Bobble Hat Pathway

Author:  Name and title  Vanessa Sturt Senior ANNP  
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Contact details:  vanessa.sturt@nhs.net  e.jennis@nhs.net

Guideline History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
<th>Approved By</th>
</tr>
</thead>
<tbody>
<tr>
<td>29/12/2020</td>
<td>Reviewed by Vanessa Sturt, addition of preterm pathway links</td>
<td>Neonatal Guidelines Group</td>
</tr>
<tr>
<td>Sept 21</td>
<td>Reviewed by Vanessa Sturt</td>
<td></td>
</tr>
<tr>
<td>June 2022</td>
<td>Minor edits only, ratified by chairman’s action</td>
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Executive summary

The Bobble Hat Pathway has been put in place to identify those babies at risk of clinical deterioration following birth and provide a standardised observation for monitoring clinical progress and feeding support.

Term, well babies are categorised as Green, Amber or Red Bobble Hat depending on risk factors (table 1) identified by the British Association of Perinatal Medicine. Observations are documented on the Badger system and are displayed using a visual prompt alerting abnormal parameters by colour coding based on the BAPM NEWTT chart.

Local audits found 70% of preterm babies born less than 37 weeks and small babies weighing less than 2.5kg were readmitted for phototherapy treatment or weight loss. A vulnerable baby management plan has been put in place to protect small, preterm and clinically unwell babies from NICU admissions and/or readmissions back into hospital.

The aim of using the pathway is to reduce admissions to the neonatal unit, reduce readmissions back into hospital once babies are discharged home and reduce the separation of mother and baby by early identification and intervention for at risk infants.

The bobble hat pathway is separated into management plans direction to correct feeding plans to safeguard the well-being of the baby after birth and give clear direction in supporting staff and empowering families in the care of their baby.
# Table 1

<table>
<thead>
<tr>
<th>VULNERABLE</th>
<th>RED hat</th>
<th>AMBER hat</th>
<th>GREEN hat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies &lt; 37 weeks gestation</td>
<td>More than 37/40 less than 38/40</td>
<td>More than 37/40 less than 38/40</td>
<td>More than 38/40</td>
</tr>
<tr>
<td>Babies weighing &lt;2.5kg</td>
<td>Birthweight centile ≤ 2nd (see pregnancy summary)</td>
<td>Birthweight centile &gt; 2(^{nd}) ≤ 9(^{th}) (see pregnancy summary)</td>
<td>Birthweight over 9(^{th}) centile (see pregnancy summary)</td>
</tr>
<tr>
<td>Babies who become clinically unwell at any stage</td>
<td>All babies on EOS pathway</td>
<td>Babies on hypoglycaemia pathway</td>
<td>No other risk factors</td>
</tr>
<tr>
<td>Babies admitted to NICU or TCU</td>
<td>Unstable temperature (consider escalation to VULNERABLE)</td>
<td>• Unstable sugars escalate to VULNERABLE</td>
<td></td>
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<tr>
<td>Unstable blood glucose</td>
<td>Respiratory distress at &gt; 4 hours of age (consider escalation to VULNERABLE)</td>
<td>GBS – invasive GBS infection in previous baby or maternal GBS colonisation/bacteriuria in current pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Birth trauma</td>
<td>Jaundice &lt; 24 hours (consider escalation to VULNERABLE)</td>
<td>1(^{st}) temp &lt; 36.5</td>
<td></td>
</tr>
<tr>
<td>PPH&gt;2litres</td>
<td>Mother significantly unwell</td>
<td>LSCS, instrumental delivery, PPH &gt;1000mls, Meconium</td>
<td></td>
</tr>
<tr>
<td>Readmissions</td>
<td></td>
<td>Apgar &lt; 7 @5mins, or pH &lt; 7.1, or BE &lt; -12mmol/L</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pethidine &lt; 6 hours prior to delivery</td>
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</tr>
<tr>
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<td>Significant Safeguarding Concerns.</td>
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1. Introduction

The Bobble Hat Pathway has been put in place to identify those babies at risk of clinical deterioration following birth and provide a standardised observation for monitoring clinical progress and feeding support.

Well, term babies are categorised as Green, Amber or Red Bobble Hat depending on risk factors, using the British Association of Perinatal Medicine (BAPM) document Newborn Early Warning Trigger & Track (NEWTT) - a Framework for Practice, as guidance.

Local audits found 70% of preterm babies born less than 37 weeks and small babies weighing less than 2.5kg were readmitted for phototherapy treatment or weight loss. A vulnerable baby management plan has been put in place to protect small, preterm and clinically unwell babies from NICU admissions and/or readmissions back into hospital.

Observations are documented on the maternity Badger system and are displayed using a visual prompt alerting abnormal parameters.

The aim of using the pathway is to reduce admissions to the neonatal unit, reduce readmissions back into hospital once babies are discharged home and reduce the separation of mother and baby by early identification and intervention for at risk infants.

The bobble hat pathway is separated into management plans and feeding plans to safeguard the well-being of the baby after birth and give clear direction in supporting staff and empowering families in the care of their baby.

Parents are empowered and educated through:

1. Antenatal education
2. Parent information leaflets (Appendix 2).
3. Completing their own feeding record.
4. Access to breast pumps.
5. Daily teaching on hand expressing and positioning and attachment.
6. Daily access to infant feeding support both inpatient and community.

1. Scope

- This guidance is relevant to all staff caring for babies across maternity and transitional care.

2. Purpose
• This guideline aims to facilitate a common approach to the management of ALL babies delivered at St Peters hospital. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant, neonatal and midwifery team caring for the baby.

• This guideline is subject to regular review to ensure ongoing evidence based practice.

4 Duties and responsibilities

4.1 Responsibility of Labour Ward/Abbey Birthing Centre/Joan Booker Ward:

• Use the Bobble Hat Pathway for all babies ≥ 34/40 to facilitate safe discharge.

• After every delivery the midwife must allocate the term, well newborn baby to either the RED, AMBER or GREEN bobble hat pathway and give the baby’s allocated cot a visual cue card of the applicable bobble hat pathway to follow.

• VUNERABLE babies must be identified at birth, reviewed by the neonatal team and a clear management plan and feeding plan put in place from birth plus an allocated visual cue card.

• Any baby who becomes clinically unwell after birth is escalated to vulnerable baby management with a neonatal review and 4 hourly checks of baby well being until feeding and baby well being have normalised.

• Midwives must notify the neonatal team of any babies with risk factors for sepsis (see sepsis guideline or table 2, 3 & 4) [link]

• Midwives must notify the neonatal team of any baby who meets the vulnerable baby criteria.

• Complete observations as per pathway & inform neonatal team if baby has observations outside the normal range (indicated by amber & red on observation chart)

• If baby has observations out of normal range continue observations until reviewed and discharged by neonatal team.

• Parents should be made aware of the category their baby has been placed in and the rational. Parents and staff should refer to the relevant parent information
leaflet for feeding advice and ongoing support. Start feeding charts as indicated (Appendix 2, 3 and 4).

- The baby’s management plan (vulnerable, red, amber or green) and feeding plan must be clearly documented on the Badger system.

- Parents should be encouraged to complete their own feeding record.

- If a baby is not feeding efficiently follow the feeding management pathway with emphasis on skin to skin and additional hand expressed colostrum every 2-3 hours until baby is breastfeeding responsively. In the absence of colostrum follow the hypoglycaemia pathway.

- If a baby is not feeding efficiently check baby wellbeing (observations) every 4 hours until baby shows readiness to feed. If observations fall outside of normal range check the baby’s blood glucose and refer the baby for a paediatric review.

- All babies who are not feeding effectively by 24 hours should be reviewed by a paediatrician.

- Clinically indicated supplementation must be prescribed by a neonatal doctor or ANNP and documented on the Feeding Update section of the Badgernet system.

- Vulnerable babies and term, well babies who are not breastfeeding effectively must have a daily review of feeding and feeding plans until responsive breastfeeding is resumed (Infant Feeding Guideline).

- Supporting and protecting breastfeeding is central to all clinical decisions unless parents have chosen to bottle feed their baby.

- If a bottle fed baby does not feed effectively refer for infant feeding and paediatric review.

- If there is clinical indication to separate a mother from their baby (admission to NICU), the Milk as Medicine pathway is started to initiate and preserve lactation until the baby is able to resume responsive breastfeeding (MAM guideline, section 3).

- Vulnerable babies will follow modified responsive breastfeeding as outlined in the parent leaflet. Continues expressing is advised until 2 weight gains have been observed to initiate and maximise breastfeeding success.
• All feeding updates and assessments are documented on the Badger system until the mother and baby are discharged from midwifery care.
• Ongoing infant feeding community support is accessible and easily accessed.
• Audit data will be captured through parents and staff feedback to improve ongoing practice.

4.2 Responsibility of the Neonatal team:

• Review and run any babies with risks factors for sepsis (table 2 & 3) through the early onset sepsis calculator on the Maternity Bagdernet system and document the plan clearly.
• If a baby is clinically unwell they require urgent senior review and consideration for admission to NICU and starting antibiotics

Identifying babies at risk of early onset sepsis (EOS)


Table 2:

<table>
<thead>
<tr>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies with any <strong>single red flag</strong> risk factor</td>
<td>→EOS calculator</td>
</tr>
<tr>
<td>Babies with 2 or more risk factors</td>
<td>→EOS calculator</td>
</tr>
<tr>
<td>Babies with a single risk factor but there is clinical concern</td>
<td>→EOS calculator</td>
</tr>
<tr>
<td>Well babies with a single (non-red flag) risk factor</td>
<td>→NO EOS calculator but may require observations as per bobble hat guideline</td>
</tr>
</tbody>
</table>
## Table 3: Maternal risk factors for early-onset neonatal infection, including RED flags

<table>
<thead>
<tr>
<th>Red flag risk factor:</th>
</tr>
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<tbody>
<tr>
<td>- Suspected or confirmed infection in another baby in the case of a multiple pregnancy.</td>
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</tbody>
</table>

Other maternal risk factors:

- Invasive group B streptococcal infection in a previous baby or maternal group B streptococcal colonisation, bacteriuria or infection in the current pregnancy.
- Pre-term birth following spontaneous labour before 37 weeks' gestation.
- Confirmed rupture of membranes for more than 18 hours before a pre-term birth.
- Confirmed pre labour rupture of membranes at term for more than 24 hours before the onset of labour.
- Intrapartum fever higher than 38°C if there is suspected or confirmed bacterial infection or two readings greater than 37.5°C
- Clinical diagnosis of chorioamnionitis.
Table 4: Neonatal risk factors including RED flags

Red flag clinical indicators:

1. Apnoea (temporary stopping of breathing)
2. Seizures
3. Need for cardiopulmonary resuscitation
4. Need for mechanical ventilation
5. Signs of shock

Other clinical indicators:

- Altered behaviour or responsiveness
- Altered muscle tone (for example, floppiness)
- Feeding difficulties (for example, feed refusal)
- Feed intolerance, including vomiting, excessive gastric aspirates and abdominal distension
- Abnormal heart rate (bradycardia or tachycardia)
- Signs of respiratory distress (including grunting, recession, tachypnoea)
- Hypoxia (for example, central cyanosis or reduced oxygen saturation level)
- Persistent pulmonary hypertension of newborns
- Jaundice within 24 hours of birth
- Signs of neonatal encephalopathy
- Temperature abnormality (lower than 36°C or higher than 38°C) unexplained by environmental factors
- Unexplained excessive bleeding, thrombocytopenia, or abnormal coagulation
- Altered glucose homeostasis (hypoglycaemia or hyperglycaemia)
- Metabolic acidosis (base deficit of 10 mmol/litre or greater)
• Admit babies to TCU as per guideline. [Guideline Link]

• Review all babies <37 weeks as per the vulnerable baby management plan. Babies born 36.0-36.6 weeks are managed on the postnatal ward. Babies born 35.0-35.6 are admitted to TCU for a minimum of 48 hours before being transferred back to midwifery management. Babies born 34.0-34.6 are admitted to TCU and can be managed on TCU for 7 days before being transferred back to midwifery management.

• Parents with vulnerable infants are advised to remain in hospital for at least 3 days to establish modified responsive feeding. IF they go home before the day 3 weight and jaundice check, daily face to face midwifery appointments and a day 3 weight and jaundice check must be arranged before discharge as a safety netting precaution.

• Admit babies onto the neonatal Badger system when indicated as per guideline. [Guideline Link]

• Readmissions with hypernatraemia secondary to weight loss refer to hypernatraemia guideline [Guideline Link]

5. Training

• Annual training available for maternity and NICU staff.

• Training on induction of new maternity and neonatal staff.

6. Approval and Ratification

• This guideline will be approved and ratifies by the Joint Neonatal and Obstetric Guidelines Group.

7. Dissemination and Implementation

• This guideline will be uploaded to the trust intranet ‘Neonatal Guidelines’ and ‘Maternity Guidelines’ page and thus available for common use.
• This guideline will be shared as part of ongoing education within the Neonatal Unit and maternity unit for medical, nursing and maternity staff.

• All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

• **Review and Revision Arrangements**
  
  a. This policy will be reviewed on a 5 yearly basis.
  
  b. If new information comes to light prior to the review date, an earlier review will be prompted.
  
  c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Neonatal Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

9 **Document Control and Archiving**

• Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Neonatal Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

10 **Monitoring compliance with this Policy**

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/ Audit method</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans</th>
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<tr>
<td>e.g. All policies will be reviewed by their authors at least annually to ensure that they remain valid and in date</td>
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<td>Monthly review</td>
<td>NICU/Maternity</td>
<td>Paediatric/Maternity Governance</td>
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<td>Badger data</td>
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</table>

- All policies will be reviewed by their authors at least annually to ensure that they remain valid and in date.
11: Supporting References / Evidence Base

NICE Guidance CG 195 Neonatal infection: Antibiotics for prevention and treatment April 2021


2017 Royal college of Paediatrics and Child Health Breastfeeding in the UK - position statement. https://www.rcpch.ac.uk/resources/breastfeeding-uk-position-statement

### Appendix 1: Bobble Hat Pathway

<table>
<thead>
<tr>
<th>GREEN BOBBLE HAT</th>
<th>MANAGEMENT PLAN</th>
<th>FEEDING PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More than 38/40</td>
<td>Observations and Assessment @ birth</td>
<td>Feeding management pathway: responsive feeding/reluctant feeder management</td>
</tr>
<tr>
<td>• Birthweight over 9th centile (see pregnancy summary)</td>
<td>• Skin to skin/Joey</td>
<td></td>
</tr>
<tr>
<td>• No other risk factors</td>
<td>• Full feeding Assessment and Breastfeeding Observation Checklist completed before discharge</td>
<td></td>
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<tr>
<td></td>
<td>• Consider discharge home from 6 hours after delivery</td>
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<table>
<thead>
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<th>GREEN BOBBLE HAT</th>
<th>MANAGEMENT PLAN</th>
<th>FEEDING PLAN</th>
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<td>• More than 38/40</td>
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<td></td>
<td>• Consider discharge home from 6 hours after delivery</td>
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</table>

<table>
<thead>
<tr>
<th>AMBER BOBBLE HAT</th>
<th>MANAGEMENT PLAN</th>
<th>FEEDING PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More than 37/40 less than 38/40</td>
<td>Observations @ birth/2hours/6hours/10 hours</td>
<td>Feeding management pathway: responsive feeding/reluctant feeder management</td>
</tr>
<tr>
<td>• Birthweight centile &gt; 2nd ≤ 9th (see pregnancy summary)</td>
<td>• Skin to skin/Joey</td>
<td></td>
</tr>
<tr>
<td>• 1st temp &lt; 36.5</td>
<td>• Full feeding Assessment and Breastfeeding Observation Checklist completed before discharge</td>
<td></td>
</tr>
<tr>
<td>• GBS – invasive GBS infection in previous baby or maternal GBS colonisation/bacteriuria in current pregnancy.</td>
<td>• Consider discharge home from 12 hours if observations normal and discontinued</td>
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<tr>
<td>• LSCS, instrumental delivery, PPH &gt;1000mls</td>
<td>• Weight Day 3</td>
<td></td>
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<tr>
<td>• Meconium</td>
<td></td>
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<tr>
<td>• Babies on hypoglycaemia pathway -Unstable sugars escalate to VULNERABLE</td>
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<tr>
<td>• Apgar &lt; 7 @5mins, or pH &lt; 7.1, or BE &lt;-12mmol/L</td>
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<td>• Multiple birth</td>
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<tr>
<td>• Pethidine &lt; 6 hours prior to delivery</td>
<td></td>
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<tr>
<td>• NAS</td>
<td></td>
<td></td>
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<tr>
<td>• Significant safeguarding concerns</td>
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<table>
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<th>RED BOBBLE HAT</th>
<th>MANAGEMENT PLAN</th>
<th>FEEDING PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Observations @ birth/2hours/6hours/10 hours</td>
<td>Feeding management pathway: responsive feeding/reluctant feeder management</td>
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<td>• Skin to skin/Joey</td>
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<tr>
<td>• Full feeding Assessment and Breastfeeding Observation Checklist completed before discharge</td>
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</tr>
<tr>
<td>• Consider discharge home from 12 hours if observations normal and discontinued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Weight Day 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### VULNERABLE BABIES
- Birthweight centile ≤ 2nd (see pregnancy summary)
- All babies on EOS pathway
- Unstable temperature (consider escalation to **VULNERABLE**)
- Respiratory distress at > 4 hours of age (escalate to **VULNERABLE**)
- Jaundice < 24 hours (escalate to **VULNERABLE**)
- Mother significantly unwell
- Readmissions (if hypernatraemia see guideline for feeding & fluid management)

### MANAGEMENT PLAN
- Observations @ birth/2hours/6hours and then every 4 hours until **24 hours**
- Skin to skin/Joey
- Full feeding Assessment and Breastfeeding Observation Checklist completed before discharge
- Consider discharge home from 24 hours if observations normal and discontinued
- Weight Day 3

### FEEDING PLAN
- Feeding management pathway: responsive feeding/reluctant feeder management

### Skin to skin
- 2-3 hourly feeds
- Additional breastmilk after every breastfeed from birth
- Support expressing by hand + pump from birth
- Consider need for clinically indicated top ups
- Modified responsive feeding until 2 x weight gains.
APPENDIX 2:

Bobble Hat Parent Information: Green Hat


Bobble Hat Parent Information: Amber Hat


Bobble Hat Parent Information: Red Hat

APPENDIX 3

WITHIN ONE HOUR OF BIRTH
(STEP 1 CYCLE TO BE
REPEATED AS REQUIRED)
Start feeding chart and advise
mother how to complete it
FROM 6 HOURS OF AGE SEE
BELOW

12 HOURS OF AGE
IF BABY HAS NOT
FED ON THE
BREAST

6 HOURS OF AGE
IF BABY HAS NOT
FED ON THE
BREAST

GREEN HAT
Escalate to Amber
pathway @ 6 hours
and start
observations

AMBER HAT
Repeat STEP 1 cycle
Refer to IFT
Breast pump + Hand
express
Feed again in 2 hours

RED HAT
AS AMBER HAT
Plus:
Refer to paediatrician
In the absence of
EBM consider BSU/
Supplementation
6ml/kg

GREEN HAT
Should have been
escalated to Amber
pathway @ 6 hours

AMBER HAT
Repeat step 1 cycle
Refer to paediatrician
Refer to IFT
Breast pump + Hand
express
In the absence of EBM
consider BSU/
Supplementation
6ml/kg

RED HAT
AS AMBER HAT
Plus:
Close monitoring of
baby well-being
and effective
feeding at least
every 2 - 3 hours

GIVE ALL AVAILABLE EBM TO
BABY

TEACH/ REINFORCE
HAND EXPRESSING
COLOSTRUM

TEACH/ REINFORCE
RECOGNITION OF
BABY’S FEEDING CUES

ENCOURAGE MUM &
BABY TO BREASTFEED
NO LATER THAN 2 - 3
HOURLY

SKIN TO
SKIN/JOEY

GIVE ALL AVAILABLE EBM TO
BABY

TEACH/ REINFORCE
HAND EXPRESSING
COLOSTRUM
### APPENDIX 4: EQUALITY IMPACT ASSESSMENT

#### Equality Impact Assessment Summary

**Name and title:**

**Policy:**

<table>
<thead>
<tr>
<th><strong>Background</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Who was involved in the Equality Impact Assessment</td>
</tr>
</tbody>
</table>

Joint Neonatal and Maternity Guidelines Group

<table>
<thead>
<tr>
<th><strong>Methodology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)</td>
</tr>
<tr>
<td>- The data sources and any other information used</td>
</tr>
<tr>
<td>- The consultation that was carried out (who, why and how?)</td>
</tr>
</tbody>
</table>

The group considered the effect of the policy on the various groups within our neonatal population; and staff employed, including race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation and age.

<table>
<thead>
<tr>
<th><strong>Key Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Describe the results of the assessment</td>
</tr>
<tr>
<td>- Identify if there is adverse or a potentially adverse impacts for any equalities groups</td>
</tr>
</tbody>
</table>

The policy is inclusive

<table>
<thead>
<tr>
<th><strong>Conclusion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provide a summary of the overall conclusions</td>
</tr>
</tbody>
</table>

No adverse features of the guideline identified.

<table>
<thead>
<tr>
<th><strong>Recommendations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- State recommended changes to the proposed policy as a result of the impact assessment</td>
</tr>
<tr>
<td>- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified</td>
</tr>
<tr>
<td>- Describe the plans for reviewing the assessment</td>
</tr>
</tbody>
</table>

The Guideline is suitable for implementation.
APPENDIX 5: CHECKLIST FOR THE REVIEW AND APPROVAL OF DOCUMENTS

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

**Title of the document:**
**Policy (document) Author:**
**Executive Director:**

<table>
<thead>
<tr>
<th></th>
<th>Yes/No/Unsure/NA</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Title</strong></td>
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</tr>
<tr>
<td></td>
<td>Is the title clear and unambiguous?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
<td>Y</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Scope/Purpose</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is the target population clear and unambiguous?</td>
<td>Y</td>
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<tr>
<td></td>
<td>Is the purpose of the document clear?</td>
<td>Y</td>
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<td></td>
<td>Are the intended outcomes described?</td>
<td>Y</td>
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<td></td>
<td>Are the statements clear and unambiguous?</td>
<td>Y</td>
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<tr>
<td>3.</td>
<td><strong>Development Process</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is there evidence of engagement with stakeholders and users?</td>
<td>Y</td>
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<tr>
<td></td>
<td>Who was engaged in a review of the document (list committees/individuals)?</td>
<td>Y</td>
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<tr>
<td></td>
<td>Has the policy template been followed (i.e. is the format correct)?</td>
<td>Y</td>
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<tr>
<td>4.</td>
<td><strong>Evidence Base</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are local/organisational supporting documents referenced?</td>
<td>Y</td>
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<tr>
<td>5.</td>
<td><strong>Approval</strong></td>
<td></td>
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<tr>
<td></td>
<td>Does the document identify which committee/group will approve/ratify it?</td>
<td>Y</td>
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<tr>
<td></td>
<td>If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?</td>
<td>N/A</td>
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<tr>
<td>6.</td>
<td><strong>Dissemination and Implementation</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Y</td>
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<td></td>
<td>Does the plan include the necessary</td>
<td>Y</td>
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<td>Yes/No/Unsure/NA</td>
<td>Comments</td>
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<td>7.</td>
<td><strong>Process for Monitoring Compliance</strong></td>
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<tr>
<td></td>
<td>Are there measurable standards or KPIs to support monitoring compliance of the document?</td>
<td>N/A</td>
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<tr>
<td>8.</td>
<td><strong>Review Date</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is the review date identified and is this acceptable?</td>
<td>Y</td>
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<tr>
<td>9.</td>
<td><strong>Overall Responsibility for the Document</strong></td>
<td></td>
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<tr>
<td></td>
<td>Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?</td>
<td></td>
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<tr>
<td>10.</td>
<td><strong>Equality Impact Assessment (EIA)</strong></td>
<td></td>
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<tr>
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<td>Has a suitable EIA been completed?</td>
<td></td>
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</tbody>
</table>

### Committee Approval (insert name of Committee)
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner

<table>
<thead>
<tr>
<th>Name of Chair</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. S. Edwards</td>
<td>17 June 2022</td>
</tr>
</tbody>
</table>

### Ratification by Management Executive (if appropriate)
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner

| Date | n/a |

### Supporting relevant trust guidelines

**Neonatal guidelines**

Sepsis:

[http://trustnet/docsdata/paed/neoclinical.html#sepsis](http://trustnet/docsdata/paed/neoclinical.html#sepsis)

Nasogastric feeding transition to breast feeding:


Hypernatraemia guideline:

Maternity Guidelines

Infant feeding guideline

http://trustnet/docsdata/maternity/index4.htm

Transitional care