Document Title:	**GUIDELINES FOR ADMISSION TO THE NEONATAL UNIT**		
Document Reference/Register no:	04225A	**Version Number:**	5.1
Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Midwives, Paediatricians, ANNP's and Neonatal nurses
Ratification Issue Date: (Date document is uploaded onto the intranet)	28th February 2019	**Review Date:**	27th February 2022
Developed in response to:	Best clinical practice Review of Guideline		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			12
Issuing Division/Directorate:	Women's and Children's Directorate		
Author/Contact: (Asset Administrator)	Dr. A. Hassan, Consultant Paediatrician		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓ MEHT □ BTUH □ SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Dr Datta (Consultant Paediatrician)	**Date:**	19th February 2019
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Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** March 2019	**Distribution Method:**	Intranet and Website notified on staff focus

Consulted With:	Post/ Approval Committee/ Group:	Date:
Anita Rao/ Alison Cuthbertson	Clinical Director for Women's and Children's Directorate	19th February 2019
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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 04061 Risk Management Policy 07074 Guideline for Neonatal Resuscitation 08055 Passing a short term naso-gastric tube/oro-gastric tube on an infant 04216 Attachment and detachment of identification labels in for the newborn 11025 Serious Incident Policy

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Julie Bishop		October 2005
2.0	Sister T Laing, S Pilgrim ANNP		February 2009
2.1		Equality and diversity, audit and monitoring update, points 4, 6, 7	August 2009
3.0	Dr Hassan, T, Laing and S Pilgrim ANNP		October 2012
3.1	Sarah Moon	Clarification to 5.2 and 5.3	January 2013
3.2	Sharon Pilgrim	Amendment to 3.1 and 5.3	October 2014
4.0	Dr A Hassan, Sister T Laing, S Pilgrim ANNP		January 2016
5.0	Dr. A Hassan	Full Review - Inclusion of BAPM Transitional Care Criteria	28th February 2019
5.1	Dr. A Hassan	Clarification to point 3.1	4th March 2019

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1.0 Purpose

1.1 To ensure that infants are cared for in the optimal environment to meet their needs.

1.2 To allow flexibility in the admission criteria to minimise the separation of the mother and baby whilst ensuring that the baby's needs are met.

1.3 To ensure safe, prompt and effective delivery of care to newborn babies admitted to the Neonatal Unit through organized and coordinated work of the medical, nursing and midwifery staff.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix B)

3.0 Criteria for Admission

3.1 The following criteria are indicators for admission to the Neonatal Unit (NNU):

- Any infant delivered before 35 weeks' gestation;
- Any infant delivered with a birth weight below 1800 grams;
- Infants with persisting signs of respiratory distress;
- Any infant requiring oxygen therapy;
- Severe congenital anomalies;
- Any infant with suspected perinatal asphyxia requiring prolonged resuscitation (especially if cord pH < 7.15 or a base deficit > -10) irrespective of gestation;
- Unwell infant e.g. with signs of respiratory distress, hypothermia, hypoglycaemia requiring IV fluids,
- Hyperbilirubinemia requiring intensive phototherapy within 24 hours or likely to need an exchange transfusion;
- Seizures;
- Suspicion of severe sepsis i.e. meningitis, group B streptococcus;

- Infants with Neonatal Abstinence syndrome requiring treatment;
- Suspicion of moderately severe congenital heart defect;
- Any newborn requiring referral for surgery.

3.2 Broomfield Hospital has no dedicated Neonatal Transitional Care (NTC) facility. Babies who require NTC are admitted to the Neonatal Unit (with exception of selected babies who require 3 hourly nasogastric tube feeds who are cared for on the Postnatal Ward). (Appendix A: BAPM, NTC Criteria)

4.0 Liaison with Midwifery Teams

4.1 Nurse in Charge of NNU will call the Labour Ward Coordinator at the start and before the end of each shift.

4.2 Each morning a senior member of the neonatal team for the shift will call Labour Ward to collect the latest information about delivery suite activity and anticipated/possible admissions which will be recorded in the Neonatal Ward log of potential cases.

4.3 At the same time she will update the delivery suite team with the unit status and number of cots available for admissions.

4.4 The Doctors diary will be updated with expected admissions and repatriations.

4.5 The Labour Ward co-ordinator and Day Assessment Unit senior midwife will inform the Neonatal Unit of any impending deliveries.

4.6 Any change in the Neonatal Unit status should be escalated as per protocol as soon as possible.

5.0 Admission from Home or Birthing Units

5.1 Any infant being admitted from home following prolonged resuscitation, with signs of respiratory distress, severe sepsis, or other Neonatal emergency, must be transported in a 999 ambulance, summoned by the attending health professional who must request stating “This is an obstetric emergency” to ensure the call is placed as a priority.

5.2 Following stabilisation and discussion with the Neonatal Unit, the neonate will be transferred to the A&E department, Broomfield Hospital to be received by the prepared Neonatal Team for stabilization.

5.3 Following stabilization, the neonate will be transferred to the Neonatal Unit

6.0 Admission from Labour Ward

6.1 The Panda resuscitaires and neonatal resuscitation trolleys on the Labour Ward should be checked daily by the midwifery staff.
(Refer to the guideline entitled 'Neonatal resuscitation'; register number 07074)

6.2 After delivery; any initial resuscitation must take place prior to transfer of the baby to the Neonatal Unit. Any infant with breathing problems or where otherwise indicated should be transferred on the panda resuscitaire.

6.3 The infant can be moved once the team is comfortable that the baby is stable i.e. have patent airway, spontaneously breathing with stable circulatory status If not requiring oxygen the baby may be transferred in a cot.

6.4 Contact must be made with the neonatal unit nurse in charge prior to the baby being transferred.

6.5 The baby must have two identification baby labels securely attached on either ankle including mother's name, hospital number, date and time of birth, prior to transfer.
(Refer to the guideline entitled 'Attachment and detachment of identification labels in the newborn'; register number 04216)

7.0 Admission from Postnatal Ward

7.1 Any sick baby on the Postnatal Ward should be assessed by the neonatal team prior to transfer to the Neonatal Unit.

7.2 If the infants condition is seen to be stable, with no need for the immediate resuscitation the baby can be moved to the Neonatal Unit in his/her cot accompanied by a midwife/nurse from the Postnatal Ward staff.

7.3 In case of unstable/sick baby the necessary resuscitation and initial stabilisation while on the Postnatal Ward and then transported on the panda resuscitaire.

7.4 A full history of the care and treatment received by the infant up to that time and the reason for admission should be given.

7.5 The baby should be accompanied by the completed infant record or a short written summary to include drugs given including vitamin K and any treatment received or observations taken.

7.6 All infants who attend the NNU and require any medical treatment such as oxygen must have a full admission, including clerking by medical staff.

7.7 All Infants who attend NNU for less than 4 hours for observation or medical intervention such as an intravenous cannula must have a ward attender form completed and a trust case note folder opened prior to returning to the Postnatal Ward.

8.0 Duties of Staff involved in Admission of Sick Newborn to NICU/SCBU

8.1 Nursing staff

- Ensure an admission space always prepared and ready to use immediately;
- The cot will have been set up with the main equipment needed to provide immediate care and monitoring;
  (Refer to Appendix D)
- The Nurse in Charge (coordinator) to decide which space the infants will be admitted to, and who will be the admitting nurse;
- Admitting nurse to make sure baby has two identity bracelets and check details on them with the nurse handing over the baby;
- If the baby is ventilated ensure that the ventilator settings match the current settings on the transport ventilator before transferring the baby, Attach the sterile water and turn on the humidifier, set to 40°C;
- Weigh in the incubator for baseline weight (to assist with drug and fluid calculations);
- All infants admitted to the unit as either in patients transferred to the unit or ward attenders should be re-weighed on arrival. If the NNU weight is < 200grms different from the LW weight, the LW weight should be used to calculate drug doses. If >200grms different the NNU weight should be used;
- Ensure that the endotracheal tube (ETT) is secure and that the level of the tube is correct by noting that air entry is equal. Record the size and the level of the ETT at the fixing bar;
- Place a saturation (SaO_2) probe affixed to the best perfused limb to gain reading of the baby's oxygen levels. Record the admission $SaO_{2;}$
- Check temperature, heart rate and respiratory rate;
- Attach temperature probe and cardiac monitor leads;
- Check Blood pressure, report hypotension to the medical team;
- Check blood sugar as soon as possible from heel prick;
- Infants less than 30 completed weeks should remain wrapped in the plastic bag till all lines are secured, X-ray taken and humidity reaching 90%;
- Pass infant feeding tube (before CXR) and check for pH;
- Measure and record the head circumference;
- Arterial lines should be transducer to monitor mean arterial pressure;
- Give vitamin K if not already given;
- Ensure that a photograph of the baby is taken and given to parents along with the ITU booklet;

- Ensure that the medical staff has updated the parents about the baby's condition and progress;
- Complete the first hour of care sheet and appropriate daily record;
- Place a completed cot card with the baby's details on the incubator.

8.2 **Medical staff**

- Notify the nurse in charge immediately if you are informed by the Labour Ward about any imminent delivery which might need NICU admission;
- At delivery stabilize the infant as required, ensure the ETT (if intubated) is secure, and note the level at the fixing bar. Ensure there is adequate chest movement and equal air entry;
- Once on the NICU; assist the nursing staff moving the baby to his/her incubator on the unit, and connecting to the ventilator. Ensure the ETT still in correct place, by observing chest movements and listening to air entry;
- Adjust ventilator settings as needed, clinically;
- Give time to the nursing staff (normally about 10-15 minutes)-unless the baby is not well- to check the weight, connect the baby to monitors, take the base line observations, and check blood sugar and capillary blood gases if needed;
- Prescribe vitamin K, antibiotics and infusions as appropriate, so the nursing team can prepare while you are putting the lines;
- Insert PVL first so fluids could be started, then umbilical lines if indicated (refer to the NSC network guidelines on UAC/UVC insertion). http://meht-intranet/documents/trust-policies/external-policies-and-guidelines/ Collect admission blood samples;
- Document the procedure using the relevant label and stick in the notes (Same apply for ETT);
- Order X-rays to check ETT and lines position before starting the infusions, document position and any adjustment made on the relevant sticker placed in the notes;
- Complete admission examination, as appropriate depending on baby's condition;
- Highlight areas not examined, so it can be checked at later time e.g. red reflex, hips;
- Obtain history from maternal notes, plus the parents if possible;
- Fill in infant record as well as SEND admission notes for all infants even ward attenders;
- Complete first hour of care paperwork;
- Speak to the parents as soon as possible and update them about condition of their baby, reason for admission and current management and response;
- Document discussions with the parents in the communication page in the infant record;
- Ward attenders do not require a full neonatal infant record. The infant record found on pages 61-64 of the midwifery labour booklet are sufficient and are perforated to be

detached and added to the infant's notes. All infants requiring treatment as ward attenders require their own set of lilac notes.

9.0 Reporting any Unanticipated Admissions

9.1 For all cases of unanticipated admissions from home or wards a Datix incident reporting form should be completed by the midwife caring for the mother.

9.2 Relevant cases will be noted and may be presented and discussed in the perinatal mortality and morbidity meeting held once per month with the obstetric team.

9.3 Outcome of the case review in meetings will be summarized with recommendations formed into an action plan.

9.4 For Critical incident reporting refer to the Trust policy entitled 'Serious Incident Policy; register number 11025).

10.0 Clinical Audit Standards

10.1 The guideline will be monitored by regular audits, admission records review and inspection of the admission space on the unit.

10.2 The audit standard includes:

- Admission space should be ready at all times, with equipment as minimum meeting the requirements set in the attached;
- Newborns admitted to the NICU will have the admission booklet and SEND admission notes filled;
- Admission management check list completed and filed in the notes;
- Base line admission observations taken, including blood pressure and blood sugar, and entered on the admission sheet;
- All procedures performed documented on appropriate fully completed label and stuck in the notes;
- Above standards to be monitored by regular Audits, admission records review and inspection of the admission space on the Neonatal Unit.

11.0 Infection Prevention

11.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after undertaking any patient contact.

11.2 All staff and visitors to the Neonatal Unit must gel their hands prior to admission and remove their outside coats.

11.3 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. when obtaining blood samples.

12.0 Staff and Training

12.1 All medical and midwifery staff will be informed of the criteria for admission to the NNU.

12.2 The reasons for admission are included in the postnatal handbook available on each ward.

12.3 Teaching sessions on the identification of at risk neonate will be available on a monthly basis to all midwifery staff.

13.0 Professional Midwifery Advocates

13.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

14.0 Audit and Monitoring

14.1 Audit of compliance with this guideline will be undertaken on an annual audit basis in accordance with the Clinical Audit Strategy and Policy and the Maternity annual audit work plan. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

14.2 As a minimum the following specific requirements will be monitored:

- Responsibilities of all staff groups involved in the admission of a sick newborn to LNU/NICU/SCU;
- Criteria for the admission of a sick newborn to LNU/NICU/SCU;
- Transport arrangements for the movement of a sick newborn from the labour ward or postnatal ward to LNU/NICU/SCU;
- Transport arrangements for the movement of a sick newborn into hospital from either a home birth or midwifery led unit when problems have been identified at birth;
- Process by which the maternity unit and neonatal professionals share information about activity on a daily basis;
- Process for reporting and learning the lessons from unanticipated admissions to LNU/NICU/SCU;
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

14.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 14.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

14.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

14.5 The audit report will be reported to the monthly Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

14.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

14.7 Key findings and learning points will be disseminated to relevant staff.

15.0 Guideline Management

15.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

15.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

15.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

15.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

16.0 Communication

16.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

16.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

16.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

16.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

17.0 References

British Association of Perinatal Medicine (2017). A Framework for Neonatal Transitional Care. London: BAPM
Availane online at: https://www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf

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Rosie Hospital Neonatal Intensive Care Handbook, Cambridge (2010)

Department of Health (2004). Maternity Standard, National Service Framework for Children, Young People and Maternity Service: Maternity Services. London: COIDepartment of Health.

Confidential Enquiry into Stillbirths and Deaths in Infancy. (2003). Project 27/28.
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Royal College of Anaesthetists, Royal college of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in labour. London: RCOG Press.

Appendix A: Neonatal Transitional Care Criteria (BAPM 2017)

a) Criteria for NTC for babies from birth:

 Gestational age 34+0 to 35+6 weeks who do not fulfil criteria for intensive or high dependency care
 Birth weight > 1600 g* and < 2000 g who do not fulfil criteria for intensive or high dependency care (qualified recommendation)
 Risk factors for sepsis requiring IV antibiotics, but clinically stable
 Congenital anomaly likely to require tube feeding
 At risk of haemolytic disease requiring immediate phototherapy**

b) Additional care needs developing on the postnatal ward or at home:

 Inability to maintain temperature following an episode of rewarming and despite skin to skin contact and/or adequate clothing**
 Stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
 Inability to establish full suck feeds; predicted to require 3 hourly nasogastric tube feeds
 Significant neonatal abstinence syndrome requiring oral medication or additional feeding support
 Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly**

c) Babies readmitted from the community:

 Excessive weight loss and/or poor suck feeding requiring complementary nasogastric tube feeds
 Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly**

d) Babies “stepping down” from the NNU:

 Corrected gestational age > 33+0 weeks and clinically stable
 Current weight more than 1600 g and maintaining temperature
 Monitoring of vital signs required no more frequently than 3 hourly***
 Tolerating 3 hourly nasogastric tube feeds and maintaining blood glucose***
 Stable baby with sepsis requiring ongoing IV antibiotics
 Continuing phototherapy when serum bilirubin has stabilised following IV immunoglobulin or exchange transfusion
 Additional needs (*e.g.* nasogastric feeding, home oxygen) rooming in before discharge
 Palliative care when parent/carer doing most of the care

*It is to be expected that all babies weighing < 1600 g will be admitted initially to a NNU for observation of feeding and temperature control

** In NHS England these babies will not be coded as NTC unless they require additional treatments (*e.g.* nasogastric feeding), but it may be appropriate in some circumstances to accommodate them in a NTC setting, rather than a postnatal ward. Babies with non-haemolytic jaundice will usually be cared for in a Postnatal Ward.

***We recommend that larger NTC facilities are considered in when developing or re-organising maternity and neonatal services, with consideration being given to babies requiring more frequent monitoring or feeding to be cared for with their mother resident.

Appendix B: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

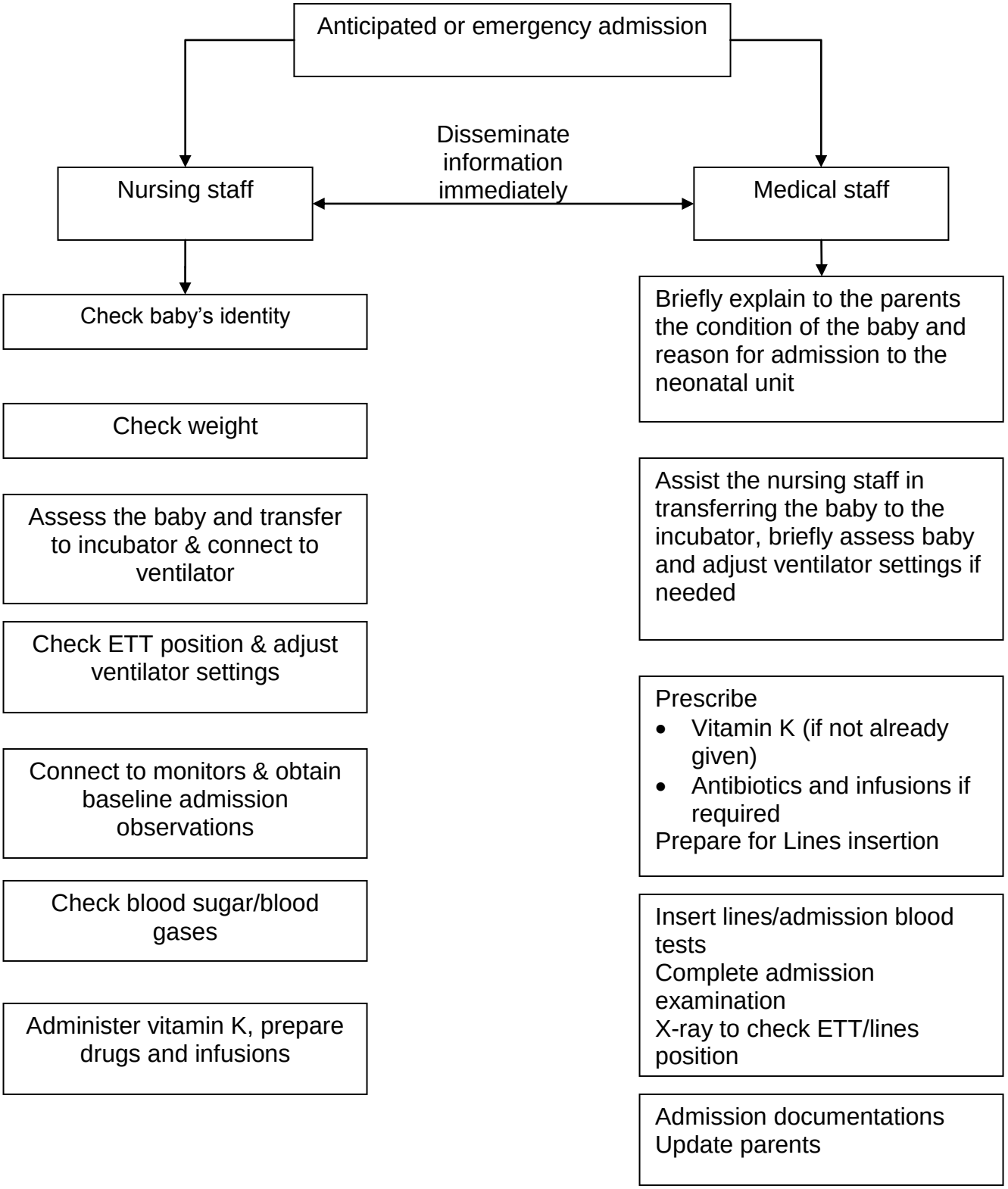
A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Dr Ahmed Hassan	**Job Title**	Consultant Paediatrician	**Date**	February 2019

Appendix C


Anticipated or emergency admission
Disseminate information immediately
Nursing staff
Medical staff
Check baby's identity
Check weight
Assess the baby and transfer to incubator & connect to ventilator
Check ETT position & adjust ventilator settings
Connect to monitors & obtain baseline admission observations
Check blood sugar/blood gases
Administer vitamin K, prepare drugs and infusions
Briefly explain to the parents the condition of the baby and reason for admission to the neonatal unit
Assist the nursing staff in transferring the baby to the incubator, briefly assess baby and adjust ventilator settings if needed
Prescribe
• Vitamin K (if not already given)
• Antibiotics and infusions if required
Prepare for Lines insertion
Insert lines/admission blood tests
Complete admission examination
X-ray to check ETT/lines position
Admission documentations
Update parents

Appendix D

Equipment and Setting up for an Admission to the Neonatal Unit

1. Pre-warmed incubator
2. Sterile water for irrigation for humidification
3. Incubator Bedding-with suitable ‘Nesting’ and weighed nappy
4. Ventilator with oxygen and air plugged in
5. Oxygen flow meter
6. Neopuff and face masks of different sizes
7. Suction unit ready for use and selection of suction catheters
8. Monitor with attachments
9. ECG leads with three electrodes attached
10. Saturation lead and probe with Posey Wrap
11. Selection of blood pressure cuffs
12. Infusion pump
13. Syringe pumps
14. Fully stocked Gratnel Trolley
15. Nursing charts and Lilac medical notes

Appendix E

NNU Resuscitation Bag checklist

Airway Bag (purple)

ET introducer
ETT 2.0, 2.5, 3.0, 3.5, 4.0 & 4.5 x 2 each
Neofit
Guedel airways, 000, 00, 0
Batteries and bulbs
Laryngoscope Handle
Laryngoscope blades miller 00,0

Umbilical Bag (yellow)

Blades
Sterile swabs
Silk sutures
Umbilical clamp and remover
Cord ties
Umbilical dilator
Dressing

Cannulation Bag (purple)

Syringe pump giving sets
Extension sets
Tagaderm IV
Steristrips
3 way connector
Neoflons
Sterets
N/Saline amps.
IV bungs

Extra sets (green bag)

Duoderm
Enteral feeding tubes
Enteral syringes
Sterile gauze swabs
Lancets
Neonatal Sa02 probes
Leukoplast tape
Tape measure
Pen torch

Surfactant Administration kits (Red)

ET surfactant admin set
Syringes
Sterile scissors
Needles

IV Fluids (Yellow)

10% Dextrose 500mls
N/Saline 100mls

Extras sets (Blue)

Woollen Hats
Prongs for transport

Resuscitation Drugs (Green)

Neonatal resuscitation drugs
Calculator
Drug additive labels

Various needles and Syringes

Syringes from 1ml – 50ml
Orange, blue, green and white needles

Umbilical Catheters in bag

Appendix F

Labour Ward Resuscitation Trolleys

2nd drawer Intubation

Plastic bags for premature babies
Guedel airways, 000, 00, 0
ETT 2.0, 2.5, 3.0, 3.5, 4.0 & 4.5 x 2 each
ET introducer X 2
Neofit X 2
Larynoscope blades size 00, 0
Spare batteries
Leucoplast
Transpore tape
Face masks 00, 0, 1.
Pen torch x 1
Surfactant administration set x 1
Disposable scissors x 2
Yankeur sucker x 2
Suction catheters x2 sizes 8, 10

2nd Drawer Cannulation

5x Syringes 2, 5, 10 and 20 mls
Paediatric blood bottles
Neoflon cannulas
Steristrips
Tagaderm cannula dressings
Sterile scissors
Splints
Green and Orange needles
N/Saline 10mls T peices

3rd Drawer Umbilical access

UVC/UAC catheter 3.5fg & 5fg
Leur lock syringes x 3 (1ml, 2.5, 5, 10, 20)
Cord Clamp x 2
N/Saline 100mls X 1
3 way tap X 2
Size 11 Blades X 2
Stitch cutter
Silk suture
2 x 50 ml Leur lock syringes
Green and orange needles
UVC bridges
Leukoplast tape
Transpore tape
Cord ties
Cord clamp cutter
Tape measure

4th Drawer Emergency drugs/IV fluids

10% Dextrose 500ml bag
Neonatal resuscitation drug box

5th Drawer

Neonatal cut down set
Paediatric stethoscope
Hats small, med, and large.
Sa02 probe x 2
Sterile gloves various sizes
Ambu bag