



**Aneurin Bevan University Health Board**

# **Guideline for the Routine Examination of the Newborn**

*N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.*

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## Executive Summary

Routine physical examinations of the neonate are an integral part of the universal Child Health Promotion Programme. Guidance can be found in the 2006 NICE guideline on routine postnatal care of women and their babies and in the document from the UK national Screening Committee, setting standards for newborn and infant physical examinations (NIPE, DH 2008). These standards address four areas of the examination: eyes, testes, hips and heart (UK NSC 2008).

Babies are examined soon after birth to identify any obvious visible unexpected features or abnormalities and to reassure parents, usually by the midwife in attendance at the birth.

It is established as good practice to carry out a more detailed examination of the baby within 24 hours of birth (Hall and Elliman, 2006) and certainly within 72 hours. During this routine examination problems can be identified, and if appropriate referred for investigation, specialist assessment and treatment, as well as being fully discussed with the parents.

The routine examination cannot identify all abnormalities that present in the neonatal period, but does provide reassurance to the parents that the baby appears healthy and is fit to go home. It also has a health promotion function by providing an opportunity to discuss baby and family health issues with parents as they are beginning to care for their new baby (Tappero and Honeyfield, 1993). Parents should be informed that not all conditions are detectable at birth and the examination is therefore repeated at 6 – 8 weeks of age.

It also has a role in:

- Reviewing any problems arising during antenatal screening, family history or labour
- preventing cot death
- recognising additional needs e.g. existing family illness, social problems or learning difficulties
- introducing other services and agencies which can provide ongoing support
- providing an opportunity to advise regarding breast feeding, general baby care and vaccination.

The examination is generally performed by either a paediatrician, ANNP or a midwife who has undergone the appropriate training course (RCM Examination of the Newborn Learning Module, EON, RCM 2009).

- Midwife has successfully undergone the appropriate educational course

### **Criteria for midwives to perform detailed neonatal examination:**

- Midwife must perform a minimum of 15-25 examinations per year, or 30-50 within a two year period. This will be ensured at their annual supervisory interview
- Appropriate referral pathways for senior paediatric review are established, for either immediate/urgent review or routine outpatient review where necessary.

### **Babies SUITABLE for examination by midwives:**

- Infants born at 37-42 weeks gestation irrespective of the mode of birth  
This includes instrumental delivery, elective caesarean section and emergency section for maternal reasons.
- Infant is apparently fit and well
- Apgars above 7 at 5 minutes
- No known fetal problems, except where a clear protocol for follow up exists and the mechanisms in place to arrange necessary follow up (e.g. maternal hypothyroidism, pelvicalyceal dilatation, risk factor for hip dislocation)
- Informed consent from parents

### **Criteria for routine examination by a paediatrician or ANNP:**

- Infants of any gestational age if problems, and all infants below 36 weeks gestation
- Infants with antenatally diagnosed problems (Unless clear protocol in place e.g. pelvicalyceal dilatation)
- Infants with intrauterine growth restriction
- Infants admitted to the neonatal unit
- Infants showing signs or symptoms of ill health or known GBS
- Apgar score of <7 at 5 mins, and/or poor cord pH <7.10
- Thick meconium at delivery requiring inflation breaths

## **1 Procedure - Standards for neonatal examination**

- Parents should be offered information both verbally and written at 28 weeks regarding newborn screening.
- Informed consent should be obtained from the parents. The examination would ideally be done by the midwife involved in other aspects of the mothers care to provide continuity.

- Prior to the examination, the obstetric notes will be reviewed to identify possible risk factors in the obstetric, medical, family, social or drug history.
- The examination takes place in front of the parents. Any parental concerns should be noted.
- The examination is conducted in a warm, well lit environment. A firm surface is required for hip examination. The setting should allow an unhurried examination and confidentiality. The baby ideally would be quiet and alert rather than hungry or crying.
- A full clinical examination is performed (see appendix 1)
- There must be 24 hour access to paediatric support in the event of an abnormality being detected or suspected.
- Any deviation from normal must be referred to the supporting paediatric team, usually the neonatal registrar, either immediately over the telephone for urgent problems or via a letter to the neonatal consultant for non urgent problems. The agreed referral pathways should be followed. Referral letters should be copied to the family's GP.
- Parents are fully informed of the findings of the examination and of any referral plans that are required.
- Existing policies are adhered to with regard to specific neonatal problems. This includes screening for congenital dislocation of the hip, management of prolonged ruptured membranes, management of infants with antenatal pelvicalyceal dilatation of the kidneys.
- Detailed records of the examination and any advice given to the parents are filed in the case notes and in the baby's hand held record.

The midwife keeps a personal record of any neonatal examination and details of the outcome. This can be used for their own appraisal as well as for audit purposes.

## **2 Audit**

Midwives who perform newborn examination should audit their work against this policy on an annual basis.

## **3 References**

1. Routine examination of the Newborn, Best practice statement, NHS Quality Improvement Scotland 2004
2. Postnatal care: Routine postnatal care of women and their babies, NICE Clinical guideline, July 2006 CG37

### 3. UK National Screening Committee: Newborn and Infant Physical Examination; Standards and Competencies (NIPE) DH 2008

## **Appendix 1**

### **What should be considered and examined during the Routine Examination of the Newborn?**

#### **1. Definition**

The routine examination is that examination undertaken usually between 6 and 24 hours of life (but certainly before 72 hours) of a baby, who is thought to be well, without significant problems, and being cared for in a postnatal ward or at home. Like any screening process it is more effective if preceded by the taking of a good history.

#### **2. Problems Anticipated from the History**

The antenatal booking visit presents an opportunity to elicit specific issues in the family history relevant to the new baby as well as those relevant to the mother and the pregnancy. For example, a family history of deafness or developmental dysplasia of the hips may indicate specific testing of the new baby. If possible any potential referrals should be discussed, and agreed beforehand with the parents and those who will be involved in the baby's care after delivery.

#### **3. Problems Arising in the Current Pregnancy**

Issues may have arisen during the pregnancy, which require special thought being given to the baby, e.g. poor fetal growth.

Review the baby's weight and head circumference, and record them on a centile chart.

#### **4. Problems Arising at Birth**

Some issues, which are potential risk factors for the baby, may arise in labour. The Maternity Unit guidelines should be adhered to regarding these factors, e.g. following prolonged rupture of membranes, history of maternal Group B Streptococci or maternal pyrexia in labour.

Appropriate plans should be made before delivery in response to any anticipated risk factors and these communicated to those responsible for the care of the baby.

#### **5. Items to be Considered if the Family Goes Home before the Routine Examination Can be Performed or before the Midwife Leaves a Family following a Home Birth**

The following should be included in the initial examination:

- Ascertain the family's concerns and give them the chance to discuss them.
- Review and plot the baby's weight and head circumference and compare with known dates to ensure no gestational or nutritional discrepancies.
- Observe if the baby is able to latch on the breast or suck a bottle, if being artificially fed, and mum is confident handling her baby to feed.
- Consider whether the baby is well enough to be managed at home.
- Consider any specific known risks in the baby's home.
- Ensure that any appropriate urgent interventions for the baby have been completed or are planned (e.g. administration of Hepatitis B immunoglobulin and vaccine to the baby).
- Ensure arrangements are in place for the routine examination of the baby to be completed.
- Ensure that the parents know how to assess their baby's general condition and to contact a midwife or doctor if required.

## **6. Performing the Routine Examination**

### Specific questions

- Any parental concerns?
- Feeding
- Has the baby passed urine +/- meconium (urinary stream in a boy)
- The examination is completed with regard to prevention of cross-infection.
- Observations prior to disturbing the baby, i.e. colour, respiration, behaviour, activity and posture.
- It may be advantageous to listen to the heart when the baby is calm, but this does not preclude later examination if possible.

### **Examine the exposed parts of the baby first**

- Scalp, fontanelle(s), face, nose, mouth including palate, ears, neck and general symmetry of head and facial features. The palate should be fully visualised using a tongue depressor and torch
- **Check eyes with an ophthalmoscope and test for the 'red reflex'.**

Undress the baby to complete the remainder of the examination.

- **Cardiovascular system** – colour, heart rate, rhythm and femoral pulse volume as well as listening to the heart for a murmur.  
*Baston and Durward (2001) recommend listening at five areas of the chest to assess heart sounds and detect murmurs. Absence of a murmur does not guarantee there is no cardiac anomaly.*
- **Respiratory** effort, rate and lung sounds
- **Abdomen** – shape, and palpate to identify any organomegaly. Check the condition and vessels in the umbilical cord.
- **Genitalia and Anus** – patency and completeness are examined. Check for undescended testes in males
- The **femoral pulses** can be palpated at this time if not already done.
- **Spine** – with baby prone inspect for completeness of bony structures and skin.
- **Skin** – while examining other aspects of the baby any skin lesions should be identified and discussed with parents.
- **Central Nervous System** – Throughout the examination observe tone, behaviour, movements and posture and elicit full newborn reflexes only if concerned. (Moro, grasp, rooting and sucking reflexes)
- **Hips** – Check symmetry of the limbs and skin folds are examined before checking hip stability. It is important to view the skin creases from the posterior aspect of the thigh
- Perform **Barlow and Ortolani's** manoeuvres. The baby must be on a firm, flat surface and ideally warm, comfortable and relaxed. In those babies who are upset, the hips should be examined at a later time.
- **Cry** – noting aspects of the baby's cry can indicate possible underlying conditions

## **Oxygen Saturation Recording**

Oxygen saturation recording has been shown to increase the detection of life threatening cardiac anomalies. The baby should have the saturations recorded by placing the probe on a foot (post-ductal saturation). Ideally the foot should be warm. A reading of >95% is considered normal. A reading of 95% or below merits the infant being referred to the paediatric team for urgent review and an echocardiogram, as a cardiac or respiratory cause needs to be excluded.

All babies born within the hospital setting, including midwifery led units, should have the saturation recording done at the time of their examination. For home deliveries, the parents should be offered the opportunity to have the recording done at their nearest hospital within the 24 hours following the examination.

**On completing the examination the baby is re-dressed and offered to the parents for a cuddle, or left comfortable in the cot while the examiner completes the documentation.**

## **7. Communication and Documentation**

- Ensure that the findings of the examination are appropriately recorded, including in personal Child Health Record.
- Confirm the findings in discussion with the parents.
- Ensure those involved in providing future health care to the family, e.g. hospital and community midwives and GPs, receive the relevant information relating to the baby.

## **8 Referral**

- The professional examining the baby must have the knowledge and ability to refer promptly and directly to the appropriate professional when a potential problem is identified.
- Local referral routes for all potential problems identified from the routine examination of the newborn should be followed.
- All babies with cardiac murmurs are referred for immediate review and investigation.
- Automatic referral of babies in which risk factors are present, regardless of clinical findings, can reduce the incidence of late presentation of hip abnormalities (Jones, 1998; Maxwell et al, 2002).
- Babies, in whom there is a history of hereditary eye conditions in the immediate family, should be referred for examination by a specialist.

- Parents are given a full explanation of the reason and timescale of the referral.

## **9. Neonatal Screening**

- Screening for blood spot (Congenital Hypothyroidism, Phenylketonuria, Cystic Fibrosis, Medium Chain Acyl CoA dehydrogenase deficiency and sickle cell disorders) and the Universal Neonatal Hearing Screening is performed in the neonatal period.
- The professional undertaking the routine examination will ensure that the parent has received information about the 'blood spot screening' and hearing test, and provide cot death prevention advice.

### **Referral pathways to the Neonatal team from Stand alone Midwifery led Centres**

#### **Pathways included:**

#### **1. Transferring neonates to the Neonatal Unit for immediate attention**

#### **2. Neonates requiring referral to a paediatrician for outpatient review**

#### **3. Findings that require explanation and reassurance and/or GP review**

#### **4. Management of Specific Neonatal conditions**

- Cardiac murmurs
- Hip problems
- Talipes
- Hypospadias
- Jaundice
- BCG
- Dysmorphic features
- Miscellaneous

#### **5. Breaking Bad News/ dysmorphic syndromes**

##### **1. Neonates requiring immediate attention**

From January 2011, the neonatal team will no longer be retrieving babies from stand alone Midwifery Led Units, MLU. Instead, in line

with all other midwifery lead units, babies needing urgent neonatal input need to be transferred using the 999 ambulance service and be accompanied in the ambulance by a midwife.

If baby requires resuscitation, follow Neonatal Life Support guidelines and ensure continued resuscitation whilst neonatal unit is contacted.

- Contact the Neonatal Registrar or Neonatal Consultant on the neonatal unit at the receiving consultant unit, usually either Royal Gwent Hospital or Nevill Hall unit via switchboard.
- **Be clear and concise** in identifying the reason for concern and the **current status** of the baby.

With the appropriate information, the decision can then be made to either:

- Arrange urgent transfer to the Neonatal Unit. This may be via a 999 ambulance or via the EMRTS team.
- Contact ambulance control to arrange ambulance transfer as per midwifery unit policy.
- Ongoing resuscitation and stabilisation will need to continue until arrival of the ambulance and during transfer. The Neonatal team can be alerted to be ready on arrival at a specified site (at RGH, usually the Bellevue entrance if baby still critically ill)
- In less urgent situations, arrange for the mother and baby to be transferred to the Royal Gwent Hospital or Nevill Hall Unit by ambulance, where the baby can be seen by the neonatal team. If not life threatening this can take place on the postnatal ward.

Keep the parents informed of your concerns and reasons for transfer.

## **2. Neonates requiring referral to a paediatrician for follow-up.**

If an abnormality has been identified that does not require immediate attention and is not life threatening, then the baby can be referred to a Neonatal Consultant to be seen in the outpatient clinic. If in doubt about the urgency, discuss with the Neonatal Registrar on the NNU at the RGH or the paediatric registrar on SCBU at NHH.

**A referral letter** is written and faxed/sent to the Neonatal Consultant who will arrange for an appointment to be sent out to the patient.

The letter should contain full details of the baby (including name, hospital number, date of birth, address, GP, parental telephone number).

A copy of the letter should be sent to the GP.

Discuss the reasons for referral with the parents and explain the follow up plan. Make sure they know who to contact if they have any concerns about the baby before they are seen in the outpatient clinic (usually the community midwife, health visitor or GP).

### **3. Findings that require explanation/ reassurance and follow up by GP.**

There are occasionally findings that are apparent on the first clinical examination that are neither life threatening or harmful to the baby but require explanation and reassurance. This can be conducted by the midwife performing the examination at the time, with sensitivity and answering any concerns or question the parents have.

If the condition or findings need a further check by the GP, a referral letter needs to be written and sent to the GP and the parents informed of the plan and who to contact with any concerns.

**Always maintain accurate records and keep a copy of any referral letters with the baby's neonatal sheet**

### **Guidelines for specific neonatal conditions**

#### **a. Heart murmurs**

If a heart murmur is detected during routine neonatal examination:

1. Note the presence or absence of any *associated worrying signs or symptoms*:

- Quality of the murmur
- Cyanosis
- Respiratory distress
- Absent femoral pulses
- Poor feeding, lethargy
- Other dysmorphic features

2. Explain your findings to the parents, the need to seek a paediatric opinion and the likelihood of the need for an echocardiogram. Give the information honestly but avoid the temptation to (possibly falsely) reassure the parents.

3. Contact the Neonatal Registrar on the Neonatal Unit at the Royal Gwent Hospital, or Paediatric Registrar at NHH explaining findings.

4. Transfer can then be arranged, either by ambulance with the midwife (+/- mother) if the baby otherwise appears well. If symptomatic as above, the urgency must be communicated to the ambulance service.

5. Ensure good documentation and that records are sent with the baby.

6. Inform team midwife and midwifery manager if murmur confirmed.

## **b. Screening for Developmental Dysplasia of the Hips (DDH)**

**Screening policy:** The current policy in ABHB, as per national guidance, is to offer a hip ultrasound to any baby with risk factors for DDH. These are:

- Family history of DDH requiring treatment (only 1<sup>st</sup> degree relatives i.e. parent or sibling)
- Breech presentations

Always ask about a family history of hip problems. In the presence of risk factors:

- Examine the baby as usual and inform parents of the findings.
- Inform parents if ultrasound is recommended
- Refer to a Neonatologist as above who will arrange an ultrasound and a clinic visit to check the examination findings. Copy to the GP as above.

### **Abnormal Hip examination:**

If the routine examination of the hips is abnormal (positive Barlows or Ortolani test), with or without risk factors, then the baby will need urgent referral to the paediatricians for a repeat examination. If an unstable (dislocated or dislocatable) hip is confirmed, referral to the orthopaedic team can be arranged by the neonatal team.

- Discuss with the neonatal registrar on the neonatal unit at RGH or paediatric registrar at NHH.
- Fax through a referral letter.
- The registrar will arrange to review the baby at the RGH or NHH within 24 – 48 hours and arrange urgent orthopaedic referral if necessary.

- Parents need informing of the plan. They should be reassured that baby is not likely to be in any discomfort and that they can handle the baby to wash and change as normal.

### **c. Talipes or Metatarsus adductus**

*Metatarsus adductus* is caused by intrauterine positioning. It may be a positional (flexible) deformity with no bony abnormality involved or a structural deformity may be present. In a structural deformity, the forefoot usually cannot be abducted beyond the midline (neutral position) and the heel (hindfoot) is in a valgus position. In a positional deformity, the forefoot is very mobile and can be easily abducted. A positional deformity will correct without treatment.

In a rigid foot, an orthopaedic consultation is necessary for early treatment.

#### *Clubfoot (Talipes Equinovarus)*

Clubfoot is one of the most common congenital anomalies with an incidence of approximately 1 per 1000 live births, bilateral in 50% of cases. A thorough examination should be made for other anomalies. There are variations in the severity of clubfoot. Some are relatively flexible and correctable with serial exercises and casting.

### **Protocol for referral:**

- Very mild and correctable deformities will improve without treatment. Parents can be advised to gently manipulate the feet into the normal posture several times a day during nappy changes.
- It is difficult on routine examination to establish whether there is a fixed or a postural deformity. Therefore, babies with possible talipes should be referred for a paediatric assessment:
  - With more severe or fixed deformities, discuss with the neonatal registrar who can arrange to see the baby within 24-48 hours at RGH or NHH.
  - With less severe deformities, fax a referral letter to the Neonatal secretaries. The Consultant can then decide how soon the baby needs to be seen and arrange an appointment. Copy the letter to the GP.
  - Physiotherapy and/or orthopaedic referral can then be arranged after paediatric review.

#### **d. Hypospadias**

1. Identify extent of problem i.e. incomplete foreskin, curvature of shaft of penis, site of urethral opening (either normally placed on tip of glans or opening along ventral or underside of penis or even within the scrotum), presence of testes and normal scrotal development.
2. Ensure infant passing urine before discharge
3. Inform parents of findings. Ask them to avoid circumcision until reviewed by a paediatrician, as the foreskin may be used in reconstruction.
4. Refer to neonatal consultant, following referral pathway as above. If in doubt contact the Registrar for advice.

#### **e. Undescended testes**

Unilateral undescended testes are relatively common in newborn boys and in the majority of cases will descend over the first few months. Advise the parents that the baby will be re-checked at the 6-8 week check with the GP. Document in the red book. If the testis remains undescended then the infant should be referred for paediatric review.

Bilateral undescended testes are more concerning and merit paediatric review in case of possible underlying problems. These infants should be discussed with the paediatric registrar to arrange review.

#### **f. Jaundice**

Virtually all babies have a transient rise in bilirubin but only about 50% are visibly jaundiced. A common dilemma is when to investigate and at what level to treat. The decision is influenced by

- Whether the baby is term or preterm
- Whether well or sick
- The presence of other factors predisposing to hyperbilirubinaemia e.g. maternal infections, maternal antibodies, blood group incompatibility, or prolonged rupture of membranes

The 2010 NICE guidance identifies risk factors for likelihood of significant jaundice as:

- Infants less than 38 weeks gestation
- A previous sibling with jaundice needing phototherapy

- Exclusively breast fed infants
- Visible jaundice in the first 24 hours

The NICE guidance is to check a bilirubin level in any baby with visible jaundice, either with a transcutaneous bilirubinometer or a serum bilirubin.

It is useful to classify jaundice based on the age at which it becomes clinically apparent

- **Early** (1-2days)                      Rare
- **Normal** (3-10 days)                Very common
- **Late** (14+ days)                    Common

#### **Early jaundice during first neonatal examination (< 48 hours):**

- Presume pathological until proved otherwise
- Discuss with neonatal registrar.
- Arrange transfer/ admission to RGH or NHH for investigation

#### **Jaundice after 48 hours, in a well baby:**

- Likely to be physiological, but assess for risk factors
- Emphasise good hydration with regular feeds
- Advise mother to report any lethargy or other signs of poor feeding or illness
- If checking SBR, warn parents baby may need admission to paediatric ward for phototherapy. It is the responsibility of the midwife to obtain the result and inform parents of the plan
- Reassessment by midwife until jaundice subsiding. Usually peaks at 5-7 days.
- If baby unwell/ poor feeding/ lethargic, needs an urgent assessment, bilirubin, +/- further investigation. Discuss with the paediatric registrar at the Royal Gwent Hospital or NHH.

#### **Jaundice after 14 days:**

- Discuss with paediatric registrar or GP.
- Baby will need to be seen in the Children's Assessment Unit for investigation of prolonged jaundice

#### **g. BCG Vaccination**

National policy recommends that neonatal BCG vaccinations should be offered to infants considered to be at increased risk of Tuberculosis.

- Babies born to parents in whose home country the incidence of TB is greater than 40 per 100,000 population.
- Babies born to parents originating from **countries other than those listed.**
  - European Union
  - Canada
  - USA
  - Australia
  - New Zealand

This includes children born to adults born in the UK but from ethnic groups originating in high risk countries.
- Babies born to parents who reside in or travel to areas for periods of 1 month or longer, where the risk of contracting Tuberculosis is thought to be high.
- Babies born to parents from specific groups such as travellers, homeless, asylum seekers and refugees.
- Babies who have someone in their close family with TB

#### Antenatally

- i) At the first antenatal visit the midwife should identify each baby requiring BCG.
- ii) Give the parent a copy of Department of Health leaflet \*"BCG and your baby" and offer further advice as necessary.
- iii) Document BCG required in special consideration area of antenatal sheet

#### At Delivery

The midwife should ask the mother if she has received a copy of the Department of Health "BCG and your baby" leaflet. Confirm with the mother that the baby meets the criteria for BCG Vaccination.

#### After Delivery

- For a baby born in the midwifery led unit or at home, the midwife must refer the baby to TB Nurse Specialist, Chest Clinic, St Woolos Hospital. The midwife should inform the health visitor and community midwife to reinforce attendance. See next page for referral letter.

- In the event the parents refuse vaccination, this should be documented in the notes and Parent Held Child Record. Parents should be counselled on risks of disease.

\* WAG "BCG and your baby" leaflet printed 2005 available to order from main stores Llanfrechfa Grange Hospital or download from [www.immunisation.org.uk](http://www.immunisation.org.uk)

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## **Paediatric BCG referral to chest clinic St Woolos**

Date:

TB Specialist Nurse  
Chest Clinic  
St Woolos Hospital

Dear Specialist Nurse

Please can you arrange for the following child to be appointed for paediatric BCG vaccination:

**Name**

**Date of Birth**

**Address**

**Telephone**

**GP**

**Health Visitor/Midwife**

## **g. Miscellaneous**

It is not possible to have a pathway for all minor problems that may be detected in the newborn period. However, what we perceive as a minor problem e.g. a birth mark or a rash, may be important and of concern to the parents. Reassure where possible and inform the GP of minor problems.

If in doubt about the appropriate course of action, the baby can be discussed with the Neonatal Registrar or referred to the neonatal clinic for an opinion.

**Single palmar crease.** This can be a normal finding and may run in the family. It also can be a marker for underlying conditions such as Downs Syndrome. If the baby is otherwise well and healthy, then reassure the parents.

### **Tongue tie:**

This is a common complaint and causes great anxiety, but rarely causes a problem with feeding. If in doubt the baby can be referred to the neonatal clinic or specialist midwife.

## **5. Detection of Abnormalities/ Dysmorphic syndromes**

### **Breaking of Bad News by midwives**

When conducting the first examination it is important to be mindful that this is an emotional period for both the mother and the father and everyone expect that their baby will be perfect.

It is an opportune time to give reassurances where necessary and educate, but if there are areas of concern it is important to consider giving some indication of these if you are intending to take further action on your findings - without initially causing alarm. If following discussion with a paediatrician you need to arrange a transfer of care it will be more readily accepted, hopefully less distressing and less of a shock.

From previous experience parents have voiced their need for honesty and information, but the midwife is not a diagnostician and should word her concerns carefully.

Diagnosis is the responsibility of the Paediatric Consultants. Information should be given in private to both parents whenever possible or at least with a close family member accompanying the mother, always explain concerns in simple terms and in accordance

with the Trust policy (Disclosure of Diagnosis and Early Counselling Following the Birth of a Baby with Major Congenital Malformation(s).)

To be told that a baby has certain behavioural or physical characteristics that are of some concern to the examiner and that require a further examination/consultation with a paediatrician, can be devastating to some parents. The mother specifically will be particularly emotional and will feel a great sense of responsibility having been the baby's guardian for the last forty weeks and feels responsible for its growth and development.

The consequences of an abnormality not only impacts on the parents but other family members too.

The breaking of bad news in relation to concerns about a neonate will never be done perfectly, but it is the midwives responsibility to convey concerns with as much sensitivity as possible.

Once you have conveyed your concerns to the parents, time for support and questions must be allocated and as smooth a transition of care to a consultant led unit as possible, either by the retrieval team or by ambulance with escort to the pre-arranged neonatal unit.

Always keep the mother's named midwife informed of developments and bring her into the supporting role for the parents as soon as possible.