

Hypoglycaemia of the Newborn (Identification and Management)

Classification :		Guideline	
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Authors Division:		Women’s and Children’s Health	
Departments/Group this Document applies to:		Maternity Paediatrics	
Approval Group: Women’s Health Guidelines Children’s Health CIG Women’s Health CIG Children’s Health PIG		Date of Approval:	04/2021
		Last Review:	01/2021
		Review Date:	04/2024
Unique Identifier: PAED/GL/169		Status: Approved	Version No: 5
Guideline to be followed by (target staff): Paediatricians, Midwives, Maternity Support Staff			
To be read in conjunction with the following documents: Milton Keynes University Hospital NHS Foundation Trust. <i>Newborn feeding policy</i> . DOC155. Version 1.1, 2017. Milton Keynes University Hospital NHS Foundation Trust. <i>Expressing colostrum antenatally</i> . MIDW/PI/48. Version 3, 2016. Milton Keynes University Hospital NHS Foundation Trust. <i>Hypothermia prevention in the pre-term <34 week neonate (plastic bag)</i> . PAED/GL/76. Version 2, 2017.			
Are there any eCARE implications? No			
CQC Fundamental standards: Regulation 9 – person centred care Regulation 12 – Safe care and treatment Regulation 14 – Meeting nutritional and hydration needs Regulation 17 – Good governance Regulation 19 – Fit and proper			

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual. The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This guideline has been developed to identify those neonates who are at risk of developing hypoglycaemia, to clarify the care planning for those who are well enough to be cared for with their mother on the maternity wards. This will reduce the risk of delayed treatment and readmissions to the neonatal unit.

Executive Summary

- To provide guidance on the prevention and management of hypoglycaemia in the at risk neonate.
- To ensure all neonates at risk are identified early and active management to prevent neurological impairment and avoidable admission to NNU.
- To reduce the incidence of hypoglycaemia in at risk neonates and keep mother and baby together where possible.
- To establish thresholds for interventions to raise blood glucose levels.

Definitions

An operational threshold approach to the management of neonates with hypoglycaemia was developed by Cornblath et al. in an article published in *Pediatrics* in 2000. This approach was adopted by the British Association of Perinatal Medicine in their 2017 guidance on the identification and management of neonatal hypoglycaemia (BAPM, 2017, p.15).

The Cornblath values are as follows:

1. A value <1.0mmol/l at any time.
2. Baby with abnormal clinical signs: single value <2.0mmol/l.
3. Baby at risk of impaired metabolic adaptation but without abnormal clinical signs: <2.0mmol/l and remaining <2.0mmol/l at next measurement. (BAPM, 2017, p.15).

Abbreviations

ANNP	Advanced Neonatal Nurse Practitioner
BM	Blood glucose Reading
BFI	Baby Friendly Initiative
EBM	Expressed Breast Milk
IUGR	Intra Uterine Growth Restriction
NEWS	Neonatal Early Warning System
SGA	Small for Gestational Age

1.0 Roles and Responsibilities:

Midwives, Paediatricians, ANNPs and Nursery Nurses are responsible for identifying babies at risk of hypoglycaemia. This includes initiating appropriate observations and interventions to prevent infant morbidity and mortality.

2.0 Implementation and dissemination of document

Staff will be orientated to this guideline as part of their induction and the yearly update Baby Friendly Initiative training sessions. The guideline will be accessible on the hospital intranet.

3.0 Processes and procedures

3.1 Rationale for these recommendations

The level of blood glucose concentration that leads to cerebral injury in neonates and adverse neurodevelopmental outcome is unknown. However, a prolonged period of hypoglycaemia, particularly if associated with clinical signs ("symptomatic hypoglycaemia") may lead to brain injury and adverse neurodevelopmental outcome.

(BAPM, 2017, p.14)

3.2 At Risk Babies

- Late preterm (35-36+6 weeks gestation) cared for on maternity wards. See also Section 3.4.7
- IUGR (≤ 2 nd centile or below). See also Section 3.4.7
- Maternal diabetes
- Maternal use of beta-blockers, such as Labetalol (**any** dose antenatally or in labour)
- Hypothermia $< 36.5^{\circ}\text{C}$
- Suspected/confirmed early onset sepsis in the baby *
- Perinatal acidosis (cord arterial pH < 7.1 & base deficit $\geq 12\text{mmol/L}$)
- Low Apgar score at birth < 5 @ 1 minute < 6 @ 5 minutes
- SGA babies (< 10 th centile) * See also Section 3.4.7.

* These babies require 4 hourly observations for 24 hours using the NEWS chart but do not initially require blood glucose monitoring. If there are any triggers on NEWS or they are not feeding effectively, they must commence the Hypoglycaemia Pathway

3.3 Clinical signs and symptoms of hypoglycaemia

The clinical signs associated with hypoglycaemia are non-specific, so **blood glucose measurement must be undertaken in any infant who presents with one or more of the abnormal signs listed below.** If a newborn appears unwell or shows signs of hypoglycaemia refer immediately to a paediatrician/ANNP.

- Jitteriness
- Altered level of consciousness
- Hypothermia $< 36.5^{\circ}\text{C}$
- Lethargy
- High pitched cry
- Hypotonia/floppiness
- Apnoea
- Seizures
- Cyanosis

(BAPM, 2017, pp.6-7)

3.4 Management of at risk babies.

3.4.1 Antenatal Recommendations

- Mothers of babies identified as at risk in the antenatal period should be encouraged to collect colostrum (see Expressing Colostrum Antenatally patient leaflet).
- Discuss the importance of skin-to-skin contact, responding to feeding cues, the benefits of breastfeeding and the importance of frequent early feeds.

3.4.2 After Birth

- Dry the baby and put a red hat on.
- Place the baby in skin-to-skin contact with the mother to provide warmth and to facilitate the initiation of feeding.
- Check maternal temperature
- Ensure that the room temperature is warm.
- **Begin care pathway in management plan A (see Appendix 1).**
- If the mother intends to breastfeed, but the baby has not latched within one hour of birth, the mother should be assisted to hand express colostrum. This should be given to the baby immediately.
- For women who choose to feed formula milk, offer 10-15ml/kg/feed within the first hour.
- Commence 4 hourly observations using the NEWS chart. These must include temperature, respiratory rate, heart rate and response to stimulus.
- Ensure at least 3 hourly feeds.

(BAPM, 2017, pp.7-8)

3.4.3 Thermoregulation

The link between hypothermia and hypoglycaemia is well known. It is crucial that babies at risk of hypoglycaemia are kept warm, with their temperature maintained between 36.5°C and 37.5°C. This begins at birth, where thorough drying of the baby is essential, skin-to-skin contact should be commenced and a red hat should be applied. The room temperature should be recorded.

Skin-to-skin contact should be the first method of choice used for thermoregulation, providing the mother's temperature is within normal limits. However, some babies may also need to be cared for in a hot cot to facilitate thermoregulation. The temperature of the hot cot is usually initially set at 39°C and reduced gradually according to clinical judgement once the baby's temperature has stabilised. Once the hot cot has been removed, the baby's temperature must be monitored 4 hourly for a further 12 hours to ensure this is stable. Skin to skin contact should be encouraged.

3.4.4 Feeding

In order to enhance early metabolic adaptation, it is vital that the baby feeds frequently and effectively.

- If the baby is not showing signs of effective feeding within one hour, encourage continuous skin-to-skin contact and teach the mother to hand express. Any colostrum expressed should be given immediately to the baby.
- Continue to express at least 8-10 times per 24-hour period (including at least once at night) until baby is feeding effectively. Support to resume breast milk feeds as soon as possible.
- All breastfeeding mothers must be shown breast compressions to increase milk transfer and be encouraged to use these at each feed.
- For women who choose to feed formula milk, see Formula volumes Appendix 1 for amounts to offer per feed.
- **Do not allow more than three hours to pass between feeds until the Hypoglycaemia Pathway has been completed.**
- Once Hypoglycaemia Pathway is complete, return to responsive feeding.
- **Continue feeding support for 24 hours after Hypoglycaemia Pathway has been completed.**
- Do not discharge until mother and midwife are satisfied that effective feeding is established and at least one BFI Breastfeeding Assessment has been completed.

A neonate over 48 hours of age should have a blood sugar reading of above 3mmol/L.

3.4.5 Management Plans

Management Plan A:

- Follow this plan for all babies at risk of hypoglycaemia following birth.
- Take first blood glucose by 4 hours of age or pre 2nd feed (if baby has fed).
- If the result is $\geq 2.0\text{mmol/L}$ feed at least 3 hourly and support breastfeeding
- Check blood glucose pre 3rd feed (no longer than 8 hours after birth)
- If the result is $\geq 2.0\text{mmol/L}$ discontinue glucose monitoring but continue feeding support for 24 hours after Hypoglycaemia Pathway has been completed.
- Complete at least one Breastfeeding Assessment (if appropriate) prior to discharge home.
- If any of the blood glucose results are $<2.0\text{mmol/L}$ follow Management Plan B (see Appendix 2)
- An unreadable BM at any point is a Neonatal Emergency and 2222 emergency should be instigated.

A baby on Management Plan A will need to have a minimum of 2 blood glucose readings $\geq 2.0\text{mmol/L}$

Management Plan B:

- Establish whether the baby has any clinical signs consistent with hypoglycaemia. Refer to paediatrician immediately.
- If the baby has no clinical signs of hypoglycaemia, administer 40% buccal dextrose 200mg/kg following prescription by Paediatrician (see Appendix 3 for volumes).
- Offer breastfeeding support. If not breastfeeding effectively hand express and give expressed breastmilk (EBM).
- If formula feeding give 10-15ml/kg/feed.
- Continue NEWS chart observations four hourly and monitor for signs of hypoglycaemia. Refer to paediatrician if any observations are abnormal.
- Recheck blood glucose pre next feed, within 3 hours.
- If $\geq 2.0\text{mmol/L}$ continue to breastfeed and/or offer EBM, or 10-15ml/kg/feed if artificially feeding and repeat the blood glucose pre next feed.
- If the next result is $\geq 2.0\text{mmol/L}$ and there are no clinical signs of hypoglycaemia discontinue glucose monitoring but continue feeding support for 24 hours after Hypoglycaemia Pathway has been completed.
- At least one Breastfeeding Assessment must be completed prior to discharge home.
- If the blood glucose is 1.0-1.9mmol/L repeat one cycle then inform the neonatal team
- If there have been 3 measurements of 1.0-1.9 mmol/L since birth inform the neonatal team, who will implement **Management Plan C** and admit the baby to NNU.
- A baby on **Management Plan B** will have a minimum of 2 blood glucoses $\geq 2.0\text{mmol/L}$, a maximum of 2 doses of 40% buccal dextrose and a maximum of 3 blood glucoses 1-1.9 mmol/L. A Paediatrician will prescribe the 40% buccal dextrose on the baby's prescription chart (see Appendix 3 for amounts).
- An unreadable BM at any point is a Neonatal Emergency and 2222 emergency should be instigated.

Midwives must complete a competency assessment prior to administering the buccal gel (see Appendix 6).

Management Plan C:

- If there are clinical signs consistent with hypoglycaemia refer to neonatal team who will implement **Management Plan C**.
- If there is a blood glucose of $<1.0\text{mmol/L}$ refer to the neonatal team who will implement **Management Plan C**.
- If there are 3 measurements of $1.0\text{--}1.9\text{mmol/L}$ since birth refer to the neonatal team who will implement this **Management Plan C** and admit baby to NNU.

Management Plan C is not under the remit of the maternity team. Baby requires admission to the Neonatal Unit. An unreadable BM at any point is a Neonatal Emergency and 2222 emergency should be instigated.

Any baby developing hypoglycaemia beyond 24 hours of age may have an underlying cause e.g. sepsis, metabolic / endocrine disorder and should be referred to the paediatrician/ANNP for further assessment, investigations and treatment.

3.4.6 Babies between 10th and 2nd Centile

If a baby is $<10^{\text{th}}$ centile but $>2^{\text{nd}}$ centile it must have 4 hourly observations for 24 hours using the NEWS chart. If there are any triggers on NEWS, it must commence the Hypoglycaemia Pathway, using the appropriate plans. Do not discharge until mother and midwife are satisfied that effective feeding is established. Temperature must be maintained and at least one breastfeeding assessment must be completed.

3.4.7 Late preterm babies and babies $\leq 2^{\text{nd}}$ Centile

In addition to completing the Hypoglycaemia Pathway, these babies must remain an inpatient until they have shown a pattern of weight gain. They must be able to maintain their temperature. They must be weighed on days 3 and 4 as an inpatient.

Ensure breastfeeding support is given. Do not discharge until mother and midwife are satisfied that effective feeding is established and at least one Breast feeding Assessment has been completed.

3.4.8 Discharge

- **Infants at risk of hypoglycaemia should not be transferred to the community until they are at least 24 hours old.**
- Ensure effective feeding has been established and at least one Breastfeeding Assessment has been performed (see Newborn Feeding policy).
- Weight gain **must be** evident in babies $\leq 2^{\text{nd}}$ centile and premature babies.
- Day 3 and Day 4 weights must be undertaken as an **in-patient**.

3.4.9 Transitional care babies

Awaiting guidance from Neonates

4.0 Statement of evidence/references

Statement of evidence:

This guideline has been written using the Framework for Practice produced by the British Association of Perinatal Medicine (BAPM) (2017). The treatment level has been established by BAPM in consultation with Bliss, the Royal College of Nursing, the Royal College of Midwives, Neonatal Nurses Association, NHS Improvement, UNICEF Baby Friendly Initiative, National Infant Feeding Network and NHS England Highly Specialised Services Team: Congenital Hyperinsulinism (CHI) service.

References:

British Association of Perinatal Medicine (2017) *Identification and management of neonatal hypoglycaemia in the full term infant: framework for practice*. [Online]. Available from: <https://www.bapm.org/resources/40-identification-and-management-of-neonatal-hypoglycaemia-in-the-full-term-infant-2017> [Accessed 7 February 2020]

Cornblath, M., et al. (2000) Controversies regarding definition of neonatal hypoglycemia: suggested operational thresholds. *Pediatrics* **105**(5), pp.1141-45.

National Institute for Health and Care Excellence (2015) *Diabetes in pregnancy: management from preconception to the postnatal period*. NICE guideline [NG3]. [Online]. Available from: <https://www.nice.org.uk/guidance/ng3> [Accessed 7 February 2020]

External weblink references:

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
	The review was to bring the guideline in line with the British Association of Perinatal Medicine Working Party	Rosamund McFadden	
4.1	Change made to appendix 1 - amended the wording slightly	Michelle Hancock	To make it more clear for staff and more user-friendly.
5	01/2021	Michelle Hancock	Complete review

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Julie Cooper	Head of Midwifery	05/10/2020	05/10/2020	All endorsed	Yes
Zuzanna Gawlowski	Consultant Paediatrician	05/10/2020	18/11/2020	All endorsed	Yes
Women and children guideline group	Women and children	31/03/2021		No	
Clinical Improvement group	Women and children	07/04/2021		No	

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
BFI Audits	UNICEF BFI Audit tool	Michelle Hancock	6 monthly	Maternity/Neonatal Quality board
ATAIN Review group		Atain team	Weekly review	Maternity/Neonatal Quality board

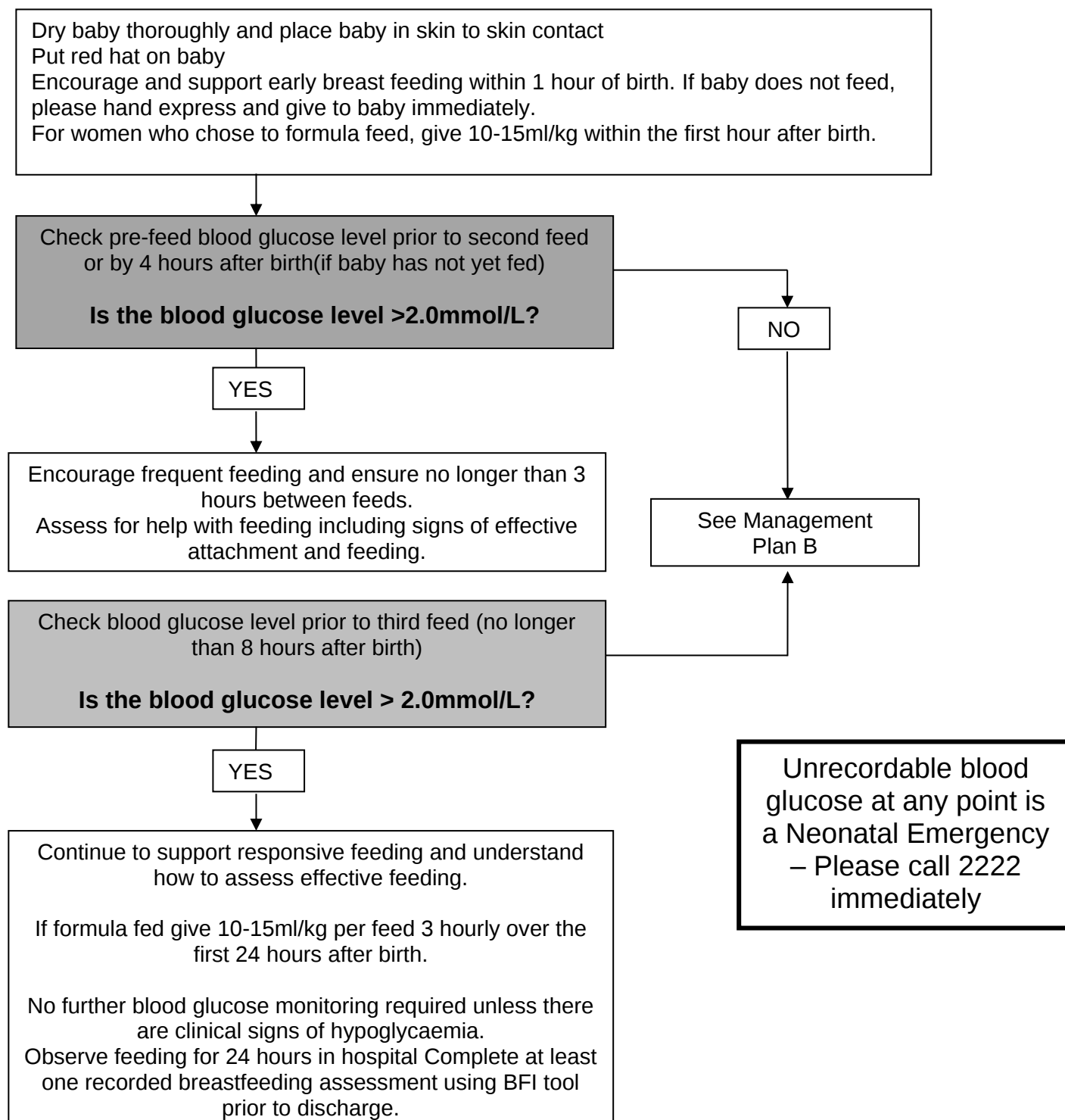
5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's and Children's	Department	Maternity
Person completing the EqIA	Michelle Hancock	Contact No.	86402
Others involved:	No	Date of assessment:	10/2020
Existing policy/service	Yes	New policy/service	No
Will patients, carers, the public or staff be affected by the policy/service?		Yes	
If staff, how many/which groups will be affected?		Maternity Staff	
Protected characteristic	Any impact?	Comments	
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff	
Disability	NO		
Gender reassignment	NO		
Marriage and civil partnership	NO		
Pregnancy and maternity	NO		
Race	NO		
Religion or belief	NO		
Sex	NO		
Sexual orientation	NO		
What consultation method(s) have you carried out?			
<i>Emails and team meetings</i>			
How are the changes/amendments to the policies/services communicated?			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	04/2024		

Appendix 1

Management Plan A: Management of neonate at risk of hypoglycaemia

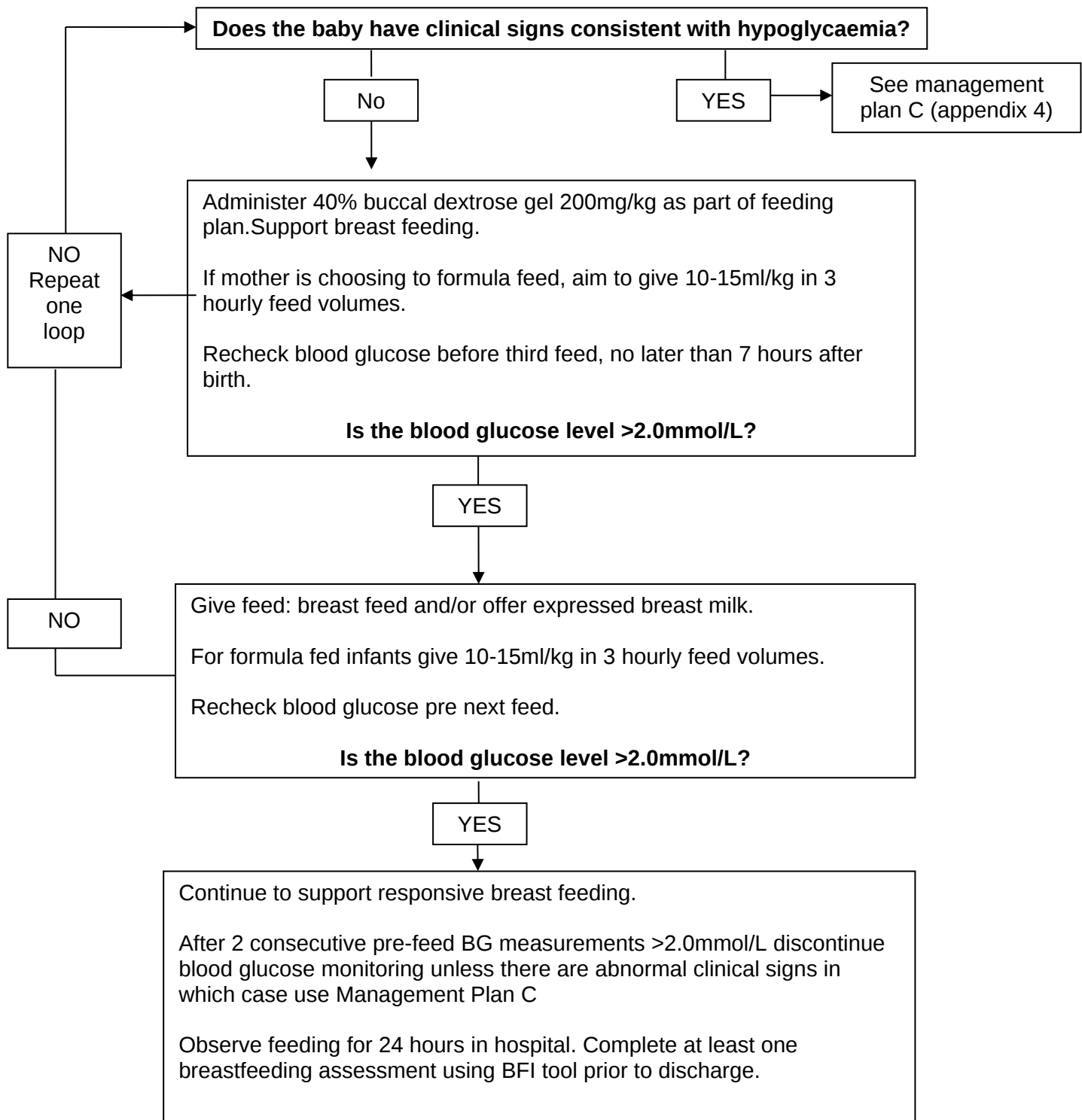


If there are any concerns regarding Hypoglycaemia, a BM can be taken at any time

Adapted from: British Association of Perinatal Medicine (2017) *Identification and management of neonatal hypoglycaemia in the full term infant: framework for practice*

Appendix 2

Management Plan B – Pre-feed blood glucose 1.0-1.9mmol/L (and no abnormal clinical signs)



**Unrecordable blood glucose at any point is a Neonatal Emergency
Please call 2222 immediately**

Adapted from: British Association of Perinatal Medicine (2017) *Identification and management of neonatal hypoglycaemia in the full term infant: framework for practice*

Appendix 3: Use of dextrose gel

Indications:

- Blood glucose 1.0-1.9mmol in infant with no abnormal clinical signs
- Infants $\geq$ 35 weeks' gestational age and younger than 48 hours after birth

Notes:

- Must be used in conjunction with a feeding plan
- For babies with blood glucose <1.0 mmol/L, use dextrose gel only as an interim measure while arranging for urgent medical review and treatment with IV glucose

Dose:

Administer 40% buccal dextrose 200mg/kg. Ensure doses are **no less than 30 minutes apart** and a **maximum of 6 doses in 48 hours** (0.5ml/kg of 40% dextrose gel).

Weight of baby (kg)	Volume of gel (ml)
1.5-1.99	1
2.0-2.99	1.5
3.0-3.99	2.0
4.0-4.99	2.5
5.0-5.99	3.0
6.0-6.99	3.5

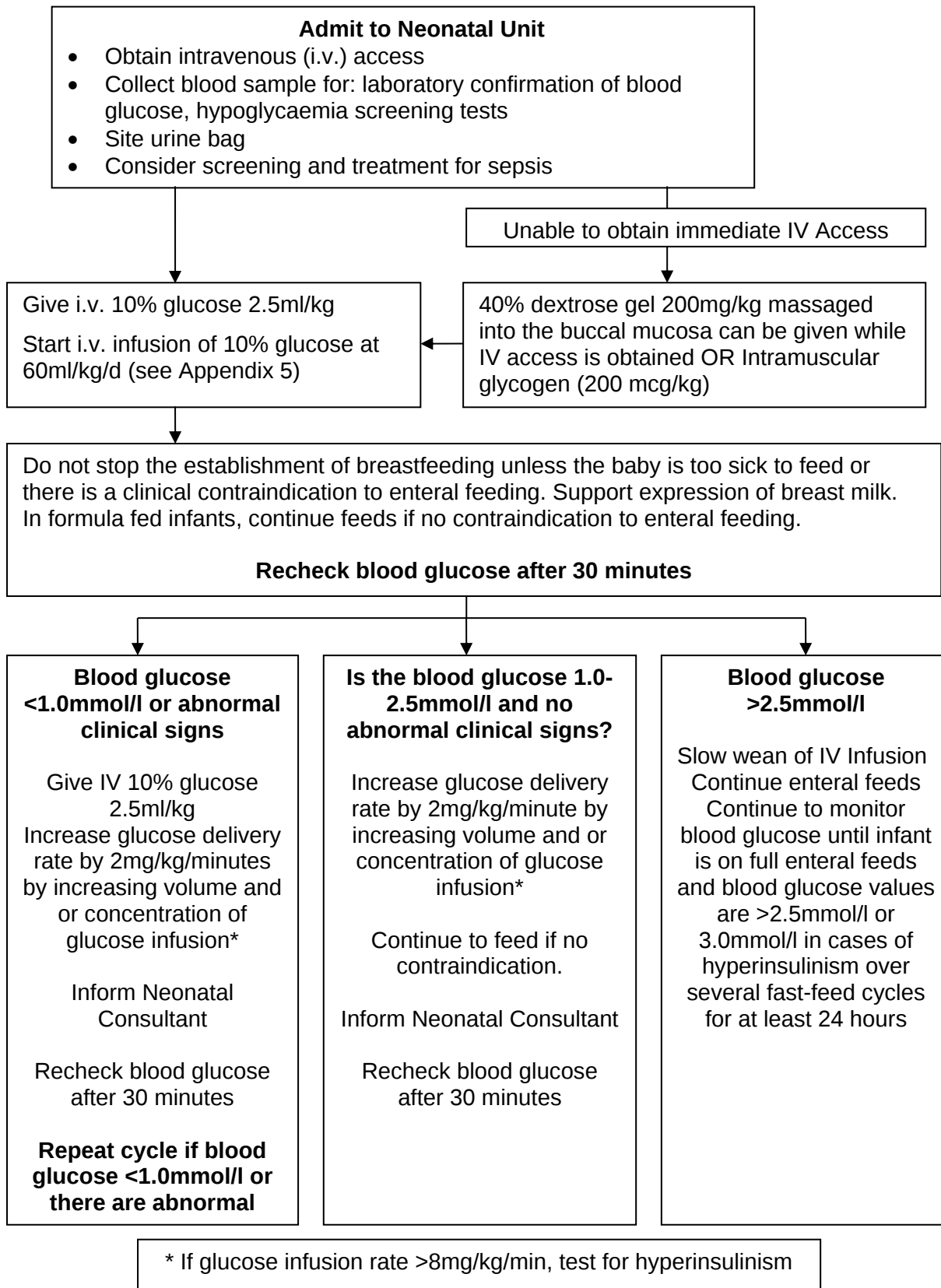
Method of administration:

- Draw up correct volume of 40% dextrose gel (Glucogel) using a 2.5 or 5ml oral/enteral syringe.
- Dry oral mucosa with gauze, gently administer gel with syringe (no needle) onto the inner cheek and massage into the mucosa using latex-free gloves.
- Offer a feed, preferably breast milk, immediately after administering dextrose gel.
- Repeat blood glucose measurement as per flow chart.

Appendix 4:

Management Plan C (Neonatal Team)

Blood glucose $<1.0\text{mmol/l}$ (and/or clinical signs consistent with hypoglycaemia)



Appendix 5: Intravenous dextrose concentration

Flow rate of 10% dextrose (ml/kg/day)	Infusion rate (mg/kg/min)
40	2.77
60	4.16
80	5.55
90	6.25
100	6.94
120	8.33
130	9.03
140	9.72
150	10.42

How to calculate mg/kg/min from ml/kg/day for any concentration of glucose:

Formula: $\text{Rate (ml/kg/day)} / 144 \times \text{glucose\%} = \text{mg/kg/min}$

How to make up any concentration of glucose in any volume:

Desired volume = V ml

Desired concentration of glucose = D%

Lower concentration of glucose = L%

Volume of lower concentration of glucose to add = LV ml

Higher concentration of glucose = H%

Volume of higher concentration of glucose to add = HV ml

Formula: $HV = V (D - L) / (H - L)$

$LV = V - HV$

Add HV ml and LV ml to get V ml of D%

Appendix 6: Administration of 40% Glucose Buccal Gel Staff Competence Form

Name of Staff:	Observer/Trainer: (Print and Sign)	Date:
Observation 1		
Practice 1		

Observation:

The midwife has watched a colleague who has achieved competency in this procedure. Appropriately identifies a baby requiring 40 % Glucose Buccal Gel

1. Checking the gel has been prescribed appropriately by a paediatrician (see Appendix 3 for doses).
2. Titrating correct amount prescribed into a 2.5 or 5ml oral syringe.
3. Administering 40% Glucose Buccal Gel to a baby by placing a gloved finger between the buccal pad (inside cheek) and the gum line, whilst gently expelling gel from the oral syringe and massaging into the buccal pad.

Practice 1:

The midwife being assessed will be able to:

1. Appropriately identify a baby requiring 40 % Glucose Buccal Gel
2. Check the gel has been prescribed appropriately by a paediatrician (see Appendix 3 for doses).
3. Titrate the correct amount of 40 % Glucose Buccal Gel prescribed into an oral syringe.
4. Administer 40% Glucose Buccal Gel to a baby by placing a gloved finger between the buccal pad (inside cheek) and the gum line, whilst gently expelling gel from the oral syringe and massaging into the buccal pad.

Trainer Observation Practice 1:

I am happy that this member of staff is confident in administering prescribed 40% Glucose Buccal Gel to a newborn, and has demonstrated competency in the four steps required.

Print.....

Sign.....Date.....

Trainer Observation Practice 1:

I am happy that this member of staff is confident in administering prescribed 40% Glucose Buccal Gel to a newborn. This midwife has observed a competent member of staff perform the four steps of this competency. I have observed this midwife successfully performing the four steps within this competency on two occasions.

Print.....

Sign.....Date.....

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Authors Job title:	☐
Authors Division:	☐
Department/Groups this document applies to:	☐
Date of approval:	☐
Review date:	☐
Approval Group/approved by (according to policy requirements):	☐
Last review date:	☐
Unique Identifier: if known (new documents will be assigned at publication)	☐
Status: Approved	☐
Version numbers are the same throughout document	☐
Scope: Who will use this document?	☐
To be read in conjunction with the following documents:	☐
Are there any eCARE implications?	☐
Latest CQC fundamental standards referenced: Trust intranet page with fundamental standards	☐
Footers completed to match main page : (on all pages)	☐
References are updated (contact the library (Jayne Plant 3077) for help if required)	☐
Consultation history includes key stakeholders required to embed document. Pharmacy are consulted if the document contains medication	☐
Audit and monitoring criteria is completed and clear (where possible reference the relevant section of the policy)	☐
Include full & correct consultation history	☐
Dissemination should be clear	☐
Check relevant hyperlinks work	☐

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