LABOUR WARD CALLS ● 1/1

This guideline is designed to clarify when paediatric staff should routinely attend deliveries and which grade of staff should be called. The paediatrician should be called when the attending midwife feels, after consultation if necessary, that the baby is at increased risk of requiring resuscitation. Therefore the SHO should not attend any delivery alone unless they have been trained in and are competent at basic neonatal resuscitation including airway management and ventilatory and circulatory support.

- Encourage obstetric team to warn neonatal team of expected problems **well in advance**
- Decide who should attend (e.g. first on-call, middle grade or consultant), and degree of urgency
- It is generally expected that the SHO attend the following deliveries but must know where and how appropriate senior help can be located if necessary.

Neonatal team should attend the following deliveries:

- Non-reassuring electronic fetal monitoring trace (CTG) or abnormal FBS, as assessed by obstetric team
- Significant meconium in liquor ((NICE define significant meconium staining as dark green or black amniotic fluid that is thick or tenacious, or any meconium stained fluid containing lumps of meconium)
- Caesarean section under general anaesthesia (see below)
- Major congenital abnormalities (Paediatric alert form should be noted on Badger)
- Vacuum extraction or instrumental deliveries performed for **fetal reasons** (see below)
- Abnormal presentations (breech, face) delivered vaginally
- Severe pre-eclampsia with seizures
- Significant antepartum haemorrhage
- Moderate-to-severe Rhesus disease
- At the Obstetric Consultants request
- Preterm delivery <36 weeks' gestation
    - 33-36 weeks - SHO to attend and inform the middle grade doctor. For twins with no foetal distress, one SHO plus NLS trained midwife is satisfactory.
    - 30-32 weeks - two paediatricians should be present (one experienced paediatrician and a senior neonatal nurse will be adequate in most cases).
    - 27-29 weeks - the consultant on call should be informed and will attend the delivery if required after discussion with the paediatric middle grade
    - 24-27 weeks - These babies should be TRANSFERRED IN UTERO. Discussions should take place with the obstetricians as per the IUT guideline

      OR

      If delivery must take place in this unit, a senior paediatrician will make every effort to speak to the parents prior to delivery and consultant will be present at the delivery when possible.
    - 22-24 weeks - Senior paediatric assistance will be needed at delivery, even if the baby is not likely to be resuscitated. Pre delivery discussion with Paediatricians / Parents essential. (See babies born at the margins of viability guideline).
    - <22 weeks -Although the paediatrician may well speak to the mother before delivery if requested, they would not normally attend the delivery or recommend active resuscitation when the gestation is known. If their presence is requested, attendance should be on the understanding that even with signs of life, resuscitation will not be instituted unless the baby is obviously more mature than anticipated

It is **not** necessary for neonatal team to attend the following deliveries:

- Elective caesarean section under regional anaesthesia
- Light meconium staining of liquor
- Breech, brow or face presentation by caesarean section under regional anaesthesia
- Twins (>37 weeks)
- Pre-eclampsia without seizures
- Maternal fever, GBS carriage, polyhydramnios
- Positive maternal antibodies (other than rhesus)
- Lift out forceps or ventouse for maternal reasons

The following factors may require neonatal team to attend birth or assess baby soon after birth (see antenatal plan in maternal notes or paediatric alert form on Badger)

- Maternal illness likely to affect baby:
  - diabetes mellitus
  - thyroid disease
  - systemic lupus erythematosus
  - myasthenia gravis
  - myotonic dystrophy
  - hepatitis B carriage
  - intrapartum antibiotics for GBS indicated but not given, or given <4 hr before delivery
  - HIV
  - HELLP syndrome
  - suspected sepsis treated with IV antibiotics
- Maternal medications that may affect baby e.g. antidepressants
- Maternal substance abuse
- Neonatal alerts:
  - abnormal antenatal scans
  - low-birth-weight baby <2.5 kg
- Pregnancy and past history
  - prolonged rupture of membranes
  - polyhydramnios
  - previous baby/perinatal death
  - family history of genetic or metabolic abnormalities