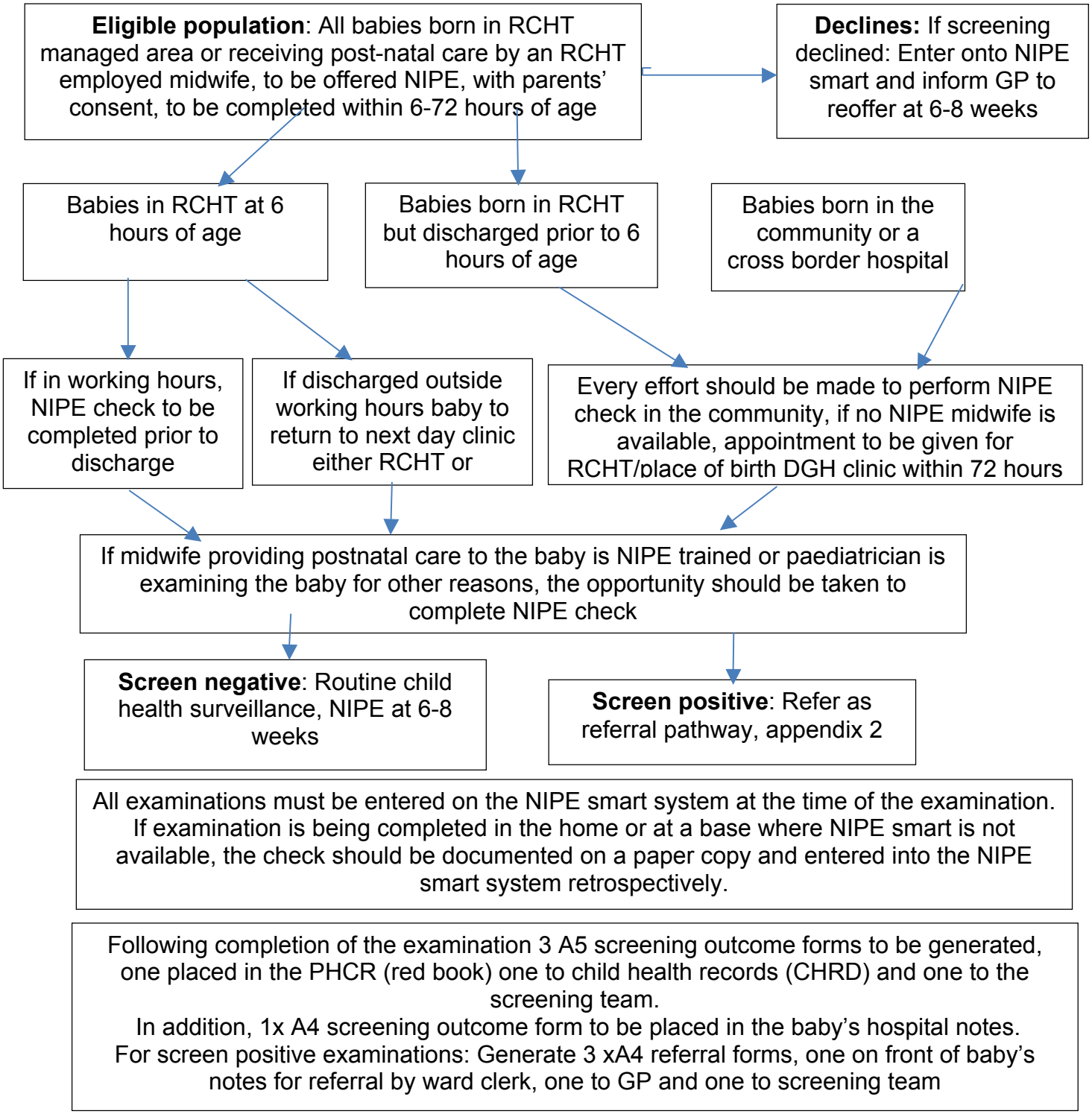
NEWBORN INFANT PHYSICAL EXAMINATION (NIPE) CLINICAL GUIDELINE

Summary.

Newborn and infant physical examination (NIPE) guideline

NIPE midwife led clinics will occur each day, including weekends, on the Postnatal Ward at RCH with allocated times for planned term baby checks and emergency slots for ad hoc referral reviews and outstanding NIPE checks identified that day. There will also be provision for some clinic time in Penrice and Helston Community Hospitals in addition to NIPE Trained community midwives able to perform checks in the home/local clinic. Where possible, arrangements for the NIPE should be made with the parents on the day of the baby's delivery



All examinations must be entered on the NIPE smart system at the time of the examination. If examination is being completed in the home or at a base where NIPE smart is not available, the check should be documented on a paper copy and entered into the NIPE smart system retrospectively.

Following completion of the examination 3 A5 screening outcome forms to be generated, one placed in the PHCR (red book) one to child health records (CHRD) and one to the screening team.
In addition, 1x A4 screening outcome form to be placed in the baby's hospital notes.
For screen positive examinations: Generate 3 xA4 referral forms, one on front of baby's notes for referral by ward clerk, one to GP and one to screening team

Newborn and infant physical examination (NIPE) guideline

1. Aim/Purpose of this Guideline

1.1. A full physical examination of the newborn (NIPE) within 72 hours after delivery is the required Standard of the UK Public Health England Screening Programme. The dual purpose of this examination is to confirm normality, thereby reassuring parents and carers, and to identify and act upon any abnormalities[1]

1.2. This guideline applies to all RCHT medical staff, advanced neonatal nurse practitioners (ANNPs), neonatal nurses and midwives qualified to undertake examination of the newborn where the Trust supports them in this role.

1.3. Full newborn examination is in addition to the initial examination undertaken by the midwife or neonatal team member directly following delivery and in addition to examinations for any medical concerns at birth

1.4. This guideline details who can perform a NIPE screen, timing of the NIPE examination, details of the examination required, recording the examination findings on the NIPE Smart system and referral pathways

2. Guidance

2.1. Information and verbal consent for routine NIPE screening should be gained from the parent/guardian prior to the screening examination wherever possible. If screening is declined, a follow up examination should be offered at 6-8 weeks

2.2. **Timing**. The first full physical newborn examination should be performed within 6 to 72 hours of the baby's delivery. Acceptable delay for NIPE screening can occur for babies whose condition is considered too unstable for a full NIPE check eg. a baby receiving NNU intensive or high dependency care. These babies should be screened as soon as is feasible

2.3. If parents intend to take baby home before 6 hours of age, or baby born in the community then the midwife will arrange for the baby to be examined either in the Community or if not possible, book at RCH clinic, within 72 hours of birth.

2.4. All babies examination findings have to be recorded on the NIPE Smart National Database see Section 3

2.5. **Training**.

All staff performing Newborn Infant Physical examinations are expected to be updated and certified annually via NIPE online training at http://cpd.screening.nhs.uk/nipe-elearning or NHS England CPD portal http://portal.e-lfh.org.uk/ and to record the examination on the NIPE Smart database at the time of the check

2.5.1. Junior doctors/Core trainees training in Paediatrics receive a specific neonatal/postnatal ward induction programme which includes supervised neonatal examinations and have the backup of Specialist Registrars, ANNPs and Consultants. They will also be expected to achieve certified competence of NIPE online update training before performing NIPE

2.5.2. ANNPs receive initial training as part of the neonatal nurse practitioner programme and continuous practice maintains their competence

alongside annual online NIPE update training

2.5.3. Midwives receive training by undertaking an Examination of the Newborn (NIPE) accredited course and continuous practice maintains competence. Midwives are expected to maintain their competence, annually update their online NIPE training and have an annual update meeting with a mentor. Exclusion criteria for midwifes performing NIPE examinations are listed in Appendix 1

2.6. Examination of the Newborn

Before examining the baby, confirmation that there are no antenatal or maternal concerns is required. A copy of any antenatal plan of care for any suspected/known problems should be placed in the neonatal notes and consulted for guidance and planning. The mother's electronic Maxims/handheld notes should be accessed for additional relevant documentation.

Key components of the NIPE screening test are examination of the heart, eyes, hips, and in male infants, examination of the testes

The examination should include:

- Review family, maternal and perinatal history, plot birth weight and head circumference on growth chart
- Ascertain any carers anxieties and observe interaction with the baby.
- Feeding method and any concerns
- Undress baby completely during the examination
- Check if meconium and urine (check urine stream in a boy) passed and document failure to do so with an action plan
- Observe baby's general condition: colour, breathing, behaviour, activity, posture and cry
- Examine the exposed parts of the baby first: facial symmetry, scalp, head, including fontanelles, nose, mouth including visualising the **palate,** tongue and gums, presence of suck reflex, position and placement of ears
- Examine the baby's **eyes** for size, position, absence of discharge and red reflexes
- Palpate the neck and clavicles, check limbs, hands, feet and digits, assessing proportions and symmetry
- Assess the cardiovascular system – colour, capillary refill time, heart rate, brachial and femoral pulse volumes, auscultate **heart** for rate, rhythm, and any added sounds
- If pulse oximetry available, record and compare oxygen saturation readings from the RIGHT hand to a reading from either foot are both over 95% and within 3% of each other
- Respiratory effort and rate, listening to air entry across chest fields
- Observe the baby's abdomen – palpate to identify any organomegaly, masses or hernia. Examine the umbilical cord
- Observe the baby's genitalia and anus, to check normal appearance, positioning and patency
- Palpate **testes** in male infants for presence or undescended position
- Inspect the bony structures and skin of the baby's spine, with the baby prone
- Note the colour and texture of the skin as well as any birthmarks or rashes

- Observe tone, behaviour, movements and posture to complete the assessment of the central nervous system (CNS) If concerned, a detailed neurological examination e.g. eliciting newborn reflexes should be performed
- Check **hips**, symmetry of the limbs and skin folds. Perform Barlow and Ortolani's tests.
- Consider any specific known risks in the baby's home, and alert appropriate professionals to parents who may have problems in caring for their baby
- Ensuring that parents know how to assess their baby's general condition and access help and inform them of the next Child Health Surveillance planned review.

2.3 **Abnormalities detected on screening process for referral for further medical investigation, treatment or care if required**

See Appendix 2 for specific NIPE referral system pathways for screen positive baby
Non urgent referrals should be within normal working hours where possible, between 9-5pm. Urgent referrals can be made at any time

2.4 **Communication and Documentation**

- A copy of any antenatal plan of care from mother's Maxims record for suspected/known problems should be placed in the neonatal notes and consulted for guidance and planning.
- The examination should be recorded onto the baby's online NIPE smart record with printouts, and filed as detailed in Section 3
- If a deviation from normal (screen positive) result or risk factor is identified, the parents should be informed and any plan for investigation, treatment or care discussed and documented in the neonatal notes. All entries should be dated, timed and signed with name and designation printed.
  The baby's NIPE smart record should be updated, recording any referrals made using the letter templates from NIPE Smart system/Maxims discharge letter/Badger discharge letter as appropriate

3. NIPE Smart system

Introduction

NIPE smart is an IT solution for the recording of the newborn examination of all babies residing in England. It provides a robust failsafe system and a consistent means of capturing data. It supports healthcare professionals in improving the quality, timeliness and consistency of the examinations and reduces the number of babies diagnosed late with medical conditions.

Cohort

From 1st April 2017, all babies born within, or cared for by the Royal Cornwall Hospital Trust managed area, will receive their newborn, NIPE examination, by a NIPE trained health professional, employee of RCHT.

Training

It will be the responsibility of the Health Professional undertaking the examination to record the findings of the examination on the NIPE smart IT system.
All staff undertaking NIPE will receive training in the smart system through either group sessions, one to one session with an experienced smart user or by online training, which will be available by the end of 2017

Accessing NIPE smart

Once training has been received, the NIPE smart application should be down loaded on to your desktop from the RCHT applications catalogue or from https://nipe.northgate.thirdparty.nhs.uk/nipe/ManualLogin.aspx

Password generation

To generate your user name you will need to provide your NHS.net email address and NMC/GMC number and for doctors in training, the date you expect to finish your paediatric allocation. Most staff will be entered in advance onto the system. If you are not registered on the database, password generation can be done either by a member of the screening team, tr-rch.screening@nhs.net or by a NIPE Smart super user.

Type in your username and then select 'forgotten password' and follow the instructions.

Documentation

The NIPE examination should be done at a site where there is access to the smart system, and the information should be entered real time, during the process of the examination. However, if this is not possible, the examination should be documented on the Infant Record form and details entered onto the smart system, as soon as reasonably possible, remembering to add date and time the examination was completed.

Once the examination is complete the following documentation should be generated.

Babies who screen negative and without risk factors:

NIPE Examiner print 3 X A5 forms and one A4 form

A5 forms:

- One for the Personal Child Health Record (PCHR) 'red book' to be inserted by NIPE examiner or handed to parent if book not available.
- One for Child Health Records Department, Pendragon House, RCH (CHRD),
- One for the Newborn screening team, Ground Floor, PAMW

A4 form:

- To be inserted in the baby's medical records by NIPE examiner.

Community setting

A5 forms:

- One for the Personal Child Health Record (PCHR) 'red book' to be inserted by NIPE examiner or handed to parent if book not available.
- One for Child Health Records Department, Pendragon House, RCH (CHRD), - Each base to have a collection point and weekly return to CHRD
- One for the Newborn screening team, Ground Floor, PAMW
  - Each base to have a collection point and weekly return to CHRD

Community A4 form:

- To be inserted at the front of the maternal handheld 'green notes' and returned to the maternity unit once the mother is discharged. The form should then be transferred to the baby's medical notes for filing in medical records

Babies who screen positive or have risk factors for hip, heart, testes or eye problems follow guidance in NIPE Referral Pathway, see Appendix 3

- Check the NIPE Referral Pathway for the problem and action as appropriate

  Print off the 3 X A5 forms as above
  Print off 1 X A4 form as above
  Print off 3 X A4 referral forms:

HOSPITAL SETTING:

- Attach one referral form to the front of baby's notes for ward clerk to send the referral
- One copy for the ward clerk to send to GP, highlighting any local risk factors which will need GP review at 6-8 week check
- One copy to RCH neonatal screening team office, ground floor PAMW

COMMUNITY SETTING:

- Referral to be made as per referral pathway. Document the referral details on the form and put a copy in the front of the handheld green notes with the baby examination form
- One copy to GP, highlighting referral details and any local risk factors that will need review at 6-8 week check
- One copy to screening team, highlighting referral details, via base weekly return process

4. Daily NIPE Clinic worklist and weekly data checks

The UK National Screening Committee (UKNSC) policy for NIPE is that all eligible babies will be offered screening. The screening should be offered and completed within 72 hours of birth.
The Health Professional that is responsible for that days NIPE clinic in RCH will, before clinic commences, check the daily work list on the NIPE smart system. This will identify all babies who are eligible for a NIPE check that day

Babies coloured neutral:

- These babies are between birth and 48 hours old. Any babies in this group and over 6 hours old and still in hospital should be added to the daily work list.
- If the Health Professional identifies any baby on this work list as being in the community, she should page the on call midwife for that area, who should then either arrange for the NIPE check to take place in the community setting or for the parents to bring the baby into the NIPE clinic.

Babies coloured amber:

- These babies are between 48-72 hours old and it is the responsibility of the health professional to ensure that the NIPE check is done before they are 72 hrs old.
- If baby is in NNU and their condition does not allow for the NIPE examination, mark this on the NIPE smart system.
- If baby is in community setting, page on call midwife and give her an appointment time for the NIPE clinic or ensure there is a NIPE examiner available in the community that can perform the check before 72 hours of age.

Babies coloured Red

- These babies are over 72 hours old and have breached the 72 hour standard.
- If baby is in hospital and their condition allows, ensure baby is examined the same day
- If baby is in the community setting health professional to contact the parents directly and offer an urgent, same day appointment at the NIPE clinic if no community staff able to perform NIPE that day

Declines
If parents decline a NIPE examination for their baby, ensure this is recorded in the NIPE smart system by:

- Selecting decline
- Complete reason
- Save (directly from risk factor tab)
- Then press 'save and exit'

In the event of a baby who is deceased

Ensure this is recorded in NIPE smart system to prevent any further distress to parents as they will be recalled for screening

Screening failsafe
Daily: Monday -Friday the screening team will check that no babies are about to breach 72 hours. Communication to take place with the Health Professional responsible for the daily NIPE clinic, to ensure that there is a plan in place for any baby about to breach the 72 hours.
Weekly: All A5 screening outcome forms and A4 referral forms to be received in the screening office, along with a weekly eclip report (a report generated from our local maternity IT system) of all births for the preceding week.
A5 screening outcome forms to be matched with eclip report: Any births without a screening outcome form to be searched for on the 'smart' system.

- If baby found on 'smart' system and examination is complete and no referral required, await arrival of the form.
- If baby found and check is complete but a referral is required, contact the examiner to ensure the referral has been made.
- If baby found on 'smart' system but no check is recorded, immediately contact the team leader/ward manager to investigate. If check has been completed but not recorded, responsible health professional to complete entry and ensure correct documentation is completed. If baby has not had NIPE check, ensure this is completed urgently and complete a datix incident form for investigation.
- If baby is not found on the 'smart' system, contact the Northgate helpdesk for advice.

Weekly: All A4 screen positive referral forms to be checked against the RCH appointment system to ensure that baby has been entered into care.

5. Key Performance Indicators (KPI's)

These are national standards set by the national screening committee.

- **Standard 1: Identify the population and coverage.** This standard provided assurance that screening is offered to all eligible babies and a conclusive screening result is available by 72 hours of birth. Acceptable performance is 95% and the achievable performance is 99.5%.

- **Standard 2: Timeliness of intervention (abnormality of the eye)** To ensure that any baby with a positive screen test for an abnormality of the eye receives and assessment by a specialist within 2 weeks of life. Acceptable performance 95% and achievable performance is 100%.
- **Standard 3: Timeliness of intervention (Developmental Dysplasia of Hips - DDH).** That babies with a screen positive test for DDH, have an assessment by specialist hip ultrasound by 2 weeks of age. Acceptable performance 95% and achievable performance 100%
- **Standard 4: Timeliness of intervention (Developmental Dysplasia of the Hips-DDH-risk factors).** That babies with a negative screen test but have identified risk factors, undergo an assessment by specialist hip ultrasound within 6 weeks of age. Acceptable performance 90% and achievable performance 95%
- **Standard 5: Timeliness of intervention (bilateral undescended testes).** That all babies identified with bilateral undescended testes are seen by a consultant paediatrician/associated specialist within 24 hours of the NIPE examination. Acceptable performance threshold 100%

6. Further information

1. Newborn and Infant Physical Examination Screening Programme Standards (2016/17) Public Health England. April2016 PHE publications gateway number: 2015772 https://gov.uk/government/collections/nhs-population-screening-programme-standards
2. National Institute for Health and Clinical Excellence (2006) CG 37 Postnatal care: routine postnatal care of women and their babies London:NICE www.nice.org.uk
3. National Screening Committee: Newborn and Infant Physical examination guidance (2016) https://www.gov.uk/government/collections/newborn-and-infant-physical-examination-clinical-guidance
4. Lee T., Skelton R.,Skene,C. (2001) Routine neonatal examination:effectiveness of trainee paediatrician compared with advanced neonatal nurse practitioner *Archives of Disease in Childhood: Fetal and Neonatal edition Vol85.no 2 pp F100-104*
5. Lomax,A (2001) Expanding the midwife's role in examining the newborn *British Journal of Midwifery Feb, vol 9.no 2 pp 10-102*

Monitoring compliance and effectiveness

Element to be monitored	Record keeping by Obstetricians and Midwives
Lead	Maternity Risk Management
Tool	1. Was an abnormality suspected or detected? 2. Was there clear documentation of the concern 3. Was a timely referral made to the paediatric SPR or Consultant 4. Was the referral clearly documented 5. Was there a timely review by the SPR/Consultant 6. Was the review documented 7. Was a clear plan of care documented 8. Was it documented that the parents were kept informed throughout the process
Frequency	1% or 10 sets, which ever is greater, of health records of newborns for whom a referral has been made will be audited over a 12 month period
Reporting arrangements	A formal report of the results will be received annually at the Maternity Forum and clinical audit forum, as per the audit plan
Acting on recommendations and Lead(s)	Any deficiencies identified on the annual report will be discussed at the Maternity Forum and clinical audit forum and an action plan developed Action leads will be identified and a time frame for the action to be completed by The action plan will be monitored by the maternity risk
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a time frame agreed on the action plan A lead member of the forum will be identified to take each change forward where appropriate. The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan

7. Equality and Diversity

7.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

7.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 3. Governance Information

Document Title	NEWBORN INFANT PHYSICAL EXAMINATION (NIPE) CLINICAL GUIDELINE			
Date Issued/Approved:	14th March 2017			
Date Valid From:	14th March 2017			
Date Valid To:	14th March 2020			
Directorate / Department responsible (author/owner):	Judith Clegg ANNP, Jan Clarkson, Newborn screening coordinator			
Contact details:	01872 252667			
Brief summary of contents	Performing a newborn examination, using the NIPE Smart database system, referral pathways, NIPE clinics			
Suggested Keywords:	Newborn. Neonatal. NIPE. NIPESmart. Midwife examination. Referral			
Target Audience	RCHT	PCH	CFT	KCCG
	✓			
Executive Director responsible for Policy:	Medical Director			
Date revised:				
This document replaces (exact title of previous version):	Neonatal referral pathway NIPE guideline			
Approval route (names of committees)/consultation:	Maternity guideline group Neonatal guidelines group			
Divisional Manager confirming approval processes	Head of Midwifery			
Name and Post Title of additional signatories	None Required			
Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings	{Original Copy Signed}			
	Name:			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	

Document Library Folder/Sub Folder	
Links to key external standards	*Governance Team can advise*
Related Documents:	1. Newborn and Infant Physical Examination Screening Programme Standards (2016/17) Public Health England. April2016 PHE publications gateway number: 2015772 https://gov.uk/government/collections/nhs-population-screening-programme-standards 2. National Institute for Health and Clinical Excellence (2006) CG 37 Postnatal care: routine postnatal care of women and their babies London:NICE www.nice.org.uk 3. National Screening Committee: Newborn and Infant Physical examination guidance (2016) https://www.gov.uk/government/collections/newborn-and-infant-physical-examination-clinical-guidance 4. Lee T., Skelton R.,Skene,C. (2001) Routine neonatal examination:effectiveness of trainee paediatrician compared with advanced neonatal nurse practitioner *Archives of Disease in Childhood: Fetal and Neonatal edition Vol85.no 2 pp F100-104* 5. Lomax,A (2001) Expanding the midwife's role in examining the newborn *British Journal of Midwifery Feb, vol 9.no 2 pp 10-102*
Training Need Identified?	Yes, university module for accreditation for midwife NIPE checks

Version Control Table

Date	**Version No**	**Summary of Changes**	**Changes Made by** *(Name and Job Title)*
August 2013	V1.0	Initial Issue. Neonatal Referral Pathway (NIPE) clinical guideline	M.Denholm, Newborn Screening
14th March 2017	V2.0	Addition of full newborn examination, NIPE Smart system, clinic information and updated referral pathways	Judith Clegg, ANNP Jan Clarkson, Newborn screening

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 4. Initial Equality Impact Assessment Form

Name of Name of the strategy / policy /proposal / service function to be assessed (hereafter referred to as *policy*) NEWBORN INFANT PHYSICAL EXAMINATION (NIPE) CLINICAL GUIDELINE		
Directorate and service area:		Is this a new or existing *Policy?*
Name of individual completing assessment: Judith Clegg		Telephone: **01872 252667**
1. *Policy* Aim* *Who is the strategy / policy / proposal / service function aimed at?*	To give all RCHT medical staff, advanced neonatal nurse practitioners (ANNPs), neonatal nurses and midwives qualified to undertake examination of the newborn guidance on the full examination of the newborn	
2. *Policy* Objectives*	To ensure that all newborns, examined by staff employed by RCHT, receive a full physical examination inline with the national screening standards	
3. *Policy* – intended Outcomes*	To identify and review any suspected or actual newborn abnormalities	
4. *How will you measure the outcome?	Compliance monitoring tool	
5. Who is intended to benefit from the *policy*?	Newborn babies and their parents	
6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? b) If yes, have these *groups been consulted? C). Please list any groups who have been consulted about this procedure.	No N/A N/A	

7. The Impact
Please complete the following table.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Rationale for Assessment / Existing Evidence
Age		**x**	
Sex (male, female, trans-gender / gender reassignment)		**x**	
Race / Ethnic communities /groups		**x**	
Disability - learning disability, physical disability, sensory impairment and mental health problems		**x**	
Religion / other beliefs		**x**	
Marriage and civil partnership		**x**	
Pregnancy and maternity		**x**	
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**x**	

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**	**No** **X**

9. If you are **not** recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director	Date of completion and submission 14th march 2017

Names and signatures of members carrying out the Screening Assessment	1. Judith Clegg 2. Jan Clarkson	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust's web site.

Signed Sarah-Jane Pedler

Date 14th March 2017

APPENDIX 1.

Midwifery staff examination of the newborn

The following exclusion criteria apply for midwife examinations. Additionally, Midwives can refer any baby to an experienced practitioner if they have concerns about performing the examination.

Exclusion criteria for midwife examination:

- Premature, under 36+6 weeks gestation
- Baby required NICU admission or paediatric referral
- Significant family history of genetic or congenital complications
- Suspected or confirmed abnormality at antenatal screening
- Suspected trauma from birth, eg. shoulder dystocia, nerve palsy
- Maternal raised antibodies/positive antenatal screening or haematological disorder

APPENDIX 2.

NIPE REFERRAL PATHWAYS

Referral Pathways for possible anomalies noted at the NIPE Check

If the healthcare professional performing the newborn examination identifies any deviation from the norm, a referral should be made to a member of the neonatal team who will be able to provide advice for further referral/review The person performing the newborn examination who identifies any deviation from normal (screen positive result) should consult the referral pathway, and contact the Registrar/SHO/ANNP on Neonatal Bleep/ via switchboard for advice

- Contact with the neonatal team should be made as soon as possible and **within usual clinic working hours where possible, 9-4pm**

- Community referrals, check referral pathway guidance and Bleep Neonatal SpR via switchboard within above working hours as appropriate

- Community midwives may, after discussion as indicated, complete the referral to the appropriate specialist independently

Any baby who appears unwell or raises concern must be immediately discussed with a senior neonatal team member, SpR or above, and assessed for potential admission/ immediate review

If a deviation from the normal is identified the parents will be informed immediately and any plan for investigation, treatment or care will be discussed and developed with them

Documentation and Communication The baby's NIPE Smart record should be marked that senior review has been indicated The **reviewer** then has responsibility to amend the record once further examination/plan of care is made. Any referrals should be clearly documented in the baby's notes, NIPE Smart system and PCHR Red Book
The Personal Child Health Record (PCHR or "Red Book") is initiated at birth and remains with the parents on transfer home in order to main effective communication and documentation between the multi-professional team and the parents in addition to any hospital medical notes.

NIPE PATHWAYS FOR HOSPITAL AND COMMUNITY REFERRALS

Abnormal examination finding	Timeframe for referral (maximum)	Initial referral pathway	Further action	Hospital referral method	Community referral method
		DYSMORPHISM			
Abnormal/ dysmorphic appearance	2 hours	Midwife to SpR or Consultant	No baby to be discharged home without review by SpR/ Consultant	SpR Bleep	**Neonatal** SpR bleep via switchboard
		HEAD SHAPE			
Abnormal head shape	Within 24 hours	Midwife to SHO/ANNP/SpR	Plot head circumference Consider review after 2-3 days	SHO/ANNP bleep	In hours Neonatal SpR bleep via switchboard
Severe or large haematoma	2 hours	Midwife to SHO/ANNP/SpR	Plot head circumference Monitor jaundice	SpR Bleep	Neonatal SpR bleep via switchboard
Boggy swelling crossing cranial suture line, not considered caput	2 hours	Midwife to SHO/ANNP/SpR	Plot head circumference	SpR Bleep	Neonatal SpR bleep via switchboard
		FACE			
Facial asymmetry	Before discharge or next working day if no eye/feeding concern	Midwife to ANNP/SHO	Ensure baby able to close eyes and suck/latch to feed	ANNP/SHO Bleep	ANNP/SHO bleep to NNU clinic
Abnormality of the ear, pits or tags	24 hours (if dysmorphic needs same day review)	Midwife to ANNP/SHO	Ear abnormal Refer to hearing screening, pits or tags no referral HV will screen hearing Record on NIPE Refer as appropriate to audiology NO renal scan	ANNP/SHO Bleep	ANNP/SHO bleep for advice then refer as needed Minor tags GP refer at 6-8 week check
Abnormal examination	**Timeframe for referral**	**Initial referral pathway**	**Further action**	**Hospital referral method**	**Community referral**

finding	(maximum)				method
MOUTH					
Natal teeth	Before discharge or within 24hrs	Midwife to SHO/ANNP/SpR	Refer to maxillofacial team *Check tooth stability	SHO/ANNP bleep Letter to maxfacial team	SpR via switchboard (may advise midwife to refer direct)
Cleft lip +/- palate	Same day	Midwife to SHO/ANNP/SpR	Admit postnatal ward Same day referral to Bristol and Orthodontic team RCH Monitor feeding ability Refer to hearing screening	SHO/ANNP bleep Contact RCH orthodontist by phone/sec and Bristol team	SpR via switchboard, admit
		EYES			
Small or absent eye	Within 24hrs	Midwife to SHO/ANNP/SpR	Refer to Ophthalmologist 1 week review	SHO/ANNP bleep Phone/email + Maxims/NIPEsmart letter	SpR via switchboard
Absent red reflex	Within 24 hours	Midwife to SHO/ANNP/SpR	Refer to SpR Ophthalmologist 1 week review m	Phone/email + Maxims/ NIPEsmart letter	Neonatal SpR via switchboard
Abnormal examination finding	**Timeframe for referral (maximum)**	**Initial referral pathway**	**Further action**	**Hospital referral method**	**Community referral method**
Abnormality of iris	Within 24 hrs	Midwife to SHO/ANNP/SpR	Refer to Ophthalmologist within 1 week	Phone/email + Maxims letter	SpR via switchboard
		RESPIRATION			
Signs of respiratory distress	immediate	Midwife to SHO/ANNP	Review for NNU admission	NNU SHO Bleep	Bleep NNU SHO/ANNP for admission
Stridor	immediate	Midwife to SHO/ANNP	Review for NNU admission	NNU SHO Bleep	Bleep NNU SHO/ANNP for admission
		CARDIOVASCULAR			
Cyanosis	immediate	Midwife to SHO/ANNP	NNU admit	NNU SHO Bleep	**999** ambulance transfer Bleep NNU SHO/ANNP for admission
Murmur, otherwise well	Same day	Midwife to SHO/ANNP	SpR discuss **As per heart murmur guideline**	NNU SHO Bleep	Neonatal SpR via switchboard
Murmur +	immediate	Midwife to	Consultant review	NNU SpR Bleep	999/

concern	review	SHO/ANNP	**As per heart murmur guideline**		Neonatal SpR via switchboard
Absent or weak femoral pulses	Immediate	Midwife to SHO/ANNP	SpR review/Consultant **As per guideline**	NNU SpR Bleep	Neonatal SpR via switchboard
		ABDOMEN			
Abdominal mass	2 hours	Midwife to SHO/ANNP	SpR review/Consultant	NNU SpR Bleep	Neonatal SpR via switchboard
Abdominal wall defect	immediate	Midwife to SHO/ANNP	Consultant review	NNU SpR Bleep	999/ Neonatal SpR via switchboard
Large liver or spleen	Within 24 hours	Midwife to SHO/ANNP to SpR	Discuss with Consultant	NNU SpR Bleep	Neonatal SpR via switchboard
Imperforate anus or abnormally positioned anus	2 hours	Midwife to SHO/ANNP to SpR	Consultant review Paediatric Surgical referral	NNU SpR Bleep	Neonatal SpR via switchboard to admit
Abnormal examination finding	**Timeframe for referral (maximum)**	**Initial referral pathway**	**Further action**	**Hospital referral method**	**Community referral method**
		GENITALIA			
Hypospadias with palpable testes and good urine stream	72 hours	Midwife to SHO/ANNP	Refer to Plastic surgeon, Mr McKenzie As guideline	Maxims letter	Discuss with SpR/+/- review then referral letter
Ambiguous genitalia/ bilateral unpalpable testes	2 hours	Midwife to SpR/Consultant	Consultant review, blood, urine, USS investigations	Phone discussion Paediatric endocrinologist	Neonatal SpR via switchboard to admit
Unilateral undescended testes	**8 weeks**	Midwife to SHO/ANNP	Referral to RCH surgeons See RCH guideline	Maxims /NIPESmart letter	NIPE Smart letter and notify GP for 6-8 week review
Bilateral undescended but palpable testes	**8 weeks**	Midwife to SHO/ANNP	Referral to RCH surgeons As guideline	Maxims /NIPESmart letter	NIPE Smart letter and GP notify for 6-8 week review
		LIMBS			
DDH Hips dislocated/ dislocatable	72 hours	Midwife to SHO/ANNP (to SpR)	Referral to Paediatric physio 1 week Hip scan 2 weeks NIPE smart letter	Ward clerk to book hip scan via NIPE Smart referral letter	Ward clerk to book hip scan
Clicky hip/s, ligamentous	72 hours	Midwife to SHO/ANNP	Hip scan 6 weeks	Ward clerk to book hip scan via NIPE Smart referral letter	Ward clerk to book hip scan

Positional talipes	72 hours	Midwife to SHO/ANNP	Referral to Paediatric physio Hip scan 6 weeks	Ward clerk to book hip scan via NIPE Smart referral letter	Referral letter to Paed physio Ward clerk to book hip scan
Fixed talipes	Same day	Midwife to SHO/ANNP	Referral to Paediatric physio 1 week Hip scan 2 weeks	Ward clerk to book hip scan via NIPE Smart referral letter	Discuss with SpR/+/- review then referral letter
Additional digits	72 hours	Midwife to SHO/ANNP	Plastic surgeon OPA 3-6 months	Maxims letter to GP for referral to surgeon	Letter to GP to refer after 6-8 week check
Brachial/ Arm palsy, suspected ± clavicle fracture	24 hrs	Midwife to SHO/ANNP	Review, +/- XRay parent info leaflet pain relief. Paed physio referral	Letter to Physio and GP	Discuss with SpR/+/- review then referral letter
Abnormal examination finding	**Timeframe for referral (maximum)**	**Initial referral pathway**	**Further action**	**Hospital referral method**	**Community referral method**
		SKIN			
Skin tags	6-8 weeks	Midwife to SHO/ANNP	GP referral to plastic surgeon	Letter to GP	Letter to **GP to review** at 6-8 week check
Birth marks	24hrs	Midwife to SHO/ANNP	Dependent on size, nature and position of lesion Record on NIPE	SpR/Consultant review	Discuss with SpR/+/- review Letter to GP
Vesicular rash	2 hours	Midwife to SHO/ANNP	Urgent review ? viral infection	SpR review	Neonatal SpR via switchboard
Rash of concern	2 hours	Midwife to SHO/ANNP	Hospital review	Senior NNU review	Bleep NNU SHO/ANNP
		SPINE			
Hairy tuft/dense patch of hair	24 hours	Midwife to SHO/ANNP	Senior review Spinal USS if significant	Senior NNU review	Bleep NNU SHO/ANNP
Simple sacral dimple defined as: <2.5cm from anus, <0.5cm wide + no other anomalies **Complex** sacral dimple/asymmetrical natal cleft or other abnormality in area	1-7 days	Midwife to SHO/ANNP	**As guideline** If simple – no review **Complex –** review and spinal USS	Senior NNU review if outside natal cleft, deep sinus	Bleep NNU SHO/ANNP
Curvature of the spine	24 hrs	Midwife to SHO/ANNP	Consultant review X Ray	Senior NNU review	Neonatal SpR via switchboard