

EXAMINATION OF THE NEWBORN INFANT	CLINICAL GUIDELINES Register No: 04225 Status: Public
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Alison Cuthbertson Anita Rao Miss Dutta Dr Agrawal Alison Cuthbertson Paula Hollis Chris Berner Toni Laing Jude Horscraft Emma Neate Sarah Moon Lavina D'Souza Deborah Lepley	Clinical Director for Women's and Children's Division Consultant for Obstetrics and Gynaecology Consultant for Obstetrics and Gynaecology Consultant Paediatrician Head of Midwifery for Women's and Children's Services Lead Midwife Acute In-patient Services Lead Midwife Clinical Governance Lead Nurse for Neonatal Practice Development Midwife Antenatal and Newborn Screening Midwife Specialist Midwife for Guideline and Audit Senior Midwife Postnatal Ward Senior Librarian, Warner Library	June 2018

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Dr Hassan	June 2018

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Author/contact for information	Sharon Pilgrim, Advanced Neonatal Nurse Practitioner Emma Neate, Antenatal and Newborn Screening Co-ordinator
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1.0 Purpose

1.1 To determine whether the newborn infant has made a successful transition from fetal life.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Aim

3.1 The newborn physical examination is a holistic assessment of the health and well-being of the newborn baby. The baby is examined from top to toe by a qualified healthcare professional, including a screening examination of the heart, hips, eyes and testes in boys.

3.2 To ascertain baseline recordings.

3.3 To impart advice and reassurance to parents.

4.0 Overview

4.1 At booking all women are provided with written information, in the form of the booklet entitled 'Screening tests for you and your baby' or in a format appropriate to their individual requirements. Parents should be offered information antenatally at approximately 28 weeks, in written form as well as verbally and should be repeated prior to the newborn examination being offered.

4.2 The following neonatal examinations should be undertaken:

- The Initial Examination
- The Routine Baby Examination
- The Formal Examination (NIPE)

4.3 The **initial examination** should be carried out by the midwife, a paediatrician or advanced neonatal nurse practitioner in the presence of the parents, in a warm environment with good light. This initial examination should be undertaken as soon as possible after birth.

4.4 A **formal examination** of the newborn should be carried out during the first 72 hours. This must be carried out by a competent practitioner – either a paediatric senior house officer, an advanced neonatal nurse practitioner (ANNP), or midwife who has undertaken the course entitled '**Newborn and Infant Physical Examination**' (NIPE).

4.5 At each postnatal contact, a **routine baby examination** should be performed with parental consent and documented in the patient's health care records

4.6 The **formal examination** will also include **four Screening Standard examinations on the eyes, heart, hips and testes**. All babies should undergo the routine screening procedures but if risk factors are present or when a possible problem is detected, further tests may be indicated. This formal examination excludes hearing test as this is done separately by Audiology staff as part of postnatal checks.
(Refer to Appendix B)

4.7 If there are no problems, this examination need not be repeated before discharge.

- 4.8 For babies being discharged from hospital at 6 hours the formal examination should be carried out as near to 6 hours as possible, avoiding times between midnight and 0600 hours.
- 4.9 At weekends and Bank Holidays a Paediatrician should be present on the Postnatal Ward from 0600 hours to commence any Paediatric NIPE required for the day; unless they are detained in another area with an emergency.

5.0 Initial Examination

- 5.1 Introduce yourself and seek consent of the mother (or both parents if present) before examining the baby.
- 5.2 Explain the purpose of the examination and undertake the following:
- Wash hands, and observe the infants colour, tone, posture and activity
 - Examine the skin and the clamped cord for signs of bleeding
 - Examine the infant thoroughly for any abnormalities working from head to toe
 - Measure head circumference
 - Take the 'axillary' temperature with a digital thermometer
 - Weigh the baby (in grammes) on the scales, lined with a paper towel, ask the mother /partner to check the weight registered.
 - Administer Konakion (vitamin K) according with parental choice and with their consent (Refer to 'Guideline for the administration of vitamin K'. Register number 08095)
 - Check the infant's two identification labels with the mother's label, ensuring that the details have been checked with the parents, before attaching them around the baby's ankles
 - Dress the baby in warm clothes and a hat
 - Note passage of urine and/or meconium
 - Record all the findings in maternity health care records/computer and baby's details on a cot label.

6.0 Routine Baby Examination

- 6.1 Undertake the following assessment:
- Begin the examination by observing the infants general appearance and behaviour.
 - Activity State, sleeping/awake, spontaneous symmetrical movements, tremors/twitching/seizures and muscle tone
 - Colour, central/peripheral cyanosis jaundice, excessive bruising and pink/pale/plethoric/mottled.

- Posture and symmetry appropriate for gestational age
- Cry, note character of cry
- Feeding – method and frequency
- Elimination of urine and meconium
- Observations – heart rate, respirations and temperature

7.0 Formal Examination

‘Newborn and Infant Physical Examination’ (NIPE)

7.1 Pre-examination check the maternal notes for:

- Family history
- Maternal medical problems
- Booking blood results
- Fetal scan results
- Antenatal details
- Risk factors for infection
- Presentation at 36 weeks gestation.
- Details of labour and delivery
- Cord gas results if recorded
- Social history

7.2 Check baby’s notes for:

- Resuscitation details
- Birth weight
- Condition of baby since birth (i.e. feeding, passed urine / meconium)

7.3 The examiner needs to provide the relevant information to parents before the examination together with an opportunity to discuss the forthcoming screens, eyes, heart, hips and testes.

7.4 A baby born in good condition following a history of meconium stained liquor; where the baby’s apgar was > 7 at 5 minutes and cord arterial pH >7.1 and observations are normal at 1 and then 2 hours old, can be formally examined by a midwife, who has the ‘Newborn and Infant Physical Examination’ (NIPE) qualification, the paediatrician or an Advanced Neonatal Nurse Practitioner (ANNP) from 6 hours following delivery. If the findings are normal the mother and baby can be discharged home. Parents should be given an information leaflet regarding light meconium stained liquor and advised to contact the Postnatal Ward on 01245 513052 or the midwife can highlight the pertinent contact numbers printed on the patient’s discharge envelope.

(Refer to the guideline for the ‘Management of Meconium Stained Liquor ‘; register number 04259)

(Refer to the guideline for the ‘Postnatal observations of babies born with prolonged rupture of membranes and meconium stained liquor’; register number 08074)

(Refer to Appendix A)

- 7.5 Ask parents about family history of congenital deafness and congenital dislocation of the hip, heart conditions or any hereditary conditions
- 7.6 Wash hands thoroughly before starting the examination.
- 7.7 The examination documented here is very systematic; in reality it can be opportunistic i.e. the ophthalmoscopic examination as soon as the baby opens the eyes; listen to the heart while baby is not crying. Some observations are made while talking to the mother and whilst undressing baby.
- 7.8 The baby should be completely undressed for the examination and appropriate attention given to maintenance of its temperature.
- 7.9 Begin the examination by observing the infants general appearance and behaviour as follows:
- Activity state, sleeping/awake, spontaneous symmetrical movements, tremors/twitching/seizures, muscle tone
 - Colour, central/peripheral cyanosis jaundice, excessive bruising, pink/pale/plethoric or mottled
 - Posture, symmetry appropriate for gestational age
 - Cry, note character of cry
- 7.10 Recording of vital signs as follows:
- Respirations: rate, characteristics i.e. nasal flaring, recession, laboured, equal movement
 - Weight: plot on centile chart – ensure appropriate for gestational age
 - Head circumference: plot on centile chart – ensure appropriate for gestational age
- 7.11 Examination of the skin as follows, noting presence of:
- Vernix
 - Injury
 - Meconium staining
 - Rashes
 - Lanugo hair
 - Texture
 - Birthmarks
 - Oedema
 - Colour
 - Bruising
- 7.12 Examine head and face for the following:
- Shape
 - Presence of caput and cephalhaematoma
 - Palpate anterior fontanelle
 - Measure occipital-frontal circumference (head circumference)
 - Inspection and palpation of the palate using direct vision with a torch and palpation with a digit
 - Inspection of the neck for webbing, thyroid enlargement or haematoma

- Facial nerve injury – eyes; co-ordinated movements, red reflexes, presence of sub conjunctival haemorrhage, size, shape, structure and reaction of pupils, abdominal discharge, epicanthic folds, 'brushfield' spots, cataracts and position
- Ears; cartilage development, size, shape, position and angle, response to noise, skin tags/sinus
- Nose; shape and size, patency, abnormal discharge
- Mouth; colour of lips and membranes, anomalies of hard/soft palate, presence of neonatal teeth, size/shape of tongue-tie, excessive saliva, evidence of infection. The gag and suck reflex may also be demonstrated

7.13 Examination of the Eye (Screening Standard): Newborn Examination

- All babies who have an eye abnormality detected on initial examination should have be further reviewed by a paediatric registrar/consultant and an immediate ophthalmology referral as urgent.
- If they require treatment they must be seen be an ophthalmology consultant before two weeks of age.

7.14 Examine the limbs as follows:

- Upper extremities; size, shape, symmetry of arms and hands, signs of fractures, paralysis and dislocations, count and inspect digits note range of movements, presence of 'simian creases'
- Lower extremities; size, shape, symmetry of legs and feet, note normal position of flexion and abduction/range of movements observe for fractures, dislocation and paralysis, count and inspect digits.

7.15 Cardiac examination as follows:

- Colour, central/peripheral cyanosis jaundice, pink/pale/plethoric or mottled; monitor oxygen saturation levels if any cause for concern
- Rate, rhythm, volume and regularity, evidence of murmurs (loudness, quality, location and timing) sound 1 and 2
- Apex beat position and character
- Note the presence and nature of both femoral pulses

7.16 Congenital Heart Defects (Screening Standard) : Newborn Examination

- All babies, who are screen positive should have pre and post ductal pulse oximetry and 4 limb blood pressures prior to an expert examination with 24 hours of the initial examination. Following this examination the need for further tests and/or an outpatient appointment should be assessed depending on the clinical condition and any significant risk of clinical deterioration.

7.17 Chest and respiratory examination as follows:

- Clavicles; observe and palpate for fractures breast tissue/nipple development/extra nipples, patency of the upper airway, respiratory distress, auscultation of the lungs note shape and symmetry of chest wall and retractions if any

7.18 Abdominal examination as follows:

- Observation of the abdomen; general and organ-specific palpation of the abdomen examination of hernial orifices, inspection of the anus, note passing of meconium, examine for hip stability using 'Ortolani' and 'Barlow' manoeuvres

7.19 Developmental dysplasia of the hip (Screening Standard): Newborn Examination (Refer to the guideline entitled 'Identification and Referral of Infants with Developmental Dysplasia of the Hips (DDH); register number 10085)

- All babies with positive risk factors, and negative examination should receive a hip ultrasound within 6 weeks.
- All babies with a positive examination should have a senior review and if confirmed an urgent ultrasound within 2 weeks and urgent orthopaedic review.

7.20 Examine genitalia as follows:

- Male infants– urethral opening, testes and hydrocele
- Female infants – urethral opening, position of clitoris, skin tags and fistulas

7.21 Undescended testes (Screening Standard): Newborn Examination

- **Only** babies with bilateral undescended testes to be seen by a senior paediatrician within 24hours.
- If Bilateral undescended testes are confirmed. Blood should be taken for U+E/Karyotype and an urgent abdominal ultrasound booked and a paediatric surgical referral sent.

7.22 Back examination as follows:

- Baby needs to be on a firm surface; note straight back; look out for swelling, hairy patches or pigmentation over the lumbo-sacral area (this may reflect spinal abnormality). Skin covered sacral pits are common and benign.
- If a sacral pit is present and it is impossible to view the base to confirm that skin is present refer for senior review and consider requesting an ultrasound.

7.23 Reflexes as follows:

- Elicit head control by 'pull-to-sit' method if the baby is more than 24 hours old.
- Examine truncal tone in ventral suspension, inspect midline of back from anterior fontanelle, note skin defects
- elicit 'moro' reflex
- elicit red reflex in both eyes
- Optional: grasp reflex, rooting reflex, stepping reflex and knee jerk

7.24 Nutritional status:

- Note method of feeding
- Nutritional status of the infant

7.25 Passage of urine:

- Assess renal function

7.26 Passage of meconium:

- Note meconium plug/delay in passing of meconium

7.27 Babies examined by midwives trained in newborn examination must fall within the following criteria:

- Birth weight 2.5kg or more, gestation 37 weeks and above
- Apgar >7 at 5 minutes and arterial cord Ph >7.1
- Spontaneous vaginal delivery with no causes for concern
- Instrumental deliveries with no apparent birth trauma
- Elective “low risk” Caesarean sections.
- Emergency Caesarean sections where the Apgar was > 7 at 5 minutes and arterial cord pH > 7.1
- Non- significant and significantly stained liquor, where Apgar score was > 7 at 5 minutes, arterial pH > 7.1 and following satisfactorily completed observations, with no signs of sepsis. If no cord PH's available and baby is born in good condition with apgars greater than 7 at five minutes; all observations are completed and fall within normal parameters then NIPE trained midwives are able to undertake the examination. (Refer to the guideline entitled 'Postnatal observations of babies born with prolonged rupture of membranes and meconium stained liquor'; register number 08074)
- Prolonged rupture of membranes (>24 hours in a term baby) following satisfactorily completed observations, with no signs of sepsis (Refer to the guideline entitled 'Postnatal observations of babies born with prolonged rupture of membranes and meconium stained liquor'; register number 08074)
- Breech deliveries, both vaginal and Caesarean, where appropriate referral is made for hip scan (Refer to the guideline entitled 'Identification and Referral of Infants with Developmental Dysplasia of the Hips (DDH); register number 10085) and (Calling Paediatric Staff and obtaining Paediatric Referral; register number 09113).
- Gestational diabetic mothers, diet controlled, when babies are stable following satisfactory observations (Refer to the guideline entitled 'Treatment of neonatal hypoglycaemia in the high risk infant'; register number 12025)

7.28 The following babies must be referred to a paediatrician or ANNP for examination as they may require treatment or follow up:

- Babies with **significant** meconium stained liquor (MSL) if point 7.26 doesn't apply.
- **Non- significant** MSL babies should be reviewed by a paediatrician if the baby's condition causes concern at any time (Refer to Appendix A for MSL flow chart) (Refer to 'Guideline for the management of MSL'. Register number 04259)
- Abnormalities detected in the antenatal period i.e. dilated renal pelvis
- Babies who at birth required intubation and advanced resuscitation or assessed at delivery with a problem
- Cord arterial pH < 7.1
- Apgar below 7 at 5
- Birth trauma
- Any congenital abnormality including congenital heart disease and family history of any genetic or inherited disorder
- Women with Insulin dependent diabetes (Refer to point 7.26)

- Blood disorders i.e. high antibody titres
- Known maternal infection i.e. herpes, GBS, hepatitis B or C, HIV
- Maternal alcohol and drug misuse
- Admitted to neonatal intensive care unit
- History of Oligohydramnios / Polyhydramnios
- Prolonged rupture of membranes i.e. > 18 hours in preterm baby < 37 weeks gestation/ offensive liquor (Refer to point 7.26)

7.29 Documentation/Action:

- On completion of the formal newborn examination, the trained healthcare professional should communicate all findings to the mother; including any concerns for referral to the paediatric team. Any discussions/ care should be documented accordingly in the 'Postnatal Care Record – Baby'
- If there are no problems, the examination should be entered onto the NIPE smart system and two copies of the report printed. One should be stapled into the Baby record the other placed in the PCHR record.
- If the NIPE smart system is not available or the report cannot be printed the baby the discharge examination section of the baby's health record postnatal, neonatal and PCHR records should be completed by hand.
- If a problem has been identified by the midwife, they should contact the paediatric registrar for advice and further review as required dependent on clinical indications. The paediatric registrar should initiate the management plan and any further investigations/treatments as indicated
- If a problem has been identified by the paediatric SHO/registrar or ANNP, dependent on the clinical indications, they may initiate the management plan and any further investigations/treatments as indicated. Where indicated, they should refer to the registrar
- Management plans and follow up arrangements should be documented in the baby's healthcare records
- The GP, community midwife and HV should be informed of any referrals. The GP / HV should receive copies of referral letters

8.0 6-8 Week Check

8.1 A further 6-8 week physical examination is conducted by the GP. The examination completes a second systematic head to toe physical examination of the infant.

9.0 Staff and Training

(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

9.1 A midwife who is registered as a 'Newborn and Infant Physical Examination' (NIPE) practitioner is responsible for providing evidence of her continued competence in the extended skill. It is recommended that this should form part of the professional portfolio.

9.2 Consolidation of practice is facilitated by the continued support offered by management to the midwife in negotiating the appropriate time and shifts in setting(s) that increase the opportunities for the midwife to conduct the examination and assessment of newborn babies.

- 9.3 All midwifery and obstetric staff must attend yearly mandatory training which includes examination of the newborn infant at birth and daily checks.
- 9.4 All midwifery and obstetric staff are to ensure that their knowledge and skills are Up-to-date in order to complete their portfolio for appraisal.

10.0 Professional Midwifery Advocates

- 10.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

11.0 Infection Prevention

- 11.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each patient contact.

12.0 Audit and Monitoring

- 12.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.
- 12.2 The Maternity Service has approved documentation for the full physical examination of the newborn, which as a minimum must include a description of the:
- Process for the first full physical examination, which as a minimum must include standards for the examination, the timeframe for the examination and a description of who can perform the examination
 - Process for referral for further medical investigation, treatment or care, if a deviation from the norm is identified
 - Process for communicating the outcome of the full physical examination with the parent(s)
 - Documentation of all of the above
 - Maternity service's expectations in relation to staff training, as identified in the training needs analysis, for all staff who perform examinations of newborns
 - Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans
- 12.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 10.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.
- 12.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

- 12.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.
- 12.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.
- 12.7 Key findings and learning points will be disseminated to relevant staff.

13.0 Guideline Management

- 13.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.
- 13.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.
- 13.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.
- 13.5 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions

14.0 Communication

- 14.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.
- 14.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.
- 14.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 14.4 Regular memos are posted on the Guideline and Audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

15.0 References

UK National Screening Committee (2016-17) Screening for You and Your Baby: Important Information to keep with your Hand Held Maternity records. Leeds: UK NSC
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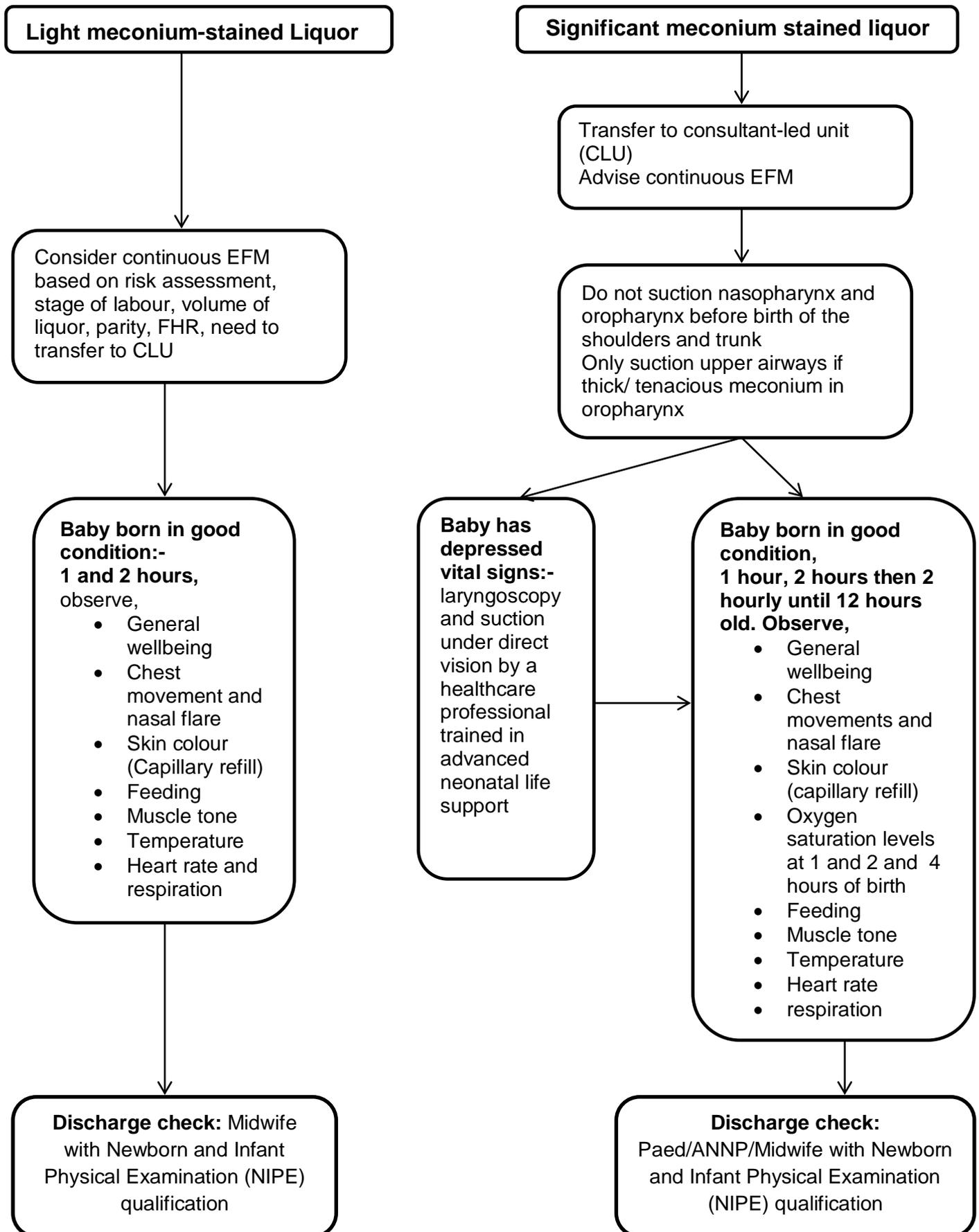
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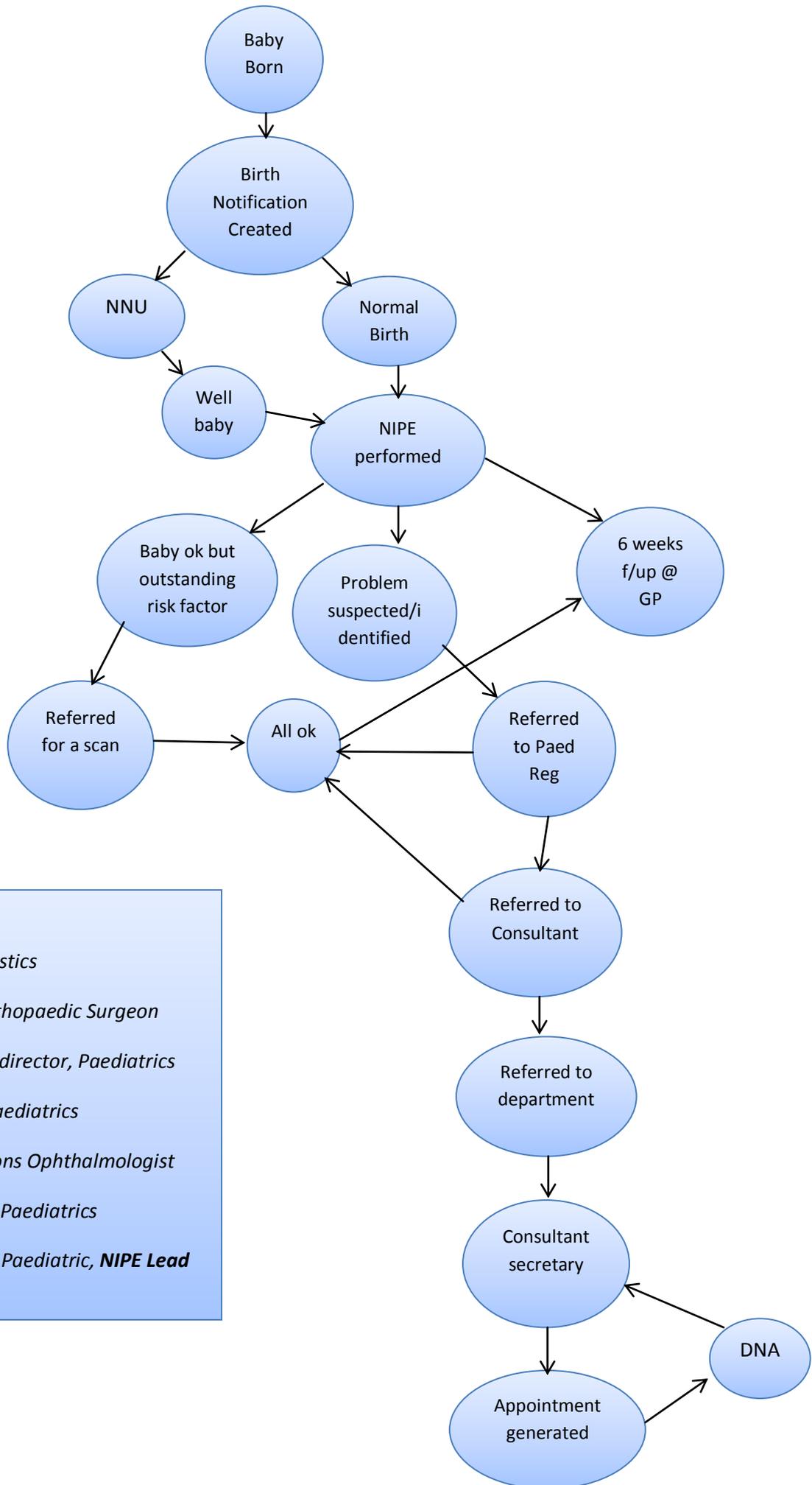
Meconium-stained Liquor Flow Chart



Formal Examination

Newborn & Infant Physical Examination (NIPE)	
Task	Refer to Point
Observing the infants general appearance and behaviour	7.9
Recording of vital signs	7.10
Examination of the skin	7.11
Examination of the head and face	7.12
Examination of the Eye	7.13
Examine the limbs (upper & lower extremities)	7.14
Cardiac examination	7.15
Congenital Heart Defects	7.16
Chest and respiratory examination	7.17
Abdominal examination	7.18
Developmental dysplasia of the hip	7.19
Examine genitalia	7.20
Undescended testes	7.21
Back examination	7.22
Reflexes	7.23
Nutritional status	7.24
Passage of urine	7.25
Passage of meconium	7.26
Documentation/Action	7.29

NIPE Screening Pathway



- Consultant List**
- Dr Sood- Cons Plastics*
 - Dr Tuite- Cons Orthopaedic Surgeon*
 - Dr Datta- Clinical director, Paediatrics*
 - Dr Cyriac- Cons Paediatrics*
 - Dr Porooshani- Cons Ophthalmologist*
 - Dr Nambiar-Cons Paediatrics*
 - Dr Hassan – Cons Paediatric, **NIPE Lead***