NEWBORN AND INFANT PHYSICAL EXAMINATION (NIPE)

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Contents

1.0 Purpose of this guideline ..................................................................................................... 5
   This guidance is relevant to: ............................................................................................. 5

2.0 Purpose of the NIPE ............................................................................................................ 5

3.0 See also: ............................................................................................................................. 5

4.0 NIPE Training for nurses and midwives .............................................................................. 6
   4.1 Delivery of NIPE Programme ...................................................................................... 6

5.0 NIPE Competencies ............................................................................................................ 6
   5.1 NIPE New Starters ..................................................................................................... 7

6.0 Information for parents ......................................................................................................... 7

7.0 User involvement ................................................................................................................. 8

8.0 Babies eligible for NIPE ...................................................................................................... 8
   8.1 Stillbirth or Neonatal Death ......................................................................................... 8
   8.2 Babies being discharged home ................................................................................... 9
   8.3 Baby being fostered or adopted .................................................................................. 9
   8.4 NIPE not completed before discharge ....................................................................... 9
   8.5 NIPE not completed for well-baby before 72 hours ................................................... 10
   8.6 NIPE declined ........................................................................................................... 10

9.0 NICU Babies ...................................................................................................................... 11

10.0 NIPE Clinic ........................................................................................................................ 11
   10.1 Environment ............................................................................................................. 11
   10.2 Equipment ................................................................................................................ 12

11.0 Daily MEON Tasks .......................................................................................................... 12
   11.1 Create Daily worklist ................................................................................................. 12
   11.2 Flag NICU babies .................................................................................................... 13
   11.3 Read Messages in S4N and NIPE emails .................................................................... 13
   11.4 ‘High Risk Babies’ .................................................................................................... 13
11.5 Review in-process records ................................................................. 14
11.6 Mark babies as deceased ................................................................. 14
11.7 Change Primary Contact ................................................................. 15
11.8 Independent midwife homebirths ...................................................... 15
11.9 Move Records ................................................................................. 15
11.10 Transfer babies into area ............................................................... 15
11.11 Enter outcomes for babies who had senior review .......................... 15
11.12 Who examines which babies? ......................................................... 16

12.0 NIPE Examination ........................................................................... 16
12.1 Physical examination ................................................................. 17
12.2 NIPE Documentation ................................................................. 19
12.3 Screen Negative Babies ............................................................... 20
12.4 Screen Positive Babies ............................................................... 20

13.0 Referrals ......................................................................................... 20
13.1 Postnatal handbook - referrals ....................................................... 21
13.2 Hip abnormality suspected ............................................................ 21
13.3 Hips normal but risk factors for developmental dysplasia of the hips 22
13.4 Hips examination normal but ‘other’ conditions ............................. 22
13.5 Heart Abnormality suspected ....................................................... 22
13.6 Heart examination normal but risk factors for cardiac abnormality 22
13.7 Eyes abnormality .......................................................................... 23
13.8 Testes Abnormality ....................................................................... 23

14.0 Smart 4 NIPE IT System ................................................................. 23
14.1 Creating S4N record automatically .............................................. 23
14.2 No NHS number ........................................................................... 23
14.3 Creating S4N record manually .................................................................................. 23
14.4 Birth documented in the wrong notes ........................................................................... 24
14.5 Baby gender incorrect .................................................................................................. 24
15.0 S4N not accessible ......................................................................................................... 24
16.0 NIPE Failsafe .................................................................................................................... 25
  16.1 NIPE Failsafe Team ...................................................................................................... 25
  16.2 Failsafe weekly tasks .................................................................................................. 25
  16.3 Transfer of unscreened baby to another care provider .................................................. 26
  16.4 Transfer of screen positive baby to another care provider .............................................. 26
  16.5 Pre-defined searches on S4N ....................................................................................... 26
  16.6 Failsafe monthly Tasks ................................................................................................ 26
  16.7 Key Performance Indicators (KPI's) ............................................................................. 27
    16.7.1 Quarterly/Annually ................................................................................................. 27
  16.8 Incomplete Outcomes .................................................................................................. 28
17.0 BCG Monthly Report .................................................................................................... 28
  17.1 Monthly BCG report .................................................................................................... 28
18.0 Covid .................................................................................................................................. 28

Insert Flow chart here if relevant ...................................................................................... Error! Bookmark not defined.

References .......................................................................................................................... 29

Appendix 1 – Screening and NIPE Failsafe emails ................................................................. 30
Appendix 2 - Useful links for National Resources (adapted from S4N) ...................................... 30
Appendix 3 - NIPE Peer review form ..................................................................................... 33
Appendix 4 – Baby check competency sign off for General Paediatric Doctors ..................... 34
Appendix 5 – BCG appointments on PAS or Patient Centre .................................................... 36
1.0 Purpose of this guideline

This document details the process for the Newborn Infant Physical Examination (NIPE) screening programme at Ashford & St. Peter’s NHS Foundation Trust (ASPH). It describes the responsibilities of the team and the individual practitioners responsible for the provision of the NIPE.

Implementation of this policy will ensure that all eligible babies are offered NIPE screening and where accepted are screened within 72 hours of birth. All babies who require a further specialist referral will be seen within the timeframe set out in the National Screening Committee’s Newborn Infant Physical Examination Standards & Competencies (2008).

This guidance is relevant to:

- All Midwives / nurses caring for newborn babies
- NIPE Screeners - staff qualified to undertake NIPE including Midwife Examiner of the Newborn (MEON), Advanced Neonatal Nurse Practitioners (ANNP), Neonatal doctors and GP Trainees
- The NIPE Failsafe team - Includes the Screening Coordinator, the NIPE Lead midwife/nurse and the Screening Failsafe Officer

2.0 Purpose of the NIPE

The main aim is to identify and refer all children born with congenital abnormalities of the eyes, heart, hips, and testes, where these are detectable, within 72 hours of birth. NIPE includes screening for congenital cardiac defects, developmental dysplasia of the hip, some ocular disorders including congenital cataract and undescended testes as well as a general physical examination.

The NIPE is in addition to the initial examination undertaken by the midwife directly following the delivery and in addition to examinations for any medical concerns at birth. The NIPE should be performed within 72 hours, by a Paediatrician or a qualified Midwife or Nurse.

A second NIPE screening occurs between 6 to 8 weeks to further identify those abnormalities that may become detectable at that age thereby reducing morbidity and mortality. This examination is usually by the General Practitioner.

These ages are recommended by Public Health England (PHE) based on best practice and current evidence and should facilitate a prompt referral for early clinical assessment.

Screening is performed universally on all newborn babies but screening may be delayed where a clinical decision is made to delay the examination if the baby is too premature or too unwell to have the examination at this time. Screening should be completed as and when the baby’s condition allows.

3.0 See also:


ASPH SOP - Managing Screening Incidents

ASPH BCG SOP

Current PPE and Covid guidelines

Smart for NIPE (S4N) Resources available to S4N users on the NIPE IT system

### 4.0 NIPE Training for nurses and midwives

Examination of the Newborn can be only be undertaken by a midwife who has successfully completed an accredited course within their midwifery training or post-registration. ANNPs receive NIPE training as part of the neonatal nurse practitioner programme.

#### 4.1 Delivery of NIPE Programme

The Midwifery Managers will ensure an adequate numbers of midwives are trained to be able to deliver the programme and that one or more coordinators are in place with admin support to ensure timely reporting and response to information requests. There will be adequate cover arrangements in place to sustain the programme including out of office hours. Safe access to this service will be available for all eligible babies taking account of vulnerability and disability.

### 5.0 NIPE Competencies

Each practitioner is accountable for their practice and is required to maintain their competencies and knowledge. They are required to achieve post-basic learning, work in a framework of professional accountability, and maintain competence to carry out the physical examination and screening of the newborn to the highest standard and to identify gaps in their own knowledge and any training needs.

It is expected that every midwife undertaking NIPEs will:

- complete the ‘e-LfH - NHS Newborn Infant Physical Examination Programme’ annually ([https://portal.e-lfh.org.uk/](https://portal.e-lfh.org.uk/)) and provide a copy of the certificate of completion to the NIPE Failsafe Officer
- Complete and document 12 NIPE examinations annually using NIPE system
• Provide evidence to NIPE Failsafe team of an annual peer review of an actual newborn examination using the NIPE Peer Review Form – to be created

ANNP trainees will be qualified to undertake NIPE when they have completed their Newborn Examination module and had competency signed off by their Consultant supervisor. The ANNP trainee will provide evidence of sign off to NIPE Failsafe Team who will provide access to the NIPE Smart system. The Failsafe Officer will maintain a record of training completed and competency assessments for nurses and midwives.

Doctors are expected to demonstrate on-going professional development to their clinical supervisors.

The NIPE Lead Midwife / Nurse will arrange annual educational - update session for NIPE screeners.

5.1 NIPE New Starters

Administrators in each area of the division responsible for new starters will provide the NIPE Lead with names and details of new starters who are qualified to complete NIPE examinations and who need access to the S4N system.

These details will include:

- Full Name
- Role e.g. midwife, ANNP, GPST, consultant
- Work email address
- Work contact numbers
- NMC or GMC numbers
- Starting date and expiry date for access to S4N

NIPE qualified midwives joining the Trust or existing midwives who complete training will not be authorised to complete NIPE or be added to the NIPE roster until they:

- provide evidence of recognised NIPE qualifications to NIPE Lead
- are trained by a recognised NIPE trainer in their area for local NIPE process, S4N use, and BadgerNet use,
- are assessed as competent by a practising NIPE examiner using Peer Review form.

Junior doctors/core trainees in Paediatrics will receive a neonatal induction programme which includes supervised neonatal examinations and will have the backup of Specialist Registrars, ANNPs and Consultants.

All NIPE examiners will be trained to use the S4N system. This will be led by the NIPE lead and the NIPE super users who will be responsible for cascading this training to other NIPE examiners.

6.0 Information for parents
Midwives and nurses will inform parents about the NIPE examinations during the antenatal period and postnatally before the newborn examination is offered. Parents should be advised that the examination is purely a screening examination and cannot always predict or exclude severe congenital abnormalities (particularly cardiac).

Written information is provided in the PHE approved leaflets ‘Screening tests for You and Your Baby’ which is available on the BadgerNet Maternity Notes App and ‘Screening test for you and your baby: babies in special care units’ which explains the screening tests for babies in SCBU, NICU, or PICU.

Use appropriate interpreter services or appropriate types of information to ensure the information is accessible. Do not use local campaigns or information without PHE approval.

Parents will be informed of the findings at each examination and be advised to report any concerns about their baby’s wellbeing to a healthcare professional at any time. They will be informed of reviews or referrals and timescales. They should be offered Trust Parent Information Leaflets which are available on S4N or on TrustNet.

7.0 User involvement

The NIPE Failsafe Team will:
Demonstrate collection of user views,
Demonstrate how these user views will influence the service

8.0 Babies eligible for NIPE

All newborn babies are eligible and should be offered NIPE. This includes babies born under care of Ashford & St. Peter’s Maternity Services and those babies born elsewhere that transfer into our area that have not been screened.

Each Midwife or Nurse is responsible for ensuring that all newborn babies in their care are offered and that arrangements are made for NIPE within 72 hours from birth or if baby is too ill or premature to be screened that this is documented in the clinical notes.

The NIPE will ideally be done before transfer home or to another unit. This maximizes the opportunity for completing the examination within 72 hours.

For homebirths there should be a plan documented by the midwife for NIPE within 72 hours.

8.1 Stillbirth or Neonatal Death

To help avoid further unnecessary distress to the parents the midwife/nurse caring for mother and baby must inform the:

Maternity coding team – tel. ext. 2658
NIPE team (asp-tr.nipe@nhs.net)
Hearing screening team – (Khft.newbornhearingclinic@nhs.net)
8.2 Babies being discharged home.

The midwife discharging mother and/or baby will document NIPE, Hearing screening and BCG status in BadgerNet Transfer of Care to Community Care record. The discharge midwife/nurse will confirm the BadgerNet Transfer of Care Report for baby is complete and correct and will save this report at discharge. When the report is saved it will be sent automatically to GP, Health Visitor and to Community Midwife Team if address is in area. For out of area babies the discharge midwife will inform the receiving midwife team and will send Transfer of Care Reports to that team by NHS email.

The community midwife taking over care of babies will confirm for all babies in our area that the NIPE screen has been completed and will document this in the clinical notes (Badgernet).

8.3 Baby being fostered or adopted

The midwife caring for any babies where mother is not to be primary contact, e.g. a baby being fostered, will liaise with the NIPE team to update the S4N records.

8.4 NIPE not completed before discharge.

If NIPE has not been completed at discharge home the discharging midwife must document a plan to complete NIPE within 72 hours on the ‘Transfer of Care to Community’ form in BadgerNet.

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

The discharging midwife will perform a pre-ductal (right hand) and post-ductal (any other limb) oxygen saturation measurement.

The oxygen saturation reading should be 95% or above and the difference between the pre and post ductal reading should be no more than 3%. If the difference is greater than 3% the measurement should be repeated one hour later in the absence of any other concerns. If second reading is abnormal escalate to neonatal doctor. If normal, baby can be discharged.

If there are other concerns the baby is to be reviewed as soon as possible by a neonatal doctor or ANNP before baby is discharged.

The responsibility for identifying eligible babies remains with the birth unit until formally passed to another provider which ideally will be managed using S4N.

If the baby is going ‘out of area’ the receiving maternity team must be informed by the discharging midwife when emailing Transfer of Care report that NIPE has not been
completed, to ensure that the NIPE is completed within 72 hours. The email will be copied to the NIPE Failsafe Team screening. The NIPE Failsafe Team will transfer the S4N record to the receiving care location. The rostered NIPE midwife will document the plan in the S4N record as a case note.

Babies who move into area before screening is due are the responsibility of ASPH. Any babies that have moved into our area needing NIPE examination should be followed up by the rostered MEON who will make plan for examination to take place as soon as possible. Babies remain eligible until 6 weeks of age but NIPE should be completed as close to 72 hours as possible.

The community midwife taking over care of babies who were born elsewhere will confirm NIPE, hearing and BCG status at the first contact or visit. The status for each will be documented by the midwife in the clinical notes. Those who have not been screened should be offered screening and where accepted midwife will liaise with NIPE team to arrange screening as soon as possible.

8.5 NIPE not completed for well-baby before 72 hours

If a NIPE is not completed within 72 hours arrange a NIPE through the NIPE Clinic or maternity manager, to be undertaken as soon as possible. If NIPE has been missed due to screening pathway failure inform the NIPE Failsafe team who will investigate and action in line with ASPH screening incident guidance. Complete datix.

Infants up to and including three months of age who have not had NIPE completed should have examination undertaken as soon as possible where consent is given. Liaise with NIPE team, neonatal team and/or manager to arrange suitable practitioner and suitable venue. If ASPH undertakes screening the outcomes should be documented on S4N. If the GP undertakes the screening, document this plan in the clinical notes. If there is a S4N record the rostered NIPE midwife will move the record out of area. The outcomes will not be recorded on S4N.

If the first Newborn Infant Physical Examination is performed at or after 6 weeks of age, it is not necessary to undertake it again.

8.6 NIPE declined

The NIPE examiner will document the offer of screening and acceptance or decline in S4N and the Personal Child Health Record (“red book”) and in Badgernet. This will then be available in the Transfer of Care Report (discharge summary) which the discharge midwife will send to GP and to Health Visitor.

The NIPE examiner will also inform the GP using the letter available in S4N that NIPE has been declined.

Inform the parent/s that if screening is declined, a follow up examination will still be offered at 6-8 weeks.
9.0 NICU Babies

The Neonatal team will review daily the S4N list of NICU babies that have not had NIPE completed. If baby is well enough the NIPE screen will take place within 72 hours of age.

Where a baby is well enough to be transferred from NICU to the post-natal ward and midwifery care the NIPE will be completed before transfer.

Screening may be delayed if the baby is premature or not well enough. Complete screening as soon as the baby’s condition allows. Complete each element of NIPE screening as and when baby’s condition allows.

Document in S4N any reason for delaying NIPE. This will enable the NIPE Failsafe Team to account for these babies in the KPI data submission, giving the reason for delay as mitigation against the 72-hour performance threshold.

Some elements of the NIPE screen may need to be repeated in very preterm babies. Babies less than 32 weeks gestational age should be screened for retinopathy of prematurity (ROP).

Referrals should still be made as per national standards for screen positive cases. Referral timescales should not be adjusted for preterm babies, apart from hip ultrasound referrals. As per national standards, hip ultrasound scans for babies born prior to 34 weeks gestation should be delayed until 38 weeks corrected age.

Where a baby is being transferred to another unit all reasonable efforts should be made to complete NIPE before the transfer. Responsibility lies with the birth unit until the record is formally transferred using NIPE S4N. The NICU clerical team will transfer the S4N record to the receiving care location and will inform the receiving unit that NIPE has not been completed. If NIPE is complete and referral follow ups are required out of our area the NICU clerical team will inform the receiving unit when record is transferred. If referrals are required and the record is not transferred ASPH NIPE Failsafe Team will be responsible for entering outcomes of any referrals.

10.0 NIPE Clinic

10.1 Staffing

A midwife-led NIPE clinic will run 7 days a week from 08:30 - 16:30. A qualified NIPE midwife (MEON) is allocated to the NIPE roster on Healthroster. The roster is the responsibility of the NIPE Lead. In addition, on weekdays (not including Bank Holidays) there will be an allocated ‘baby check’ doctor from the paediatric SHO rota. Where there is no rostered midwife for any reason the on-call midwifery manager will liaise with shift leaders, and/or staffing coordinator to arrange cover from MEONs working that day or to look for bank cover. If no MEON is available the manager will liaise with neonatal team to review and manage the daily NIPE workload.

10.2 Environment
Examinations will usually take place in the nursery for babies on Joan Booker Ward. The NIPE examiner will attend ABC and LW if required to examine any babies. A parent should be present for the examination. Ideally both parents will be present but this will depend on the space available and current infection control guidelines.

10.3 Equipment

It is the responsibility of each NIPE examiner to:

- Ensure that they have the necessary equipment available to carry out their duties safely and effectively
- Ensure that they are trained to effectively and safely use any equipment required to carry out their duties and responsibilities
- To report any damaged, non-functioning, stolen or missing equipment to a line manager

Equipment will include:

- Ophthalmoscope
- Neonatal stethoscope
- Oxygen Saturation monitor with working probe
- Tongue depressor
- Tape measure
- Firm, safe surface for examination
- Hand and equipment cleansing solutions / wipes
- PPE as recommended by current guidelines
- Access to BadgerNet and to S4N system

Availability of equipment is the responsibility of the Joan Booker Ward Manager.

- S4N is a web-based program that can be accessed on the internet. The url is https://nipe.northgate.thirdparty.nhs.uk/S4N/nhsbaby

11.0 Daily MEON Tasks

11.1 Create Daily worklist

The MEON will produce a daily worklist from S4N of babies that have not been screened and those that are ‘in process’. Compare this list against the list of babies in BadgerNet as babies will occasionally not have S4N record and may be missed if only using the S4N list. There is a list in BadgerNet Maternity of babies that have not had NIPE completed or documented. (Baby Lists Tab > Test folder > Due detailed/NIPE).

The worklist will be checked at least once daily by the rostered MEON.
The MEON will review the daily worklist every morning, identify any babies requiring an examination by the neonatal team and will liaise with the neonatal team on Transitional Care.

Babies approaching 72 hours of age will be prioritised for examination. They are highlighted on the S4N list with Amber colour and must be examined that day. Babies that have missed the 72 hour-target will be highlighted with Red colour and must be followed up urgently if not NICU babies.

Check that babies who have been discharged without an examination have been given an appointment to return for NIPE, or to have home visit with a community MEON if available. The NIPE clinic midwife will contact LW and ABC to determine if there are any babies requiring an examination or 6-hour discharge. The NIPE examiner will attend ABC and LW if required to examine any babies.

11.2 Flag NICU babies

All records are created as non-NICU. When a baby is transferred to NICU the NICU clerical team will change status of baby to NICU. If this has not been done when the Daily Worklist is being produced the rostered MEON will do this.

11.3 Read Messages in S4N and NIPE emails

All S4N users will receive messages relating to S4N. These should be acknowledged in S4N. Check for emails to NIPE group that need action.

11.4 ‘High Risk Babies’

These are babies delivered at SPH who require particular care at or after birth, although they may appear entirely well. These babies usually fall into 2 categories:

1) Those with an anomaly detected antenatally. The mothers of these babies will have been seen by the Fetal Medicine Team at SPH who will have performed detailed scans and tracked the progression of the anomaly during the pregnancy. Sometimes they will also have been seen by other specialists (eg: fetal cardiology, paediatric renal).

2) Those with a strong family history or circumstance that puts them at higher risk of anomaly which needs to be investigated /excluded postnatally (eg: maternal lupus predisposing to congenital heart block.)

It is therefore ESSENTIAL that anyone undertaking NIPE examinations takes the time to review all of the available antenatal information on BadgerNet, and postnatal management plans, prior to examining and making plans for the baby.

Information is available on the ‘pregnancy summary’ page on BagerNet but please pay particular attention to the information in the ‘Management Plan’ and ‘Fetal Medicine Management Plans and review all ‘Scan Results’.
Examples below:

![Management Plan example]

**Management Plan**
Dilated renal pelvis of fetus
The baby need renal scan in the postnatal period as per protocol
Dr NIPE

![Fetal Medicine Management Plan example]

**Fetal Medicine Management Plan**
Date and Time: 26 Jun 20 at 15:06
Management Plan: Baby will need a postnatal scan of the kidney.
Completed by: Monika Mills

![Scan Results example]

**Scan Results**
- USS Report Document: 27 May 20 at 09:11
- USS Report Document: 13 May 20 at 12:11

Please refer to the postnatal ward handbook and intranet guidelines for specific management and referral pathways. The doctor or ANNP examining baby will document their review and actions as a ‘specialist review’ on the baby tab of the mother’s BadgerNet as well as completing the usual NIPE records.

A high risk spreadsheet for these babies will be updated at the weekly fetal medicine meeting and will be available to neonatal doctors and ANNPs on the T: drive. A nominated neonatal doctor will update this every Tuesday for babies that have been born. These will be discussed every Wednesday at the local fetal medicine meeting as a failsafe check to ensure actions are completed.

If any plans have not been actioned they will be actioned as a priority and the case investigated by the NIPE Lead who will feedback learning points to the Screening Coordinator, NIPE Consultant and to the NIPE examiner.

**11.5 Review in-process records**

NICU babies may have in process records as elements of the examination may be completed separately. Non-NICU babies should not normally have in-process records. Check the status and amend or complete where possible.

**11.6 Mark babies as deceased**
When a baby dies the S4N system must be updated. The midwife /nurses caring for baby will inform the rostered NIPE midwife. The rostered MEON will update the S4N record and if not already done will inform the NIPE Failsafe Team and the Hearing Screening team by email Appendix 1 – Screening and NIPE Failsafe emails

11.7 Change Primary Contact

Where mother is not to be primary contact, e.g. a baby being fostered, the NIPE examiner will update the Primary Contact details in the S4N record. Deselect ‘primary contact’ and ‘send letters’ in S4N record and add new contact details.

11.8 Independent midwife homebirths

A record occasionally appears on the worklist for a baby that does not appear to have been born under the care of St. Peters’ Maternity Unit.

Check the address. If address is in the local care location area, Ashford & St. Peter’s are responsible for the NIPE. If there was homebirth with an independent midwife the MEON will check arrangements for NIPE with parent or with independent midwife.

Where Independent Midwife or GP is going to complete NIPE document this in S4N and move the S4N record out of area.

If Independent Midwife or GP is not going to complete the NIPE the rostered MEON will liaise with community midwife team leader and arrange NIPE within 72 hours at home or in Abbey Wing.

11.9 Move Records

Where a baby is moving out of England or to a hospital that does not use S4N the ward staff will inform the NIPE team. Ideally the NIPE will be completed before moving.

If the NIPE has not been completed the discharge midwife will inform the receiving care provider that NIPE has not been completed. The rostered MEON will move the record out of area. If the NIPE has been completed the S4N record does not need to be moved.

11.10 Transfer babies into area

Occasionally the S4N system allocates a baby to the wrong care location area. This occurs most commonly with homebirths. This may also occur when the wrong, or no, care location is entered when the NHS number is created.

The NIPE examiner searching for the record by NHS number will be informed that the record is in a different care location. The NIPE examiner will transfer the record into our care location in order to complete the NIPE documentation. There is a guide in the resources section of the S4N system.

11.11 Enter outcomes for babies who had senior review
S4N records where senior review has been requested should have summary outcome of that review recorded. This will be documented in S4N ideally by senior reviewer or by the NIPE examiner.

11.12 Who examines which babies?

The majority of babies will be examined by either a MEON midwife or ‘baby check’ doctor. Certain babies, as laid out below, will need to be examined by a member of the neonatal team and this will usually happen as part of a routine daily check. All other babies can generally be examined by either a MEON midwife or the allocated ‘baby check’ doctor.

It is expected that the MEON use their clinical judgement and, if required, discuss with a senior neonatologist to establish who will examine the baby. If the allocated ‘baby check’ doctor is also a paediatric specialist trainee with neonatal experience then it may be appropriate for them to carry out NIPE examinations on behalf of the neonatal team.

At the weekend, when there is no allocated baby check doctor, the midwife will review the workload and can ask the neonatal team to assist if workload is too high to be managed by one examiner.

Babies should normally be at least 6 hours old to allow for extra-uterine adaptation, however the examination can be carried out earlier than 6 hours to allow for early discharge if appropriate. In this case, if any cardiac abnormalities are found it would be appropriate to repeat the check after 6 hours of age prior to making any referrals.

The neonatal team will examine:

- Babies who have Management Plan or Fetal Medicine Management Plan in BadgerNet for neonatal review
- Babies under the care of NICU or Transitional Care
- Babies having intravenous antibiotics or any babies having extended Kaiser pathway observations past 24 hours of age
- Babies with current abnormal observations for any other reason
- Babies with birth weight below 2nd centile
- Babies of mothers with history of drug and alcohol abuse
- Babies whose mothers are positive to HIV, Hepatitis B, or Herpes (primary or current infection)

MEON can complete NIPE in the following cases but the baby will not be discharged until the required observations are completed and normal:

- meconium stained liquor
- prolonged rupture of membranes
- diabetic mothers
- Group B streptococcus positive mothers who have had adequate antibiotic prophylaxis

12.0 NIPE Examination
The NIPE Practitioner will review the maternal and neonatal records on BadgerNet including Alerts, Neonatal Summary Report in BadgerNet Maternity Baby notes, the Fetal Medicine Review and Plan Reports in mother’s notes, Antenatal ultrasound scan reports in BadgerNet, Antenatal Care Summary and Things to Do in Baby’s Summary of Care. Any paper notes e.g. notes from other hospitals should be reviewed.

Explain purpose and limitations of examination to and obtain verbal consent from a parent. Explain that NIPE is a continuation of the health surveillance programme for their baby – this includes the National Blood Spot Screening; Hearing screening and a repeat of the NIPE between 6-8 weeks by the GP.

Offer opportunity for examination to be performed in a private space. Elicit any concerns or queries about baby from parent/s.

The NIPE Practitioner will ask a parent to complete the Family History on page 5 of PCHR and review the details to determine any significant risks.

The NIPE Practitioner will revisit the TB risk assessment with parents and amend on BadgerNet if not correct. All eligible babies will be offered BCG vaccine when NIPE is undertaken. A list of high incidence countries from latest WHO figures is available on BadgerNet. Document whether or not BCG is required in S4N in the Risk Factors section.

Neonatal BCG vaccines should be offered in a timely manner as per current guidance.

BCG will be administered by the MEON during the NIPE clinic. If BCG is not wanted before discharge home document as declined and BCG will not be provided after discharge home.

If BCG vaccine is accepted but it cannot be administered before discharge home, MEON or midwife caring for baby will document reason for not giving BCG and will make an appointment for baby to return to BCG clinic on PAS or Patient Centre. Document the appointment in BadgerNet. There are 3 BCG appointments available daily between 14:00 – 15:00. The BCG clinic code is BCGMAT.

12.1 Physical examination

Follow current infection control guidelines.

Wash hands and prepare equipment.

Perform a pre ductal (right hand) and post ductal (any other limb) oxygen saturation measurement. The oxygen level should be >= 95% and the difference between the pre and post ductal reading no more than 3%. If the difference is greater than 3% the levels
should be repeated one hour later in the absence of any other concerns. If there are other concerns the baby is to be reviewed ASAP by a neonatologist.

Perform a systematic examination including:

- Activity
- Colour
- Posture
- Cry
- Reflexes - sucking, swallowing, gag, grasp reflex, step reflex, Moro reflex.
- Head circumference
- Heart: rate, rhythm
- Lungs
- Abdomen
- Femoral Pulses
- Fontanelles
- Sutures
- Skin
- Eyes
- Ears
- Nose
- Mouth including palate
- Examination of the entire length of the palate from the gums to the uvula should be carried out by visual inspection using a torch and tongue depressor
- Chest
- Breasts
- Clavicles
- Abdomen
- Genitalia
- Anus
- Back
- Gestational age
- Upper extremities
- Hips
- Nutritional status
- Passage of urine
• Passage of meconium

For guidance on the examination, specific conditions and actions needed refer to the Postnatal Ward Handbook which is available on Trustnet in ‘Neonatal Guidelines: Transitional Care and Postnatal Ward’, or via this link http://trustnet/docsdata/paed/Guidelines_Neonatal/Postnatal%20Wards%20Handbook%20Sep%202020.doc

Seek a neonatology review if there is any suspicion of illness in the neonate and then do the following:

• Perform baseline observations of temperature, O2 saturations, heart rate and respirations and obtain a capillary blood glucose sample. Refer to the neonatal registrar.

• Hand over to named midwife responsible that a review has been requested and ensure the baby is observed closely until the review has taken place. Document the findings clearly in the notes.

Any bruising or suspected fracture must be escalated immediately to a senior neonatal doctor and recorded in the baby’s notes.

12.2 NIPE Documentation

NIPE examiners are responsible for recording each screening examination and the outcomes in:

• The S4N record
• The Personal Child Health record (PCHR) known as the ‘Red Book’,
• The clinical notes - BadgerNet Maternity / Neonatal,
  - Document acceptance and completion of NIPE in BadgerNet in a Baby Examination form.
  - S4N is the primary record for NIPE results but if possible document full examination details in BadgerNet as mother has direct access.

Each NIPE practitioner has a unique log in for the S4N system and is responsible for ensuring this data is contemporaneously uploaded. To obtain access to the S4N system contact a S4N super user or NIPE Lead Midwife/Nurse.

NIPE S4N is a web-based system and can be accessed on the internet on trust iPad for example: https://nipe.northgate.thirdparty.nhs.uk/S4N/nhsbaby

If there is delay, e.g. home visit with no access to NIPE system, the practitioner is responsible for returning to add this data. The default time is ‘now’ so if documenting retrospectively change the time to reflect when examination was actually done.

NIPE examiner will print 3 copies of the S4N record. S4N by default produces 3 copies of the NIPE screen results and 3 copies of the NIPE local data when selecting ‘Print All
Documents’ in S4N. Where possible print these as 3 double sided pages rather than 6 single sided pages.

- 1 copy marked for PCHR record
  - Place this in Red Book or give to parent
- 1 copy marked for Notes
  - NIPE examiner will file this copy in baby paper notes folder (Purple folder). This will be scanned by the ward clerical team into baby’s clinical records. (Currently Evolve)
- 1 copy marked for GP
  - NIPE Practitioner will leave this copy in the tray provided
  - Ward clerical staff copy will send this to the GP in the post
- Record any marks, bruising or blue spots on two copies of the Body map printed from S4N
  - 1 copy to PCHR
  - 1 copy into baby notes (Purple folder)

12.3 Screen Negative Babies
Inform parents that NIPE examination will be undertaken again at 6 – 8 weeks of age as some conditions can develop or become apparent later. As this is usually with GP advise parents they will need to make appointment with GP surgery. Advise parents to contact healthcare professional if any concerns about their baby.

12.4 Screen Positive Babies
Babies suspected of having abnormalities or identified as at risk of abnormalities needing follow up. If required, escalate any concerns to appropriate Neonatal doctor.

Discuss findings, need for referral and any concerns with parent. Record parents’ reactions (if appropriate), and arrangements for any referral.

Create relevant referral letters and send them to the relevant department.

Record senior review and actions in the S4N record outcomes.

13.0 Referrals
Screen positive babies will be referred in line with local arrangements and with National Standards.

Non urgent concerns in an otherwise well baby including ophthalmic concerns, unilateral undescended testes, additional digits and skin tags can be referred as per the Postnatal Ward hand book. Discuss with neonatal team any non-urgent neonatal inpatient review. Ensure that the parents, and the midwives on the ward, know the plan for review.

Screen positive babies who are born in hospital and need senior neonatal doctor review for heart and bilateral undescended testes should have this completed within 24 hours of
the examination or before discharge (whichever is sooner). The NIPE examiner will document the initial outcomes and plan in the outcomes section of the NIPE S4N record.

Where an abnormality is found or expected and further follow up is necessary referral is to be made by the clinician undertaking the examination. Ensure a copy of the referral is in the baby’s notes (purple folder). The named consultant must be informed when a referral is made to another specialty.

Babies with screen positive results for unilateral undescended testes should be followed up by the GP. Use standard referral letter available in S4N and place in GP tray in Nursery for clerical staff to send to GP.

In all cases the screen positive result should be recorded on S4N to make sure that referral has been made and baby seen. This will support follow-up at a later stage.

It is essential that outcome data is entered on S4N for all screen positive referrals in line with national standards and NIPE service specification.

Outcomes for bilateral undescended testes and heart can usually be completed prior to discharge. Referrals for hips and eyes generally occur later. The NIPE Failsafe team will enter outcomes for babies who have follow up appointment after discharge.

If bilateral undescended testes are identified the NIPE practitioner will request a senior review and they will make the relevant follow up appointments and communicate to the parents if necessary.

13.1 Postnatal handbook - referrals

The Postnatal Handbook provides guidance around referral for specific conditions. It is available on Trustnet in Neonatal Guidelines: Transitional Care and Postnatal Ward, or via this link:


13.2 Hip abnormality suspected

Including:

- difference in leg length
- knees at different levels when hips and knees are bilaterally flexed
- restricted unilateral limitation of hip abduction (with a difference of 20 degrees or more between hips)
- gross bilateral limitation of hip abduction (loss of 30 degrees abduction or more)
- positive Ortolani or Barlow manoeuvres (palpable ‘clunk’, dislocated or dislocatable hips)
These babies should have hip ultrasound within 4 weeks of age. The orthopaedic appointments team will collect details direct from S4N using the pre-defined search every day, Monday to Friday, and will arrange ultrasound appointment within 4 weeks of age, or as soon as possible if more than 4 weeks of age at time of NIPE hip screen.

13.3 Hips normal but risk factors for developmental dysplasia of the hips

Babies with normal hip examination but national risk factors for hip dysplasia should have hip ultrasound within 4 weeks of age. The orthopaedic appointments team will collect these babies details direct from S4N using the pre-defined search daily Monday to Friday and will arrange appointments within 4 weeks of age.

The National Risk Factors are:
1. First degree relative with hip abnormality in childhood
2. Breech presentation at or after 36 completed weeks of pregnancy, irrespective of presentation at delivery or mode of delivery.
3. Breech presentation at delivery between 28 and 36 weeks gestation.
4. In the case of multiple birth: if any of the babies had breech presentation, all babies in the pregnancy will have ultrasound scans

13.4 Hips examination normal but ‘other’ conditions

Babies with normal hip examination but who have other skeletal conditions such as torticollis, talipes, hydrocephalus, will be referred for a 6 week ultrasound scan of the hips. Isolated clicks are not a positive finding and would come under ‘other’ but do not require referral for hip scan unless the examiner is unsure and a second opinion by an experienced clinician is unclear.

The NIPE examiner will tick ‘other’ in the hip section of the S4N record and document their findings in the ‘comments’ box. If a referral is required tick ‘referral’ to enable the orthopaedic team to pick up the referral direct from S4N. The Rowley Bristow appointments team will arrange ultrasound screening appointment for 6 weeks and provide details to the parents/guardians.

13.5 Heart Abnormality suspected

Babies with suspected cardiac abnormality should be seen by a senior paediatrician with expertise in cardiology. The urgency will depend on suspected condition. There are no NIPE cardiac standards – follow National Clinical Guidance.

Any baby with a suspected major or critical heart condition should be seen as a matter of urgency and definitely before discharge home.

13.6 Heart examination normal but risk factors for cardiac abnormality

Check Fetal Medicine Review and Plan and follow plan.

If no plan has been documented discuss with ANNP or neonatal doctor and make appropriate plan.
13.7 Eyes abnormality

Dark area within red reflex or dim or absent red reflex. These babies should be referred and be seen by consultant or paediatric ophthalmology service by 2 weeks of age.

13.8 Testes Abnormality

**Unilateral undescended testes**

If unilateral undescended testes is identified the NIPE examiner will request a GP follow-up in 6 weeks. The NIPE examiner will be document this in the outcomes section of the S4N record, and inform the parents.

**Bilateral undescended testes**

Babies with bilateral testes either absent or incorrect position should be seen by a senior paediatrician within 24 hours of examination to exclude metabolic and intersex conditions. Where testes are felt bilaterally but high in the inguinal canal, this should be managed as screen positive. The NIPE examiner will escalate any suspicion of bilateral undescended testes or ambiguous genitalia to the paediatric team for urgent review.

The NIPE examiner will document the findings in the S4N record. They will also record the initial outcomes of the review and any follow up plan in the outcomes section of the S4N record.

14.0 Smart 4 NIPE IT System

Smart for NIPE (S4N) is a National standalone IT system created by Northgate to record NIPE. It is the PHE recommended NIPE record for NHS Trusts. Northgate also provides the Hearing Screening IT system. There is a resource section within S4N for users that has guides for using and managing the S4N system.

14.1 Creating S4N record automatically

The S4N record is created when the birth is notified, and the NHS number is generated. Birth data and demographics should be entered into the NHS number registration system as soon as possible after birth and before any screening takes place.

14.2 No NHS number

If the NHS number cannot be created after the birth inform the shift leader and/or Badgernet lead. If this cannot be resolved the midwife at delivery will email the coding team (asp-tr.ASP-Maternity-Coding@nhs.net), the NIPE team (asp-tr.nipe@nhs.net) and the Hearing screening team (khft.newbornhearingclinic@nhs.net) to ensure that screening is not missed.

14.3 Creating S4N record manually
Where there is delay or failure in generating NHS Number or in the creation of S4N despite NHS number being generated a record can be manually added by NIPE user on S4N using ‘Add Patient’.

If a baby does not have NHS number and the NIPE examiner creates a manual record the examiner MUST add the baby’s hospital number to the S4N record and must inform the NIPE Failsafe team with hospital number and name. A duplicate record will be created when the NHS number is generated. It is important that there is only one record per baby so these records must be merged as soon as possible. These records will be merged by the Failsafe Officer soon as possible. The use of hospital number to identify baby will help ensure the correct records are merged.

14.4 Birth documented in the wrong notes

The midwife at delivery must double check mother’s details before documenting a birth and must double check mother’s details again before generating the NHS number for baby to ensure the birth is in the correct notes and baby demographics will be correct in BadgerNet and in S4N.

If a birth is documented in the wrong notes the midwife will inform the shift leader, the coding team, the hearing team, the NIPE team and the NIPE Failsafe team. Complete Datix.

The shift leader will ensure:

- That the birth and delivery are removed from the wrong notes
- The error is reported to NHS Spine
- The Coding team has informed so that all records can be checked and other teams including Child Health will be informed.
- That the MEON and the Hearing team are aware.
- The midwife will then create a new NHS number for baby

14.5 Baby gender incorrect

If the wrong gender has been documented in BadgerNet when the NHS number was generated the S4N will be incorrect. Gender should be changed on S4N manually prior to NIPE to get the correct template for the screen results. If NIPE has already been completed the screen results will be incorrect because the testes section will change and will need to be redone. If you are unable to do this contact the NIPE Failsafe Team. The gender on PAS/Patient Centre should also be changed. Changing gender on PAS will automatically change gender on BadgerNet. (If not changed on PAS it will keep overwriting Badgernet with incorrect gender). Also inform the coding team who will inform the National Spine and Child Health Services.

15.0 S4N not accessible

Contact the Northgate Helpdesk for advice. Tel: 08450 705 902 or Email: NIPE.helpdesk@nhs.net
Complete Datix Incident Report.

There is a word template on the Trust Network Drives for the S4N NIPE record that can be completed electronically and then printed (T:\Maternity\NIPE SMART\Blank Proformas).

If no internet and network access, paper copies are available in the NIPE room (Nursery) on Joan Booker ward.

When NIPE has had to be documented on paper inform the NIPE Failsafe Team by email and ensure a signed copy of the examination findings is available in the baby’s notes. The NIPE Failsafe Officer will document NIPE on S4N when S4N becomes available.

16.0 NIPE Failsafe

16.1 NIPE Failsafe Team

The NIPE Lead will take primary responsibility for managing the NIPE SMART System S4N).

The Failsafe team will conduct regular checks to ensure that the full eligible population is offered NIPE, that all accepted screens are undertaken and that all results of screening are acted on in accordance with the pathway and that the screening programme meets the local and national standards.

16.2 Failsafe weekly tasks

Daily monitoring Monday to Friday through the Failsafe Officer through Northgate and reported to the NIPE Lead Midwife and the Antenatal Screening Coordinator.

Check email messages and S4N messages
S4N Administrators will receive messages in S4N relating to transfers, merge conflicts etc. and these will be viewed and actioned at least weekly by the Failsafe team.

Check BadgerNet List of Babies due NIPE (Baby List > tests > ‘Due detailed/NIPE’).
Ensure that all babies have NIPE documented in BadgerNet. Follow up babies that have not been examined.

Check the S4N transfer log
The S4N transfer log should be checked, at least weekly, to confirm accuracy and identify any discrepancies, which can then be addressed (available only to Admin users).
Records will be transferred out by Failsafe Office when baby is transferred to another Trust before NIPE completed or if a record has been transferred in error. A comment should be added to explain when prompted by S4N. Transfer records in or out of St. Peters care location. The NICU clerical team will transfer records for babies transferring into or out of NICU.

Complete inactive records
Merge any duplicate records
Run pre-defined searches on S4N
  Locate babies with outstanding outcomes using predefined search in S4N
  Track babies that have been referred and check that appointments have been sent, received and attended
  Enter outcomes when available.
Enter NIPE results that could not be entered when S4N was not accessible. Data will be available from BadgerNet NIPE record or from paper proformas completed by NIPE examiner.

16.3 Transfer of unscreened baby to another care provider

Transfer of baby that could not be screened prior to transfer formally hands over responsibility for screening. This should be documented in the baby’s discharge notes. This will also be communicated by email to the receiving care provider by the person transferring the S4N record.

16.4 Transfer of screen positive baby to another care provider

The receiving provider is responsible for follow-up and recording of post-referral outcomes. If the birth unit chooses to keep responsibility they must enter outcomes on S4N.

16.5 Pre-defined searches on S4N

The NIPE Failsafe Officer will run these pre-defined searches in the S4N library on a weekly basis:
  Newborn Failsafe
  EYE Abnormality Suspected - Failsafe awaiting outcome
  HEART - Failsafe awaiting outcome
  HIPS Abnormality Suspected - Failsafe awaiting outcome
  HIPS Risk Factors and No Abnormality - Failsafe awaiting outcome
  Newborn Review by Senior Clinician - Failsafe Review Required
  TESTES BILATERAL Abnormality Suspected - Failsafe awaiting outcome
  TESTES UNILATERAL Abnormality Suspected - Failsafe awaiting outcome

16.6 Failsafe monthly Tasks

Review the nationally provided monthly NIPE KPI reports and follow up babies identified as 'not screened' or who have not attended for post screen positive referral appointment (KPI breaches). KPI breaches will be reported to the screening coordinator and to the Head of Midwifery.

Data collection for Key Performance Indicators and reporting on the effectiveness of the screening programmes, in order to be continually improving the service. This will be reported monthly to Head of Midwifery and to NIPE group (asp-tr.nipe@nhs.net)

All NIPE results and outcomes of screening recorded will be communicated to the Child Health Record Department. Child Health Services are provided with administrative access to the S4N system for our care location.
Publish monthly NIPE newsletter to include compliance with standards, feedback from referrals.

16.7 Key Performance Indicators (KPI's)

These are national standards set by the national screening committee. KPI data will be taken by PHE directly from S4N starting April 2020 (Q1 2020 to 2021). The Failsafe checks will ensure that all relevant coverage and outcome data is in S4N records including date of post screen positive referral appointment and review.

Standard 1: This standard provides assurance that screening is offered to all eligible babies, and a conclusive screening result is available by 72 hours of birth. Eligible babies includes babies less than or equal to 72 hours of age who transfer into ASPH care without a screening result and excludes babies who die within 72 hours of birth. Acceptable performance is 95% and the achievable performance is 99.5%. (These may not be realistic for some units and are under review for tertiary referral centres).

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 an 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 4 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%

16.7.1 Quarterly/Annually:

Review the National Quarterly report.

Quarterly data to be collated between 2 and 3 months after each quarter end. Deadlines: 30 September (Q1), 31 December (Q2), 31 March (Q3), 30 June (Q4). KPI data should be counted where the maternity service is responsible for the baby at the time of newborn screening.
Before data submission, mitigation information may be taken into consideration and additional data added. This may reflect NIPE screening activity that is not recorded on S4N for whatever reason, for example, newborn 72-hour examinations undertaken by GPs in primary care settings or neonatal units. Screening may be delayed where a clinical decision is made to delay the examination as the baby is too premature or too unwell to have the examination at this time. Screening should be completed as and when the baby’s condition allows. These babies should be accounted for and the reason explained in the commentary as mitigations against performance thresholds.


Data collection and KPI reporting will be completed on a monthly basis and reported to the Director of Midwifery

**16.8 Incomplete Outcomes**

The Failsafe Office will manage any records that do not have outcomes following guidance in the S4N Oversight and Cohort Management Guide. All records should have an outcome on the system. There should be an identifiable reason for data not being entered on the system. Records should be set formally as inactive, by choosing an appropriate 'incomplete' screening outcome.

If the NIPE examination is a true missed case then the incident reporting pathway should be activated, followed and the incident investigated. NIPE Lead midwife will investigate and complete Screening Incident report.

**17.0 BCG Monthly Report**

**17.1 Monthly BCG report**

BCG must be offered at all eligible babies at NIPE. BCG data will be collected monthly and reported to Head of Midwifery, to Child Health and to PHE by the Failsafe team. This will include data for BCG offered to eligible babies at first NIPE, BCG accepted or declined at NIPE, date BCG was administered and eligible babies that were not offered BCG. Any eligible babies that were not offered BCG vaccine at NIPE will be investigated by the NIPE Lead and reported.

**18.0 Covid**

Newborn and infant screening should continue in line with national guidance, but it is acknowledged that circumstances during pandemic may mean screening has to be delayed.
For babies with positive screening results, referrals should continue to be made in line with National Guidance and take place wherever possible at the earliest opportunity.

In exceptional circumstances the NIPE screening can be completed on day 4 or 5 with newborn blood spot screening. This must be agreed by Manager.

The reasons for any delay in screening or in referral to specialist appointments must be documented as a case note in the S4N record.

Assess for COVID-19 symptoms as part of the risk assessment prior to NIPE. PPE as per PHE and Trust guidance is required for all healthcare professionals. Eye protection must be included in PPE when there is any risk of splashing; blood, body fluids, secretions (including respiratory secretions) or excretions.

Where possible, all procedures and investigations should be carried out in a room with a minimal number of staff and one parent present.

NIPE Newborn Pathway


References


Newborn and infant Physical Examination Screening Programme Standards (2016/17) Public Health England NHS
Appendix 1 – Screening and NIPE Failsafe emails

Contact emails:

NIPE team (MEON, ANNP and NIPE Lead Consultant) – asp-tr.nipe@nhs.net

NIPE Failsafe team – asp-tr.nipefailsafeteam@nhs.net

Coding Team – asp-tr.ASP-maternity-coding@nhs.net

Hearing screening team – khft.newbornhearingclinic@nhs.net

Appendix 2 - Useful links for National Resources (adapted from S4N)

Screening tests for you and your baby booklet:

NIPE Screening Programme Handbook:
NIPE Screening Programme Standards:


NIPE Screening Programme e-learning resource:


NIPE Quality Improvement Documents:


NIPE:


Standard 1: Identify the population and coverage

Rationale

This standard provides assurance that:

- screening is offered to parents of all eligible babies;
- each baby (where the offer is accepted) has a conclusive screening result.
PHE Screening NICU leaflet:


PHE Screening Blogs can be found at:
https://phescreening.blog.gov.uk/
Appendix 3 - NIPE Peer review form

To be completed annually and first page returned to NIPE Lead Midwife/Failsafe Officer, both pages to be retained by midwife for own records of feedback gained.

Name_________________________________________________________________

Peer Reviewer_________________________________________________________

Date________________________

Infection control procedures followed   Yes ☐ No ☐

Notes reviewed and suitability for MEON confirmed   Yes ☐ No ☐

Explanation of check to parents and consent gained   Yes ☐ No ☐

Check completed systematically and accurately   Yes ☐ No ☐

Findings explained to parents   Yes ☐ No ☐

Appropriate referrals made (if needed)   Yes ☐ No ☐

Check documented correctly   Yes ☐ No ☐

If any areas not achieved please explain further:

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Detailed feedback for midwife, please include areas of good practice as well as any areas for improvement:

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Date:

Signed:
Appendix 4 – Baby check competency sign off for General Paediatric Doctors

Baby Check Competency sign off for General Paediatric doctors

For doctors who haven’t done baby checks before

- Minimum 10 baby checks need to be entered here with at least 5 checks at a competency grade 3
- First 2 checks taught and last 2 checks signed off later by NICU SHO / registrar / ANNP / HDU Consultant
- Remaining 6 checks to be supervised by MEON

For Paediatric trainees already trained to do baby checks

- minimum 2 checks needs to be of standard 3 competency, signed off by a senior doctor as above

All checks – The supervisor to recheck heart, femorals, eyes, hips and testes to ensure checks are performed to standard.

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials of baby /DOB</th>
<th>Competency Grades</th>
<th>Heart, eyes, hips and testes checked and signed off by supervisor</th>
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<td>0 – Observed baby check</td>
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<td>1 – Understands, but not competent to do</td>
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<td>2 – Able to do with supervision and guidance</td>
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<td>3 – Able to do unsupervised</td>
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Appendix 5 – BCG appointments on PAS or Patient Centre

Clinic code – BCGMAT.
BCGMAT has 3 appointments per day Monday to Friday, 13:00, 13:20, 13:40.

1. **Open Patient Centre**
   a. Select Patient – HN or NHS no. for baby
      Do not create a new Hospital number if baby is not on the system. Check if baby was born with ASPH.
      If Baby was not born at ASPH refer back to GP who will refer to hospital of birth or to Epsom out of area clinic.

2. **Open Appointments & Outpatients**
   a. Refer and book appointment
      a. **Add episode.** The fields you need to complete are:
         i. **Registration** – Check address and GP details are correct
            a. **Consultant**
               Consultant = Mid (midwife)   Speciality = Mat (maternity)
            b. **Referral**
               Category = NHS (NHS patient)
               Referral Source = SR (self referral) (or GP if referral letter)
               Referral date = t (today) or the date referred if referred by GP/Health Visitor
               Reason = AD (Advice and consultation)
               Priority = Routine
               Comment. Add any comments.
      ii. **Click on OK**

Select Clinic
Clinic BCGMAT
Search diary
Select first available appointment
Advise parents to bring PCHR (Red book) to appointment.