Aims

- To observe and assist the neonate in adaptation to extra uterine life
- To provide a thermo-neutral environment and support thermoregulation
- To promote parent-infant bonding and initiate chosen method of feeding
- To identify any abnormalities.
- To recognise clinical deterioration and respond in a timely and appropriate manner.

Key points

- All health practitioners are to handover the deteriorating patient using ISOBAR to assist the communication process when accountability and responsibility for patient care is transferred.

Equipment

- Neonatal History sheet (MR410)
- Neonatal shadow file
- Nappy
- Warm towel & baby blankets
- 2 x Neonatal ID bands
- Stethoscope
- Disposable cord clamp
- Clamp & scissors
- Thermometer
- O2 saturation monitor
Neonate: Immediate Care after Birth

**Procedure**

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<tr>
<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tr>
<td>1. At birth, make an immediate assessment of the infant. If stable then immediately place the neonate skin-to-skin on the mother’s chest. If the infant is not stable or there is concern, transfer the infant to the resuscitation cot and reassess or initiate resuscitation as appropriate.</td>
<td>Signs of clinical and physiological instability often precede a cardio-respiratory arrest. In many cases these events may be prevented if the cause of deterioration is recognised early and acted upon before the neonate deteriorates beyond the point of reversibility.</td>
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<td>2. Dry the neonate with a warm towel, remove the wet towel and cover the neonate with warm, dry blankets. The whole body and the head should be covered. Recommended air temperature to provide thermal protection is 25-28°C. In the event of SGA/IUGR babies recommended air temperature is as follows: Newborn weight 1.0 – 1.5kg: 30 – 33°C Newborn weight 1.5 - 2.0kg : 28 - 30°C Newborn weight 2.0 – 2.5kg : 26 - 28°C</td>
<td>To promote initial attachment between parents and neonate. Skin-to-skin contact prevents heat loss by conduction. This minimises heat loss to a cooler surface thus reducing potential for cold stress.</td>
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<td>3. Clamp and cut the umbilical cord. Delayed clamping and cutting of the cord is determined by the</td>
<td>See Clinical Guidelines, O&amp;M, Intrapartum, Third Stage: Active Management.</td>
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<tr>
<td>• Neonatal condition</td>
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<td>• Maternal condition</td>
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<td>• Requirement for early blood collection</td>
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Obstetrics & Midwifery
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<td>4. Assess the Apgar score at one minute and five minutes post birth. Document the Apgar scores on the Neonatal History sheet (MR410).</td>
<td>The Apgar score is used to assess adaptation to extra uterine life. It measures heart rate, respiratory effort, colour, muscle tone and reflex response. The APGAR scores provide information on the neonate’s early transition. Feeding within the first hour of life helps to prevent hypoglycaemia and hyperbilirubinemia.</td>
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<td>5. Promote breastfeeding of the neonate within the first hour of life by supporting skin-to-skin contact and allowing the neonate to root and latch on spontaneously</td>
<td>Identification bands identify the neonate with its mother and enables linking with associated documentation.</td>
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<td>6. Apply two white identification (ID) bands to the neonate’s ankle with the mother’s UMRN number on it. When the neonate’s own UMRN number has been issued, replace the original (mother’s UMRN) identification band for 2 neonatal ID bands (listing the neonate’s details), preferably one on each ankle. Confirm that the mother’s details on the neonate’s identification bands match.</td>
<td>See also: Clinical Guideline O&amp;G, Patient Administration: Patient Identification</td>
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<td>7. Apply a disposable umbilical cord clamp 1-2 centimetres from the umbilicus. Check the clamp security and then cut the cord on the distal side of clamp with the cord scissors. Ensure no bleeding from the site.</td>
<td>Note: For babies who require umbilical vein catheterisation, leave at least 4cm of cord between the umbilicus and the cord clamp.</td>
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Clinical Observations

8. For the first hour after birth: Perform an assessment of the following every 15 minutes and document:
   - Respirations (Normal rate 30-60 bpm)
   - Colour (Normal – centrally pink acrocyanosis is normal in the first 24 hours)
   - Position in a supine head neutral position, enabling a patent airway

Within the first hour perform:
   - Temperature (Normal 36.5-37.4°C)
   - Heart rate (HR normal 120-160 bpm)
   - SpO2: probe on right wrist (normal 95-100%)
   - Tone (normal: good flexion & reactivity)

The World Health Organization suggests continued regular monitoring within the first hour of birth of the placenta. Respond according to condition & notify Shift Coordinator and the Neonatal Medical Officer of abnormalities detected.

See KEMH- NCCU Clinical Guidelines Newborn Resuscitation Algorithm, Recognising and Responding to Clinical Deterioration in NCCU

Examine the neonate in good lighting.

See page 3 for additional observations required for specific circumstances.

9. After the first hour (if within normal limits), repeat assessment hourly for the next 2 hours for: temperature, respirations, HR, colour & tone.

Inform the mother to notify midwifery staff immediately of any changes in: colour, tone, respirations, behaviour.

10. Perform Early Onset Sepsis (EOS) score.

11. Perform and record in front of the mother / partner:
   - the cephalocaudal examination
   - the neonate’s weight, length and head circumference.

Apply nappy & clean, warm blankets.

Check for malformations and any issues with the presenting part.

See Clinical Guideline, O&M, Neonatal Care: Neonatal Examination.
Observations to be Performed in addition to those outlined above:

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<tr>
<th>Additional Risk Factor/s</th>
<th>Additional Observations Required</th>
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<tr>
<td>Operative Birth</td>
<td><strong>Vacuum Assisted Birth</strong></td>
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<td>Hats and bonnets should not be used</td>
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<td></td>
<td>• Observation for subgaleal haemorrhage (SGH) at 2, 4 and 8 hours of age as follows: Palpate the scalp to assess for resolution of the chignon</td>
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<td>• Palpate the scalp to note any ballotable mass or movement of fluid (gravity dependent), note the colour and head shape including displacement of the ears or pitting oedema.</td>
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<td>• Document all observations on the neonatal care plan.</td>
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<td><strong>Additional Midwifery Observation is required following:</strong></td>
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<td>• Total vacuum extraction time &gt; 20 minutes and / or 3 pulls and / or 2 cup detachments.</td>
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<td>• 5 minute Apgar score &lt; 7</td>
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<td>• At clinician request</td>
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<td>• Routine surveillance observations are causing concern</td>
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When there is clinical suspicion of SGH immediately following birth, or abnormalities are noted on increased surveillance:

- Prompt review by a paediatrician
- When additional observations for SGH are required, they are to continue for at least the first 12 hours of life.
- Hourly for the first 2 hours and then 2 hourly for a further 6 hours.

| Meconium Stained Amniotic Fluid | Assess 2 hourly (until 12 hours of age)\(^8\):
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<td>• Temperature, HR, respiratory rate (also observe/document any abnormalities in chest wall movements, pattern &amp; effort), tone, colour, feeding, general wellbeing</td>
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<td>• $\text{SpO}_2$ (at 1, 2 &amp; 4 hours of age)(^9)</td>
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<td>• If any observations are outside the normal parameters, report them to the paediatric medical team for review.</td>
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<td>• See full guideline: O&amp;M: Intrapartum: Meconium Stained Amniotic Fluid</td>
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</table>
Neonate: Immediate Care after Birth

| At risk of early onset sepsis | All neonates ≥35 weeks: Assess using the Neonatal Sepsis Calculator, and manage as per NCCU Clinical Guideline: Sepsis: Septic Calculator- Assessment of Early- Onset Sepsis in Infants >35 weeks using the Neonatal Sepsis Calculator. If calculator unavailable and neonate at risk: Temperature, heart rate, respiration rate, colour, tone:
|                            | • Every 3-4 hours / with feeds for at least 48 hours (can discharge home ≥24 hours* if adequate IVABs in labour, ≥37 weeks, meets discharge criteria, access to medical services, & an adult able to comply with home observations** will be present).
|                            | • See Clinical Guidelines:
|                            | - Neonatal Observations (for Additional observations)

| Near-term neonate (35°⁰ - 36°⁶ weeks) and / or Birthweight: 2.0 - 2.5kg | Temperature 3-4 hourly before feeds until 24 hours of age.
|                                                                      | Temperature before feeds until the temperature has been within the normal range for a further 24 hours.

* If requested by the mother, early discharge before 24 hours may only be considered if adequate intrapartum IVABs and after senior neonatal medical team review/ approval.
** Inform the parents about the signs/ symptoms of infection, how to document neonatal feeding / general wellbeing / temperature, and what to do if abnormalities or concerns.

**Note:** Listed above are the minimum additional observations and further observations may be required depending on individual circumstances.

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### References and resources


Related policies

WA Health Patient Identification Policy 2014
WA Health Operational Directive 0486/14

Related WNHS policies, procedures and guidelines

Obstetrics & Gynaecology: Patient Administration: Patient Identification
Obstetrics & Midwifery: Intrapartum: Third Stage: Active Management; Meconium Stained Amniotic Fluid
NCCU, Section: Newborn Resuscitation Algorithm;

Keywords: adaptation to extra uterine life, APGAR, neonatal care following birth, neonatal assessment following birth, recognise clinical deterioration, immediate assessment of the newborn, neonatal observations following birth

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Endorsed by: MSMSC  
Date: DDMonthYYYY

Standards Applicable: NSQHS Standards: 1 Governance, 5 Patient ID/Procedure Matching, 6 Clinical Handover, 9 Clinical Deterioration,

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