Ashford and St. Peter's Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE

TITLE: Neonatal Airway Support for Paediatric Team Intubations.	
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PURPOSE
To identify criteria, process, tasks, roles and equipment to be considered for the provision of senior neonatal support for intubations managed by the paediatric team.
AIM
To provide a structured approach and good communication, in the situation where a neonatal/paediatric intubation is required within described criteria, outside of the Neonatal Intensive Care Unit (NICU) or Labour Ward (LW).
SCOPE
Applicable to all healthcare professionals involved/potentially involved in intubations where senior neonatal support is requested, outside of NICU or LW. It covers the criteria, process, tasks, roles, areas of discussion and resources relevant to this procedure. It takes into account the predictable potential challenges in multiple staff members working outside of their usual team, in a different location, managing a highly stressful situation.
COMPETENCIES
All staff involved in paediatric intubation situations should be aware of this SOP and function within their usual remit and skill level.
PROCESS
See guidance below.
RESPONSIBILITIES
Suggested responsibilities as set out below.
RISKS
The management of a paediatric intubation requiring neonatal airway support carries significant clinical and operational risks. This framework aims to reduce these risks using a structured approach and good communication, ensuring roles are clear amongst staff from multiple different teams. Staff should use clinical judgement, following appropriate guidance, documenting deviations with clear rationale.
MITIGATION FOR RISKS
See guidance below.

The neonatal consultant team are willing to provide advanced neonatal airway support, however NICU cannot be left unsafe.

Infants to consider include:

o Ex-preterm babies up to a maximum corrected gestational age of 3 months

o Neonates (up to 28 days)

o Weight < 5 kg

o Concerns regarding a difficult airway (cystic hygroma, micrognathia, hypotonia, cleft palate etc)

o Other medical conditions thought to make intubation more complex

Do NOT CRASH call the NICU team, as this could leave the NICU unsafe.

Referrals should be consultant to consultant.

The paediatric consultant can contact the neonatal HDU consultant directly 9am-5pm.
[Please use joint WhatsApp group to find out who to contact.]

Call switchboard OOH if unsure of who to contact - ask for NICU consultant on call.

If unable to contact, bleep NICU Nurse in Charge on 5268.

Pre-Intubation tasks:

o Clear introduction of team – name and role

o Identify roles for intubation process

o Limit attendance to essential staff only

o Outline plan – equipment, ETT size, drugs, personnel, management of deterioration etc

Suggested Roles:

o **Paediatric Consultant** – Team leader, medical management of underlying illness, ongoing plan for monitoring, transport and management of cardiac arrest if it arises.

o **Paediatric** (or requested NICU) Nurse at the cotside - Manage comfort, temperature etc.

o **Anaesthetics/ITU** – Airway, Intubation drugs, Ventilator settings.

o **Neonatal Consultant** – Airway.

o **Other roles** - to be assigned to wider team present, including updating/supporting parents, scribe etc.

Areas of potential discussion:

Role allocation? – can be flexible depending on skill mix

Who has the first intubation attempt, who is the second intubator?

Which Video Laryngoscope (VL) to be used?

What to consider bringing from NICU:

- VL screen and blade (If available, after informing NICU team)

- NICU nurse if available

NICU consultant to ensure all equipment is cleaned and returned back to NICU

Documentation:

It is the responsibility of the respective leads to clearly document their role and effect / impact in the EPR notes, ideally before leaving the area.