of feeding is an essential part of assessing the overall health of a baby.

2.1.2. At each healthcare professional interaction an assessment of feeding and wellbeing should take place.

2.1.3. Early signs of dehydration, such as weight loss, abnormal stool/ urine patterns (see chart below), prolonged jaundice, lethargy or reduced level of consciousness, irritability or low-grade fever, must be treated as an indicator for concern and the baby should be weighed regardless of age as part of an overall assessment. Monitoring of weight will provide objective measure of feeding effectiveness and the potential for dehydration.

Minimum Stool and Urine Output Per Day

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 wet nappies per day, heavier.
Stools Number per day, colour, consistency.	1 or more, dark, green/ black tar like (meconium).	2 or more, changing in colour and consistency- brown/ green/ yellow, becoming looser (changing stools).	2 or more, yellow, may be quite watery.	2 or more, least size of £2 coin, yellow and watery, seedy appearance.

2.2. Weighing Guidance

2.2.1. Ideally babies should be weighed on their abdomen or sides, and gently wrapped- both of which are designed to reduce the startling and discomfort to the neonate.

2.2.2. Wrapped weighing:

2.2.2.1. First weigh the baby blanket and nappy and note any present nasogastric tube (NGT)/ cannula/ nasal prongs in situ.

2.2.2.2. Place the baby in their dry nappy in the blanket and place the baby on their side or abdomen down on the scales, gently swaddled.

2.2.2.3. Register the total weight, then deduct the weight of nappy, blanket, and any present adjuncts.

2.2.3. All babies should be weighed:

- At birth.
- Day 3 of life for babies with risk factors which have put them

under transitional care.

- Day 5 of life.
- When there are early indicators for concern (as detailed in 2.1.2 of Guidance, above.)

2.3. Additional weighing

When there is concern regarding weight gain or effective feeding, baby should be weighed every four days or as per individualised care plans. This can then facilitate the calculations (ml/kg/day) where required.

When a baby remains an inpatient for an extended period of time, regular weighing should take place in line with clinical developments, ideally every four days or twice a week.

2.4. Calculating weight loss

2.4.1. After the baby has been weighed as part of the overall assessment, the total weight loss should be calculated as shown below:

$$\frac{\text{(Birth weight – Current weight)}}{\text{Birth weight}} \times 100 = \text{total weight loss percentage (\%)}$$

2.4.2. All weights should be documented on electronic notes, Badgernet, inpatient notes and also in the parent held record (red book). **Failure to do this has far reaching implications to the management of feeding.**

2.4.3. Once the weight loss has been calculated, a feeding assessment completed and a discussion of feeding choice has taken place, a plan of care can be formulated with the parents, using the following care pathway.

2.5. Management pathway for babies with weight loss

If a baby has been identified to have a weight loss the care pathway below should be followed.

2.5.1. <8% Weight loss for breastfed babies - NORMAL
Reassure caregiver that weight loss is within normal parameters. **Observe a FULL feed**. • Complete full feeding assessment and document in electronic notes. • Discuss responsive feeding. • Discuss baby's urine and stool output.

- Ensure caregiver has access to feeding support.
- Encourage skin to skin.
- Ensure that a minimum of 8 feeds in 24hours, with one at night is taking place.
- Ensure feeding parent understands effective feeding and signs of effective milk transfer.

2.5.2. < 8% Weigh loss for formula fed babies - NORMAL

Reassure caregiver that weight loss is within normal parameters.

Observe a FULL feed.

- Complete full feeding assessment and document in electronic notes.
- Discuss responsive, paced bottle feeding.
- Discuss baby's urine and stool output.
- Ensure caregiver has access to feeding support.
- Encourage skin to skin.
- Check understanding of safe sterilisation of equipment, making a feed from powder, and examine feed volumes being given.

2.5.3. 8-10% Weight loss for breastfed babies - REQUIRES INPUT

Discuss parameters of normal weight loss with parents in a supportive way.

Observe a FULL feed.

- Complete full feeding assessment and document in electronic notes.
- Discuss baby's urine and stool output.
- Assess feeding parent's milk supply.
- Encourage skin to skin.
- Ensure feeding parent understands effective feeding and signs of effective milk transfer.
- Discuss responsive feeding.
- Ensure a minimum of 8 feeds in 24hours, with at least one feed at night, and encourage caregiver use of Feeding Chart/App of choice to record feeds.
- Encourage feeding parent to offer both breasts at each feed.

- Expression of milk at 2-3 times in 24hours or after any feed which is not effective, and at least once during the night.
- Support to give expressed milk – Please see Clinical Guidance Alternative Methods of Giving Breastmilk or Formula Milk to babies born at or after 37 weeks gestation.
- Support mother with any breast and nipple concerns.
- Ensure caregiver has access to feeding support.
- Check understanding of safe sterilisation and washing of equipment.
- Review and reweigh baby in 48hours unless additional concerns arise.
- Share a written feeding plan with parents.

If weight **increases** continue to monitor as per routine management. If weight **decreases** refer to management plan 3 (below) and consider support from the Infant Feeding Team in your care planning.

2.5.4. 8-10% Weight loss for formula fed babies - REQUIRES INPUT

Discuss parameters of normal weight loss with parents in a supportive way.

Observe a FULL feed.

- Complete full feeding assessment and document in electronic notes.
- Discuss baby's urine and stool output.
- Check understanding of safe sterilisation of equipment and making a feed from powder.
- Examine feed volumes being given.
- Consider overfeeding, vomiting and reflux as a cause of failure to gain weight.
- Explore feeding bottle being used and consider teat, flow, and bottle type as a cause of infant difficulty in feeding.
- Ensure caregiver has access to feeding support.
- Discuss responsive, paced bottle feeding.
- Encourage skin to skin.
- Review and reweigh baby in 48hours unless additional concerns arise.
- Share a written feeding plan with parents.

If weight **increases** continue to monitor as per routine management. If weight **decreases** refer to management plan 3 (below) and consider support from the Infant Feeding Team in your care planning.

2.5.5. 10-12% Weight loss for breastfed babies – ACTION NEEDED

Compassionately explain to parents that baby requires additional milk to support development and weight gain.

Observe a FULL feed.

- Complete full feeding assessment and document on electronic notes.
- Discuss baby's urine and stool output.
- Assess feeding parent's milk supply. Consider galactagogues with support from Infant Feeding Team.
- Support mother with any breast and nipple concerns
- Consider if a tongue tie is causing feeding issues.
- Encourage regular and/or prolonged skin to skin.
- Discuss responsive feeding and early feeding cues.
- Ensure feeding parent understands effective feeding and signs of effective milk transfer.
- Ensure a minimum of 8 feeds in 24hours, with one at night, and encourage caregiver use of Feeding Chart/App of choice to record feeds.
- Encourage feeding parent to offer both breasts at each feed.
- Review and support feeding parents with methods of expression. Recommend expressing as often as manageable after feeds.
- Baby to be given extra visible milk - the volume of each feed given may be varied in a responsive feeding approach totaling 100-150mls over each 24 hour period. In the absence of sufficient expressed breastmilk being available, artificial milk will need to be offered.
- Obtain informed consent prior to giving supplementary artificial formula milk to a breastfeeding baby.
- Support to give additional milk – Please see Clinical Guidance Alternative Methods of Giving Breastmilk or Formula Milk to babies born at or after 37 weeks gestation.
- Ensure caregiver has access to feeding support.
- Review and reweigh baby in 48hours unless additional concerns arise.

- Share a written feeding plan with parents.

If weight **increases** continue to monitor until baby has reached birth weight. If weight **decreases** refer to Infant Feeding Team immediately, and if this not possible follow management plan 4 (below).

Refer to Neonatal SHO if there are any concerns regarding the wellbeing of the baby: consider jaundice, lethargy, pyrexia and hypothermia.

2.5.6. 10-12% Weight loss for formula fed babies – ACTION NEEDED

Observe a FULL feed.

Compassionately explain to parents that baby requires additional volumes of formula to support development and weight gain.

- Complete full feeding assessment and document in electronic notes.
- Explore feeding bottle being used and consider teat, flow, and bottle type as a cause of infant difficulty in feeding.
- Consider if a tongue tie causing feeding issues.
- Discuss responsive feeding and early feeding cues.
- Encourage regular and prolonged skin to skin.
- Ensure a minimum of 8 feeds in 24hours, with one at night, and encourage caregiver use of Feeding Chart/App of choice to record feeds.
- Check understanding of safe sterilisation of equipment and making a feed from powder.
- Examine feed volumes being given, ensure baby is having the correct mls/kg/day for their age. If baby is already having 150mls/kg/day then a trial of 165mls/kg/day should be commenced.
- Consider overfeeding, vomiting and reflux as a cause of failure to gain weight.
- Ensure caregiver has access to feeding support.
- Review and reweigh baby in 48hours unless additional concerns arise.
- Share a written feeding plan with parents.

If weight **increases** continue to monitor until baby has reached birth weight. If weight **decreases** refer to Infant Feeding Team immediately, and if this not possible follow management plan 4 (below).

Refer to Neonatal SHO if there are any concerns regarding the wellbeing of the baby: consider jaundice, lethargy, pyrexia and hypothermia.

2.5.7. >12% Weight Loss - IMMEDIATE INTERVENTION

This can be a very distressing time for feeding parents.

Compassionate and coordinated management at this stage is essential.

- Baby must be referred for assessment and possible admission by the neonatal medical team via neonatal outpatient department, maternity postnatal ward or paediatric observation unit/Polkerris dependent on unit activity.
- Senior review should be sought if there are any delays in assessment or concerns about baby's wellbeing.
- The Infant Feeding Team should review as soon as possible.
- Datix should be completed by the assessing practitioner.

Feeding Plan for Breastfed babies with weight loss over 12%:

A feeding plan should be made involving parents as partners in care.

Observe a FULL feed.

- Complete full feeding assessment and document on electronic notes.
- Discuss baby's urine and stool output.
- Assess feeding parent's milk supply. Consider galactagogues with support from Infant Feeding Team.
- Support mother with any breast and nipple concerns.
- Consider if a tongue tie causing feeding issues.
- Encourage regular and/or prolonged skin to skin.
- Discuss responsive feeding and early feeding cues.
- Ensure feeding parent understands effective feeding and signs of effective milk transfer.
- Ensure a minimum of 8 feeds in 24hours, with one at night, and encourage caregiver use of Feeding Chart/App of choice to record feeds.
- Encourage feeding parent to offer both breasts at each feed.
- Optimise milk transfer with switch feeding and breast compressions.
- Review and support feeding parents with methods of expression. Recommend expressing as often as manageable after feeds.
- Ensure caregiver has access to feeding support.

- Review and reweigh baby in 48hours unless additional concerns arise.
- Share a written feeding plan with parents.

Additional volumes of visible milk will need to be given; volumes of milk are dependent on sodium levels – see chart below. Methods of giving extra milk should be discussed with parents and be supportive of ongoing breastfeeding. Please see Clinical Guidance Alternative Methods of Giving Breastmilk or Formula Milk to babies born at or after 37 weeks gestation.

Feeding Plan for Formula Fed babies with weight loss over 12%:

Observe a FULL feed.

- Complete full feeding assessment and document in electronic notes.
- Explore feeding bottle being used and consider teat, flow, and bottle type as a cause of infant difficulty in feeding.
- Consider if a tongue tie is causing feeding issues.
- Discuss responsive feeding and early feeding cues.
- Encourage regular and prolonged skin to skin.
- Ensure a minimum of 8 feeds in 24hours, with one at night, and encourage caregiver use of Feeding Chart/App of choice to record feeds.
- Check understanding of safe sterilisation of equipment and making a feed from powder.
- Examine feed volumes being given, reviewing mls/kg/day. When recommending volumes to be given this should be with consideration to the sodium levels – see chart below.
- Consider smaller but more frequent volumes.
- Consider overfeeding, vomiting and reflux as a cause of failure to gain weight.
- Ensure caregiver has access to feeding support.
- Review and reweigh baby in 48hours unless additional concerns arise.
- Share a written feeding plan with parents.

Caution: Output, weight loss and feeding history are key factors in the clinical assessment. Professionals must remain alert to the fact that newborn babies with hypernatremic dehydration may not exhibit classical signs of dehydration e.g., skin turgor, sunken fontanelle, sunken eyes, dry mucous membranes, signs of poor perfusion such as increased capillary refill time or blue/ cool peripheries.

Any infant readmitted to the acute setting for a feeding related issue: Consider tongue tie. Assess for tongue tie if competent to do so, documenting your assessment

as part of the readmission Infant Feeding Assessment, including the TABBY score. If you suspect a tongue tie, refer to Infant Feeding Team for assessment for a division via rcht.infantfeedingteam@nhs.net. See management of Ankyloglossia guideline for assessment forms.

2.6. Babies who are slow to gain weight

2.6.1. All babies should have regained their birth weight by 3 weeks old. Babies who are slow to gain weight in the first 3 weeks should be reviewed regularly by the midwifery team to ensure that baby remains well, and an appropriate plan of care is in place to optimise feeding. The Infant Feeding Team can be contacted to support care planning for the slow to gain weight neonate.

2.6.2. Otherwise well babies over ten days of age with continued weight loss or showing static or faltering growth in the first 28 days of life, should be discussed with the Infant Feeding Team in order for effective and consistent support and care planning to be put in place with appropriate healthcare practitioners.

2.7. Referral to Neonatal team

2.7.1. Referral should be made to the neonatal (Senior House Officer) SHO for all babies who experience a weight loss from birth weight of >12% regardless of their age up to 28days of age.

2.7.2. The neonatal SHO will inform Neonatal, Postnatal ward or Paediatric ward, accordingly.

2.7.3. The Postnatal or Paediatric ward will contact the Infant Feeding Team/Neonatal Infant Feeding Team to review the baby as soon as possible after arrival.

2.7.4. Referral can also be made if the healthcare practitioner feels more intensive support is required with a lesser weight loss.

2.8. On arrival for neonatal review

2.8.1. All babies will have baseline observations taken including a repeat weight (NEWTT chart).

2.8.2. All babies will have a blood test (including urea, electrolytes and creatinine) and blood gas (gives an immediate serum sodium) and other bloods if jaundiced or other conditions suspected.

2.8.3. Blood results will be compared to the chart below.

Serum sodium for babies with >12% weight loss.				
Serum Sodium.	(135-149) (if low consider alternative diagnosis such as CAH).	150 - 154mmol/l.	155-169 mmol/l.	>170 mmol/l.
Rehydration period.			48 hours.	72-96 hours.
Admission Criteria.	If unwell review by neonatal registrar.	If unwell review by neonatal registrar.	Admit to Wheal Fortune or Polkerris depending on baby's condition.	Discuss with Consultant on call Admit to Neonatal Unit (NNU) side room or Paediatric High Dependency Unit (HDU).
Fluid regime.	Top ups at 6mls/kg/feed (as tolerated by baby).	Top ups after feeds at 50% of daily requirement.	Enteral feeds at 100mls/kg day in addition to breastfeeding. If unwell infant- consider IV fluids with senior guidance.	Enteral feeds at 100 mls/kg day in addition to breastfeeding. If unwell- consider intravenous fluids (0.9% saline plus glucose). Seek senior guidance.
Monitoring.	Continued feeding support, stool, and urine output. Midwifery review in 24- 48 hours.	Continued feeding support. Stool and urine output. Midwifery review in 24 hours. Urea, electrolytes to be rechecked every 12 hours until sodium <150 mmol/l.	Continued feeding support. Urea, electrolytes, and blood sugar 12 hourly until sodium <150 mmol/l. Aim for a maximum drop of ½ mmol per hour. Stool and urine output.	Continued feeding support. Urea, electrolytes, and blood sugar 12 hourly until sodium <150 mmol/l. Aim for a maximum drop of ½ mmol per hour. Stool and Urine output.

2.8.4. Following review baby can return home with an appropriate feeding plan and close follow up from the midwifery and/or infant feeding team.

2.8.5. A full history will be taken from the parents.

2.8.6. A healthcare professional must observe a full feed and a Breastfeeding Assessment Form or Formula Feeding Assessment Form must be completed.

2.8.7. If there are further concerns regarding the baby's health, medical review will be sought from the (NNU) Registrar.

2.8.8. Care planning will be documented in the handheld record following review and with reference to the Care Pathway.

2.8.9. The member of staff who reviews the baby must ensure that community midwife/health visitor and/or Infant feeding team are in place to provide follow up feeding support to the primary carer and baby.

2.8.10. Ensure Datix incident form has been completed by the healthcare professional who has assessed the baby and made a care plan.

2.9. Prior to discharge

No baby admitted with weight loss should be discharged without a documented onward feeding plan made with parents as partners in care and a baby weight at discharge.

2.10. Discharge from Midwifery care

2.10.1. The care of the baby and the family should be handed over to the health visitor at 10- 14 days of age only **if the baby has regained its birth weight.**

2.10.2. Care should remain with the midwife if the baby has not regained birth weight, although if there has been a recognised upward trend of weight and the baby is within 1% of its birth weight then discharge can be considered if all other parameters are normal.

2.10.3. Individualised plans of care can be discussed with the Infant Feeding Team.

2.10.4. If feeding plans are in place at discharge, the care plan must be discussed with the parents as partners in care and clearly documented on EuroKing or emailed to the relevant Health Visitor team.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Audit of Babies under 28 days for readmission with weightless concern carried out as a rolling audit by Infant Feeding Team.
Lead	Infant feeding coordinator.
Tool	Monitoring through incident reporting.
Frequency	All babies with weight loss >8% - >12%.
Reporting arrangements	A formal report of the results will be received annually at the maternity patient safety forum, infant feeding steering group and clinical audit forum.
Acting on recommendations and Lead(s)	Any deficiencies identified on the annual report will be discussed at the maternity patient safety, infant feeding steering group and clinical audit forum and an action plan developed. Action leads will be identified and a time frame for the action to be completed by infant feeding coordinator. The action plan will be monitored by the infant feeding steering group until all actions complete.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a time frame agreed on the action plan. A lead member of the forum will be identified to take each change forward where appropriate. The results of the audits will be distributed to all staff through the patient safety newsletter/ audit forum as per the action plan.

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:	Weighing and Care Planning for Newborn Babies with Weight Loss Clinical Guideline V3.0
This document replaces (exact title of previous version):	Weighing newborn babies and pathway for babies with significant weight loss (>10%) Clinical Guideline V2.3
Date Issued/Approved:	November 2023
Date Valid From:	November 2023
Date Valid To:	November 2026
Directorate / Department responsible (author/owner):	Infant Feeding Coordinator
Contact details:	Rcht.infantfeedingteam@nhs.net
Brief summary of contents:	Weighing and care planning for newborn babies with weight loss >8%->10%
Suggested Keywords:	Infant feeding. Weight loss. Weighing. Newborn babies. Care planning.
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 Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Melanie Gilbert
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	Dommelen et al (2006) Reference chart for relative weight change to detect hypernatraemic dehydration www.archdischild.com NICE (2006) Routine postnatal care of women and their babies
Training Need Identified?	No
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
16th Jan 2018	V1.0	New issue	Helen Shanahan Infant Feeding Lead
September 2020	V2.0	Complete version update	Janey Ashton, Infant Feeding Co-Ordinator
October 2020	V2.1	Amendments made to section 2.4.1. to correctly reflect the weight loss calculation	Janey Ashton, Infant Feeding Co-Ordinator
June 2022	V2.2	Addition of requirement for tongue tie assessment	Chris Bell; Neonatal Consultant
August 2022	V2.3	Table shown at section 2.5 amended to swap immediate action required and action required rows	Chris Bell; Neonatal Consultant

Date	Version Number	Summary of Changes	Changes Made by
October 2023	V3.0	Section 2.2.3 updated to remove need to weigh prior to discharge. Section 2.3 updated to state inpatient weighing should take place every four days or twice a week. Table at 2.8.3 updated re. enteral feeds and breastfeeding.	Katie Hicks; Infant Feeding Coordinator

All or part of this document can be released under the Freedom of Information Act 2000.

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:	Weighing and Care Planning for Newborn Babies with Weight Loss Clinical Guideline V3.0
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 inform all midwifery staff on the appropriate management of weight loss in a neonate.
2. **Policy Objectives**	Ensure the correct methods of management are used in the management of weight loss in the neonate
3. **Policy Intended Outcomes**	Neonatal well being
4. **How will you measure each outcome?**	Monitoring through incident reporting
5. **Who is intended to benefit from the policy?**	Women and babies

Information Category	Detailed Information
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
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- 04 October 2023
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

Protected Characteristic	(Yes or No)	Rationale
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).
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