



CLINICAL PRACTICE GUIDELINE

# Labour: Neonatal team attendance at birth

This document should be read in conjunction with this [Disclaimer](#)

## Key points

1. A member of the Neonatal Directorate shall be called to attend at the birth for possible resuscitation in the conditions listed below.
2. Sufficient notice shall be given to enable the staff members to get to Labour and Birth Suite and Theatre, to check and prepare the resuscitation trolley and to obtain a history of the relevant pregnancy and labour details so that potential problems can be anticipated.
3. Neonatal medical staff attending births includes RMOs, Registrars, Senior Registrars and Consultants.
4. Births are divided into three different groups depending upon the level of paediatric support likely to be required.
5. For all **Group Three** patients, a resuscitation cot with full intensive care facilities should be in the Labour and Birth Suite or Theatre.
6. The decision to call personnel to attend births is the responsibility of the obstetric staff. Whenever possible he/she should personally contact the appropriate member of the Neonatal Directorate. When paging the staff member, it is advisable to include a telephone extension so that the neonatal doctor can call to advise of his/her availability to attend.
7. A Caesarean section shall not commence unless a medical member of the Neonatal Directorate is present in Theatre.

**Group One:** - Call the Neonatal RMO on pager 3219

**Note:** Neonatal Registrars will support Neonatal RMO's at every birth until the RMO is deemed competent and confident in attending births alone.

- 35-37 weeks gestation
- Forceps (low cavity)
- Vacuum extraction (low cavity)
- Pre-eclampsia
- Intrauterine growth restriction
- Membranes ruptured greater than 24 hours if no antibiotics have been administered four hours prior to birth

- Maternal sepsis, mother receiving IVABs, positive GBS screen, previous infant with GBS, maternal GBS bacteraemia
- Elective caesarean section for non-complicated term infants under regional anaesthesia
- Maternal diabetes if mother required Insulin during pregnancy and/or labour
- Maternal Morphine analgesia administered within 4 hours prior birth
- Women taking a Selective Serotonin Reuptake Inhibitor(SSRI) or Serotonin and Norepinephrine reuptake Inhibitor (SNRI) medication

**Group Two:** Call the:

1. Neonatal Registrar (pager 3249) PLUS
2. Neonatal RMO (pager 3219)
  - 32-35 weeks gestation
  - All breech births
  - Poor obstetric history – previous perinatal and neonatal death
  - Multiple pregnancy
  - High or mid cavity forceps / vacuum extraction
  - Trial of instrumental birth in theatre
  - Elective caesarean section < 38 weeks and > 41 weeks
  - All Non-elective caesarean sections
  - Elective caesarean sections under general anaesthesia
  - Meconium stained amniotic fluid, fetal bradycardia, other acute fetal compromise
  - Rhesus isoimmunisation
  - APH / Intrapartum bleed. If medical clearance has been given to the women to birth in the FBC then the paediatric team is not required at the birth.

**Group Three (high risk):** Call the:

1. Senior Neonatal Registrar (pager 3377) PLUS
2. Neonatal Registrar (pager 3249) PLUS
3. Neonatal RMO (pager 3219).




Note: The Senior Registrar will notify the Neonatal Consultant at his/her discretion.

- All births of 32 weeks gestation or less
- Multiple pregnancy < 34 weeks
- Severe acute fetal compromise
- Severe rhesus isoimmunisation e.g. hydrops
- Known high risk congenital anomalies such as diaphragmatic hernia

**Related WNHS policies, procedures and guidelines**

Neonatology Clinical Guidelines:

- [Resuscitation: Algorithm for the Newborn](#)
- [Resuscitation: Neonatal](#)
- [Resuscitation: Medications and Fluids](#)

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