KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ADMISSION RECORD: GC/HC

Baby of:		**IP Number:**		**Seq. no.**	

Hospital:		**Unit:**	
Date of Birth:		**Time of Birth:**	
Date of Admission:		**Time of Admission:**	
Admitted from:		**Sex:**	
Reason for admission:			
Composite Gestational Age: (For all babies per Ballard's form)	weeks	**Weight on admission:**	gms

Social History						
Mother	Y/N	**Father**	Y/N	**No. of siblings:**		
Well		Well		**Primary caregiver of children:**		
Sick		Sick		**Household income & Grants:**	R	
Demised		Demised		**Location of home:**		
Employed		Employed		Piped Water:	Y	N
Learner		Learner		Electricity:	Y	N
Married		Resident with mother		Sanitation:	Y	N
Language:				**Religion:**		
Education level achieved?						
Nearest clinic:				**Time from Hospital:**		
Other Details:						

Ante Natal/ Intrapartum Problems / risk factors:							
STEROIDS		**RPR**		**Rh**		**HIV**	

Condition on arrival:											
Lines/ETT/Dressings:											
Observations:		ACTIVITY:		COLOUR:		PULSE:		BP:			
TEMP:		RESP:		FIO_2		SATS:		GLUCOSE:			
Emergency signs:											
Gasping-Abnormal breath with long pause afterwards				Temperature less than (<) 35°C				Extreme lethargy			
Respiratory rate less than 20 bpm				Hypoglycaemia less than 1.5mmol/l				Pallor			
Heart rate < 100 or > 180bpm											
Classify:								**Bed allocation:**		**HC / GC**	
Action:											

Examination: To be completed by Doctor on admission to unit.	**Time of MO Exam:**	

GENERAL: Condition (sick or well) Colour Hydration Skin Pressure areas

Assess for priority signs	Y		Y		Y
Hypothermia- less than 36.5°C		Pallor		Purulent discharge from eyes	
Pyrexia- More than 37.5°C		Cyanosis		Red/swollen eyelids	
Hypoglycaemia- less than 2.6 mmol/l		Jaundice		Rash/pustules on the skin	
Hyperglycaemia- More than 8 mmol/l		Oedema		Necrotic area/wound	
Dehydration-decreased skin turgor/sunken fontanel/ dry mouth		Umbilicus-Redness/purulent discharge.			

RESPIRATORY SYSTEM:

Respiratory support and settings:

Breath sounds Chest movement Airway

Assess for priority signs	Y		Y		Y
Severe resp. distress: FiO_2 > 60%		**Mod. resp. distress:** FiO_2 30-60%		**Mild resp. distress:** FiO_2<30%	
Fast breathing more than 80bpm		Fast breathing 60-80bpm		Fast breathing above 60bpm	
Severe recession or grunting		Recession or nasal flaring			
Apnoea					
Central cyanosis					

CARDIO VASCULAR SYSTEM: Heart sounds Pulses

Assess for priority signs	Y		Y		Y
Tachycardia more than 160bpm		Hypertension-MAP > 50mmHg (prem)> 65mmHg (term)		Peripheries cold/pale	
Bradycardia less than 120bpm		Hypotension-MAP 5-10mmHg less than Gest. age			
Abnormal heart sounds or murmur		Capillary Refill time (CRT) more than 3 secs			

CENTRAL NERVOUS SYSTEM: Activity/posture Tone Seizure activity Grasp

Moro Fontanelles

Assess for priority signs	Y		Y		Y
Increased tone		Seizure activity: Subtle: Staring or mouthing		Bulging fontanelle	
Truncal hypotonia		Fisting/ cycling movements of arms/legs		Inappropriate/ reduced response to handling/pain	
Decreased activity		Clonic: Repetitive jerking of limb/s			
		Tonic: Stiffness/sustained posturing			

GASTRO INTESTINAL SYSTEM: Distension Discolouration Tenderness Bowel sounds

Organomegaly Umbilicus

Assess for priority signs	Y		Y		Y
Tense abdomen		Failure to pass meconium		Enlarged liver / spleen	
Abdominal wall discolouration		Decreased / absent bowel sounds			
Abdomen tender to touch		Bile stained vomiting / drainage			

Assessment/ Problem list: Include probable & possible problems & factors for & against.

Plan: Insert and complete Clinical Management Checklist (C/L) for each assessed risk/ classified problem.											
RESPIRATORY SUPPORT:											
Nil		Nasal prongs (NP)		NP & Head box		Nasal CPAP		High Flow Humidified O_2			
Settings:	Flow		FiO_2		PEEP						
Other:											

FLUIDS and FEEDS Complete feeding and fluids C/L. Record orders on Intake chart			
Required fluids:	ml/kg/day	**Daily total:**	ml/day
Feeds:			
IV Fluids:			

MEDICATIONS:

FURTHER MANAGEMENT:

INVESTIGATIONS: Select appropriate							
Full Blood count (FBC)		C Reactive protein (CRP)		Blood Culture		Blood gas	
Chest X-Ray		Abdominal X-Ray		HIV PCR		LP	
Other:							

Admission Nursing Care Plan/Checklist	Y	N		Y	N
Complete all observations on assessment chart			Pass naso-gastric tube if nil /mild resp. distress		
Nurse under radiant warmer if unstable			Pass oro-gastric tube if mod./sev. resp. distress		
Attach temperature probe with reflective cover			Place on free drainage if NPO		
Set control to “Baby” mode			Date gastric tube		
Set temperature at 36.5°C			Date and colour code IV line		
Cover with plastic sheet			Ensure First Exam form has been completed		
Place in prewarmed (36°C) incubator if stable			Plot weight and assess fetal growth		
Cover head with fabric/woollen cap			Ensure Vit. K and eye prophylaxis given		
Position in flexed, midline, contained position (nested)			Ensure baby has been identified: ID bands		
Limit light and noise levels			Name on bed		
Place alcohol based hand rub(ABHR) at foot of bed			Complete Orientation section of Health Ed. form		
Use 5ml ABHR before touching incubator or baby			Give Welcome pamphlet if available		
Use hydrocolloid dressing under all tape			Commence expressing EBM within 6hrs of birth		
Reason for not completing any of the above:					
Other care given:					

Date:			Time:		
Sign MO:		Print:		MP No.	
Sign RN:		Print:		SANC No.	

MOTHER												HOME LOCATION:	
Current Location:					Health check completed?		Y / N					Care of baby:	
Feeding choice:	EBM		Formula			Milk production.							
Counselling given:	Yes		No		Recorded on counselling form?		Yes		No		Seen by social worker?		
Health Ed. given:	Yes		No		Recorded on education form?		Yes		No		Yes		No
Visitors:	Baby's father				Baby's siblings		Grandparents				Other-specify:		
Any problems:													
Interventions:													

SAFETY CHECKS	To be completed immediately after handover by day and night staff. Record information as required.					
CHECK		PLAN	DAY	✓	NIGHT	✓
I.D	**ID bands**	Check 2 legible ID bands are in situ **Location:**				
RESUS.	**Resuscitator.**	Accessible to bed & checked	Checked		Checked	
	Mask: Clean.	Size 1-term, 0-prem **Mask Size:**				
	Suction. At bed & checked.	Maintain pressure at 20 KPa. **Pressure:**	KPa		KPa	
		Size 6Fg-prem, size 8Fg-term **Catheter Size:**	Fg		Fg	
ALARM SETTINGS	**Oxygen saturations.**	Low 89% High 95%. High 100% if no oxygen **Settings:**	**Low:**		**Low:**	
			High:		**High:**	
	Heart Rate.	Low 100bpm High 180bpm **Settings:**	**Low:**		**Low:**	
			High:		**High:**	
	Respiratory Rate.	High 80bpm Low 20bpm **Settings:**	**Low:**		**Low:**	
			High:		**High:**	
IV	**Infusion/syringe pumps**	Check rate/dose. Syringe (not pump) labelled.	Checked		Checked	
	Lines correctly connected.	Trace all lines/NG tube to connections.	Checked		Checked	
	IV /Umbilical strapping.	Restrap immediately if loose/soiled. **Depth:** _____	Checked		Checked	
			Restrapped		Restrapped	
HYGIENE	**Patient care container.** Cleaned & restocked.	70% alcohol changed daily. Vaseline, nappies, saline amps, aqueous cream	Restocked		Restocked	
	Alcohol Based Hand Rub. (ABHR)	At foot of bed. Changed according to hosp. policy-no cracks	Present		Present	
			Changed		Changed	
EQUIPMENT	**Type of bed occupied**	Record if baby is nursed in a cot, closed incubator/radiant warmer				
	Radiant warmer temp. probe	Attach with reflective cover on Lt. abdomen Silver side down. Wire also secured Rt. abdom.	Secured		Secured	
	Radiant warmer Set Temp.	This is not the incubator temperature. It is the desired baby temp. Set at 36.5°C **Setting:**	**°C**		**°C**	
RECORDS	**Ballard score completed**	Record composite gestational age on cover	Completed		Completed	
	Birth parameters plotted. Wt, L & COH	Plot on appropriate Growth standards chart	Plotted		Checked	
	Clinical Management Checklists (C/L)	Present, current and signed	Checked		Checked	
SIGN:						

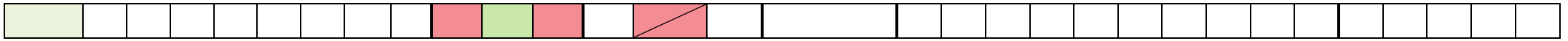
ABBREVIATIONS IN DOCUMENT

BP= Blood pressure; bpm= beats/breaths per minute; CF=Cardiac failure; COH=Circumference of head; CPAP= Continuous positive airways pressure; EBM= Expressed breast milk; ET= Endotracheal tube; FBC = Full blood count; FiO_2=Fraction of Inspired oxygen; GC= General Care ; Gest= Gestational; gms= grams; HC= High Care;HIV= Human immune virus; ID = Identity; IP= In patient; IV= Intravenous; kg= kilogram; L=Length; LP= lumbar puncture; MAP= Mean airway/arterial pressure; mls= millilitres; MO= Medical officer; Mx=Management; NNS= non-nutritive sucking; NPO_2=Nasal prong oxygen; NPO= Nil per Os, PEEP= Positive end expiratory pressure; Photo = phototherapy; Prev= Previous; Resp=Respiratory; RH=Rhesus factor; Prev= Previous; RPR=Rapid plasma regain, secs= seconds; temp=Temperature; UVC=Umbilical venous catheter; Wt=weight; < = less than; > = more than

TIME	GENERAL ASSESSMENT	METABOLIC	CNS	ACTION	GENERAL CARE	DEVELOPMENTAL CARE
PLAN	• Perform a general assessment at least every change of shift and as indicated below. • Assess condition for any change or emergency signs: Gasping, respiratory rate < 20, tongue blue; heart rate < 100 or > 180, pallor; extreme lethargy or unconscious. Contact MO immediately. • Assess eyes and cord for signs of infection. • Copious purulent discharge from the eye with swelling must be reported and treated as an emergency. • Change dressing if breakthrough evident or leaking. Do not apply gauze dressing to open wound. • **If on nCPAP:** Check nasal perfusion. Nostrils must be visible, warm & pink.	• **Maintain glucose 2.6-8mmol/l** • Check on admission, 3hrly till stable & then PRN if: jittery, cold, lethargic, vomiting, IV infiltrated. • Ensure temp. and oxygen levels are normal. • If < 2.6 mmol/l give milk feed or start IV fluids • If <1.7 mmol/l or symptomatic: Give 2-3ml/kg NNL/10% glucose IV bolus. • Check U&E if persistently low or seizures. • Document type, number & duration of any seizures. • Commence treatment: seizures > 3 mins or >3 seizures/ hr or cardiorespiratory compromise. • If asphyxiated: ○ Start encephalopathy checklist & HIE score sheet ○ Observe for signs of hypoxic injury: hypoglycaemia, ↓bowel sounds, poor perfusion, peripheral cyanosis, blood/protein in urine		• Call MO immediately for any change in condition • Insert and complete relevant C/L for any problem identified	• If eyes red/swollen/discharging clean 3hrly (from inside out) with saline • Clean cord with Chlorhexidine tincture or alcohol • Clean mouth with sterile water and apply Colostrum / EBM to lips and gums (Vaseline if EBM not available) • Apply emollient cream to dry skin and barrier cream / Vaseline to the buttocks every nappy change. • Position baby head up and prone (as much as possible) to reduce the risk of reflux induced apnoea, aspiration and to improve oxygenation. • Encourage KMC as early, frequently and for as long as possible • Commence phototherapy **immediately** if baby appears jaundiced. • Turn phototherapy off when taking blood for a Total Serum Bilirubin (TSB) • If receiving phototherapy, cover eyes with phototherapy eye shield and open the nappy.	• **At risk for developmental delays, positional disorders, stress & disturbed sleep** • Shield eyes from light • Cluster care • Nurse in foetal position - shoulders curved, joints flexed & midline positioning of head & limbs • Signs of stress/pain? Stop activity, swaddle/ give KMC/ hold baby in flexed position with your hands, give NNS/ sucrose / analgesia • Allow parents to visit 24hrs/day. Other visitors during visiting hours

FREQUENCY	Condition	Eyes	Skin	Mouth	Cord	Perineum	Nasal perfusion	Wound	Glucose mmol/l			Activity	Seizure activity	Number/hr		Eye care	Cord care	Mouth care	Skin care	Buttock care	Position change	Probe Change	Phototherapy	Nappy open	Eye Shield	Incubator covered	Flexed/ Midline	KMC	Stress/pain signs	Stress/Pain Mx
									< 2.6	2.6 - 8	> 8																				
HC	6 hrly	6 hrly	6 hrly	6 hrly	6 hrly	6 hrly	3 hrly/PRN	PRN	PRN	Daily/PRN	PRN	3Hrly	PRN	PRN		PRN	3hrly	6 hrly	PRN	3hrly	3hrly	3hrly	6 hrly	6 hrly	6 hrly	3hrly	3hrly	3hrly PRN	3hrly	PRN
GC	12 hrly	12 hrly	12 hrly	12 hrly	12 hrly	12 hrly	NA	PRN	PRN	PRN	PRN	6 hrly	PRN	PRN		PRN	6 hrly	12 hrly	PRN	6 hrly	6 hrly	3 hrly	6 hrly	6 hrly	6 hrly	3 hrly	3 hrly	Continuous	6 hrly	PRN

Name: _____ IP No._____ Date: _____



TIME	TEMPERATURE	CARDIO- VASCULAR SYSTEM	RESPIRATORY SYSTEM	RESPIRATORY SUPPORT (BiPAP/ nCPAP)	ACTION
PLAN	• **Maintain axillary temp. 36.5-37.5°C** • If on radiant warmer: Apply plastic blanket in 1st week of life. • Closed incubator temp 36°C on Day 1. Adjust according to baby's temp. and incub. temp. table thereafter. • Check glucose if temp. low • Prevent convective, conductive, radiant and evaporative heat loss • Apply cap	• **Maintain HR 120-160bpm** • Report any sudden change in colour • Perfusion: Ensure Capillary refill time(CRT) is 3 secs. or less • Tachycardia- check temp, pain, signs of sepsis • Bradycardia- Call MO. Check for apnoea, low sats, seizures BP mean: Normal ± Gest. age • Ensure BP cuff is not too small- check guide on cuff (causes elevated readings)	• **Monitor resp. rate 40-60bpm** • **Maintain Sats 90-94% in oxygen** • If apnoeic: stimulate, extend neck, suction, bag • Ensure temp. and glucose levels are normal. • Suction nasopharynx if baby apnoeic or increased respiratory distress. Use a new size 6 or 8 Fg suction catheter & sterile gloves each time. • For **severe distress**-commence BiPAP (if available) or basic nCPAP immediately. If **mild and preterm** commence nCPAP. **If mild & term** or no CPAP available -commence nasal prong FIO_2 at 1L/min and 30% oxygen.	• **Add** head box oxygen to NP if baby not maintaining sats. on 2L nasal prong oxygen. Consult referral hospital. • **CPAP settings:** PEEP 5. Oxygen 30% • **BiPAP settings:** PEEP 6cm/H_2O. PIP 10cm/H_2O. Rate 40bpm. Oxygen 30% • Increase/decrease oxygen by 2-5% every 5mins until sats in normal range. • Sats <90% on 40% FIO_2 CPAP- contact referral hospital. • Maintain water level in humidifier chamber & empty any water from circuit tubing. • If FIO_2 <30% wean to basic nCPAP or nasal prongs (NP). Wean NP flow if no resp. distress and maintaining sats.	• Call MO immediately for any change in condition • Insert and complete relevant C/L for any problem identified

FREQUENCY																																
																										nCPAP only						
HC	3 hrly	3 hrly	3 hrly	PRN	3 hrly	PRN	3hrly	PRN	3hrly	PRN	3-6hrly	3-6hrly	PRN	3hrly	PRN	PRN	3hrly	PRN	6 hrly	PRN	3hrly	3hrly	3hrly	3 hrly	3hrly	3hrly	3hrly	3hrly	PRN				
GC	NA	6 hrly	6 hrly	PRN	6Hrly	PRN	6 hrly	PRN	6 hrly	PRN	NA	NA	PRN	6 hrly	PRN	PRN	6 hrly	PRN	3hrly	PRN	6 hrly	6 hrly	NA	NA	NA	NA	NA	NA	PRN				
ASSESS	**Plastic blanket?**	**Cap**?	**Heater output/ Incub. temp.** %/°C	**Temperature** °C <36.5	36.5-37.5	>37.5	**Colour / Perfusion**	**Heart Rate** bpm <100	100-160	>160	**BP** mmHg	**Mean** mmHg	**Resp. Rate** bpm < 40	40-60	> 60	**Saturations** % < 90	90-100-No Oxygen 90-94 -On oxygen	> 94 -On Oxygen	**Respiratory distress**	**Apnoea**	**Oxygen method**	**FIO_2**%	**Flow** L/min	**Rate**	**MAP/PEEP** cm/H_2O	**PIP** cm/H_2O	**Water refill/ Empty tubes?**	**Humidifier temperature**	**Suction Vol./description**					

Name: _____ IP No._____ Date: _____

TIME	INTAKE-FEEDS	INTAKE-IV FLUIDS	ASSESMENT/ACTION

PLAN / ORDERS

- Total fluid intake includes oral and IV fluids
- Promote breast feeding/Donor milk if no EBM.
- Commence expressing breast milk within 6hrs of birth.
- Ensure mother empties breasts at each expression.
- Feed baby in skin to skin position if possible.
- Do not keep NPO for longer than 3 days without TPN.
- Observe for signs of feeding readiness: wakes for feeds, alert, rooting, sucking on hands etc
- Transition slowly from NG to breast feeds
- Review the need for an IV line daily and remove as soon as possible.
- If infiltrated ensure IV is resited within 1 hr. If IV is not resited-increase oral feeds to ensure delivery of total required fluid volume.
- Date and change IV lines every 72 hrs. Record on Safety Checklist.
- Total intake and output daily

LINE No.	FEEDS	Line 1	Line 2	Bolus
FLUID				
VOL/RATE				
SIGN				
REVIEWED				
SIGN				

- Hourly, assess position & condition of insertion site & distal perfusion. Inform MO immediately of any phlebitis/swelling /absent backflow/ poor perfusion.
- Clean cord 3hrly with chlorhexidine if cannulated.
- Ensure IV dressing is clean and intact. Change if loose, soiled or wet.
- Scrub any access port with 70% alcohol for 15 secs & allow to dry before accessing. Record (HS) in action column.

TIME	Vol	How	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Line 1 Site	Line 1 Cond.	Line 2 Site	Line 2 Cond.	Action
0700														
0800														
0900														
1000														
1100														
1200														
1300														
1400														
1500														
1600														
1700														
1800														
1900														
2000														
2100														
2200														
2300														
2400														
0100														
0200														
0300														
0400														
0500														
0600														
Totals:														
TOTAL INTAKE:	mls													

TIME	GIT & RENAL SYSTEMS							OUTPUT							
PLAN	• Keep nil per os if aspirates/vomitus are blood stained, if bowel sounds are absent or decreased or if urine contains blood and protein. Place NG tube on free drainage. • Monitor abdominal girth daily if baby has abdominal distention or necrotising enterocolitis • Commence non-nutritive sucking at breast or with dummy as soon as possible. • Report any change in sucking once oral feeding commenced.							• Aspirate NG tube prior to feeds to confirm location and any abnormality in type of aspirate. Return aspirates • Report failure to pass stool for more than 1 day • SG ≤1010 –↑hydration SG >1010-↑dehydration • Blood and protein associated with renal damage. Test on admission if asphyxiated							
FREQUENCY HC	3 hrly	6 hrly	PRN	6 hrly	12 hrly			PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
FREQUENCY GC	3 hrly	12 hrly	PRN	12 hrly	Daily			PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
ASSESS	**Sucking**	**Abdomen**	**Abdominal Girth**	**Bowel sounds**	**PH** **Blood**	**SG** **Protein**	**Glucose/ Other**	**Urine volume**	Urine description	**Stool volume**	**Stool description**	**Aspirate vol.** -Mls	**Aspirate description**	**Vomitus volume**	**Blood** -Mls
TOTAL OUTPUT:															

HANDOVER CHECKLIST Sign below that all the following information has been handed over.	
1. Name and Day of life	10. Specific orders
2. Gestation at birth	11. Mothers condition, support required & any problems
3. Problem list and progress	12. Baby's current condition, colour and activity
4. Emergency/ Priority signs identified	13. Any abnormal observations and action taken
5. Respiratory Support- Mode, FiO_2, Saturations, Settings	14. Urine and stools passed and any abnormality
6. Daily fluid requirement	15. Feeds given and how tolerated
7. IV fluids and Feeds ordered	16. IV fluids given
8. Medications (Check that all have been given)	17. Location and condition of IV sites

SHIFT TIMES	NURSE REPSONSIBLE FOR CARE:				RECEIVED BY: (Handed over to)			
	SIGNATURE	NAME	SANC NO.	DESIG	SIGNATURE	NAME	SANC NO.	DESIG

Assessment summary and Action Plan- Day Staff:			**Time:**		
Baby is stable with no abnormal observations or danger signs.	**Y**	**N**	Baby is tolerating feeds and passing stools.	**Y**	**N**
Mother is healthy and caring well for baby.	**Y**	**N**	Baby is gaining weight.	**Y**	**N**
Action Plan:					

Assessment summary and Action Plan- Night Staff:			**Time:**		
Baby is stable with no abnormal observations or danger signs.	**Y**	**N**	Baby is tolerating feeds and passing stools.	**Y**	**N**
Mother is healthy and caring well for baby.	**Y**	**N**	Baby is gaining weight.	**Y**	**N**
Action Plan:					

MULTIDISCIPLINARY NOTES Consultant review, doctor, nurse, rehab team, social worker, dietician etc

Nurses should include **interim/crisis entries only**. All other information is found on the assessment record. **NB Time, Sign , Print name and Practice no. for each entry**

 Name: _________________________ IP No._______________ Date: _________________

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Name: ___________________________ IP No.________________ Date: __________________

Name: _____ IP No._____ Date: _____