10 CARE OF THE NEONATE

10.1 CARE OF THE NEONATE IN LABOUR AND BIRTH SUITE

10.1.1 IMMEDIATE CARE OF THE NEONATE

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 accordingly.
- Good handover is essential to recognising and responding to clinical deterioration. 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)
- Warm towel & baby blankets
- Disposable cord clamp
- 2 x Neonatal ID bands
- Clamp & scissors
- Nappy
- Stethoscope
- Thermometer
- O2 sats monitor

PROCEDURE ADDITIONAL INFORMATION

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 you are unsure then transfer the infant to the resuscitation cot and reassess or initiate resuscitation as appropriate.

   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.

2. Dry the neonate with a warm towel, then cover the neonate with warm, dry blankets.

   To promote initial attachment between parents and neonate. Skin-to-skin contact prevents heat loss by conduction. This reduces the potential for heat loss through evaporation and conduction and thus cold stress.

3. Clamp and cut the umbilical cord.

   See Clinical Guidelines, Section B, 5.10.1 Active Management of the Third Stage.

4. Assess the Apgar score at one minute and five minutes post birth.

   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.

   Document the Apgar scores on the Neonatal History sheet (MR410).

5. Promote breastfeeding of the neonate within the first hour of life by supporting skin-to-skin contact and encouraging the mother to put the baby to the breast.

   Feeding within the first hour of life helps to prevent hypoglycaemia and hyperbilirubinemia.
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 two 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.

Identification bands identify the neonate with its mother and enables linking with associated documentation. Refer to the Code Black Guideline - for Principles of Risk Reduction (abduction). See also: Clinical Guideline Section A: 2.1.2 Neonatal Identification

7. Apply a disposable umbilical cord clamp 1-2 centimetres from the umbilicus. Check the security of the clamp and then cut the cord on the distal side of the clamp with the cord scissors. Ensure there is no bleeding from the site. Note: For babies who require umbilical vein catheterisation, leave at least 4cm of cord between the umbilicus and the cord clamp.

8. For the first hour after birth: Perform an assessment of the following every 15 minutes and document:
   - Respirations (Normal rate 30-60)
   - Listen for grunting, look for chest/rib recession, tachypnoea, and patent airway/position.
   - Heart rate (Normal 110-160)
   - Colour (Normal – Pink)
   - Check SaO2 on right hand/wrist if unsure)
   - Tone/level of consciousness.
   - Temperature (Normal 36.5 to 37.4)

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 also NCCU Section 1: Newborn Resuscitation Algorithm. Recognising and Responding to Clinical Deterioration NCCU GUIDELINE
Examine the neonate in good lighting.

9. After the first hour (if within normal limits), repeat assessment of respirations, HR, colour, tone/level of consciousness hourly for the next two hours.

   - Inform the mother to notify midwifery staff immediately of any changes in:
     - Colour
     - Tone
     - Respirations
     - Behaviour.

See also Clinical Guideline B: 10.2.2 Observations.

Notify the shift coordinator and the Neonatal Medical Officer of any abnormalities detected.
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<tr>
<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tr>
<td>10. Perform and record in front of the mother / partner:</td>
<td>Check for malformations and any issues with the presenting part. See Clinical Guideline, Section B:10.3.1 Examination of the Neonate.</td>
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<td>• the cephalocaudal examination</td>
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<td>• the neonate’s weight, length and head circumference.</td>
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<td>11. Apply a nappy and clean, warm blankets.</td>
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<td>- Operative Birth – no additional observations unless specified.</td>
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<td>- Meconium Stained Amniotic Fluid – temperature, heart rate and respirations to be taken at birth, every 15 minutes during the first hour following birth, at 1 and 2 hours of age and repeated 2-3 hourly before feeds until 12 hours of age.</td>
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<td>- Babies at Risk of Early Onset Sepsis (included positive Group B Streptococcal(GBS)culture, GBS bacteriuria, previous infant with invasive GBS disease, ruptured membranes &gt; 18 hours, preterm birth, intrapartum maternal temperature &gt; 38°C).</td>
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<td>- Where adequate intrapartum antibiotics have been given for maternal risk factors – temperature, heart and respiratory rates shall be taken at birth, every 15 minutes during the first hour following birth, then 1 hourly for 4 hours, then before each feed / 4 hourly for 24 hours.</td>
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<td>- Where there has been inadequate maternal antibiotic prophylaxis observations as above and refer to the full neonatal guideline for further tests and assessments Infection, Screening and Management of Infection.</td>
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<td>- Near Term Newborn Infant ( &gt;35 &lt;37 weeks) and / or 2.0kg – 2.5kg</td>
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<td>Temperature at birth, 15 minutely during the first hour following birth, then 1 hourly for 3 hours, then 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.</td>
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REFERENCES (STANDARDS)


National Standards –
Legislation -
Other related documents – KEMH Clinical Guidelines:
- A: 2.1.2 Neonatal Identification
- B: 5.10.1 Active Management of the Third Stage
- B: 10.2.2 Observations
- B: 10.2.7 Management of the Neonate with a Temperature Below 36.5°C
- B: 10.3.1 Examination of the Neonate.
- NCCU Section 1: Newborn Resuscitation Algorithm
- WNHS Emergency Preparedness (See Code Black - Abduction minimisation guidelines - Appendix 4)

RESPONSIBILITY
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Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.