



## CLINICAL PRACTICE GUIDELINE

# Neonatal care: Immediate care for babies

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

### Aims

1. Observe and assist the neonate in adaptation to extra uterine life <sup>1</sup>
2. Promote parent-infant bonding<sup>1</sup> and initiate chosen method of feeding
3. Recognise and abnormalities and/or clinical deterioration and respond in a timely and appropriate manner.

### Key points

1. Ask the woman's consent before all procedures and observations.
2. Document escalation of care as clinically indicated.

### Procedure

1. At birth make an immediate assessment of the neonate.
  - If stable then immediately place the neonate skin-to-skin on the mother's chest.
  - If the neonate is not stable or there is concern, transfer them to the resuscitation cot/area and reassess or initiate resuscitation as appropriate.
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<sup>2</sup> is 25 - 28°C.  
In the event of SGA/IUGR babies recommended air temperature is as follows:
  - Birth weight 1.0 – 1.5kg: 30 – 33°C
  - Birth weight 1.5 - 2.0kg : 28 - 30°C
  - Birth weight 2.0 – 2.5kg : 26 - 28°C
3. Clamp and cut the umbilical cord. See also O&G [Labour: Third Stage](#) guideline
4. Apply umbilical cord clamp 1-2 centimetres from the umbilicus.
  - For neonates who require umbilical vein catheterisation, leave at least 4cm of cord between the umbilicus and the cord clamp.

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.

5. Assess the Apgar score at one minute and five minutes post birth. Document the Apgar scores on the Neonatal History sheet (MR410).
6. Continuous O2 saturation monitoring is to commence before/at commencement of skin to skin and before the midwife leaves the bedside/woman.

Continuous O2 saturation is to continue for 2 hours.

Document O2 saturation and HR of baby at commencement and cessation of O2 sat monitoring.

- Continuous O2 saturation normal (normal  $\geq$  95%)

**For Community Midwifery Program (CMP)** babies born at home with readings  $<95\%$  consultation and transfer to the supporting hospital for further assessment is required. If after consultation the supporting hospital is not willing to accept care the paediatric Senior Registrar or above at KEMH is to be consulted for transfer into KEMH.

7. Document the following observations at 60, 120 and 180 minutes:

- Temperature (normal 36.5 - 37.4 °C)
- Heart rate (normal 120- 160bpm)
- Respiratory rate (normal 30-60/min)

If an oximeter is not available, the following assessment should occur every 15 minutes for the 1st hour, and then hourly for the next 2 hours. Record:

- Temperature (normal 36.5 - 37.4 °C)
- Heart rate (normal 120-160bpm)
- Respiratory rate (normal 30-60/min)
- Colour
- Tone
- Unobstructed airway.

Inform the mother and support persons to notify staff immediately of any changes in colour, tone, respirations, behaviour.

8. Promote breastfeeding within the first hour of life by supporting skin to skin contact and allowing the neonate to root and latch on spontaneously.
9. Apply two white identification (ID) bands to the neonate's ankle with the mother's UMRN number on it.<sup>3</sup> (excluding home birth)

When the neonate's own UMRN number has been issued, replace the original (mother's UMRN) identification band<sup>3</sup> 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.

10. If baby  $\geq 35$  weeks assess early onset sepsis score using the Neonatology guideline: [Sepsis Calculator- Assessment of Early Onset Sepsis in Infants >35 weeks.](#)

If calculator unavailable and neonate is at risk of GBS sepsis (see Neonatology guideline: [Sepsis: Infection in the Neonate](#)). Temperature, heart rate, respiration rate, colour, tone to be taken and recorded.

- Every 3-4 hours / with feeds for at least 48 hours (can discharge home  $\geq 24$  hours\* if adequate IVABs in labour,  $\geq 37$  weeks, meets discharge criteria, access to medical services, & an adult able to comply with home observations\*\* will be present.<sup>4</sup>

\* 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.

\*\*\* **For neonates born at home with the CMP, consultation is required with the supporting hospital to formulate a plan of management.**

12. Perform and record in front of the mother / partner the:

- cephalocaudal examination.
- neonate's weight, length and head circumference.

Apply nappy & clean, warm blankets.

**Observations to be performed in addition to those outlined above:**

Additional risk factor/s	Additional observations required
Assisted Birth	<p><b>Vacuum Assisted Birth</b></p> <p>Hats and bonnets should not be used.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Document all observations on the neonatal care plan.</li> </ul> <p><b>Additional Midwifery Observation is required following:</b></p> <ul style="list-style-type: none"> <li>• Total vacuum extraction time &gt; 20 minutes and / or 3 pulls</li> </ul>

	<p>and / or 2 cup detachments.</p> <ul style="list-style-type: none"> <li>• 5 minute Apgar score &lt; 7.</li> <li>• At clinician request.</li> <li>• Routine surveillance observations are causing concern.</li> </ul> <p><b>When there is clinical suspicion of SGH immediately following birth, or abnormalities are noted on increased surveillance:</b></p> <ul style="list-style-type: none"> <li>• Prompt review by a paediatrician.</li> <li>• When additional observations for SGH are required, they are to continue for at least the first 12 hours of life.</li> <li>• Hourly for the first 2 hours and then 2 hourly for a further 6 hours.</li> </ul>
<p><a href="#">Meconium Stained Amniotic Fluid</a></p>	<p>Assess 2 hourly (until 12 hours of age):</p> <ul style="list-style-type: none"> <li>• Temperature, heart rate, respiratory rate, SpO<sub>2</sub> (also observe/document any abnormalities in chest wall movements, pattern &amp; effort), tone, colour, feeding, general wellbeing.</li> <li>• SpO<sub>2</sub> (continuous monitoring for 2 hours after birth).</li> <li>• If any observations are outside the normal parameters, report them to the paediatric medical team for review.</li> <li>• See full guideline: Obstetrics &amp; Gynaecology: Labour: <a href="#">Meconium Stained Amniotic Fluid</a>.</li> </ul>
<p>Near-term neonate (35<sup>+0</sup> - 36<sup>+6</sup> weeks) and / or Birthweight: 2.0 - 2.5kg</p>	<p>Temperature 3-4 hourly before feeds until 24 hours of age.</p> <p>Temperature before feeds until the temperature has been within the normal range for a further 24 hours.</p>

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

References and resources	
1.	Green CJ, Wilkinson JM. Maternal newborn nursing care plans. St Louis: <b>Mosby</b> ; 2004.

2. World Health Organization. Thermal protection of the newborn: a practical guide. **WHO**. 1997. Available from: [https://www.who.int/maternal\\_child\\_adolescent/documents/ws42097th/en/](https://www.who.int/maternal_child_adolescent/documents/ws42097th/en/)
3. WA Health patient identification policy. . **Department of Health, WA**. 2014. Available from: <http://www.health.wa.gov.au/circularsnew/pdfs/13052.pdf>
4. Centres for Disease Control and Prevention (CDC). Prevention of perinatal group b streptococcal disease. **MMWR**. 2010;59(RR-10). Available from: <http://www.cdc.gov/mmwr/pdf/rr/rr5910.pdf>

**Related policies**

WA Health [Operational Directive 0486/14](#): [WA Health Patient Identification Policy 2014](#)

**Related WNHS policies, procedures and guidelines**

Obstetrics & Gynaecology:

- Intrapartum: [Labour: Third Stage](#); [Meconium Stained Amniotic Fluid](#);
- Neonatal Care: [Neonatal Observations](#); [Neonatal Hypothermia: Management for Temperature <36.5°C](#); [Neonatal Examination](#) & [QRG](#)

Neonatology: [Resuscitation Algorithm for the Newborn](#); [Sepsis Calculator- Assessment of Early Onset Sepsis in Infants >35 weeks](#); [Sepsis: Infection in the Neonate](#)

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