

# [Newborn exam](https://assignbuster.com/newborn-exam/)

The government initiatives to reduce junior doctors’ hours within the NHS Plan (DH 2000) have increased the call for midwives to expand their traditional role and take on some of the tasks that in the past have mainly been carried out by junior doctors (Kings Fund 2011). Having been working within the community setting as a midwife for the past three years I was interested in extending my role in order to provide more holistic care for my caseload of clients and their babies.

Holistic care for mothers, babies and their families is highly recommended within the midwifery profession and is known to provide an improved experience for women (Changing Childbirth (DOH 1993a) NMC 2012, NICE 2006). The Newborn and Infant Physical Examination (NIPE) is one element of the UK National Screening programme and is offered to all parents for their baby within 72 hours of birth and then repeated again at 6 weeks of age, usually by their GP.

This role is one of the tasks that has been highlighted where midwives can expand their role (Marshall & Raynor 2010). The trust where I work has recently introduced community clinics where parents can take their baby in order to have the newborn examination performed, therefore allowing early discharge home from the unit enabling early family bonding. With this in mind I commenced the Newborn and Infant Physical Examination course.

Screening has been used within the NHS for many decades and is a process that enables the health professional to highlight healthy members of the population that could potentially have a health related problem (UK National Screening Committee 2008). The NIPE is a head to toe examination that will enable a practitioner to detect in an apparently healthy baby any abnormality that can then be referred onto the appropriate professional for further investigation.

This can then improve the newborns future health by providing early intervention and prevention of further complications (DOH 2009). It particularly focuses on the eye, heart, hips and testes in the male infant. The importance of these particular areas is of great significance to the baby’s future health. An undetected congenital cataract may lead to the child being blind in that eye. A missed heart defect may not be diagnosed until the parents present with a very unwell or even dead infant.

If developmental dysplasia of the hip is not treated early enough following birth it could lead to several episodes of major surgery or even disability in the future. Bilateral undescended testes can lead to problems with future fertility. There are many issues surrounding the NIPE that are argued about within the literature Green and Oddie (2008) question whether the NIPE provides the population with and improvement to overall health or if it just gives the parents reassurance that could in the future be proved wrong, due to the NIPE being a screening tool and not a diagnostic test.

Within the content of this essay I will be critically analysing the NIPE and some issues around this topic focusing particularly on the examination of the hips. Since being a midwife, and a mother, I have always found this part of the examination most difficult to watch someone perform as it appears to be uncomfortable for the baby. Therefore on commencing the course I have been aware of the discomfort it appears to give the newborn and also the distress this could in turn cause for the parents.

I will also be looking into the issues regarding which professional is best qualified to be performing the examination and also if there are any benefits or risks as to the place that it is undertaken. When I am performing the examination I will mainly be alone in the community setting either at a children’s centre or within the home environment, so therefore it is imperative that I am aware of any limitations this may present for the baby, parents or me.

As previously mentioned there is a growing trend within many obstetric units for midwives to carry out the NIPE examination. Within the trust that I am based midwifery led clinics are held on the post natal ward and also within the community for the sole purpose of performing the newborn examination. Bloomfield et al (2003) discussed where the examination should take place and found differing opinions. The benefits of being in hospital were noted to be that medical back up was available and it was more convenient for further immediate referral process.

Community examinations were thought to be more likely to enable the parents to ask questions and mention concerns due to the relaxed environment. Following the Maternity Matters report (DOH 2007) advocating that women should have a greater choice for place of birth the home birth rate has increased and is continuing to do so. It is therefore ideal for community based NIPE facilities so that women do not have to attend hospital at all following a home birth.

On reflection the examinations that I have witnessed and performed unfortunately seem to have been a way to speed up the postnatal discharge procedure therefore freeing up beds within the unit and not due to providing a more continuous midwifery led experience for the parents and baby as Hutcherson (2010) found. The ideal situation would be to perform the examination on the newborn belonging to the mother you have seen through antenatal care and will be caring for post natally therefore providing continuous care for your personal caseload of clients, as discussed by Baston & Durward (2010).

The patient satisfaction and overall job satisfaction in this case scenario would be high for all involved but unfortunately I feel in practice will be a rare occurrence. Eventually I believe that in our trust when there are enough trained midwives within each geographical area the possibility of a midwife performing newborn examinations on babies within the teams’ caseload is possible. This far from being the ideal scenario is the closest it will probably get to the holistic care sought after by myself and many other midwives.

The EMREN (Evaluation of Midwife Role extension in the routine Examination of the Newborn) study carried out by Townsend et al (2004) looked into aspects of the NIPE one of them being whether a midwife was as capable as a senior house officer when carrying out the NIPE and discovered not only that this was the case but that the mothers satisfaction level may be increased if a midwife performed the NIPE and that also money may be saved by the NHS.

Having observed SHO’s, appropriately trained midwives and advanced neonatal practitioners (ANP) performing the NIPE I felt that the midwives and ANP’s communicated far more effectively with both the baby and parents therefore better fulfilling the communication aspect of the competency’s indicated by the UK National Screening Committee (2008). They also provided more detailed information on parenting and public health issues during the examinations which should be an integral part of the NIPE (Baston & Durward 2010).

There has been much interest recently into whether pulse oximetry should be part of the newborn screening for congenital heart defects. The UK National Screening Committee is at the present time looking into whether this should be included within the NIPE as part of the screening for congenital heart defects in the newborn. It has been recommended in recent studies and has found to increase the detection rate of congenital heart defects (Ewer et al 2011, Chang 2009). Within our trust I have seen this performed on three ewborns following their NIPE, due to nasal flaring, slight cyanosis and a raised respiratory rate, all have proved to be within the normal range. The saturation monitors are present in the units’ clinic rooms where newborn examinations are performed but the community midwives working in children’s centres or at home do not have access to a monitor. Therefore this could be cause for concern for parents of babies that are being examined in the community. This then presents the ethical dilemma that newborns are being offered a different aspect within the NIPE depending on where it is carried out.

Powell et al (2013) found that parents were happy about having the pulse oximetry screening carried out on their newborn but questions need to be asked if they would prefer to not have it done in favour of the NIPE being performed more conveniently within the community. Ewer (2012) discusses the benefits of introducing pulse oximetry monitoring but without any mention of community based NIPE, or newborns that were born in the home environment. Another concern that I have witnessed and am aware of is not having access to all the antenatal notes of the mother within a community setting.

On two occasions the mother has been discharged without the appropriate paper work or has not brought it to the clinic appointment. Obviously within the unit the antenatal and labour notes are easily accessible, within the community if the mother hasn’t the appropriate information then the parents word must be taken. Having all information relating to the antenatal and interpartum periods is an essential part of the midwives role when performing the NIPE. The practitioner must be aware of antenatal and interpartum occurrences to be able to fulfil the competence set by the UK National Screening Committee (2008).

When first undertaking the NIPE’s I found the examination of the hips the hardest part of the procedure, mainly because the baby would quite often cry and struggle a little and this would cause the parents to be distressed and concerned. I also, in the past, as a midwife and mother observing this procedure felt uncomfortable. Having now done a larger amount of these examinations and reading and understanding the relevant literature find them easier to perform. Screening for developmental dysplasia of the hip is based n the fact that if not picked up in the newborn could create the need for major surgical procedures in later life also with a poorer future outcome, Dezateux & Rosendahl (2007). Developmental dysplasia of the hip used to be widely known as congenital dislocation of the hip but has been renamed since the 1990’s. The factors behind this change are that it is now recognised that the condition is not always ‘ congenital’ and rarely ‘ dislocated’ and more likely to be ‘ displaced’, Bracken et al (2012).

The definition of developmental dysplasia of the hip is very obscure as there are varying degrees and it quite often develops after birth, overall it describes a disorder where the hip joint is unstable and occasionally dislocated. The hip joint consists of the femoral head, the rounded end of the bone which sits within the cartilage of the socket joint known as the acetabulum. There are thought to be different factors as to why the hip joint becomes unstable. At around seven weeks gestation hip formation has already begun, problems can start to occur then.

If the femoral head is wrongly positioned from the start it could result in the formation of a too shallow socket. During pregnancy the hip joint can be affected by external and internal forces, for example oligohydramnios, lack of foetal movement due to foetal conditions, breech presentation (Hurley 2009, McDonald & Jenkins 2008). The incidence of developmental dysplasia of the hip varies in the literature, at birth it is thought to be 1-20 in 1000 but the majority of these stabilize without any treatment within the first few weeks of life, bringing the incidence down to 1-2 in 1000 (Campion & Benson 2007).

The incidence is higher in female babies, it is believed due to the female newborn being more susceptible to the maternal hormones therefore the joints are more relaxed, Hurley 2009. It is also more prevalent if a sibling or parent has had developmental dysplasia of the hip, McCarthy et al (2005) and McDonald & Jenkins. Other factors mentioned by McDonald & Jenkins (2008) include first born infants, multiple gestation and occurring in the left hip more frequently than the right.