Department of Paediatrics
Induction
August 2017

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1. Welcome and introduction to Paediatrics

Welcome to paediatrics at Stoke Mandeville and Wycombe. We are a friendly unit and there is a great opportunity for you to develop your paediatric and neonatal experience. We hope you will enjoy and benefit from your placement with us. It may seem overwhelming at first and the following booklet is designed to help you understand how the department works and your role within it. We look after children in a number of clinical settings and we aim for you to have an opportunity to experience all of them. The key to success is in good teamwork, communication, and flexibility.

Clinical Areas

**STOKE**
- Ward 3
  - 3 Bays
  - 12 Cubicles
  - Handover Room
  - Staff Room

Paediatric Outpatients
- Blood Clinic
- SHO Clinic
- prolonged jaundice, reviews

Admin
- Secretaries
- Doctors Office
- Consultant Offices

A&E
- PDU
- RESUS

**WYCOMBE**
- Children’s Day Unit (Ward 7)
- Doctors Office
- Outpatients
- Minor injuries and Illnesses unit (MIIU)

**WYCOMBE**
- Neonates and labour ward
  - NICU
  - Rothschild (Post nates)
  - Labour ward/theatres

**STOKE**
- Ward 3
  - 3 Bays
  - 12 Cubicles
  - Handover Room
  - Staff Room

Wycombe

The Wycombe Children’s Day Unit (ward 7) operates from 09:30 to 21:00 Monday to Friday. On your first Wycombe shift please go to Children’s Ward 7 at 9:30 am and the registrar working with you will orientate you to the clinical areas. You will deal with GP referrals, patients with open-access that may self-refer, and children booked in for reviews.

We aim to be a happy supportive department. If you are experiencing any difficulties with the job, with other members of staff, or with your training then you should let your supervisor or any senior colleague you feel comfortable approaching know sooner rather than later. Most difficulties can be overcome but not if we don’t know about them!
**Induction**

You will no doubt suffer a degree of information overload during your first few days. If anything is unclear or you have difficulties during induction then please ask. It's a really good idea to read this booklet before you start, but you'll gain much more from it if you then re-read it a month or so into the job, when a lot more will make sense to you.

Please ensure that you have completed your mandatory training by logging on to NLMS and completing the practical sessions where relevant. You should have/ will receive a password from the NLMS (National Learning Management System) team. Please leave a copy of your completed training matrix with Wendy Williams within 28 days of starting the post. In addition, please book yourself on to a BLS and PBLS session if you haven’t received this training as part of the induction programme.

**Layout of Ward 3 Stoke Mandeville**

![Diagram of Ward 3](image)

**Teaching and Training**

We work hard within the confines of a busy department to arrange a structured teaching programme. Please make every effort to attend these sessions and raise any difficulties in attending as early as possible. **A significant proportion of learning happens by the bedside on ward rounds and in PDU from both seniors and colleagues.**

- **Monday** – 1300-1400: Journal club/ Paediatric M&M (3rd Monday)
- **Tuesday** – 0900-0930: Xray MDT
- **Wednesday** – 0800-0900: SpR Teaching
  - 1400-1600: Child Protection peer review (1st Wednesday of the month)
- **Thursday** – 1300-1400: FY2-ST3 grade teaching (Bleep free)

Academic half days are held once a month and coincide with the trust audit days.
Note: You will need to complete your annual trust mandatory online training modules within 4 weeks of joining the trust.

Assessments

Work based assessments / supervised learning events, are a part of trainees’ life and we all appreciate the need to complete these assessments. You need to be proactive and plan ahead in order to help consultants and senior colleagues fit in assessments around busy schedules.

Nursing Staff

We work very closely together with our nursing staff and they are an invaluable source of help and advice. Neonatal and Paediatric nurses have a great deal of experience of sick children and they spend a lot more time with the patients than we do. They generally have a very good idea when things are not right, and if they are concerned about a child then so should we be. There are quite a few different shifts that you’ll cover and many different staff that you’ll work with, so make sure you introduce yourself to people and especially let them know if you’re new and would appreciate their guidance (and patience!).

Audit / Journal Club

You will be allocated a slot to do a journal club presentation. If you are unable to do, then the onus is on you to swap with one of your colleagues. When choosing a paper, try and choose something that is relevant but also of particular interest to you. It may be worth checking with one of the registrars that the paper or topic has not already been covered. The paper itself should be e-mailed to everyone a week before your presentation to allow everyone to read it. The idea is not to present the paper but to critically appraise it. You can avail the facilities of the outreach librarian who is there to help and often participates in the journal club.

Presentation skills are important to develop and we encourage you to get involved in case presentations at M&M meetings and in academic half day presentations.

We encourage you to take an active role in the development of our departmental practices. There are many opportunities for involvement in audits, clinical guidelines, and practice development (SIP’s). You should discuss possibilities with your educational supervisor early in your placement. Advice and support is available from your colleagues and from the audit department. Dr Prakash Dey, Consultant, is the audit lead for the department. You will need to get the audit form signed by him and forward it to Linda Skelton in the audit department, who will be very happy to help you. Please add your audit to Audit list in Paeds Share drive and forward the recommendations to Linda when you have presented your audit.

Sickness

We understand that at times, you are unable to work because of sickness. However it is your responsibility to contact the consultant in charge on that day and it is not acceptable to just leave a message with the night team or a junior colleague. You need to make contact with the consultant every day you are off and keep them up to date about when you are likely to be able to return. A return to work interview needs to be done with the consultant and a yellow time sheet be filled at the end of the month for the purpose of records.

Please note absences of 4 – 7 calendar days require an Inland Revenue Self Certificate, available from your GP’s surgery or via the Inland Revenue website. Absences over 7 calendar days require a Medical Certificate signed by your GP or Consultant.
Gaps in the rota may arise at very short notice as a result of sickness and paediatric locums are hard to find, therefore we very much appreciate your flexibility and goodwill in rearranging your rotas and taking up any locums that may come up. Any problems with the rota should be discussed with Dr Alzoubidi, who is in charge currently of the rota for FY2-ST3 grades and Dr Boon Tang for issues with the registrar rota.

Handover Lists
You will be given access to the “paed-share drive” where handover lists are kept. The trust takes confidentiality seriously. Please use SBAR to handover. Please dispose of handover lists in the confidential waste bins and log out of computers when you have finished with them. If you don’t know how to print them double-sided please ask a member of the Admin team.

Common Problems
It will build your confidence and help you a great deal to read up on the most common conditions you are going to see during your placement. A suggested starting point is

- Recognising a sick child, interpreting PEWS and NEWS chart
- Acute and chronic asthma in children (BTS guidelines)
- Bronchiolitis, UTI (NICE Guideline), Head Injury (NICE guideline)
- Paracetamol overdose, Pneumonia in children, Croup
- Diarrhoea and vomiting (NICE guideline), The child with a limp
- Post natal problems

Please have a read through: https://www.england.nhs.uk/patientsafety/re-act/

And http://www.rcpch.ac.uk/safe-system-framework/3-recognising-deterioration/safe-system-framework-3-recognising-deterioration

So in summary, welcome, learn lots, and enjoy your placement!

2. Departmental Induction Programme

GP VTS Induction
Wednesday 2nd August 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1330 - 1430</td>
<td>Welcome/roles and responsibilities</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td></td>
<td>Dr Beth Cheesebrough</td>
<td></td>
</tr>
<tr>
<td>1430 - 1515</td>
<td>Intranet, DOCGEN and IT access</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td></td>
<td>Evolve</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kris Butterworth</td>
<td></td>
</tr>
<tr>
<td>1515 - 1600</td>
<td>Common neonatal problems</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td></td>
<td>Dr Prakash Dey</td>
<td></td>
</tr>
<tr>
<td>1600 - 1645</td>
<td>PEWS chart and recognition of a sick child</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td></td>
<td>Claire Taylor</td>
<td></td>
</tr>
<tr>
<td>1645 - 1700</td>
<td>Paediatric Oncology</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td></td>
<td>Dr Beth Cheesebrough</td>
<td></td>
</tr>
</tbody>
</table>
GP VTS Induction
Thursday 3rd August 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1330 - 1400</td>
<td>Rota/Leave/Admin Johanna Baker</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td>1400 - 1500</td>
<td>Prescribing &amp; Maths challenge Dr Michelle Russell-Taylor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safe prescribing: Fluids and safe prescribing, drug charts Kimberly Mak</td>
<td>Ward 3 Seminar room</td>
</tr>
<tr>
<td>1500 - 1630</td>
<td>Paediatric Basic Life Support Resus Team</td>
<td>Dining Room, Post Graduate Centre</td>
</tr>
<tr>
<td>1630 - 1715</td>
<td>Neonatal basic life support and equipment Gaynor Tyler</td>
<td>NICU</td>
</tr>
</tbody>
</table>

3. Trainee and Supervisor DETAILS August 2017

Clinical and Educational Supervisors

<table>
<thead>
<tr>
<th>Trainee</th>
<th>Level</th>
<th>Clinical Supervisor</th>
<th>Educational Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angus Perry</td>
<td>VTS</td>
<td>Boon Tang</td>
<td>Charles Todd, Wendover Surgery</td>
</tr>
<tr>
<td>Chris Callue</td>
<td>VTS</td>
<td>Rania Alzoubidi</td>
<td>Andy Theobald, Bedgrove Surgery</td>
</tr>
<tr>
<td>Ahmad Saif</td>
<td>VTS</td>
<td>Beth Cheesebrough</td>
<td>Laura O'Malley, Meadowcroft Surgery</td>
</tr>
<tr>
<td>Tejal Parekh</td>
<td>VTS</td>
<td>Sanjay Salgia</td>
<td>Rashmi Sawhney, Riverside</td>
</tr>
<tr>
<td>Sunjay Paul</td>
<td>VTS</td>
<td>Michelle Russell-Taylor</td>
<td>Sajid Zaib, Oakfield Surgery</td>
</tr>
<tr>
<td>Sonia Hussain</td>
<td>VTS</td>
<td>Baneera Shrestha</td>
<td>Mark Howcutt, Haddenham Health Centre</td>
</tr>
<tr>
<td>Saima Shah</td>
<td>VTS</td>
<td>Kamal Sawhney</td>
<td>Penny MacDonald, Marlow Group</td>
</tr>
</tbody>
</table>

4. Rota:

You should have received a copy of the rota template by now. Monthly rota will be sent out by Wendy Williams Wendy.Williams@buckshealthcare.nhs.uk. There will be opportunities to discuss aspects of how the rota works during induction day.

Please note that all leave applications will need to go through Dr Roy Osgood and Dr Boon Tang for the middle grade rota and Dr Rebecca Puddifoot and Johanna Baker and Dr Alzoubidi for the FY2-ST3 rota (paedsrota@gmail.com). Annual leave is built in your 18 week cycle rota. Study leave should be requested at least 6 weeks in advance.

For GP trainees, we aim to ensure that you attend 100% your teaching days which will be considered as study leave. For those of whom we haven't managed to attend least 70% study leave (for attending teaching days) during the 6 months, we will encourage you to attend on your off day and you can have a lieu day for this. For those who are able to achieve 70% attendance, if you wish to attend any more of your training days in your off days, you may get a lieu day, only if the rota allows (this cannot be guaranteed).
ALL GPST TRAINEES ON PAEDS SHOULD LOOK AT THE ROLLING ROTA THEY RECEIVE AT INDUCTION AND WORK OUT HOW MANY TEACHING DAYS THEY WILL BE ABLE TO ATTEND

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME</th>
<th>ACTIVITY</th>
<th>CLINICIAN</th>
<th>LOCATION</th>
</tr>
</thead>
</table>

The position can be summarised as thus:

1. GPST’s can expect to attend **four of the six** teaching sessions during their paediatric placement. Attendance of the others will be welcomed where it is possible, within the constraints of the Band 1A rota.
2. If the GP trainee is **on call on the day of GP teaching** (this is possible to find out with a fixed rota and fixed teaching dates) they **MUST** organise a swap out of the on call duties in order to attend teaching.
3. If they are not on call but are down to work a short day they could either try to arrange a swap or can discuss attendance with the rota co-coordinator. They will try and accommodate this if possible.
4. If a trainee attends teaching when rota’d to be at work - and HAS NOT ARRANGED COVER - this will be counted as a Study Leave day.
5. If a trainee attends a teaching session on a day that they are on annual leave or rostered as ‘off duty’, they will qualify for an extra day off in lieu.
6. The rota co-coordinator will try to accommodate as many trainees as is possible when it comes to teaching but the responsibility of the rota co-coordinator is first and foremost to maintain safe staffing levels. The paediatric rota co-coordinator is not ultimately responsible for the GP trainees’ teaching attendance.

During your community week if you choose to do something else e.g. attend clinics Dr Kanga (community rota organiser) and the rota co-ordinator need to be informed in advance.

5. **Monthly Educational schedule**

You will receive this by e mail every month. Please check your inbox as soon as you have your logins set up. Educational sessions are highlighted in blue. Departmental academic half days co-incide with the trust audit days. These sessions incorporate talks on interesting topics by guest speakers on new developments/best practice as well as providing an opportunity for presenting audits.

6. **Weekly time table**
<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Event</th>
<th>Room/Consultant</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>MON</td>
<td>08.30</td>
<td>NICU Ward Round and handover</td>
<td>NICU Consultant</td>
<td>Paediatric Office on Labour Ward</td>
</tr>
<tr>
<td></td>
<td>08.30</td>
<td>Paeds Ward Round and handover</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>13.00</td>
<td>- [Journal Club/Paeds M&amp;M (3rd Monday)]</td>
<td>Registrars/FY2-ST3</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Jaundice Clinic</td>
<td>FY2-ST3</td>
<td>Children’s Outpatients</td>
</tr>
<tr>
<td>TUES</td>
<td>08.30</td>
<td>Handover NICU and Ward</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>09.00</td>
<td>X-ray meeting</td>
<td>Dr Cathy Melvin</td>
<td>X-ray Seminar Room</td>
</tr>
<tr>
<td></td>
<td>09.30</td>
<td>Ward Round</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>09.30</td>
<td>NICU Ward Round</td>
<td>Consultant</td>
<td>NICU</td>
</tr>
<tr>
<td></td>
<td>11.30</td>
<td>MDT NICU Sit Down Ward Round</td>
<td>Multi-professionals</td>
<td>Paediatric Offices Labour Ward</td>
</tr>
<tr>
<td></td>
<td>11.30 -13.30</td>
<td>Clinical Governance Meeting (3rd Tuesday)</td>
<td>Consultants</td>
<td>Ward 3 seminar room</td>
</tr>
<tr>
<td></td>
<td>12.45</td>
<td>Perinatal Mortality Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEDS</td>
<td>08.00</td>
<td>- Registrar Teaching</td>
<td>Consultant</td>
<td>Seminar Room in the POD</td>
</tr>
<tr>
<td></td>
<td>08.30</td>
<td>NICU Handover and Ward Round</td>
<td>Consultant</td>
<td>Paediatric Office on Labour Ward</td>
</tr>
<tr>
<td></td>
<td>08.30</td>
<td>Handover and Ward Round</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>12.30</td>
<td>Multi-Professionals</td>
<td></td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>1400 -1600</td>
<td>Child Protection Review Meeting (1st Wed of the month)</td>
<td>Dr Ray/Dr Sawhney/Dr Mallya</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td>THUR</td>
<td>08.30</td>
<td>NICU Ward Round and Handover</td>
<td>Consultant</td>
<td>Paediatric Office on Labour Ward</td>
</tr>
<tr>
<td></td>
<td>08.30</td>
<td>Ward Round and Handover</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
<tr>
<td></td>
<td>12.00 -14.00</td>
<td>FY2-ST3 Teaching</td>
<td>Various Consultants and Registrars</td>
<td>Mandeville Wing Meeting Room 1</td>
</tr>
<tr>
<td></td>
<td>1300-1400</td>
<td>CPC (Grand Round)</td>
<td></td>
<td>Post Graduate Centre SMH</td>
</tr>
<tr>
<td></td>
<td>1400</td>
<td>Blood Clinic</td>
<td>FY2-ST3/SHO/Nurses</td>
<td>Children’s Outpatients</td>
</tr>
<tr>
<td>FRI</td>
<td>08.30</td>
<td>NICU Ward Round and Handover</td>
<td>Consultant</td>
<td>Paediatric Office Labour Ward</td>
</tr>
<tr>
<td></td>
<td>08.30</td>
<td>Ward Round and Handover</td>
<td>Consultant</td>
<td>Ward 3 Seminar Room</td>
</tr>
</tbody>
</table>
Annual and Professional Leave

Please refer to the trust annual and professional leave policy document on the trust intranet website and see appendix B. Should you need to arrange a swap to cover your leave then the ‘Agreement to rota change form’ should be filled out. See appendix C.

8. Departmental contact numbers- These can be found in appendix A
### 9. Specialist Paediatric Clinics

#### 10. SPECIALIST PAEDIATRIC CLINICS - CHILDREN'S OUTPATIENTS AT STOKE MANDEVILLE, WYCOMBE AND AMERSHAM HOSPITALS

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Name</th>
<th>Specialty/Speciality</th>
<th>Location</th>
<th>Code</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>0915</td>
<td>Dr Atanu Dutta</td>
<td>Endocrine</td>
<td>Stoke Mandeville</td>
<td>TBA</td>
<td>4 x year check with Elaine</td>
</tr>
<tr>
<td></td>
<td>0930</td>
<td>Debbie Cotter/ Carol Clarke</td>
<td>Feeding Clinic</td>
<td>Stoke Mandeville</td>
<td>Carol</td>
<td>Check with Carol</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Dr Cheesebrough</td>
<td>Pediatric oncology/hematology</td>
<td>SMH</td>
<td>TBA</td>
<td>1st and 3rd Monday of every month</td>
</tr>
<tr>
<td>TUES</td>
<td>0840</td>
<td>Dietician</td>
<td>Dietetics</td>
<td>Stoke Mandeville</td>
<td>Carol</td>
<td>Check with Carol</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr Taffy</td>
<td>Endocrine</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 4 x per year check with Louise</td>
</tr>
<tr>
<td></td>
<td>0930</td>
<td>Dr Hill</td>
<td>Special Needs Meeting</td>
<td>Sue Nicholls Centre</td>
<td>Debra</td>
<td>1st and 3rd of month</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Miss Hicks</td>
<td>Orthopaedic</td>
<td>Stoke Mandeville</td>
<td>Sec</td>
<td>Check with Secretary</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Dr Kim</td>
<td>Genetics</td>
<td>Wycombe</td>
<td>OPD</td>
<td>Check with OPD re dates/times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WED</td>
<td>0900</td>
<td>Nickey Berry</td>
<td>Infant Behavioural Test</td>
<td>Stoke Mandeville Hearing Assessment Centre</td>
<td>Lynda</td>
<td>5153 Check with Nickey</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr Adwani</td>
<td>Cardiology</td>
<td>Wycombe Hospital</td>
<td>Louise</td>
<td>120 5125</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr McDonald</td>
<td>Cystic Fibrosis</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>(120) 5125 2nd &amp; 4th Wednesday of every month. Check with Debbie</td>
</tr>
<tr>
<td>THUR</td>
<td>09.00</td>
<td>Nickey Berry</td>
<td>Audiology/Neonatal</td>
<td>SMH</td>
<td>Lynda</td>
<td>5153 Check with Nicky</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr Diedrie Cilliers</td>
<td>Genetics</td>
<td>Stoke Mandeville</td>
<td>Any</td>
<td>120 4611 Every Thursday</td>
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<td></td>
<td>0900</td>
<td>Dr Shrestha</td>
<td>Allergy</td>
<td>Amersham</td>
<td>Mandy</td>
<td>5144 Check with Mandy(one/month)</td>
</tr>
<tr>
<td></td>
<td>0915</td>
<td>Dr S Ramdas</td>
<td>Neurology</td>
<td>Wycombe Aylesbury</td>
<td>Debbie</td>
<td>(120) 5125 110 5144 1 x month except August Different dates to Wycombe</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mandy</td>
<td>5144 Check with Mandy(1 time/year)</td>
</tr>
<tr>
<td></td>
<td>1400</td>
<td>Dr Ryan/ Dr Dutta</td>
<td>Endocrine</td>
<td>Stoke Mandeville</td>
<td>TBA</td>
<td>2 times per year</td>
</tr>
<tr>
<td>FRI</td>
<td>0900</td>
<td>Dr Adwani</td>
<td>Cardiology</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
<td>5144 Check with Mandy(one/month)</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr Cheesebrough</td>
<td>Haematology</td>
<td>Stoke Mandeville</td>
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<td>2nd Friday of the month</td>
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<td>1400</td>
<td>Dr Shrestha</td>
<td>Dermatology</td>
<td>Amersham</td>
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<td>5144 Check with Mandy</td>
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</tbody>
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**NOTE 1:** If a Clinic coincides with Academic Half Day then they won’t take place

**NOTE 2:** Please check the Educational Schedule for information on Teaching sessions.
# 10. Paediatric Clinics

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Doctor</th>
<th>Specialty</th>
<th>Clinic</th>
<th>Name</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>MON</td>
<td>09.00</td>
<td>Dr Alzoubidi</td>
<td>Developmental/neurological</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
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<td>Dr Sarkar</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
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<tr>
<td></td>
<td>09.00</td>
<td>Dr Russell-Taylor</td>
<td>General</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Dr Salgia</td>
<td>General</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>(120) 5125</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Dr Tang</td>
<td>General</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501</td>
</tr>
<tr>
<td></td>
<td>14.00</td>
<td>Dr Cheesebrough</td>
<td>General</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>120 5125 2nd and 4th Monday of every month</td>
</tr>
<tr>
<td>TUES</td>
<td>09.00</td>
<td>Dr Russell-Taylor</td>
<td>General</td>
<td>Amersham</td>
<td>Louise</td>
<td>(120) 5501  Twice a month check with Secretary</td>
</tr>
<tr>
<td></td>
<td>0900</td>
<td>Dr Rastogi</td>
<td>General</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501  Twice a month check with secretary</td>
</tr>
<tr>
<td></td>
<td>1400</td>
<td>Dr Russell-Taylor</td>
<td>Diabetes</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501  Twice a month check with secretary</td>
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<td>5144  Check with Debra</td>
</tr>
<tr>
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<td>Dr McDonald</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
<td>5144  Alternate Tuesday check with Mandy</td>
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<td>WED</td>
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<td>Dr Sarkar</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>TBA</td>
<td>6369</td>
</tr>
<tr>
<td></td>
<td>09.00</td>
<td>Dr McDonald</td>
<td>General</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>(120) 5125 1st and 3rd Wed of every month</td>
</tr>
<tr>
<td></td>
<td>09.00</td>
<td>Dr McDonald</td>
<td>General</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>(120) 5125 2nd and 4th Wed of every month</td>
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<tr>
<td></td>
<td>09.00</td>
<td>Dr Sawhney</td>
<td>General</td>
<td>Amersham</td>
<td>Mandy</td>
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<td>1400</td>
<td>Dr Russell-Taylor</td>
<td>Diabetes</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501  Every 3rd week this is at Amersham</td>
</tr>
<tr>
<td></td>
<td>1400</td>
<td>Dr Salgia</td>
<td>General</td>
<td>Wycombe</td>
<td>Debbie</td>
<td>(120) 5125 1st Wednesday of the month only</td>
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<td>Dr B Shrestha</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
<td>5144</td>
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<td></td>
<td>14.00</td>
<td>Dr Dey</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>Elaine</td>
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<td>THUR</td>
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<td>Dr Dutta Registrar</td>
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<td>Dr Salgia</td>
<td>General</td>
<td>Amersham</td>
<td>Debbie</td>
<td>(120) 5125  Check with Debbie. Not on the 1st Thursday of every month.</td>
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<td>General</td>
<td>Wycombe</td>
<td>Louise</td>
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</tr>
<tr>
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<td>General</td>
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<td></td>
<td>1400</td>
<td>Dr Rastogi</td>
<td>General</td>
<td>CGX or WGH</td>
<td>Louise</td>
<td>(120) 5501  Check with Louise</td>
</tr>
<tr>
<td></td>
<td>1350</td>
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<td>Adolescent Diabetes</td>
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<td>Dr Sawhney</td>
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<td>(120) 5501</td>
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<td>0900</td>
<td>Dr Tang</td>
<td>General</td>
<td>Wycombe</td>
<td>Louise</td>
<td>(120) 5501  Weeks 2 and 4 only</td>
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<td>General</td>
<td>Stoke Mandeville</td>
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<tr>
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<td>Dr Dey Reg</td>
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<td>Stoke Mandeville</td>
<td>TBA</td>
<td>6369</td>
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<tr>
<td></td>
<td>14.00</td>
<td>Dr McDonald</td>
<td>General</td>
<td>Stoke Mandeville</td>
<td>Mandy</td>
<td>5144</td>
</tr>
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</table>
11. IMPORTANT INFORMATION ABOUT CORRESPONDENCE

As you may be aware, the trust has gone paperless. Notes are on EVOLVE and letters are on DOCGEN. Both of this will be covered at Induction. Mandy Thompson will be able to help you if you have any queries.

PLEASE ENSURE THAT ALL TELEPHONE CONVERSATIONS WITH PARENTS OR OTHER PROFESSIONALS ARE DOCUMENTED IN THE PATIENTS' CLINICAL CONTINUATION SHEET ON EVOLVE WHEN PAPER NOTES ARE NOT AVAILABLE.

Open Door Notes:

Some patients are unwell enough to be given (Permanent) “Open Door” access which means that patients have access to Ward 3/clinicians and advice at any time. Only consultants can grant permanent open door access and they will write a summary letter to GPs informing them of this. An alert will be put on Evolve (secretaries will action this).

If open door notes are unavailable out-of-hours then recent clinic letters can be accessed from the M Drive.

Some patients are offered (Temporary) “Open Door” access which is different to the above in that it is a short term facility and doesn’t require any of the above paperwork.

12. Paediatric clerking

There is a clerking proforma for use in PDU/Ward 7. This is a helpful guide ensuring a thorough systematic approach.

Please ensure that you

- Write in BLACK ink
- That each page has patient identifiers at the top i.e. name, hospital number or NHS number & date of birth
- Number the top of each page consecutively
- Date & time each entry & the top of any continuation sheet
- Sign the bottom of each entry & each page, print your name & include your grade and bleep number
- Include who has referred the child, where you are seeing them e.g. A&E or MPU, and who is accompanying the child & giving the history
- If you need a chaperone for the examination or for delicate conversations please include their name in the notes at the relevant stage of the proceedings.

13. Out and In-patient Admin

The labs are moving forward wherever possible for all requests to be on ICE.

We have a major problem in paediatrics with those blood tests being done when called back into blood clinic. Historically the nurses have not been sure what the tests are that we want and which the consultant the child belongs to and so the chasing and sorting of abnormal results becomes challenging and unsafe. We want to put a process in place to help this.

To just confirm with everyone how the on call consultant responsibility works.
The POW covers all admissions for the week they are on Fri 9am-Friday 9am UNLESS the patient is known to a specific consultant even if they come in for a different problem ie known for diabetes, in with febrile illness.

The NOW covers admissions in the neonatal unit from Mon 9am of the week they start to Friday 5pm.

The weekend from Friday 5pm to Monday at 9am for neonatal work belongs to the POW not the consultant doing the neonatal ward round for the weekend.

Most consultants are paired, one Wycombe based and one Stoke based except for Beth and Craig who have clinics on both sites. This means that follow up with a consultant depends on where the child lives. Please ask if you are not sure at discharge.

The consultant who just comes to cover the on call overnight does not take the admission for that night as they are not the continuity of care.

There are occasional exceptions as always but this is the general rule.

The plan we would like to implement going forwards for documentation and investigations is below.

1) If a paediatric patient is seen and notes are written in, eg – maternity, PDU, ward 7 and follow up investigations are required these need to be requested on ICE and then the box “postponed” marked (this will prevent the form being printed somewhere).

2) When an appointment is booked as much information including hosp /NHS number will be vital.

3) When they come to blood clinic the nurses can then access the form and print it off. No request - no test.

4) Wherever possible especially if it is a baby from Roths coming for repeat TFT’s for maternal disease or U and E’s for raised creatinine or high calcium’s a brief clinical note on Evolve stating this is useful. Even the child coming back to ward for review it would be helpful. Sometimes we can’t find notes or they are not yet scanned to evolve. This will improve efficiency.

5) When the child has the investigation the results come back to the acute team (ward 3 or ward 7) although they should come to the consultant if OPD bloods. If abnormal we can look at evolve – see the entry for the reason and then decide how best to discuss with family and which consultant to liaise with.

6) Any action taken on any results should also be documented on Evolve if the child has no current notes available to write in.

Each time a patient attends for consultation/advice, bloods/procedures it needs to be documented in the notes and signed. You can add continuation sheets on Evolve and it is suggested that all communication and discussion is documented.

Each visit needs to be logged so that the ward/outpatient area/PDU can claim back the cost involved. This includes ward attenders and day cases. A ward attender is when the patient is attended by a nurse/doctor but not admitted. A day case is when the patient occupies a bed for a procedure no matter how short the visit. Day Cases can range from blood transfusions/infusions to MMR’s and any type of injection which requires monitoring. All will need a discharge summary filling out so that clinical coding can cost the episode.

When a patient is asked to attend the ward, outpatient area or PDU, for whatever reason, their details should be put in the correct diary so that the ward clerks can request the notes or make up the necessary documentation.
**Finance**

Every time a patient is seen on the ward by a doctor or nurse we have to make a charge. If you see a patient for five minutes or five hours, whether for a blood test/review/etc, please fill out a discharge summary form to tell us, so we can deal with it.

**Tracking**

All Paediatric notes are kept behind reception for 14 days (unless they have an apt elsewhere)
All Surgical notes are kept for one week.
We obtain notes for all appointments that appear in the diaries and they are kept behind reception in alphabetical order or in the outpatient area in date order. If you need to use them, please return them when you are finished.

For any queries please speak to Karen on 5168 or Kim on 6426

**14. Arranging blood tests and follow up**

When patients are discharged and need a follow up OPA or blood test, please first check their address and book these at the appropriate hospital i.e. Aylesbury patients at SMH and Wycombe patients at WGH. For the areas in between, patients will often know which hospital is nearest, so check with them first.

For patients seen at SMH but needing an OPA at WGH, consultants are paired across the two sites. See table below. Essentially this means that if a patient was admitted whilst a WGH consultant was on take but needs an OPA at SMH then you need to find out which SMH consultant they are paired with.

Following discharge from the neonatal unit/ward 3/PDU/WACU, request ward clerk to arrange the necessary follow up with the relevant consultant.

For those neonates requiring follow up from the post natal ward, please inform the consultant and his/her secretary by e mail so that appropriate follow up is arranged.

<table>
<thead>
<tr>
<th>Stoke Mandeville</th>
<th>Wycombe Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Dutta</td>
<td>Dr Tang</td>
</tr>
<tr>
<td>Dr Shrestha</td>
<td>Dr Chawda</td>
</tr>
<tr>
<td>Dr Alzoubidi</td>
<td>Dr Sawnhney</td>
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<td>Dr Russell-Taylor</td>
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<td>Dr Sarkar</td>
<td>Dr Salgia</td>
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<td>Dr McDonald</td>
<td>Dr McDonald</td>
</tr>
<tr>
<td>Dr Cheesebrough</td>
<td>Dr Cheesebrough</td>
</tr>
</tbody>
</table>

To arrange a blood test for a child or baby at Wycombe Hospital please ring (120) 6487 and for Stoke ring 6426.

**15. Blood clinic and jaundice clinic**

You may be requested to help with the blood Clinic on Thursday if there is a difficulty. Other reviews can be arranged throughout the week as necessary. If you arrange an appointment for a child, you must provide enough information for the clerks to be able to identify the patient. We need a readable name, date of birth and who requested the appointment (name of GP surgery, HV, name of consultant), and please write your name on the request too.
There is an FY2-ST3 run prolonged Jaundice / Review clinic on Monday and Wednesday. It is the responsibility of the person dealing with the case to chase results and inform GP and parents (standard templates are available in the shelves behind the ward clerk in ward 3). Notes for jaundiced babies are kept in the appropriately named tray behind reception.

The department is looking in to making this a nurse led clinic which is being piloted currently. Once finalised, it will be communicated to you.

**Results**

Results need to be signed DAILY so that they can be filed in the notes before they leave the ward. This is important because, as a common example, a child may have gone home on antibiotics to which an infection is resistant, and renal damage could result. We hang them on a clip at the back of the nursing station on the Medical Side every day, when they are actioned; they can be put in the confidential waste bin. **Please make a written entry in clinical continuation sheet on Evolve when you have actioned an abnormal result, esp when you have called and left a message on an answer phone.**

### 16. Paediatric Emergencies

**Overview**

Within the department you will always be working as part of a team however there may be situations where you will need to recognize and manage a seriously unwell child while help arrives.

**Where?**

You may be asked to help with an emergency anywhere within the hospital however the usual sites are Ward 3, A&E/PDU, NICU, labour ward, and postnatal ward. You should make a point of familiarizing yourself with the location of paediatric resuscitation equipment in these locations.

**How do I know when to call for help?**

*If in doubt, ask for help.* It is important to remember that children are different to adults and normal values are different in children. You need to work out what should be normal for the age of child you are dealing with. Never ignore an abnormal number. For example children with a high fever may be tachycardic and tachypnoeic but an afebrile child with a tachycardia or abnormal blood pressure (high or low) should be urgently assessed.

**Normal values**

<table>
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<th>Resp Rate</th>
<th>HeartRate</th>
<th>Sys BP</th>
</tr>
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<tr>
<td>&lt;1</td>
<td>30 - 40</td>
<td>110 - 160</td>
<td>70-90</td>
</tr>
<tr>
<td>2 - 5</td>
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<td>95 - 140</td>
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<td>80 - 120</td>
<td>90 - 110</td>
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<tr>
<td>&gt; 12</td>
<td>15 - 20</td>
<td>60 - 100</td>
<td>100 - 120</td>
</tr>
</tbody>
</table>

Estimating weight:  \((3 \times \text{age}) + 7\)
The nursing staffs have a great deal of experience and will let you know if they are concerned about a child. Their concerns should be taken seriously as they are usually right.

All children are now given a PEWS (paediatric early warning system) score as part of their routine observations. Take a moment to read the explanation of the system printed on the back of every observation chart.

**Who?**
If you are concerned about a baby or child then you should call for help or ask someone to call for help. There is often a needless delay in help arriving because someone told the nearest person to “get my reg” or “call for help”. In the interests of getting yourself help as soon as possible you need to be clear:

1) Ask someone specifically **“Can you please…”**
2) Give clear instructions e.g. “dial 2222 and say paediatric emergency on postnatal ward”
3) Always use crash bleep system (2222) if you are seriously concerned about a child, it doesn’t matter if it turns out the child wasn’t too unwell and it avoids unnecessary delays. No-one will ever criticize you for putting out a call if you are worried.
4) Close the loop “… and come back and let me know when you’ve put out the call”

Paediatric and neonatal nurses have often got a great deal of experience with emergencies and are an invaluable source of help.

**What do I do?**

In the appendices you will find basic algorithms for the management of
a) unwell children ([Appendix E Paediatric Life Support](#))

b) Neonates ([Appendix F Neonatal Life Support](#))

There are specific guidelines for different conditions in resuscitation areas and you should make an effort to locate them early in your placement. This will be covered in your induction.

**17. Post Nates**

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**Postnatal checks**

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**Common neonatal problems – what to do.**

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Paediatrics Dept, Stoke Mandeville
Jennifer Turnbull
Contents

- Roles on Rothschild ward
- The baby check – step by step
- BCG vaccine, thyroid tests, renal pelvic dilatation, oral vitamin K, hepatitis vaccine
- Unwell babies
- Meconium
- Infections and Group B Strep
- Jaundice
- Hypoglycaemia
- Congenital Anomalies
- Hip dysplasia
- Talipes/Club foot
- Other musculoskeletal problems
- Renal pelvic dilatation
- Heart murmur
- Skin problems
- Ears
- Head swellings
- Sacrum
- Genitalia and anus, hypospadias
- Bowels and bladder
- Syndromes
- Normal neonatal feeding

Further info is available from:

- Clinical guidelines on intranet (look by specialty under paeds, obstetric and neonatal, the search doesn’t work well.) Specifically there are detailed guidelines on Group B Streptococcus infection, examination of the newborn, jaundice and hypoglycaemia
- Paeds folders on paediatric trolley
- Nursery nurses
- Neonatal SpR

Role on Rothschild ward

There are usually 2-3 FY2-ST3’s covering the postnatal ward. The baby checks should run as a clinic in the Paeds room, with the nursery nurse/midwife bringing babies with mothers and notes. Let the ward staff know what you’re doing and ask specifically for their help. The 2nd person can do reviews at the bedside, whilst the third acts as a float and helps with community referrals regarding poor feeding, jaundice etc. There is scope to interact with mothers and explore maternal health and well-being and the support services that is available for them. Being able to see plenty of normal babies and common postnatal problems makes this a valuable learning exercise.

You will often have pressure from many directions to do things in particular orders. Try to bear in mind which are the sick babies and which are well and just eager for home. Also try to make an efficient plan rather than darting from bay to bay.

- Daily review of any unwell babies – jaundice, antibiotic treatment, hypoglycaemia. (These are listed in table on handover sheet and by the midwives in the Roths’ book)
- Routine Baby Checks – listed in paeds book on Roths'
- Assessment of babies < 10 days old coming back from community – weight loss, jaundice, poor feeding. When discharging these babies they will all need discharge summaries.
- Blood tests - “true glucose” blood sugars on the gas machine – the Roths’ staff do BMs and bilirubins, but you will need to do the true glucoses.
- Red plastic wallets – all babies requiring follow-up need red wallets. All documentation should be filed in the red folders so that it can be scanned and put on EVOLVE (electronic record system)
- Update handover list at end of the day (saved under handover lists on paedshare drive)

**The Baby check**

The initial baby check is part of the core health plan for under-fives. It should be performed between 6 and 72 hours of age. You will be shown how to during induction. Please ask the registrar or consultants to do a miniCEX when you perform a baby check for the first time. This is important both for your competence but also your confidence, and it is highly recommended that you arrange this. This can be done in SCBU when you first attend. There are trained midwives in the postnatal ward who can supervise you doing a baby check. See appendix G for some guidance on how to do the baby check, but the proforma that you need to complete is online on the national “NIPE” system. You'll be shown this and given your login details at induction. The print-outs from this are the record for the notes, the parents and the Community team, so it’s important that you complete all parts accurately.

**ACTIONS NEEDED AFTER A BABY CHECK**

**Vaccines – BCG**

- Babies who will live in or who have a grandparent from areas with a high incidence of TB (40/100,000) are offered BCG. It takes 2 months to be effective.
- It can also be offered to those likely to travel to a high risk area within 2 years. There is a list of countries requiring BCG at the front of the paeds folder.
- Give BCG leaflet. Check there are no contraindications (Active TB in mother or household contact, maternal HIV, known maternal immunological disease, steroids or immunosuppression)
- Fill in consent form and get mother/father to sign
- Prescribe BCG on front of yellow drug chart – “BCG vaccine 0.05ml intradermal” and inform midwife.
- There has been a national shortage in BCG vaccinations so check with the ward about how they are delivering these injections at present.

**Vaccines – Hepatitis B**

- Given if maternal Hep B carrier or IV drug use, plan should be in the notes. Vaccine kept on NICU, given by us. An advanced plan is usually made and a record of this should be in the large folder on the ‘hot’ side of NICU, but it is not always there, especially if mothers have booked late.
**Thyroid function tests**

Babies of hyperthyroid mothers may have antibody related hyperthyroidism. Mothers with hypothyroidism may have been hyperthyroid and had thyroid ablation, so check about this. Currently babies of every hyperthyroid mother should have had cord bloods sent for TSH and antithyroid antibodies. Chase these, if not done you will need to bleed the baby. Book a repeat check of thyroid function at 10-14 days, as below.

Babies of hypothyroid mothers are currently booked into clinic for thyroid function tests at 10-14 days (call Stoke outpatients on 6484, or call WACU if Wycombe based). It is the responsibility of the Rothschild FY2-ST3 to arrange this.

**Hip ultrasound:**

May be required if breech, fixed talipes or torticollis (see hip section).

**Renal Tract Ultrasound and trimethoprim:**

May be required if there was renal pelvic dilatation (check guideline below).

**Oral vitamin K:**

Usually babies receive IM Vit K after birth, but there once was a leukaemia scare about IM vitamin K so some parents choose oral. The extra doses need to be prescribed on a TTO and GP informed.

- **Bottle fed:** 2 mg Phytomenadione on Day 0 and at day 4 to 7
- **Breast fed:** 2 mg phytomenadione at day 0, day 4-7 and at 1 month

**UNWELL/AT RISK BABIES**

**Meconium**

Babies born with meconium liquor:
- Grade 1 – brown/green stained liquor
- Grade 2 – good volume of liquor with solid particles of meconium
- Grade 3 - large particles of meconium, very little normal liquor

Grades 2 and 3 require paediatrician at delivery. Babies have 4 hourly obs (temp, HR, RR) done for 12 hours.

Babies with meconium aspiration syndrome are usually unwell. They have significant respiratory distress and patchy shadowing with air trapping on x-ray.

**Group B Streptococci (GBS)**

Group B Strep can cause a rare but serious infection. 25% of women carry the bacterium as part of normal flora. Disease in the baby is rare – 0.5 cases/1000, but carries a 10% mortality. Risk factors are used to identify babies at greater risk and reduce the risk of infection by giving antibiotics during labour and/or to the baby.
Refer to GBS guideline 417 for details (on intranet, search guidelines for “GBS” if the following link does not work http://swanlive/sites/default/files/guideline_417.pdf), but in summary…

Antibiotic treatment of the neonate
N.B.: Interim guidance – Guideline covering Neonatal Early Onset Sepsis Management is currently being written and will replace the guidance below once finalised.

(a) Antibiotics are indicated in the following:
  - Any neonate presenting at any gestation with respiratory or septic symptoms.
  - In multiple births, if one neonate is diagnosed with GBS sepsis, treat all siblings.
  - Any neonate born to a mother who had a condition where IAP (Intra partum antibiotics) is advised but who failed to receive antibiotic prophylaxis at least 2 hours before delivery.
  - Preterm neonate even if mother received IAP (discuss with registrar/consultant)
  - If mother has had previous baby with GBS sepsis.
  - Term, well neonate of mother with known incidental GBS carriage plus one or more other risk factors

  Prolonged rupture of membranes (more than 24 hours).
  Maternal fever in labour (temperature above 38°C), including suspected chorioamnionitis (see section 5).
  GBS infection in a previous baby.
  Maternal GBS urinary infection in current pregnancy.
  Incidental maternal carriage of GBS detected during current pregnancy

  - If mother received intravenous antibiotics for invasive infection 24 hours before or after birth.

(b) Antibiotics are not indicated in the following:
For a term, well neonate of a mother with known incidental GBS carriage without any other risk factor and has received intra partum antibiotics. Observation only is required for 24 hours.

Management of neonate
Before antibiotic treatment is started, a partial or full septic screen would be required. A full septic screen would include all the investigations listed below.

Full blood count, CRP, Blood culture, +/- chest X-ray, +/- lumbar puncture where clinically appropriate and safe, surface swabs for MRSA and ESBL

Antibiotic regimen of choice is benzylpenicillin (given as slow IV bolus) plus gentamicin (given as slow IV bolus). See empirical antibiotic guidelines in the Paed clinical guideline section of the intranet.

Repeat CRP is rechecked at 24 hours, and gentamicin levels are checked at 36 hours, 1 hour prior to the 2nd dose.

Consider stopping antibiotics at 48 hours if neonate is well and cultures remain negative. If pathogen is isolated, review antibiotic regimen in light of sensitivities and clinical condition of neonate.

Routine surface culture specimens including gastric aspirates are not necessary if neonate is well.
Babies on the post natal ward with abnormal observations or clinical concerns should be discussed with registrar and considered for a sepsis screen and antibiotics. A partial septic screen is needed if baby is being given antibiotics purely due to protocol. A full sepsis screen (includes LP) is needed if baby is unwell. Antibiotics are continued for at least 48 hours, until 48 hour blood culture is back and negative. Babies on antibiotics should be reviewed daily by the postnatal FY2-ST3 doctors.

NOTE: Septic babies do not behave like septic adults. They present in many ways, including poor feeding, mild hypothermia below 36 degrees, or persistent hypoglycaemia. If in doubt, ask a SpR, and if they’re not available and you are worried, ask the on call consultant for advice.

Jaundice

There are two ways of assessing jaundice (i) a transcutaneous bilirubin check (TBC or bilicheck) and (ii) serum bilirubin (SBR). Community midwives can only measure TBC which is less reliable than an SBR. Therefore, always use serum bilirubin measurement (SBR) when:

- Jaundiced in the first 24 hours of life.
- <35 weeks gestation at birth.
- When babies are at/above relevant treatment threshold for their postnatal age and for all subsequent measurements.
- TCB measurement indicates a bilirubin level greater than 250 micromol/litre. Check the result by measuring the serum bilirubin.

Plot the bilirubin level on gestation appropriate charts according to age in hours. Continue to measure and record the SBR level every 6 hours until the level is >50 below the treatment threshold and is stable or falling.

TAKE CARE TO USE THE APPROPRIATE JAUNDICE CHART FOR THE CORRECT GESTATION.
ONLY BABIES MORE THAN OR EQUAL TO 38 WEEKS WILL BE PLOTTED ON THE TERM CHARTS.
AT EVERY OPPORTUNITY, CHECK THAT THE BILIRUBIN LEVEL IS PLOTTED IN THE CORRECT GESTATIONAL CHART

1. Jaundice in First 24 Hours

Jaundice within the first 24 hours is pathological so inform the SPR and look for:

- rapid haemolysis due to Rhesus disease or ABO incompatibility (Take FBC, group and DAT – direct antibody test/Coomb’s, retics and a blood film). If risk factors identified antenatally (maternal antibodies) midwives should send off cord blood for these tests.
- infection therefore do a sepsis screen +/- antibiotics.

2. Jaundice after 24 hours

This is likely to be physiological but exaggerated in bruised infants, infants of diabetic mothers, polycythaemic babies

If bilirubin is At/Above phototherapy line:

- Start phototherapy if above treatment line or rapid rise (> 10 per hour)
- Check FBC, Group and DAT, film, PCV with next SBR
- Repeat SBR after 4 - 6 hours to assess response
- If inadequate response change to double phototherapy (bed and overhead light) and inform SpR
If Adequate response continue phototherapy and repeat 6-8 hourly to monitor trend. (Follow the neonatal jaundice guideline on the intranet)
If SBR is below PTTx line:
- Reassess in 12 hours. If < 50 below line and stable, can go home.

Mild jaundice can be easy to miss as neonates don’t always have yellow sclerae. Press on the nose or forehead in good light and if in doubt, a TBC can be done. What is mild in the morning can be serious in the afternoon.

**Hypoglycaemia**

Healthy term babies can cope on small amounts of milk in the first 1-2 days by using stores. Some babies risk hypoglycaemia due to inadequate stores or hormonal/metabolic derangement.

At risk babies:
- Weight < 2.5kg
- Weight >4.5 kg and mum has not had a GTT in pregnancy
- Infants of diabetic mothers
- Any baby showing signs of hypoglycaemia (jittery, excessively drowsy)
- Babies born in poor condition cord gas with pH< 7.0

At risk babies should be fed every 3 hours and have blood sugars checked before every feed. Nursery nurses normally do these but at times you will be asked and you will be asked to make decisions on actions required. BMs should be done for 24 hours, but can be stopped after 3 consecutive normal BMs if feeding regularly and well.

Actions:
**IF PRE FEED:**
- BM > 2.6 – feed as normal, repeat before next feed. Consider stopping when 3 consecutive normal BMs, though continue if not feeding well.
- BM 2.6 or less – check True Glucose (capillary tube on gas machine). If that also low feed and check 1 hour post-feed. Check temperature and keep warm (keeping warm reduces glucose consumption).
- If breast feeding and hypoglycaemia not responding discuss formula with parents. Early on in your job it’s good to discuss this with the Nursery Nurses or your SpR first, as many parents may be keen to exclusively breast feed, and early exposure to formula slightly increases the risk of cow’s milk protein intolerance. However, neonatal hypoglycaemia can cause brain damage so it must be managed.
- If baby not taking feed or post top-up-feed BM still low discuss with SpR – may need to come to NICU for NG feeds/IV dextrose.
CONGENITAL ANOMALIES

Hip Dysplasia

Talipes equinovarus (Club foot)

Talipes equinovarus: Formally: hind foot in rigid equinovarus and forefoot short, wide, adducted and supinated.
Foot twisted inwards and downwards. Talus is deformed, calcaneous is flattened and shortened, Achilles’ shortened.
Positional talipes is caused by posture in utero. The foot will naturally hold a talipes-like position, but can manually be brought into normal position. Fixed talipes cannot. If you scratch foot (as if testing plantar reflex) the normal foot should respond with dorsiflexion, eversion and fanning of toes. If talipes it won’t do this.

Associated with breech presentation, oligohydramnios, amniotic band, genetic defects (Eg Edwards), maternal ecstasy use and smoking.

- **Positional talipes**: If mild and fully correctable, teach parents to tickle feet (run a nail lightly up the lateral side of the foot, heel to toe, in such a way that the baby dorsiflexes and everts its foot) to encourage normal position – to do this with each nappy change. If more severe, bilateral or parental concern can refer to physio (forms in folder).
- **Structural talipes**: If structural, or if you are unsure whether or not fixed refer to Miss Hicks, Consultant Orthopaedic Surgeon who covers paediatric patients.

**Other musculoskeletal problems**

- Single palmar crease - Document, but no action if isolated
- Polydactyly – contact SpR
- Syndactyly - contact SpR
- Overlapping fingers or toes – consider trisomy, contact SpR
- Fractured clavicle – assess clinically if shoulder dystocia, big baby, difficult delivery or not moving arm. Contact SpR

More information at: www.buckshealthcare.nhs.uk/CYP

**Renal Pelvic Dilatation / Vesicoureteric Reflux**

Renal pelvic diameters are measured at 20 weeks, and repeated at 36 weeks if abnormal. Any dilatation over 7mm will need further investigation.

- Ensure baby has passed urine before discharge and does not have palpable bladder.
- If male and there is severe dilatation (>10mm) ask parents to leave nappy off and observe for a stream with a good arc. If no urine steam or palpable bladder – discuss with SpR, they are likely to need a scan within 48 hours and may need U&Es.

If there is a family history of severe vesico-ureteric reflux in a first degree relative (parent/sibling) then discuss with consultant to consider a non-urgent MCUG. Please remember to arrange parents to collect a prescription from us for 3 days of cephalaxin during the procedure as there are problems in getting this from their surgery (prophylaxis for the procedure)
ANTENATAL HYDRONEPHROSIS  
(Renal Pelvic Dilatation>7mm)  

- Antenatally detected:  
  Unilateral RPD 7-18mm
  - Arrange Renal USS at 6 weeks of age  
  - No Trimethoprim  
  - Named consultant to review results

- Antenatally detected:  
  Unilateral RPD > 10 mm  
  Bilateral RPD > 7 mm
  - Any Complex RISK Factors?  
    - Palpable bladder  
    - Caliceal dilatation  
    - Ureteric dilatation  
    - Ureterocele  
    - Any parenchymal abnormality  
    - Oligohydramnios
  - USS Scan (4-14 days)  
    - Check Renal function  
    - Start Trimethoprim 2mg/kg 24 hourly  
    - Refer to JR Paed Urology (Phone + letter)

- RPD < 10 mm (Unilateral) OR RPD < 7 mm (Bilateral)
  - Discharge  
  - No F/U

- RPD > 10 mm (Unilateral) OR RPD > 7 mm (Bilateral)
  - Rescan at 3-6 months of age
  - Report received by Consultant  
    - Start Trimethoprim 2mg/kg 24 hourly (if not already on)
    - Outpatient follow up

- RPD > 15 mm Unilateral
  - N.B. PUJ obstruction needs to be ruled out
  - Micturating cystourethrogram (MCUG)  
    - Follow antibiotic guidance for MCUG

- Vesicoureteric Reflux (VUR)
  - DMPSA 3/12  
    - Continue Trimethoprim UTI leaflet  
    - Refer to Urology  
    - If dysplasia, scarring, recurrent UTI or VUR Gr 3 to 4

- No Vesicoureteric Reflux (VUR)
  - Review need for Trimethoprim  
    - Rescan at 6 months of age

- RPD 7-10mm (Unilateral) OR RPD < 7 mm (Bilateral)
  - Repeat USS at 3-6 months, if no change/improving - stop Trimethoprim  
  - Rescan at 3-6 months of age

- RPD > 10 mm (Unilateral) OR RPD > 7 mm (Bilateral)
  - No VUR
  - Review need for Trimethoprim  
    - Rescan at 6 months of age

- If Unilateral RPD >15 mm or bilateral or calyceal dilatation
  - MAG 3 UTI leaflet

- If Unilateral RPD 10-15mm
  - Paed Clinic F/U

- If Obstruction: Refer to Urologist
  - If no Obstruction: Repeat USS 6/12.  
  - If no change discharge with UTI leaflet

Abbreviations
- RPD - Renal Pelvic Dilatation

Jean Yong, Atanu Dutta, Cathy Melvin  
“Up to date” Postnatal evaluation of unilateral prenatal hydronephrosis
Documentation of the following is necessary in the clinical notes

- Cyanosis, RR, HR, Thrills, Hepatomegaly, Dysmorphic features
- Murmur characteristics, Brachial and femoral pulses
- Pre- and post-ductal sats, Likely diagnosis
SKIN PROBLEMS

Erythma neonatorum/toxicum

- white/yellow pustule surrounded by red halo
- Gets worse over 2-3 days then resolves
- Lasts for 5 to 7 days (occasionally longer)
- non-infective, no action required but good to point out that will get worse

Neonatal acne

- like acne, but no blackheads, usually resolves, no treatment

Benign pustular melanosis

- Fragile pustules in any place, leave pigmented patch when rupture. Usually last a few days, pigmentation remains for longer.

Milia

- inclusion cysts
- small white spots, mainly on face and scalp
- on palate = Epstein’s pearls
- harmless, will resolve over few months
Stork bites/salmon patches/Angel Kisses – “Naevus Simplex”

- Pink-red marks on forehead and nape of neck. Represent dilated superficial capillaries. Tend to be midline and symmetrical. Blanch on pressure, redder when crying. 95% of forehead ones tend fade within 2 years, back of neck 50% remain.
- no clinical significance.

Portwine stains – “naevus flammeus”

Usually unilateral or asymmetrical well defined red-purple marks on face, but can be anywhere. Can be pale pink at birth. Malformation of mature and deeper capillaries. These don’t fade, but grow in proportion with body and become darker and sometimes raised. Some important associations (Sturge-Weber Syndrome, Klippel-Trenaunay-Weber, glaucoma if trigeminal distribution) so discuss with SpR.

Capillary haemangiomas/ strawberry naevus/infantile haemangioma

Raised red lumpy areas anywhere on body, made up of disorganised proliferation of endothelial cells. Usually appear after birth. Most will get bigger over 6 months, then get start to break down and involute by 10 years. May be sore at this time. If over critical areas* or very extensive they should be referred to Dermatology to consider oral propranolol or active monitoring. Usually just need to point out to parents and document. Deeper ones can look like a raised bruise with telangiectasia. If small and non-concerning advise seeing GP if worried (as they can become very large and cause considerable anxiety).

*Critical areas include:
- Lesions over the airway (or in liver or GIT, found on scans)
- Lesions in the periorbital region
- Very large, rapidly growing lesions
- Areas at risk of complications resulting in ulceration, scarring, disfigurement:
- Present ulceration or bleeding, or those being persistently rubbed e.g. on the nappy line
- Any lesion on the face or ear
- Pedunculated lesions

**Mongolian blue spots**
Flat, bluish, bruise-like patches, commonly over buttocks or lower back. More common in dark skinned babies. Of no significance, but helpful to point out and document present from birth to avoid future child protection concerns.

**Ears**
- **Pre-auricular pits**: benign in isolation but flag to look for other cranio-facial abnormalities, renal problems). No action required
- **Pre-auricular skin tags**: can be associated with facial problems, renal problems or chromosomal problems. If isolated features, no action required.

**Caput succadeneum and cephalohaematoma**
**Caput** – oedematous scalp swelling superficial to the cranial periosteum. Can cross over suture lines. Occurs at presenting part.

**Chignon** – caput caused by Ventouse cup. Can be very bruised and sore but will still be superficial and not contained within suture lines – higher risk of jaundice

**Cephalohaematoma**
Subperiosteal bleeding. Contained within sutures. Can cause anaemia and jaundice, but most just resolve. Will need to be reviewed to ensure not rapidly enlarging.
Document these and consider risk of jaundice. Baby may need paracetamol if not settling or severe. No follow-up as most will resolve.

**Sacral dimples or pits**
Most are benign and simply need attention to hygiene. No action if in natal cleft. An ultrasound to look for spina bifida is only required if there is a hairy tuft, a lipoma, or if the dimple is outside of the natal cleft and more than 5mm from the midline. If arranging ultrasound, arrange outpatient follow up with the named consultant.

**Female Genitalia**
**Vaginal discharge**: or even small withdrawal bleed is normal – results from exposure to mother’s hormones. Point out and reassure

**Vaginal skin tags**: also common, if small no action, most will regress.

**Male Genitalia:**

**Hypospadias:**
The opening of the urethral orifice on ventral surface of penis. Associated with:
- Ventral urethral opening
- Downward bending of penis (chordee)
- Hooded appearance (only half of penis covered with foreskin)
- Spraying on urination
Actions:
- Referral letter to Mr Ghosh (consultant plastic surgeon) + copy in notes + copy to GP
- Yellow notes
- Advise parents that surgeons will see soon, but operation usually delayed until pre-school age (heals better out of nappies). It is essential that the child is not circumcised as the foreskin tissue is used in the repair. Meanwhile don’t expect any problems apart from abnormal (and often messy) stream.

Absent testis:
- If one testis can be palpated, but not the other one explain that it may descend later. GP will check at 6 weeks and will refer if still not down by 1 year. Write to GP
- If bilateral, refer to SpR as may need to confirm that child is male and does not have ambiguous genitalia.

Bowels and bladder
- Non-patent anus – speak to SpR
- Not passed urine – renal pelvic dilatation should come back if wool in nappies to try
- Not opened bowels within 48 hrs.

SYNDROMES

Trisomy 21 – Down’s
- Facies
- Hypotonia
- Large tongue
- Single palmar crease, wide toe gap

Trisomy 18 – Edward’s
- Microcephaly
- Wide spaced eyes
- Rockerbottom feet
- Cardiac defects
- Abdo wall defects
Trisomy 13 - Patau

- small babies
- microcephaly
- rockerbottom feet
- cleft lip and palate
- holoprosencephaly
- polydactyly

FEEDING

Usual infant feeding

Breastfeeding Basics

Doctors are not experts on breastfeeding – this is the realm of the midwives. However brief support and advice from a doctor can mean a lot to parents, and the way that we approach breastfeeding in babies with hypoglycaemia, jaundice, weight loss and prematurity can influence breastfeeding rates. Here are three high impact actions:

Firstly, give brief motivational advice
- The biggest impact of breast milk is to reduce risk of gastroenteritis, otitis media and LRTI, including hospitalization rates
- Reduced risk of SIDS and childhood leukaemia
- Reduced risk of breast/ovarian cancer and osteoporosis for Mum
- Helps Mum lose weight (uses 500 calories/day)
- Saves time and money (formula costs £30-£40/month, prep of bottles is time consuming)

Secondly, advise that the first two weeks are crucial for establishing a good supply of breast milk. Frequent stimulation of the breasts is needed to “switch on” all the possible milk-producing cells. Therefore if the baby cannot effectively feed from the breast then Mum needs to frequently express milk. Midwives and nursery nurses will advise on practicalities but reinforce the importance of expressing frequently, particularly in any baby that is having formula top-ups. Before the milk comes in (approx. D3) hand expressing is best and you can reassure Mum that she will only get a small volume (eg a few drops the first time) but this will gradually increase the more she expresses.

Thirdly, tell breastfeeding mums to take a vitamin D supplement (10 microgram OD – can be bought on its own or is contained in multivitamins marketed for breastfeeding mums).

A note on using formula top-ups:
Formula is a vital tool for babies in certain risk groups. However, we should use it only when strictly necessary as using formula in hospital has an impact on breastfeeding success. For example, Mums whose babies were supplemented with formula in hospital were 3 times more likely to have stopped breastfeeding by the time their baby was 2 months old.

Key facts

1. Doctors have a big impact on breastfeeding motivation and success rates
2. Breastfeeding reduces childhood infections, SIDS and maternal cancer
3. The first two weeks are critical for establishing a good milk supply. Mums may need to express if baby is not feeding well
4. Breastfeeding mums should take a vitamin D supplement

“For those parents who are already initiating breastfeeding/expression, a well-placed word of encouragement from the baby’s doctor can strengthen their resolve at a difficult time... that flood of hormones post-birth, coupled with exhaustion, can leave you feeling very vulnerable indeed”

The effect of early supplementation may include decreased milk production due to reduced removal of milk from the breast, difficulties in developing effective breastfeeding & reduced maternal confidence in the ability to successfully breastfeed with reinforcement of a negative belief that human milk is insufficient for an infant”

– Cochrane review 2011

“Doctors have a big impact on breastfeeding motivation and success rates”

“Breastfeeding reduces childhood infections, SIDS and maternal cancer”

“The first two weeks are crucial for establishing a good milk supply. Mums may need to express if baby is not feeding well”

“Breastfeeding mums should take a vitamin D supplement”

“For those parents who are already initiating breastfeeding/expression, a well-placed word of encouragement from the baby’s doctor can strengthen their resolve at a difficult time... that flood of hormones post-birth, coupled with exhaustion, can leave you feeling very vulnerable indeed”

“The effect of early supplementation may include decreased milk production due to reduced removal of milk from the breast, difficulties in developing effective breastfeeding & reduced maternal confidence in the ability to successfully breastfeed with reinforcement of a negative belief that human milk is insufficient for an infant”

– Cochrane review 2011
**Feeding Plans**

A feeding plan is a specific volume of milk that baby needs to be offered 3 hourly. They are used for babies who have lost >10% weight at day 5, babies who are on double light phototherapy (as this should not be interrupted for feeds) and babies who have repeated low BMs. In this hospital, they are worked out as follows:

<table>
<thead>
<tr>
<th>Day</th>
<th>Volume</th>
<th>Day</th>
<th>Volume</th>
<th>Day</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>40ml/kg/day</td>
<td>3</td>
<td>80ml/kg/day</td>
<td>5</td>
<td>120mg/kg/day</td>
</tr>
<tr>
<td>2</td>
<td>60ml/kg/day</td>
<td>4</td>
<td>100mg/kg/day</td>
<td>6+</td>
<td>150ml/kg/day</td>
</tr>
</tbody>
</table>


Remember, these are not “normal” feeding volumes – if there is no sign of baby being unwell, parents should be led by their baby with no target volume or frequency suggested. If a baby on a feeding plan is breastfeeding Mum should first offer the breast. Then baby is offered the full volume for that feed, either as EBM or formula (they don’t have to take it). At some point before the next feed Mum needs to express to get EBM for the next top-up and stimulate supply. Expressing cannot be used to “check how much baby is getting” or “see how much is left in the breast after the feed”. This three-stage process is extremely draining so reassure mums it is only for the short term until baby stabilises. Encourage Mums to seek support from breastfeeding clinic to re-establish ‘normal’ breastfeeding.

How to know if breastfeeding is going well

<table>
<thead>
<tr>
<th>How many feeds?</th>
<th>Nature of feeds?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Day 0-1: at least 3/day</td>
<td>- Baby wakes for feeds</td>
</tr>
<tr>
<td>- Day 3+: at least 8/day</td>
<td>- Feed starts with rapid sucks,</td>
</tr>
<tr>
<td>*if risk factors for hypoglycaemia need to feed 3 hourly from birth</td>
<td>then slower sucks with pauses and swallowing</td>
</tr>
<tr>
<td>Note: gap between feeds matters less than number in 24 hours</td>
<td>- Baby ends the feed spontaneously and is content</td>
</tr>
<tr>
<td>Length of feeds?</td>
<td>- Both breasts are offered each feed</td>
</tr>
<tr>
<td>- Generally good feeds are between 10 and 45 mins</td>
<td>- Breasts and nipples are comfortable</td>
</tr>
<tr>
<td>- Feeds &gt;1 hour may mean baby is not feeding effectively</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many wet nappies per day?</th>
<th>How many poos per day (for the 1st month of life)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Day 1-2: at least 1</td>
<td>- Day 1-2: at least 1</td>
</tr>
<tr>
<td>- Day 3-4: at least 3</td>
<td>- Day 3-4: at least 2 (changing from meconium to lighter coloured stool)</td>
</tr>
<tr>
<td>- Day 5-7: at least 5</td>
<td>- Day 5: at least 2 (yellow stools)</td>
</tr>
<tr>
<td>- Day 7+: at least 6</td>
<td></td>
</tr>
</tbody>
</table>

Don’t check BMs unnecessarily
Healthy term babies often feed infrequently in the first 24-48 hours after birth (eg 3-4 times in 24 hours – could be gaps of 6-8 hours). Because they are able to mobilise ketone bodies they are unlikely to suffer any ill effects. Therefore we should only check BMs in babies with risk factors for hypoglycaemia (as outlined in the Trust guideline), unless they are symptomatic. In the first 24 hours, the trust guideline advises that normal, term babies who are reluctant to feed should have 6 hourly BEWS but not have paed involvement unless baby appears unwell. An unnecessary blood sugar is likely to start a spiral of further BMs and formula top ups, undermining Mum’s confidence.

Note that jitteriness is “excessive repetitive movements of one or more limbs, which are unprovoked and usually relatively fast. It is important that this is not simply a response to stimuli.”

Breast milk for preterm babies
The key benefit for premature and small babies is decreased rate of NEC. Other benefits include decreased risk of late onset sepsis, increased IQ and decreased metabolic syndrome in later life. If you are asked to counsel Mums at risk of preterm birth, mention expressing breast milk as one of the most important things Mums can do to help their babies while they are in the NICU. They should start hand expressing as

“There is no evidence that long feed intervals adversely affect healthy newborns who are kept warm and who are breastfed when they show signs of hunger” - Trust guideline
soon as possible after birth, ideally within the hour, and they will need to express at least 8 times a day, including once in the middle of the night. The earliest we would expect a baby to feed directly from the breast for short periods would be 32-34 weeks. Also note that for preterm babies the feeding plan volumes are one day ahead as they start at 60ml/kg/day for day 0-1: 60/80/100/120/150.

References:

http://www.unicef.org.uk/BabyFriendly

Summary slide for common neonatal problems

Heart Murmurs
Follow guideline, arrange OPA and give information leaflet to parents

Maternal Hypothyroidism
If caused by thyroid ablation – follow hyperthyroidism guidelines
Book TFTs 10-14 days

Risk of TB exposure
Check Green Book
Written Consent and give leaflet
Prescribe on drugchart

Maternal Hyperthyroidism
Check Cord / baby blood for TSH and antithyroid Ab
Book repeat TFTs 10-14 days

Positional Talipes
Advise parents to tickle feet with nappy change
Refer to physio if severe

Fixed Talipes
Refer to Miss Hicks

DDH
Risk factors only – USS requested
Clicky hips – USS only
Dislocated/dislocatable – urgent referral to Miss Hicks

Hypospadias
Refer to Plastics
Advise no circumcision

Absent Testis
Unilateral – advise GP to review in 6 weeks
Bilateral – SPR review

Antenatal Renal Pelvic Dilatation
See guidelines

Other Musculoskeletal Problems
e.g. polydactyly
SPR Review

All needs to be documented in the notes
Write a letter to the GP, request notes to be compiled. This list is not exhaustive but covers everything I’ve come across in a year here. Ask the neonatal SpR (Bleep 794) for any other concerns. No question too silly – most new FY2-ST3s haven’t seen many normal babies and take a while to become confident (femoral pulses, testes and hips are common difficulties).

**18. Neonatal daily schedule**

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.m.</strong></td>
<td>8.30 – 9am Handover</td>
<td>8.30 – 9am Handover</td>
<td>8-9am Registrar Teaching</td>
<td>8.30 – 9am Handover</td>
<td>8.30 – 9am Handover</td>
<td>8.30 – 9am Handover</td>
<td>8.30 – 9am Handover</td>
</tr>
<tr>
<td></td>
<td>Consultant ward round</td>
<td>9-9.30am X-ray meeting</td>
<td>8.30 – 9am Handover</td>
<td>Consultant ward round</td>
<td>Consultant ward round</td>
<td>Consultant ward round</td>
<td>Consultant ward round</td>
</tr>
<tr>
<td></td>
<td>Weekly summary sheets (pink and blue)</td>
<td>Consultant ward round</td>
<td>Consultant ward round</td>
<td>Consultant ward round</td>
<td>Consultant led Case discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weigh+ plot babies</td>
<td>11.30 - 1pm sit down MDT rounds (social issues, discharges, antenatal referrals)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measure head circumference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Make ROP referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>Audiology referrals</td>
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<tr>
<td></td>
<td>Check immunisations</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>P.m.</strong></td>
<td>12:45-2pm Perinatal M+M (1st Tuesday every month)</td>
<td>1-2pm Journal club</td>
<td>Routine bloods Update SEND 4pm Handover</td>
<td>12-2pm FY2-ST3 teaching Routine bloods Update SEND 4pm Handover</td>
<td>Update SEND 4pm Handover</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2-3pm CrUSS to be done and reviewed by NOW consultant/ Dr Salgia</td>
<td>Update SEND 4pm Handover</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Update SEND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4pm Handover</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Night</strong></td>
<td>White daily summary for hot side babies</td>
<td>White daily summary for hot side babies</td>
<td>White daily summary for hot side babies</td>
<td>White daily summary for hot side babies</td>
<td>White daily summary for hot side babies</td>
<td>White daily summary for hot side babies</td>
<td>Pink and blue weekly summaries for all babies (hot side priority)</td>
</tr>
</tbody>
</table>

--- NOW Consultant = Neonatal Consultant of the week
Every day:
- Sign results (bloods and paper X ray reports)
- Update SEND. Login using surname and forename for both username and password. Change password after first login. Training will be provided when you are posted in the unit.
- Update problem list on front of baby’s notes

19. A-Z of Neonatal unit

APGAR scores:
Score 0-2 for: Breathing, Heart rate, Tone, Colour and Response to stimulation at 1, 5 and 10 mins

ANTIBIOTICS:
See Guidelines as these change, but examples include PROM >18h if insufficient maternal treatment, or >1 risk factor. Well preterm babies: Benzylpenicillin 50mg/kg bd and Gentamycin (see protocol for dosage and frequency) Remember to take cultures, FBC & CRP when putting in cannula! Also needs 1ml 0.9% saline flush writing up prn and a VIP chart!!

BABY CHECKS:
Must be done on day 1 (i.e. between 24-48 hours of life) at latest. Remember to check: history!! Including Mum’s blood group and cord DAT, Examination: anterior fontanelle, eyes (+red reflex), ears, palate, clavicles, breathing pattern, hands, heart sounds, abdomen including history of urine and meconium and feeding, umbilical stump, femoral pulses, genitalia including anus, hips (including family history), tone, reflexes (Step, Suck, Grasp, Moro (WARN the parents!!)) and skin colour/rashes. If problems refer to intranet and/or protocol folder then call reg. If suspect Down’s call reg immediately.

BLEEPS: 71 – Wait – Bleep no – Extension
FY2-ST3 794, Neonatal SpR 684, NICU nurses 897, Consultant 556

CONTACTS:
NICU 6113/6115
Delivery Suite 6103
Theatres 6111
Biochem 5460
Haem 5452
Xray (urgent) 6969

DELIVERIES:
Paed FY2-ST3 should attend if: Meconium, instrumental if there is fetal distress, LSCS if fetal distress, preterm <36 weeks, fetal distress or abnormality, multiple births
**EMERGENCIES:** Call for HELP!! Remember ABC. AIRWAY is the commonest problem. Keep Warm!!

**FORCEPS:** (and other instrumental deliveries): Remember to look for bruising and jaundice and check for facial symmetry in baby check. If skin is broken refer to Plastics as inpatient.

**S/N GAYNOR:** Will give you training on the equipment including codes for the gas machine etc

**GROWTH:** Charts plotted on SCBU on Monday. Please ensure all babies admitted have one. For babies coming back to Rothschild with weight loss over 12.5%, remember to check Na, SBR, pcv after history and examination.

**HOT COT:** Useful for taking bloods etc. as warm and manoeuvrable! ALWAYS ask for help from the nurses when cannulating

**INFANT OF DIABETIC MOTHER:** If IDDM then needs sugar monitoring. If gestational (IDDM/NIDDM) baby to stay with Mum and for early feeding and sugar monitoring protocol on Roths.

**JAUNDICE:** Refer to charts on Roths/SCBU. Remember that jaundice within 24h of birth can be a sign of serious illness i.e. sepsis, haemolytic disease of newborn etc. Different charts depending on gestation.

**KONAKION (Vit K):** Standard term babies receive 1mg im. Please refer to chart in the pharmacy folder on NICU. Need verbal consent from parents as some prefer oral (staggered dosing, IM is preferable).

**LOW BIRTH WEIGHT:** Consider admitting to NICU any baby under 2kg

**MURMURS:** Note position, grade, type. Check colour and pulses. Explain to parent that there is an extra sound and this is common in babies. See flow chart in post natal section

**NEONATAL OUTPATIENTS:** SpR clinic/Consultant clinic – please ensure the baby has their own set of notes (Ward clerks on Roths) and a referral letter is done saying why you want them seen!

**OPHTHALMOSCOPES:** 1 on Roths, 2 on NICU. PLEASE do not remove from NICU.

**QUIET TIME:** On SCBU 1-3pm. Please try to avoid procedures etc during this time

**RETINOPATHY:** screening required on all babies under 32 weeks gestation

**RESUSCITATION:** DRY the baby, position the airway, assess ABC. Give IPPV if unsure of breathing or heart rate <100. Call for help early!!

**SUGAR MONITORING:** Refer to protocol. For all infants of diabetic mothers. Also consider in IUGR and macrosomic babies. Check prefeed and approx 30-60 mins post feed. Abnormal is <2.6 on true glucose (gas machine)

**TTO’s:** For those discharged on stable doses of medications, please write up TTO’s at least 24h prior to discharge

**ULTRASOUND:** For renal pelvis dilatation or hips – Refer to protocol on intranet/in folder!! Cranial Ultrasound if <32 weeks

**VITAMINS:** For all preterm babies on breastmilk or term formula once fully fed. Dalivit 0.3ml od. From day 56 – Iron supplements – Sytron 1ml od.
WARD ROUNDS: Start at 0900. Full examination and plotting head circumference and weight on a Monday.

XRAY: In babies with respiratory distress typically 4-6 hours after birth at earliest. Also in event of heart murmur.

YOUR RESPONSIBILITIES: To be enthusiastic, to learn, to ask for help when unsure and work as a team with the nurses and other doctors – you will enjoy your attachment so much more!!

WARD ROUND FORMAT

Make sure all pages have a sticky label with patient details and the pages are numbered, dated, timed and signed. All deletions need to be countersigned and dated. Babies in the hot room should have the night summary proforma sheet completed with as much detail as possible.

Overnight on Sunday, a Weekly Summary sheet should be completed for the hot room babies by the night FY2-ST3. The day team should complete the weekly summary sheet for all other babies during the morning ward round.

Weekly summary sheets are coloured blue for boys and pink for girls.

NEW ADMISSIONS

You won’t be expected to lead these. Inform your senior and the nursing staff if you haven’t had much experience. To give an idea of a typical admission so you’ll know how you can be helpful:

A baby will be brought round on a resuscitaire, from theatre, labour ward or Roths (perhaps by you!). The nurses will weigh the baby, do swabs, admission obs and then move aside to let the medical staff begin their own assessment and tasks.

- **A is for Airway:** you may be asked to hold the baby’s head in neutral position, or hold the mask in place if the baby is receiving PEEP.
- **B is for Breathing:** you may be asked to ventilate the baby if needed. Ask about rates and pressures, but usually 30mmHg for term and 25mmHg for preterm, 60 breaths per minute.
- **Intubation and Curosurf:** prem babies and others with RDS may require intubation for delivery of surfactant. Watch carefully how this is done and you’ll get to deliver it later.
- **C is for Circulation:** IV access and bloods; on your first shifts this is unlikely to be you, but you can prepare a cannulation tray and check who will be doing this. Ask for help if you are attempting to cannulate, and don’t try more than twice. All babies need a VIP chart. Please label and send the bloods. **NB** cannulation can be taking place while airway, breathing, and intubation are taking place, so don’t wait for these to finish before making sure access is gained by someone.
- **Drug charts:** there is a lever arch Drugs Folder at the far end of the ‘hot’ room, which tells you how to prescribe common drugs. You can also get hold of a laminated card to attach to your ID badge with the commonest doses. Babies are likely to need Vitamin K (need to document consent from parents to give usual IM dose), antibiotics if premature/other indications, IV dextrose (maintenance +/- bolus) for hydration and/or correction of hypoglycaemia (common!). Ask if you’re unsure. The nurses may be drawing these up already in anticipation.
- **Warmth:** Keep the baby warm and dry, including during procedures. Make sure the temperature is checked if you are concerned as they cool very quickly and this is associated with poorer outcomes.
- **UVC and UAC:** umbilical lines inserted for access and monitoring
- **Record keeping:** the baby record may still be on the labour ward. You may need to go and get this. Ensure records are kept contemporaneously, as a lot happens and it can be
hard to think back after the event. In the notes folders you'll find separate sections for medical notes, nursing notes, family communication, blood gas chart, blood results chart.

- **Charts**: all babies have an Admission Profile Sheet. This is a good place to refer for parents' details and admission obs, for completing Badgernet. Also, obs chart, fluid input/output chart, fluid prescription chart, drug chart, gentamicin prescription chart.

### 20. Community guide

FY2-ST3 doctors attend community for a week at a time on a rolling schedule.

Timetables are coordinated by Dr Bird and trainees will spend time with both North and South teams as well as the therapy teams and specialist/school nurses. Please be prepared to travel during this week.

To arrange the rotation please contact Dr Bird at least two weeks in advance and please be aware that Dr Bird works Mon-Wed only.

As a general rule, annual leave, study leave and days in lieu will not be granted during the community rotation, unless there are specific reasons to make an exception. **If you do wish to take leave during this week for any reason, please contact Dr Bird in advance to discuss as Dr Bird’s approval is required for leave during community week.**

Similarly, if you are off sick during community week, please inform Dr Bird.

A lot of effort is put in to arrange the programme and it is disappointing when trainees cannot attend.

### Useful Addresses and Contact numbers

**Community Paediatrics Department (South Team Administrative and Clinical Base)**

Wycombe Hospital  
Queen Alexandra Road  
High Wycombe  
HP11 2TT

Community Paediatric Secretaries 01494 426602 /6205 /6208  
Dr K Sawhney – Phone queries – Mandy Thompson – 01296 315144

**Community Paediatrics Department (North team administrative base + North Therapy base)**

66 High Street  
Aylesbury  
HP20 1RB

Community Paediatric Secretaries 01296 566049 /052

**Amersham Hospital**

Whielden St  
Amersham  
HP7 0JD

**Rayners Hedge (Clinic base for North Team and therapies)**

Croft Rd  
Aylesbury  
HP21 7RD
21. Safe Prescribing

Prescribing for children is very important to get right and easy to get wrong. Try and follow these basic principles:

1) Remember all paediatric prescriptions depend on Weight and occasionally surface area.
2) You should always check the dose in the BNFc and cross check with a second person if available
3) There are very knowledgeable and helpful pharmacists regularly on Ward 3 and NICU please ask them for help.
4) If you are unsure about a prescription, Don’t write it.
5) Always check allergies.
6) Write clearly and sign your name legibly.
7) Check what medications children are on at home and when they last took over the counter medication.
8) Don’t forget the formulary folder on NICU.

H:\Presentations\Safe prescribing.2011

There is a useful tool developed by the Royal College of Paediatrics, please make use of it and familiarize yourself with safe prescribing.
http://www.rcpch.ac.uk/training-examinations-professional-development/quality-training/pediatric-prescribing-tool/pediatr

Hypoglycaemia and safe use of Insulin

Another useful tool for diabetic patients is www.diabetes.nhs.uk. On this website there is a specific learning module on safe insulin prescribing (http://www.diabetes.nhs.uk/safe_use_of_insulin/) and also management of hypoglycaemia in children.

22. Child Protection

You are likely to have some involvement in these cases. Gerry Linke, who’s office is in PDU, is the Trust Lead and would be delighted to advise you about training. There are level 1,2 and 3 modules on NLMS which would be advisable for your education but are also essential as part of the GPVTS before you can go into GP practice. It’s a good idea to do these in case you need to do an assessment and write a report, and so that you’ll be more likely to spot cases that present.

Q:\CHILD PROTECTION PLAN LISTS\Child Protection
23. Trainee support:
Please look at the following document which details the support available for trainees in the oxford region

C:\Documents and Settings\atanu.dutta\Desktop\Induction\TraineeSupportFinalMar11.pdf

24. Incident reporting (Datix)  Trigger List for Clinical Risk Reporting
These situations should trigger the completion of a clinical risk IR1 form.

- Unexpected death
- Unexpected readmission or return to Theatre
- Unexpected admission to HDU, ITU or transfer to another hospital
- Wrong patient / wrong body part indicated or operated on
- Surgical foreign body left in situ
- Misplaced naso or orogastric tube not detected prior to use
- Hospital acquired infection
- Medication / infusion errors or omissions
- Lost, inaccurate, illegible, unavailable or other problem with accessing medical records
- Patient Identification failures
- Lack of adequate facilities / equipment including staff and beds
- Equipment malfunction / failure
- Tissue Viability problems including category 2, 3 or 4 pressure ulcers
- Failures in communication
- Failure to act on results
- Lack of pre-operative assessment, preparation, consent or marking
- Failure to detect risk factor (e.g. allergy)
- Lack of monitoring / observation
- Falls
- Episode of VTE within 100 days of hospital admission
- Acute illness caused by ingestion, inhalation or absorption through the skin
- Violence, abuse / harassment
- Breaches of confidentiality e.g. failure to keep patient identifiable material secure; unauthorised disclosure of information
- Theft
- Problems with IV and IA lines
- Infusion errors
- Removal of child from the Ward (other than those with parental responsibility)
- Delays which compromise patient care
- Self harm
- Failure of follow up arrangements
- Security of patients breached
- Child Protection procedures not adhered to
- Failure to seek informed consent
### Appendix A: Useful contact details

#### 1. Paediatric Consultants:

<table>
<thead>
<tr>
<th>Consultant Name</th>
<th>Base</th>
<th>Extension</th>
<th>Specialist interests</th>
<th>Other roles</th>
<th>Secretary</th>
<th>Secretary Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Beth Cheesebrough</td>
<td>WGH</td>
<td>5346</td>
<td>Oncology</td>
<td>Oncology lead</td>
<td>Debbie Cafferkey</td>
<td>120 5125 6369</td>
</tr>
<tr>
<td></td>
<td>SMH</td>
<td></td>
<td></td>
<td></td>
<td>Helena Burton-Skingley</td>
<td></td>
</tr>
<tr>
<td>Dr Atanu Dutta</td>
<td>SMH</td>
<td>5161</td>
<td>Diabetes &amp; Endocrinology</td>
<td>College Tutor</td>
<td>Helena Burton-Skingley</td>
<td>6369</td>
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<tr>
<td>Dr Rania Alzoubidi</td>
<td>SMH</td>
<td>5157</td>
<td>Neurodisability</td>
<td></td>
<td>Mandy Thompson</td>
<td>5144</td>
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<tr>
<td>Dr G C Rastogi</td>
<td>WGH</td>
<td>120 5077</td>
<td>Oncology</td>
<td></td>
<td>Louise Page</td>
<td>120 5501</td>
</tr>
<tr>
<td>Dr Lesley Ray</td>
<td>WGH</td>
<td>120 6701</td>
<td>Community Paediatrician</td>
<td>Lead for Child Protection</td>
<td>Linda Tucker</td>
<td>120 6602</td>
</tr>
<tr>
<td>Dr Michelle Russell-Taylor</td>
<td>WGH</td>
<td>120 5078</td>
<td>Diabetes &amp; Endocrinology</td>
<td>SDU lead</td>
<td>Louise Page</td>
<td>120 5501</td>
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<tr>
<td>Dr Sanjay Salgia</td>
<td>WGH</td>
<td>120 5878</td>
<td>Neonatology and neurodevelopment</td>
<td>Governance lead</td>
<td>Debbie Cafferkey</td>
<td>120 5125</td>
</tr>
<tr>
<td>Dr Gopa Sarkar</td>
<td>SMH</td>
<td>5648</td>
<td>Neonatology</td>
<td></td>
<td>Helena Burton-Skingley</td>
<td>6369</td>
</tr>
<tr>
<td>Dr Prakash Dey</td>
<td>SMH</td>
<td>6368</td>
<td>Neonates and Cardiology</td>
<td></td>
<td>Helena Burton-Skingley</td>
<td>6369</td>
</tr>
<tr>
<td>Dr Kamal Sdhawney</td>
<td>WGH</td>
<td>120 6112</td>
<td>Community Paediatrician</td>
<td>ADHD Child Protection</td>
<td>Mandy Thompson</td>
<td>5144</td>
</tr>
<tr>
<td>Dr Baneera Shrestha</td>
<td>SMH</td>
<td>5317</td>
<td>Gastroenterology, Paediatric Allergy</td>
<td>Dermatology and eating disorder Liaison</td>
<td>Mandy Thompson</td>
<td>5144</td>
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<tr>
<td>Dr Boon Tang</td>
<td>WGH</td>
<td>120 5117</td>
<td>Gastroenterology</td>
<td></td>
<td>Louise Page</td>
<td>120 5125</td>
</tr>
<tr>
<td>Dr Craig McDonald</td>
<td>WGH</td>
<td>5123</td>
<td>Respiratory / cystic Fibrosis</td>
<td></td>
<td>Debbie Cafferkey</td>
<td>120 5125 5144</td>
</tr>
<tr>
<td></td>
<td>SMH</td>
<td></td>
<td></td>
<td></td>
<td>Mandy Thompson</td>
<td></td>
</tr>
<tr>
<td>Dr Niketa Chawda</td>
<td>WGH</td>
<td></td>
<td></td>
<td></td>
<td>Louise Page</td>
<td>120 5501</td>
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2. Speciality Doctors

<table>
<thead>
<tr>
<th>Speciality Doctor</th>
<th>Dr Abhi Mazumder</th>
<th>Special interest in Paediatric Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speciality Doctor</td>
<td>Dr Nishantie Perera</td>
<td>Specialist interest Haematology/Oncology</td>
</tr>
<tr>
<td>Speciality Doctor</td>
<td>Dr Saira Rizwan</td>
<td></td>
</tr>
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</table>

| Junior Doctors Support Secretary | 5158 |

3. Ward Staff

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<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Services Matron</td>
<td>Kate Bulbeck</td>
<td>6155</td>
</tr>
<tr>
<td>Ward 3 Sisters</td>
<td>Anna Kerr</td>
<td>5141</td>
</tr>
<tr>
<td>Childrens Day Unit (Wycombe) Sister</td>
<td>Clare Gomm</td>
<td>120 5506</td>
</tr>
<tr>
<td>Ward Clerks</td>
<td>Karen Earwicker</td>
<td>5168</td>
</tr>
<tr>
<td>OPD Receptionist</td>
<td>Stephanie</td>
<td>5168</td>
</tr>
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4. Other Nursing Staff

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Extension</th>
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<tr>
<td>Community Paediatric Nurses</td>
<td>Georgina Thorne</td>
<td>5142</td>
</tr>
<tr>
<td>Named Nurse for Child Protection</td>
<td>Emma Rolfe</td>
<td>5165 (mobile via Switchboard)</td>
</tr>
<tr>
<td>Safeguarding Children’s Nurse</td>
<td>Emma Rolfe</td>
<td></td>
</tr>
<tr>
<td>Neonatal Services Interim Matron</td>
<td>Charlotte Sewsarran</td>
<td>6122</td>
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5. Other Unit Numbers

<table>
<thead>
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<tbody>
<tr>
<td>Neonatal Unit</td>
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</tr>
<tr>
<td>Rothschild Postnatal Ward</td>
<td>6158/6159</td>
</tr>
<tr>
<td>Delivery Suite</td>
<td>6103/6104</td>
</tr>
<tr>
<td>Theatre</td>
<td>6111</td>
</tr>
</tbody>
</table>

Appendix B  Planned leave request form
<table>
<thead>
<tr>
<th>NAME</th>
<th>Dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Site</td>
<td>Head of Dept</td>
</tr>
</tbody>
</table>

**ANNUAL LEAVE REQUEST**
Inclusive Dates:  
Number of working days leave requested

Annual leave entitlement for current year (incl bank holidays/stat days/long service entitlements)  
Remaining annual leave entitlement before this request made

**STUDY/PROFESSIONAL LEAVE**
Inclusive Dates:  
Please also complete the relevant form which can be obtained from the Medical Education Departments at WH and SMH

**ADDITIONAL NHS RESPONSIBILITIES**
Inclusive Dates:  
Please specify

**EXTERNAL DUTIES TO THE TRUST**
Inclusive Dates:  
Please specify

Clinical activities to be cancelled during leave period if granted (activity/date/time/site). It is your responsibility to inform all affected departments and colleagues of your absences.

**Locum required?**  Explain reasons.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date request submitted</th>
</tr>
</thead>
</table>

| Signature and position of person authorising leave | Date authorised |

Paediatric Department Annual Leave Request Form  
For Junior and Middle Grade Doctors
NAME ………………………………………………………………………………………
GRADE ………………………………………………………………………………………

DATES LEAVE REQUIRED
FROM ……………………………………………………………………………………

TO
…………………………………………………………………………………………

DURING THIS PERIOD MY ON CALLS ARE COVERED BY:
DATE …………………DOCTOR ……………………………
DATE ………………… DOCTOR ……………………………

NUMBER OF DAYS ANNUAL LEAVE TAKEN IN THIS ROTATION

…………………………
NUMBER OF DAYS REMAINING IN THIS ROTATION

…………………………

SIGNED BY REQUESTING DOCTOR………………………………………………..

SIGNED BY DOCTOR IN CHARGE OF ROTA ……………………………………..

FOR CONSULTANT USE:
  I support this request for annual leave and arrangements for cover have been agreed
SIGNED …………………………………………………………………………………

NAME OF CONSULTANT ………………………………………………………………. 

Appendix C  Agreement to rota change form
AGREEMENT TO ROTA CHANGE FORM
BETWEEN………………………AND…………………………

<table>
<thead>
<tr>
<th>YOUR NAME</th>
<th>WHO ARE YOU SWAPPING WITH</th>
<th>WHICH DATES ARE YOU SWAPPING</th>
<th>WHAT AREA SHOULD YOU BE WORKING</th>
<th>WHAT TIME SHOULD YOU BE WORKING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Signed by original Doctor ........................................
Print Name ............................................................
Signed by agreeing Doctor .........................................
Print Name ....................................................................

Date of agreement to change..........................................

This form must be signed by both doctors who are agreeing to the swap and in advance of the dates to be changed.

Appendix D Information Technology Share Access Request Form

Please fill up the form with your details. During Induction, the form will be signed and sent to IT for authorisation.
Please contact the IT-Service desk on 01296 315904 with any queries.

Appendix E Paediatric basic life support
Paediatric Basic Life Support
(Healthcare professionals with a duty to respond)

UNRESPONSIVE?

Shout for help

Open airway

NOT BREATHING NORMALLY?

5 rescue breaths

STILL UNRESPONSIVE?
(no signs of a circulation)

15 chest compressions
2 rescue breaths

After 1 minute call resuscitation team then continue CPR
Paediatric Advanced Life Support

Unresponsive?
Commence BLS
Oxygenate / ventilate
Call Resuscitation Team
CPR 15:2
Until defibrillator / monitor attached
Assess rhythm

Shockable
(VF / pulseless VT)
1 Shock
4 J/kg or AED
(advanced as appropriate)
Immediately resume
CPR 15:2 for 2 min

Non-Shockable
(PEA / Asystole)
Immediately resume
CPR 15:2 for 2 min

During CPR:
• Correct reversible causes*
• Check electrode position and contact
• Attempt / verify: IV / IO access
  airway and oxygen
• Give uninterrupted compressions when trachea intubated
• Give adrenaline every 3-5 min
• Consider: amiodarone, atropine, magnesium

* Reversible Causes
  Hypoxia
  Hypovolaemia
  Hypo/hyperkalaemia/metabolic
  Hypothermia
  Tension pneumothorax
  Tamponade, cardiac
  Toxins
  Thromboembolism

Appendix F Neonatal Life support
Resuscitation Council (UK)

Newborn Life Support

Dry the baby
Remove any wet towels and cover
Start the clock or note the time

Assess (tone), breathing and heart rate

If gasping or not breathing:
Open the airway
Give 5 inflation breaths
Consider $\text{SpO}_2$ monitoring

Re-assess
If no increase in heart rate
look for chest movement

If chest not moving:
Recheck head position
Consider 2-person airway control
and other airway manoeuvres
Repeat inflation breaths
Consider $\text{SpO}_2$ monitoring
Look for a response

If no increase in heart rate
look for chest movement

When the chest is moving:
If heart rate is not detectable
or slow ($<60 \text{ min}^{-1}$)
Start chest compressions
3 compressions to each breath

Reassess heart rate every 30 s
If heart rate is not detectable
or slow ($<60 \text{ min}^{-1}$)
consider venous access and drugs

Acceptable* pre-ductal $\text{SpO}_2$
2 min 60%
3 min 70%
4 min 80%
5 min 85%
10 min 90%

* See reference 297

Appendix G – New born baby check
There is no right or wrong way to do this, but you do need a system and this one works for me.

1) Babies should ideally be brought to you in the paediatric room on Roths with notes.
2) Explain to the mother that you need to ask some questions and examine the baby to identify any important problems and ask if she could strip baby off and check that the nappy is clean whilst you read through her pregnancy and labour notes. Ask her to keep baby wrapped in a blanket until you are ready. (If clinic is not running it can be good to get two ladies preparing simultaneously, so that at least one is ready and not doing something else when you return).
3) Get purple Obstetric notes (should live in filing cabinet by nurses desk) and baby notes (should be on bedside clipboard) and go through green pregnancy notes, antenatal scans and white hospital notes for info.
   a) Medical history – thyroid problems, infections, genetic conditions.
   b) Pregnancy problems (high risk screening tests, scan abnormalities, restricted growth, renal pelvic dilatation, medication use)
   c) Delivery problems (infection risk, asphyxia risk, blood loss)
4) Take ophthalmoscope, tape measure and tongue depressor.
5) General chit-chat including feeding method, how feeding is going and whether baby has passed urine and opened bowels. Anything they have noticed that they want you to check?
6) Hold baby, still wrapped in blanket, propped slightly in left hand - rock gently to settle.
7) If eyes open – check now.
8) Check palate and suck with little finger, and with ophthalmoscope light when baby gags (use tongue depressor if full view not seen).
9) Feel fontanelles and sutures and note bruises/caput/ haematoma
10)Ears - ? low set, pits, tags
11)Look at facial features, markings, and bruises from delivery
12)Open blanket slightly – look at chest, listen to heart (rock if cries, or get to suck finger)
13)Examine hands and arms (single crease, brachial plexus injury, # clavicle)
14)Lie baby flat, loosen nappy tabs
15)Feel femorals (easier before starts crying – if cries offer a finger to suck (your’s or mother’s)).
16)Examine abdomen (any infection around cord, organomegaly….cue crying from this point on.
17)Check genitalia – part labia in girls, reassuring comment to mum on any discharge. Check anus is patent (whether has meconium or not as could pass PV if there were a fistula). Palpate both testes – may need to milk down from inguinal area with one hand and feel with other hand. Check penis – abnormal foreskin consider hypospadias.
18)Check hips – Barlow and Ortolani
   a) Barlow: Again at 90 degrees, push the femurs down posteriorly whilst adducting the thigh. A positive test will dislocate the hip posteriorly.
   b) Ortolani : Flex hips and knees to 90 degrees. Press anteriorly onto Gt trochanters with index finger and abduct thigh with thumbs. If positive test you will feel a clunk as the femoral head relocates anteriorly into the acetabulum
19)Examine feet for talipes and other anomalies
20)Turn baby onto front (held with your left hand around chest)
21)Assess tone
22) Palpate along spine, particularly lumbo-sacral. Note any pits, dimples or skin changes. Any Mongolian blue spots, birth marks, or marks from instrumental deliveries.

23) Support in sitting position. Explain you are going to make them jump, which looks a bit cruel, then support head and shoulders slightly off bed with one hand and hold arms in front of chest with the other hand. Drop head and shoulders back slightly, whilst releasing hands. The arms should extend and abduct before returning to the midline. Should be symmetrical.

24) Wrap again

25) Check eyes if not yet managed – rocking whilst standing up tends to open them, or if relaxed open by hand.

26) Measure head circumference

27) Explain findings

28) Check if any hip problems in babies in mum, dad or siblings. If this or other risk factors for hip dysplasia explain will need another appointment for this.

29) Check country of origin of parents – considering BCG.

30) Document – for all normal findings put a cross, explain any abnormal findings.