Document Title:	**CALLING PAEDIATRIC STAFF AND OBTAINING PAEDIATRIC REFERRAL**		
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Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Midwives, Obstetricians, Anaesthetists
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Developed in response to:	NICE guidelines, RCOG guidelines 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:**			9,12
Issuing Division/Directorate:	Women's and Children's		
Author/Contact: (Asset Administrator)	Joyce Mcintosh, Lead Nurse Neonatal Unit		
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Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Dr Hassan, Consultant Lead for Risk Management	**Date:**	19th May 2019
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Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** May 2019	**Distribution Method:**	Intranet & 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	18th April 2019
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Jude Horscraft	Practice Development Midwife	
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Deborah Lepley	Warner Library	26th April 2019

Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 04259 Management of Meconium stained liquor 07074 Neonatal Resuscitation 07056 Management of Neonates born to human immune-deficiency virus (HIV) positive mothers 04262 Management of Shoulder dystocia 06029 Transfer of Mothers and Babies to Different Care Settings 08054 Management of antenatally diagnosed renal pelvis dilatation and other congenital renal anomolies 04225 Examination of the Newborn infant

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Sharon Pilgrim		December 2009
2.0	Sharon Pilgrim		February 2013
2.1	Sharon Pilgrim	clarification to point 11.0	February 2014
3.0	Dr Hassan		1st March 2016
4.0	Joyce McIntosh	Full Review	20th May 2019

INDEX

1.0 Purpose

1.1 To ensure that the correct staff are available at every delivery.

1.2 To identify which deliveries a paediatrician should be present at and ensure that staff are aware of their responsibilities for calling paediatric staff.

1.3 To ensure that infants who are identified as clinically unwell or at risk are seen by a paediatrician promptly.

1.4 To ensure that the correct referral pathway is followed for accessing clinic appointments for infants.

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 C)

3.0 Paediatric Referral during the Antenatal Period

3.1 The midwife should complete a **neonatal referral form** to communicate the patient's details to the paediatric team for the following conditions:
(Refer to Appendix A)

- Multiple pregnancies (higher order more than 2 fetuses);
- HIV positive mothers;
- Mothers who have had a previous baby with group B streptococcus (GBS) Sepsis/meningitis;
- Significant structural abnormalities diagnosed on ultrasound;
  (Refer to the "Management of antenatally diagnosed renal pelvis Dilatation and other congenital renal anomolies'; register number 08054)
- All cases that require referral to specialist units for treatment or advice;
- Mothers with a high antibody titre i.e. anti D, C and Kel;
- Severe oligohydramnios;
- Abnormal dopplers;
- Genetic /hereditary disorders;
- Idiopathic thrombocytopaenia in the mother;
- Social i.e. drug abuse, alcohol abuse in the current pregnancy;
- Any other condition that will require paediatric input at birth.

4.0 Paediatric Attendance for Broomfield Consultant-led Unit Labour Ward/Obstetric Theatre

4.1 A paediatric senior house officer (SHO) or Advanced neonatal nurse practitioner (ANNP) should be bleeped prior to commencement of an elective lower segment caesarean section (LSCS) for the following reasons:

- Performed under general anaesthesia;
- Where fetal wellbeing is known to be compromised i.e. placental insufficiency multiple births;
- Known fetal abnormality;
- Prematurity less than 37 weeks' gestation.

4.2 A paediatric senior house officer/ANNP/registrar should be bleeped prior to commencement of **all** emergency lower segment caesarean section (LSCS).

4.3 A paediatric senior house officer/ANNP should be bleeped to attend the Labour Ward in the following circumstances:

- All instrumental deliveries (except low lift-outs);
- Prematurity less than 37 weeks gestation;
- Meconium stained liquor: **significant** meconium or meconium with the presence of decreased liquor or meconium with a suspicious cardiotocograph (CTG);
  (Refer to the 'Management of meconium stained liquor';
  register number 04259)
- Multiple pregnancy;
- Known fetal abnormality;
- Fetal distress and/or fetal scalp acidosis PH less than 7.2;
- Mal-presentation.

5.0 Crisis Situations and other Circumstances Requiring the Additional Presence of the Paediatric Registrar

5.1 The paediatric registrar should be present in the following circumstances:

- All deliveries less than 32 weeks gestation;
- When or if a baby requires intubation and ventilation;
- Life threatening congenital malformations;
- Severe shoulder dystocia;
  (Refer to the 'Management of shoulder dystocia'; register number 04262)
- Not responding to bag and mask ventilation or is born with no or poor Apgars, shocked or in anticipation of the above.

6.0 Code Blue

6.1 **Code Blue** is the emergency call to be put out for any collapsed baby. It is for emergency use only.
(Refer to the 'Neonatal resuscitation'; register number 07074)

6.2 Code Blue switchboard will fast bleep the following:

- On call paediatric registrar;
- On call paediatric senior house officer (SHO);

7.0 Calling for Paediatric Assistance for Labour Ward or Postnatal Ward

7.1 Ensure that accurate details include location; degree of urgency; time and estimated interval before birth are available to give to the responding paediatrician.

7.2 Identify the levels of urgency which could be routine, urgent or an emergency i.e. code blue.

7.3 Commence neonatal resuscitation in accordance with 'Neonatal Resuscitation' (07074) if required.

8.0 Paediatric Review Promptly after Delivery

8.1 The following babies should be reviewed promptly after delivery. Those babies:-

- Born to mothers with diabetes;
- Born to mothers with drug dependence;
- Born to mothers with prolonged rupture of membranes and known to be Group B streptococcus (GBS) carriers;
- Born to mothers who are HIV or Hepatitis B positive;
- With abnormal renal scan requiring medical treatment;
- Born to mothers with rhesus antibodies.

9.0 Midwife Referral of a Sick Baby in the Community/Midwife-Led Units

9.1 Use the bleep system to call the paediatric registrar covering the Neonatal Unit (NNU).

24 hours: #6555 3522.

9.2 If an infant is to be transferred to NNU/Postnatal Ward, call the NNU/ Postnatal Ward to inform staff and communicate the relevant details.

9.3 Arrange the transfer to Broomfield Hospital by East of England Ambulance Service if concerned about a clinical condition.
(Refer to the 'Transfer of mothers and babies to different care settings'. Register number 06029)

9.4 Any infant being admitted from home or the Midwifery-led Units 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.

10.0 Referral pathway for Consultant Review of Clinically Stable Infants following Discharge Home

10.1 Referrals to a paediatric consultant for infants, who have not been admitted to the Neonatal Unit, should be made using the 'Referrals for postnatal babies to have follow up appointment with paediatric consultant' referral sheet and handed to the postnatal ward clerk.
(Refer to Appendix B)

10.2 The following should be photocopied and handed to the postnatal ward clerk:
baby delivery record, baby postnatal record, drug chart (if applicable), alert form (if applicable) and any other relevant information for example scans, referrals from other hospitals.

10.3 Referrals to other specialities should be written on the A5 sheet headed 'Consultation request' and faxed to the appropriate department.

10.4 When making a referral for an infant of an HIV positive mother, a referral sheet (Appendix B) should be completed. These must be submitted immediately in order for the appointment to be made within the time frame.
(Refer to the '"Management of neonates born to human immune-deficiency virus (HIV) positive mothers'; register number 07056)

10.5 Referrals should be made as soon as possible.
(Refer to Appendix B)

11.0 Referral pathway for Hip Ultrasounds

(Refer to the guideline entitled 'Identification and Referral of Infants with Developmental Dysplasia of the Hips (DDH); register number 10085)

11.1 Babies with risk factors for DDH but no clinical signs of instability who have an otherwise normal neonatal examination should have a hip ultrasound scan arranged as an outpatient in 4-6 weeks. Any follow-up if the scan is abnormal will then be made directly with the orthopaedic team by the scan department.

11.2 Infants with hips that are dislocated or with limited abduction or abnormal hip anatomy require an urgent referral to the orthopaedic team and an early ultrasound within 2 weeks.

12.0 Infection Prevention

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

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

13.0 Staff and Training

13.1 All medical and midwifery staff will have training in the resuscitation of the newborn on a yearly basis.

13.2 Staff should be aware of the location and operation of the emergency equipment necessary for the resuscitation of the newborn.

13.3 Teaching sessions on the identification of at risk and sick neonates should be available on a monthly basis to all midwifery staff.

13.4 Midwifery staff should be aware of when and how to call a code blue.

14.0 Professional Midwifery Advocates

14.1 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.

15.0 Audit and Monitoring

15.1 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.

15.2 The findings of the audit will be reported to and approved by the Women's and Children's Clinical Audit Group meeting; 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.

15.3 The Women's and Children's Clinical Audit Group report will be reported to the Women's and Children's Directorate Governance Meeting on a quarterly basis and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

15.4 Key findings and learning points from the Women's and Children's Clinical Audit Group will be reported within the quarterly directorate report to the CCG.

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

16.0 Guideline Management

16.1 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.

16.2 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.

17.0 Communication

17.1 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.

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

18.0 References

National Institute for Health and Care Excellence (2008) Antenatal Care for uncomplicated pregnancies. Clinical Guideline (CG62) London: NICE. www.nice.org.uk/guidance/cg62

Royal College of Anaesthetist, Royal College of Midwives, Royal college of Obstetricians and Gynaecologists, Royal College of Paediatricians and Child Health (2007) Safer Childbirth. Minimum standards for the organisation and delivery of care in labour. London: RCOG Press
www.rcog.org.uk

Appendix A

Mid Essex Hospital Services NHS Trust

Neonatal Alert Form

First Name	**Surname**	
NHS No	**Hospital No**	**Referral Date**
EDD	**Gestation**	**Consultant**

Background history & problem summary

Delivery Plans

Broomfield Hospital ☐ Not Decided ☐

Other Hospital _____

Neonatal Alert Form Criteria

Please use the neonatal alert form for the following conditions:

- Multiple pregnancy (higher order > 2 fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosedon ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti-D, C and Kell
- Severe oligohydramnios / IUGR
- Abnormal dopplers
- Genetic / hereditary conditions in the immediate family that may affect the fetus
- Social e.g. drug abuse, alcohol abuse in this pregnancy
- Any other condition that will require paediatric input at birth

Postnatal Plan *(paediatric)*

Designation: Date:

Print Name: Signature:

Appendix B

REFERRALS FOR POSTNATAL BABIES TO HAVE A FOLLOW UP APPOINTMENT WITH A PAEDIATRIC CONSULTANT OR REGISTRAR

Name of Baby:	
DOB:	
Hospital Number:	

CONSULTANT PAEDIATRICIAN/REGISTRAR:

Appointment Requested for:	Weeks
Referring Doctor: (Please print name)	
Reason for Referral:	

INVESTIGATIONS CARRIED OUT ON POSTNATAL WARD
(Please document ALL investigations and results prior to requesting appointment)

Date	Investigation	Result

PLEASE COMPLETE THE FOLLOWING FOR INFANTS WITH RENAL ANOMALIES:

Pelvic Dilatation Measurements on Antenatal Scan at:	Left Kidney	Right Kidney
21/40 – 23/40		
32/40		
TRIMETHOPRIM STARTED	Yes	No

PLEASE ENSURE THE FOLLOWING DOCUMENTS ARE PHOTOCOPIED AND SENT WITH THE REFERRAL TO NICOLA SAYER, NEONATAL UNIT:

	Photocopied Yes/No
Baby Delivery Record	
Baby Postnatal Records	
Drug Chart (if applicable)	
Alert Forms	
Any other relevant information, i.e. scans, referrals from other hospitals	

Signed..... Date.....

This form to be used for Paediatric outpatient appointments only

Appendix C: Preliminary Equality Analysis

This assessment relates to: Calling Paediatric Staff And Obtaining Paediatric Referral/ 09113

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	Joyce McIntosh	**Job Title**	Matron Neonatal Unit	**Date**	April 2019