Examination of the Newborn by Midwives

Clinical Director

Date: 01 / 11 / 2010

Head of Midwifery

J. Payne

Date: 01 / 11 / 2010
## Meta Data

<table>
<thead>
<tr>
<th>Guideline Title:</th>
<th>Examination of the Newborn by Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Author:</td>
<td>M. Dobson, J. Crighton, S. O’Neill</td>
</tr>
<tr>
<td>Guideline Sponsor:</td>
<td>Obstetrics and Gynaecology Directorate</td>
</tr>
<tr>
<td>Date of Approval:</td>
<td>1st November 2010</td>
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<tr>
<td>Approved by:</td>
<td>Obstetrics &amp; Gynaecology Directorate</td>
</tr>
<tr>
<td>Review Date:</td>
<td>1st November 2013</td>
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<td>Related Policies/Topic/Driver</td>
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<td></td>
<td>• Breech presentation and ECV</td>
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<td>• Care of the Newborn at Delivery</td>
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<td></td>
<td>• Early, Neonatal Postnatal Discharge</td>
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<td>• Home birth, including pool birth at home</td>
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<td></td>
<td>• Infections in pregnancy</td>
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<td>• Meconium Stained Liquor</td>
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<td>• Training needs analysis</td>
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<td>• Transfer guideline</td>
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## Revision History

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Reason for Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>November 2010</td>
<td>M Dobson J Crighton S O’Neill</td>
<td>merged</td>
</tr>
</tbody>
</table>
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1. Flowchart 1 – Systematic Examination of the Newborn

**Review history**
- Maternal: medical, obstetric, fetal screening/investigations, medication, family, social
- Newborn: mode of birth, resuscitation, medications, observations, feeding since birth

Commence systematic examination - ‘head to toe’ / ‘front to back’

**General appearance**

**Growth status**
- Head circumference, weight
- Plot on appropriate centile chart

**Head, skull & neck**
- Mouth-palate, teeth, tongue, jaw size. Skull - shape, size, scalp, fontanelles, sutures, moulding, caput, cephalhaematoma, trauma. Sternum, mastoid

**Face/Features - Eyes, nose & ears**

**Clavicles, arms, hands**
- Clavicle #, mobility. Length, symmetry, digits (syn/poly-dactyly), tone movement, oedema, palmar creases.

**Chest**

**Abdomen**

**Genitourinary**

**Hips, legs, feet**

**Back & spine**
- Spinal column, skin. Symmetry of scapulae and buttocks. Dimples, hair tufts, naevi, abnormal skin patches.

**Neurological**
- Assess posture, behaviour, spontaneous movements, muscle tone, cry, reflexes (Moro, Rooting, Suck, Grasp, Stepping/Walking).

**Discharge planning:**
- Discuss with parents – routine screening tests i.e. hearing, USS hips for breech babies
- Complete neonatal health record

**NB.**
- Neonatal examinations should be undertaken in the presence of either parent, OR a suitably nominated proxy
- Ideally, every baby should have a full examination before discharge
- Good, clear documentation, particularly any trauma from delivery
- Seek advice/refer as required
2. **Overview / Introduction**

*Definition: The neonatal examination is a systematic examination of the newborn baby. This examination is an integral part of child health surveillance.*

The timing of the examination should reflect the physiological adaptations the neonate makes to extra uterine life. The exact timing will in part be determined by the time of birth and the parent’s wishes regarding discharge home, if in hospital.

3. **Objectives of the Guideline**

To ensure a consistent, safe and systematic approach to examination of the newborn who are considered to be low risk.

4. **Body of the Guideline**

Verbal informed consent for neonatal examination is to be obtained by the examiner, and one or either parent present, or a proxy agreed by the mother.

A ‘general’ initial examination of the newborn is undertaken shortly following birth, and findings recorded appropriately in the intrapartum and postpartum notes. This initial examination does not negate from the full physical examination that should be undertaken prior to relocation of care to community. The detailed examination should be carried out within 72 hours of birth.

While it is recommended that all neonates undergo a full physical examination prior to relocation into the community; in extreme circumstances the neonate can undergo this examination by a community midwife, providing the midwife is competent in examination of the newborn and is able to review the neonate within 12 hours of relocation from hospital. For early neonatal examination in community (for home births) &/or hospital, the minimum age for neonatal examination is 2 hours old, with appropriate follow up care, if required, in place.

- If there is a deviation from the norm then prompt referral to the neonatologist is made if in Heartlands(BHH) or Good Hope Hospital(GHH) this will be done via the hospital bleep system or switch board;
- if home delivery or Solihull birthing unit(SBU) they contact the neonatal unit at BHH for advice and arrange appointment on ward 14 BHH;
- if within the Good hope area home birth then the community midwife will contact the Children’s Assessment Unit(CAU) ward 6 GHH for an appointment

Midwives undertaking examination and discharge of the neonate must have completed a recognised course ‘Examination of the Newborn by Midwives’ this is a certified qualification obtained through the University to provide a full physical examination of the newborn by a midwife. Upon passing they are then deemed competent to exam the newborn (refer to Training needs analysis).
### Inclusion and exclusion criteria:

<table>
<thead>
<tr>
<th>Problem: (A-Z)</th>
<th>Midwife discharge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>APGARS</td>
<td>If APGARS below 7 at 5 minute.</td>
</tr>
<tr>
<td>Assisted Delivery (Forceps / Ventouse)</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>BCG</td>
<td>Midwife may administer and discharge baby provided competent in administration of vaccine.</td>
</tr>
<tr>
<td>Birth Weight &lt;2.5kg at term</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Breech</td>
<td>If no other concerns, and with appropriate follow up care/referrals to physiotherapist, midwife may discharge.</td>
</tr>
<tr>
<td>Chromosomal abnormalities (known)</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Clicky Hip (incl. family history)</td>
<td>If no other concerns, and with appropriate follow up care/referrals to physiotherapist, midwife may discharge.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>If gestational diabetes, diet controlled, and diabetes has remained stable during pregnancy midwife may discharge; providing baby has completed relevant post delivery blood glucose monitoring, feeding is stable and no other concerns have been raised</td>
</tr>
<tr>
<td>Dilated renal pelves</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Dislocated hips – family history / previous child</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Down's Syndrome</td>
<td>If no obvious anomalies suggestive of Down's Syndrome midwife may discharge. Know Down's Syndrome to refer to neonatologist.</td>
</tr>
<tr>
<td>Fetal abnormalities</td>
<td>Any confirmed fetal anomalies during antenatal screening, or suspected anomaly post delivery to be referred to neonatologist.</td>
</tr>
<tr>
<td>Group B-haemolytic strep (GBS) – at risk</td>
<td>Upon completion of routine GBS neonatal observations, providing baby is term (&gt;37/40) and appears well, midwife may discharge.</td>
</tr>
<tr>
<td>Lower Segment Caesarean Section (LSCS.C/S)</td>
<td>Providing baby is term (&gt;37/40) and does not fall into any other listed category midwife may discharge.</td>
</tr>
<tr>
<td>Meconium stained liquor</td>
<td>Midwife may discharge following completion of routine meconium observations.</td>
</tr>
<tr>
<td>Neonatal Death (NND) previous history</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Polyhydramnios</td>
<td>If nasogastric (NG) tube secretions are 'normal' and no concerns regarding babies feeding midwife may discharge.</td>
</tr>
<tr>
<td>Prolonged Rupture of Membranes (PROM)</td>
<td>If maternal and neonatal observations have been stable within a 24 hours period post delivery midwife may discharge.</td>
</tr>
<tr>
<td>Neonatal unit (NNU)</td>
<td>Babies who have been admitted to NNU, even short-stay i.e. grunting / hypoglycaemia to be discharged by neonatologist.</td>
</tr>
<tr>
<td>Resuscitation (active)</td>
<td>Refer to neonatologist. (including the use of Naloxone), or resuscitation was undertaken for ≥3 minutes (including bag &amp; mask ventilation) referral to a neonatologist should be made for discharge.</td>
</tr>
<tr>
<td>Shoulder Dystocia</td>
<td>Refer to neonatologist.</td>
</tr>
<tr>
<td>Small for Gestational Age</td>
<td>If birth weight &lt;2.5kg, or plots below 10\textsuperscript{th} centile on growth chart in</td>
</tr>
</tbody>
</table>
Thyroxine medication in mother

Refer to neonatologist.

Twins

Term gestation, with no other concerns midwife may discharge

NB. Midwifery orientated tasks are to be taken into consideration first, in-line with service needs.

**Procedure & documentation**

- Obtain maternal history regarding pregnancy, date, time and type of delivery.
- Obtain family history and particularly any sibling history.
- Obtain maternal consent for examination of her baby
- Discuss with mother how she perceives the baby is progressing e.g. feeding
- Observe the baby for posture, movement, tone, colour and obvious deviations from the norm, such as facial palsy and dysmorphic features
- Refer to the neonatologist by contacting the on call doctor via the hospital switch board system or if in hospital using the baton bleep number for the neonatologist
- Referral to the physiotherapy department is made through the neonatologist
- Communicate all findings to the parent(s) & document

**Process for undertaking a systematic examination of the following:**

**General observation:**

- Colour – pale, blue, jaundice, pigment
- Posture and behaviour – Tone, responsiveness
- Respiratory – Distress, cry
- Skin – Mongolian blue spots, birthmarks, dry, abrasions, bruises

**Auscultation:**

- Heart – observation, heart sound, murmur
- Lungs – breath sounds
- Abdomen – bowel sounds

**Palpation and observation:**

- Head and skull – features, hair, moulding, fontanelles, sutures, caput, cephalhaematoma, trauma
- Face – appearance, haemangiomas, asymmetry
- Ears – dimples, position, appearance
- Eyes – red reflex (left and right), appearance, squint, conjunctivitis, discharge, haemorrhage
- Mouth and palate – palate, teeth
- Neck and clavicles – clavicle fracture, mobility, sternomastoid
- Chest – shape, nipples
- Abdomen – liver, spleen, masses, tone
- Umbilicus – smell, discharge, hernia
- Upper limbs, hands – length, digits, palmar creases, syn/poly-dactyly, tone, movement, oedema
- Lower limbs, feet – length, digits, syn/poly-dactyly, tone, movement, talipes, oedema
- Genitalia – hypo/epi-spadias, testes, hydrocoele
- Anus – position, patency
- Femoral pulses – both palpable
- Back and spine – dimples, hair tufts, naevus, abnormal skin patches
- Breech – leg problems, family history (of dislocated hips)
• Hips – Ortolani and Barlow / ultrasound (if required) – do either or both
• Reflexes – grasp, moro, rooting, stepping
• Bowels open – from day 1
• Urine passed

Prompt notification to a Registrar should occur if any abnormalities are detected. If deemed an emergency then the hospital telephone number 2222 is used stating “Neonatal Emergency” area and site location. For home births or SBU then dial 999 and transfer into hospital

**Documentation:** Record all findings from the examination, any deviations and subsequent action(s) taken, and any parental explanations. File all neonatal documentation in the neonatal medical notes.

5. **Reason for development of the Guideline**

To ensure a uniform and consistent approach to examination of the newborn, thus providing a safe multidisciplinary care framework across the Trust.

6. **Methodology**

Development of guidelines adheres to a process of examining the best available evidence relevant to the topic; incorporating guidance and recommendations from national and international reports.

Finalised guidelines will ultimately be approved and ratified by the Directorate locally.

7. **Implementation**

Following approval the guideline will be disseminated and available for reference to all members of the multidisciplinary team via the Trust intranet site. A paper copy will be stored in a marked folder within a designated clinical area.

8. **Monitoring**

Following clinical audit of a guideline, an addendum to change in clinical practice maybe be necessary. Any change to a clinical guideline requires that it must be ratified by the Directorate locally.

Review dates for guidelines will be set at a period of three years; however this set period can be overridden in the light of new clinical evidence.

All unused/previous guidelines will be achieved electronically and in paper format within the Trust.

Adherence and efficiency of clinical guideline will be monitored through regular clinical audit.

Auditing of a clinical guideline will be multidisciplinary, allocated and overseen by the Clinical Audit Lead.
<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Tool</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Minimum requirements:</td>
<td>Maternity notes</td>
<td>Annual review of 1% of all health records of newborns from all care settings</td>
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<tr>
<td></td>
<td>Newborn notes</td>
<td>Annual report of number of trained midwives competent to examine the newborn baby</td>
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<td>Training report</td>
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<td>Transfer sheets</td>
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<td>Reporting arrangements</td>
<td>Acting on recommendations and lead(s)</td>
<td>Change in practice and lessons to be shared</td>
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<td>The completed reports</td>
<td>The leads will use the electronic tracker system for audit to track action plans, which will have stated time frames</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
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<td>will go to the</td>
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<td>clinical governance</td>
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<td>group and be presented</td>
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<td>at the departmental</td>
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<td>audit meetings.</td>
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<td>Action plans will be</td>
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<td>documented in minutes.</td>
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<td>9. Application of the</td>
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<tr>
<td>Guideline</td>
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<tr>
<td>This guideline applies</td>
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<tr>
<td>to all midwives who</td>
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<tr>
<td>have undertaken a</td>
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<td>recognised Examination</td>
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<td>of the Newborn Course.</td>
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<td>10. References</td>
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<tr>
<td>Recognition to Sandwell and West Birmingham Hospitals NHS Trust Guideline</td>
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### 11. Appendices

**Appendix 1 - Launch and Implementation Plan for Clinical Guidelines**

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Action</th>
<th>Who</th>
<th>When</th>
<th>How</th>
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</thead>
<tbody>
<tr>
<td>If previous document is in use: proposed action to retrieve out-of-date copies of the document (electronic and/or paper)</td>
<td>Maggi Dobson</td>
<td>Upon ratification</td>
<td>Logged and archived electronically, and in paper format within each trust</td>
</tr>
<tr>
<td>Initiate addition to clinical guidelines SharePo</td>
<td>Maggi Dobson</td>
<td>Upon ratification</td>
<td>Trust intranet</td>
</tr>
<tr>
<td>Communicate new guideline/changes to guideline</td>
<td>Maggi Dobson Carolyn Deegan Audit Leads Clinical Risk Trust Trainers</td>
<td>Following ratification</td>
<td>Guideline distribution panel will be informed of ratification. Regular updates to be given at audit meetings, directorate meetings, and through mandatory training programmes</td>
</tr>
<tr>
<td>Offer awareness training / incorporate within existing training programmes</td>
<td>Clinical leads Trust Trainers</td>
<td>Following ratification</td>
<td>Through induction and mandatory training programmes</td>
</tr>
<tr>
<td>Circulation of document (paper)</td>
<td>Maggi Dobson</td>
<td>Upon ratification</td>
<td>To a designated area within each trust site</td>
</tr>
<tr>
<td>Circulation of document (electronic)</td>
<td>Maggi Dobson</td>
<td>From draft 1 through to ratification</td>
<td>All drafts via core distribution panel and again upon ratification</td>
</tr>
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</table>
Appendix 2 - Clinical Guidelines Appraisal Checklist

All new clinical guidelines must be appraised using this appraisal checklist before submission to the Clinical Standards Committee for formal ratification (adapted from Appraisal of Guidelines Instrument, AGREE Collaboration, 2001).

The appraisal tool will be completed by the clinical guideline Lead or Author with the support and advice of the Directorate of Healthcare Governance.

Please see the guidance on using the Appraisal Instrument for a more detailed user guide.

1. The overall objective(s) of the guideline is (are) specifically described.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

2. The patients to whom the guideline is meant to apply are specifically described.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

3. The target users of the guideline are clearly defined.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

4. The health benefits, side effects and risks have been considered in formulating the recommendations.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

5. The recommendations are specific and unambiguous.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

6. The different options for management of the condition are clearly presented.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

7. Key recommendations are easily identifiable.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

8. The guideline presents key review criteria for monitoring and audit purposes.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
9. There is an explicit link between the recommendations and the supporting evidence.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

10. A timescale for reviewing the guideline is provided.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

11. The guideline was consulted with individuals from all the relevant professional groups.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

**SCORE= 37** (NB a score of at least 33 must be obtained before formal ratification by the Clinical Standards Committee can be obtained)

**Guideline Distribution listing - core members**

<table>
<thead>
<tr>
<th>Internal reviewers:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetricians</td>
<td>A-Z listing</td>
</tr>
<tr>
<td>Obstetric Consultant BHH &amp; Audit Lead</td>
<td>Barber Katherine</td>
</tr>
<tr>
<td>Gynaecology Consultant GHH</td>
<td>Cartmill Richard</td>
</tr>
<tr>
<td>Gynaecology Consultant BHH</td>
<td>Chakravarti Swati</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant GHH</td>
<td>Emmanuel Kenneth</td>
</tr>
<tr>
<td>Obstetric Consultant BHH/SOL</td>
<td>Griffin Christopher</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant GHH</td>
<td>Honest Honest</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant GHH</td>
<td>Houghton Susan</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant GHH</td>
<td>Howland Elizabeth</td>
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<td>Obstetric &amp; Gynaecology Consultant BHH</td>
<td>Hutchon Susan</td>
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<tr>
<td>Obstetric &amp; Gynaecology Consultant BHH</td>
<td>Irani Shirin</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant BHH/SOL</td>
<td>Matharu Gurminder</td>
</tr>
<tr>
<td>Obstetric &amp; Gynaecology Consultant BHH</td>
<td>Papaioannou Spyros</td>
</tr>
<tr>
<td>Obstetric Consultant BHH/GHH</td>
<td>Patni Shalini</td>
</tr>
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<td>Infertility, Gyna Endocrinology &amp; Paediatric Gynaecology</td>
<td>Payne Elizabeth</td>
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<tr>
<td>Obstetric &amp; Gynaecology Consultant BHH</td>
<td>Pradhan Poonam</td>
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<tr>
<td>Obstetric Consultant GHH</td>
<td>Rhodes Cathy</td>
</tr>
<tr>
<td>Clinical Governance &amp; Obstetric &amp; Gynaecology Consultant BHH/HEFT</td>
<td>Sunanda Gargeswari</td>
</tr>
<tr>
<td>Clinical Director &amp; Obstetric Consultant HEFT</td>
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*this list is not exhaustive as relevant specialities will be consulted in relation to guideline, and distribution is often circulated for wider consultation via core members*

**Title of Guideline:** Examination of the Newborn by Midwives

**Directorate:** Obstetrics & Gynaecology

**Clinical Guideline Lead:** Dr Cathy Rhodes

**Date of Appraisal:** 1st November 2010