

Trust Guideline for Attendance at Deliveries

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A Clinical Guideline

For Use in:	Delivery suite, Midwifery led birthing unit (MLBU), Cley ward, Blakeney ward.
By:	Neonatal medical and nursing staff, obstetric and midwifery staff
For:	Deliveries requiring a neonatal presence
Division responsible for document:	Women and Children
Key words:	Newborn, resuscitation, delivery
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Assessed and approved by the:	Clinical Guidelines Assessment Panel (CGAP) If approved by committee or Governance Lead Chair's Action; tick here <input checked="" type="checkbox"/>
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To be reviewed by:	David Booth and Jacqui Jones
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Compliance links: (is there any NICE related to guidance)	None
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

Clinical Guideline for: Attendance at delivery guideline

Author/s and job title: D Booth, Consultant Neonatologist, J. Jones, Senior Advanced Neonatal Nurse Practitioner

Approved by: Chair of CGAP

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1. Quick reference guideline

Classification of Risk	Composition of Team
<p>Very High Risk Gestation <28 weeks Estimated birth weight <1000g Hydrop fetalis Severe Rh immunisation at <34 weeks Severe malformations diagnosed antenatally Extreme fetal compromise, including evidence of severe hypoxia/fetal haemorrhage Prolapsed cord Placenta abruption Any other delivery, designated as very high risk after discussion between obstetric and paediatric staff</p>	<p style="text-align: center;">Consultant <i>or</i> Specialist Registrar <i>or</i> Senior ANNP + ANNP <i>or</i> SHO + Neonatal Nurse <i>or</i> Midwife</p> <p>The consultant is to be notified prior to delivery by the registrar to determine the teams composition</p>
<p>High Risk Gestation 28-32 weeks Estimated birth weight <1500g Multiple pregnancies <32 weeks Thick meconium with fetal compromise Shoulder dystocia Reduced fetal movement before the onset of labour + poor CTG + meconium stained liquor Major antepartum haemorrhage/placenta praevia</p>	<p style="text-align: center;">Specialist Registrar <i>or</i> Senior ANNP + ANNP <i>or</i> SHO + Neonatal Nurse <i>or</i> Midwife</p>
<p>Moderate Risk Gestation >32 weeks <37weeks IUGR Maternal diabetes mellitus with macrosomia Multiple pregnancies Breech and abnormal presentation (vaginal delivery) Ventouse extraction or forceps delivery with fetal compromise Emergency caesarean section under general anaesthetic Meconium stained liquor Narcotic administration to mother within 4 hours of delivery Intrauterine infection</p>	<p style="text-align: center;">ANNP <i>or</i> SHO with NLS training and previous supervised experience of attending deliveries + Neonatal Nurse <i>or</i> Midwife</p>
<p>Low Risk Elective caesarean section (including for breech) Forceps and Ventouse extraction with no fetal compromise Normal delivery over 36 weeks</p>	<p style="text-align: center;">Midwife with NLS training</p>

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2. Abbreviations

ANNP = advanced neonatal nurse practitioner

SHO = senior house officer = tier 1 medical practitioner, typically ST1-3

NLS = newborn life support

3. Objective

This guideline identifies the risk categories for neonatal deliveries, who should attend those deliveries and what level of training is required.

4. Broad recommendations

Personnel who are trained in the skills of resuscitation at birth should attend every delivery. If it is expected that the infant will need advanced resuscitation, more than one experienced person should attend.

The lower the gestational age the greater the need for assistance and the greater the skill required in resuscitation.

If an infant is born unexpectedly in poor condition both the Specialist Registrar/Senior ANNP and SHO/ANNP should be called urgently, via switchboard:

Crash call: phone 2222 and state 'neonatal emergency team' followed by ward, room number and telephone extension

- For less urgent (non-crash) situations, use the Alertive system to contact tier 1 or tier 2 NICU staff
 - NICU tier 2 Special Care (24/7) – registrar grade / senior ANNP
 - NICU tier 1 Special Care/Deliveries (24/7) – SHO or junior ANNP

The responsible neonatal consultant for each day is clearly identified on the white board on delivery suite and can be contacted via Alertive: NICU consultant intensive care (9-5). Out of hours, use switchboard as previously to contact consultants.

5. Staff Training

All staff involved in the care of the newborn infant should ideally have attended the Newborn Life Support (NLS) course and should:

- Reinforce their training with a yearly update in resuscitation skills.
- Regularly attend local perinatal mortality and morbidity meetings
- Undertake NLS updates every 4 years

6. Senior House Officer (SHO)

Should be up to date with their NLS requirements.

They will need local orientation and initial supervision.

The supervision should be formalised and documented.

7. Advanced Neonatal Nurse Practitioners

ANNPs who have undergone recognised training and had a period of supervised practice can undertake resuscitation.

8. Specialist registrar or Senior ANNP

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Should have at least six months experience of regional neonatal intensive care and be orientated to local delivery suite and neonatal resuscitation policy at induction.

To maintain their skills it is proposed that they should be involved in teaching neonatal resuscitation locally.

9. Consultants

Should maintain their skill by teaching resuscitation locally.

Should be responsible for the organisation and audit of skills and training.

10. Clinical audit standards derived from guideline

The paediatric and maternity services are committed to the philosophy of clinical audit, as of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental clinical governance meetings. The results will also be summarised and a list of recommendations formed into an action plan with a commitment to re-audit within 3 years, resources permitting.

- a) All staff attending deliveries will have received Newborn Life Support training.
- b) Local yearly mandatory updates are attended.
- c) Identified staffing teams should attend very high, high and moderate risk deliveries.

11. Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this guideline based on a previous regional guideline. During its development it has been circulated for comment to staff on the neonatal unit and presented at the neonatal unit guidelines review forum.

This version has been endorsed by the Clinical Guidelines Assessment Panel.

12. Distribution list/ dissemination method

Trust Intranet

13. References/source documents

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