East of England Neonatal Antibiotic Policy

Authors: Nigel Gooding, Lead Pharmacist, East of England Neonatal ODN
Dr Oghenetega Edokpolor, Bedford Hospital Neonatal Unit

For use in: Eastern Neonatal Units
Guidance specific to the care of neonatal patients

Used by: Medical Staff, Neonatal Nurse Practitioners, pharmacists, microbiologists and infection prevention and control teams.

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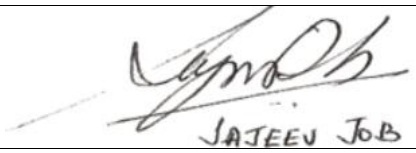
Clinical Lead Sajeev Job	

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1. Introduction

1.1 This guideline sets out the regional agreement on antibiotic use for the management of suspected or confirmed neonatal sepsis. It has been developed in agreement with regional microbiologists, infection prevention and control nurses, neonatal nurses and a pharmacist. This has been developed as part of a regional approach to standardising the use of antimicrobial therapy in the neonatal population within the East of England. Individual units may make amendments based on local susceptibility information (see section 11).

1.2 This policy should be read in conjunction with the NICE documents
Neonatal infection: antibiotics for prevention and treatment. NICE guideline (NG195)

1.3 The guideline includes detail on the Kaiser Permanente Risk Calculator (KP-SRC) to be used in infants born at 34 weeks and above when assessing risk for early onset sepsis.

1.4 The guideline should be used in conjunction with the network guideline for using the KP-SRC. Web address for KP-SRC is
https://neonatalsepsiscalculator.kaiserpermanente.org/
The calculator is also available on the admissions page of Badgernet.

1.5 This guideline is designed to be used in conjunction with and not as a replacement for clinical assessment of the baby where decisions are made about the management of suspected and confirmed sepsis.

2.Audit Standards

2.1 100% of babies should have a blood culture and CRP taken before starting antibiotics

2.2 100% of babies should have their CRP checked at 18-24 hours following commencement of antibiotic treatment

2.3 Where the Kaiser Permanente Sepsis Risk Calculator has been used ,

- The total number of babies being assessed using the calculator
- Number of babies correctly identified by the calculator who develop culture confirmed infection
- Number of babies incorrectly identified by the calculator who do not develop culture confirmed infection
- Number of babies missed by the calculator who develop culture confirmed neonatal infection

3. Background

3.1 Mortality and morbidity from neonatal sepsis remain significant, with early recognition and treatment likely to improve outcomes. As symptoms and signs of sepsis can be subtle, empirical antibiotic treatment should be started in any neonate who is unwell and in some cases for infants with significant risk factors.
**Please see separate policy for management of MRSA colonisation.*
**This policy does not specifically address maternal Group B Streptococcus – see RCOG – Green-Top Guideline No.36 (13/09/2017) or local policy*[1].

4. Indications for starting antibiotics

4.1 The opinion of an experienced neonatal nurse/midwife should be taken very seriously, as should parental concerns about their own infants' condition.

4.2 Use tables 1 and 2 (NICE, 2026) to identify red flags (risk factors and clinical indicators that should prompt a high level of concern regarding early-onset neonatal infection).

4.3 Review the maternal and neonatal history and carry out a physical examination of the baby including an assessment of the vital signs i.e temperature, respiratory rate, heart rate, capillary refill time, level of consciousness and oxygen saturations if signs of respiratory distress.

4.4 Use the following framework based on risk factors and clinical indicators, including red flags (see tables 1 and 2), to direct antibiotic management decisions:

- In babies who are 34 weeks gestation or more, with any red flags, or with two or more amber risk factors or clinical indicators apply the KP-SRC to guide management. However if there are any immediate clinical concerns start antibiotics without delay.
- In babies who are less than 34 weeks gestation, with any red flags, or with two or more amber risk factors or clinical indicators, perform a septic screen and commence antibiotics.
- If antibiotics are recommended, these should be administered as soon as possible and **always within one hour of the decision to treat**.

4.5 In babies without red flags and only one amber risk factor or one amber clinical indicator, using clinical judgment, consider:

- whether it is safe to withhold antibiotics, **and** whether it is necessary to monitor the baby's vital signs and clinical condition – if monitoring is required continue it for at least 12 hours (at 0, 1 and 2 hours and then 2-hourly for 12 hours) using a newborn early warning system.

- See local guidelines and local pathways for monitoring

Table 1: Risk factors for early-onset neonatal infection, including 'red flags'

Risk Factors	Red Flag
Suspected or confirmed infection in another baby in the case of a multiple pregnancy	**Yes**
Invasive GBS in a previous baby or maternal GBS colonisation, bacteriuria or infection in current pregnancy	
Preterm birth following spontaneous labour (before 37 weeks' gestation)	
Confirmed rupture of membranes for more than 18 hours before a preterm birth	
Confirmed rupture of membranes for more than 24 hours before a term birth	
Suspected or confirmed maternal sepsis in the intrapartum or early postpartum period	
Confirmed or suspected chorioamnionitis	

Table 2: Clinical indicators of possible early-onset neonatal infection (observations and events in the baby), including 'red flags'

Clinical Signs	Red Flag
Apnoea	**Yes**
Seizures	**Yes**
Need for cardiopulmonary resuscitation	**Yes**
Need for mechanical ventilation	**Yes**
Signs of shock	**Yes**
Altered behaviour or responsiveness	
Altered muscle tone (eg floppiness)	
Feeding difficulties (eg feed refusal)	
Feed intolerance, including vomiting, excessive gastric aspirates and abdominal distension	
Abnormal heart rate (bradycardia or tachycardia)	
Signs of respiratory distress (including grunting, recession, tachypnoea)	
Hypoxia (eg central cyanosis or reduced oxygen saturation level)	
Persistent pulmonary hypertension of newborns	
Jaundice within 24 hours of birth	
Signs of neonatal encephalopathy	
Temperature abnormality (less than 36°C or higher than 38°C) not unexplained by environmental factors	
Unexplained excessive bleeding, thrombocytopenia, or abnormal coagulation	
Altered glucose homeostasis (hypoglycaemia or hyperglycaemia)	
Metabolic acidosis (BE ≥ -10 mmol/L)	

4.6 Group B Streptococcus (GBS)

The use of antibiotics for the asymptomatic infant of a GBS colonised mother remains controversial as up to 20% of pregnant women are GBS carriers[2]. However the incidence increases with other risk factors for early onset sepsis (when presenting with clinical disease):

- Previous infant with invasive GBS disease
- Preterm (<37 weeks gestation)
- Pyrexia in labour
- Rupture of membranes for > 18 hours if preterm or >24 hours if term
- No antibiotics or insufficient antibiotics given to mother[1]

5. Investigations prior to starting antibiotics

5.1 Blood cultures and a CRP should *always* be taken before starting treatment.

5.2 Decision for treatment and management should not be based on CRP levels alone. In addition to interpretation of the CRP level, consider white cell count. A low WCC or absolute neutropenia could be significant, as well as the infants broader clinical picture.

5.3 Consider performing a lumbar puncture to obtain a cerebrospinal fluid (CSF) sample in a baby who did not have a lumbar puncture at presentation who is receiving antibiotics, if it is thought safe to do so and if:

- there is a strong clinical suspicion of early-onset neonatal infection or
- the baby has clinical symptoms or signs suggestive of meningitis or
- there is a positive blood culture (except Coagulase negative staphylococcus), or
- there is no satisfactory response to antibiotic treatment.

Measure blood glucose in babies immediately before lumbar puncture, so that CSF to blood glucose ratio can be calculated.

Do not perform a lumbar puncture if

- if platelets are <50 x 10^9/l or if the baby is coagulopathic. In these situations, consider correction prior to the procedure being undertaken.
- There is extensive or rapidly spreading purpurea
- there is an infection at the Lumbar Puncture site
- there are risk factors for an evolving space occupying lesion
- there are symptoms suggestive of raised intracranial pressure
    - new focal neurological features (including seizures of posturing
    - abnormal pupillary reactions
    - there is a progressive or sustained or rapid fall in the patient's level of consciousness.

5.4 It is recognised that there are other non-infectious causes of a rise in CRP, so babies with an isolated rise in CRP should be discussed with a senior paediatrician and the need to perform a lumbar puncture considered, taking into account the overall clinical picture. Decisions should be clearly documented in the baby's notes.

5.5 CSF investigations in babies with suspected bacterial meningitis

Perform the following cerebrospinal fluid investigations in babies with suspected bacterial meningitis:

- red and white cell count and cell type (including differential white cell count)
- total protein
- glucose concentration (to calculate cerebrospinal fluid to blood glucose ratio)
- microscopy for bacteria (using gram stain)
- microbiological culture and sensitivities
- PCR for relevant pathogens.

- Store the remaining cerebrospinal fluid in case more tests are needed.
- Ensure that cerebrospinal fluid, cell counts, total protein and glucose concentrations are available within 4 hours of lumbar puncture.
- When interpreting the results of cerebrospinal fluid investigations, take into account:
  - red cells in the sample, which may suggest blood contamination or a different diagnosis
  - whether earlier antibiotics may have reduced the diagnostic reliability of these investigations.
- Interpret cerebrospinal fluid results using standard age-appropriate threshold values (taking into account factors such as gestational age, chronological age, birth weight, and earlier antibiotic use or suspected immunodeficiency).
- Interpret cerebrospinal fluid results in babies alongside the clinical presentation and maternal history.
- If cerebrospinal fluid results are abnormal, consider alternative viral, mycobacterial, fungal or non-infectious causes as well as bacterial meningitis.

5.6 Other useful investigations include FBC and CXR. *In cases of suspected chorioamnionitis the placenta should be sent for histological* examination and culture.

5.7 Treat and stabilise any of the following before performing a Lumbar Puncture

- unprotected airway
- respiratory compromise
- shock
- Uncontrolled seizures
- Bleeding risk

5.8 Inability to obtain a CSF sample should not delay treatment. On occasion this may need to be delayed but most babies can tolerate a LP if supervised appropriately during the procedure.

5.9 It is possible to send CSF for PCR diagnostics if antibiotics have already been given[10,11].

6. Choice and Duration of antibiotics

6.1 Choice of empirical antibiotics should be discussed at regular intervals with the local microbiology team to discuss local sensitivity and resistant patterns that may require local deviation from the NICE guidelines on antibiotic choice.

6.2 Do not use CRP results alone to make decisions about starting, continuing or stopping antibiotics.

6.3 Empirical antibiotic choice depends on the circumstances surrounding suspicion of infection

- For infants with early onset sepsis see recommended empirical antibiotic choice in section 13.1

The usual duration of antibiotic treatment for babies with a positive blood culture, and for those with a negative blood culture but in whom there has been strong suspicion of sepsis, should be 7 days.

6.4 Intramuscular (IM) antibiotics may be considered in cases where IV access cannot be obtained. Use should be discussed with the pharmacy.
Note that not all antibiotics included in section 13 can be administered via IM injection. The following antibiotics could be considered for IM administration if appropriate and should only be used following discussion with a senior clinician: -

- Benzylpenicillin
- Cefotaxime
- Flucloxacillin
- Gentamicin (rarely)

6.5 Consider continuing antibiotic treatment for more than 7 days if:

- the baby has not yet fully recovered or
- based on the pathogen identified on blood culture (seek expert microbiological advice if necessary).
  - Group B Streptococcus 10 days if bacteraemia (for meningitis benzylpenicillin for 14 days + gentamicin for 5 days)
  - E.Coli 10 days if bacteramia (for meningitis cefotaxime for 21 days + gentamicin for 5 days)
  - Listeria monocytogenes 21 days

Longer treatment durations may also be required for some other causes of bacteraemia / meningitis following discussion with microbiology)

For those where meningitis is suspected but the pathogen is unknown, treat with amoxicillin and cefotaxime.
For Listeria, consider stopping Cefotaxime and treating with amoxicillin and Gentamycin (NICE 2026)

6.6 If continuing antibiotics for longer than 36 hours despite negative blood cultures, review the baby at least once every 24 hours. On each occasion, using clinical judgment, consider whether it is appropriate to stop antibiotic treatment, taking account of:

- the level of initial clinical suspicion of infection
- the baby's clinical progress and current condition, and
- the levels and trends of C-reactive protein concentration.

6.7 Antibiotics should usually be stopped at 36 hours if cultures are negative **and** the initial clinical suspicion of infection was not strong **and** if the baby's clinical condition is reassuring with no clinical indicators of possible infection, **and** the levels and trends of C-reactive protein concentration are reassuring.

6.8 However, if there was a significant CRP rise or the baby was particularly unwell, a minimum 5-7 days empirical antibiotic course should be prescribed.

6.9 When continuing intravenous antibiotics for more than 36 hours for babies with suspected sepsis despite negative blood cultures, review the baby at least once every 24 hours. Consider at each review whether it is appropriate to stop antibiotic treatment, taking account of:

- the level of initial clinical suspicion of infection and
- the baby's clinical progress and current condition and
- the levels and trends of C-reactive protein concentration are reassuring.

6.10 For babies born from 35 weeks gestation, with negative blood cultures who need antibiotics for more than 36 hours because the initial clinical suspicion of infection was strong, consider switching to oral antibiotics (see section 7) if:

- the baby's clinical condition is reassuring, with no current clinical indicators of ongoing infection **and**
- the levels and trend of C-reactive protein concentration are now reassuring **and**
- the baby is tolerating oral feeds

Any decision on switching to oral antibiotics or enabling a baby to go home must be agreed by a senior neonatologist or paediatrician (consultant or similar level).

6.11 Use amoxicillin as the oral antibiotic, unless local bacterial resistance data indicates a different antibiotic is needed.

6.12 Confirmed cases of neonatal meningitis should be discussed with the local *microbiologist*. Check viral PCR on CSF if no bacterial growth.

6.13 Repeating the LP prior to stopping antibiotics is generally not recommended, however this is at the discretion of the attending consultant

6.14 Good practice will include documenting an indication for the antibiotic and a review date for the prescription, on the prescription chart.

6.15 For those treated for meningitis, identify the need for, and arrange appropriate outpatient follow up for possible complications – cognitive, neurological, developmental, hearing, psychosocial, education and renal complications.

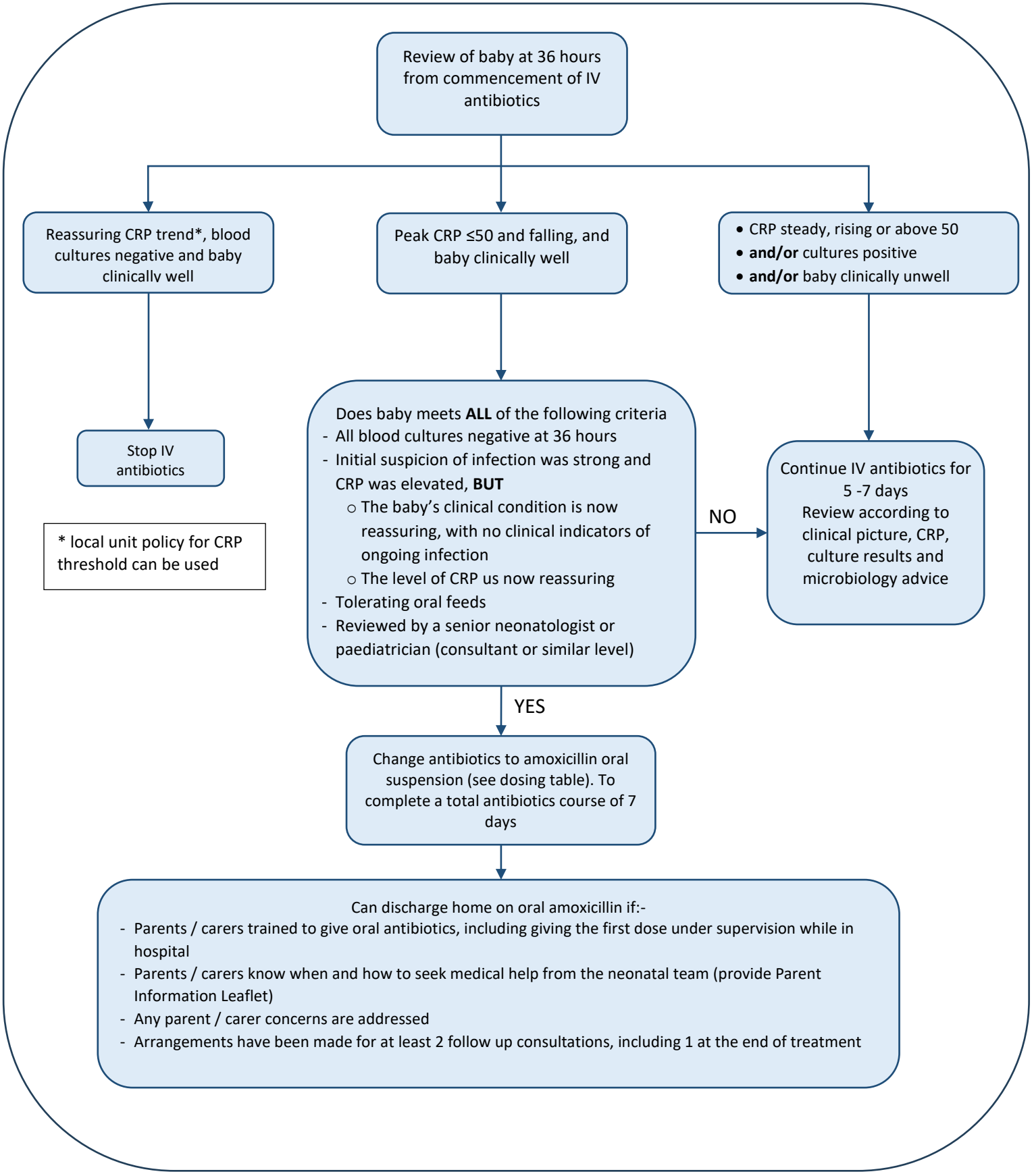
7 IV to oral antibiotic stepdown and discharge home on oral antibiotics

7.1 Switching to oral antibiotics

IV antibiotics for suspected early onset infection can be switched to oral antibiotics at 36 hours, provided the baby meets the eligibility criteria (see also flowchart in 7.2)

- The total duration of antibiotic treatment, including both IV and oral, should be 7 days.
- Following the switch, the course of oral antibiotics may be completed at home, removing the need for ongoing admission to the neonatal unit or transitional care unit if the baby is otherwise stable.
- The first dose of oral antibiotics must be administered before discharge to ensure it is well-tolerated.
- The first dose of oral antibiotics should be given no sooner than 8 hours after the last dose of IV benzylpenicillin
- The baby should be observed for a minimum of 2 hours after receiving the first oral dose.

7.2 Eligibility criteria for switching from IV to oral antibiotics in early onset infection



7.3 Oral antibiotic regimen

Amoxicillin oral suspension 125mg/5mL can be dose banded as per dosing table 1. This dosing is based on 30mg/kg/dose three times a day.

Amoxicillin oral suspension 125mg per 5mL			
Infant weight (kg)	**Dose to prescribe (mg)**	**Volume to give (mL)**	**Frequency**
2.0 – 2.39	65mg	2.6mL	**THREE times a day**
2.4– 2.79	75mg	3.0mL	
2.8 – 2.99	85mg	3.4mL	
3.0 – 3.49	100mg	4.0mL	
3.5 – 3.79	115mg	4.6mL	
3.8kg+	125mg	5.0mL	

DURATION: 7 days total antibiotic duration (includes combination of IV and oral antibiotic).

7.4 Exclusion criteria for changing from IV to oral antibiotics in suspected early onset infection

Babies who meet any of the following criteria should not be switched to oral antibiotics

- Positive blood, cerebrospinal fluid (CSF), or line cultures.
- CRP > 50.
- CRP remains elevated / keeps increasing despite IV antibiotics.
- Blood cultures could not be obtained from the baby.
- A decision has been made to treat for meningitis
- Safeguarding, transport, or comprehension concerns that may warrant completion of antibiotics in the hospital setting.
- Ongoing clinical concerns despite IV antibiotic treatment, including:
    - Fever or hypothermia.
    - Abnormal liver or renal function on blood tests.
    - Unusual rashes.
    - Lethargy or poor feeding.
    - Any other clinical concerns

7.5 Planning for discharge on oral antibiotics

Administering Oral Antibiotics: Parents should be instructed on how to administer oral antibiotics and given an opportunity to ask questions before discharge.

Information for parents and carers: Provide parents with a Parent Leaflet before discharge (Appendix 1).

Accessing Support: Ensure parents understand the correct pathway to seek help if concerns arise.

Follow-Up Appointment: Arrange a telephone follow-up appointment prior to discharge and confirm that parents are aware of the details.

Recognising Signs of Infection: Counsel parents on the key signs of infection and advise when to seek medical attention, including:

- Unusual behaviour, such as constant crying or being unusually quiet.
- Unusual floppiness or reduced activity.
- Difficulty feeding or trouble tolerating feeds.
- Abnormal temperature (unrelated to environmental factors), either below 36°C or above 38°C.
- Rapid breathing, grunting, or respiratory distress.
- Changes in skin colour, such as pallor, mottling, or cyanosis.

7.6 Follow up for babies discharged on oral antibiotics

Babies treated with oral antibiotics at home should receive a minimum of 2 follow up consultations following discharge, of which 1 of these should be at the end of treatment. This can be via telephone follow up.

Units must follow local process for how this follow up is undertaken, but key questions for parents must include the following: -

- Has your baby completed the oral antibiotic course?
- Did your baby tolerate the antibiotics well? Were there any issues with administration?
- Do you have any concerns about your baby's behaviour? Are they alert and waking for feeds?
- Is your baby feeding well?
- Is your baby wetting nappies and passing stools regularly?
- Has your baby been weighed since discharge?

8 Late Onset Neonatal Infections

Table 3: Clinical indicators of possible late-onset neonatal infection (observations and events in the baby)	
Category	**Indicators**
Behaviour	-Parent/Care- giver concern for change in behaviour -Looks unwell to a HCP -Does not wake up, when roused, doesn't stay awake. -Weak high-pitched or continuous cry.
Respiratory	-Tachypnoea (> 60 breaths per minute) -Grunting -Apnoea -Oxygen Saturations <90% in air or increased above baseline
Circulation and Hydration	-Persistent tachycardia (HR >160bpm) -Persistent bradycardia (HR<100bpm)
Skin	-Mottled or ashen -Cyanosis of skin, lips or tongue -Non-blanching rash on skin
Other	-Temperature <36C or >38C unexplained by environmental factors -Alteration in feeding pattern -Abdominal distension -Seizures -Bulging fontanelle

8.1 In those where sepsis is suspected beyond 72 hours of age, FBC, blood cultures, CRP should always be taken prior to starting antibiotics.

8.2 LP should be considered where there is strong clinical suspicion of neonatal infection or there are clinical symptoms or signs suggesting meningitis.
Do not undertake a LP if:

- platelets are <50 x 10^9/l or if the baby is coagulopathic. In these situations, consider correction prior to the procedure being undertaken.
- There is extensive or rapidly spreading purpurea
- there is an infection at the Lumbar Puncture site
- there are risk factors for an evolving space occupying lesion
- there are symptoms suggestive of raised intracranial pressure
    - new focal neurological features (including seizures of posturing
    - abnormal pupillary reactions
    - there is a progressive or sustained or rapid fall in the patient's level of consciousness.

If an infant is too unstable to tolerate an LP, do not delay giving antibiotics. An LP may be performed up to 1 week after starting antibiotics, however a negative PCR or low cell count should be interpreted with caution particularly if performed after the first 72 hours after commencing antibiotics.

8.3 If there are respiratory or abdominal concerns, X-rays should also be performed.

8.4 Do not routinely perform urine microscopy and culture as part of investigations of late-onset neonatal infection for babies on the neonatal unit

8.5 Consider stopping antibiotics after 48 hours if the blood culture is negative, **and** the initial suspicion of infection was not strong, **and** the baby's clinical condition is reassuring, with no clinical indicators of possible infection, **and** CRP levels are reassuring and on a downtrend.

8.6 For late-onset neonatal infection without meningitis, give antibiotic treatment for 7 days for babies with a positive blood culture. Consider continuing antibiotic treatment for more than 7 days if:

- the baby has not yet fully recovered **or**
- longer treatment is needed because of the pathogen identified on blood culture (for example, Gram-negative bacteria or Staphylococcus aureus; seek expert microbiological advice if necessary) **or**
- longer treatment is needed because of the site of the infection (such as intra-abdominal co-pathology, necrotising enterocolitis, osteomyelitis or infection of a central venous catheter).

8.7 Use a shorter treatment duration than 7 days when the baby makes a prompt recovery, and either no pathogen is identified or the pathogen identified is a common commensal (for example, coagulase negative staphylococcus).

8.8 If continuing antibiotics for longer than 48 hours for suspected late-onset neonatal infection despite negative blood culture, review the baby at least once every 24 hours. At each review, decide whether to stop antibiotics, taking account of:

- the level of initial clinical suspicion of infection **and**
- the baby's clinical progress and current condition **and**
- the levels and trends of C-reactive protein.

9 Removal of Central Lines

9.1 Removal of central lines should be considered in any septic infant who fails to improve.

9.2 Central lines should ideally be removed in the presence of culture positive sepsis in particular staph aureus, gram negative or fungal sepsis.

9.3 If the baby has suspected or proven coagulase negative staphylococcus in the presence of a long line, vancomycin or Teicoplanin should be administered via the long line and may remain in situ.

9.4 Repeated bacteraemia relating to line sepsis, despite adequate therapeutic levels of vancomycin, should result in the removal of the central line.

9.5 Surgical or long-term intensive care babies may become colonised with **resistant organisms.** When treating sepsis in these babies consider administering antibiotics which cover their resistant organism. The choice of antibiotic for use as second line antibiotic may depend on local sensitivity pattern particularly during confirmed outbreaks.

9.6 Where the central line has been removed for any of the above reasons, the tip should be sent for MC&S.

9.7 In cases of fungal sepsis where a long line is in situ, treat for 2 weeks with anti fungal and discuss with local microbiologist. Ideally the line should be removed.

10 Therapeutic Drug Monitoring

Gentamicin:

10.1 Check the trough levels prior to the second and the fifth dose. Once levels have been taken and if renal function is assessed as being satisfactory, give the dose of gentamicin.

10.2 If there are any concerns about renal function, withhold the dose of gentamicin until the level has been reported and is <2mg/Litre (up to the first three doses) and <1mg/Litre (if more than three doses are given). If there are serious concerns about renal function, consider the use of cefotaxime as an alternative to gentamicin.

10.3 The third dose of Gentamicin **should not** be given unless a normal gentamicin level has been received and is documented.

10.4 For extended dosing interval regimens normal levels are <2mg/Litre (pre dose trough) for courses that last for up to 3 doses and <1mg/L for courses of more than 3 doses. If levels are higher than this increase the intervals between doses as indicated on the gentamicin prescription chart and protocol.

10.5 Generally levels should be checked every third dose unless more frequent monitoring is indicated.

10.6 If a trough level result is reported as being >2mg/L (for courses up to 3 doses) OR >1mg/L for courses of more than 3 doses, these babies will also require urea and electrolytes testing. All babies receiving gentamicin will require hearing screening. Those with high levels will require an additional screen at 8 months.

10.7 For selected babies, peak blood gentamicin concentrations should be considered

- babies with oedema
- macrosomic babies (birth weight > 4.5kg)
- unsatisfactory response to treatment
- proven gram-negative infection.

Measure peak concentration 1 hour after the gentamicin dose and consider increasing the gentamicin dose if it is < 8mg/L

Vancomycin:

10.8 Vancomycin levels for intermittent regime should be measured just prior to the 3rd dose and every 5th dose thereafter aiming for trough levels between 10-20 mg/L.

If a central line in in situ, consider prescribing a continuous vancomycin infusion. Even if the line is removed, a continuous infusion may still be prescribed to be administered via the peripheral line. This is at the discretion of the attending Consultant. Monitoring of continuous vancomycin levels as per the local continuous vancomycin guideline – 12 to 24 hours after the first dose and subsequently afterwards. Aim for a level of 15 – 25mg/L

11 Unit Specific Sensitivities

Individual units may make amendments to the standard antimicrobial recommendations in this guideline, based on any local microbiology susceptibility information *or population health* and in discussion with their local microbiology department.

Individual units may have specific resistant organisms. Units should review their individual sensitivities on a 6 monthly basis in conjunction with their microbiology and infection control teams and provide a risk management plan to tackle such issues.

12 Parent Information

12.1 If considering antibiotic treatment because of clinical concerns about possible early-onset neonatal infection, discussions with parents should include:

- the rationale for the treatment
- the risks and benefits in the individual circumstances
- the observations and investigations that may be needed to guide clinical
- management (for example, when to stop treatment)
- the preferred antibiotic regimen, route of administration and likely duration of treatment
- the impact, if any, on where the woman or her baby will be cared for
- potential long-term effects of the baby's illness and likely patterns of recovery
- Provide reassurance if no problems are anticipated
- Offer a parents an information leaflet so they have information to refer to, especially those for whom the KP-SRC has been used to assess risk of infection.

12.2 When a baby who has had a group B streptococcal infection is discharged from hospital:

- advise the woman that if she becomes pregnant again:
  - there will be an increased risk of early-onset neonatal infection
  - she should inform her maternity care team that a previous baby has had a
  - group B streptococcal infection
  - antibiotics in labour will be recommended
- inform the woman's GP in writing that there is a risk of:
  - recurrence of group B streptococcal infection in the baby, and
  - group B streptococcal infection in babies in future pregnancies.

12.3 If a woman has had group B streptococcal colonisation in the pregnancy but without infection in the baby, inform her that if she becomes pregnant again, this will not affect the management of the birth in the next pregnancy

12.4 For those who have a positive CSF culture and are treated for meningitis, discuss the course of the disease, possible complications and support available during this hospitalization.
Also discuss the risk of passing on the infection and whether close contacts need to take any preventive measures (for example, for meningococcal meningitis or Haemophilus influenza type b).

13. Antibiotic schedules

13.1 Early onset sepsis – up to 72 hours of age

Indication	Drug, dose and route	Dose interval	Notes
Early onset infection	**BENZYLPENICILLIN 25mg/kg IV** **BENZYLPENICILLIN 50mg/kg IV** ****If meningitis is suspected****	**12 hourly up to 7days** **Or 8 hourly if very unwell** **8 hourly 7-28 days** **6 hourly from 1 month**	• Usually started at birth. • Use intravenous Benzylpenicillin with gentamicin as the first-choice antibiotic regimen for empirical treatment of suspected infection unless microbiological surveillance data reveal local bacterial resistance patterns indicating a different antibiotic. • Higher dose of Benzylpenicillin (50mg/kg) is recommended for babies who have meningitis to achieve bactericidal concentration in the CSF. Some centres may also use this as their starting dose • If the baby appears very ill if receiving 25mg/kg 12 hourly, consider shortening the dose interval to every 8 hours or changing dose to 50mg/kg 12 hourly • If there is microbiological evidence of gram negative bacterial sepsis, add another antibiotic such as cefotaxime. If gram negative infection is confirmed, stop benzylpenicillin • For gentamicin, care is needed with prescribing times and trough levels (see appendix 1 & 2) • Consider monitoring one hour ('peak') concentration in neonates with poor response to treatment, with oedema, Gram-negative infection, or with birth-weight greater than 4.5 kg (consider increasing dose if 'peak' concentration is less than 8 mg/litre in severe sepsis).
	PLUS **GENTAMICIN 5mg/kg IV** *See later guidance on drug monitoring	**Up to 7 days 5mg/kg every 36 hours** **≥7days 5mg/kg every 24 hours (BNF-C)**	

Indication	Drug, dose and route	Dose interval	Notes
Early onset infection WITH Suspected CSF involvement	**AMOXICILLIN 100MG/KG**	**12 hourly up to 7 days** **8 hourly 7-28 days**	• Decision to be made by a senior clinician, especially if blood stained CSF. • If meningitis is suspected but the causative pathogen is unknown, treat with intravenous amoxicillin and cefotaxime. If meningitis is caused by Gram negative infection, stop amoxicillin and treat with cefotaxime alone. If E coli is amoxicillin sensitive, continue treatment with amoxicillin and stop the cefotaxime. • If GpB Strep is confirmed in CSF then antibiotics should be changed to Benzylpenicillin, giving a dose of 50mg/kg and gentamicin 5mg/kg. Treatment using Benzylpenicillin should be continued for 14 days. Gentamicin to be given for 5 days. • Cephalosporins increase the proportion of infants with sterile CSF after 48-72 hrs of treatment for meningitis, but have not been shown to reduce morbidity or mortality compared to penicillin and an aminoglycoside. If Listeria is in blood culture or CSF, treat with amoxicillin and gentamicin.
	PLUS **CEFOTAXIME 25mg/kg IV** **BUT 50mg/kg in severe infection**	**12 hourly up to 7days** **8 hourly 7-20 days** **6 hourly 21-28 days**	
E-Coli infections **If no improvement after 48 hours.**	**CEFOTAXIME 25mg/kg IV BUT 50mg/kg in severe infection**	**12 hourly up to 7days** **8 hourly 7-20 days** **6 hourly 21-28 days**	• If no CNS infection: 10 days of IV therapy • E. coli meningitis: 21 days of IV Cefotaxime (+Gentamicin for first 5 days)
	PLUS **GENTAMICIN 5mg/kg IV (whilst awaiting sensitivities from microbiology**	**Up to 7 days 5mg/kg every 36 hours** **≥7days 5mg/kg every 24 hours (BNF-C)**	

<table>
<tr><th>Indication</th><th>Drug, dose and route</th><th>Dose interval</th><th>Notes</th></tr>
<tr>
<td>Early onset infection IV to oral stepdown with amoxicillin</td>
<td colspan="2">
<table>
<tr><th colspan="4">Amoxicillin oral suspension
125mg per 5mL</th></tr>
<tr><th>Infant weight (kg)</th><th>Dose to prescribe (mg)</th><th>Volume to give (mL)</th><th>Frequency</th></tr>
<tr><td>2.0 – 2.2</td><td>65mg</td><td>2.6mL</td><td rowspan="6">THREE times a day</td></tr>
<tr><td>2.3 – 2.6</td><td>75mg</td><td>3.0mL</td></tr>
<tr><td>2.7 – 2.8</td><td>90mg</td><td>3.6mL</td></tr>
<tr><td>2.9 – 3.5</td><td>100mg</td><td>4.0mL</td></tr>
<tr><td>3.6 – 4.3</td><td>115mg</td><td>4.6mL</td></tr>
<tr><td>4.4 – 5.0</td><td>125mg</td><td>5.0mL</td></tr>
</table>
</td>
<td>To complete total antibiotic duration (IV and oral) of 7 days.

See section 7 for further information including criteria for switch from IV to oral</td>
</tr>
</table>

13.2 Late onset sepsis: after 72 hours with no central access

<table>
<tr><th>Indication</th><th>Drug, dose and route.</th><th>Dose interval</th><th>Notes</th></tr>
<tr><td rowspan="3">Late onset infection

after 72 hours with no central access</td><td>FLUCLOXACILLIN
50mg/kg IV</td><td>Up to 7 days 12 hourly

7-20 days 8 hourly

21- 28 days 6 hourly</td><td rowspan="2">• Consider an LP. Where the condition of the baby does not allow for this, LP should be undertaken as soon as possible if indicated.

• Inability to gain a sample should not delay treatment)

• Intrapartum antibiotic treatment of mother will not prevent late onset GBS in the infant. Where late onset GBS is <u>confirmed</u> on culture, replace flucloxacillin with benzylpenicillin and continue gentamicin.

• Early onset meningitis is likely to have associated bacteraemia, but later onset may have no positive cultures outside CSF.

• Flucloxacillin & Gentamicin are the best choice for suspected late sepsis in the absence of endemic MRSA colonisation and when CSF is normal[6] (Some units may use a different antibiotic choice for late onset sepsis as agreed with the local microbiology department on the basis of local antibiotic resistance.

• Define the patient’s suspected condition.</td></tr>
<tr><td>PLUS

GENTAMICIN
5mg/kg IV</td><td>up to 7 days 5mg/kg every 36 hours

≥7 days 5mg/kg every 24 hours</td></tr>
<tr><td colspan="2">If any signs of CSF involvement consider Cefotaxime and Gentamicin</td><td></td></tr>
</table>

13.3 Late onset sepsis WITH a central line or with a known MRSA infection

Indication	Drug, dose and route	Dose interval	Notes
Late onset infection **With a central line or a known MRSA infection**	**VANCOMYCIN 15mg/kg IV (consider continuous infusion – see local protocol)** **OR** **TEICOPLANIN 16mg/kg loading dose then 8mg/kg 24 hours later IV**	**Up to 29weeks every 24 hours** **29-35 weeks every 12 hours** **≥35 weeks every 8 hours** **(or by continuous vancomycin infusion – follow local unit dosing guideline)** **24 hourly**	• The use of broad spectrum Cephalosporins should be limited as far as possible, aiming to reduce the incidence of MRSA and of invasive fungal sepsis. • As coagulase negative sepsis generally has a low mortality and morbidity, it may be justifiable to reserve Vancomycin for cases known to be Flucloxacillin/Penicillin resistant[7]. • Continuous infusion of vancomycin is preferable if there is a central line in situ • MRSA bacteraemia in preterm infants is associated with an

	PLUS **Gentamicin 5mg/kg IV** **OR** **CEFOTAXIME 25mg/kg IV BUT 50mg/kg in severe infection**	**Up to 7 days 5mg/kg every 36 hours** **≥7 days 5mg/kg every 24 hours (BNF-C)** **12 hourly up to 7days** **8 hourly 7-20 days** **6 hourly 21-28 days**	indwelling IV line in 80% cases, and almost always with previous antibiotic exposure[8,9]. • If Pseudomonas isolated change Cefotaxime to Ceftazidime (severe infection dose) • **If concerns about renal toxicity use Cefotaxime** ***If vancomycin and gentamicin are used in combination – monitor renal function and for toxicity closely in extremely premature neonates***

13.4 Late onset with respiratory disease

Indication	Drug, dose and route	Dose interval	Notes

Late onset infection **with respiratory disease** **<u>OR</u>** **Suspected Herpes Simplex at any time** **<u>OR</u>** **Any sepsis not responding to treatment at any time.**	**ACICLOVIR 20mg/kg IV**	**8 hourly for 21 days**	• Neonatal Herpes Simplex is a rare severe infection which should be treated promptly • Consider adding aciclovir for any sepsis not responding to treatment. • See EOE guideline of management of babies born to mothers who have or may have Herpes Simplex Virus infection

13.5 Suspected abdominal pathology at any stage

<table>
<tr><td rowspan="4">Suspected abdominal pathology at any stage</td><td colspan="2">METRONIDAZOLE
<u>Up to 26 weeks corrected gestational age.</u>
15mg/kg as a single dose followed after 24 hours by 7.5mg/kg daily

<u>26-34 weeks corrected gestational age</u>
15mg/kg as a single loading dose followed after 12hours by 7.5mg/kg every 12 hours

<u>Neonate ≥ 34 weeks corrected gestational age</u>
15mg/kg as a single dose followed after 8 hours by 7.5mg/kg every 8 hours.
If baby is not already on gentamicin, then this should also be added to treatment</td><td rowspan="4">• Increase the dosing interval of Metronidazole in hepatic but not renal failure

• Babies with suspected or confirmed Necrotising Enterocolitis should be treated with Metronidazole and Gentamicin <u>plus:</u>

Benzylpenicillin

<u>OR</u>

Vancomycin - If coagulase negative staphs are being covered, where there is possible line associated sepsis or where there is Penicillin allergy.

Some units may locally use an alternative regime of piperacillin/tazobactam + vancomycin.

If vancomycin and gentamicin are used in combination – monitor renal function and for toxicity closely in extremely premature neonates</td></tr>
<tr><td rowspan="3">Necrotising Enterocolitis</td><td>PLUS
+ GENTAMICIN 5mg/kg IV</td><td>Up to 7 days 5mg/kg every 36 hours

≥7 days 5mg/kg every 24 hours</td></tr>
<tr><td>PLUS

BENZYLPENICILLIN 25mg/kg (or 50mg/kg) IV</td><td>12 hourly up to 7days

8 hourly 7 – 28 days

6 hourly from 1 month</td></tr>
<tr><td><u>OR</u>

VANCOMYCIN 15mg/kg IV</td><td>Up to 29weeks every 24 hours
29-35 weeks every 12 hours
≥35 weeks every 8 hours

(or by continuous vancomycin infusion – follow local unit dosing guideline)</td></tr>
</table>

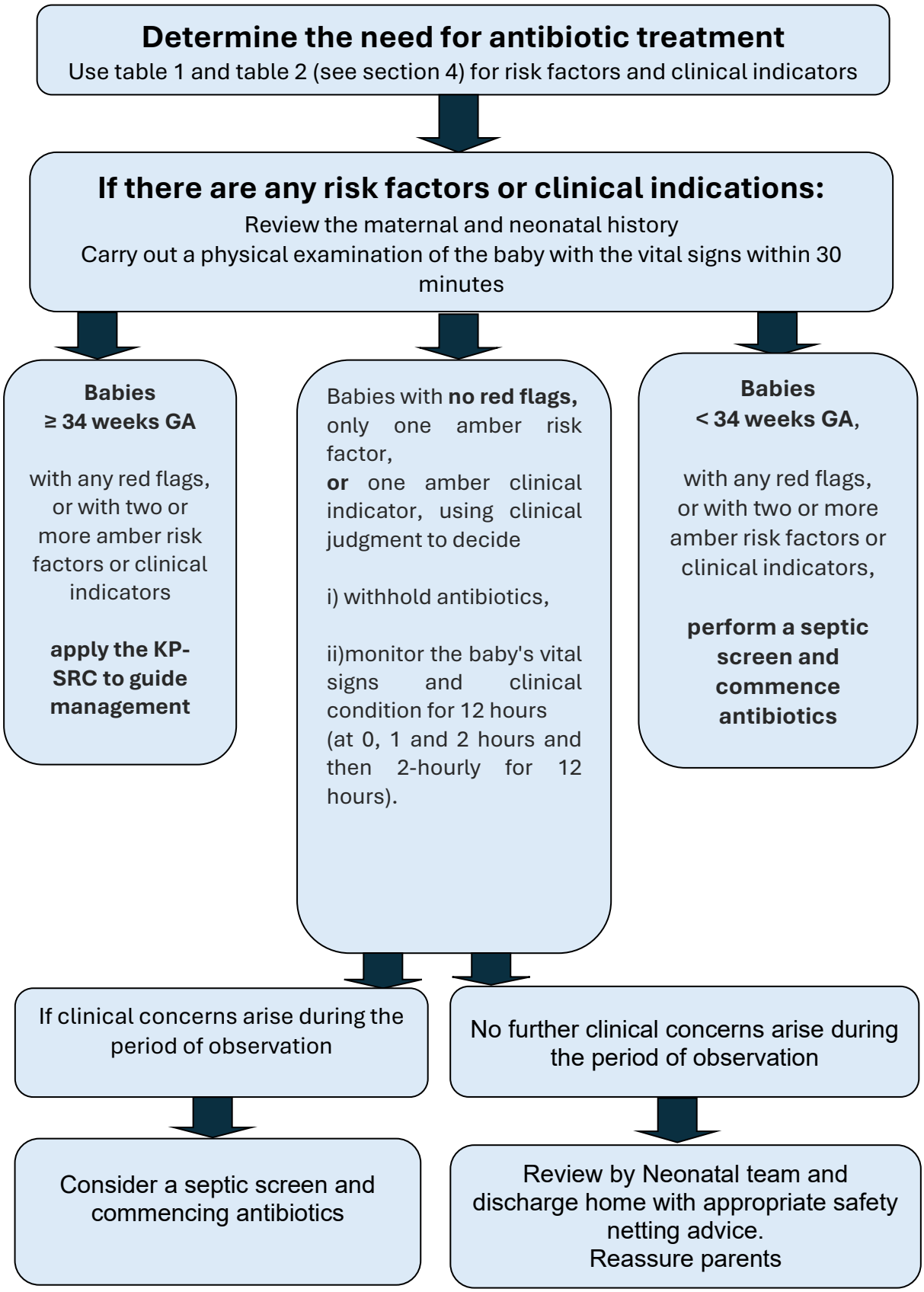
13.6 Fungal prophylaxis

Indication	Drug, dose and route	Dose interval	Notes
Prophylactic antifungal **(Consider with use of Cefotaxime and Vancomycin)**	**Nystatin suspension.** **Prophylactic dose 25,000 units (0.25mls)** **Treatment dose is 100,000u (1ml)** **ORALLY**	**6 hourly**	• If giving Fluconazole stop Nystatin • Prophylactic use of systemic Fluconazole reduces the incidence of invasive fungal infections in VLBW infants but further trials are needed to assess the affect on mortality, neurodevelopment and emergence of antifungal resistance. • There is a lower risk of developing fungal resistance with nystatin compared to fluconazole so this should be first line. Only use Fluconazole if oral administration of Nystatin is not possible • Prophylactic use of nystatin should given in the following babies: Babies treated with antibiotics for suspected late-onset neonatal bacterial infection if they have a birthweight of up to 1500g or were born less than 30 weeks. • Prophylactic use of nystatin should be considered in the following babies: • Babies weighing less than 1500g and/or less than 28 weeks gestation • Preterm or ELBW babies with central lines in situ

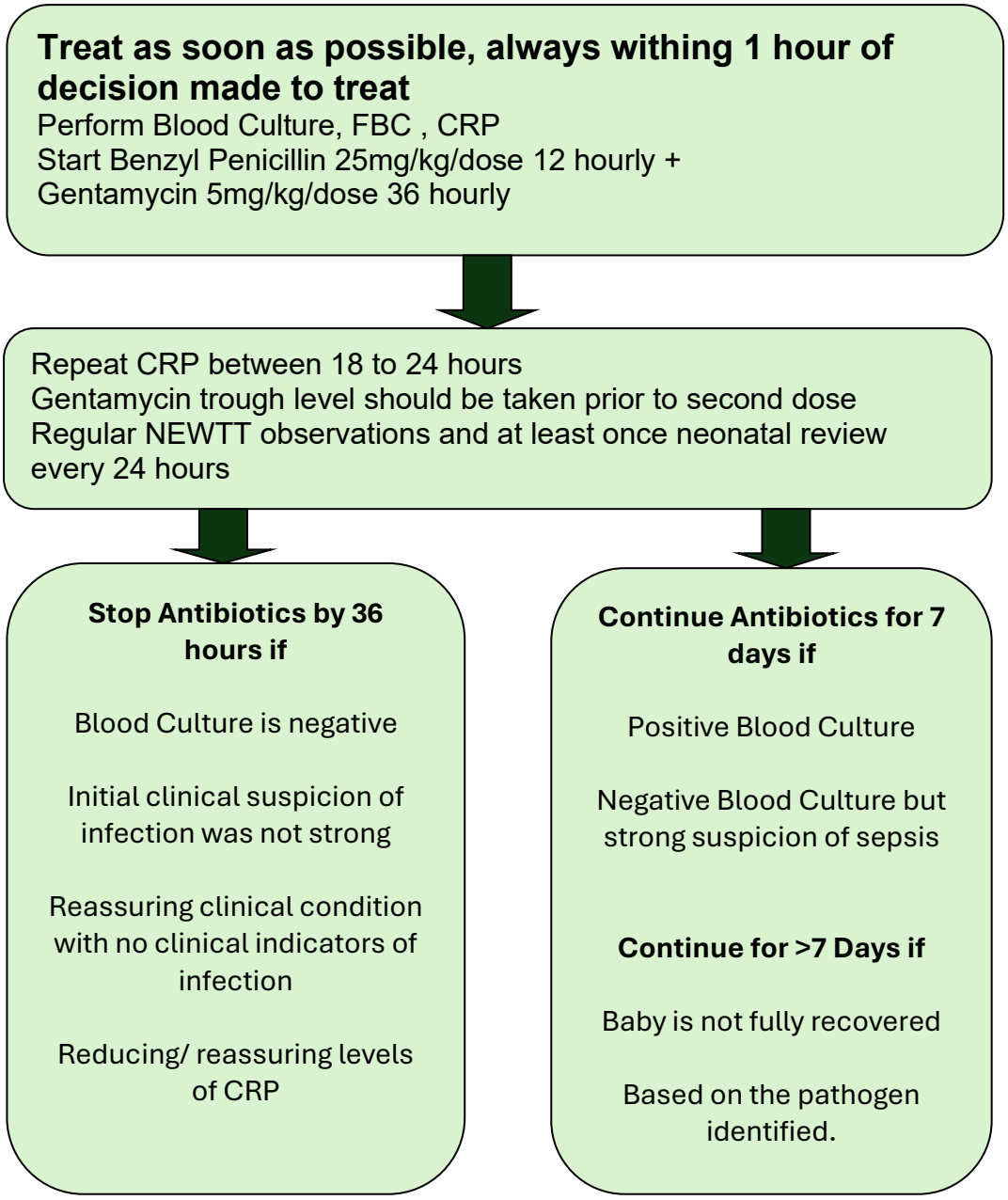
13.7 Infants admitted from the community: Meningitis (bacterial) and meningococcal septicaemia

Drug	Dose and route	Dose interval	Notes
Cefotaxime	**50mg/kg**	**12 hourly up to 7 days age** **8 hourly 7 – 20 days age** **6 hourly 21 – 28 days age**	Please refer to NICE guidance NG240: Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management for further information.
If risk factors for Listeria ADD **Amoxicillin**	**100mg/kg**	**12 hourly up to 7 days age** **7 hourly 7 – 28 days age**	

14. Determining the need for antibiotic treatment



15. Summary of the management of antibiotic treatment for neonates with suspected Early Onset Neonatal Infection



16. Treatment of localised infections – eye and umbilicus

Eye infections

Although minor conjunctivitis with encrusting of the eyelids is common and often benign, a purulent discharge may indicate the presence of a serious infection (for example, with Chlamydia or gonococcus).

In babies with a purulent eye discharge

- Take swab samples urgently for Microbiological investigation (using Methods that can detect chlamydia and Gonococcus)
- Start systemic antibiotic treatment for possible gonococcal infection (Cefotaxime)

Umbilical infections

In babies with clinical signs of umbilical infection, such as a purulent discharge or periumbilical cellulitis (for example, redness, increased skin warmth or swelling)

- Perform a blood culture
- Take a swab for microscopy + culture
- Start IV flucloxacillin and gentamicin
- If the microbiology is not a Gram-negative infection stop the gentamicin

References

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2. Jones N, Oliver K, Jones Y, Haines A, Crook D. (2006) Carriage of group B streptococcus in pregnant women from Oxford, UK. *Journal of Clinical Pathology*. 59:363-366. [III]

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10. Johnson CE, Whitwell JK, Pethe K, Saxena K, Super DM. (1997) Term newborns who are at risk for sepsis: are lumbar punctures necessary? *Pediatrics*. April;99(4):E10. [III]

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12. Cotten CM, McDonald S, Stoll B, Goldberg RN, Poole K, Benjamin DK Jr; National Institute for Child Health and Human Development Neonatal Research Network. (2006) The association of third generation cephalosporin use and invasive candidiasis in ELBW infants. *Pediatrics*. August;118(2):717-22.

13. NICE guidance (NG195) Neonatal infection: antibiotics for prevention and treatment - published 20 April 2021, updated 13 May 2026

14. NICE guidance NG240: Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management March 2024

15. NOAH (Neonatal Oral Antibiotics at Home) website . Health Innovation West https://healthinnovationsouthwest.com/programmes/noah-neonatal-oral-antibiotics-at-home/

Appendix 1 – Regional Gentamicin Chart

East of England Neonatal ODN

NAME OF YOUR UNIT TO GO IN HERE

Hospital Number:
Surname:
First Names:
Date of birth:
NHS no: ___ / ___ / ____
Use Hospital identification label

PRESCRIPTION SHEET FOR I.V GENTAMICIN ONLY – (Staple to main Drug Chart)

DOSING AND MONITORING OF IV GENTAMICIN

Dose and frequency: 5mg/kg/dose up to 7 days after birth– ONE dose every 36 hours
≥7 days after birth – ONE dose every 24 hours

Monitoring: Trough level pre 2nd dose (and give 2nd dose if renal function satisfactory) and pre-5th dose unless more frequent monitoring is indicated. Generally, levels should be checked every 3rd dose.

Expected trough level: For courses **UP TO 3 doses** Level <2mg/l For courses **OF 3 doses or more** level <1mg/L.

Dose adjustments if levels >2mg/L(up to 3 doses) >1mg/L (more than 3 doses):
If on 24 hourly dosing extend interval to 36 hourly (level and hold before next dose – must be <2mg/L (if less than 3 doses) <1mg/L (if 3 or more) before next dose given
If on 36 hourly dosing extend interval to 48 hourly (level and hold before next dose – must be <2mg/L (if less than 3 doses) <1mg/L (if 3 or more) before next dose given

Weight ..... **Corrected gestational age at start of treatment** ..... **weeks**

Date	Time to be given	Drug	I.V Dose	IV route i.e. PVL or LL	Frequency of administration	Signature of Prescriber	Printed Name of Prescriber	Write **'LEVEL and GIVE'** or **'LEVEL and HOLD'**.	Double checking prompt used*	Given by		LEVELS		Pharm
										Initials*	Time	Initial when level taken	Result of level	
-- / -- / --	-- : --	Gentamicin	mg								-- : --			
-- / -- / --	-- : --	Gentamicin	mg					**LEVEL AND**			-- : --			
-- / -- / --	-- : --	Gentamicin	mg								-- : --			
-- / -- / --	-- : --	Gentamicin	mg								-- : --			
-- / -- / --	-- : --	Gentamicin	mg								-- : --			
-- / -- / --	-- : --	Gentamicin	mg								-- : --			

*** Lead checker to sign uppermost section of box.**

Name of your hospital here

East of England Neonatal ODN

Reasons for non-compliance with double checking prompt

Nursing staff to detail reasons for non-conformance with NPSA double checking prompt below.

Shaded columns to be entered by auditor only.

Date	Time	Details of non-conformance with double checking prompt	Signature	Measurement Extranet	
				Date entered	Signature
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				
-- /--/--	-- : --				

Appendix 2 – Regional Vancomycin Chart

East of England Neonatal ODN NHS

Name of your unit in here

PRESCRIPTION SHEET FOR I.V VANCOMYCIN ONLY

(Staple to main Drug Chart)

DOSING AND MONITORING OF IV VANCOMYCIN

Dose 15mg/kg/dose

Frequency of administration: up to 29 weeks every 24 hours
29-35 weeks every 12 hours
≥35 weeks every 8 hours

Monitoring:

Take trough level pre-3rd dose and pre-8th dose unless more frequent monitoring is indicated. Generally, levels should be checked every 5th dose

Expected trough level: 10-20mg/l

Addressograph

VANCOMYCIN ONLY

Weight .....

Date	Time to be given	Drug	I.V Dose	IV Route i.e. PVL or LL	Frequency of administration	Signature of Doctor	Write **'LEVEL and GIVE'** or **'LEVEL and HOLD'**.*	Sign when level taken	Result of level	Given by		Pharm
										Initials	Time	
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									
		Vancomycin	mg									

***LEVEL and GIVE** indicates that a level is to be taken, and that the next prescribed dose may be given without waiting for the result.
LEVEL and HOLD indicates that a level is to be taken, and no further doses are to be given until the result is obtained.

Appendix 3 – Patient Information leaflet – oral antibiotics

INFORMATION FOR PARENTS ABOUT ORAL NEONATAL ANTIBIOTICS FOR EARLY ONSET NEONATAL INFECTION

East of England Neonatal Operational Delivery Network

Why does my baby need antibiotics

Your baby is having antibiotics because they have an infection, or because doctors think they might be at risk of infection. Your baby will need antibiotics for at least 36-48 hours. If the tests show no infection, your baby may stop the antibiotics.

However, your baby might need more oral (by mouth) or intravenous (through a drip) antibiotics.

The doctors will explain what will happen next.

This leaflet explains what neonatal infection is and what signs to watch for when you go home with your baby on oral antibiotics

What is early onset neonatal infection?

Early onset neonatal infection is when a baby gets an infection in the first 72 hours of life. Newborn babies are more likely to get infections because their immune system (which helps fight illness) is still developing. The signs of infection can be hard to spot but, if not treated they can lead to serious illness or even be life-threatening. This is why babies who may have an infection, or who are at risk of infection, are started on antibiotics quickly.

Why is my baby being changed from injection or oral antibiotics?

Your baby has already had some antibiotics as in injection and is doing well.

However they still need to continue with antibiotics which can now be given by mouth (oral) as there is some infection concern. Once the oral antibiotic course has been finished, your baby will have received a 7 day total course of injection and oral antibiotics.

The oral antibiotic can be given at home if the doctors are happy that your baby can be discharged.

At home, someone from the neonatal team will contact you at least twice (including at the end of the antibiotic course) to check how your baby is doing and if you have any concerns or questions.

What are the signs and symptoms of infection to watch for when my baby is discharged?

If you are worried about your baby when they are on oral antibiotics at home, please seek medical advice.

These are the signs to look out for in your baby:

- Unusual behaviour such as crying a lot or being quiet
- Being floppy
- Trouble feeding or being sick a lot
- A temperature that is too low (below 36°C) or too high (above 38°C)
- Fast breathing or grunting noises
- A change in the colour of the skin

How should I give oral antibiotics to my baby?

Before your baby goes home, staff will show you how to give the oral antibiotic (called amoxicillin) and answer any questions you may have.

Further information on how to administer medicine to your baby can be found by scanning the QR code to the right with your smartphone

What should I do if my baby is sick (vomits)?

- If your baby is sick less than 30 minutes after taking the antibiotic medicine, give them the same dose again.
- If your baby is sick more than 30 minutes after taking the antibiotic medicine, do NOT give another dose. Wait until the next time a dose is due to continue giving the medicine.
- If your baby is sick again, ask for medical advice

Where can I find out more information about amoxicillin?

Amoxicillin is a safe medicine for newborn babies (even if the mother has a penicillin allergy). It can however cause some short term side effects which include diarrhoea and vomiting. If this happens please ask for medical advice.

Further information on amoxicillin, can be found by scanning the QR code below with your smartphone.

Who to contact if you have any queries?

If you have any worries or need advice while your baby is being treated with oral antibiotics, please ask for medical advice from the neonatal unit you were discharged from.

If you need help urgently, call 999 or go to your nearest Emergency Department

Written by: Nigel Gooding, Lead Pharmacist East of England ODN
Approved:
Reference: Adopted from NOAH Patient Information. Health Innovation West (viewed 10.04.26)

Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

<table>
<tr><td colspan="2">Details of person completing the form:</td></tr>
<tr><td>Title:</td><td>Organisation:</td></tr>
<tr><td>First name:</td><td>Email contact address:</td></tr>
<tr><td>Surname:</td><td>Telephone contact number:</td></tr>
<tr><td colspan="2">Title of document to be excepted from:</td></tr>
<tr><td colspan="2">Rationale why Trust is unable to adhere to the document:</td></tr>
<tr><td>Signature of speciality Clinical Lead:

Date:</td><td>Signature of Trust Nursing / Medical Director:

Date:</td></tr>
<tr><td>Hard Copy Received by ODN (date and sign):</td><td>Date acknowledgement receipt sent out:</td></tr>
</table>

Please email form to: add-tr.eoeneonatalodn@nhs.net requesting receipt.
Send hard signed copy to: Kelly Hart

EOE ODN Office Manager
Box 402
The Rosie Hospital
Cambridge University Hospital NHS Foundation Trust
Robinson Way
Cambridge CB2 0SW