What's New, What Matters, and What Saves Lives

NCPR UPDATE 2025

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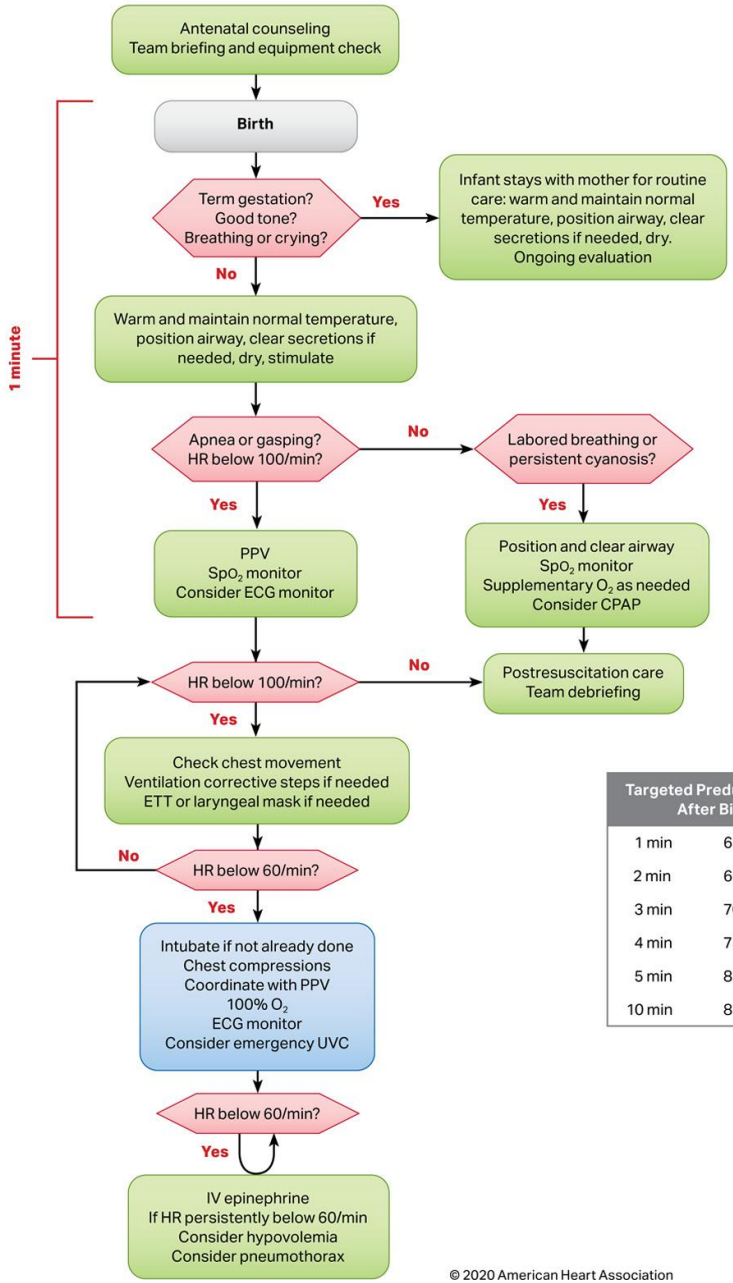
สาขาวิชาทารกแรกเกิด ภาควิชากุมารเวชศาสตร์
โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล

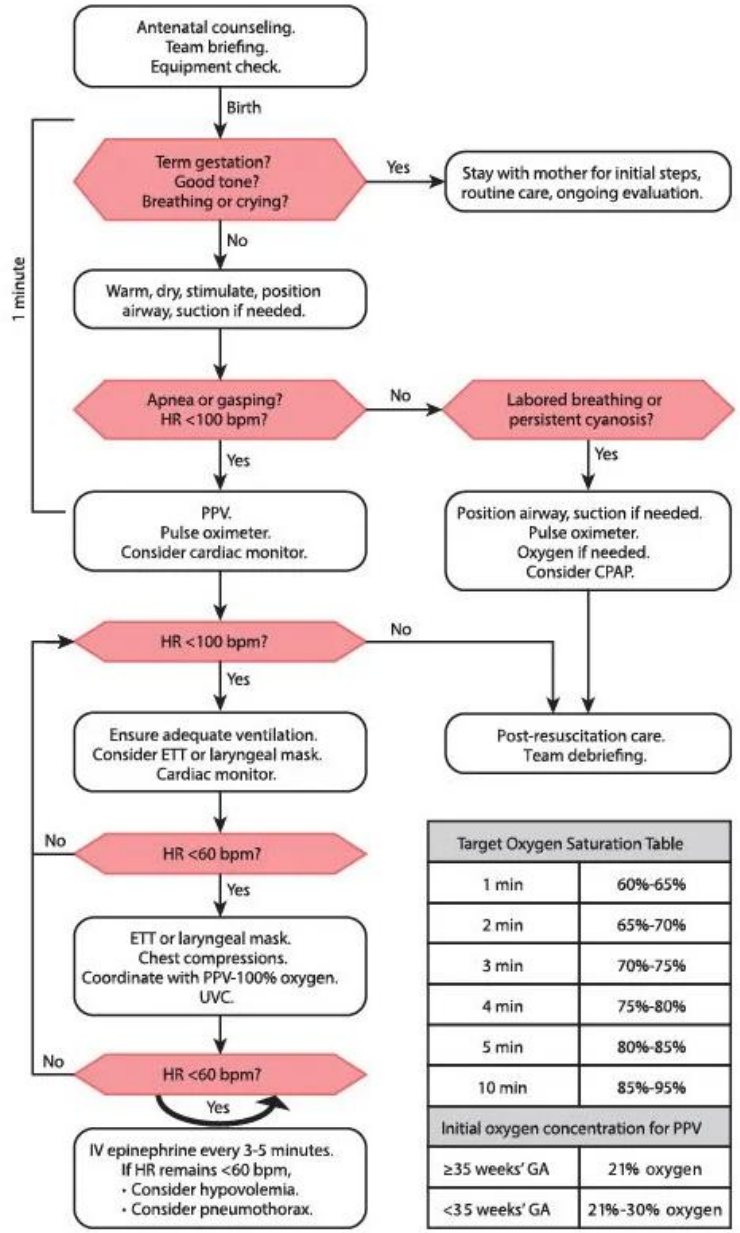
May 2026

Neonatal Resuscitation Algorithm

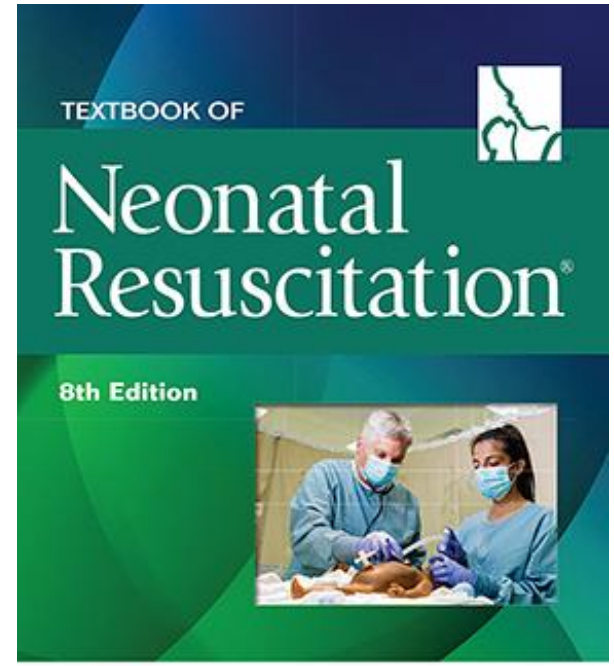


Targeted Preductal SpO_2 After Birth	
1 min	60%-65%
2 min	65%-70%
3 min	70%-75%
4 min	75%-80%
5 min	80%-85%
10 min	85%-95%

Neonatal Resuscitation Program® 8th Edition Algorithm



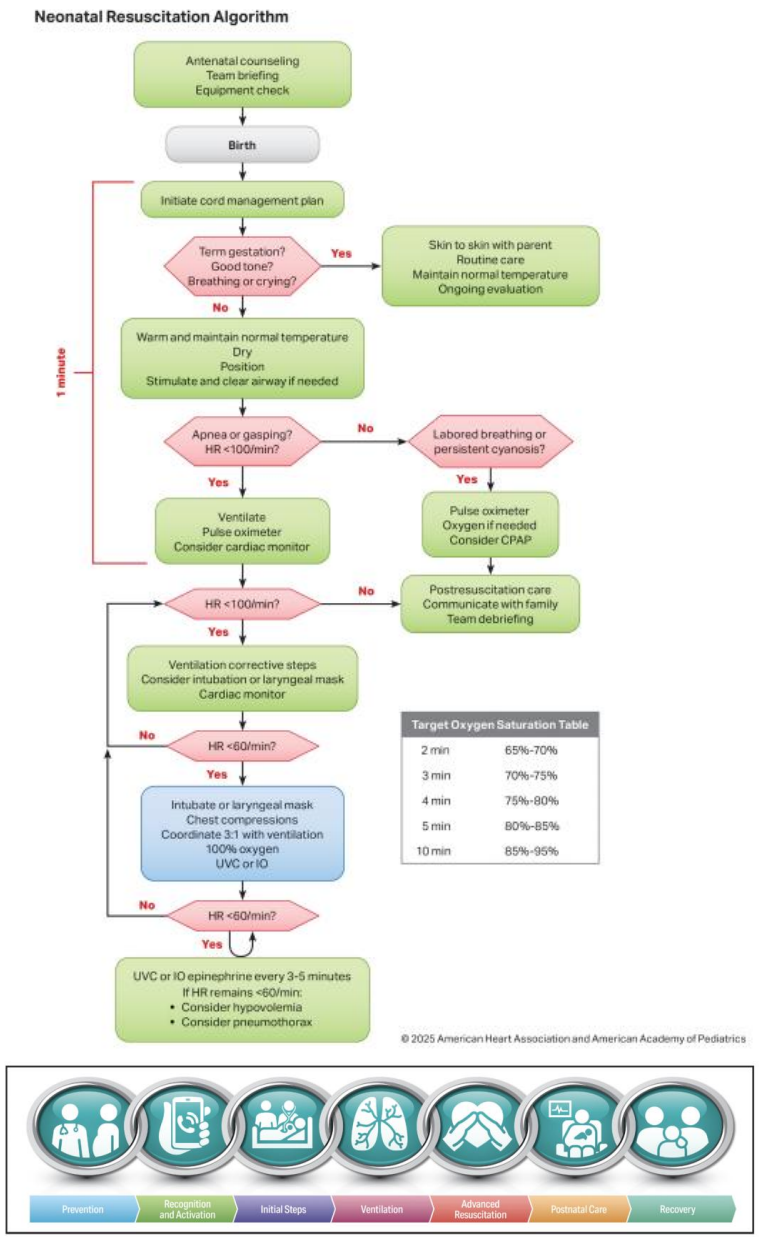
Target Oxygen Saturation Table	
1 min	60%-65%
2 min	65%-70%
3 min	70%-75%
4 min	75%-80%
5 min	80%-85%
10 min	85%-95%
Initial oxygen concentration for PPV	
≥35 weeks' GA	21% oxygen
<35 weeks' GA	21%-30% oxygen

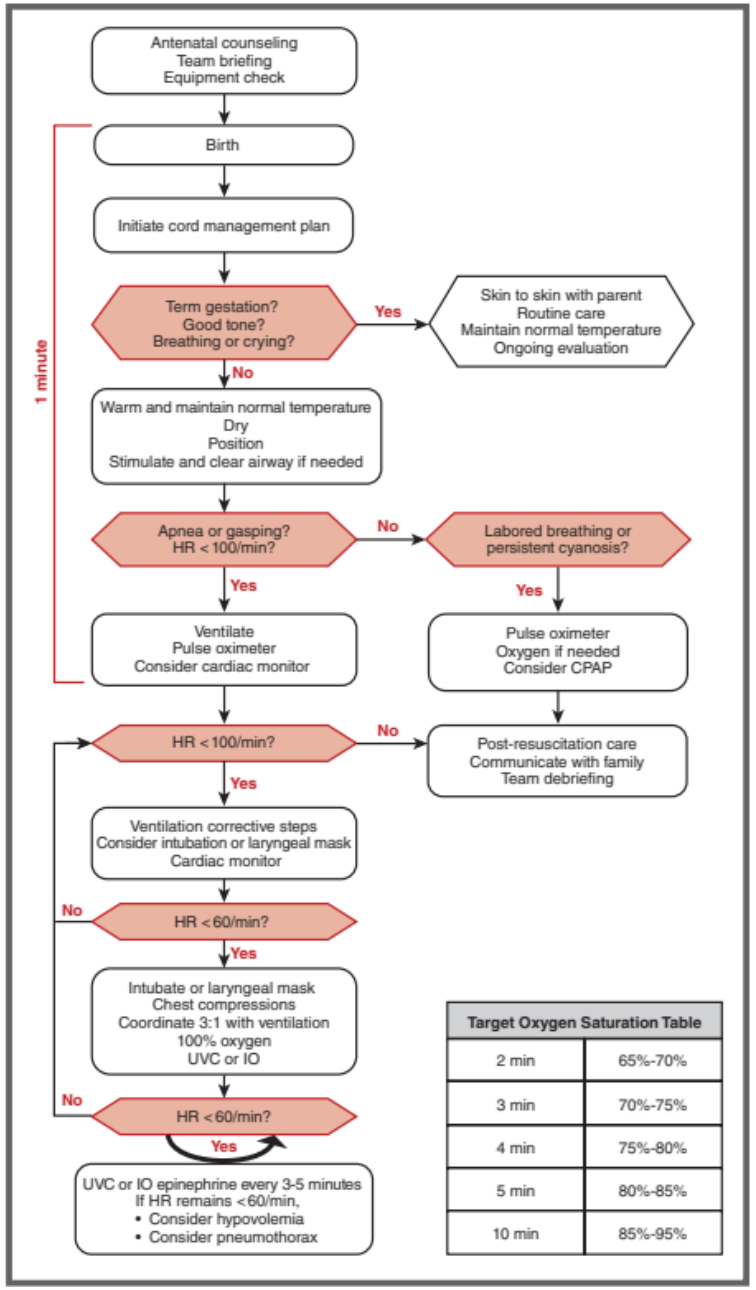


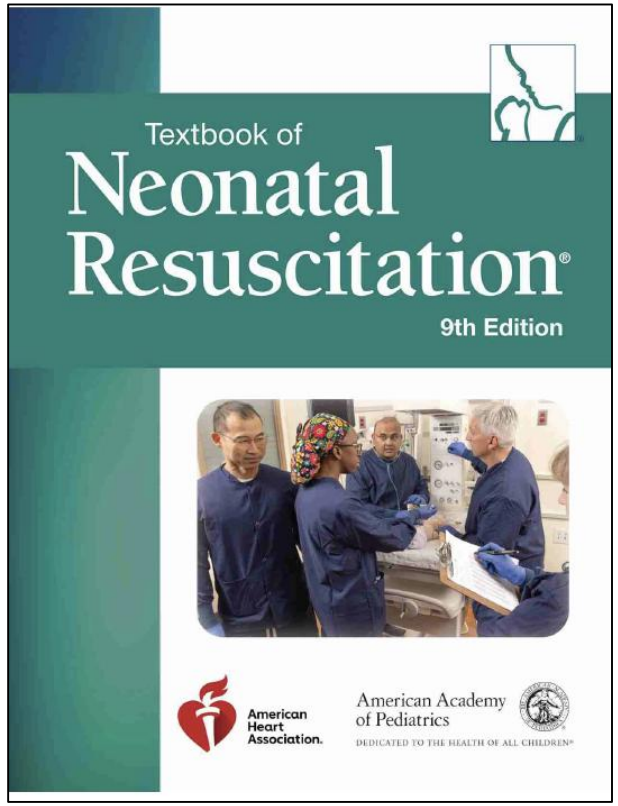
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

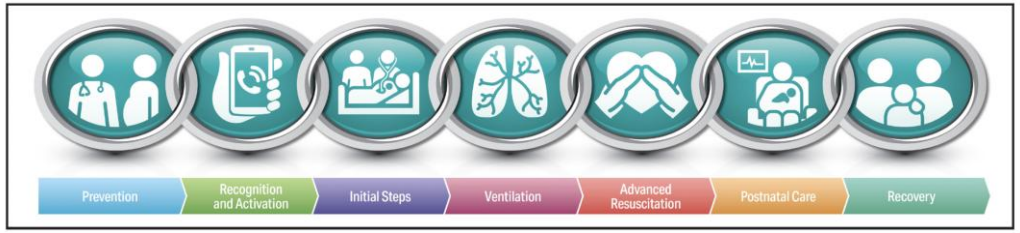
American Heart Association.

Neonatal Resuscitation Program®









Newborn chain of care

Prevention	**Optimal care during pregnancy**
Recognition & activation	**In utero transfer, Anticipate risks**
Initial steps	**Maintain normal temperature, defer UC clamping, skin-skin contact**
Ventilation	**CPAP, PPV, intubation**
Advanced resuscitation	**Chest compression, epinephrine, central line (UVC or IO)**
Postnatal care	**Monitor high-risk newborns (who need resuscitation beyond initial steps)**
Recovery	**Follow-up, promote short- and long-term health**

LESSON 1: Foundations of Neonatal Resuscitation

LESSON 2: Anticipating and Preparing for Resuscitation

LESSON 3: Initial Steps of Newborn Care

LESSON 4: Ventilation

LESSON 5: Endotracheal Intubation

LESSON 6: Chest Compressions

LESSON 7: Medications

LESSON 8: Resuscitation and Stabilization of Infants Born Preterm

LESSON 9: Post-resuscitation Care

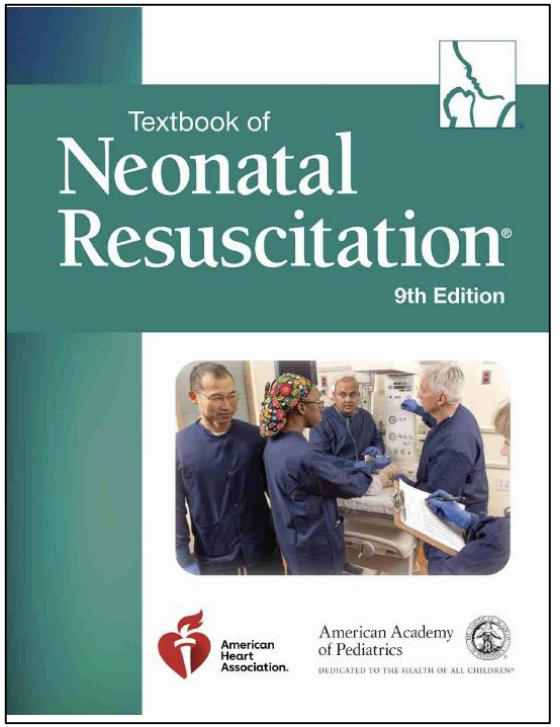
LESSON 10: Special Considerations

LESSON 11: Ethics and Care at the End of Life

LESSON 12: Improving Resuscitation Team Performance

LESSON 13: Resuscitation Outside the Delivery Room

LESSON 14: Bringing Quality Improvement to Your Resuscitation Team



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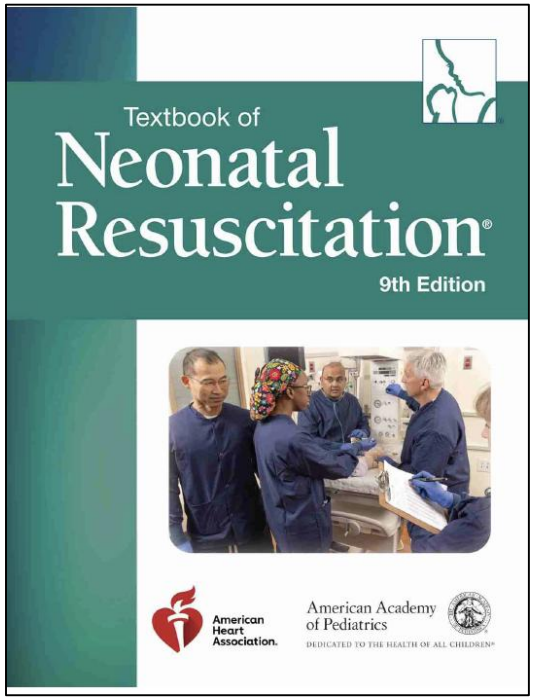
LESSON 14: Bringing Quality Improvement to Your Resuscitation Team

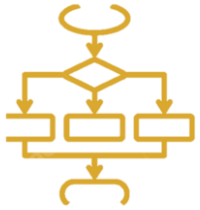
LESSON 15: Resuscitation and Stabilization of Newborn Infants With Congenital Heart Disease

LESSON 16: Resuscitation in the Neonatal Intensive Care Unit

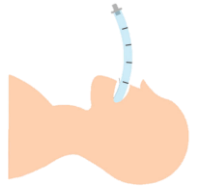


Practice Changes (14 points)

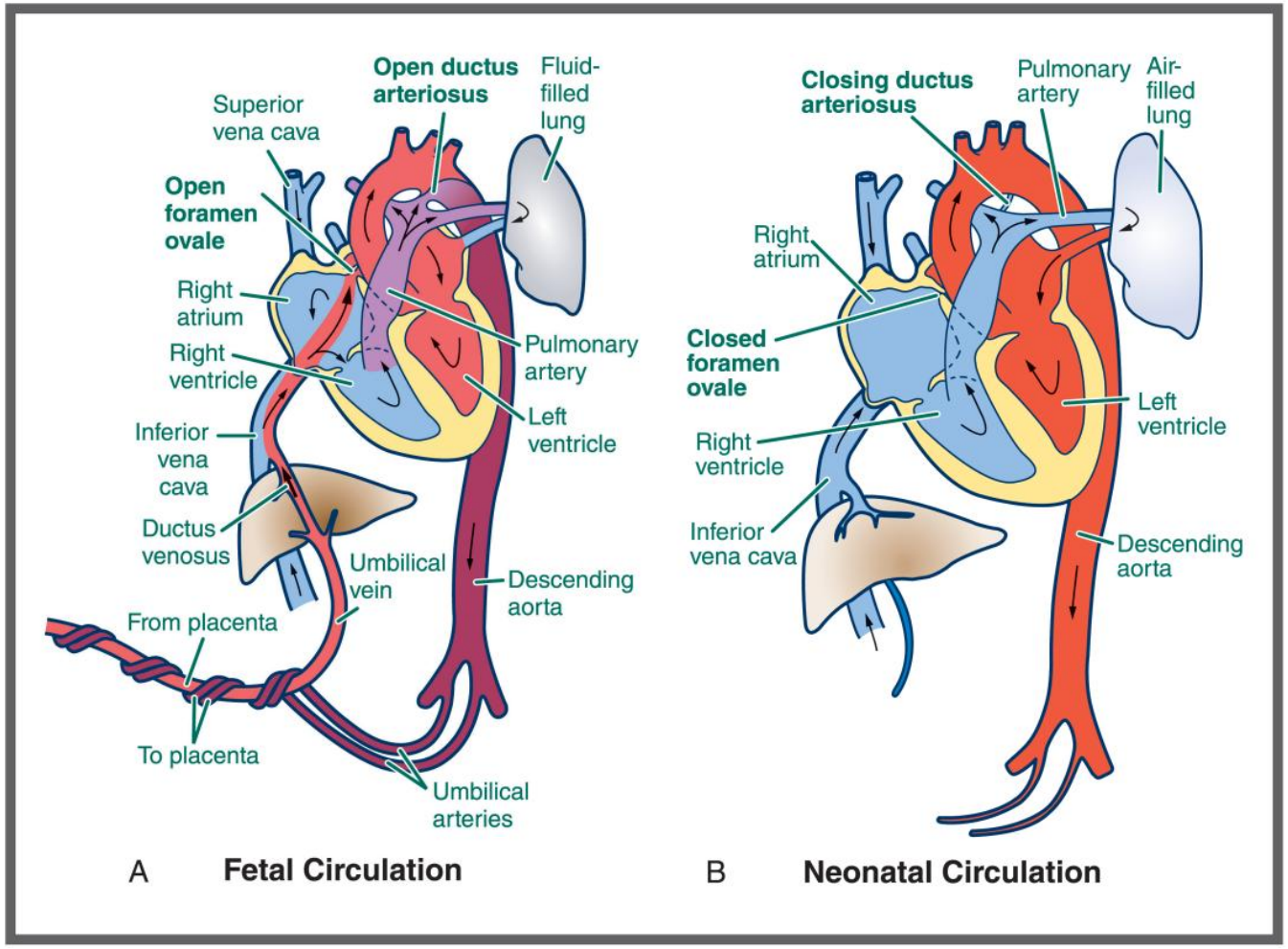
1. Add Birth & Initial cord management plan
2. Deferred cord clamping
3. Umbilical cord milking
4. Remove ‘suction’
5. Terminology of PPV
6. Target oxygen saturation table
7. Initial oxygen concentration for preterm
8. Initial peak inflation pressure (PIP)
9. Ventilation rate
10. Time period before ventilation corrective steps
11. Ventilation corrective steps sequence
12. LMA used as a primary device
13. ETT size
14. ETT depth





Fetal to neonatal circulation



- There is no gas exchange in the fluid-filled lungs of the fetus
- When a newborn infant breathes, pulmonary vessels relax, and blood flows to the air-filled lungs before returning to the left side of the heart

Goal of neonatal care at birth

- **Help to facilitate the transition**
- Fetus with fluid-filled uterine environment and placental circulation to the newborn relying on lung-based gas exchange
- The most important priority is the establishment of adequate lung inflation & ventilation

After birth

Within 30 sec after birth, 85% of term newborn infants will begin breathing

- 10% will begin breathing in response to drying and stimulation
- 5% require assisted ventilation
- 1% require intubation
- 1-3 per 1,000 newborn infants require chest compressions or emergency medications

Newborns are different from adults

Adult

- Adult cardiac arrest is commonly caused by coronary heart disease
- The lungs are filled with air during arrest
- Chest compression is the main

Newborn

- Fetal respiration is performed by the placenta
- Respiratory failure is the major problem (healthy heart)
  - Early phase: tactile stimulation may be able to initiate spontaneous breathing
  - Late phase: need assisted ventilation and beyond

Effective ventilation is the most important and effective step!

The Neonatal Resuscitation Program Algorithm

- **6 blocks**
- **1.** Preparation >> **2.** Initial evaluation >> **3.** A >> **4.** B >> **5.** C >> **6.** D
-  = assessment
-  = action
- Adequately performed the steps of each block before moving on to the next block

1

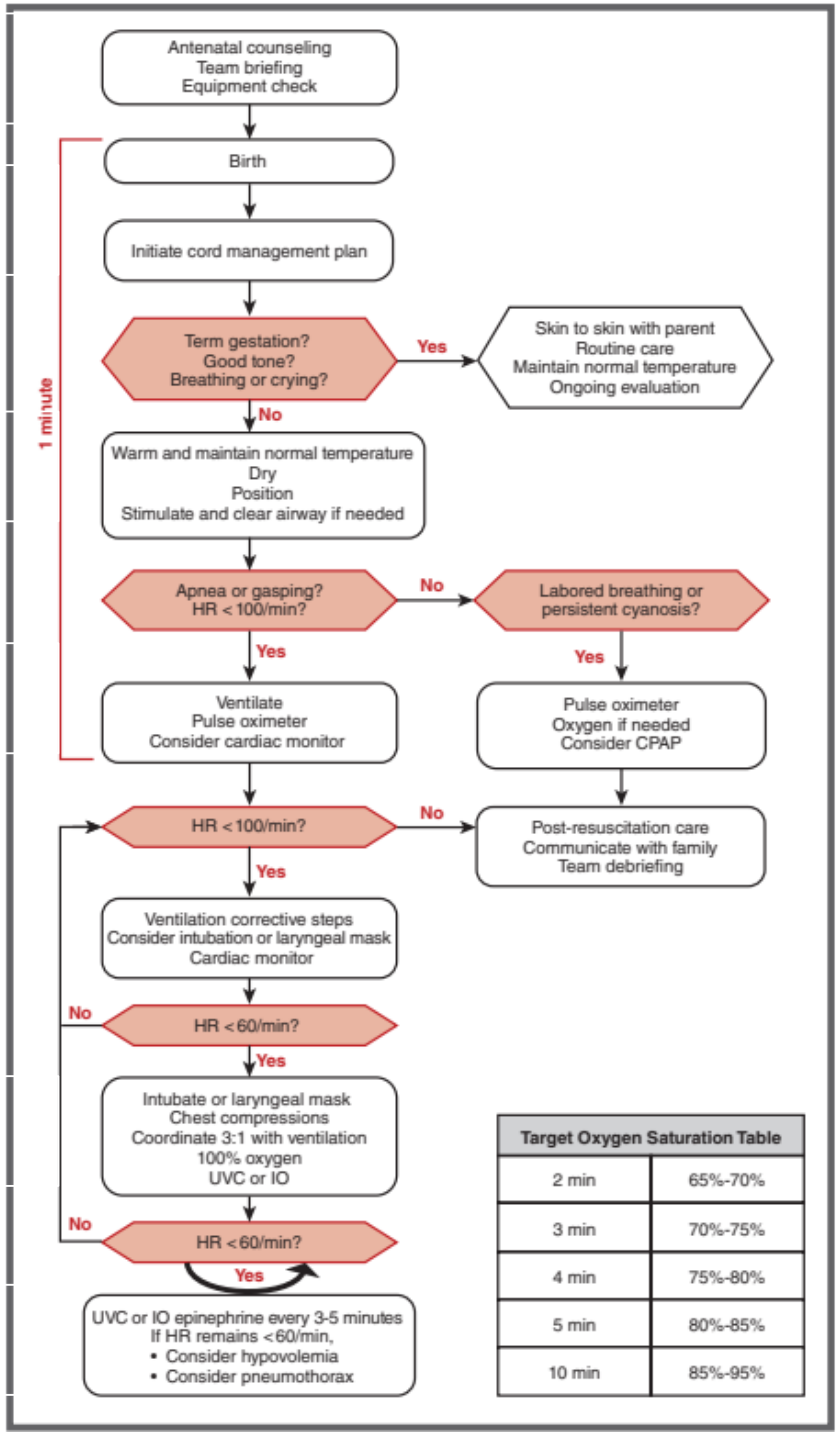
2

3

4

5

6



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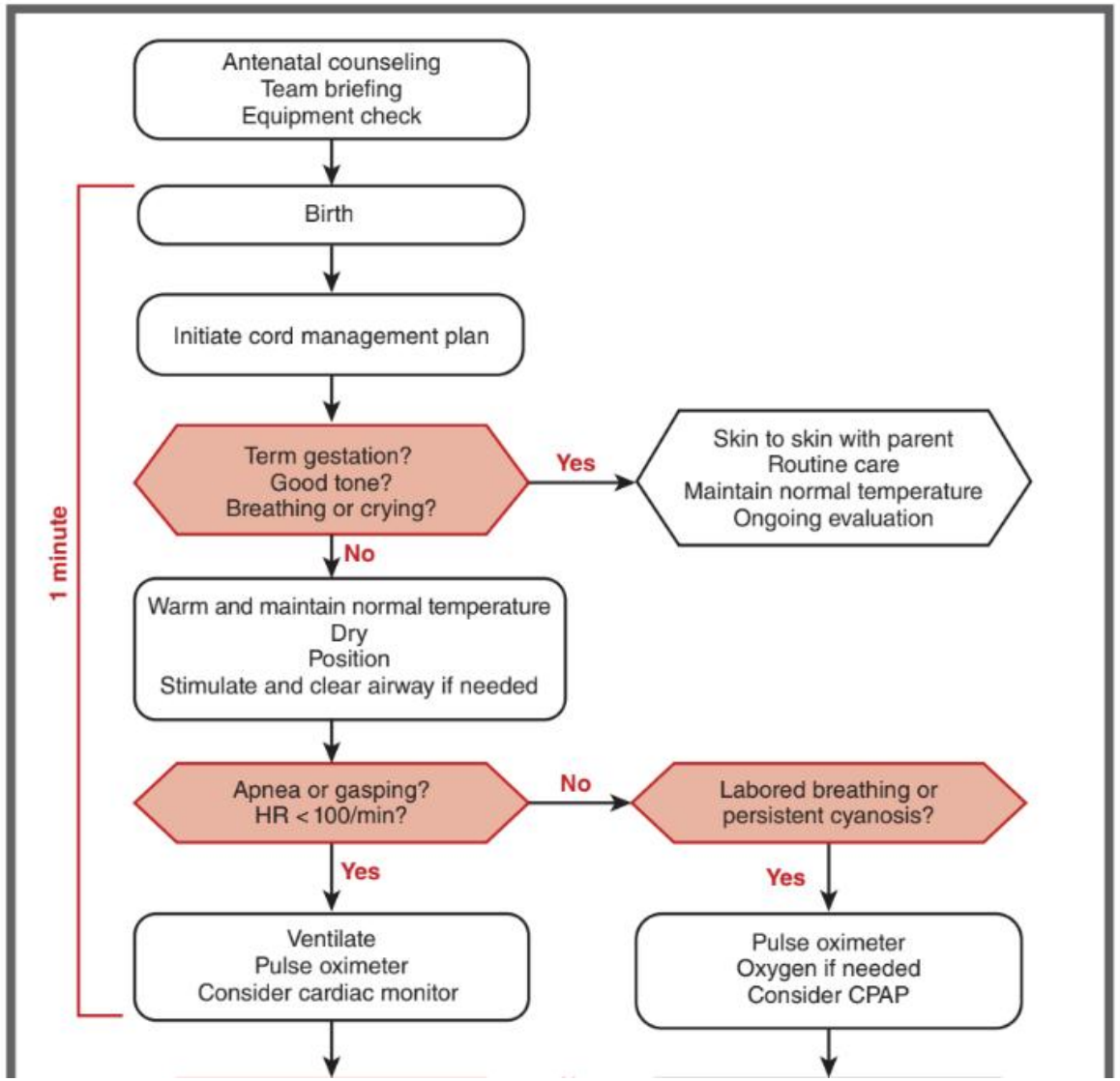

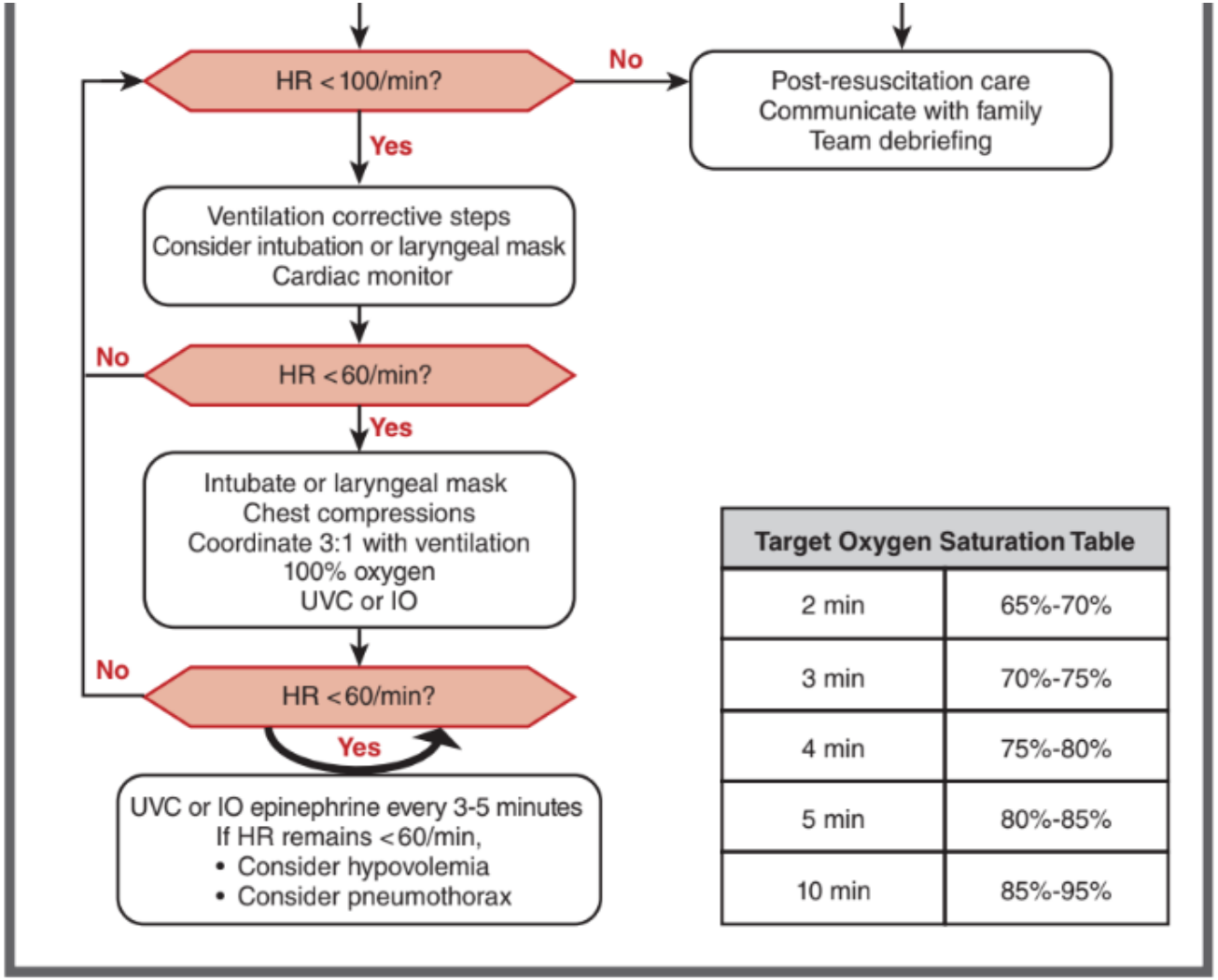

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Effective team

Teamwork

Communication

Leadership

Close-loop communication: direct the request to a specific individual, call your team member by name, make eye contact, speak clearly instructions, ask the receiver to report back as the task is completed

Anticipating and preparing for NCPR

- Some newborn infants without any risk factors will require resuscitation
- **Every birth** should be attended by **at least 1** qualified individual who can initiate resuscitation and whose only responsibility is managing the newborn infant
- If **risk factors +**, **at least 2** qualified individuals should be present
- If **advanced resuscitation** is needed, **the full team** should be present

BS

4 key questions

1. What is the expected gestational age?
2. Is the amniotic fluid clear?
3. Are there any additional risk factors?
4. What is the umbilical cord management plan?

Pre-resuscitation team briefing

- Assess risk factors
- Identify **the team leader**
- Review the resuscitation plan
- Anticipate potential complications and plan a team response
- Delegate tasks
- Identify who will document events as they occur
- Determine what supplies and equipment will be needed
- Identify how to call for additional help
- Address any concerns raised by team members

An effective team leader

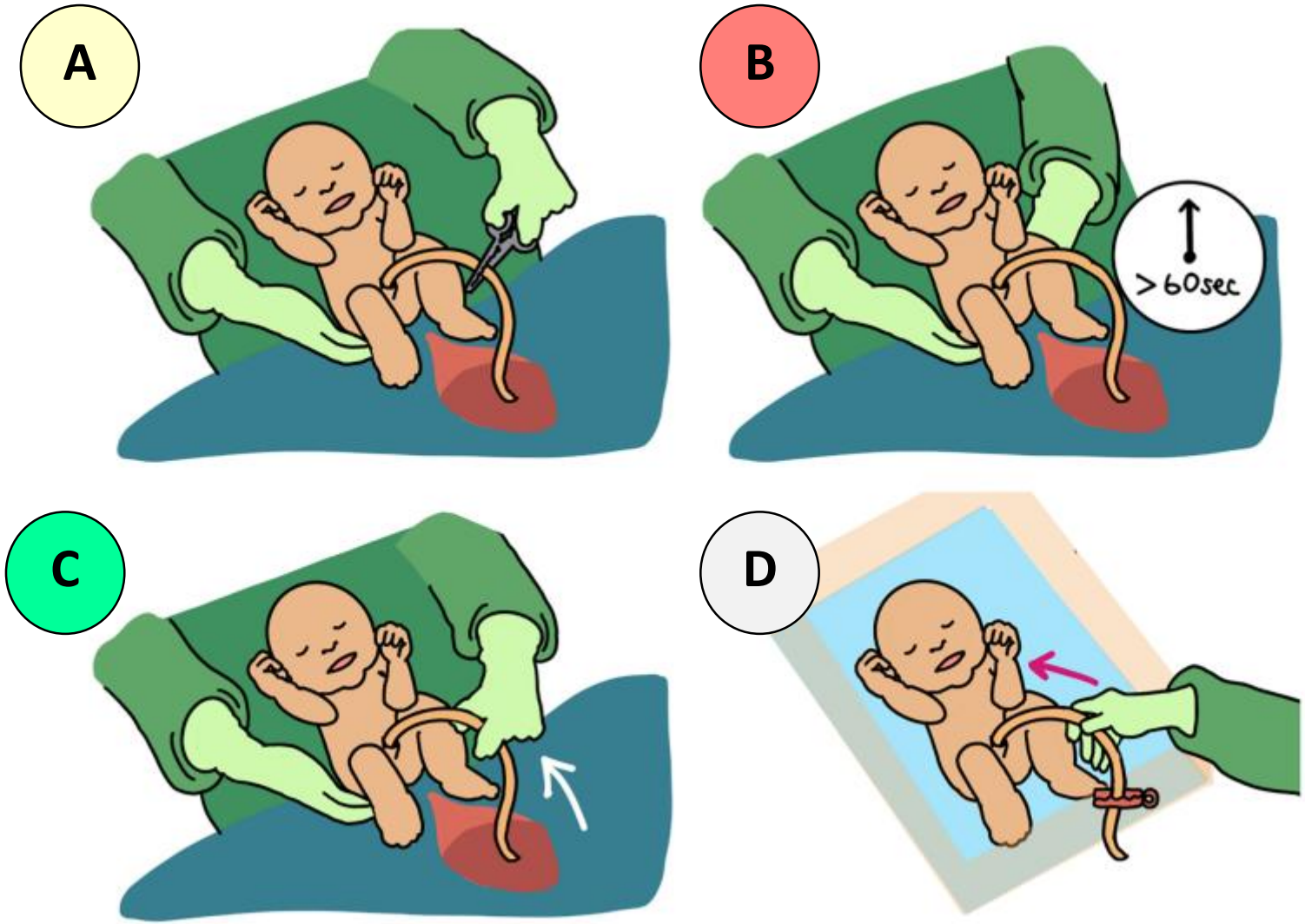
- Has **good communication skills**
  - Giving clear directions to specific persons
  - Sharing information
  - Delegating responsibilities to ensure coordinated care
  - Maintaining a professional environment
- Allowing all team members to contribute their unique talents
- Focus on "**a big picture**" not a single activity (situation awareness)
- If the leader is involved in a procedure, leadership should be handed over clearly to another qualified person
- A team leader does not have to be the most senior member

Cord management plan

- Before birth, establish the plan with the OB for the timing of umbilical cord clamping
- Benefits of deferred cord clamping (DCC)
  - Term: increased Hct and iron levels, improved neurological outcomes
  - Preterm: increased survival, less hypotension, and fewer blood transfusion

- **Cord management plan**
  - **Early cord clamping (ECC)**
  - **Deferred cord clamping (DCC)**
  - **Intact umbilical cord milking (intact ICM) - option**

Different methods of cord management



A: ECC, B: DCC, C: intact UCM, D: cord cut with CM

Koo J, Kilicdag H, Katheria A. Umbilical cord milking-benefits and risks. *Front Pediatr*. 2023;11:1146057.

Cord management plan

Indications of ECC

- Non-intact placental circulation: placental abruption, bleeding placenta previa, or cord avulsion
- Multiple gestations
- IUGR, poor uteroplacental flow

Vigorous newborns

- Most newborn infants do not require immediate resuscitation
- DCC for at least 60 sec
- Perform the initial steps during this time

Non-vigorous newborns

- No definite recommendation
- May briefly DCC while begins the initial steps >> then evaluate
- GA ≥35: who remain non-vigorous despite stimulation: intact UCM may be a reasonable
- GA 28 - 34: not enough evidence to recommend routinely intact UCM
- GA <28: not recommend intact UCM (due to associate with severe IVH)

Initial steps of newborn care

Initial evaluation

- To determine if they can be transitioned with their parent or if they should be moved to a radiant warmer
- **Rapidly ask 3 questions**
  - **Term?**
    - **Preterm** >> bring the infant to a radiant warmer
  - **Good muscle tone?**
  - **Crying or breathing?**
  - **If any “No”: bring the infant to a radiant warmer!**

Initial steps of newborn care

Term & vigorous

On the mother's chest/abdomen

- Provide warmth (skin-skin contact and cover with a warm blanket)
- Dry and discard wet towels
- Position the head & neck to open the airway
- Clear secretion if needed, by wiping the infant's mouth & nose with a cloth
- Assess - activity, breathing, color, tone and temp

Counting HR in 6 sec x 10

Non-vigorous term & Preterm

At a radiant warmer

- Provide warmth, monitor temp, and keep temp 36.5-37.5°C
- Dry and discard wet towels (use a plastic bag if GA <32 wk instead)
- Position the head & neck to open the airway
- Stimulate if needed by gently rubbing
- Clear secretion if needed using a syringe bulb or a suction catheter (-80 to-100 mmHg)
- Assess - breathing (apnea/gasping?) and then
  - HR (<100?)

Begin ventilation at 1 min of life if apnea, gasping or HR <100

Pulse oximeter

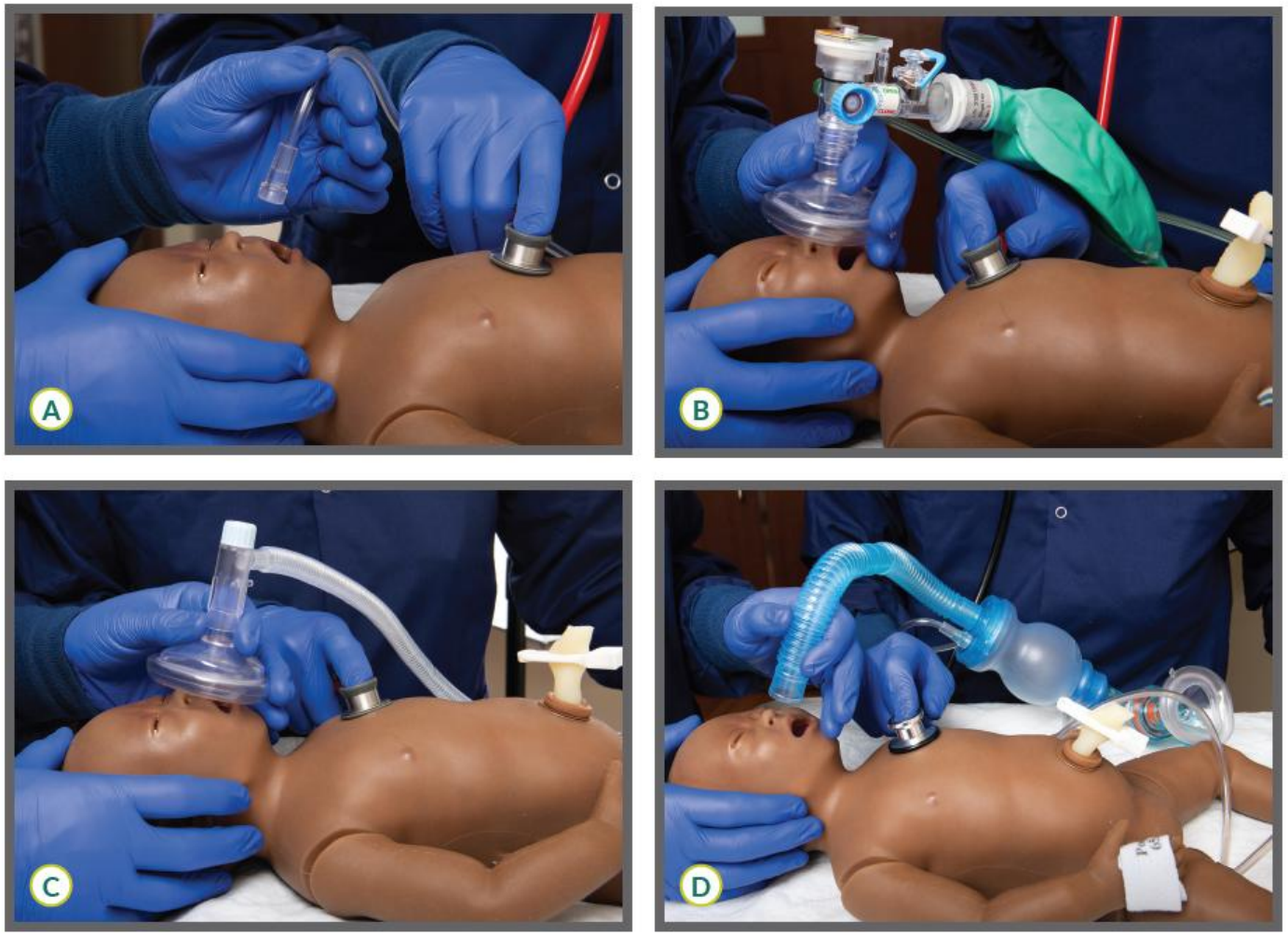
- **Indications**
  - When resuscitation is anticipated
  - To confirm your perception of persistent cyanosis
  - If supplemental oxygen is given
  - When assisted ventilation is required
- **Position**
  - The infant's right hand or wrist (pre-ductal)

Target saturation

2 min	**65-70%**
3 min	**70-75%**
4 min	**75-80%**
5 min	**80-85%**
10 min	**85-95%**

The ideal oxygen saturation for newborns right after birth is unclear and still debated

Free-flow oxygen supplementation

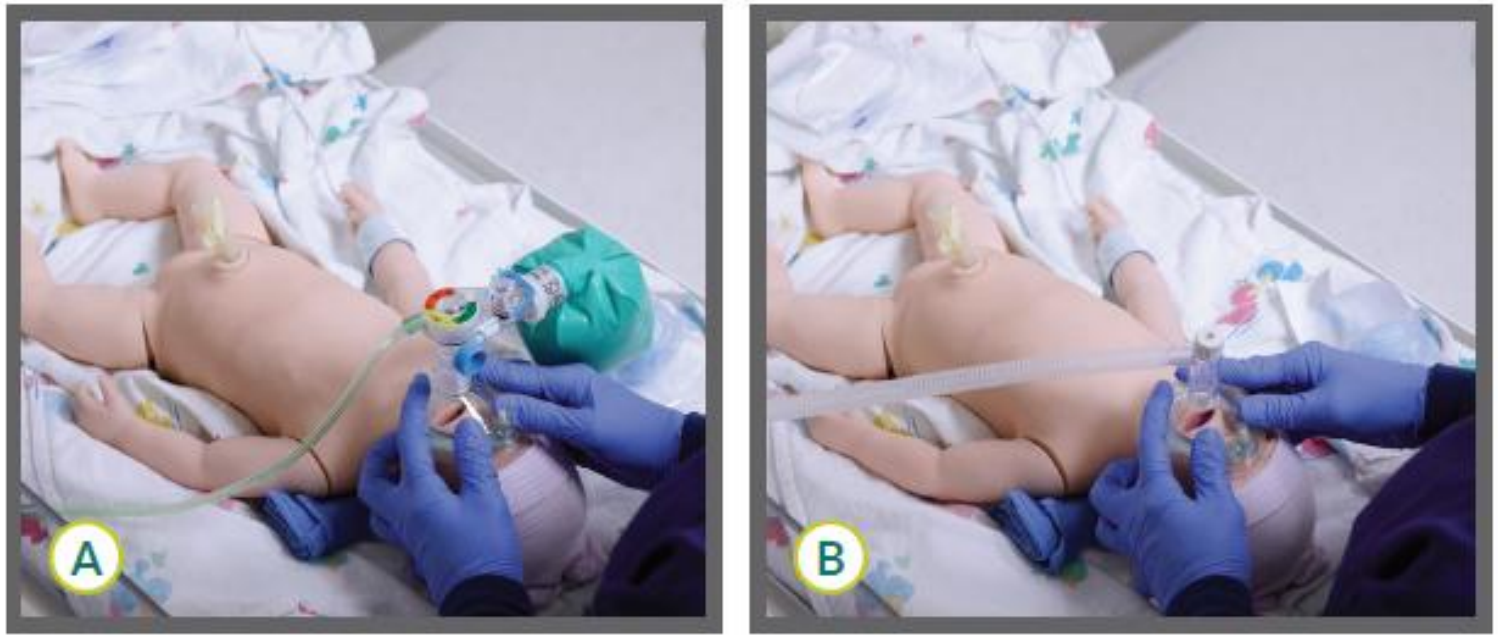


- Adjust the flow meter to 10 L/min
- Begin with 30% oxygen (using a blender)
- If a blender is not available, adjusting the FiO_2 by moving the tubing or mask closer to or farther from the face
- To prevent heat loss, if used for a prolonged period, gases should be heated and humidified

Continuous positive airway pressure (CPAP)

Indications

- Spontaneous but labored breathing
- Persistently low SpO_2 despite giving 100% free-flow oxygen



Meconium-stained amniotic fluid (MSAF)

- Need at least 2 qualified people
- Routine laryngoscopy with or without intubation for tracheal suction is not suggested

Vigorous newborns

- May stay with the parent for the initial steps of newborn care

Non-vigorous newborns

- May briefly DCC and begin the initial steps of newborn care

Ventilation

- After completing the initial steps, assisted ventilation is indicated if
  - No breathing (apneic) *OR* gasping
  - HR <100 bpm
  - Breathing and HR ≥100 bpm, but the SpO_2 cannot be maintained within the target range despite the use of free-flow supplemental oxygen or CPAP
- Should be started within 1 min of birth
- 3 types of devices used for ventilation
- Call for help if you are alone

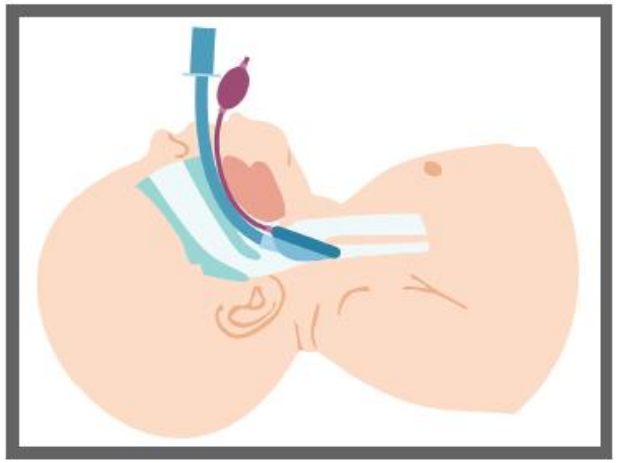
Ventilation

- Position yourself at the newborn infant’s head.
- Position the newborn infant’s head and neck - sniffing
- Position the mask on the newborn infant’s face, rest on the chin and cover the mouth and nose, but not the eyes
- 1-hand hold or 2-hand hold

Laryngeal Mask Airway – primary device

It may be used as

- **The initial ventilation device instead of a resuscitation face mask**
- **An alternative to endotracheal intubation**
- **Size 0-1**
- **~ 2-5 kg - infants**



Initial settings for ventilation

FiO_2	≥35 weeks = 21% 32-34 weeks = 21%-30% <32 weeks ≥30%
Gas flow	10 LPM
Rate	30-60 bpm
PEEP	Initial 5 cm H_2O
PIP	25 cmH_2O Range: ≥32 weeks = 25-30 cmH_2O <32 weeks = 20-25 cmH_2O

Ventilation

- **30 - 60 bpm**
- Use the rhythm…"**breathe,** two, three*;* **breathe,** two, three*;* **breathe,** two, three…

Target saturation

9th edition	
2 min	65-70%
3 min	70-75%
4 min	75-80%
5 min	80-85%
10 min	85-95%

If the HR is increasing

✓

>> Continue ventilation and check HR after 30 sec after ventilation

If HR is not increasing

✘

- **Chest is moving**

  >> Continue ventilation and check HR after 30 sec after ventilation

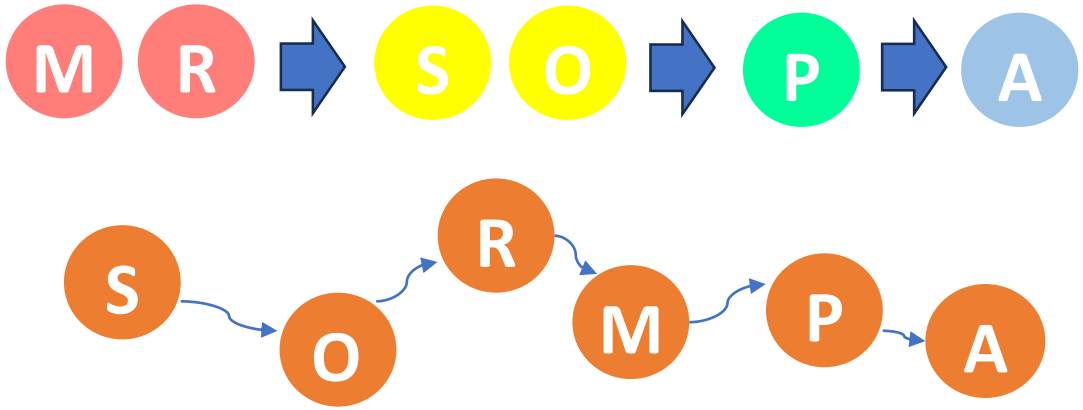
- **No chest movement**

  >> Start ventilation corrective steps

Time period before ventilation corrective steps: 15-30 sec of starting ventilation

Ventilation Corrective Steps Sequence

- Based on your assessment of the infant and clinical situation
- May choose the steps that are most likely to be helpful and prioritize the order



The MR SOPA Ventilation Corrective Steps

Corrective steps	Actions
M: Mask adjustment.	Reapply the mask and lift the jaw forward Consider the 2-hand hold
R: Reposition the head & neck.	Place head neutral or slightly extended
S: Suction the mouth and nose.	Use a bulb syringe
O: Open the mouth.	Use a finger to gently open the mouth.
P: Pressure increase.	Increase in 5–cmH_2O increments. Max pressure is 40 in term, 30 cm H_2O in preterm.
A: Alternative airways.	Insert a laryngeal mask or an endotracheal tube

You may choose the steps that are most likely to be helpful and prioritize the order in which you perform them

Using a carbon dioxide detector to help assess the effectiveness of ventilation

Endotracheal intubation

Indications

- HR <100 bpm and is not increasing after optimizing ventilation with a face mask or LMA
- Before starting chest compressions
- For direct tracheal suction due to thick secretion
- Congenital anomalies such as CDH

*If intubation is not successful, may use an LMA during chest compressions

Endotracheal intubation

Straight Miller laryngoscope blade

- For term newborn: size No. 1
- For preterm newborn: size No. 0
- For ELGAN#: size No. 00

#ELGAN, extremely low gestational age infants

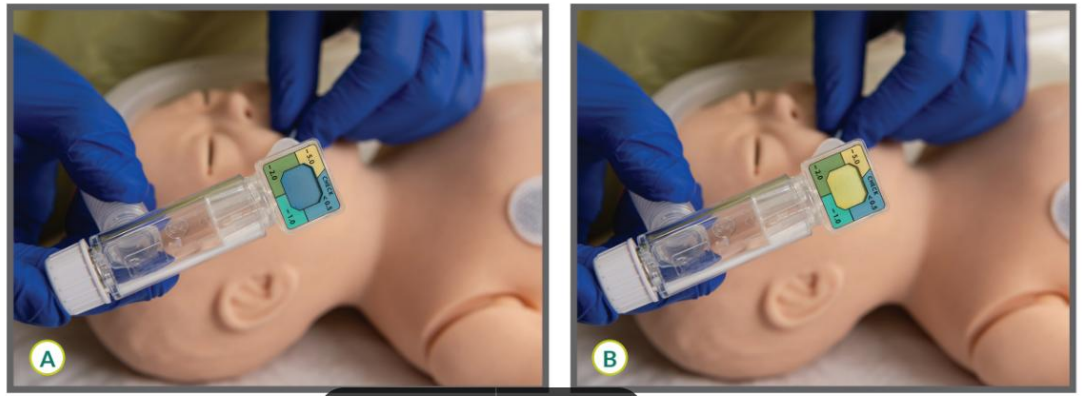
Endotracheal Tube Size

Weight (g)	GA (wk)	ETT size*
<800	22-25	2.5**
800-1200	26-28	2.5
1201-2200	29-34	3.0
>2200	>34	3.5

*ETT size (mm ID)
**2.0 mm ID ETT (optional) may be considered

Endotracheal intubation

- The intubation should be completed within approximately 30 sec
- The primary methods of confirming ETT insertion within the trachea are detecting exhaled CO_2 and a rapidly rising HR



- If ventilation with a correctly inserted ETT does not result in chest movement, suspect airway obstruction >> direct tracheal suction

Endotracheal intubation

1 Endotracheal Tube Depth – Tip to gum

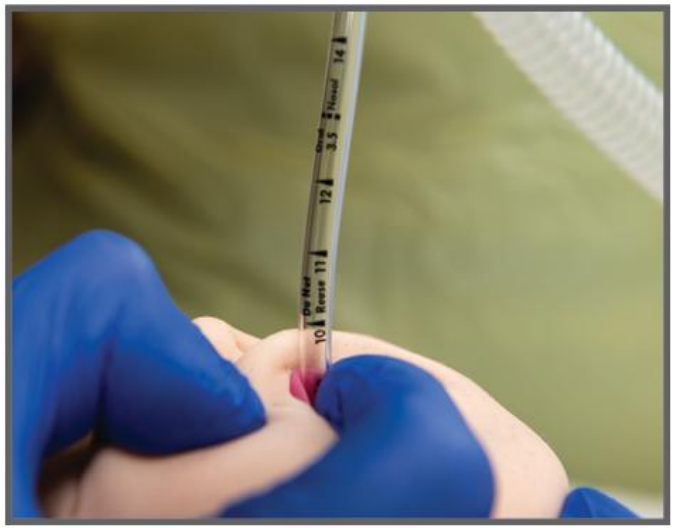
GA	Depth (cm.)	BW (g)
<23	5.0-5.5	<500
23-24	5.5	500-600
25-26	6.0	700-800
27-29	6.5	900-1000
30-32	7.0	1100-1400
33-34	7.5	1500-1800
35-37	8.0	1900-2400
38-40	8.5	2500-3100
41-43	9.0	3200-4200

2 The nasal-tragus length (NTL)

The estimated insertion depth = NTL + 1 cm.

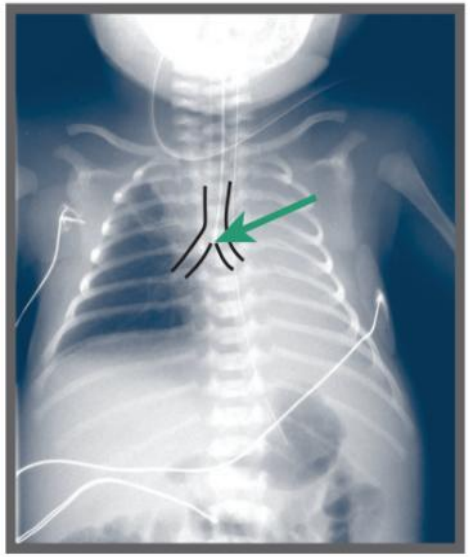
Endotracheal intubation

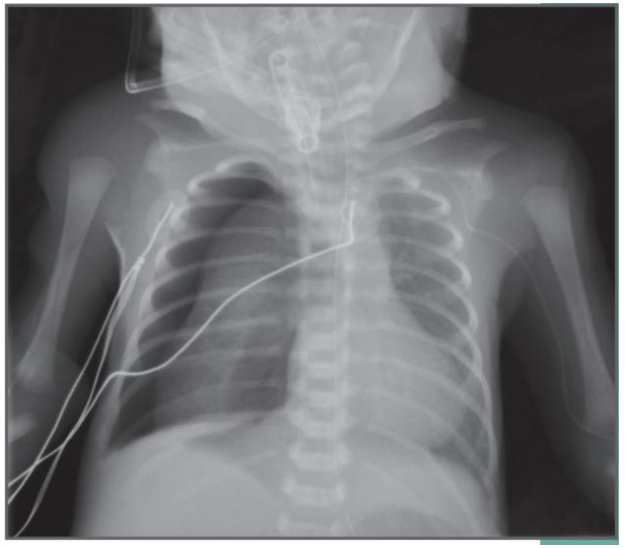
- **The ETT depth is measured to the anterior edge of the baby's upper gum in the midline**
- **Tip-to-gum instead of tip-to-lip**



DOPE

- If a newborn infant's condition worsens after endotracheal Intubation: "**DOPE mnemonic**"






Chest compressions

Indications

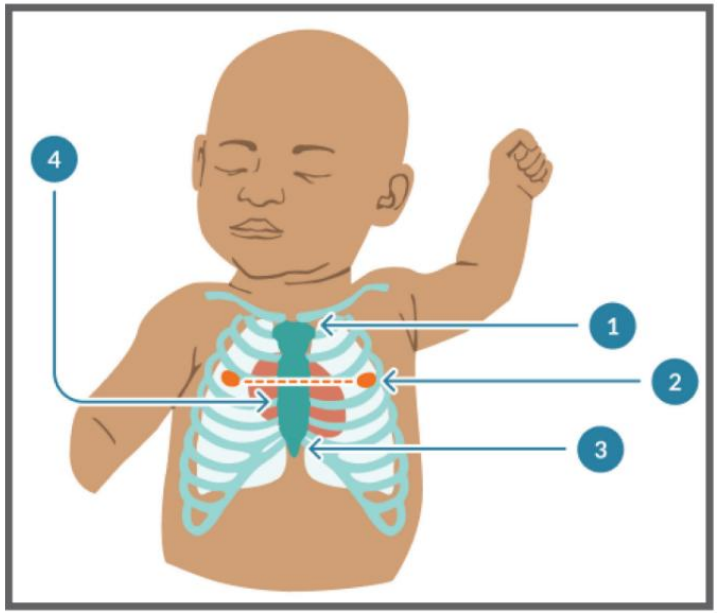
- HR <60 bpm despite at least 30 sec of ventilation that inflates the lungs (chest movement)
- Chest compressions are not indicated before achieving effective ventilation

Chest compressions

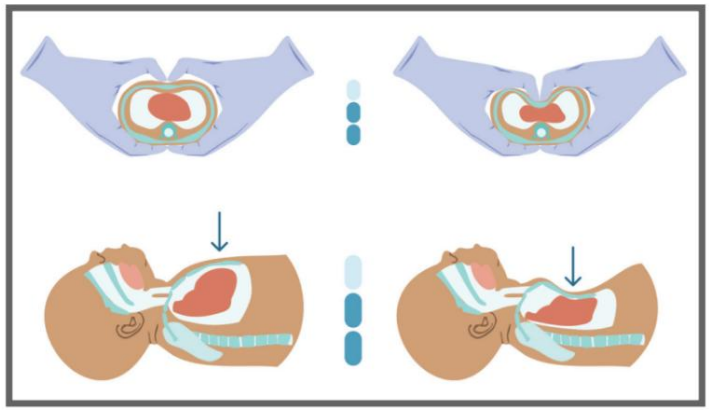
- Ventilation should have been provided through a properly inserted ETT
- If compressions are started, call for help >> preparing for vascular access and epinephrine administration
- Once intubation is completed and the tube is secure, the compressor should move to the head of the bed

Chest compressions

Position	At the head of the bed
Technique	2-thumbs
Depth	1/3 of AP diameter
location	the lower third of the Sternum (just below an imaginary line connecting the infant's nipples
Rate	120 per min
Ratio	3 CC + 1 vent during each 2 sec-cycle
Rhythm for coordination	1-and-2-and-3-and-breath, 1-and-2-and-3-and-breath (and = chest recoil)
FiO_2	100%
Duration	60 sec



1. Sternum, 2. Nipple line, 3. Xiphoid, 4. Compression area



Chest compressions

- A cardiac monitor is the preferred method for assessing HR
- After administering chest compressions for 2-5 min, the compressor may experience fatigue >> consider changing roles
- Stop chest compressions when HR is ≥60 bpm
- When HR is not improving with compressions and ventilation:
  - ETT / LMA properly inserted?
  - Chest moving?
  - Use 100% oxygen?
  - 3:1 in 2 sec-cycle?
  - Compression 1/3 of AP diameter?

Epinephrine

Indications

- If the infant's HR <60 bpm after
  - At least 30 sec of ventilation with chest movement, **and**
  - Another 60 sec of chest compressions coordinated with ventilation using 100% O_2

Epinephrine

Conc	**1:10,000**
Preferred route	IV > IO > ETT
Dose IV and IO	0.2 mL/kg (0.1-0.3)
Dose ETT	1 mL/kg (0.5-1)
Administration	Rapidly infuse
Flush for only IV and IO	3 mL-NSS
Timing for assessment	1 min after administration
Repeat	Every 3-5 min

Volume expander

Indications

- If not responding to the steps of resuscitation and there are signs of shock or a history of acute blood loss

Volume

Type	NSS
	PRC gr O (if severe anemia)
Dose	10 mL/kg
Administration	5-10 min
* (Use caution with preterm infants whose GA <32 weeks)	

Medications

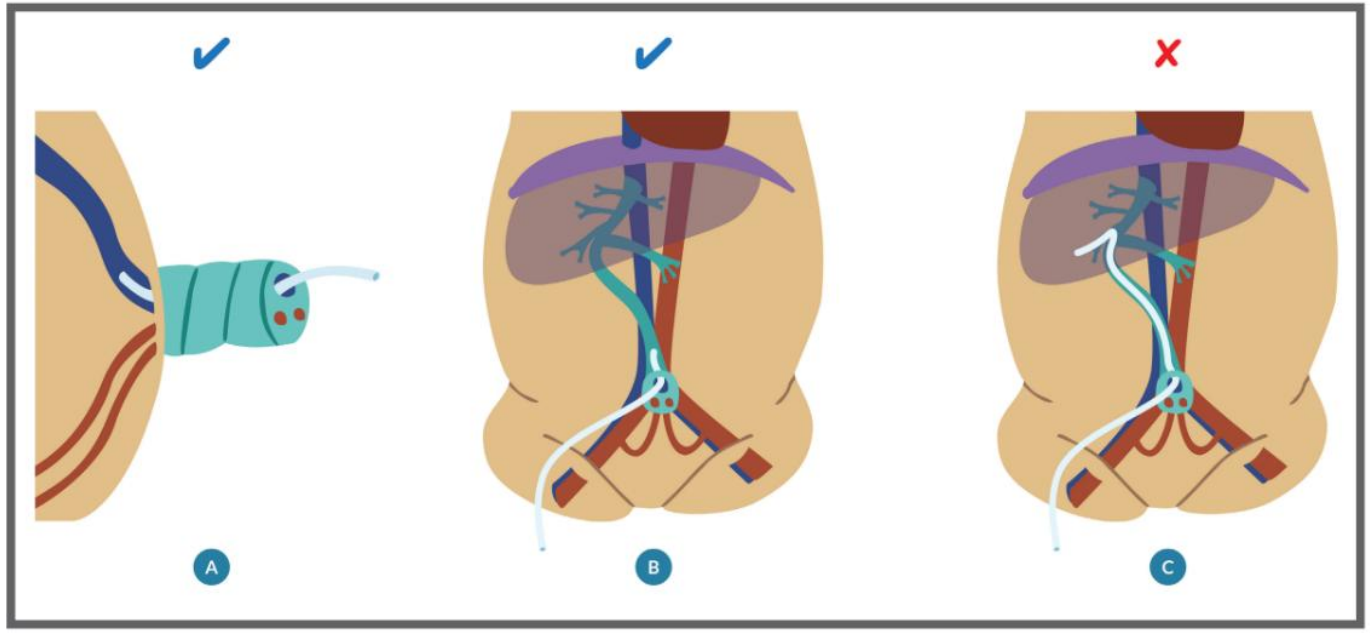
- When HR is not improving with ventilation, compressions, epinephrine, and volume expander:
  - ETT / LMA properly inserted?
  - Chest moving?
  - Use 100% oxygen?
  - 3:1 in 2 sec-cycle?
  - Compression 1/3 of AP diameter?
  - Correct dose of epinephrine?
  - Dislodgement of UVC line / IO?
  - Pneumothorax or pericardial effusion?

Cessation of CPR

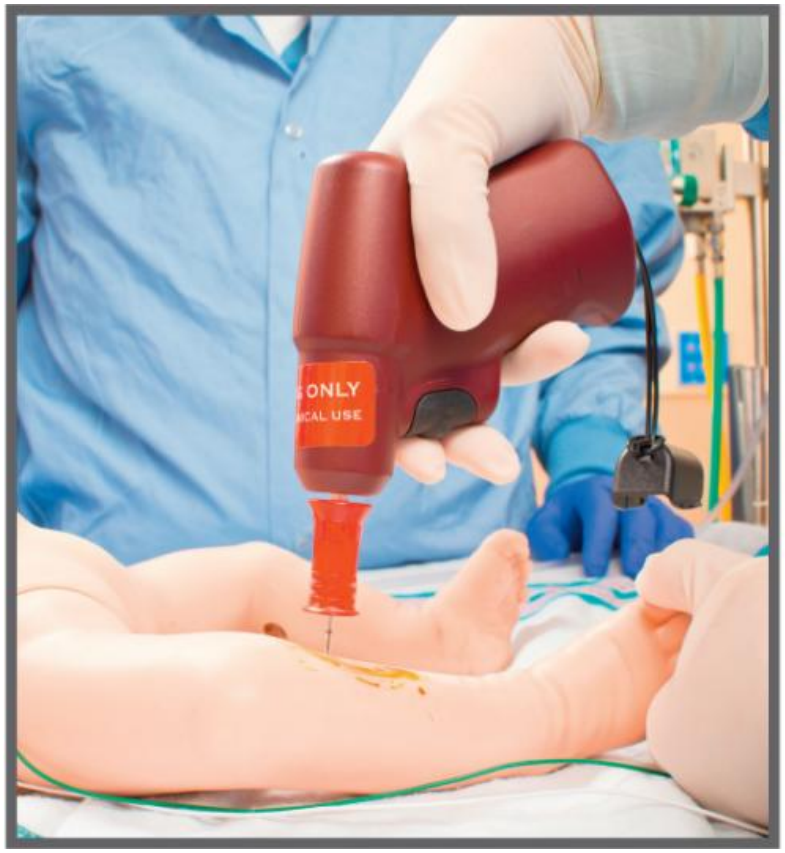
- A reasonable time frame for considering cessation of resuscitation efforts is around 20 min after birth; based on patient and contextual factors

UVC insertion

- 3.5 or 5 Fr
- 3-4 cm beyond the abdominal wall, can aspirate a free flow of blood



Intraosseous



- Approximately 2 cm below and 1-2 cm medial to the tibial tuberosity
- Correct needle insertion is indicated by the feeling of being firmly secured in the bone and not wiggling (not blood drawn)

Resuscitation and Stabilization of Infants Born Preterm

Measures to keep the preterm newborns warm

- Set the room temp to 23-25°C
- Preheat the radiant warmer well before the time of birth
- After delivery, quickly place a hat on the head
- Use a prewarmed transport incubator
- Maintain the infant's axillary temperature between 36.5-37.5°C
- If GA <32 week
  - Use a thermal mattress as an additional heat source
  - Wrap the newborn infant in a polyethylene plastic bag or wrap

Decreasing the risk of neurologic injury in preterm infants

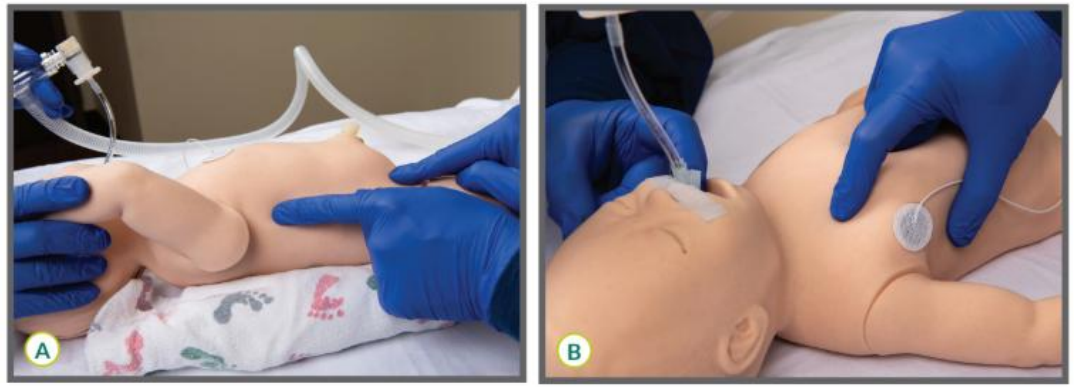
- Handle the newborn infant gently
- Do not position the newborn infant's legs higher than the head

  (Trendelenburg position)
- Avoid using high pressure during ventilation or CPAP
  - Use the lowest PIP necessary to achieve and maintain HR >100 bpm
  - Maximum inflation pressure is 30 cmH_2O
- Use a pulse oximeter and blood gases to monitor and adjust ventilation and FiO_2
- Do not rapidly infuse intravenous fluids (>5-10 min)

Special considerations

Pneumothorax

- 4th ICS at the anterior axillary line or
- 2nd ICS at the midclavicular line



Pleural effusion

- 5th-6th ICS along the posterior axillary line

Special considerations

Gastroschisis

- Position the infant and exposed bowel on the right side to optimize perfusion
- Avoid prolonged face mask ventilation to prevent air from distending the bowel
- Insert an OG
- In an emergency, an UVC can be inserted

Omphalocele

- Position the infant and omphalocele on the right side to optimize perfusion
- Avoid rupturing the sac
- Newborns with large omphaloceles may require respiratory support, including CPAP or mechanical ventilation
- An umbilical vein catheter cannot be used for emergency vascular access

HLHS with RAS/IAS

D-TGA with RAS/IAS

TOF with absent pulmonary valve

Ebstein anomaly

TAPVR with obstruction

Heart block

Tachyarrhythmia

6 CHD additional pre-delivery Questions

- Heart lesion?
- Additional factors to ask in prebrief that change stability and preparation?
- Stability (immediately after birth)?
- Heart Rate target?
- Oxygenation target?: oxygen use
- Perfusion/ Systemic BF?
- Meds, Equipment, Extra People needed

HAS ROP MEEP

6 cardiac-specific pre-delivery questions	Answers
Heart lesion?	TOF
Additional factors to ask in prebrief that change stability and preparation?	The degree of cyanosis after birth depends on the degree of obstruction across the pulmonary valve
Any modification to the heart rate targets?	No
Any modifications to the SpO_2 targets?	With significant pulmonary valve obstruction, the modified pre-ductal target SpO_2 will be 75%-85% by approximately 10 minutes after birth or as recommended by the cardiologist
Is this CHD expected to cause problems with systemic blood flow or perfusion?	No
What additional equipment, medications, or personnel are needed?	PGE infusion may be required. Notify cardiology and the critical care unit following institutional guidelines

Table 15-2. Congenital Heart Disease at High Risk for Instability in the Delivery Room

Congenital Heart Disease	Low Oxygen Saturation	Abnormal Heart Rate	Decreased Systemic Perfusion	Stabilization Steps to Consider
HLHS with RAS or IAS	Yes	No	Yes	Intubate, sedate and paralyze, PGE infusion, emergent cardiology intervention.
d-TGA with RAS or IAS	Yes	No	Yes, severe hypoxemia from poor mixing may reduce systemic perfusion.	Intubate, sedate and paralyze, PGE infusion, emergent cardiology intervention.
TOF with absent pulmonary valve	Possible respiratory failure due to airway compressions	No	No	Prone position, intubation, sedate and paralyze.
Ebstein	Possible depending on severity	Possible tachyarrhythmias	Possible depending on severity	Multiple potential interventions required.
TAPVR with obstruction	Not immediately but respiratory failure may develop soon after birth	No	No	Vascular access.
Tachyarrhythmia with heart failure	No	Yes	Yes	Vascular access, rate control (adenosine or cardioversion).
Heart block with heart failure	No	Yes	Yes	Vascular access, rate control (epinephrine or isoproterenol).

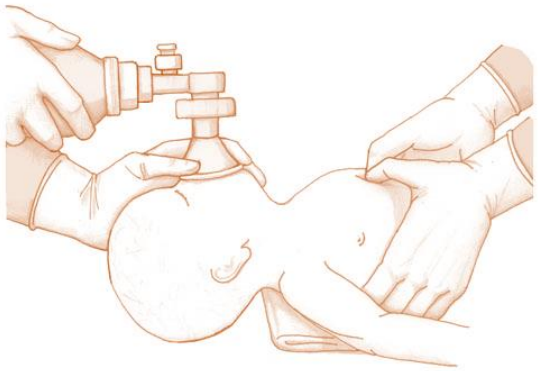
NRP or PALS

Resuscitation in the Neonatal Intensive Care Unit

What you will learn

- The unique aspects of resuscitation in the neonatal intensive care unit (NICU)
- Common causes of clinical decompensation among infants in the NICU
- Basic emergency management of arrhythmias in the NICU
- Considerations for cardiopulmonary arrest prevention and post-resuscitative care in the NICU
- When to consider using pediatric resuscitation algorithms and guidelines

Supplemental Lesson 16



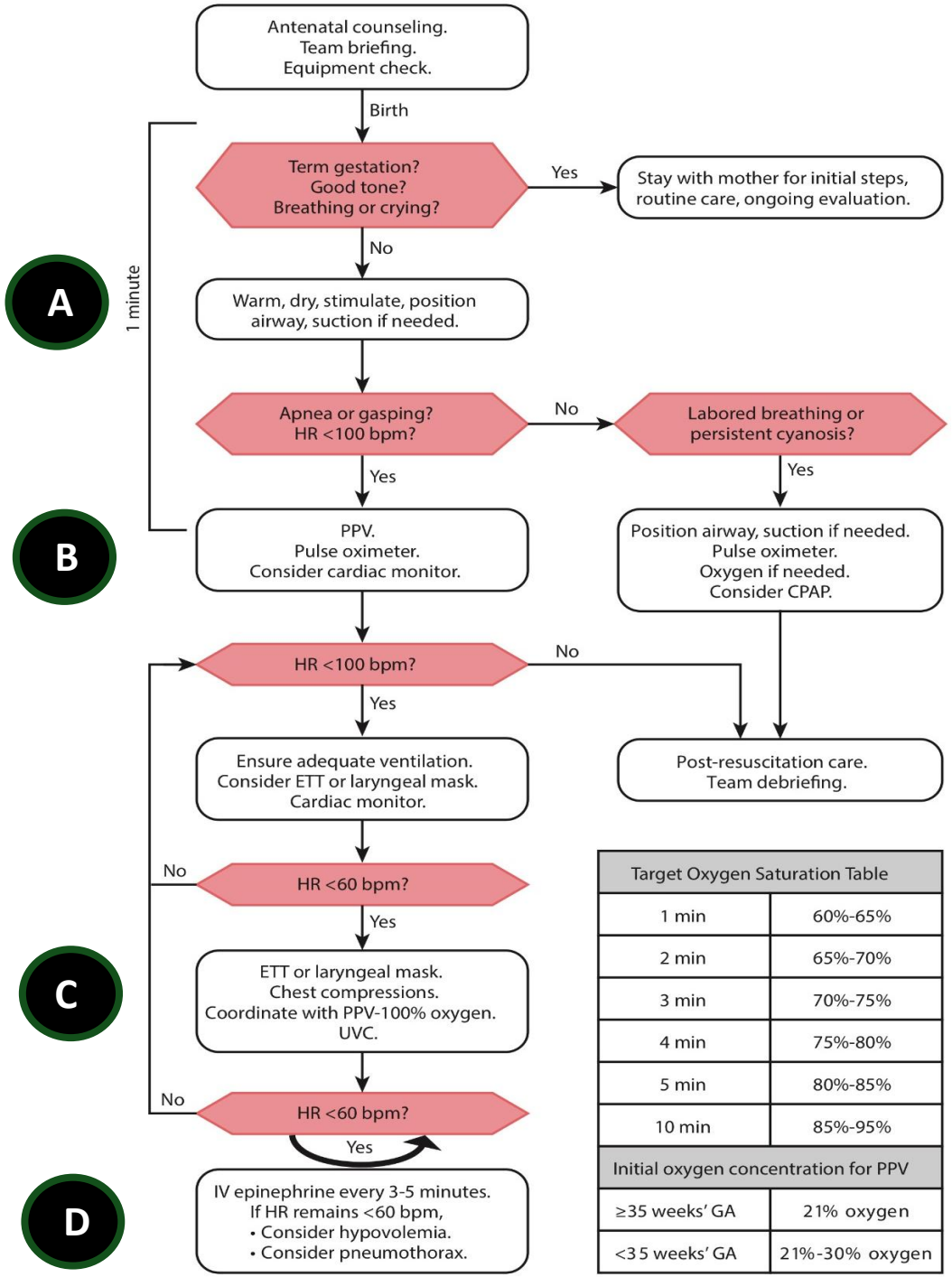
NRP

PALS
PEDIATRIC ADVANCED LIFE SUPPORT

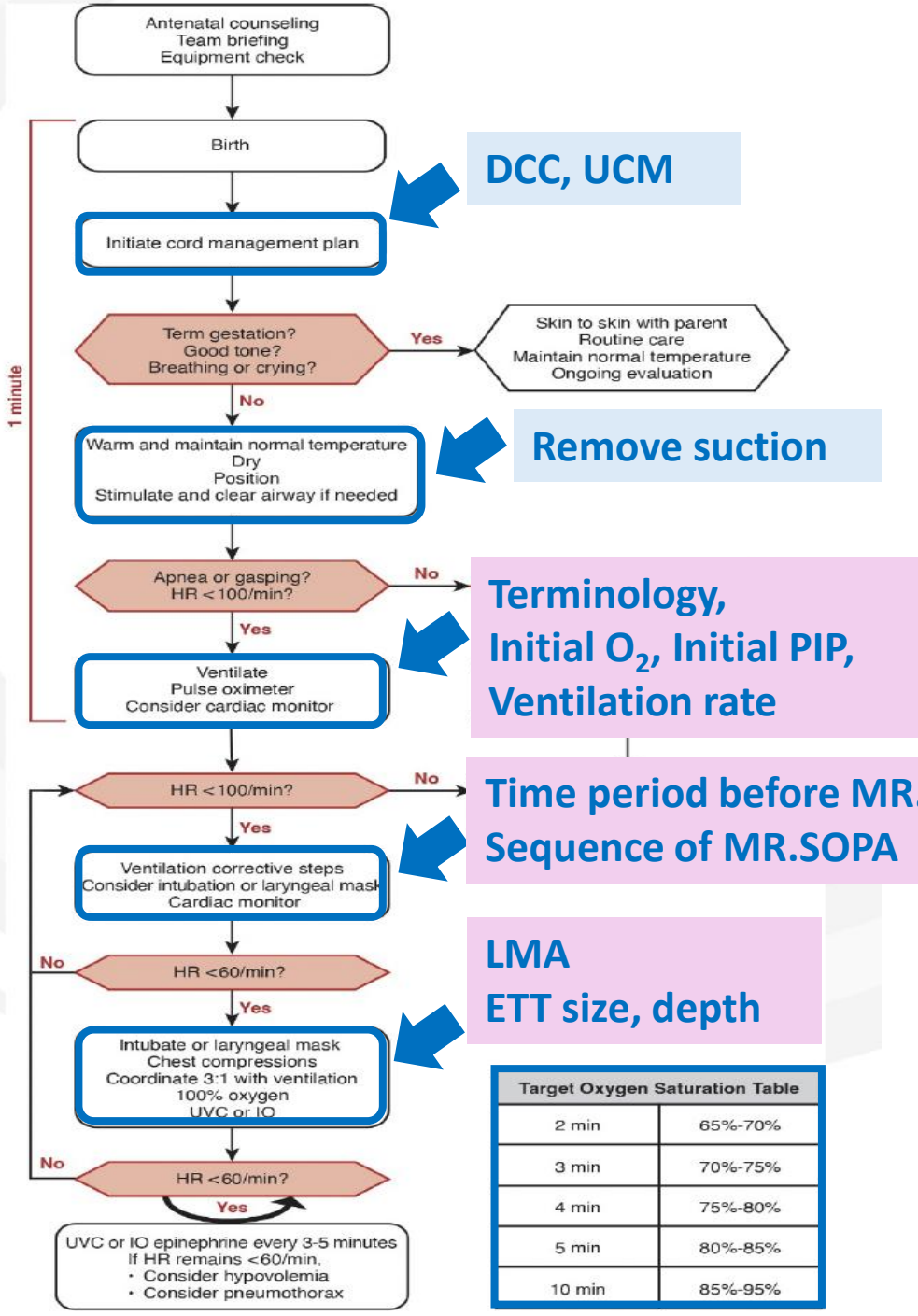
Common causes of clinical decompensation in NICU

- **Acute respiratory compromise**
- **Cardiovascular compromise**
  - Shock
  - Pericardial effusion and cardiac tamponade
  - Arrhythmia (brady-/tachyarrhythmia)

If a primary cardiac etiology for cardiopulmonary arrest is suspected, the ventilation-to-compression ratios recommended in the PALS program may be considered



Target Oxygen Saturation Table	
1 min	60%-65%
2 min	65%-70%
3 min	70%-75%
4 min	75%-80%
5 min	80%-85%
10 min	85%-95%
Initial oxygen concentration for PPV	
≥35 weeks' GA	21% oxygen
<35 weeks' GA	21%-30% oxygen



DCC, UCM

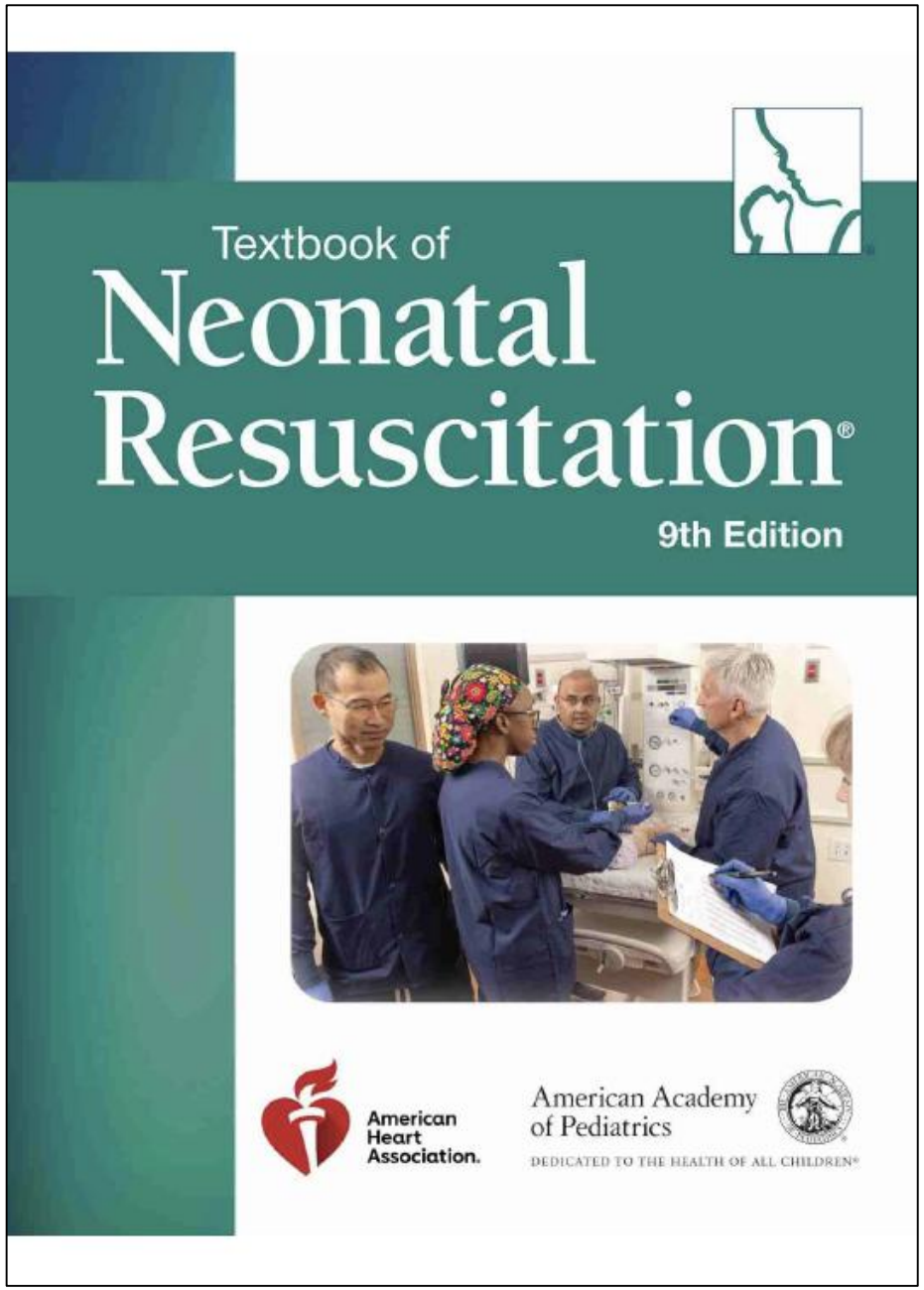
Remove suction

Terminology,
Initial O_2, Initial PIP,
Ventilation rate

Time period before MR.SOPA,
Sequence of MR.SOPA

LMA
ETT size, depth

Target Oxygen Saturation Table	
2 min	65%-70%
3 min	70%-75%
4 min	75%-80%
5 min	80%-85%
10 min	85%-95%



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