OSCE Checklist: Newborn Baby Assessment (NIPE)

Introduction		
1	Wash your hands and don PPE if appropriate	
2	Introduce yourself to the patient including your name and role	
3	Confirm the patient's name and date of birth	
4	Briefly explain what the examination will involve using patient-friendly language	
5	Gain consent to proceed with the examination	
6	Adequately expose the child for the assessment	
7	Encourage the parent(s) to ask questions during the check and to participate where appropriate	
History		
8	Take a brief history of the pregnancy and the delivery (e.g. mechanism of delivery, complications)	
Weight		
9	Measure the infant's weight and plot on a weight chart	
General inspection		
10	Inspect the infant for clinical signs suggestive of pathology (e.g. pallor, cyanosis, jaundice)	
Tone		
11	Assess tone by gently moving the newborn's limbs passively and observing the newborn when they're picked up	
Head		
12	Measure the infant's head circumference and record it in the baby's notes	
13	Inspect the shape of the head and note any abnormalities	
14	Palpate the anterior fontanelle: note if it feels flat (normal), sunken or bulging (abnormal)	
Skin		
15	Inspect the skin for colour abnormalities (e.g. pallor, jaundice), bruising/lacerations and birthmarks	
Face		
16	Inspect the face for dysmorphic features, asymmetry, trauma and nasal abnormalities	
Eyes		
17	Inspect the eyes for abnormalities (position, shape, erythema, discharge)	
18	Assess the fundal reflex in each eye	
Ears		
19	Inspect the pinna: note any asymmetry, skin tags, pits or the presence of accessory auricles	
Mouth and palate		

20	Look for clefts of the hard or soft palate and inspect the tongue for ankyloglossia	
Neck and clavicles		
21	Inspect the neck for abnormalities (shortened length, lumps, clavicular fracture)	
Upper limbs		
22	Inspect the upper limbs for abnormalities (e.g. asymmetry, missing fingers, single palmar crease)	
23	Palpate and compare the brachial pulse in each upper limb	
Chest		
24	Inspect the chest for abnormalities and assess the infant's respiratory rate and work of breathing	
25	Auscultate the lungs	
26	Auscultate the heart	
27	Assess pulse oximetry	
Abdomen		
28	Inspect the abdomen for abnormalities (e.g. distension, hernias, cord stump infection)	
29	Palpate the abdomen to assess for organomegaly	
Genitalia		
30	Inspect the genitalia and note any abnormalities (position of the urethral meatus, testicular swelling, absent testicle, fused labia)	
Lower limbs		
31	Inspect the lower limbs for abnormalities (e.g. asymmetry, oedema, ankle deformities, missing digits)	
32	Assess tone in both lower limbs	
33	Assess movement in both lower limbs	
34	Assess the range of knee joint movement	
35	Palpate and compare femoral pulses	
36	Perform Barlow's test	
37	Perform Ortolani's test	
Back and spine		
38	Inspect the back and spine for abnormalities (e.g. scoliosis, hair tufts, naevi, sacral pits)	
Anus		
39	Inspect the anus for patency	
Reflexes		
40	Assess a selection of newborn reflexes (e.g. palmar grasp, rooting reflex, ,Moro reflex)	

To complete the examination...		
41	Explain to the parent(s) that the examination is now finished and offer to dress the baby	
42	Share the results of the assessment with the parents, explaining the reason for any referrals you feel are required	
43	Check if the parents have any further questions	
44	Thank the parents for their time	
45	Dispose of PPE appropriately and wash your hands	
46	Summarise your findings	
47	Document your findings and suggest further investigations/referrals	