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Health Board

The management and prevention of hypoglycaemia in the undiagnosed/ unplanned, at-risk neonates born in a community setting

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Accountable Executive:	Executive Director of Nursing, Quality, Women and Family Health
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Parent Policy:	
Scope:	Maternity

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

To ensure that you are always using the latest version of this written control document, please refer to the version on the Corporate Governance SharePoint site

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Associated Policies and Written Control Documents

Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant (Birth – 72 hours) A BAPM Framework for Practice | British Association of Perinatal Medicine 2024

Wales Maternity and Neonatal Network Guideline for the Identification and Management of Infants at Risk of Neonatal Hypoglycaemia in the First 48 Hours of Life An Adaptation of the BAPM Framework for Practice (2021)

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial Issue	February 2023
2	Update to glucogel guidance as per BAPM, 2024 Reference to MAT 102 Deterioration of the Newborn (NEWTT2 – Newborn Early Warning Track and Trigger): A Framework for Practice - Standard Operating Procedure Addition of section 10 – management of the term infant reluctant to feed at birth	11/06/2026

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Infant Feeding Coordinator / Interim Infant Feeding Coordinator
NEWTT2 Working Group

Circulated to the following for Consultation

Date	Role / Designation
08/06/25	Womens and Childrens Infant Feeding Champions and specialist infant feeding service
08/06/25	PTHB Midwifery team
08/06/25	PTHB Midwifery Leadership and Management team
08/06/25	PTHB Women & Children’s Policy Group members
08/06/25	Safeguarding team
08/06/25	Medicines management
17/06/25	Maternity and Neonatal Strategic Network

Groups Approved at

Date	Group
01/07/25	Maternity Guidelines Group
19/08/25	Women and Children's Policies and Procedures Governance Group

1.0 Introduction

Certain infants are at risk of neurological sequelae of neonatal hypoglycemia. High-risk infants have an impaired counter-regulatory response. Therefore, the usual ways in which newborn infants utilise glycogen and fat stores and synthesise glucose are compromised. This therefore makes them more susceptible to hypoglycemia.

Measures should be in place to identify them at birth for early milk/energy provision and monitoring of blood glucose concentration. These babies are not recommended to be born in Powys due to the risk of fetal distress in labour and hypoglycaemia in the neonate. However, this guideline looks at how to manage babies who are unexpectedly/undiagnosed born in Powys.

2.0 Objective

The aim of this guideline is to safely manage babies at risk of hypoglycaemia in the first 48-hours after birth. It aims to keep mothers and babies together, and to reduce the risk of brain injury.

3.0 Definitions

- **PTHB** – Powys Teaching Health Board
- **AF** – Artificial feeding
- **BF** – Breastfeeding
- **EBM** – Expressed breast milk
- **DGH** – District General Hospital
- **MLU** – Midwife-Led Unit
- **SGA** – Small for gestational age

4.0 Equality, Diversity and Inclusion

Powys Teaching Health Board Maternity Services are committed to:

- The elimination of unlawful and unfair discrimination
- The active promotion of equal opportunities for women and their families and our workforce
- The protection of the human rights of women and their families and our workforce

- The promotion of inclusive relationships between groups who share protected characteristics and those who don't
- The valuing of the diversity inherent in the communities we serve and in our workforce.

The words 'woman' and 'women' have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility caring for a baby. It is recognised that there are many different family arrangements.

When translation services are required, there is the expectation that a face-to-face translator or digital interpretation services will be provided. The Language Line App is available to all maternity staff to use for this purpose. Consideration is required with written documents and leaflets to be provided in a woman's preferred or 1st language.

For further support and advice contact PTHB Equality Team:
powys.equalityandwelsh@wales.nhs.uk

5.0 Responsibilities

Responsibilities in relation to this guideline are:

5.1 Head of Midwifery and Sexual Health Services

The Head of Midwifery and Sexual Health Services must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

5.2 Assistant Head of Midwifery and Sexual Health Services

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff
- Liaising with District General Hospitals (DGH) to feedback where care has fallen outside of this guideline

5.3 Infant Feeding Co-Ordinator

The infant feeding coordinator has responsibility for:

- Supporting implementation of this document
- Reviewing any new evidence or guidance that is produced that may influence the service

- Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration.
- Provide training and audit of the use of glucose 40% oral gel via the buccal route.

5.4 Women and Children’s Risk and Governance lead

The Women and Children’s Risk and Governance Lead has responsibility for:

- Monitoring review of incidents in relation to content of this document

5.5 Midwives

All midwives working in the maternity services have responsibility for:

- Reading and being familiar with contents of this document
- Referring neonates appropriately for additional care where required
- Working to the requirements of their role within the scope of this guideline

6.0 Identification of babies at risk

Measurement of blood glucose concentration should be performed for any infant who has one or more of the risk factors or clinical signs below and therefore should be immediately transferred out of Powys to the nearest DGH to be commenced on the hypoglycaemia pathway. The following are classified as at-risk babies:

1. Intrauterine growth restriction <2nd customised centile or clinically wasted appearance

Powys Teaching Health Board will be identifying the 2nd centile through use of the customised GROW chart, generated using GROW 2.0)

N.B when liaising regarding transfer of these infants for the hypoglycaemia pathway, please note some units may identify the 2nd centile using the WHO gestation and sex specific values in the table below

Gestational age at birth (completed weeks)	Birth weight (kilograms)	
	Boys	Girls
37	2.10	2.00
38	2.30	2.20
39	2.50	2.45
40	2.65	2.60
41	2.80	2.75
42	2.90	2.85

- 2. Babies born to diabetic mothers**
- 3. Babies born less than 37 weeks gestation**
- 4. Hypothermia (<36.5°C)** not improving with initial steps to provide thermal care within an hour
- 5. Need for resuscitation or fetal compromise** (i.e. Low APGAR score <7 @ 5 mins)
- 6. Infants of mothers taking beta-blockers** in the third trimester and/or at time of delivery
- 7. Suspected early onset infection or Maternal sepsis in labour** where the baby is born before transfer
- 8. Abnormal feeding behaviour** ascertained through a full feeding assessment (within the postnatal handheld record), to identify reluctance to feed, defined as:
 - a. Not waking for feeds (babies may only wake for feeds 3-5 times in the first 24 hours; after the first 24 hours babies should feed at least 8 times in 24 hours).
 - b. Not sucking effectively (weak suck or inability to suck)
 (see section 10 and appendix for guidance on the identification and management of the term infant reluctant to feed)
- 9. Rare conditions/family history where the baby is at risk of hypoglycaemia** flagged up antenatally or by Neonatologist

7.0 Signs and symptoms of hypoglycaemia in infants (NEWTT2)

All babies regardless of risk factors should be monitored for signs of symptomatic hypoglycaemia

- Hypothermia (<36.5°C) not improving with initial steps to provide thermal care within an hour
- Cyanosis
- Apnoea
- Altered level of consciousness
- Seizures
- Hypotonia
- Lethargy
- High pitched cry
- Abnormal feeding behaviour; reluctant, refusal or irritable.
- Drowsiness or lethargy
- Jitteriness - defined as excessive repetitive movements of one or more limbs, which are unprovoked and not in response to a stimulus is common and is not by itself an indication to measure blood glucose. In an at-risk baby, it may be a sign of hypoglycaemia.

8.0 Management of the infant born at risk and/or showing signs of hypoglycaemia

All at risk infants are recommended to be transferred to the nearest DGH for commencement on the hypoglycaemia pathway immediately after birth.

Standard management should include:

- Dry baby (unless below 32 weeks – as per NLS algorithm [Resus Council UK, 2021]), and immediately place hat on baby's head
- Provide routine thermal control measures. If appropriate, baby should remain skin to skin, covered by warm towels. If this is not possible with the mother then this should be recommended with the birth partner. If no one is available to do skin to skin/temperature remains <36.5 despite routine warming measures or when transferring, consider use of the Ready Heat[©] Warming Cocoon, as low temperature can worsen hypoglycaemia. Baby should be wrapped in 1 towel prior to wrapping in the cocoon.
- Ensure baby has an effective feed within the 1st hour of life. If breastfeed is noted to be ineffective then any available colostrum should be hand expressed immediately and given via the most appropriate method (syringe/finger/cup feeding). If parents choose to formula feed, then the recommended volume of formula milk to offer is 10mls/kg.
- Discussion with the parents/ carers that their baby is recommended to be on the hypoglycaemia pathway. The significant risks of hypoglycaemia and hypothermia, including risk of poor outcomes must be discussed with parents.

If the baby is asymptomatic and requires just observation, then they can be transferred with the mother and midwife in a taxi (in line with MAT068 All Wales Guideline for Maternity Transfers from Community or Freestanding Midwifery-Led Units).

In the case of any infants showing **clinical signs of hypoglycaemia** then immediate transfer should be arranged via ambulance alongside a single dose of glucose 40% oral gel (0.5mls/kg) prior to transfer, as well as the above management processes.

The glucose oral gel should be administered via the buccal route:

1. Draw up correct volume of glucose 40% oral gel (e.g. Glucogel) using a 2.5 or 5ml oral/enteral (purple) syringe

2. Dry oral mucosa with gauze, gently squirt oral gel with an oral syringe onto the inner cheek of the infant, or onto your gloved finger, and massage oral gel into the buccal mucosa using latex-free gloves. Ideally split the dose half onto left inner cheek and half onto right inner cheek to aid absorption.
3. Offer a feed, preferably breast milk, immediately after administration of glucose 40% oral gel (Appendix A)

9.0 Prevention of infant hypoglycaemia in the community setting

Routine care for all infants who have **no preexisting risk factors for hypoglycaemia**

- Discuss ongoing and regular skin to skin to help with thermoregulation and lactation
- Initiate the first feed within 1st hour of life
- Babies with no risk factors do not need a hat placed on their head after birth and mum should be encouraged to keep baby warm in skin to skin through use of breathable blankets/ towels over baby.
- The midwife should NOT discharge the woman from the birth centre/ leave the home environment prior to the baby having an effective feed and mum is happy with positioning and attachment if breastfeeding.
- Midwives should discuss signs of hypoglycaemia/hypothermia and ensure families are aware of where to seek advice and support prior to leaving the home/birth centre following birth.

10.0 Management of the term infant reluctant to breastfeed in the community setting

A reluctant feeder is a baby who is not showing feeding cues. A baby who is eager to feed but needs support is not a reluctant feeder, and adequate timely feeding support should be offered.

In cases of a term infant born in the community setting with no additional risk factors or clinical manifestations of hypoglycaemia, it is reasonable to allow baby time to feed up to 6 hours post birth, whilst following an active feeding plan (Appendix C).

If the baby is not effectively feeding, encourage continuous safe skin-to-skin contact and show and support the mother to hand express. Any colostrum expressed should be fed to the baby immediately, using a method that is best suited to the infant's capabilities and parent's preferences.

- Discuss ongoing and regular skin to skin to help with thermoregulation and lactation
- Initiate the first feed, within 1st hour of life
- Observations performed and plotted 2 hourly in line with NEWTT2 guidance.
- These babies do not need a hat placed on their head after birth and mum should be encouraged to keep baby warm in skin to skin through use of breathable blankets/ towels over baby (unless thermoregulation issues identified through observations)
- Encourage 2-3 hourly feeding (BF/ EBM via syringe) – see section 10.1), until effective feeding achieved, then continue responsive feeding.
- The mother should be shown how to hand express and should be given colostrum harvesting syringes where ineffective feeding has been noted and encouraged to hand express 2 hourly to protect lactation, giving any volume obtained to baby via syringe/cup.
- The midwife should NOT discharge the woman from the birth centre/ leave the home environment prior to the baby having an effective feed and mum is happy with positioning and attachment if breastfeeding. This can be evidenced thorough completion of the breastfeeding assessment tool within the postnatal handheld record.

If infant formula is introduced, support the mother to resume breast milk feeds as soon as possible if that is her intention, and protect by lactation by continuing skin to skin and regular hand expressing.

For women who choose to exclusively formula feed, offer 10mls/kg within the first hour. A recommended volume for formula fed infants is given because formula milk has lower availability of cerebral alternative fuels in comparison to breastmilk. This volume is not applicable to breastmilk.

This active feeding plan is recommended to be used up to 6 hours post birth, after this time the recommendation would be to continue the active feeding plan at a DGH where continuous observation can be continued 4 hourly until effective feeding established. If there are no clinical signs of hypoglycaemia then there is no indication to administer glucose gel prior to transfer. Transfer in these cases should be individually assessed; a clinically stable infant who has received regular EBM or supplemented with formula may be suitable to transfer with parent and midwife via taxi (MAT 068 All Wales Guideline for Maternity Transfers from Community or Freestanding Midwifery-Led Units)

Any variation where baby scores 2 (1 score being feeding concerns) or more on the NEWTT2 Chart or with clinical symptoms of hypoglycemia, the infant should be transferred for review at DGH without delay. Alongside initiation of transfer midwives should:

- Treat infant immediately with buccal glucose gel (0.5mls/kg) (Appendix A)
- Support a feed as soon as possible (Breastfeed/EBM recommended due to the increased availability of cerebral alternative fuels, or formula if parents wish)
- Provide routine thermal control measures
- Consider a warming aid pre and during transfer
- Ensure observations performed at least hourly, documented on NEWTT2 chart (increase the frequency according to the clinical condition)
- 999 Transfer via Ambulance and liaise with neonatologist at DGH regarding ongoing care during transfer

10.1 Assisted feeding (cup/syringe)

Occasionally it may be helpful to give a baby small amounts of colostrum using a cup or oral syringe as part of an active feeding plan. Ensure baby is alert, with good tone prior to commencing feeding.

Syringe feeding - To give a syringe feed safely, the calm and alert baby should be held in the mother's arms slightly upright, not flat.

The oral syringe is gently placed in between the gum and cheek and a little colostrum gently instilled, no more than 0.2ml at a time.

Allow the baby time to taste and enjoy the milk. Stop if the baby starts sucking, allow time to swallow, then give a little more.

Finger feeding using an oral syringe

Finger feeding can be used to help stimulate the sucking reflex while feeding with an oral syringe.

Ensure hands are washed, with trimmed nails (gloves to be worn by staff if assisting). Ensure the baby is calm and alert, held in the parent's arms, slightly upright, not flat.

You can also place pillows on your lap so that the baby is facing you in a semi-upright position - ensuring baby is securely supported.

Slide your finger into baby's mouth, (nail side towards baby's tongue). The tip of the pad of your finger should rest where the hard and soft palate meet at the roof of the mouth. Keep your finger straight to

encourage correct tongue position. Avoid applying pressure to the roof of baby's mouth, just gentle contact.

Once the baby begins to suck, gently introduce the tip of the syringe into the corner of the baby's mouth in between the gum and cheek

Press gently on the syringe plunger to introduce a small amount of milk 0.2mls at a time. Allow the baby time to taste and become accustomed

The baby should start sucking in a rhythmic manner. While baby is sucking, observe for signs that baby may need to pause the feed. When the baby stops sucking, stop pressing the plunger on the syringe.

Move onto cup feeding once you have more than 5ml to give. If there is a clinical indication to provide formula or a mother makes an informed choice to provide formula this can also be given in a cup.

Cup feeding - To give a cup feed safely, hold baby in an upright position, ensuring that baby's neck and shoulders are well supported. Make sure baby is fully awake, calm and alert.

Half-fill the cup and hold it so that it just touches baby's mouth. It should reach the corners of their mouth and rest lightly on their bottom lip.

Do not pour the milk into their mouth; tip the cup just enough so that baby can lap up.

Keep the cup in this tilted position and allow them to start again when they are ready.

11.0 Safeguarding

If any safeguarding concerns or significant risk factors are identified for an unborn child or young person/vulnerable adult practitioners must follow Wales Safeguarding Procedures (2019) and SGP036 Safeguarding Policy [Policies & Written Control Documents - SGP 036 Safeguarding Policy.pdf \(sharepoint.com\)](#) . Advice and support concerning any safeguarding issue can be sought from PTHB Safeguarding Team via the Safeguarding Hub on 01686 252806 or email PowysTHB.Safeguarding@wales.nhs.uk (Monday-Friday 09:00-17:00, excluding Bank Holidays). Outside of office hours, Local Authority can be contacted on 0345 0544 847 or contact Silver on Call.

All registered practitioners should access appropriate safeguarding supervision and training as per guidance. [Safeguarding Supervision \(sharepoint.com\)](#)

12.0 Monitoring Compliance, Audit & Review

A Datix must be submitted for all cases of transfer for neonatal review. Any Datix submitted where this SOP has been followed will be reviewed by the infant feeding coordinator to assess compliance with the SOP. Datix submissions are reviewed as part of the weekly maternity

meetings. All cases of transfer are reviewed to ensure processes have been followed. Any lessons learned and good practice will be shared with the wider team.

This guideline will be audited one year after implementation to ensure adherence to it.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

13.0 Reference and Bibliography

Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant (2024) | British Association of Perinatal Medicine ([Identification and Management of Neonatal Hypoglycaemia Sept 24.pdf](#))

MAT 068 – All Wales Guideline for Maternity Transfers from Community or Freestanding Midwifery-Led Units (2024) wisdom.nhs.wales/health-board-guidelines/powys-guidelines/mat-068-transfers-from-community-or-freestanding-midwifery-led-units-all-wales-guideline/

Guideline for the Identification and Management of Infants at Risk of Neonatal Hypoglycaemia in the First 48 Hours of Life An Adaptation of the BAPM Framework for Practice, 2021. [Guideline for the prevention and management of Hypoglycaemia in high risk infants on the postnatal ward](#)

MAT 102 Deterioration of the Newborn (NEWTT2 – Newborn Early Warning Track and Trigger): A Framework for Practice - Standard Operating Procedure

Newborn Life Support Algorithm. Resuscitation Council UK (2021) [Newborn Life Support Algorithm 2021.pdf](#)

[What is Finger Feeding? - Breastfeeding Support](#)

Appendix A: Standard Operating Procedure (SOP) for the use of Glucose Gel for Infants Symptomatic of Hypoglycaemia in the community setting

Access Master Template here: [Standard Operating Procedure \(SOP\) for the use of Glucose Gel for Infants Symptomatic of Hypoglycaemia in the community setting.docx](#)

Clinical condition	Neonatal hypoglycaemia
Criteria for inclusion	<ul style="list-style-type: none"> Babies born in the community/MLU who are symptomatic of hypoglycaemia and requiring transfer to hospital for hypoglycaemia pathway
Criteria for exclusion	<ul style="list-style-type: none"> Babies <35 weeks' gestation Babies over 48 hours of age
Seek further advice / escalate	<ul style="list-style-type: none"> Urgently if any clinical manifestations of hypoglycaemia Discuss 2nd dose with neonatal team

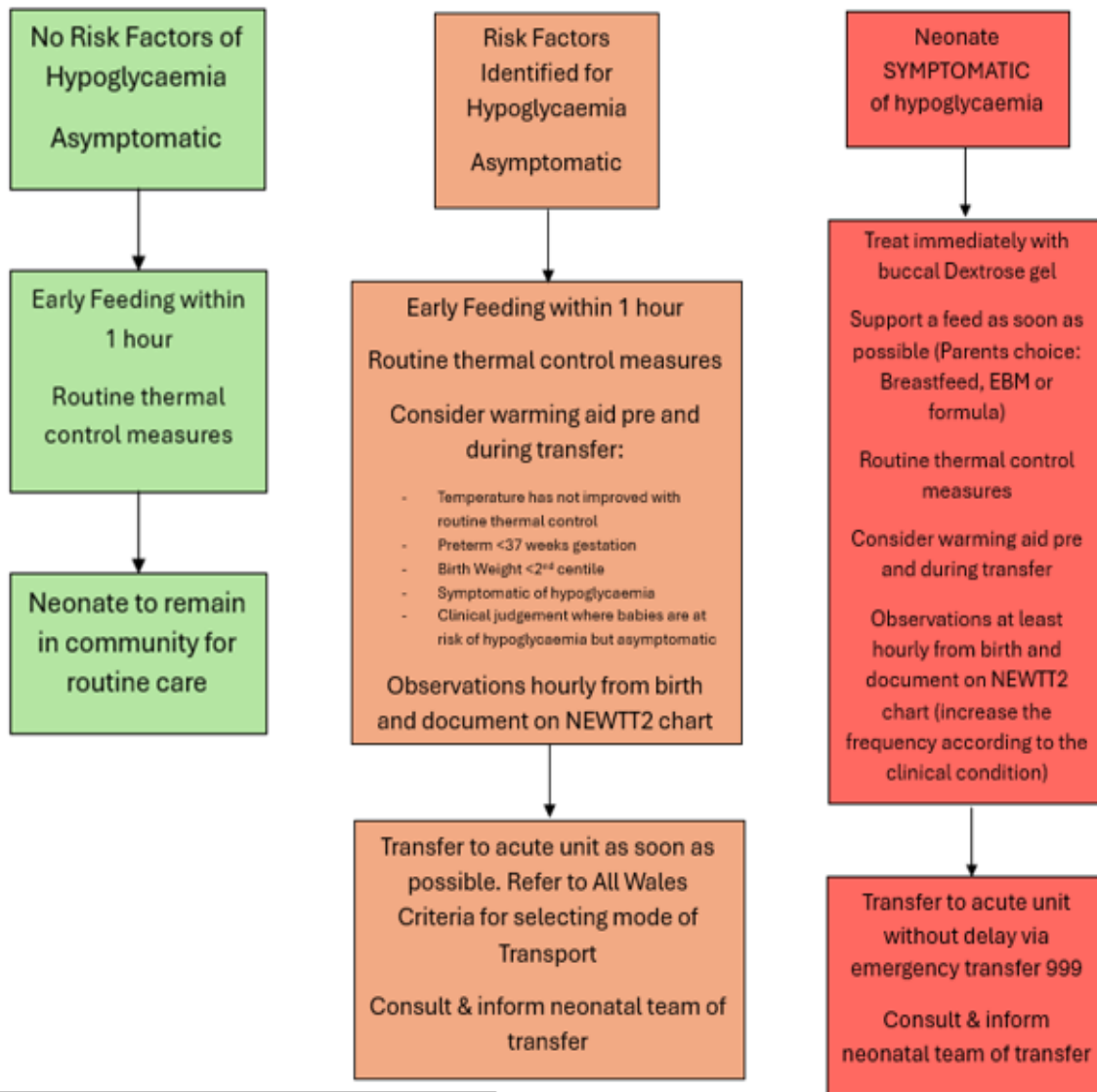
Description of treatment															
Name of medicine	Glucose 40% oral gel														
Legal status of medicine	Not applicable – not classed as a medicine														
Form	Oral Gel														
Strength	40%														
Dosage	0.5ml/kg of glucose 40% oral gel <table border="1" data-bbox="673 1113 1372 1407"> <thead> <tr> <th>Weight of baby (Kg)</th> <th>Volume of Oral Gel (ml)</th> </tr> </thead> <tbody> <tr> <td>1.5-1.99</td> <td>1ml</td> </tr> <tr> <td>2.0-2.99</td> <td>1.5ml</td> </tr> <tr> <td>3.0-3.99</td> <td>2ml</td> </tr> <tr> <td>4.0-4.99</td> <td>2.5ml</td> </tr> <tr> <td>5.0-5.99</td> <td>3ml</td> </tr> <tr> <td>6.0-6.99</td> <td>3.5ml</td> </tr> </tbody> </table>	Weight of baby (Kg)	Volume of Oral Gel (ml)	1.5-1.99	1ml	2.0-2.99	1.5ml	3.0-3.99	2ml	4.0-4.99	2.5ml	5.0-5.99	3ml	6.0-6.99	3.5ml
Weight of baby (Kg)	Volume of Oral Gel (ml)														
1.5-1.99	1ml														
2.0-2.99	1.5ml														
3.0-3.99	2ml														
4.0-4.99	2.5ml														
5.0-5.99	3ml														
6.0-6.99	3.5ml														
Route of administration	Buccal														
Storage	In drugs cupboard within the birth Centre environment, until the best before date on packaging.														
Method of administration	<ul style="list-style-type: none"> Draw up correct volume of glucose 40% oral gel (e.g. Glucogel) using a 2.5 or 5ml oral/enteral (purple) syringe Dry oral mucosa with gauze, gently squirt oral gel with an oral syringe onto the inner cheek of the infant, or onto your gloved finger, and massage oral gel into the buccal mucosa using latex-free gloves. Splitting the dose equally; half onto left 														

	<p>inner cheek and half onto right inner cheek to aid absorption.</p> <ul style="list-style-type: none"> • Offer a feed, preferably breast milk, immediately after administration of glucose 40% oral gel
Frequency of administration and total treatment quantity	<ul style="list-style-type: none"> • One dose by community midwife – discuss further doses with neonatologist. • At least 30 minutes between doses
Adverse reactions	<ul style="list-style-type: none"> • None anticipated • Document and report any witnessed side effects
Verbal advice for patient/carer	Discussion documented in patient notes
Follow up	As per medical assessment
Arrangements for referral for medical advice	Follow hypoglycaemia pathway and refer accordingly
Records of administration for audit	Document in patient notes

Staff	
Professional qualifications	Registered Midwife
Training	Registered Midwife

Appendix B: NEWTT2 Hypoglycaemia Pathway in Community Flow Chart

[Appendix B NEWTT2 Hypoglycaemia Pathway in Community Flow Chart.docx](#)



Risk factors for Hypoglycaemia

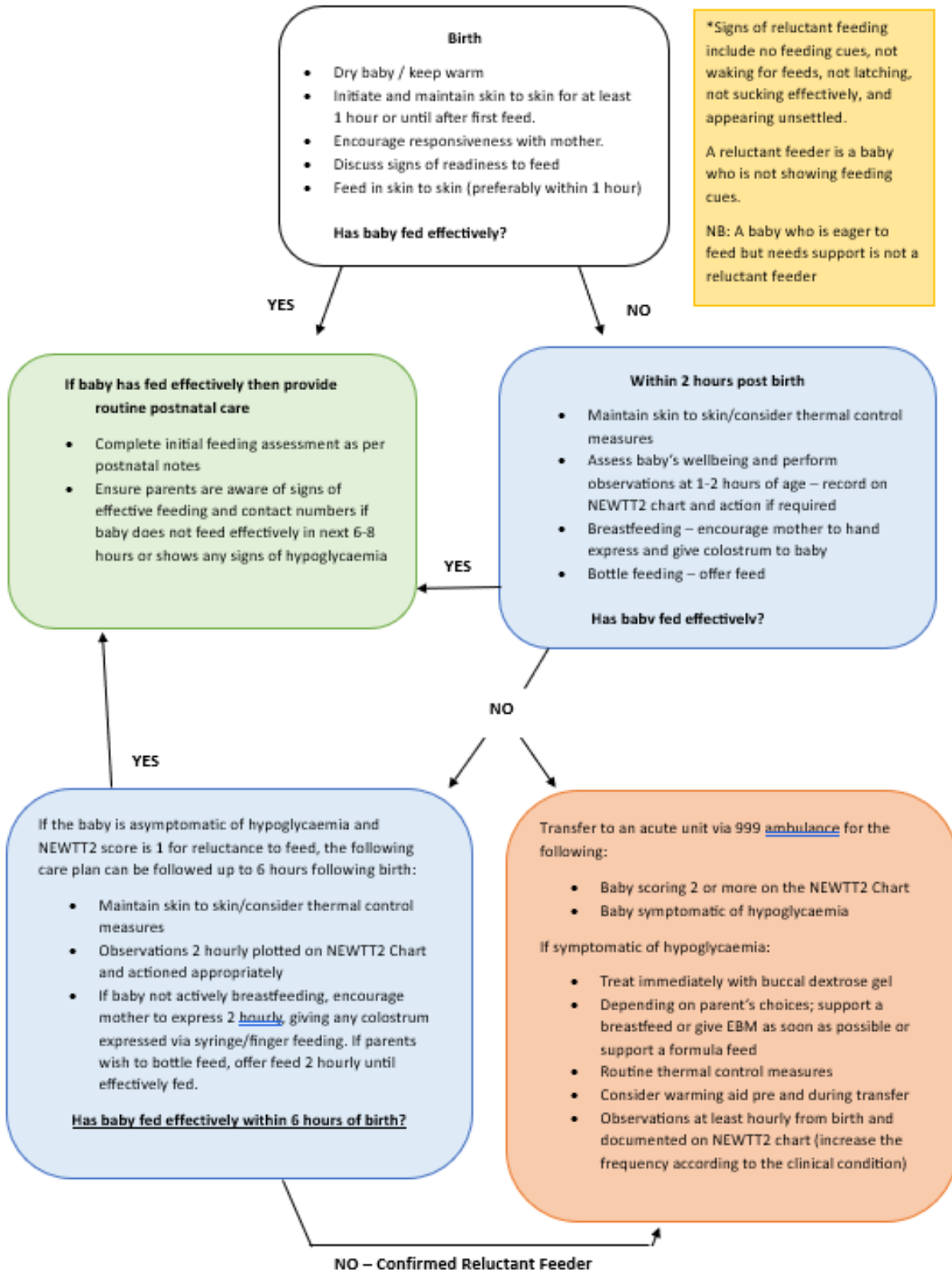
- Maternal beta blockers
- Birth weight <2nd Centile
- Infants of diabetic mothers
- Hypothermia unresponsive to thermal care
- Preterm <37 weeks
- Low APGAR Score ≤ 7 @ 5 minutes
- Feeding concerns – reluctant, refusal or irritable
- Suspected early onset infection

Symptoms of Hypoglycaemia

- Lethargy
- High pitched cry
- Abnormal feeding behaviour
- Altered level of consciousness
- Hypotonia
- Seizures
- Hypothermia < 36 degrees
- Cyanosis
- Apnoea

Appendix C: Pathway for the term infant reluctant to feed at birth (Adapted from BAPM,2023)

[Appendix C Pathway for the term infant reluctant to feed at birth \(Adapted from BAPM,2023\).docx](#)



Equality Impact Assessment

It is not mandatory to complete an Equality Impact Assessment (EIA) for a written control document. If you feel it would be of benefit, please complete the box below and attach an EIA as an appendix to this document.

Has an Equality Impact Assessment (EIA) been completed		NO
Name of the person giving this response	Laura Jones Interim Infant Feeding Co-ordinator	
If NO:	N/A	
If YES:		