**Introduction**

This leaflet provides information for parents and carers of babies admitted to the Neonatal Unit (NNU). It covers consent for treatment and the procedures which might be undertaken.

**Consent**

'Consent' means giving your agreement or permission to the NNU staff to care for and treat your baby. We will give you written and verbal information so you can understand your baby’s condition and the treatment/tests required. You will be able to ask questions at any time. Then you will be able to make a decision about your baby’s care.

Consent is obtained from someone with 'parental responsibility' and involves both communication and understanding by the parent. If parents are married, valid consent can be obtained from either parent. If parents are not married, valid consent can only be obtained from the father if he is to be named on the birth certificate, and the mother confirms she wishes him to have parental responsibility.

We know that this is a difficult time for you, as your baby has been admitted to the Neonatal Unit because he or she requires extra nursing and medical care which cannot be provided on the post-natal wards. Some babies will require full intensive care; whilst others need ‘Special Care’ involving mainly help with feeding. ‘Routine’ care on the Neonatal Unit involves many procedures and treatments which are not routine elsewhere, but which are necessary for your baby at this time. We will always try to keep you informed of what we propose for your baby and will seek your agreement (consent) for that. Most of the time, the fact that you accept that your baby is being looked after on the unit, is taken as a sign that you also agree to routine procedures such as taking blood for basic tests, or x-rays.

Occasionally, it is necessary to carry out emergency procedures and treatments for which we would usually seek your consent first. At all times, we will consider what is best for your baby and will always contact you as soon as possible, once your baby is more stable.

There are some treatments and investigations for which we will specifically seek consent. Some of these require your signature on a form. This does not necessarily mean that these are more important, but simply reflects a different consent process. At all times, you should feel well informed about the proposed treatment to be able to make a decision as to whether you agree to it or not. Do ask if you are in doubt. If there is disagreement about what is planned, we will respect your opinion, but will always want to act in your baby’s best interests. Very occasionally, second opinions may be sought by either party.

A list of some of the commoner procedures and treatments which your baby may undergo is given on the next pages, to ensure that you are aware of them.

We hope that this helps you to understand some aspects of the care which your baby is receiving. Please remember that you can always ask if anything is unclear to you.

**Common procedures**

**Taking blood**

* Full Blood count (FBC). This give us the Haemoglobin level, (if your baby is anaemic or not)
* White cell count (the cells which fight infections) and platelet count (cell fragments which help clotting)
* Biochemistry. We measure the salts in the body; kidney and liver function
* Glucose level
* C-reactive protein (CRP). A marker of infection and/or inflammation
* ‘Cultures’. To see whether there is any infection in the blood
* Gases. Measure the carbon dioxide, oxygen and acidity of the blood
* Drug levels. Checking the amount of a medicine in the blood

• Neonatal screening. Nationwide tests for a variety of congenital conditions

• Head ultrasound scan. We check the brain structure and look for any bleeds or signs of infection

• Intubation. Inserting a tube into the baby’s trachea (wind-pipe), for administration of surfactant (see later)

or connection to a ventilator

• Extubation. Removing the breathing tube

• Sending blood, urine or other samples for culture (to see whether there is an infection)

• A lumbar puncture (LP). Inserting a needle into the lower back to remove cerebrospinal fluid (CSF), to test for meningitis

• Inserting a gastric tube (through the nose or mouth into the stomach) - usually to allow feeding, but sometimes to keep the stomach empty

• Eye check for Retinopathy of Prematurity (ROP). In babies less than 1.5 kg and/or less than 32 weeks gestation at birth, to assess development of the back of the eye.

**Inserting**

* A drip/venflon/line. Allowing us to take blood and give drugs and fluids
* An arterial line. To allow accurate measurement of blood gases and blood pressure
* Umbilical lines. Usually only in the smallest babies in the first few days, to allow blood sampling and giving of drugs and fluids
* • Long lines. A very fine line for giving total parenteral nutrition (TPN) and sometimes antibiotics.

**Common treatments**

**Antibiotics**

We start antibiotics if we feel there is any risk of infection. In the first 48 hours, we use **Benzylpenicillin** and **Gentamicin**. These are safely used in many neonatal units. However, we always measure the level of Gentamicin in the blood, as high levels can affect hearing and kidney function. In this hospital, babies who received Gentamicin are automatically offered a hearing test, regardless of drug

levels. You will be asked to sign a consent form for this test. Different antibiotics are used if started after 48 hours of life. Antibiotics may be changed if your baby remains unwell, or we have extra information from the Microbiology Department, such as culture results.

**Surfactant**

A substance which is made in the lungs, except in preterm babies. Antenatal steroids help boost production but sometimes extra is needed after birth. Surfactant helps to stop the lungs collapsing.

**Ventilation**

Taking over or assisting breathing with a ventilator.

**CPAP (continuous positive airway pressure)**

Extra pressure to the lungs, to help keep them expanded. Given using a mask or short prongs in the nose.

**High-flow**

Warm, humid oxygen or air at 3 to 8 litres per minute, given via prongs in the nose. Another way of supporting

breathing.

**Low flow oxygen**

Given via prongs in the nose at rates of 0.01 to 1 litre/minute.

**Total parenteral nutrition (TPN)**

An intravenous form of feeding for babies which gives them all the nourishment they need to grow until they have built up to full milk feed

**Use of formula milk**

Formula milk is sometimes needed until breastfeeding/expressing are established. There are some special formulas which may be used.

**Vitamins and iron**

For any baby admitted under 35 weeks gestation and for smaller older babies. Multivitamins are started when your baby if on full milk feeds. Iron is started on day 28. These are needed for normal growth.

**Immunisations**

To protect your child from a variety of viral and bacterial infections. You will be asked to consent for these, which are given at the same age as for other babies, at 2, 3 and 4 months.

We offer certain babies’ immunization against Respiratory Syncytial Virus (RSV), the virus which can cause a chest infection called bronchiolitis.

**Sucrose**

Oral sucrose is given to some babies for procedural pain. The effect lasts a few minutes but it would need the baby to suck the few drops placed in the mouth or on the pacifier that is placed in the baby’s mouth.

**Morphine**

Used for sedation and pain relief in babies receiving intensive care.

**Caffeine**

Given to premature babies, to keep their breathing regular.

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Neonatal Units

Prince Charles Hospital – Telephone Number 01865 728860

Royal Glamorgan Hospital – Telephone Number 01443 443523



**A Parent’s Guide To Consent in the Neonatal Unit**

[](http://www.google.co.uk/url?url=http://www.abclawcenters.com/practice-areas/neonatal-birth-injuries/neonatal-intensive-care-unit-nicu/&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjpkrudrJbOAhUDKMAKHdzwDlc4jAEQwW4IGjAB&usg=AFQjCNEtru2p0GVcmKtDzC5xQDKOe8a4Ew)