

# **Division of Women, Children & Sexual Health**

## **Neonatology Directorate**

# **Postnatal Pack for Paediatricians and Neonatologists Cross Site**

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# Introduction

This is the postnatal pack designed to have some quick guides to some common issues you may find on the postnatal ward.

Always refer to the full guidelines and seek senior advice if there are any concerns.

# Topics

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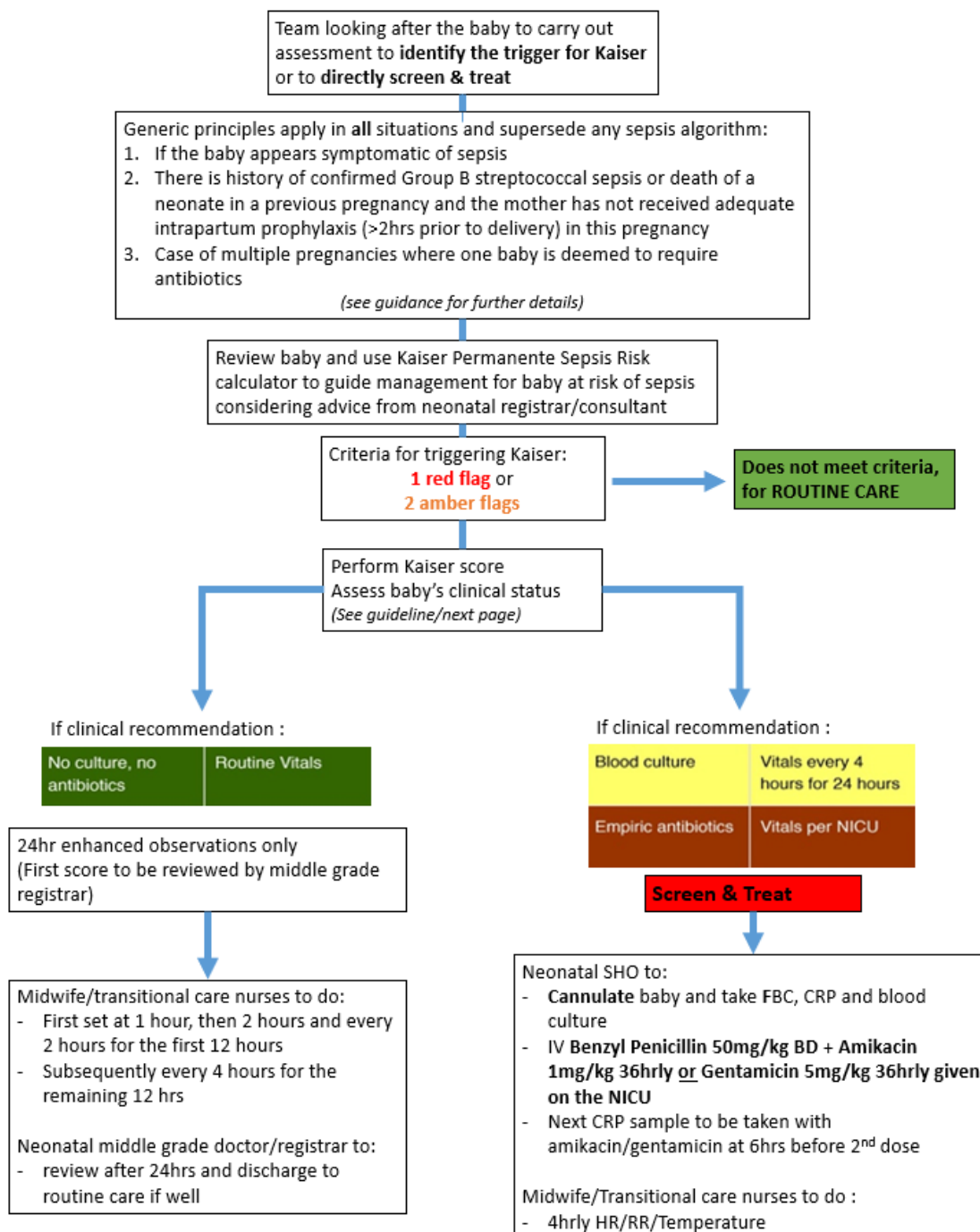
# Infection/Kaiser: Early Onset Sepsis Risk Assessment for Infants ≥ 34 Weeks Management Plan

## Risk Factors

- GBS with inadequate antibiotic prophylaxis (<2hrs from delivery)
- Previous GBS death/invasive infection
- Maternal sepsis within 24hrs postpartum
- Intrapartum fever 38°C and if there is a suspected or confirmed bacterial infection
- Clinical diagnosis of chorioamnionitis
- GBS with adequate antibiotic prophylaxis (>2hrs from delivery)
- Preterm birth with spontaneous labour <37weeks
- PROM >18hrs preterm birth
- PROM>24hrs in term birth

## Clinical Indicators

- Apnoea
- Need for cardiopulmonary resus
- Any temp <36.5 or >38
- Feeding difficulties
- Feed intolerance including vomiting
- Abnormal heart rate bradycardia or tachycardia
- Jaundice within 24hrs of birth
- Altered glucose (hypo or hyperglycaemia)



Please enter details below.

Predictor	Scenario
Incidence of Early-Onset Sepsis <sup>?</sup>	0.8/1000 live births
Gestational age <sup>?</sup>	40 weeks 1 days
Highest maternal antepartum temperature <sup>?</sup>	37 Celsius
ROM (Hours) <sup>?</sup>	25
Maternal GBS status <sup>?</sup>	<input type="radio"/> Negative <input type="radio"/> Positive <input checked="" type="radio"/> Unknown
Type of intrapartum antibiotics <sup>?</sup>	<input type="radio"/> Broad spectrum antibiotics > 4 hrs prior to birth <input type="radio"/> Broad spectrum antibiotics 2-3.9 hrs prior to birth <input type="radio"/> GBS specific antibiotics > 2 hrs prior to birth <input checked="" type="radio"/> No antibiotics or any antibiotics < 2 hrs prior to birth

Calculate » Clear

## How to Kasier Score

The sepsis risk calculator can be found at <https://kp.org/eoscalc>

Incidence to be set at 0.8/1000 live births

Use Celsius

Risk per 1000/births			
EOS Risk @ Birth	<b>0.35</b>		
EOS Risk after Clinical Exam	Risk per 1000/births	Clinical Recommendation	Vitals
Well Appearing	<b>0.14</b>	No culture, no antibiotics	Routine Vitals
Equivocal	<b>1.73</b>	Blood culture	Vitals every 4 hours for 24 hours
Clinical Illness	<b>7.30</b>	Empiric antibiotics	Vitals per NICU

Classification of Infant's Clinical Presentation: [Clinical Illness](#) [Equivocal](#) [Well Appearing](#)

Assign the 'CLINICAL STATUS' of the baby using one of the following three options, using the guide in the table below. **The neonatal team must document in the notes the clinical status of the baby at birth.**

Clinical Exam	Description
Clinical Illness	<ol style="list-style-type: none"> <li>Persistent need for NCPAP / HFNC / mechanical ventilation (outside of the delivery room)</li> <li>Hemodynamic instability requiring vasoactive drugs</li> <li>Neonatal encephalopathy / Perinatal depression               <ul style="list-style-type: none"> <li>Seizure</li> <li>Apgar Score @ 5 minutes &lt; 5</li> </ul> </li> <li>Need for supplemental O<sub>2</sub> ≥ 2 hours to maintain oxygen saturations &gt; 90% (outside of the delivery room)</li> </ol>
Equivocal	<ol style="list-style-type: none"> <li>Persistent physiologic abnormality ≥ 4 hrs               <ul style="list-style-type: none"> <li>Tachycardia (HR ≥ 160)</li> <li>Tachypnea (RR ≥ 60)</li> <li>Temperature instability (≥ 100.4°F or &lt; 97.5°F)</li> <li>Respiratory distress (grunting, flaring, or retracting) not requiring supplemental O<sub>2</sub></li> </ul> </li> <li>Two or more physiologic abnormalities lasting for ≥ 2 hrs               <ul style="list-style-type: none"> <li>Tachycardia (HR ≥ 160)</li> <li>Tachypnea (RR ≥ 60)</li> <li>Temperature instability (≥ 100.4°F or &lt; 97.5°F)</li> <li>Respiratory distress (grunting, flaring, or retracting) not requiring supplemental O<sub>2</sub></li> </ul> </li> </ol> <p>Note: abnormality can be intermittent</p>
Well Appearing	No persistent physiologic abnormalities

# Jaundice

Parents, carers and health care professionals should look for jaundice in babies at every opportunity especially in the first 72 hours. Jaundice is one of the most common conditions needing medical attention in new-born babies. Approx. 60% of term and 80% of preterm babies develop jaundice in the first week of life.

If jaundiced within the first 24hrs of life – consider sepsis

## Assess risks for early jaundice

- Born at under 38 weeks
- Siblings needed phototherapy
- Significant bruising/ difficult delivery
- Intention to exclusively breast feed especially if primigravida
- Intention to exclusively breast feed, and < 48 hours post LSCS
- Need for resuscitation at birth
- English not mother's first language +/- staff cannot be certain of support network
- Rhesus-D negative mother with a baby Rh positive and DAT positive

## When to use the Transcutaneous Bilirubinometer

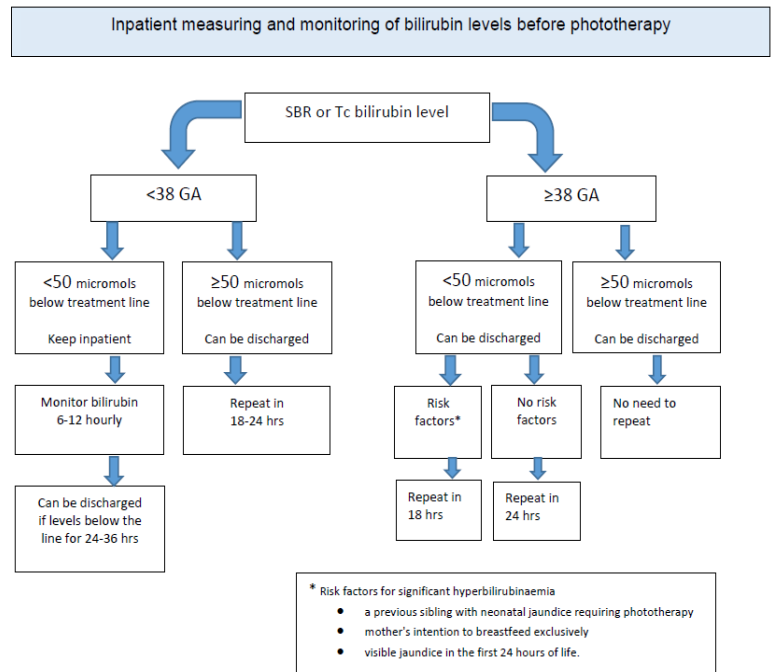
Serum bilirubin is the 'gold' standard

- After 24hrs of life
- From 35weeks gestation

### DO NOT USE

- During and after phototherapy
- Older than 14 days
- Below 34 weeks

If reading >250 a serum bilirubin must be taken



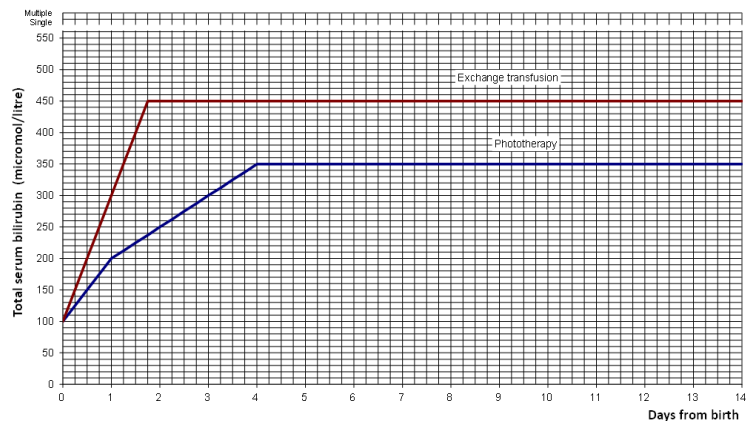
**Treatment threshold graph for babies with neonatal jaundice** NHS National Institute for Health and Clinical Excellence

Baby's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Hospital number \_\_\_\_\_ Time of birth \_\_\_\_\_ Direct Antiglobulin Test \_\_\_\_\_

Shade for phototherapy \_\_\_\_\_ Baby's blood group \_\_\_\_\_ Mother's blood group \_\_\_\_\_

Click below and choose gestation **>=38** weeks gestation



Investigations if phototherapy treatment threshold is exceeded		
Maternal	Infant	If less than 24 hours old or bilirubin within exchange transfusion range
<ul style="list-style-type: none"> <li>• ABO group</li> <li>• Rh(D) group</li> <li>• serum screen for unusual isoimmune antibodies</li> </ul>	<ul style="list-style-type: none"> <li>• ABO group</li> <li>• Rh (D) group</li> <li>• direct antiglobulin test – DAT*</li> <li>• serum bilirubin</li> </ul>	<ul style="list-style-type: none"> <li>• FBC and film</li> <li>• reticulocyte count</li> <li>• G6PD level</li> <li>• basic neonatal profile (biochemistry)</li> <li>• investigation of sepsis as appropriate</li> </ul>
<small>*DAT- Interpret the result taking account of the strength of reaction, and whether mother received prophylactic anti-D immunoglobulin during pregnancy.</small>		

## Always plot bilirubin on the gestation specific graph

Always ensure a feeding plan is in place if there is a concern of jaundice

Start phototherapy when SBR is above the phototherapy line for infant's gestation

### Bilirubin level monitoring

- 4-6hrs after initiation
- 6-12hrs once SBR stable or dropping
- Seek senior advice if on prolonged treatment

### Single or double phototherapy

- Usually start on single
  - Use double if within 50 of exchange transfusion line or rising rapidly
  - Seek senior advice if starting on double
- Will need admission to the neonatal unit if above the exchange transfusion line

# Thyroid: Maternal and Neonatal Thyroid Disease

## Babies who need testing of thyroid function

Babies of mothers with history of unresolved Grave's disease (i.e. still on medications or post thyroidectomy -chemical or surgical)

- TSH and T4 should be tested on day 7-10 of life
- These babies do not need to stay in hospital after birth for any particular observations as usually asymptomatic in the first week.
- They need testing regardless if mother had iodine treatment or thyroidectomy as mother may still be producing antibodies (even if she herself is hypothyroid post thyroidectomy and on Thyroxine).
- If results suggest thyrotoxicosis baby needs to be brought from home for a neonatal and endocrinology review.

## Babies with symptoms of congenital hypothyroidism

- LGA, post-mature, umbilical hernia, +/- goitre, +/- RDS.
- Sleepiness, poor feeding, constipation, abdominal distension, hypothermia, poor perfusion, oedema.

Universal screening for congenital hypothyroidism on New-born Blood Spot Test:

- It detects raised level of TSH
- It will not detect suppressed TSH present in Grave's disease
- It will not detect secondary (central) hypothyroidism as in this condition TSH is low.

## Neonatal thyrotoxicosis

Rare, only occurs in 1% to 5% of maternal Grave's Disease cases.

Most cases are transient and due to maternal Grave's disease.

Presents at 1-6 weeks, resolves by 4-6 months.

Signs and symptoms:

- IUGR, goitre, proptosis, oedema, sweating
- Irritable, increased appetite, weight loss, diarrhoea
- Tachycardia, arrhythmia, heart failure, acrocyanosis
- Hepatosplenomegaly, enlargement of thymus, lymphadenopathy
- Thrombocytopenia, raised PCV
- Advanced skeletal maturation

**Diagnosis:** T4 and TSH -avoid measuring TFTs in the first week of life due to natural surge of thyroid hormones at birth  
Isotope scan not usually necessary.

**Management:** Endocrinology team to advise.

Usually same anti-thyroid medication as mother (usually propylthiouracil or carbimazole).

May need to use high doses and add thyroxine to achieve normal T4 levels.

Can add propranolol and aqueous iodine.

**Breastfeeding:** if maternal daily dose  $\geq 15$ mg carbimazole or  $\geq 150$ mg propylthiouracil, split the dose and monitor baby's thyroid function. If lower maternal dose than above - no risk.

## Neonatal hypothyroidism

1: 3500 live births

Causes:

- A/hypoplastic or ectopic thyroid (sporadic) (TSH $\uparrow$ , T4 $\downarrow$ , T3+/- $\downarrow$ ) 85-90%
- Biochemical defect (autosomal recessive) (TSH $\uparrow$ , T4 $\downarrow$ , T3+/- $\downarrow$ ) 10-15%
- Hypothalamic (T4 and T3 $\downarrow$ , TSH +/- $\uparrow$ )
- Pituitary (TSH, T4, T3 all $\downarrow$ ) 2%
- Transient hypothyroidism - particularly preterm babies 2%

This will be detected on Neonatal Blood Spot

Management

Delayed treatment beyond the first few weeks of life compromises neurodevelopment particularly if initial T4 levels are very low.

TRH stimulation and radioisotope scanning rarely indicated in new-born but if so must be done before or immediately after starting treatment.

As soon as the diagnosis made and blood for confirmatory TFTs taken (do not wait for results) – start thyroxine 10-15mcg/kg once daily.

Monitor TFTs weekly initially to maintain T4 at upper limits of normal.

TSH may remain but only increase thyroxine if TSH remains raised beyond the first few weeks.

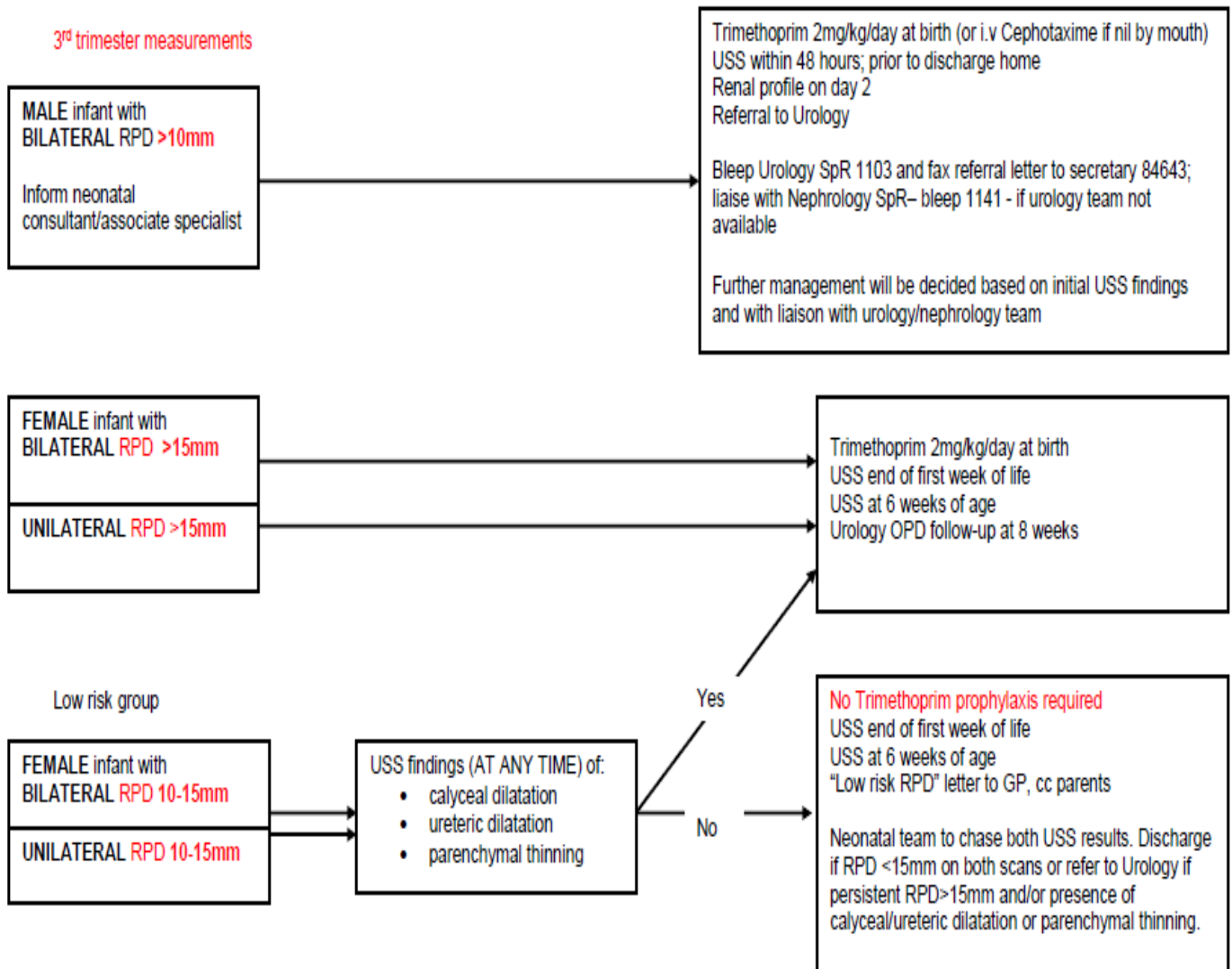
At 6-8 weeks, monitor TFTs, growth, and development and thereafter 2-3 monthly.

At 1 - 2 years, treatment will be stopped temporarily (having converted to triiodothyronine) and thyroid function reassessed.

Refer to Paediatric Endocrinology Clinic on discharge from the Neonatal Unit or discuss with them sooner if any problems.

# Renal: Common Renal Issues

## Postnatal management of prenatally detected hydronephrosis



## DELAYED PASSAGE OF URINE

It is normal for babies to pass urine within 24 hours of birth:

- Review full history with mother & midwives
- Look in maternal notes for any evidence of oligohydramnios or other abnormalities on antenatal scans e.g. abnormal renal antenatal scans
- Fully examine baby particularly checking for signs of sepsis, dehydration or urinary retention. Check the external genitalia are normal
- Inform Registrar or consultant covering postnatal ward

If the history and clinical examination are normal then check feeding has been established, encourage oral intake and review in 4 hrs. If there is still no passage of urine then put on a urine bag, check neonatal profile and request a renal tract ultrasound scan. If the scan is abnormal refer to the Paediatric Nephrology team:

- If there are signs of urinary retention contact the Paediatric Nephrology team +/- Paediatric Urology team before considering siting a urinary catheter

## Male Genitalia: Problems with Male External Genitalia

### Hypospadias

Abnormally placed meatus, chordee and hooded foreskin.

Distal hypospadias – glanular or distal penile hypospadias & no chordee. Usually needs no treatment as a neonate:

- Check stream (maybe poor if meatal stenosis - uncommon) and refer to Paediatric Urologist if poor
- Give reassurance and explanation
- Warn not to circumcise as foreskin may be needed for surgery
- Refer baby back to the GP with a letter asking to refer to Paediatric Urologist at corrected age of 12 months

### Proximal hypospadias

- Assess presence of testes and if absent, consider ambiguous genitalia
- Inform registrar or consultant
- Request early Paediatric Urology opinion before discharge
- Arrange renal ultrasound scan before discharge

### Hydroceles

- Distinguish from hernia by clinical examination
- Reassure parents and inform that highly likely to resolve spontaneously within the 2 years of life
- GP to refer to Paediatric Surgeon if present at 2 year or refer earlier if problems develop e.g. associated hernia or enlarging tense hydrocele

### Undescended Testes

Testes are usually palpable at term but maybe retractile. Small, under-developed scrotal sac may imply maldescent.

#### Unilateral

- Inform parents of findings and ask GP to review at 6 weeks
- If unilateral have not descended by 6 months GP should refer to Paediatric Surgeon or Urologist
- Orchidopexy usually done by 1 year of age or sooner if other associated problems, e.g. hernia

#### Bilateral

If there are bilateral impalpable testes then check for associated anomalies e.g. Prune belly syndrome, ambiguous genitalia and Prader-Willi syndrome.

Request registrar or consultant review.

Discuss with Registrar/Consultant – will need referral to Urology/Endocrine.

For ambiguous genitalia – see guideline and discuss with senior.

# Hips: Examination of the Newborn

Produced by: LGT Paediatric/Neonatal Team and Maternity ANNB Screening Team  
 Published: Jul 2020  
 Updated: November 2021  
 Review: September 2023



**Lewisham and Greenwich**  
 NHS Trust

## Examination of the Newborn

Pathway for babies identified with a hip abnormality or DDH risk factor requiring hip scan

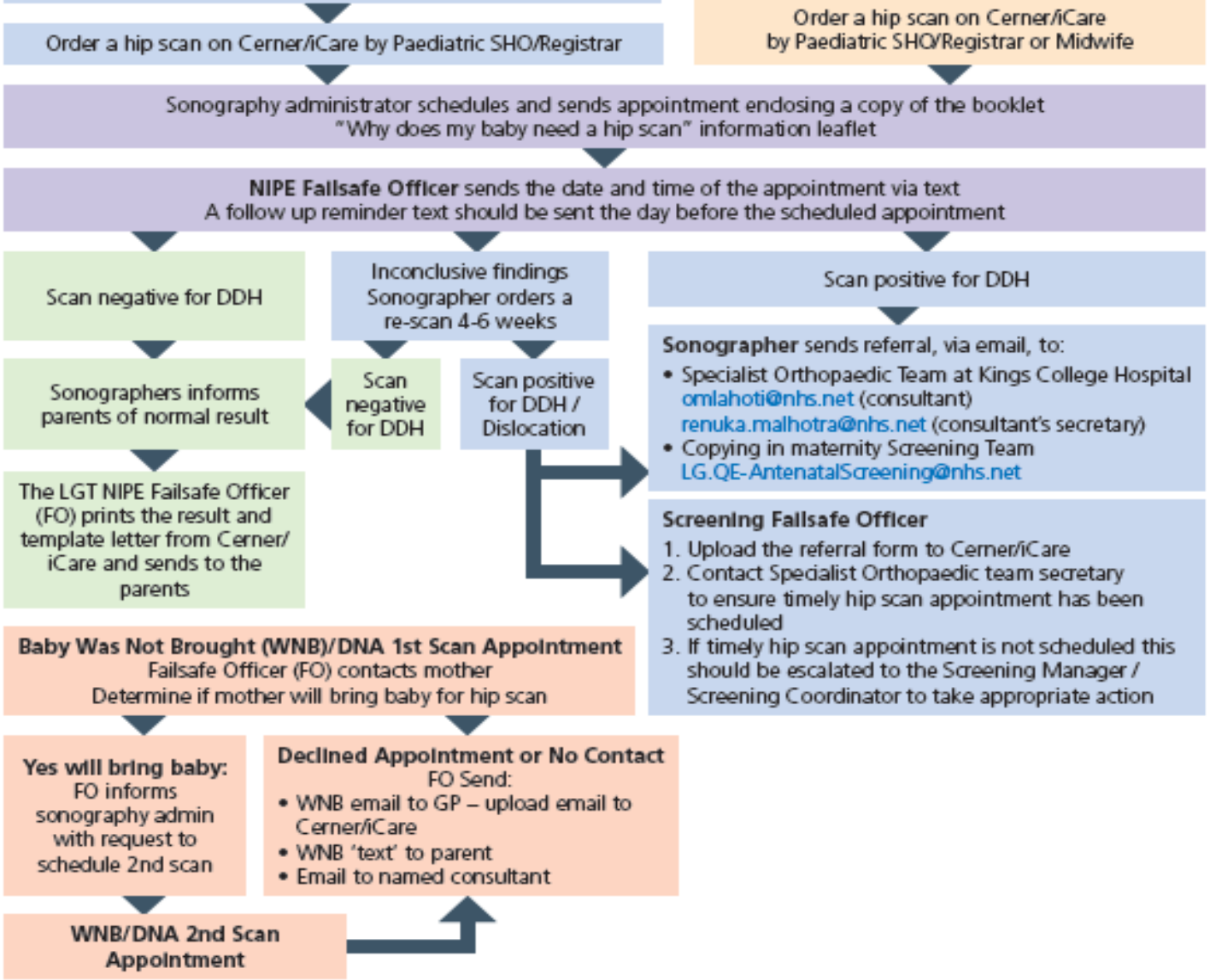
### Hip abnormality (national guidance)

1. Positive Ortolani manoeuvre (dislocated hip)
2. Positive Barlow manoeuvre (dislocatable hip)
3. Discrepancy in leg length
4. Knees at different levels when hips & knees are bilaterally flexed
5. Restricted unilateral limitation of hip abduction (difference of 20° or more between hips)
6. Gross bilateral limitation of ip abduction (loss of 30° abduction or more)

If hip abnormality suspected baby will need review by Paediatric Registrar/consultant before ordering scan

### DDH Risk Factors (national guidance unless otherwise stated)

1. First degree relative with hip problems at a young age needing splint/harness/operation
2. Breech presentation ≥ 36 weeks gestation, irrespective of presentation at birth – this includes babies who had successful external cephalic version
3. Breech presentation at birth from ≥ 28 weeks gestation
4. Multiple pregnancy with either one or more babies fulfilling the above criteria
5. Significant oligohydramnios (local guideline)
6. Fixed Talipes (local guideline)

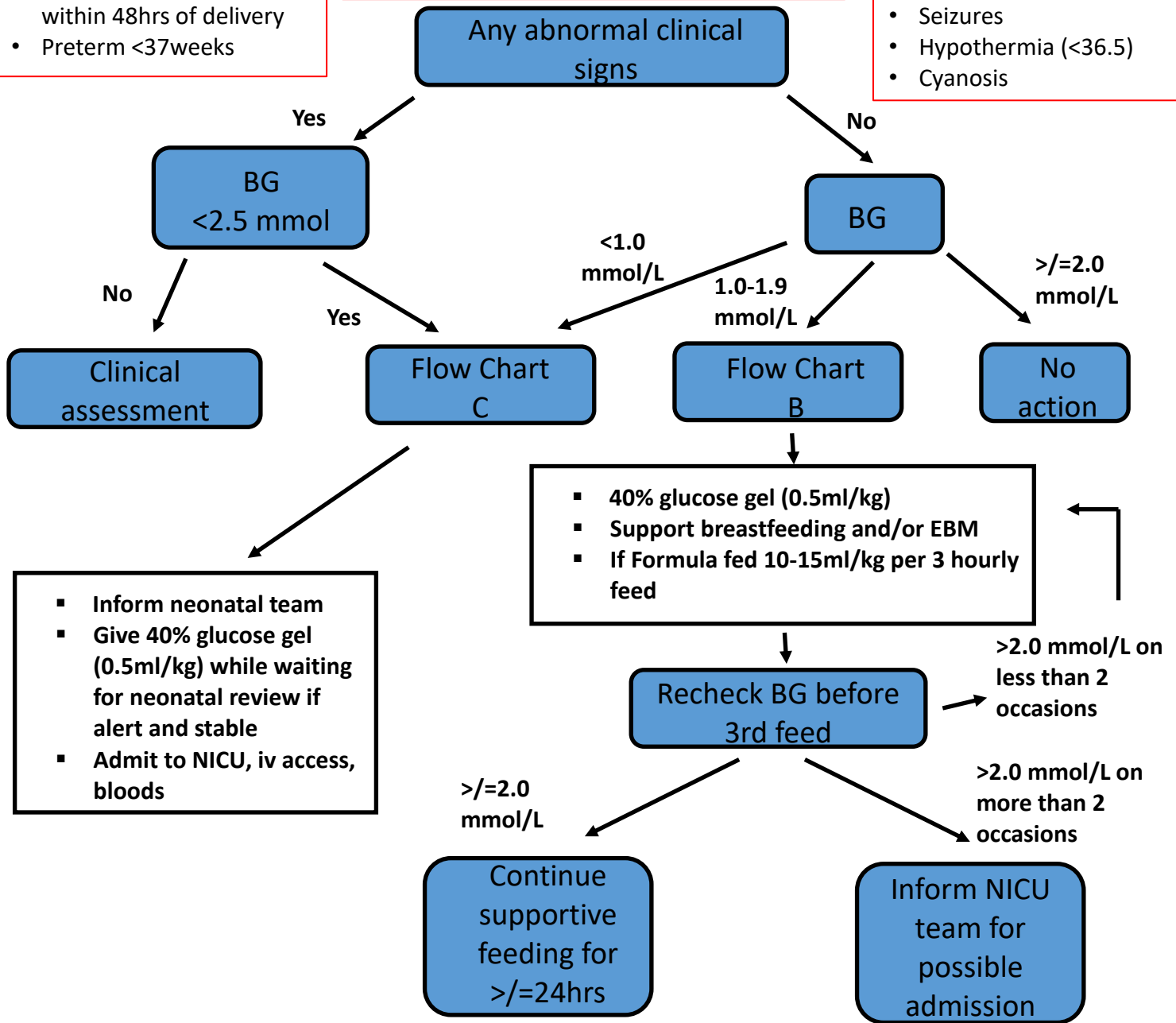


To be used in conjunction with Management of Hypoglycaemia in Neonates guideline  
**Hypoglycaemia**

**NOTE: If blood sugar is below the normal thresholds (< 2 for term babies and < 2.6 for preterm babies) on the handheld device, this needs to be cross-checked on a blood gas before treatment of Hypoglycaemia, unless clinical situation demands urgent management**

- Infants who require routine blood glucose monitoring
- IUGR (<= 2<sup>nd</sup> centile )
  - Infants of diabetic mothers
  - Maternal beta blocker use within 48hrs of delivery
  - Preterm <37weeks

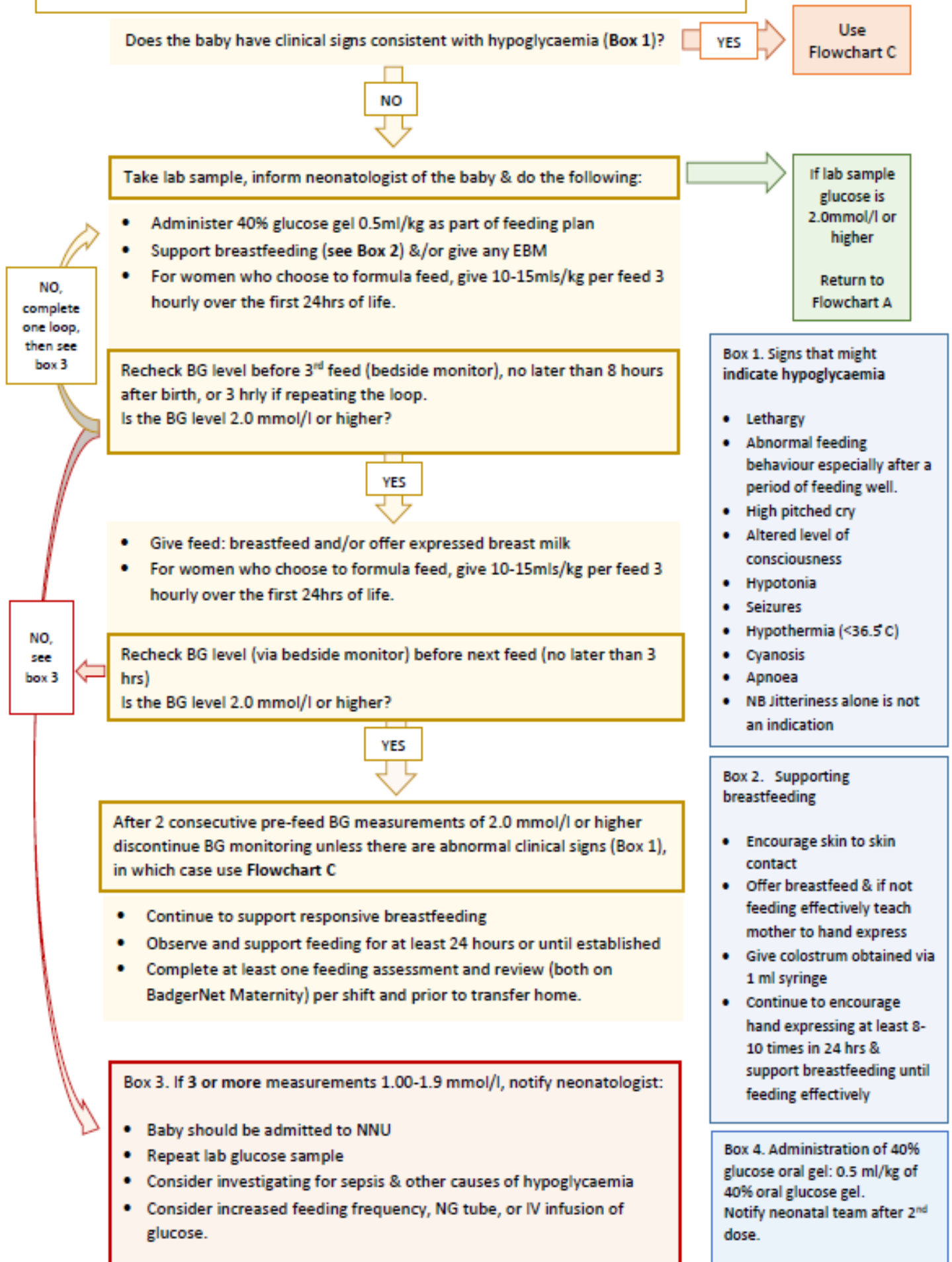
- Signs of hypoglycaemia
- Lethargy
  - Abnormal feeding behaviour especially after a period of feeding well
  - High pitched cry
  - Altered level of consciousness
  - Hypotonia
  - Seizures
  - Hypothermia (<36.5)
  - Cyanosis



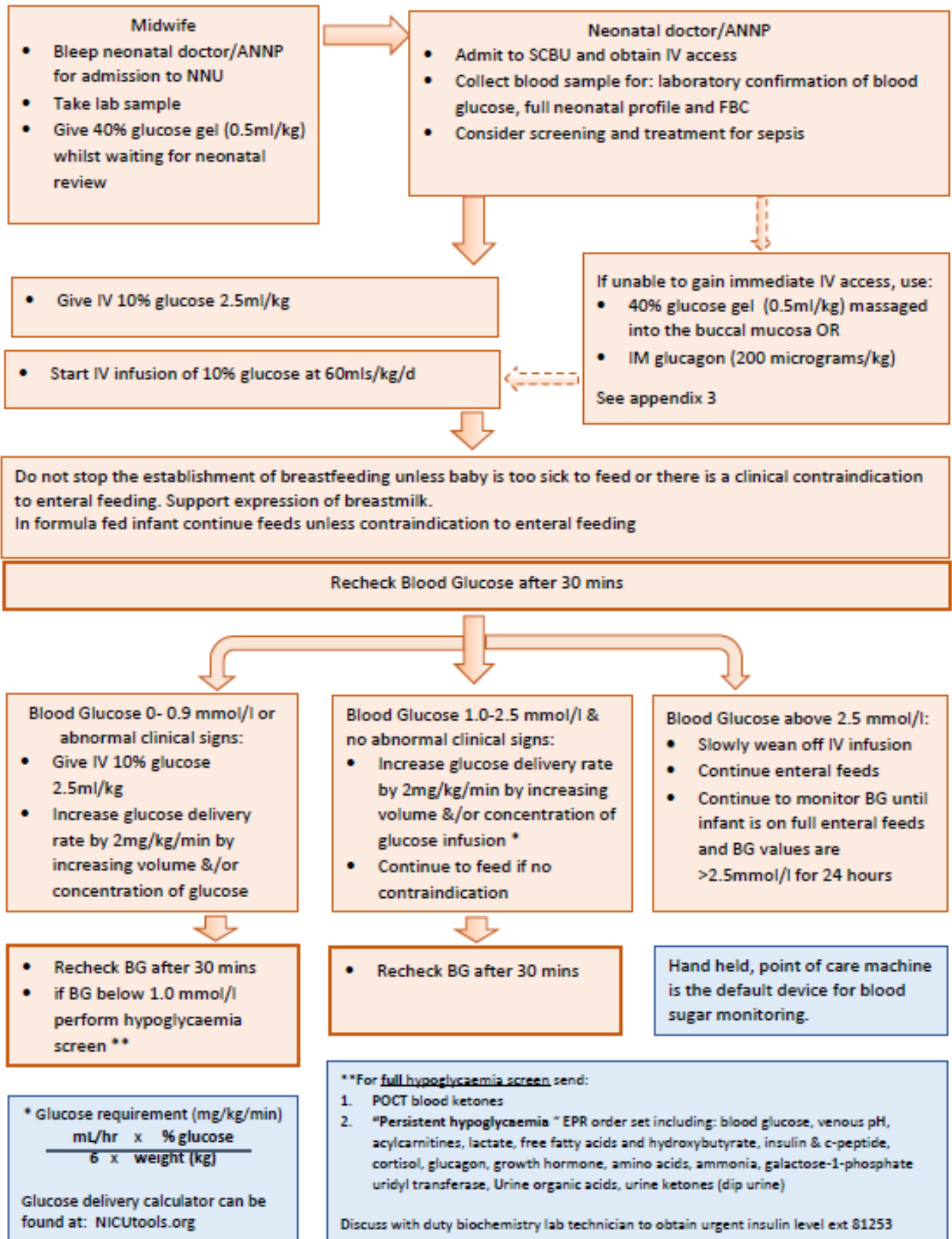
**Table 1. Definitions of Hypoglycaemia**

Blood Glucose	Interpretation	Refer to
<b>&gt;= 2.0 mmol/L</b>	Normal in asymptomatic term babies	-
<b>1.0 – 1.9 mmol/L</b>	May represent transition in asymptomatic term babies	Flowchart B
<b>&lt;1.0 mmol/L</b>	Treat as emergency	Flowchart C
<b>&lt;2.5 mmol/L</b>	Accompanied by abnormal clinical signs requires treatment	Flowchart C

## Flow chart B: Pre-feed BG 1.0-1.9mmol/L and no abnormal clinical signs



## Flowchart C. Blood glucose 0- 0.9mmol/l and /or clinical signs consistent with hypoglycaemia



## **Low Birth Weight (LBW), Small-for-Gestational Age (SGA) and Intrauterine Growth Restriction (IUGR)**

### **Definitions**

- LBW – BW <2500g
- SGA – Definition:  $\leq$ 2nd centile for gestational age
- IUGR – A pathological restriction of the genetic growth potential of a fetus.
- This may result in the fetus showing evidence of fetal compromise (e.g. abnormal Doppler studies, reduced liquor volume).
- There are multiple causes for this (These babies would usually have been identified by the obstetric team and had CMV and toxoplasma serology checked).
- They would need close review and should be observed for at least 24hours.
- Particular attention should be paid to temperature regulation, feeding and blood glucose.
- They are also prone to polycythaemia and jaundice.
- If the baby is well at delivery and weighs >1.8kg, it can go to the postnatal ward. TORCH can be considered in case the baby is symmetrical IUGR with a high index of suspicion of exposure to congenital infection during pregnancy.

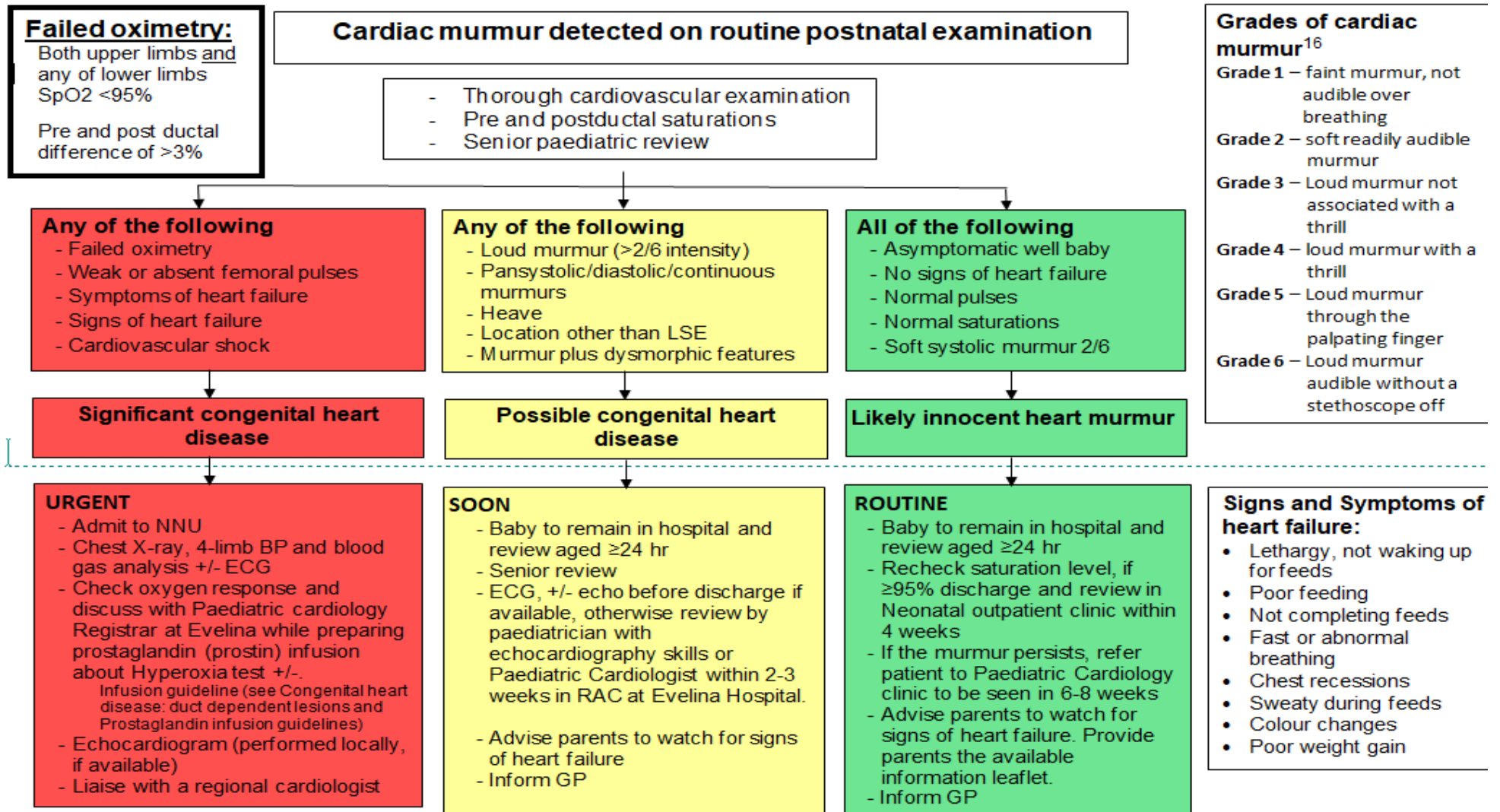
### **Complications include hypoglycaemia, hypothermia, hypocalcaemia, polycythaemia, poor feeding and jaundice**

- Ensure babies are classified and managed as Transitional Care
- Apply Red Hat care bundle as per protocol
- Don't discharge home before 72 hours of life
- Encourage early and frequent (3-4 hourly initially) breast feeding; or if formula feeding start at 90mL/kg/day and increase by 30mL/kg/day unless contraindicated
- Monitor for and treat hypoglycaemia according to protocol
- Examine closely for polycythaemia and check PCV with FBC if suspected or if hypoglycaemia or jaundice becomes a problem
- Avoid hypothermia by ensuring baby has a hat on and is adequately wrapped or using overhead heater if necessary. Babies below 1800g require admission to NNU
- Weigh before discharge – if lost > 10% birth weight delay discharge, assess state of hydration and review fluid intake after discussion with consultant or registrar - if weight loss >12%, check serum sodium (due to risk of hypernatraemia) - if weight loss >15% or Sodium level >160 mmol/l- admit to SCBU

# Neonatal Heart Murmur

Neonatal Heart Murmur Guideline – version 1 - (03/2020)

## B. Neonatal Heart Murmur -Clinical Guideline<sup>15</sup>



# Hepatitis B Positive Mothers

Lead: Delivery Suite Midwife or Paediatrician/Neonatologist

Hepatitis B: Management in Pregnancy and the Newborn Version 5

Lead: Infectious Diseases (ID) Midwife

Delivery Suite: Mother Hepatitis B Positive Result

**Delivery Suite Midwife**

Inform Paediatrician/Neonatal Doctor of delivery

**Low Infectivity**

**Birth Weight > 1500 gram**

Booked LGT, Booked Elsewhere & Un-booked in Labour\*

**Paediatrician/Neonatologist**

- Obtain consent
- Administer Hepatitis B Vaccine within 24hrs of birth
- Complete PCHR (Red Book)
- Complete Paediatric/Neonatal Local Checklist
- File Checklist in Neonatal Record

**Low Infectivity**

**Birth Weight ≤ 1500 grams**

Booked LGT, Booked Elsewhere & Un-booked in Labour\*

**Paediatrician/Neonatologist**

- Urgent order of HBIG from Colindale as per Local Paediatric/Neonatal Hepatitis B Checklist
- Obtain consent
- Administer Hepatitis B Vaccine within 24hrs of birth
- Complete PCHR (Red Book)
- Complete Paediatric/Neonatal Local Checklist
- File Checklist in Neonatal Record

**High Infectivity**

**Booked LGT**

**New Surveillance Pathway**

(Introduced April 2021)

**Delivery Suite Midwife**

- Locate Hepatitis B Box in Delivery Suite Fridge and follow instructions
- Take maternal serology sample after delivery

**Delivery Suite Midwife or Paediatrician/Neonatologist**

- Take baby's Hepatitis B dried bloodspot PRIOR to administration of HBIG/Hepatitis B vaccine

**Paediatrician/Neonatologist**

- Administer HBIG/Hepatitis B Vaccine within 24hrs of Birth, but after dried bloodspot
- Complete PCHR (Red Book)
- Complete Paediatric/Neonatal Local Checklist
- File Checklist in Neonatal Record

**Delivery Suite Midwife**

- Store:
- Serology sample, dried bloodspot, and HBIG paperwork
- In Hepatitis B box and return to Delivery Suite Fridge

**High Infectivity**

**Booked Elsewhere / Un-booked in Labour / Declined Screening Antenatally**

These women will not be included in the new surveillance pathway introduced in April 2021

**Paediatrician/Neonatologist**

- Urgent order of HBIG from Colindale as per Local Paediatric/Neonatal Hepatitis B Checklist
- Obtain consent
- Administer Hepatitis B Vaccine within 24hrs of birth
- Complete PCHR (Red Book)
- Complete Paediatric/Neonatal Local Checklist
- File Checklist in Neonatal Record

Screening Team: ID Midwife

Complete Local Hepatitis b checklist, which includes information GP< CHIS or vaccine administration at birth and need for 2<sup>nd</sup> vaccine at 4 weeks

Upload Hepatitis B data to ISOSS the National Hepatitis B database

## HIV Positive Mothers

### Sunflower Babies – HIV Positive Mothers

**Zidovudine:** The infant should receive Zidovudine within 4 hours of delivery. This can be administered orally or parenterally, depending on which route is most appropriate.

**DOSE:** (>34 +0 weeks gestation) – please refer to dosing tables if <34 weeks gestation.

**Orally:** 4mg/kg of Zidovudine suspension every 12 hours.

**OR**

**Parenterally:** 1.5mg/kg of Zidovudine injection diluted 5% glucose to a maximum concentration of 2mg/ml.

This should be infused over 30 minutes every 6 hours.

The Zidovudine should be continued until the baby is 4 weeks old.

Ensure a TTO of sufficient quantity of 4 weeks is supplied on discharge.

#### **Testing and follow-up for infant:**

**Infants should have HIV Proviral DNA blood taken** – 2 purple EDTA paediatric bottles – NOT cord blood **PRIOR** to discharge

**Please order on iCare using the code HDNA**

**Please ensure each bottle is has an iCare label or babies name, MRN and DOB.**

**Please send both samples and iCare printouts and FORM 2 to Virology.**

#### **NOTIFICATION OF BIRTH BY JUNIOR PAEDIATRIC DOCTOR**

Children & Young People Medical Secretary Team must be informed of the birth and baby's details by the next working day. Please complete appendix 1, page 3 and deliver completed form the CYP Medical Secretary's office Dolphin Admin corridor.

The Medical Secretary will contact parent to organise repeat blood tests and appointments with Dr Evers at 6 weeks and 3 months.

**The infant should have the normal neonatal check prior to discharge.**

## Drug Withdrawal

You will usually be alerted to this possibility in the notes or via the social work pages (yellow notes).

However, these babies do occasionally slip through the net!

Medications for drug withdrawal include.

Opiates, Benzodiazepines, citalopram, sertraline.

Check what medications mother is on and if in doubt discuss with the senior team.

Common signs of drug withdrawal include sneezing, jitteriness, high pitched cry, restlessness and fisting.

These can be normal on their own, or be signs of sepsis, which needs to be excluded.

If a child displays these signs, ask the midwives to keep a drug withdrawal chart (found in the filing cabinet in the post-natal ward), and send urine for toxicology.

These babies need senior review and may need to be observed on SCBU.

If mother has taken cocaine, babies need an eye check and cranial ultrasound scan (causes vasoconstriction).

Please ensure and document that social services involved.

Before doing urine toxicology – please consider the indication for doing so, who the results will go to, and what action will be taken, discuss with registrar or consultant before sending and ensure plan is clearly documented in the notes.

Please discuss all infants that there are significant social concerns about with the registrar or consultant.

## Flow Chart for Mothers/Birthing People Taking Mental Health Medication in the Perinatal Period

**Mother/birthing person taking a single anti-depressant or antipsychotic**



**Ensure mother/birthing person has the correct patient information leaflet  
Observe baby for signs of withdrawal for 24 hours and ensure feeding is appropriate before discharge**

**Midwife to review in the community the day after the discharge**

**Mother/birthing person taking multiple medications  
e.g. sertraline and olanzapine**



**Ensure mother/birthing person has the correct patient information leaflet for all medications**

**Observe baby for signs of withdrawal for 48 hours**

**Midwife to review in the community the day after the discharge**

### **Independent cases:**

- 1. High doses of medication that were unable to be reduced in pregnancy**

**Liaise with mother's/birthing person's mental health team – ideally there has been a pre-birth MDT**

- 2. A Mother/birthing person that wishes to be discharged before 24 hours**

**Paediatric/Neonatal review: What level of support does the mother/birthing person have at home?**

**Ensure the partner or support person is aware of signs of withdrawal and what to do**

**Midwife to review in the community the day after discharge**

## **Associated Guidelines**

Below is a list of the full guidelines summarised in this pack

- EOS & KP - Kaiser Permanente Score: Early Onset Sepsis Risk Assessment for Infants  $\geq 34$  Weeks, Lewisham & Greenwich (L&G) Guideline
- Jaundice - Newborn Jaundice: Inpatient and community assessment and the use of phototherapy on the Maternity Ward, L&G Guideline
- Thyroid - Neonatal Manual Chapter 14: Postnatal Ward, Evelina Guideline
- Renal and male genitalia - Neonatal Manual Chapter 9: Renal and Genito-urinary, Evelina Guideline
- Hips - Examination of the Newborn Hips, L&G Guideline
- Hypoglycaemia Management of Hypoglycaemia in Neonates, L&G Guideline
- Heart Murmur- Neonatal clinical Guideline, L&G Guideline
- Hepatitis B: Management in Pregnancy and the Newborn Guideline, L&G Guideline
- HIV - Sunflower birth pack, L&G Guideline
- Drug withdrawal – Perinatal Mental Health, L&G Guideline