Neonatal Resuscitation: Who Attends Low, Moderate and High Risk Births Procedure

Effective: 19 August 2019

1. Guiding Principles

This document is to be read in conjunction with the Broome Hospital Medical Model of Care and WACHS Recognition and Response to Acute Deterioration in the Newborn Policy.

Broome Hospital provides elective low and moderate risk obstetric services, and emergency (unplanned) high risk deliveries for maternal or fetal compromise. Efforts to relocate or evacuate high risk women and their in-utero infant(s) to tertiary care is to occur whenever practicable.

Broome Hospital provides Clinical Services Framework (CSF) Level 4/5 neonatal nursery services, with continuous onsite District Medical Officer (DMO) cover and 24 hour access to consultant paediatricians. A DMO/NP 'Neonatal Resus' on-call rota forms part of the Broome Hospital rostering arrangements for moderate risk deliveries.

Decisions relating to the presence of additional support for possible neonatal resuscitation events lie with the obstetric and/or midwifery staff. The stratification of neonatal resuscitation risk will be considered as low, medium or high, according to the table below:

Low Risk: Standard, uncomplicated pregnancies and labour without fetal distress or compromise, with gestational age 37+ weeks. Attended by neonatal resuscitation competent* Midwives +/- obstetric medical staff.

Moderate Risk: Births with a moderate concern for maternal or Fetal wellbeing. Attended by neonatal resuscitation competent** DMO or Nurse Practitioners (NP) according the published on-call "Neonatal Resuscitation" roster.

High Risk: Births with a significant concern for maternal or fetal wellbeing. Attended by the Consultant Paediatrician** or Paediatric Registrar** on-call. Escalation to request Consultant attendance may be made at any time by the DMO, Paediatric or Obstetric staff.

Attending DMO's and medical staff are to attempt to meet the mother and family in advance of complex interventions (ie theatre, instrumentation) to identify themselves, explain their role and convey risk factors that may influence aftercare and treatment.

* All midwives and obstetric medical staff **must** have annual credentialing and currency in Basic Neonatal Resuscitation

**All DMO's/NP's on the Neonatal Resus Roster, and all Paediatric Consultants and Registrars, must have annual credentialing and currency in Basic Neonatal Resuscitation (REN003), and complete the KEMH (or equivalent) Neonatal Resuscitation Program (NRP) every three years.

2. Procedure

i) Obstetric and/or midwifery staff determine the requirements for additional expertise, according the table below, and contact the personnel themselves

ii) Consultant Paediatricians are available 24/7 to attend births, at the request of primary treating staff

iii) All designated neonatal resuscitation staff attending a birth are responsible for checking and setting up the resus cot, and procuring the necessary equipment according the perceived risk

Low Risk Deliveries	Moderate Risk Deliveries	High Risk Deliveries
Neonatal Resus competent midwife, +/- obstetric medical staff	As for low risk deliveries, PLUS Neonatal Resus competent DMO / NP (or a co-opted paediatric medical staff member)	As for low risk deliveries, PLUS Neonatal Resus competent Consultant Paediatrician or Paediatric Registrar (on-call consultant may be requested at any time)
Routine, uncomplicated pregnancy and labour without fetal distress or compromise, in births with gestational age 37+ weeks. Request for assistance from the DMO/NP team or Paediatric medical team can be made at any time by midwifery or obstetric staff.	• All births 35-37 weeks gestation • Meconium stained liquor • Abnormal CTG indicating possible fetal compromise • Elective or non-elective caesarean section, using regional or general anaesthesia • GBS screen positive/previous infant with GBS and inadequate intrapartum antibiotic cover (<2 hours) • Pre-eclampsia • Instrumental delivery (low cavity vacuum or forceps) • Maternal diabetes requiring insulin during pregnancy and/or delivery • Known IUGR >2kg • Poor or limited antenatal care • Prolonged rupture of membranes > 24 hours (with or without antibiotic prophylaxis)	Any moderate risk deliveries at the request of treating staff, PLUS: • All births <35 weeks gestation • Undiagnosed breech • Cord prolapse • Abnormal CTG indicating likely compromise • Abnormal fetal scalp blood sample • Maternal sepsis and/or chorioamnionitis. • Congenital abnormalities which may affect breathing, cardiovascular function or other aspects of perinatal transition. • Uncontrolled maternal diabetes. • Known IUGR <2kg • Multiple birth, irrespective of gestation

	• Maternal chronic illness (eg anaemia, cyanotic congenital heart disease, rheumatic heart disease, hypertension) • Drug exposure – Prescribed narcotics in labour, if administered <4 hrs before delivery – Antenatal substance use (suspected or acknowledged) • Maternal SSRI or SNRI use in pregnancy	• APH / Placental abruption • Rhesus iso-immunisation • Previous FDIU, perinatal death, neonatal death • Code Blue / MET Call

3. Definitions

DMO	District Medical Officer
WACHS	WA Country Health Service
CSF	Clinical Services Framework
NP	Nurse Practitioner
CTG	Cardiotocography
SGH	Subgaleal Haemorrhage
GBS	Group B Streptococcus
IUGR	Intrauterine Growth Restriction
IV	Intravenous
SSRI	Selective Serotonin Reuptake Inhibitors
SNRI	Serotonin and Noradrenaline Reuptake Inhibitors
APH	Antepartum Haemorrhage
FDIU	Fetal death In Utero
RHD	Rheumatic Heart Disease
MET	Medical Emergency Team
NRP	Neonatal Resuscitation Program

4. Roles and Responsibilities

All Broome Hospital midwifery, obstetric and paediatric staff are required to escalate or refer care according to this policy, and abide by the overarching WACHS governance structure to deliver equitable and safe care

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

Health Record Management Policy

7. Evaluation

Monitoring of compliance with this document is to be carried out by the Kimberley Regional Paediatric Service, every three (3) years (or sooner if clinically warranted), using the following means or tools:

- Procedure review through Paediatric Service Business Meetings
- As determined by Neonatal/Paediatric Morbidity and Mortality review process

8. Standards

National Safety and Quality Health Service Standards
1.5, 1.1e, 1.6, 5.10, 5.11, 5.12, 8.1, 8.4, 8.6, 8.9, 8.10, 8.11, 8.13

9. References

WACHS Recognition and Response to Acute Deterioration in the Newborn Policy

Broome Medical Model of Care

KEMH Policy “Resuscitation: Who Attends Birth”

Bunbury Hospital “Paediatric Team Attendance for ‘At Risk’ Births Procedure”

Responsibility for Neonatal Resuscitation at Birth, RANZCOG

American Academy of Paediatrics, 2016.Textbook of Neonatal Resuscitation 7thEd

10. Related Policy Documents

WACHS Recognition and Response to Acute Deterioration in the Newborn Policy

11. Policy Framework

Clinical Governance, Safety and Quality

This document can be made available in alternative formats on request for a person with a disability

Contact:	Nurse Practitioner Paediatrics Kimberley (S. Stokes)		
Directorate:	Nursing and Midwifery Services	**EDRMS Record #**	ED-CO-18-85155
Version:	1.00	**Date Published:**	19 August 2019