SKILLS AUDIT: EXAMINATION

Date:		**Unit:**	
Nurse/ Doctor assessed:			
Non-Compliant:	<80% compliance		
Compliant:	80-100% Compliance		

Equipment required:		
1. Resus. Mannequin	2. Thermometer	3. Nappy
4. Blanket and cap	5. Hand spray	6. Neonatal record

Scenario

"You are caring for a mother and baby four hours after a normal birth. The baby breastfed and received eye care during the first hour after birth. You are ready to do a newborn exam. Demonstrate/describe how you would prepare for this procedure.

NO.	INDICATOR	NC	C	Comment
Prepares equipment and baby				
1.	Introduces her/himself to mother. Explains procedure and encourages mother to be present			
2.	Checks the neonatal record and asks mother about any history of illness or problems during her pregnancy or delivery			
3.	Checks the growth chart and informs mother if baby's length, weight and COH are appropriate.			
4.	Asks mother if she has noticed any problems or has any concerns about her baby			
5.	Asks mother how the baby is feeding and whether the baby has passed urine or stool			
6.	Listens to the mother attentively and encourages her to ask questions			
"The mother reports that she felt very nauseous in her first 3 months and felt very large at the end of the pregnancy. The nurses told her that there was a lot of water around the baby. She states that the baby has sucked well but has not yet passed a stool"				
7.	Reassures the mother that vomiting in the 1st 3 months is normal and that he/she will carefully check the baby for any problems.			
8.	Ensures a neutral thermal environment-excludes drafts, closes curtains, ensures room is warm or uses radiant warmer			
9.	Prepares a clean, warm, dry, stable surface close to the mother			
10.	Ensures a good light source			
11.	Washes hands			
12.	Identifies baby-checks ID band information			
13.	Check's baby's axillary temperature and ensures it is ≥36.5°C			
14.	Ensures baby is undressed with just a nappy			
"Please proceed to examine the baby."				
Assesses general appearance and neurological status				
15.	Throughout the exam, the participant tells the mother what he/she is doing, explains findings, and answers questions.			
16.	Uses the First examination on Pg. 5 of Neonatal record to guide her examination			
17.	Looks and listens before touching			
18.	Checks general appearance, colour, wasting			
19.	Observes position, behaviour (alertness) and activity			
20.	Checks tone and movement			
21.	Checks hearing and vision			
22.	Checks for clenching of hands			
23.	Checks rooting, sucking, moro, grasp and other reflexes			
24.	Checks skin for infection, rashes, marks, other abnormalities			
	A. Totals			
"During your exam you notice a rash with small firm, yellow-white pustules with a surrounding erythematous base. Please describe to the mother what this is and how it needs to be managed."				

25.	Identifies erythema toxicum			
26.	Explains that this is common and normal. It will resolve on its own and the mother should not squeeze the spots nor apply anything to the rash.			
Performs through regional examination from head to toe. Describes what abnormalities she/he is looking for.				
27.	Examines shape of head and fontanelles			
28.	Checks eyes: size, positon, lids, conjunctiva, pupil, iris, cornea			
29.	Checks nose: Shape, nostrils, any discharge			
30.	Checks mouth: lips, tongue, palate, gums, teeth, membranes, saliva, jaw			
31.	Checks ears: site and appearance			
32.	Examines neck: shape, masses, clavicles			
33.	Observes appearance of breasts			
34.	Feels the brachial and femoral pulses			
35.	Counts the heart rate			
36.	Checks the capillary refill time			
37.	Feels for an hyperactive precordium			
38.	Observes for signs of heart failure			
39.	Observes for signs of respiratory distress and counts breaths			
40.	Observes chest shape and movement			
41.	Observes shape of abdomen, skin colour and for oedema			
42.	Checks umbilicus: blood vessels, bleeding, signs of infection			
43.	Palpates for the liver, spleen, kidneys and any masses			
44.	Listens for the apex beat on both sides of the chest and for any murmurs			
45.	Listens to breath sounds and air entry			
46.	Listens for bowel sounds			
47.	Opens nappy and checks inguinal canal & genitalia: penis, scrotum, vulva, clitoris			
48.	Parts the buttocks and checks for patent anus			
49.	Observes the position of the arms and appearance of hands			
50.	Observes the appearance of the legs and feet			
51.	Performs Barlow and Ortolani tests for hip dislocation			
52.	Observes appearance and palpates spine			
53.	Replaces nappy and cap and secures baby skin to skin with mother			
54.	Washes hands			
"During your physical exam, you observed that the abdomen appeared slightly distended and the anus did not appear to be patent. Please explain your findings to the mother and how it needs to be managed."				
55.	Gently and compassionately explains polyhydramnios, failure to pass stool and physical findings. Explains that the baby needs to be checked by a doctor. The baby must not be fed by the mouth anymore and will be admitted in the neonatal unit where a drip will be erected to provide fluid for the baby. The baby may need to go to a bigger hospital for surgery.			
56.	Records findings and maternal counselling in the neonatal record			
57.	Reports findings to the doctor			
58.	Arranges for baby to be transferred to the neonatal unit.			
	B. Totals			
	A. Totals brought forwards			
	Combined Totals			
	Compliant total / 58			
	Final Percentage	X100 =	%	

Assessed by:					
Sign:		**Print:**		**Desig:**	

In Discussion with the Individual:	
Gaps Identified:	
Action Plan:	

Guide to normal and abnormal findings. The healthcare worker should show a good knowledge of the following but does not need to mention them all during the exam		
General inspection		
Wellbeing	Active, alert.	Lethargic, appears ill.
Appearance	No abnormalities.	Gross abnormalities. Abnormal face.
Wasting	Well nourished.	Soft tissue wasting.
Colour	Pink tongue.	Cyanosis, pallor, jaundice, plethora.
Skin	Smooth or mildly dry. Vernix and lanugo. Stork bite, mongolian spots, milia, erythema toxicum, salmon patches.	Dry, marked peeling. Meconium staining. Petechiae, bruising. Large or many pigmented naevi. Capillary or cavernous haemangioma. Infection. Oedema.
Neurological		
Behaviour	Alert, responsive.	Drowsy, irritable.
Position	Flexion of all limbs at term.	Extended limbs or frog position in preterm and ill infants.
Movement	Active. Moves all limbs equally when awake. Stretches, yawns and twists.	Absent, decreased or asymmetrical movement. Jittery or convulsions.
Tone		Decreased or increased.
Hands	Intermittently clenched.	Permanently clenched.
Cry	Good cry when awake.	Weak, high pitch or hoarse cry.
Vision	Follows a face, bright light or red object.	Absent or poor following.
Hearing	Responds to loud noise.	No response.
Sucking	Good suck and rooting reflexes after 36 weeks gestation.	Weak suck at term.
Moro reflex	Full extension then flexion of arms & hands. Symmetrical.	Absent, incomplete or asymmetrical response.
Regional examination		
Head		
Shape	Caput, moulding.	Cephalhaematoma, subaponeurotic bleed. Asymmetry, anencephaly, hydrocephaly, encephalocoele.
Fontanelle	Open, soft fontanelle with palpable sutures.	Full or sunken anterior fontanelle. Large or closed fontanelles. Wide or fused sutures.
Eyes		
Position		Wide or closely spaced.
Size		Small or abnormal eyes.
Lids	Mild oedema common after delivery.	Marked oedema, ptosis, bruising.
Conjunctivae	May have small subconjunctival haemorrhages.	Pale or plethoric. Conjunctivitis. Excessive tearing when nasolacrimal duct obstructed.
Cornea, iris and lens	Cornea clear, regular pupil, red reflex.	Opaque cornea, irregular pupil, cataracts, no red reflex, squint, abnormal eye movements.
Nose		
Shape	Small and upturned.	Flattened in oligohydramnios.
Nostrils	Both patent. Easy passage of feeding catheter.	Choanal atresia. Blocked with dry secretions.
Discharge		Mucoid, purulent or bloody secretions.
Mouth		
Lips	Sucking blisters.	Cleft lip. Long smooth upper lip in fetal alcohol syndrome.
Palate	Epstein's pearls.	High arched or cleft palate.
Tongue	Pink.	Cyanosed, pale, or large.
Teeth	None at birth.	Extra or primary teeth.
Gums	Small cysts.	Tumours.
Mucous membranes	Pink, shiny.	Thrush, ulcers.
Saliva		Excessive if poor swallowing or oesophageal atresia.
Jaw	Smaller than in older child.	Very small.
Ears		
Site	Ears vertical.	Low-set ears.
Appearance	Familial variation.	Skin tag or sinus. Malformed ears. Hairy ears.

Neck		
Shape	Usually short.	Webbing, torticollis.
Masses	No palpable lymph nodes or thyroid.	Cystic hygroma. Goitre. Sternomastoid tumour.
Clavicle		Swelling or fracture.
Breasts		
Appearance	Breast bud at term 5 to 10 mm. Enlarged, lactating breasts.	Extra or wide spaced nipples. Mastitis.
Heart		
Pulses	Brachial and femoral pulses easily palpable. 120–160 beats per minute.	Pulses weak, collapsing, absent, fast or slow or irregular.
Capillary filling time	Less than 4 seconds over chest and peripheries.	Prolonged filling time if infant cold or shocked.
Blood pressure	Systolic 50 to 70 mm at term.	Hypertensive or hypotensive.
Precordium	Mild pulsation felt over heart and epigastrium.	Hyperactive precordium.
Heart failure		Oedema, hepatomegaly, tachypnoea or excessive weight gain.
Lungs		
Respiration rate	40-60 breaths per minute. Irregular in REM sleep. Periodic breathing with no change in heart rate or colour.	Tachypnoea above 60 breaths per minute. Gasping. Apnoea with drop in heart rate, pallor or cyanosis.
Respiratory distress	Nil or Mild recession in preterm infant.	Severe recession
		Expiratory grunt
		Inspiratory stridor a sign of upper airway obstruction.
Percussion		Dull with effusion or haemothorax. Hyperresonant with pneumothorax.
Chest shape	Symmetrical.	Hyperinflated or small chest.
Chest movement	Symmetrical.	Asymmetrical in pneumothorax and diaphragmatic hernia.
Abdomen		
Umbilicus	2 arteries and 1 vein.	1 artery, 1 vein. Infection. Bleeding or discharge. Hernia. Exomphalos.
Skin		Periumbilical redness or oedema.
Shape		Distended or hollow.
Liver	Palpable 1 cm below coastal margin, soft.	Enlarged, firm, tender.
Spleen	Not easily felt.	Enlarged, firm.
Kidneys	Often felt but normal size.	Enlarged, firm.
Masses	No other masses palpable. Full bladder can be percussed.	Palpable mass.
Auscultation		
Apex beat	Heard maximally to left of sternum.	Heard best in right chest in dextrocardia.
Murmurs	Soft, short systolic murmur common on day 1.	Systolic or diastolic murmurs.
Air entry	Equal air entry over both lungs.	Unequal or decreased.
Adventitious sounds	Transmitted sounds.	Crackles, wheeze or rhonchi.
Bowel sounds	Heard immediately on auscultation.	Few or absent.
Genitalia		
Penis	Urethral dimple at centre of glans.	Hypospadias.
Testes	Descended by 37 weeks.	Undescended.
Scrotum	Well formed at term.	Inguinal hernia. Fluid hernia.
Vulva	Skin tags, mucoid or bloody discharge.	Fusion of labia.
Clitoris	Uncovered in preterm or wasted infants.	Enlarged in adrenal hyperplasia.
Anus	Patent.	Absent or covered.
Urine	Passed in first 12 hours.	Poor stream suggests posterior urethral valve.
Stools	Meconium passed within 48 hours of birth. Yellow stools by day 5. Breastfed stool may be green and mucoid.	Blood in stool. White stools in obstructive jaundice. Offensive watery stools.
Limbs		
Arms	Flexed position in term infant.	Brachial palsy.
Hands		Extra, fused or missing fingers. Skin tags. Single palmar crease. Hypoplastic nails.
Legs	Mild bowing of lower legs common.	Dislocatable knees in breach.
Feet	Positional deformation.	Clubbed feet. Abnormal toes.
Hips		
Movement	Click common. Fully abducted.	Dislocated or dislocatable. Limited abduction.
Spine		
Appearance	Coccygeal dimple or sinus. Straight spine.	Sacral dimple or sinus. Scoliosis. Meningomyelocoele.

Moro: Raise the head of a supine baby approximately 30° from the cot and then drop it into the hand of the examiner level with the surface. **Barlows:** One hand immobilizes the pelvis, while the other hand moves the opposite thigh into mid-abduction and pushes backwards with the thumb. Test is positive if hip dislocates. **Ortolani:** Hold both thighs so that the examiner's fingers are over the outer side of each thigh and thumbs rest on the inner side of each thigh. Abduct both thighs. If a hip is dislocated, a 'clunk' can be felt and heard as the trochanter moves back into the acetabulum.