Trust Guideline for the Management of: Newborn Life Support

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None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

- David Booth, Consultant Neonatologist – co-author
- Priya Muthukumar, Consultant Neonatologist – chief of service, paediatrics
- Florence Walston, Consultant Neonatologist – clinical lead, NICU
- Kirsty Lewis, Resuscitation Officer – key contact for NLS course and resuscitation council UK
- Clinical Guidelines Assessment Panel

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

Clinical guideline applicable to Norfolk and Norwich United Hospitals NHS Foundation Trust

Guidance Note

This guideline has been approved by the Trust's Clinical Guidelines Assessment Panel as an aid to the diagnosis and management of relevant patients and clinical circumstances. Not every patient or situation fits neatly into a standard guideline scenario and the guideline must be interpreted and applied in practice in the light of prevailing clinical circumstances, the diagnostic and treatment options available and the professional judgement, knowledge and expertise of relevant clinicians. It is advised that the rationale for any departure from relevant guidance should be documented in the patient's case notes.

The Trust's guidelines are made publicly available as part of the collective endeavour to continuously improve the quality of healthcare through sharing medical experience and knowledge. The Trust accepts no responsibility for any misunderstanding or misapplication of this document**.**

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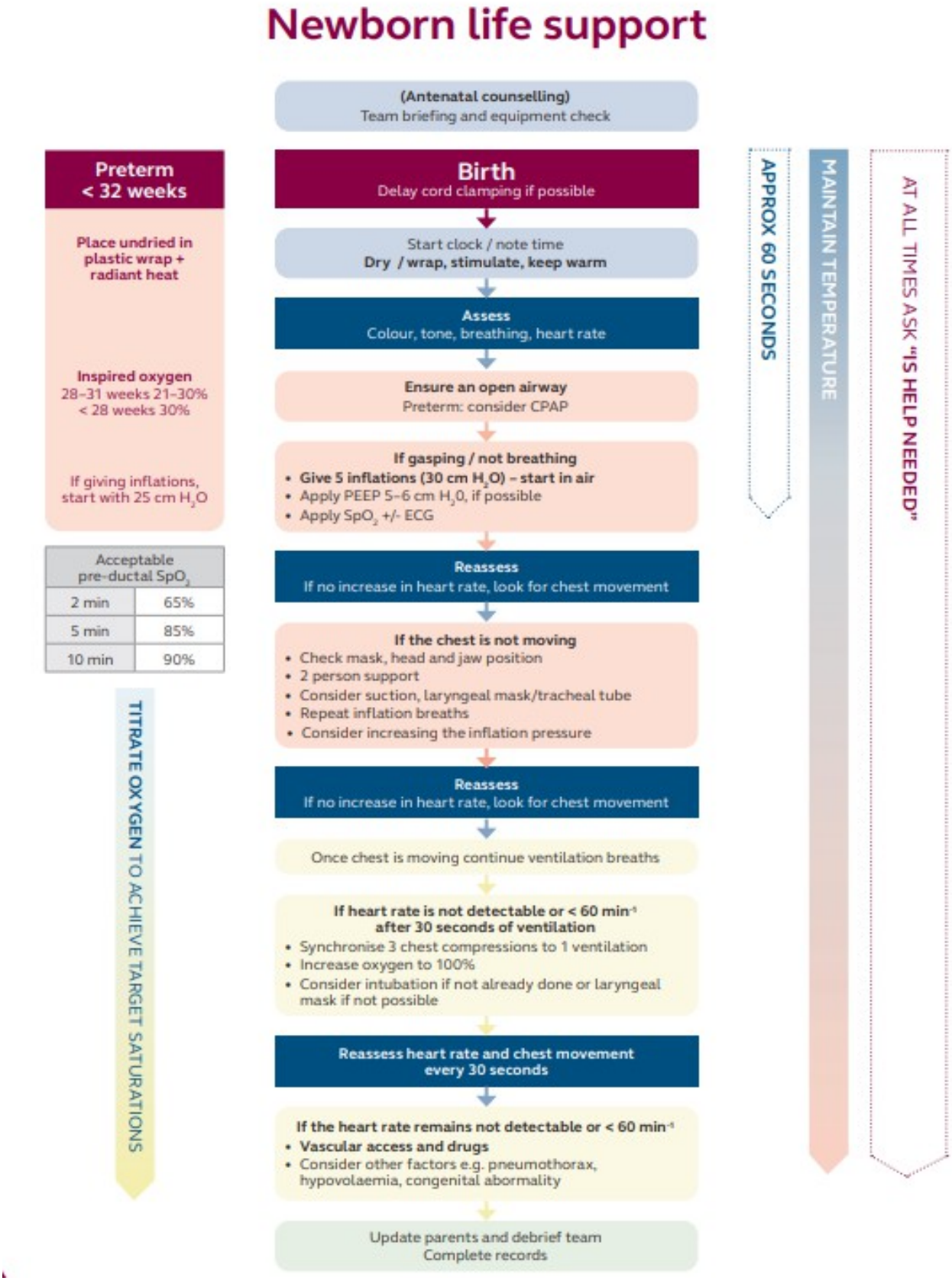
Quick reference guideline for term infants

Resuscitation Council (UK) 2021 - Newborn Life Support



1. Introduction

1.1. Rationale

The need for resuscitation at birth cannot always be predicted. A logical approach to newborn life support (NLS) that can be instigated and performed by any member of the healthcare team with basic training is therefore recommended as a method to provide a safe and systematic approach to those few babies that need more than gentle stimulation at birth.

1.2. Objective

The objective of this clinical guidelines is to:

- Ensure safe and effective newborn life support as recommended by the Resuscitation Council (UK).

1.3. Scope

- For use by all nursing, midwifery and medical staff that attend newborn resuscitation.
- For use in Delivery Suite, Postnatal ward, Neonatal Intensive Care Unit. Solely for use in neonatal resuscitation situations – additional sites where this may occasionally be applicable include the emergency department and the antenatal ward.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
NNUH	Norfolk and Norwich University Hospitals
NLS	Newborn life support
MAS	Meconium aspiration syndrome
LMA	Laryngeal mask airways
ANNP	Advanced Neonatal Nurse Practitioner
EIA	Equality Impact Assessment

2. Responsibilities

- David Booth, Consultant Neonatologist – co-author
- Priya Muthukumar, Consultant Neonatologist – chief of service, paediatrics
- Florence Walston, Consultant Neonatologist – clinical lead, NICU
- Kirsty Lewis, Resuscitation Officer – key contact for NLS course and resuscitation council UK

- Clinical Guidelines Assessment Panel

3. Processes to be followed

3.1. Resuscitation Equipment

The resuscitation equipment used by the maternity service must be checked daily against the checklist that can be found on all resuscitaires and which will confirm that the equipment is fit for use. This process will be documented in the record book available on every resuscitaire. The neonatal emergency grab bag is located on NICU and must also be checked and signed daily against a checklist to confirm it is fit for use.

3.2. Broad recommendations

Passage through the birth canal is a hypoxic experience for the fetus, since significant respiratory exchange at the placenta is prevented for the 50-75 seconds duration of the average contraction. Though most babies tolerate this well, the few that do not may require help to establish normal breathing at delivery. NLS is intended to provide this help and comprises the following elements:

- Drying and covering the newborn baby to conserve heat
- Assessing the need for any intervention
- Opening the airway
- Aerating the lung
- Rescue breathing
- Chest compression
- Administration of drugs (rarely)

3.3. Physiology

If subjected to sufficient hypoxia in utero, the fetus will attempt to breathe. If the hypoxic insult is continued the fetus will eventually lose consciousness. Shortly after this the neural centres controlling these breathing efforts will cease to function because of lack of oxygen. The fetus then enters a period known as primary apnoea.
Up to this point, the heart rate remains unchanged, but soon decreases to about half the normal rate as the myocardium reverts to anaerobic metabolism – a less fuel efficient mechanism. The circulation to non-vital organs is reduced in an attempt to preserve perfusion of vital organs. The release of lactic acid, a by-product of anaerobic metabolism, causes deterioration of the biochemical milieu.

If the insult continues, shuddering (whole-body gasps at a rate of about 12 per min) is initiated by primitive spinal centres. If the fetus is still in utero, or if for some other reason these gasps fail to aerate the lungs, they fade away and the fetus enters a period known as secondary, or

terminal, apnoea. Until now, the circulation has been maintained but, as terminal apnoea progresses, the rapidly deteriorating biochemical milieu begins to impair cardiac function. The heart eventually fails and, without effective intervention, the baby dies. The whole process probably takes almost 20 min in the term newborn human baby.

Thus, in the face of asphyxia, the baby can maintain an effective circulation throughout the period of primary apnoea, through the gasping phase, and even for a while after the onset of terminal apnoea. Thus, the most urgent requirement for any asphyxiated baby at birth is that the lungs be aerated effectively. Provided the baby's circulation is sufficient, oxygenated blood will then be conveyed from the aerated lungs to the heart.

The heart rate will increase and the brain will be perfused with oxygenated blood.
Following this, the neural centres responsible for normal breathing will, in many instances, function once again and the baby will recover.

Merely aerating the lungs is sufficient in the vast majority of cases. Although lung aeration is still vital, in a few cases cardiac function will have deteriorated to such an extent that the circulation is inadequate and cannot convey oxygenated blood from the aerated lungs to the heart. In this case, a brief period of chest compression may be needed. In a very few cases, lung aeration and chest compression will not be sufficient, and drugs may be required to restore the circulation. The outlook in this group of infants is poor.

3.4. Suggested sequence of actions

3.4.1. Keep the baby warm and assess

1. Babies are born small and wet. They get cold very easily, especially if they remain wet and in a draught. Whatever the situation it is important that the baby does not get cold at this stage. If intervention is required, in a term or near-term baby, dry the baby, remove the wet towels, and cover the baby with dry towels. For uncompromised babies, a delay in cord clamping of at least one minute from the complete delivery of the infant, is recommended.
2. Preterm babies of less than 32 weeks gestation are best placed, without drying, into food-grade plastic wrapping, avoiding the face, under a radiant heater (see Plastic bags to prevent hypothermia at birth in preterm babies (Thermoregulation) Trust Doc ID: 1244. This process will provide significant stimulation and will allow time to assess tone, breathing, and heart rate.
3. Reassess these observations regularly every 30 seconds or so throughout the resuscitation process but it is the heart rate which is the key observation. The first sign of any improvement in the baby

will be an increase in heart rate. Consider the need for help; if needed, ask for help immediately.

4. A healthy baby will be born blue but will have good tone, will cry within a few seconds of delivery and will have a good heart rate within a few minutes of birth (the heart rate of a healthy newborn baby is about 120-150 beats per minute). A less healthy baby will be blue at birth, will have less good tone, may have a slow heart rate (less than 100 beats per minute), and may not establish adequate breathing by 90-120 seconds. An ill baby will be born pale and floppy, not breathing and with a slow, very slow or undetectable heart rate.
5. The heart rate of a baby is best judged by listening with a stethoscope. It can also be felt by gently palpating the umbilical cord but a slow rate at the cord is not always indicative of a truly slow heart rate – feeling for peripheral pulses is not helpful.
6. A pulse oximeter is probably the best way of assessing heart rate and oxygenation in the delivery room. A pulse oximeter will be available on the transport incubator and should be taken to all preterm (<32 week gestation) deliveries, and should be used for any infant where prolonged resuscitation is required. With practice it is possible to attach a pulse oximeter probe and to obtain a useful reading of heart rate and oxygen saturation within about 90 seconds after delivery.

3.4.2. Airway

1. Before the baby can breathe effectively the airway must be open. The best way to achieve this is to place the baby on his back with the head in the neutral position, i.e. with the neck neither flexed nor extended. Most newborn babies will have a relatively prominent occiput, which will tend to flex the neck if the baby is placed on his back on a flat surface. This can be avoided by placing some support under the shoulders of the baby, but be careful not to overextend the neck. If the baby is very floppy (i.e. has no or very little tone) it may also be necessary to apply chin lift or jaw thrust. These manoeuvres will be effective for the majority of babies requiring airway stabilisation at birth.
2. Airway suction immediately following birth should be reserved for babies who have obvious airway obstruction that cannot be rectified by appropriate positioning. Rarely, material may be blocking the oropharynx or trachea. In these situations, direct visualisation and suction of the oropharynx should be performed. For tracheal obstruction, intubation and suction on withdrawal of the endotracheal tube may be effective.

3.4.3. Breathing

Most babies have a good heart rate after birth and establish breathing by about 90 seconds. If the baby is not breathing adequately **give 5 inflation breaths**, preferably using air. For those resuscitaires on Delivery Suite that have no air/oxygen blend facility, a bag and mask device in air should be used. Until now the baby's lungs will have been filled with fluid. Aeration of the lungs in these circumstances is likely to require sustained application of pressures of about 30 cm H_2O for 2-3 seconds – these are 'inflation breaths' (20-25 cm H_2O in preterm babies). If the heart rate was below 100 beats per minute initially then it should rapidly increase as oxygenated blood reaches the heart.

1. If the heart rate does increase then you can assume that you have successfully aerated the lungs.
2. If the heart rate increases but the baby does not start breathing for himself, then continue to provide regular breaths at a rate of about 30-40 per minute until the baby starts to breathe on his own.
3. If the heart rate does not increase following inflation breaths, then either you have not aerated the lungs or the baby needs more than lung aeration alone. By far the most likely is that you have failed to aerate the lungs effectively.
4. If the heart rate does not increase, *and* the chest does not passively move with each inflation breath, then you have not aerated the lungs.
5. If the lungs have not been aerated then consider:
    - Is the baby's head in the neutral position?
    - Do you need jaw thrust?
    - Do you need a longer inflation time?
    - Do you need a second person's help with the airway?
    - Is there an obstruction in the oropharynx (laryngoscope and suction)?
    - What about a laryngeal mask airway (LMA)
    - Is there a tracheal obstruction?

Check that the baby's head and neck are in the neutral position; that your inflation breaths are at the correct pressure and applied for sufficient time (2-3 seconds inspiration); and that the chest moves with each breath. If the chest still does not move, ask for help in maintaining the airway (2 person jaw thrust) and consider an obstruction in the oropharynx or trachea, which may be removable by suction under direct vision.

Consider using a laryngeal mask in infants of >_ 34 weeks gestation (2000g)if there are problems with establishing effective ventilation with a facemask.

A starting pressure of 25cm H2O is suggested for preterm babies < 32 weeks gestation

Initial delivered oxygen concentration depends upon gestation:

>_ 32 weeks gestation – 21% oxygen

28-32 weeks – 21-30% oxygen

< 28 weeks – 30% oxygen

In babies <32 weeks, delivered oxygen concentration should be titrated to achieve saturations of >80% at 5 minutes

If the heart rate remains slow (less than 60 beats per minute) or absent following 5 inflation breaths, despite good passive chest movement in response to your inflation efforts, start chest compression.

When starting chest compressions, increase the delivered oxygen to 100%

3.4.4. Chest compression

If the heart rate remains very slow (<60min) or absent after 30 seconds of good quality ventilation, start chest compressions

1. Almost all babies needing help at birth will respond to successful lung inflation with an increase in heart rate followed quickly by normal breathing. However, in some cases chest compression is necessary.
2. Chest compression should be started only when you are sure that the lungs have been aerated successfully.
3. In babies, the most efficient method of delivering chest compression is to grip the chest in both hands in such a way that the two thumbs can press on the lower third of the sternum, just below an imaginary line joining the nipples, with the fingers over the spine at the back.
4. Compress the chest quickly and firmly, reducing the antero-posterior diameter of the chest by about one third.

The ratio of compressions to inflations in newborn resuscitation is 3:1.

5. Chest compressions move oxygenated blood from the lungs back to the heart. Allow enough time during the relaxation phase of each compression cycle for the heart to refill with blood. Ensure that the chest is inflating with each breath.

6. In a very few babies (less than one in every thousand births) inflation of the lungs and effective chest compression will not be sufficient to produce an effective circulation. In these circumstances drugs may be helpful.

3.4.5. Drugs

1. Drugs are needed rarely and only if there is no significant cardiac output despite effective lung inflation and chest compression.
2. The drugs used include adrenaline (1:10,000), occasionally sodium bicarbonate (ideally 4.2%), and glucose (10%). They are best delivered via an umbilical venous catheter.
3. The recommended intravenous dose for adrenaline is 20 micrograms/kg (0.2mL/kg of 1:10,000 solution). If this is not effective, a dose of up to 30 micrograms/kg (0.3 mL/kg of 1:10,000 solution) may be tried.
4. If the tracheal route is used, it must not interfere with ventilation or delay acquisition of intravenous access. The tracheal dose needed is 100 microgram/kg = 1ml/kg
5. The dose for sodium bicarbonate is between 1 and 2 mmol/kg of bicarbonate (2 to 4 mL/kg of 4.2% bicarbonate solution).
6. The dose of glucose recommended is 250 mg/kg (2.5 mL/kg of 10% glucose).
7. Very rarely, the heart rate cannot increase because the baby has lost significant blood volume. If this is the case, there is often a clear history of blood loss from the baby, but not always. Use of isotonic crystalloid rather than albumin is preferred for emergency volume replacement. In the presence of hypovolaemia, a bolus of 10 mL/kg of 0.9% sodium chloride or similar given over 10 - 20 seconds will often produce a rapid response and can be repeated safely if needed.

3.5. Resuscitation or stabilisation

Most babies born at term need no resuscitation and they can usually stabilise themselves during the transition from placental to pulmonary respiration very effectively.

Provided attention is paid to preventing heat loss and a little patience is exhibited before cutting the umbilical cord, intervention is rarely necessary. However, as mentioned above, some babies will have suffered stresses or insults during labour. Help may then be required which is characterised by interventions designed to rescue a sick or very sick baby and this process can then reasonably be called resuscitation.

Significantly preterm babies, particularly those born below 30 weeks gestation, are a different matter. Most babies in this group are healthy at the time of delivery and yet all can be expected to benefit from help in making the transition. Intervention in this situation is usually limited to maintaining a healthy baby during this transition and is more appropriately called stabilisation.

In the past both situations have been referred to as resuscitation and this seems inappropriate and likely to cause confusion.

Infants who have required resuscitation may later deteriorate. Post resuscitation cate should be in an environment in which close monitoring can be provided.

3.6. Umbilical cord clamping

For healthy term infants delaying cord clamping for at least one minute or until the cord stops pulsating following delivery improves iron status through early infancy. For preterm babies in good condition at delivery, delaying cord clamping for up to 3 min results in increased blood pressure during stabilisation, a lower incidence of intraventricular haemorrhage and fewer blood transfusions. However, babies are more likely to receive phototherapy. There are limited data on the hazards or benefits of delayed cord clamping in the non-vigorous infant.

Delaying cord clamping for at least one minute is recommended for newborn infants not requiring resuscitation, but if this is not possible cord milking is an option in babies > 28 weeks gestation. At present there is insufficient evidence to define an appropriate time to clamp the cord in babies apparently needing resuscitation. However, this may be because time is the wrong defining parameter and perhaps the cord should not be clamped until the baby has started breathing.

3.7. Oximetry and the use of supplemental oxygen

If resources are available, pulse oximetry should be used for all deliveries where it is anticipated that the infant may have problems with transition or need resuscitation.
Oxygen saturation and heart rate can be measured reliably during the first minutes of life with a modern pulse oximeter.

The sensor must be placed on the right hand or wrist to obtain an accurate reading of the pre-ductal saturation. Placement of the sensor on the baby before connecting to the instrument may result in faster acquisition of signal. In most cases a reliable reading can be obtained within 90 seconds of birth. Pulse oximetry can also provide an accurate display of heart rate during periods of good perfusion.

In healthy term babies, oxygen saturation increases gradually from approximately 60% soon after birth to over 90% at 10 minutes. Aim to

achieve target oxygen saturations above the 25th percentile for healthy term infants in the first 5 minutes after birth. In term and preterm infants >_32 weeks requiring respiratory support, begin with air (21%). In preterm infants 28-31 weeks gestation 21-30% oxygen. <28 weeks gestation 30% oxygen

(In preterm infants hyperoxaemia is particularly damaging and if oxygen is used to achieve a saturation above 95% the risk of hyperoxaemia is high. Therefore, the rate of rise in oxygen saturation after birth in preterm infants should not exceed that seen in term infants, although some supplemental oxygen may be required to achieve this. REMOVE)

In infants <32 weeks gestation the target should be to avoid an oxygen saturation below 80% and/or bradycardia at 5 minutes of age. Both are associated with a poor outcome. Check the delivered inspired oxygen concentration and saturations frequently (e.g. every 30 seconds) and titrate to avoid hypoxia and hyperoxia

3.8. Colour

Using colour as a proxy for oxygen saturation is usually inaccurate. However, noting whether a baby is initially very pale and therefore either acidotic or anaemic at delivery may be useful as an indicator for later therapeutic intervention.

3.9. Airway suctioning with or without meconium

Suction is rarely required.

A multi-centre randomised controlled trial[1] has shown that routine elective intubation and suctioning of vigorous infants at birth did not reduce meconium aspiration syndrome (MAS). A further randomised study[2] has shown that suctioning the nose and mouth of such babies on the perineum and before delivery of the shoulders (intrapartum suctioning) is also ineffective. Whilst non-vigorous infants born through meconium stained amniotic fluid are at increased risk of MAS, tracheal suctioning has not been shown to improve the outcome.

There is no evidence to support or refute suctioning of the mouth and nose of babies born through clear amniotic fluid.

Routine *intrapartum* oropharyngeal and nasopharyngeal suctioning for vigorous and non-vigorous infants born with clear and/or meconium-stained amniotic fluid is not recommended.

3.10. Recommendation

Consider using an LMA during resuscitation of the newborn infant if face mask ventilation is unsuccessful and tracheal intubation is unsuccessful or not feasible. The LMA may be considered as an alternative to a face mask

for positive pressure ventilation among newborn infants weighing more than 2000 g or delivered ≥34 weeks gestation. It may also be used as an alternative to tracheal intubation as a secondary airway for resuscitation among newborn infants weighing more than 2000 g or delivered ≥34 weeks gestation. There is limited evidence evaluating its use for newborn infants weighing <2000 g or delivered <34 weeks gestation and none for those infants receiving compressions.

Use of the LMA, nonetheless, should be limited to those individuals who have been trained to use it. Its use has not been evaluated in the setting of meconium stained fluid, during chest compressions, or for the administration of emergency intra-tracheal medications.

3.11. Drugs in resuscitation at birth

Ventilation and chest compression may fail to resuscitate less than 1 in 1000 babies. In this group, resuscitation drugs may be justified. Whilst there is evidence from animal studies for both adrenaline and sodium bicarbonate in increasing return of spontaneous circulation, there is no placebo-controlled evidence in human babies for the effectiveness of any drug intervention in this situation. Even for adults and children in cardiac arrest, there is insufficient evidence to suggest that vasopressors improve survival to discharge.

For this reason use of drugs before achieving lung aeration followed by chest compressions (known to be effective resuscitative interventions) can never be justified.

3.12. Therapeutic hypothermia

Term or near-term infants, with evolving moderate to severe hypoxic-ischaemic encephalopathy, should be treated with therapeutic hypothermia. Cooling should be initiated as soon as possible (consider switching off the overhead heater) and conducted under clearly-defined protocols with treatment in neonatal intensive care facilities and the capabilities for multidisciplinary care. Treatment should be consistent with the regional guideline for therapeutic hypothermia.

3.13. When to stop resuscitation

In a newly-born baby with no detectable cardiac activity, and with cardiac activity that remains undetectable for 10 minutes, it is appropriate to consider stopping resuscitation.

The decision to continue resuscitation efforts beyond 10 min with no cardiac activity is often complex and may be influenced by issues such as the presumed aetiology of the arrest, the gestation of the baby, the presence or absence of complications, and the parents' previous expressed feelings about acceptable risk of morbidity. This decision

should usually be taken by a senior member of the neonatal team i.e. Consultant, Senior ANNP or middle grade doctor.

4. Training and Competencies

Ideally, all staff undertaking resuscitation at birth will have attended the UK resuscitation council approved training course (renewed every 4 years). In intervening years refreshers are offered as part of mandatory training and for new staff, awaiting their first training course, in-house training is given to assess and confirm competency to participate.

5. Related Documents

Thermoregulation - Trust Docs ID: 1244

6. References

1) Newborn Life Support – Resuscitation at birth. 4th Edition (2016) Resuscitation Council (UK)
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6) Trevisanuto D, Cavallin F, Nguyen LN, et al. supreme laryngeal mask airway versus face mask during neonatal resuscitation: a randomized controlled trial.
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8) Fawke J, Wyllie J, Madar J, Ainsworth S, Tinnion R, Chittick, R, Wenlock N, Cusack J, Monnelly V, Lockey A, Hampshire S. Newborn resuscitation and support of transition of infants at birth Guidelines. Resuscitation Council UK May 2021

7. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee / dept	Frequency of monitoring
Compliance	Retrospective case note review of babies receiving resuscitation to determine compliance with the guideline	Via audit, author and co-author to undertake	NICU Governance department (monthly meeting each 2nd Wednesday in each month))	Annual

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action. Then sent to Women's and Children's Governance committee to be submitted to the divisional board. who will ensure that the actions and recommendations are suitable and sufficient.

8. Appendices

There are no appendices for this document.

9. Equality Impact Assessment (EIA)

Type of function or policy	New

Division	Women's and Children's	**Department**	NICU
Name of person completing form	Jacqui Jones	**Date**	30.05.23

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race				No
Pregnancy & Maternity				No
Disability				No
Religion and beliefs				No
Sex				No
Gender reassignment				No
Sexual Orientation				No
Age				No
Marriage & Civil Partnership				No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	No impact			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.