Guideline for midwives undertaking neonatal examination

Specialty:	Women and Childrens' Directorate
Date Approved:	08th October 2018
Approved by:	Joint Perinatal Forum
Date for Review:	01st November 2021

Title of Guideline:	**Guideline for midwives undertaking neonatal examination**
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Issue / Version No:	V2018.1
Next Review / Guideline Expiry:	Review date: 1st November 2021
Details of persons included in consultation process:	Neonatal Consultants, Midwifery Team
Name of Pharmacist (mandatory if drugs involved):	N/A
Please list any policies/guidelines this document will supercede:	N/A
Keywords linked to document:	PROM – Prolonged rupture of membranes IUGR – Intrauterine Growth Restriction Term babies
Date approved by Joint Perinatal Forum	8th October 2018
File Name: Used to locate where file is stores on hard drive	

Introduction:

Examination of the newborn is a comprehensive clinical examination offered to all babies within 72 hours of birth and preferably within the first 24 hours. The purpose of this examination is to screen and facilitate early detection of congenital defects of the heart, hips, eyes and testes. It may also identify a neonate showing signs of ill health or at-risk of being ill. It can serve to reassure parents and to provide them with health education and advice. Normally a junior paediatric doctor or ANNP undertakes this examination. However, midwives who have successfully completed the necessary training course and who have been deemed to be competent may perform this examination in accordance with the Standards for competence for registered midwives (NMC 2008), 16:

"within the limitatations of the individuals own competence, knowledge and sphere of professional practice consistent with legislation and relating to midwifery practice"

The routine newborn examination ideally should not be performed before the child is six hours old to reduce the confusion related to detection of physiological transitional changes. However, if the infant is discharged prior to this time and medical contact cannot be ensured within the next 72 hours, then a full examination should be carried out but the family advised to see their general practitioner as soon as possible for a further check. Midwives undertaking such examination should be familiar with up to date guidelines of the Health Board for managing babies on the postnatal ward. Midwives must keep a record of all examinations undertaken, and perform a minimum of 30 examinations a year in order to maintain professional competency. A diary of activity will be maintained by the midwife for appraisal and audit purposes. This diary will be reviewed at the annual Professional Development review according to the All Wales Policy. Any critical incidents will be reported through the hospital incident reporting system. If a midwife is unable to carry out the required number of assessments in a calendar year, they should arrange to complete 3 observed Newborn Examinations with either an experienced Newborn Examination Midwife or one of the senior medical staff (Registrar, senior ANNP or Consultant) for assessment of competency.

Examination:

Prior to undertaking the newborn examination the midwife must review the case notes to identify any risk factors for ill health (this includes obstetric, medical, family, and social and drug history). The midwife should ensure the following -

- Obtain informed consent from the parents
- Undertake the examination in the presence of a parent
- Undertake a comprehensive clinical examination
- Routine pulse - oximetry is offered to all babies. This is an additional measure to improve detection of congenital heart disease and other illnesses. This facility may not be available for babies having the Newborn Examination in the community but can be offered to be undertaken in hospital if the family is willing to attend.
- Record details of any examination and advice given to parents in the case notes, including the body map in the postnatal community record
- Any comment for attention of the GP can be communicated by letter or by entry within the Child Health Record and also communicated to the parents
- Record any deviation from the normal and make the appropriate referral to the paediatric medical staff in accordance with the most recent postnatal ward guidelines for further evaluation or investigation as appropriate
- Organise appropriate vaccination (i.e. BCG/ Hepatitis B) according to up to date ABMU Health Board postnatal guidelines.
- Consider advising exclusively breastfeeding mothers and those at particular risk of Vitamin D deficiency to supplement babies with Multivitamin drops such as Abidec in order to prevent Vitamin D Deficiency (Refer to NHS choices website for up to date advice).

Criteria of babies suitable for examination by Midwives

- All low-risk term babies (≥37/40)
- In addition, high-risk babies (For e.g. IUGR, Infant of diabetic mother, risk of neonatal abstinence syndrome, Maternal PROM or meconium at delivery) requiring close monitoring and repeated observations can undergo routine examination by the midwife if they have completed the required observations/pathway without concern. **The midwife will be supported by medical staff at all times and overall care of such infants remains the joint responsibility of the medical and midwifery team.**
- Babies with unilateral antenatal hydronephrosis where clear guidelines on referral and investigation is available.

The experienced Newborn Examination Midwives may examine infants outside of these criteria with full support from the Neonatal Medical staff. These infants will need a formal review by the medical staff prior to discharge.

Criteria of babies not suitable for examination by Midwives

- Any infants showing current signs of ill health
- Infants born preterm or with significant growth restriction (<0.4th centile)
- Infants admitted to a neonatal unit
- Infants with known major congenital anomalies (excludes unilateral antenatal hydronephrosis as above)
- Infants born by *difficult* instrumental delivery.
- Infants born in poor condition at birth (Need for resuscitation, poor cord gases, difficult / traumatic delivery)
- History of Maternal Grave's disease or hyperthyroidism

Referral Guidelines:

Urgent Referral (see referral pathway)

Those infants deemed to require an urgent paediatric assessment will be immediately transferred to an appropriate neonatal unit/ SCBU. The referring midwife is responsible for informing the receiving neonatal unit of her intention to transfer the

infant, to ensure that they are open to admissions and are able to receive the infant. She should also make arrangements for appropriate and safe transfer of the baby. An interim management plan and safe mode of transport must be agreed with the accepting paediatrician and documented in the notes. Maintenance of a stable airway and temperature must be a priority during transport.

Criteria of babies that require urgent medical review (includes but are not limited to):-

- Any infant showing signs and symptoms of serious ill health for e.g. need for resuscitation, breathing difficulty, convulsions etc.
- Any infant with a suspected cardiac defect (i.e. Heart murmur or
- absence of femoral pulses)
- Any infant found to have an imperforate anus, abdominal distension or bile stained vomit
- Any infant who becomes jaundiced in the first 24 hours of life.
- Serious birth injuries such as fractures / Erb's palsy etc
- Bilateral undescended (not palpable) testes (require medical review within 24 hours)

Non-urgent referrals for which a medical input is required:

(Please refer to the paediatrician on call - ideally a registrar grade doctor if available) for an agreed plan of action before the woman is discharged. Refer to the paediatrician on call for the site. For issues related to babies at birthing centre at NPT please refer to paediatricians at POW).

The following are examples of non-urgent referrals -This list is not exhaustive and the midwife is professionally responsible and accountable for referring any infant she suspects of having a congenital anomaly, or who displays abnormal neonatal behaviour.

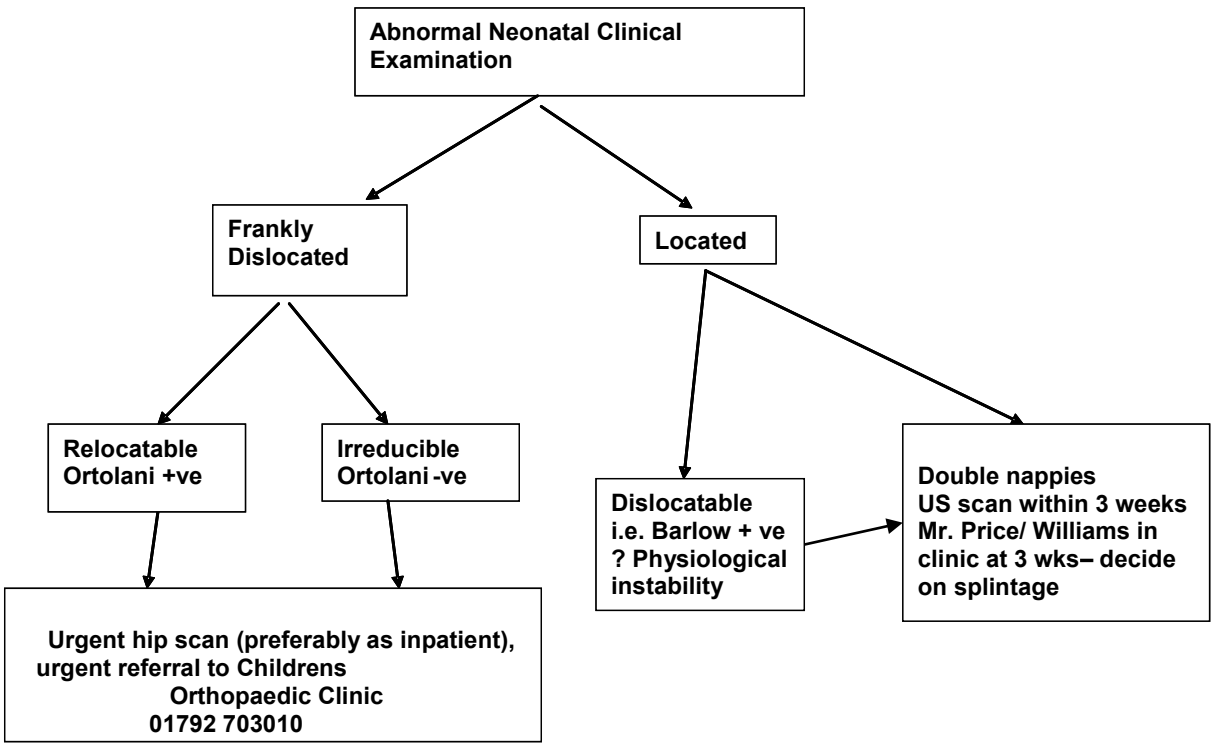
• Absence of red reflex of the eyes – Refer to Paediatric Registrar on call for plan of action and review.

- Abnormal hip examination – Discuss with Paediatric Registrar for review. Arrange a time and venue.
- Risk factors for Congenital Hip Dysplasia: - If clinical examination normal - refer for hip USS to be undertaken at 4 to 6 weeks of age. If Hip examination abnormal - refer to Paediatric registrar on call for plan of care as above. Please see attached guideline.
- Talipes (positional) – This is now regarded as a variation of normal. Explanation to parents .No Follow up required.
- Unilateral undescended testes, or the presence of a hydrocele - Follow up by GP at 6/52 baby check. Inform parents and make a note in the red book.
- Skin Tags– Reassure parents. Refer infant for review by GP at 6/52 baby check and further referral as appropriate.
- Hypospadias – If abnormality more severe than glandular hypospadias - Refer to paediatrician on call for review and plan of action.

- Maternal Hypothyroidism – please see attached flowchart

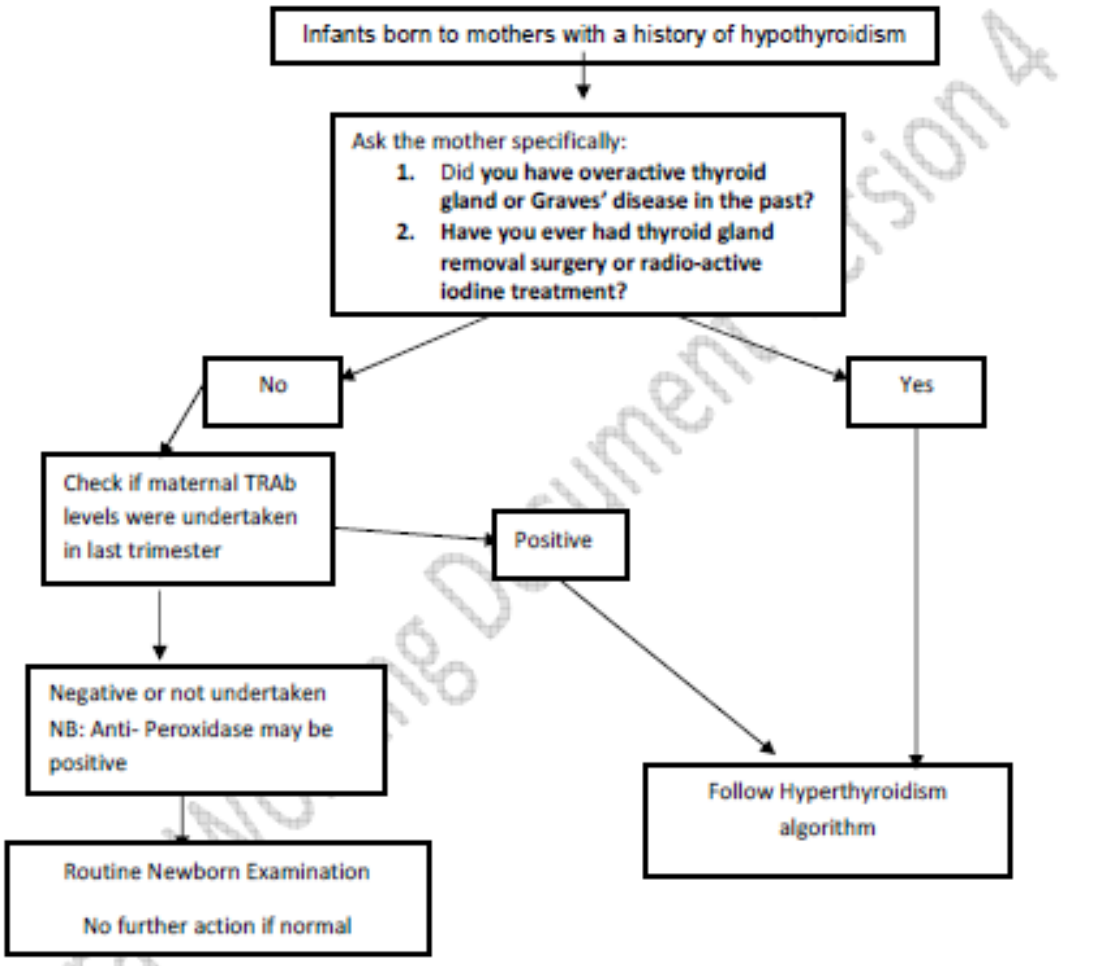
- Maternal Hyperthyroidism or Graves disease – babies should be referred to the Paediatrician for newborn examination

Neonatal Hip Protocol– Clinically Abnormal Hips



Management algorithm of infants born to mother with known hypothyroidism:

Rationale: Pregnant women with hypothyroidism have regular Thyroid Function Tests (TFT) to optimise therapy. Even with current hypothyroid /euthyroid status, some women with past history of Graves' disease may continue to have elevated TRAb levels in their circulation that may cross placenta and increase the risk of fetal/ neonatal thyrotoxicosis. Mothers with such history should have TRAb levels checked in pregnancy, particularly if they never had documented negative TRAb levels. History of Graves' disease in the mother or a positive TRAb level increases the risk of neonatal hyperthyroidism. A negative TRAb level in the last trimester reduces the risk of neonatal thyrotoxicosis in the infant.



***Thyroid peroxidise antibodies (TPO-Abs) in the mother is diagnostic of the autoimmune origin of the disorder but is not useful to formulate treatment plan for the baby. TRAb levels are more predictive of risk of affection of the neonate. TRAb measurements do not indicate if these are stimulating or blocking antibodies.*