TRUST POLICY

RESUSCITATION OF THE NEWBORN
A1090

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All document profile details are recorded on the last page.

All documents must be reviewed by the last day of the month shown under “review date”, or before this if changes occur in the meantime.

FAST FIND:

ACTION CARD AC1 – IMMEDIATE ASSESSMENT AT BIRTH

ACTION CARD AC2 – RESUSCITATION AT BIRTH

ACTION CARD AC3 – ADVANCED RESUSCITATION

ACTION CARD AC4 – NEWBORN LIFE SUPPORT

DOCUMENT OVERVIEW:

This policy is for all health professionals who may be involved in the resuscitation or stabilisation of the newborn in the hospital or community setting.

This document may be made available to the public and persons outside of the Trust as part of the Trust’s compliance with the Freedom of Information Act 2000
RESUSCITATION OF THE NEWBORN

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ACTION CARD AC1 – IMMEDIATE ASSESSMENT AT BIRTH
ACTION CARD AC2 – RESUSCITATION AT BIRTH
ACTION CARD AC3 – ADVANCED RESUSCITATION
ACTION CARD AC4 – NEWBORN LIFE SUPPORT
1. **INTRODUCTION**
1.1 Neonatal or newborn resuscitation is a specialist skill required by all those who may be attendant at birth.

1.2 This policy is written in accordance with the document “Cardiopulmonary Resuscitation - Standards for Training and Clinical Practice” (Resuscitation Council (UK), 2005) and should be read in conjunction with – Newborn Life Support: Resuscitation at Birth 3rd Edition. Resuscitation Council: London. (2011) see action card AC4 Newborn Life Support.

2. **DEFINITIONS**
2.1 Newborn Life Support is a structured approach to the assessment and management of newborns needing support in physiological adaptation to extra-uterine life.

3. **PURPOSE**
3.1 This policy is for all health professionals who may be involved in the resuscitation or stabilisation of the newborn in the hospital or community setting.

4. **ROLES AND RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
<th>Resources</th>
<th>Review/ Monitoring</th>
<th>Implementation</th>
<th>Records</th>
<th>Reporting</th>
</tr>
</thead>
</table>
| All groups named below | • following this and associated policies/procedures  
• utilise the information within this guideline to provide the best evidence based practice  
• take reasonable care of self and others  
• All registered staff who care for newborns in the hospital or community setting should be competent to perform newborn basic life support if called upon to do so.  
• It is the individual’s responsibility to ensure they are trained on equipment they will need to use in their clinical practice and seek re-training to ensure their competence is maintained.  
• All staff should follow the same principles and practice of resuscitation to ensure the team works effectively together. Training should emphasise the anticipation of problems and calling for expert help via the appropriate system early  
• Those staff members who receive resuscitation training should ensure these skills are maintained and are required to attend updates annually unless otherwise indicated in the training needs analysis appendix (refer to Trust Maternity Mandatory Training Policy).  | X         | X                  | X              |         |           |
| Named Midwife       | • Ultimately responsible for coordination of care for woman and newborn  
• To ensure plans for care are clearly documented in the health record  
• communicate with the multi-professional team  | X         | X                  |                |         |           |
| Midwives            | • work closely with members of the multidisciplinary team to ensure that the newborn receives timely interventions and optimum care to achieve the best outcome  
• document and record all observations and management plans  
• ensure excellent communication between team members  
• To act as experts in the field of normal care and refer when deviation from the normal care pathway occurs  | X         | X                  |                |         |           |
| Obstetricians       | • work closely with members of the multidisciplinary team to ensure woman receives timely interventions and optimum care to achieve the best outcome for mother and newborn  
• document and record all observations and management plans  
• ensure excellent communication between team members  | X         | X                  |                |         |           |
Anaesthetists • work closely with members of the multidisciplinary team to ensure that the woman receives timely interventions and optimum care to achieve the best outcome for mother and baby • document and record all observations and management plans • ensure excellent communication between team members

Neonatologists • Designated link neonatologist for NNU and delivery suite is responsible for the clinical standards in relation to the care of the newborn • work closely with members of the multidisciplinary team to ensure that the newborn receives timely interventions and optimum care to achieve the best outcome for baby • document and record all observations and management plans • ensure excellent communication between team members

Maternity and Newborn Clinical Forum • Responsible for review and amendment of policies and guidance • Monitoring effectiveness of policy • Audit and actions

GOGG (Gloucestershire Obstetric Guidelines Group) • Approval and maintenance • Implementation

Clinical Governance • Ratification • Outstanding audit actions

5. NEWBORN RESUSCITATION SKILLS

5.1 ALL staff must know:

- where appropriate equipment is kept
- how to use the equipment
- how to maintain and check the equipment.

Neonatal Resuscitation Annual Training (See GHNHSFT Maternity Mandatory Training Policy)

<table>
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<tr>
<th>ESSENTIAL</th>
<th>NON-ESSENTIAL</th>
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<tr>
<td>Nurses</td>
<td>All other staff</td>
</tr>
<tr>
<td>Nursery Nurses</td>
<td></td>
</tr>
<tr>
<td>Neonatal Nurse Practitioners</td>
<td></td>
</tr>
<tr>
<td>All neonatal nurses attending births with paediatric staff</td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td></td>
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<tr>
<td>Obstetricians</td>
<td></td>
</tr>
<tr>
<td>Neonatologists</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic staff – permanent members of staff who cover maternity</td>
<td></td>
</tr>
</tbody>
</table>

5.2 Nationally Recognised Resuscitation Courses

5.2.1 If any staff members have successfully completed nationally recognised resuscitation courses, such as the Resuscitation Council (UK)’s Newborn Life Support (NLS) Course, they will be deemed competent to carry out aspects of resuscitation covered in that course. They will not require updates in those skills on an annual basis for the time that the qualification remains valid.

5.2.2 The time the course remains valid is set by the overseeing national body who determine when re-certification is required. If staff members are an accredited instructor for such a course, they will be deemed competent whilst they remain so.

6. PREPARATION FOR RESUSCITATION

6.1 Place of birth

6.1.1 Most deliveries will take place in the delivery suite in Gloucester, midwife led birth units in Cheltenham, Gloucester or Stroud or as a planned home delivery. However, birth can happen unexpectedly in other locations where practitioners may be called upon to resuscitate the newborn, such as the emergency department or other hospital locations. In these...
circumstances, practitioners should know where necessary equipment is located and how to call for expert assistance (see below).

6.2 Early call for expert assistance (See Table 1)

6.2.1 Senior assistance should be sought as early as possible. This may be needed especially for babies less than 32 weeks gestation, for twins or for any case where significant problems are anticipated.

Table 1

<table>
<thead>
<tr>
<th>Gloucester Royal Hospital (level 2 unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To call for a neonatologist bleep</td>
</tr>
<tr>
<td>• 2404 for ST1-3/ ANNP on-call (available 24 hours a day).</td>
</tr>
<tr>
<td>• 2403 for the neonatal registrar (ST 4-8) on-call (available 24 hours a day).</td>
</tr>
<tr>
<td>• The consultant on-call for neonatology is available via switchboard 24 hours a day</td>
</tr>
<tr>
<td>• In all situations, the level of support should be escalated from middle grade (ST4-8) to Consultant if baby not responding to resuscitation.</td>
</tr>
</tbody>
</table>

6.2.2 If newborn resuscitation is required following birth in a midwife led unit, early expert assistance should be sought and emergency transfer arrangements should be made.

6.2.3 When making the call, basic information should be given indicating the urgency of the call, the gestation of the pregnancy and reasons for the call, as well as the location of the impending delivery, including hospital site. This enables the doctor to ask the midwife to arrange for additional help as necessary, or call themselves.

6.3 Urgent assistance – Neonatal Emergency Team

6.3.1 If assistance is needed urgently, then the ‘Neonatal Emergency’ bleep should be used. This will alert the resuscitation team more rapidly, and enable a swift response. Telephone 2222 and clearly state “Neonatal Emergency Team to…” the ward/department and which hospital site. e.g. Neonatal Emergency Team to Delivery Unit, Gloucestershire Royal Hospital

6.3.2 The staff member making the call should listen to the switchboard operator repeating this message back to them before replacing the receiver.

6.3.3 If a need for advanced resuscitation is anticipated, call for senior help at an early stage. (eg. special cases in point 10). Maintain a low threshold for calling for senior help at any stage of resuscitation.

6.4 Universal Precautions

6.4.1 All team members should wear appropriate protection.

6.5 Immediate preparation prior to delivery

6.5.1 The midwife/obstetrician in charge of the case should provide a brief relevant history to the attending Neonatologists and the maternal notes should be reviewed to identify any important factors such as:

- Suspicious or abnormal CTG trace
- Intrauterine growth retardation
- Fresh meconium staining
- Prematurity
- Recent maternal opioids
- Multiple births
- Breech births
- Substance misuse
6.6 Prepare Equipment

6.6.1 Staff responsible for the birth and or the baby at birth need to ensure that all equipment is clean, assembled, in working order and ready for use, appropriate to the birth setting.

- Delivery suites, Birth units, Postnatal wards
  - A resuscitaire providing a firm level surface, an overhead heater and a gas supply will be available. In addition, the neonatal resuscitation trolley provides equipment for advanced neonatal resuscitation.

- Home delivery
  - A firm level surface should be prepared with towels for drying the baby and equipment to provide airway and breathing support if necessary. Attention to thermal control for the infant should be maintained throughout (ie close doors and windows, keep the infant warm during resuscitation).

- Emergency department
  - Obtain towels for drying and shut doors and windows to prevent the newborn getting cold. Equipment to support airway and breathing and to undertake advanced neonatal life support is available on the paediatric resuscitation trolley. Call for expert help early as detailed above.

- Other hospital locations (eg carpark, tower block wards)
  - Call for expert help. Dry the baby and close doors and windows to avoid draughts. Basic life support can be undertaken with minimal equipment (see below). The neonatal team will bring the neonatal transport bag (located on the neonatal unit in Gloucester) with advanced resuscitation equipment.

- Newborn Resuscitation during transfer by Ambulance see also GHNHSFT Maternity Transfer and Discharge Policy
  - The ambulance trolley will provide a firm surface; use the heat pad from the baby POD or ambulance kit to ensure warmth. Cover baby as far a possible with warm dry blankets and turn the heat up in the ambulance.
  - Resuscitation is not possible in the baby POD and should not be used if newborn resuscitation is required
  - The midwife remains the lead professional during the transfer and ongoing resuscitation
  - Continue resuscitation during transfer journey following Action card 2 resuscitation at birth (See action card AC2) and ACTION CARD AC4 – NEWBORN LIFE SUPPORT

6.6.2 All resuscitation equipment should be regularly checked against the equipment checklist provided and the form (in use locally), dated and signed as complete unless comments indicate otherwise.

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Equipment</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Suite</td>
<td>Resuscitaires</td>
<td>checked daily against the checklist and signed as complete</td>
</tr>
<tr>
<td></td>
<td>Neonatal emergency trolley</td>
<td>checked weekly against the checklist, signed as complete and ‘sealed’ as complete</td>
</tr>
</tbody>
</table>
Neonatal Unit Resuscitation equipment
- Trolley ITU nursery checked daily against checklist and signed as complete
- Trolley Nursery1 checked weekly against checklist and signed as complete
- Trolley Transitional care checked weekly against checklist and signed as complete
  Red emergency resuscitation bag checked weekly against checklist and signed as complete
  Transport Incubator checked weekly against checklist and signed as complete

Birth Unit’s Resuscitaire checked daily against checklist and signed as complete
Neonatal emergency trolley checked weekly against the checklist, signed as complete and ‘sealed’ as complete

Maternity Ward Resuscitaire checked daily against checklist and signed as complete
Neonatal emergency trolley checked weekly against checklist and signed as complete

Homebirth / Community Emergency equipment checked after each use and at least monthly against checklist and signed as complete

All staff who check and sign the checklist as complete take responsibility should an item be missing at next check or during use

6.6.3 Preparation:
- Switch on the resuscitaire (if available)
- Prepare an area for resuscitation (if no resuscitaire)
- Close the windows
- Check air or oxygen gas supply is available and working, or check self inflating bag is in working order
- Check suction working
- Put heater on full power (if available)
- Ensure mother’s case records are to hand
- Consider bringing into the room advanced resuscitation equipment in the trolley in case required.
- Ensure that polyethylene bags are ready for use for babies less than 32 weeks gestation
- Start clock at time of delivery and note timings of interventions.

7. IMMEDIATE ASSESSMENT AT BIRTH (See action card AC1)

8. RESUSCITATION AT BIRTH (See action card AC2)

9. ADVANCED RESUSCITATION (See action card AC3)

10. SPECIAL CASES
10.1 Premature infants

10.1.1 Every effort should be made to ensure a consultant Neonatologist is present at delivery and supervises the stabilisation of all babies less than 28 weeks gestation (CESDI, 2003).

10.1.2. Ensure early thermal care as preterm babies are even more vulnerable than term babies to hypothermia.

10.1.3 For infants equal to or less than 32 weeks gestation polythene wrapping immediately after birth reduces the postnatal decrease in body temperature in very low birth weight babies by minimising evaporative and conductive loss under radiant heat. These infants should immediately be placed in opened polyethylene bag from the shoulders down with only the head.
dried and a hat put on. The baby should remain under radiant heat turned on to maximum power. Note – Ensure that a plastic cord clamp, rather than metal is in place before the baby is placed in bag (Vohra, 1999).

10.1.4 All transfers of preterm infants should take place in a warmed incubator.

10.2 **Resuscitation Versus Stabilisation**

10.2.1 Preterm babies have a need for ‘stabilisation’ rather than ‘resuscitation’ on the whole. The Neonatologist is present at delivery not because a hypoxic insult is likely (although it may co-exist), but to stabilise the baby who is less well adapted to extra-uterine life. Consideration should be given to:

- Early intubation or CPAP
- Administration of exogenous surfactant
- Lower lung inflation pressures
- Oxygen usage

10.3 **Meconium Aspiration**

10.3.1 Screaming babies have an open airway. If the baby is floppy - have a look.

10.3.2 If particulate meconium aspiration occurs in utero it is likely to be in response to significant insult leading to the gasping phase after primary apnoea. The outcome will be determined more by the insult than the meconium aspiration. Upper airway suction is only indicated in the presence of thick particulate meconium in the non-breathing floppy newborn. A tracheal tube can be inserted under direct vision with the ET tube used as a suction device. It is important for midwife, doctor and nurse to know in advance how the tubing connects together.

10.3.3 Midwife only at scene - suctioning of the oropharynx under direct vision should be performed.

10.3.4 Neonatologist or ANNP - Laryngoscopy can used to allow suctioning nearer to and beyond the vocal chords in the floppy, non breathing newborn.

10.3.5 NB – Suctioning can cause hypoxia and vagal stimulation; both of which can cause bradycardia.

10.4 **Surgical cases**

10.4.1 Any cases of evisceration of organs should be managed with sterile coverings, appropriate positioning and urgent discussion with the neonatal surgical team.

10.5 **Oxygen usage (Resuscitation council, 2010)**

10.5.1 Pulse oximetry should be used for all deliveries where it is anticipated that the infant may have problems with transition or need resuscitation. Oxygen saturation and heart rate can be measured reliably during the first minutes of life with a modern pulse oximeter where it is anticipated that the infant may have problems with transition or need resuscitation.

10.5.2 The sensor must be placed on the right hand or wrist to obtain an accurate reading of the preductal saturation. Pulse oximetry can also provide an accurate display of heart rate during periods of good perfusion.

10.5.3 In healthy term babies, oxygen saturation increases gradually from approximately 60% soon after birth to over 90% by 10 min. In preterm infants hyperoxaemia is particularly damaging and if oxygen is used to achieve a saturation above 95% the risk of hyperoxaemia is high. Therefore the rate of rise in oxygen saturation after birth in preterm infants should not exceed that seen in term infants, although some supplemental oxygen may be required to achieve this.
10.5.4 For term infants, air should be used for resuscitation at birth. If, despite effective ventilation, oxygenation (ideally guided by pulse oximetry) remains unacceptable, use of a higher concentration of oxygen should be considered.

10.5.5 Preterm babies less than 32 weeks gestation may not reach the same arterial blood oxygen saturations in air as those achieved by term babies. Blended oxygen and air should be given judiciously and its use guided by pulse oximetry. If a blend of oxygen and air is not available use what is available.

11. USE OF NALOXONE (NARCAN) (See Table 2)

11.1 Naloxone is not an emergency drug. Naloxone reverses opiate narcotics that may have been given to the mother. The urgent priority in the apnoeic infant is standard resuscitation with naloxone being considered only once the airway is secure and the heart rate is normal.

Table 2

The dose:
- Babies greater than 2 kg: 0.5 mL IM of adult strength Narcan (0.5 mL = 200 micrograms)
- Babies less than 2 kg: 0.25 mL IM of adult strength Narcan (0.25 mL = 100 micrograms)

11.2 N.B. The effect of pethidine can last for up to 24 hours whereas the effect of IM Naloxone will last only a few hours.

11.3 Naloxone must NOT be given where the woman has taken drugs of misuse during pregnancy.

12. COMMUNICATION AND RECORD KEEPING

12.1 Communication with parents

12.1.1 Always speak to the parents soon as possible. Information given to the parents should be objective and should avoid prejudging care.

12.1.2 Communication with the delivery suite is of utmost importance if a baby needs transferring during resuscitation.

12.2 Record keeping (See Table 3)

12.2.1 Keep clear, detailed, factual notes that are legible dated and signed. Make an accurate and comprehensive record of the neonatal resuscitation and include what happened as soon as possible afterwards. Documentation of the delivery should be left to the practitioner conducting the delivery.

Table 3

- Who was present at delivery?
- When you called for help and why?
- The time help arrived and the condition of the baby when help arrived.
- What was done and when it was done and details of any responses.
- The baby’s heart rate at birth and when it first exceeded 100 beats / minute.
- Whether gasping respiration preceded the onset of rhythmical breathing, when gasping started and for how long it lasted.
- When the baby started to breathe evenly, regularly and effectively 30 – 60 times per minute (even if gasping is still occurring intermittently).
- The date and time of writing your entry and your name printed and your signature.

13. TRAINING

13.1 See GHNHSFT Maternity Mandatory Training Policy
13.2 All skills and equipment training must be entered on the central training record. It is the staff member’s manager who is responsible for ensuring records are updated by informing the relevant personnel to input onto the training database.

13.3 It is expected that all community and birth unit midwifery staff will undertake resuscitation council NLS training.

<table>
<thead>
<tr>
<th>Level of training required</th>
<th>Staff Group / s</th>
<th>Division / Department</th>
<th>Frequency of training / update</th>
<th>Method of training delivery</th>
<th>Lead and department responsible for provision of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>All Midwives</td>
<td>Women and Children’s Division</td>
<td>Annually</td>
<td>Skill Drills day</td>
<td>Education and Training Faculty</td>
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<tr>
<td>C</td>
<td>Community and birth unit Midwives</td>
<td>Women and Children’s Division</td>
<td>4 yearly</td>
<td>NLS</td>
<td>Resuscitation Council course</td>
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<tr>
<td>A</td>
<td>Obstetricians</td>
<td>Women and Children’s Division</td>
<td>Annually</td>
<td>Skill Drills day</td>
<td>Education and Training Faculty</td>
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<tr>
<td>A</td>
<td>Anaesthetists</td>
<td>Women and Children’s Division</td>
<td>Annually</td>
<td>Skill Drills day</td>
<td>Education and Training Faculty</td>
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<tr>
<td>B</td>
<td>Neonatal staff</td>
<td>Women and Children’s Division</td>
<td>Annually or at induction</td>
<td>Induction training or external life support course</td>
<td>Paediatric induction programme coordinator</td>
</tr>
</tbody>
</table>

*Levels of Training
A = Awareness (Micro-teach, drop in session, e-learning)
B = ½ day (2.5 – 3 hours) (workshop, training event, e-learning)
C = Full day (5-6 hours) (workshop, training event)
D = Course (more than one day training)

14. MONITORING OF COMPLIANCE
14.1 This list is not exhaustive and additional criteria may be included at the Trust discretion

14.2 Team leaders are responsible for ensuring the monitoring of equipment and safety checks in their areas. These are reported monthly.

14.3 Specific audit will be undertaken if concerns arise through risk management or monitoring. This will include lead professionals, availability of neonatal staff and training compliance.

14.4 Action plans will be developed and reviewed as required by the instigating body

14.5 The audit will be carried out using the standardised audit tool and methodology as agreed by the maternity audit team and in line with the audit process.

14.6 The audit results will be presented to the multidisciplinary Obstetrics and Gynaecology Audit presentation meeting.

14.7 Where deficiencies are identified, an action plan will be developed by the author, following the Multidisciplinary Obstetrics and Gynaecology Audit presentation meeting. These action plans are implemented and monitored by the Associated Forum.

14.8 Sample sizes selected will be dependent on the cohort size. The data collection period will be identified by the Maternity quality Lead

15. REFERENCES


<table>
<thead>
<tr>
<th>Authors</th>
<th>Version</th>
<th>Reason for review</th>
<th>Ratified</th>
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<tbody>
<tr>
<td>Neonatologist</td>
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<td>New guideline</td>
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<td>Russell Reek Consultant</td>
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<td>August 2013 V3.1</td>
<td>Addition of newborn resuscitation during ambulance</td>
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<td>SPONSOR</td>
<td>Dhushyanthan Mahendran</td>
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<tr>
<td>AUTHORS</td>
<td>Simon Pirie</td>
<td></td>
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<td>ISSUE DATE</td>
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| APPROVAL DETAILS | September 2003 – GOGG  
05/06/2007 item 4.1.2 – GOGG  
24/07/2007 item 3u – Clinical Policy Group  
12/08/2008 item 3 – GOGG  
12/09/2008 – Clinical Policy Group  
09/10/2008 item 127/08.19 – Senior Nurse Committee  
27/10/2009 item 4.2 – GOGG  
13/11/2009 item 143/08.7 – Senior Nurse Committee  
10/11/2009 item 21 – Clinical Policy Group  
10/12/2009 item 165/09.24 – Senior Nurse Committee  
01/11/2011 item 4.3 – GOGG  
20/08/2013 GOGG  
04/11/2014 GOGG pt 2.15 |
| DISSEMINATION DETAILS | Upload to Policy Site; cascaded via Women and Children’s Division |
| EQUALITY IMPACT ASSESSMENT | Added to policy 30/11/2009 |
| KEYWORDS         | Newborn, resuscitation |
| RELATED TRUST DOCUMENTS | GHNHSFT Maternity Mandatory Training Policy  
GHNHSFT Maternity Transfer and Discharge Policy |
| OTHER RELEVANT DOCUMENTS | ACTION CARD AC1 – IMMEDIATE ASSESSMENT AT BIRTH  
ACTION CARD AC2 – RESUSCITATION AT BIRTH  
ACTION CARD AC3 – ADVANCED RESUSCITATION  
ACTION CARD AC4 – NEWBORN LIFE SUPPORT |
Gloucestershire Hospitals
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

INITIAL SCREENING

1. Lead Name: Kirsty Davis  
   Job Title: Practice Development Midwife

2. Is this a new or existing policy, service strategy, procedure or function?  
   New  Existing ✓

3. Who is the policy/service strategy, procedure or function aimed at?  
   Patients  Carers  Staff ✓  Visitors
   Any other  Please specify:

4. Are any of the following groups adversely affected by this policy:  
   If yes is this high, medium or low impact (see attached notes):
   Disabled people: No ✓ Yes ___  
   Race, ethnicity & nationality: No ✓ Yes ___  
   Male/Female/transgender: No ✓ Yes ___  
   Age, young or older people: No ✓ Yes ___  
   Sexual orientation: No ✓ Yes ___  
   Religion, belief & faith: No ✓ Yes ___

If the answer is yes to any of these proceed to full assessment.  
If the answer is no to all categories, the assessment is now complete.

Date of assessment: 30/11/2009  Completed by: K. Davis
Signature: Job title: PDM
Director: Signature:

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIA’s are completed in accordance with this procedure.