KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ADMISSION RECORD: ICU/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:	
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

RESPIRATORY SYSTEM:		
Respiratory support and settings:		
Breath sounds	Chest movement	Airway

CARDIO VASCULAR SYSTEM:	Heart sounds	Pulses

CENTRAL NERVOUS SYSTEM:	Activity/posture	Tone	Seizure activity	Grasp
Moro	Fontanelles			

GASTRO INTESTINAL SYSTEM:	Distension	Discolouration	Tenderness	Bowel sounds
Organomegaly	Umbilicus			

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

PLAN: Insert and complete a Clinical Management Checklist (C/L) for each assessed risk/ classified problem.			
RESPIRATORY SUPPORT:			
FLUIDS and FEEDS: Complete Feeding and Fluids C/L. Record orders on Intake page.			
Required fluids:	ml/kg/day	**Daily total:**	ml/day
Feeds:			
IV Fluids:			
MEDICATIONS:			

 Name: _____ IP No._____ Date: _____

FURTHER MANAGEMENT
INVESTIGATIONS:

Admission Nursing Care Plan/ Checklist- Nurse	Y	N		Y	N
Nurse under radiant warmer if unstable			Pass naso-gastric tube if nil /mild resp. distress		
Attach temperature probe with reflective cover			Pass oro-gastric tube if mod./sev. resp. distress		
Set control to "Baby" mode			Place on free drainage if NPO		
Set temperature at 36.5°C			Date gastric tube		
Cover with plastic sheet			Date and colour code IV line		
Place in prewarmed (36°C) incubator if stable			Ensure First Exam form has been completed		
Cover head with fabric/woollen cap			Plot weight and assess fetal growth		
Position in flexed, midline, contained position (nested)			Ensure Vit. K and eye prophylaxis given		
Limit light and noise levels			Ensure baby has been identified: ID bands		
Place alcohol based hand rub(ABHR) at foot of bed			Name on bed		
Use 5ml ABHR before touching incubator or baby			Complete Orientation section of Health Ed. form		
Use hydrocolloid dressing under all tape			Give Welcome pamphlet if available		
			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	ACTION DAY	✓	ACTION NIGHT	✓
I.D	**ID bands**	Check 2 legible ID bands are in situ **Location:**				
RESUSCITATION	**Resuscitator.**	Accessible to bed & checked	Checked		Checked	
	Mask: Clean.	Size 1-term, 0-prem **Mask Size:**				
	Suction. At bed & checked. Use inline suction catheter	Maintain suction pressure at 20 KPa. **Pressure:** Size 6Fg-prem, size 8Fg-term **Catheter Size:**	KPa Fg		KPa Fg	
ALARM SETTINGS	**Oxygen saturations.**	Low 89% High 95%. High 100% if no oxygen **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Heart Rate.	Low 100bpm High 180bpm **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Respiratory Rate.	High 80bpm Low 20bpm **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Peak Inspiratory Pressure (PIP)	Set 2 above and below current settings **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Positive End Expiratory Pressure (PEEP)	Set 2 above and below current settings **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Expired tidal volume	High 7ml/kg (Term 9ml/kg) Low 3ml/kg **Settings:**	**Low:** **High:**		**Low:** **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	
	ETT/IV /Umbilical strapping.	**ETT Depth: _____** **Umbil. Art : _____ Venous:_____**	Checked Restrapped		Checked 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 Changed		Present Changed	
EQUIPMENT	**Type of bed occupied**	Record if baby is nursed in a 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
Amp= Amplitude; Art=arterial; BP= Blood pressure; bpm= beats/breaths per minute; CF=Cardiac failure; COH=Circumference of head; CPAP= Continuous positive airways pressure; CVC=Central venous catheter EBM= Expressed breast milk; FiO2=Fraction of Inspired oxygen; FQY= Frequency; GC= General Care ; Gest= Gestational; HC= High Care; IP= In patient; IV= Intravenous; kg= kilogram; L=Length; LP= lumbar puncture; MAP= Mean airway/arterial pressure; mls= millilitres; MO= Medical officer; Mx=Management; NPO_2=Nasal prong oxygen; NPO= Nil per Os, P_{aw}-Airway Pressure; PEEP= Positive end expiratory pressure; Photo = phototherapy; PIP=Peak Inspiratory Pressure; Prev= Previous; Resp=Respiratory; secs= seconds; SOP=Standard operating procedure; TPN= Total Parenteral Nutrition; TV=Tidal volume; Umbil=umbilical; UVC=Umbilical venous catheter; Wt=weight; < = less than; > = more than

NB * Frequency of assessments (FQY): Frequency of assessment stipulated refers to intensive care. Frequency of HC assessments is dependent on the acuity of the patient but, for vital signs, is at least 3hrly.

 Name: _____ IP No._____ Date: _____

TIME	GENERAL ASSESSMENT							GENERAL CARE							DEVELOPMENTAL CARE				
PLAN	• 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. • Asses 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 or leaking							• Clean eyes 3hrly (from inside out) with saline if red/swollen/discharging • Clean cord with Chlorhexidine tincture • Clean mouth with sterile water and apply colostrum / EBM to lips & gums • Apply emollient cream to dry skin • Apply barrier cream or Vaseline to the buttocks • Nurse baby semi fowlers to reduce reflux and reflux induced apnoea. **NB** Position prone as much as possible esp. if ventilated							• **At risk for developmental delays, positional disorders, stress & disturbed sleep** • Commence intermittent KMC from Day1 • Cluster activities and shield eyes from light • Ensure baby is in foetal position -shoulders curved, all joints flexed and midline • Signs of stress? Stop activity. Swaddle/ KMC/ contain baby. Give NNS / sucrose / analgesia • Allow parents to visit 24hrs/day. Other visitors during visiting hours				
FQY*	3hrly	6hrly	6hrly	6hrly	6hrly	6hrly	PRN	PRN	3hrly	3hrly	PRN	3hrly	3hrly	3hrly	3hrly	3hrly	3hrly	PRN	**Action** Insert and complete relevant C/L for any problem identified
ASSESS	**Condition**	**Eyes**	**Skin**	**Mouth**	**Cord**	**Perineum**	**Wound**	**Eye care**	**Cord care**	**Mouth care**	**Skin care**	**Buttock care**	**Position change**	**Probe change**	**Eyes shielded**	**Midline/ flexed**	**KMC**	**Signs of stress**	
07																			
08																			
09																			
10																			
11																			
12																			
13																			
14																			
15																			
16																			
17																			
18																			
19																			
20																			
21																			
22																			
23																			
24																			
01																			
02																			
03																			
04																			
05																			
06																			

CONDITION		SKIN, MOUTH,CORD & BUTTOCKS				WOUND		CARE GIVEN		POSITION		PROBE	
W	Well	H	Healthy	N	Necrosis	H	Healthy	EBM	Breast milk	RL	Right lateral	R	Right
S	Stable	P	Peeling	MP	Moist Pink	G	Granulating	E	Emollient cream	LL	Left Lateral	L	Left
I	Improving	RA	Rash	D	Dry/Cracked	S	Sloughy	B	Barrier cream	P	Prone	A	Arm
US	Unstable	R	Red	T	Thrush	E	Exuding	ZC	Zinc and castor oil	S	Supine	F	Foot
ES	Emergency sign	PA	Pressure area	F	Flare (Umbilical)	I	Infected	M	Mycostatin	HU	Head up	H	Hand
C	Critical	B	Bruised	Bl	Bleeding	N	Necrotic	V	Vaseline	F	Flat	E	Ear
D	Dying	L	Lesion	CO	Cord off	S	Surgical	CH	Chloromycetin	KMC	Kangaroo position		
		O	Oedema	PO	Pitting oedema			S	Saline				

EYES				EYES SHIELDED		SIGNS OF STRESS							
C	Clear	G	Green disch.	I	Incubator cover	FS	Finger splaying	HT	Hypotonia	N	Nil-flexed, quiet alert/ sleeping		
R	Red	J	Jaundiced	E	Eye shield	F	Fisting/toe curls	S	Sneezing / Hiccups				
PD	Purulent disch.	S	Swollen			HE	Hyperextension	C	Prolonged crying				

Name: _____ Date: _____ Chart No. _____

TIME	CENTRAL NERVOUS SYSTEM	METABOLIC SYSTEM
PLAN	• If asphyxiated: ○ Assess need for body cooling within one hour of birth if asphyxiated ○ Daily complete enceph. & cooling checklists & HIE score sheet ○ Keep temperature in normal range if no cooling available ○ Observe for signs of hypoxic injury: hypoglycaemia, decreased bowel sounds/ no stools, poor perfusion, peripheral cyanosis & blood/protein in urine. • Weekly Head Circumference (COH) if hydrocephalus. • Check dextrostix and U&E if jittery • Observe for subtle signs of seizures-eg apnoea, unstable BP, tachycardia, mouthing, fisting, cycling. Document number, duration, and type of any seizures. • Commence treatment as ordered, for seizures lasting longer than 3 minutes or more than 3 seizures in an hour or if there is cardiorespiratory compromise. • Give pain Mx (sucrose, NNS, swaddling or analgesia) prior to painful procedures.	• **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 glucose low. • If < 2.6 mmol/l: give milk feed or start IV fluids. If <1.7mmol/l or symptomatic: Give 2-3ml/kg NNL/10% glucose IV bolus. • Commence phototherapy immediately if baby jaundiced. • Turn phototherapy off when taking blood for a Total Serum Bilirubin (TSB) • Only do daily (or more frequent TSB) if baby appears jaundiced or is receiving phototherapy. • If receiving phototherapy, cover eyes with phototherapy eye shield and open the nappy.

FQY*	6hrly	6hrly	6hrly	Hrly	Hrly	PRN	PRN	PRN	3 hrly	PRN	6hrly	6hrly	6hrly	PRN	6hrly PRN	PRN	**Action** Insert and complete relevant C/L for any problem identified
ASSESS	**Reflexes**	**Tone**	**Fontanels**	**State**	**Activity**	**Seizures: Type/length**	**Number/hr**	**Seizure Mx**	**Pain assessment**	**Pain Mx**	**Phototherapy**	**Eye Shield**	**Nappy open**	**Glucose** mmol/l			
														< 2.6	2.6 -8	> 8	
07																	
08																	
09																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18																	
19																	
20																	
21																	
22																	
23																	
24																	
01																	
02																	
03																	
04																	
05																	
06																	

STATE		ACTIVITY		REFLEXES (Moro, Grasp)		SEIZURES				TONE	
QS	Quiet sleep	A	Appropriate	N	Normal	A	Apnoea	F	Fisting	N	Normal
AS	Active sleep (REM)	J	Jittery	I	Incomplete	F	Focal	C	Cycling	F	Flacid
QA	Quiet alert	I	Irritable	A	Absent	G	Generalised	T	Tonic	↑H	Hypertonic
F	Fussy	S	Seizures			S	Staring	CL	Clonic	↓H	Hypotonic
Cr	Crying	L	Lethargic			M	Mouthing	K	Kernicteric	C	Central
S	Sedated	U	Unresponsive			P	Prolonged >3mins	B	Brief <3mins	P	Peripheral
		P	Paralysed							O	Opisthotonic

FONTANELLES		SEIZURE MX		PHOTOTHERAPY		GLUCOSE		PAIN MANAGEMENT Mx	
S	Soft	S	Spontaneous	S	Single	B	3ml/kg 10% dext.	S	Sucrose
T	Tense	ST	Stimulation	D	Double	C	Cocktail	NNS	Non Nutritive sucking
B	Bulging	B	Bagged	PB	Photo-blanket	IB	Insulin bolus	C	Containment
Sm	Small	L	Lorazopam			II	Insulin infusion	A	Analgesia
L	Large	M	Midazolam			5% D	5% Dextrose	LA	Local anaes.
		P	Phenobarbitone					E	Epidural

 Name: _____ Date: _____ Chart No. _____

TIME	TEMPERATURE	CARDIO- VASCULAR SYSTEM
PLAN	• **Maintain axillary temp. 36.5-37.5°C** • Nurse skin to skin as much as possible. • Radiant warmer -Apply plastic blanket 1st week of life. • Check glucose if temperature low • Cover head with cap/blanket • If in humidified incubator-Start at 40% and increase humidity hourly by 5% to maximum of 80%. Keep water container level at max with sterile H_2O.	• **Maintain HR 120-160bpm** • Report any sudden change in colour immediately • Tachycardia-check temp, pain, signs of sepsis • Bradycardia- Call MO. Check for apnoea, low sats, seizures • BP mean: Normal ± Gest. age • Hypertension-MAP >50mmHg -Prem and >65 mmHg-Term • Hypotension 5-10mmHg < gestational age • Ensure BP cuff is not too small-check guide on cuff (causes elevated readings) • Check distal perfusion of limb/s if arterial/umbilical lines present and post-surgery • Ensure good urinary output, CRT ≤ 3sec, no acidosis

FQY*	6hrly	6hrly	Hrly	Hrly	PRN	Hrly	PRN	PRN	Hrly	PRN	Hrly	Hrly	Hhrly	6hrly		6hrly	Hrly	**Action** Call MO immediately if condition changes. Insert and complete relevant C/L for any problem identified.
ASSESS	**Plastic bl. / Cap**	**Refill Incub H_2o container**	**Incubator humidity %**	**Heater output %**	**Temperature** °C			**Heart Rate** bpm			**BP** (mmHg)	**Mean** (mmHg)	**Distal perfusion**	**Pulses**		**CRT** (Secs.)	**Colour**	
					<36.5	36.5- 37.5	>37.5	<120	120-160	>160				**LR** / **LF**	**RR** / **RF**			
07																		
08																		
09																		
10																		
11																		
12																		
13																		
14																		
15																		
16																		
17																		
18																		
19																		
20																		
21																		
22																		
23																		
24																		
01																		
02																		
03																		
04																		
05																		
06																		

PERFUSION		PERIPH. PULSES		COLOUR				ABBREVIATIONS			
WP	Warm/Pink	0	Absent	P	Pink	PC	Periph. cyanosis	Bl	Blanket	L/RR	Left /right radial
M	Mobile	1	Difficult to palpate	B	Blue	CC	Central Cyanosis	Incub	Incubator	L/RF	Left/right femoral
C	Cold	2	Easy to palpate	PA	Pale	J	Jaundiced	H_2O	Water	CRT	Capillary refill time.
Pa	Pale	3	Slightly full	D	Dusky	M	Mottled	BP	Blood pressure		
		4	Full/bounding	R	Ruddy						

Name: _____ Date: _____ Chart No. _____

TIME	RESPIRATORY SYSTEM	RESPIRATORY SUPPORT
PLAN	• **Monitor resp. rate 40-60bpm** • **Maintain sats 90-94% in oxygen** • Severe distress **BiPAP** immediately. Mild distress prem-**nCPAP.** Mild distress term- **Nasal prongs** • ↓ Air entry-assess for obstruction, ETT position, pneumothorax • If apnoeic-stimulate, extend neck, suction, bag mask • Ensure baby has normal temp. and glucose • Check nasal perfusion if ventilated or on nCPAP. Ensure nostrils are visible and warm and pink.	• **nCPAP: Start PEEP at 6. PIP 4-5 above PEEP** • **Vent: Start PEEP 4-6, PIP 16-20** • Start oxygen (FIO2) at 30%. Increase/decrease by 5% every 5mins until sats in normal range. • FIO_2<30 wean to basic CPAP then NP

FQY*	Hrly	Hrly	Hrly	Hrly	Hrly	Hrly	PRN	PRN	Hrly	PRN	PRN	**Action**	PRN	Hrly	Hrly	Hrly	Hrly	Hrly	Hrly	Hrly
ASSESS	**Nasal Perfusion**	**Effort/ Distress**	**Chest movement/ Wiggle**	**Air entry Rt/Lt**	**Resp. Rate** bpm < 40	40-60	> 60	**Saturations (SaO_2)** <90%	90-100% - No O_2 90 94%-On oxygen	> 94 % -On oxygen	**Apnoea/Breathing**	Call MO immediately if condition changes. Insert and complete relevant C/L for any problem identified.	**Mode**	**FiO_2** (%)	**Flow** (L/min)	**PIP/AMP/ΔP** (cm/H_2O)	**PEEP** (cm/H_2O)	**MAP/P_{AW}** (cm/H_2O)	**Rate/ FQY** (bpm)	**IE ratio**
07																				
08																				
09																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20																				
21																				
22																				
23																				
24																				
01																				
02																				
03																				
04																				
05																				
06																				

EFFORT / DISTRESS		CHEST MOVEMENT		AIR ENTRY		BREATHING On Oscillator		MODE		ABBREVIATIONS	
N	Nil	B/E	Bilateral & equal	B/E	Bilateral & equal	S	Spontaneous	NP	Nasal prongs	FQY	Frequency
SS	Substernal R.			↓	Reduced	AP	Apnoea	HB	Head box	P_{AW}	Airway pressure
SC	Subcostal R.	↓	Reduced	LLL	Lt. lower lobe	AC	Active	nCPAP	Continuous positive airways pressure (nasal)	MAP	Mean Airway Pressure
IC	Intercostal R.	R	Right	LUL	Lt. upper lobe	ACTION				IE	Inspiratory: Expiratory
TT	Tracheal tug	L	Left	RLL	Rt. lower lobe	S	Spontaneous recovery	HFOV	High frequency oscillatory ventilation	TV	Tidal volume
NF	Nasal flare			RUL	Rt. upper lobe					PIP	Peak Inspiratory Pressure
G	Grunting	PERFUSION		RML	Rt. middle lobe	FiO_2↑	Oxygen increased	PCV	Pressure control vent.		
M	Mild	W	Warm	SOUNDS				SIMV PC	Synchronised intermittent mandatory vent. Pressure control	PEEP	Positive End Expiratory Pressure
MD	Moderate	P	Pink	CL	Clear	FiO_2↓	Oxygen decreased				
S	Severe	Pa	Pale	CR	Crackles					AMP ΔP	Amplitude/Change in pressure/Power
R.	Recession	PA	Pressure area	W	Wheezes	FL↑	Flow increased	VCV	Volume control vent.		
				RH	Rhonchi			VGPS	Volume Guarantee pressure support	FiO_2	Fraction of inspired oxygen
		N	Necrosis	S	Stridor	ST	Stimulated				
				B	Bubbling	B	Bagged	AC	Assist control	SaO_2	% Haemoglobin (Hg) saturated with O_2
						C	Compressions	FCAC	Flow cycled AC		

 Name: _____ Date: _____ Chart No. _____

TIME	LUNG DYNAMICS				RESPIRATORY CARE												
PLAN	• Maintain Exp. TV- 4-6ml/kg • Compliance <0.3ml/cm H_2O = severe lung disease. >1= for possible extubation • If resistance ↑ -suction				• Ensure piston is central on oscillator following any change of settings • Suction if apnoeic,↑resp. distress ↓air entry, ↓ sats, ↓chest movement, ↑ airway resistance. • Use closed inline suction system-change daily. • Only instil saline & percuss/vibrate if airway blockage is suspected. • Maintain water level in humidifier chamber & empty any water (rainout) from circuit tubing.												
FQY*	Hrly	Hrly	Hrly	Hrly	Hrly	Hrly	Hrly	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN	3hrly
ASSESS	**Expiratory TV** (ml/kg)	**Leak** (%)	**Compliance /kg** (ml/cmH_2O)	**Resistance** (cmH_2O/L/sec)	**Piston Central** (Y / N)	**Humidifier temp.** (°C)	**Water refill/Bag check**	**Empty tubes/water trap**	**Percussion**	**Vibration**	**Postural drainage**	**Nebulizer/Saline instil**	**E.T. secretions volume**	**E.T. secretions description**	**Naso/oropharynx volume**	**Naso/oropharynx description**	**Chest drain/s- L/ R**
07																	
08																	
09																	
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18																	
19																	
20																	
21																	
22																	
23																	
24																	
01																	
02																	
03																	
04																	
05																	
06																	

SECRETIONS				DRAINS	
S	Scanty	CL	Clear	B	Bubbling
M	Moderate	CR	Creamy	S	Swinging
L	Large	W	White	D	Draining
Lo	Loose	Y	Yellow	St	Static
T	Thick	G	Green	C	Clamped
P	Plugs	B	Bloody	CS	Continuous suction

Name: _____ Date: _____ Chart No. _____

TIME	GASTRO-INTESTINAL AND RENAL SYSTEMS	DIPSTIX	OUTPUT
PLAN	• Commence non-nutritive sucking at breast or with dummy as soon as possible. • Keep nil per os if aspirates/vomitus are blood stained, if bowel sounds are absent or decreased or if urine contains blood and protein • Ensure baby is well hydrated-moist mucous membranes & adequate urine output • Measure abdominal girth daily if there is abdominal distension • Catheter care- Clean urinary meatus twice daily with saline/sterile water. Ensure the catheter is clean and secure. Maintain a closed catheter and drainage system. Keep bag below the level of the bladder.	• SG ≤1010 – ↑hydration • SG >1010- ↑dehydration • Blood and protein- do not feed. • Glucose-monitor for polyuria	• Report failure to pass stool for more than 1 day • Report urine output if ≤1ml/kg/hr • Review the need for a catheter daily and remove as soon as possible • Aspirate NG tube prior to feeds to confirm location and any abnormality in type of aspirate. Return aspirates • Document volume of wound/drain exudate

FQY*	PRN	6hrly	6hrly	6hrly	Daily PRN	3hrly	6hrly	3hrly	PRN	PRN	PRN	**Action** Insert and complete relevant C/L for any problem identified	6 hrly			6hrly	PRN	PRN	PRN	PRN	PRN	PRN
ASSESS	**Sucking**	**Membranes moist?** (Y / N)	**Abdomen**	**Bowel sounds**	**Girth**	**Catheter care**	**Stoma condition**	**Asp. description**	**Stool description**	**Urine description**	**Wound /Drain description**		**PH** **Blood**	**SG** **Protein**	**Glucose/Other**	**Urine output** ml/kg/hr	**Urine vol.** -mls	**Stool volume** - +	**Vomitus vol.** - +	**Aspirate vol.** mls	**Wound/ Drain-** +/mls	**Blood vol.** -mls
07																						
08																						
09																						
10																						
11																						
12																						
13																						
14																						
15																						
16																						
17																						
18																						
19																						
20																						
21																						
22																						
23																						
24																						
01																						
02																						
03																						
04																						
05																						
06																						
															Totals:							
															TOTAL OUTPUT:							mls.

SUCKING		ABDOMEN		SOUNDS		ASPIRATES		STOOLS		STOMA		URINE		DRAIN/WOUND	
NA	Not applicable	S	Soft	P	Present	C	Clear	M	Meconium	P	Pink	Y	Yellow	F	Fecal
S	Strong	D	Distended	D	Decreased	M	Milky	SY	Soft yellow	D	Dusky	O	Orange	B	Blood
L	Latching	T	Tense	A	Absent	B	Blood stained	G	Green	D	Draining	P	Pink	C	Clear
W	Weak	R	Red			Bi	Bile stained	L	Loose			R	Red	Ch	Chyle
N	No effort	Sc	Scaphoid			R	Returned	B	Bloody			Cl	Cloudy	P	Pus
NNS	Non-Nutritive Sucking	BL	Visible Bowel loops			D	Discarded	C	Changing					S	Serous
								O	Offensive						
								D	Diarrhoea						

 Name: _____ Date: _____ Chart No. _____

TIME	INTAKE-FEEDS	INTAKE-IV FLUIDS

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.
- If NPO keep NGT on free drainage
- Observe for signs of feeding readiness: wakes for feed
- alert, rooting, sucking on hands etc
- Transition slowly from NG to breast feeds.
- Review the need for a central /peripheral IV catheter/cannula daily and remove as soon as possible.
- Use needle free device to access line if possible.
- Date (on drip chamber) and change IV giving set every 72 hrs (clear fluids) or 24hrs (TPN) Record on Safety Checklist.
- 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.
- Total intake and output daily and assess balance.

LINE No. /Desc	**FEEDS**														
FLUID															
VOL/ RATE															
SIGN															
REVIEWED															
SIGN															

TIME	Vol	How	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.
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:															

SUCKING		ABDOMEN		SOUNDS		ASPIRATES		STOOLS		STOMA		URINE		DRAIN/WOUND	
NA	Not applicable	S	Soft	P	Present	C	Clear	M	Meconium	P	Pink	Y	Yellow	F	Fecal
S	Strong	D	Distended	D	Decreased	M	Milky	SY	Soft yellow	D	Dusky	O	Orange	B	Blood
L	Latching	T	Tense	A	Absent	B	Blood stained	G	Green	D	Draining	P	Pink	C	Clear
W	Weak	R	Red			Bi	Bile stained	L	Loose			R	Red	Ch	Chyle
N	No effort	Sc	Scaphoid			R	Returned	B	Bloody			Cl	Cloudy	P	Pus
NNS	Non-Nutritive Sucking	BL	Visible Bowel loops			D	Discarded	C	Changing					S	Serous
								O	Offensive						
								D	Diarrhoea						

Name: _____ Date: _____ Chart No. _____

TIME	INTAKE-FEEDS	INTAKE-IV FLUIDS

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.
- If NPO keep NGT on free drainage
- 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 a central /peripheral IV catheter/cannula daily and remove as soon as possible.
- Ensure IV dressing is clean and intact.
- Use needle free device to access line if possible.
- Date (on drip chamber) and change IV giving set every 72 hrs. (96hrs if filter).Record on Safety Checklist.
- 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
- Total intake and output daily and assess balance

LINE No./Desc	FEEDS														
FLUID															
VOL/ RATE															
SIGN															
REVIEWED															
SIGN															

TIME	Vol	How	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.
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:															

FEEDS		FLUID	
EBM	Expressed breast milk	NNL	Neonatalyte
PNAN	Prenan	TPN	Total parenteral nutrition
PTB	Put to breast	RL	Ringers lactate
NGT	Naso gastic tube	5% C	5% Dextrose cocktail
NJT	Naso jejunal tube	15% C	15% Dextrose cocktail
NPO	Nil per os	½ NaCl	0.45% Saline
FM85	Breast milk fortifier	SB	Sodium bicarbonate

 Name: _____ Date: _____ Chart No. _____

TIME	INTAKE-IV FLUIDS						ASSESMENT/ACTION									
LINE No./Desc.							• Hourly, assess position & condition of insertion site & distal perfusion. Inform MO immediately of any phlebitis/swelling /absent backflow/poor perfusion. Ensure IV dressing is clean and intact. • Scrub any access port with 70% alcohol for 15 secs & allow to dry before accessing. Record (HS) in action column. • Flush PICC line PRN with 1ml heparinised saline in 5ml syringe if inline pressures are increasing and before and after infusing medications or taking blood									
FLUID																
VOL/ RATE																
SIGN																
REVIEWED																
SIGN							**PICC**	**Line 1**		**Line 2**		**Line 3**		**Line 4**		Action
TIME	Rate	Tot.	Rate	Tot.	Rate	Tot.	Flush	Site	Cond.	Site	Cond.	Site	Cond.	Site	Cond.	
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												

SITE				CONDITION		ACTIONS	
RA/H	Right arm/hand	CVC	Central venous Catheter	H	Healthy	DC	Dressing changed
LA/H	Left arm/hand	A	Arterial	P	Puffy	LF	Line flushed
RL/F	Right leg/foot	IV	Intravenous	L	Leaking	LR	Line removed
LL/F	Left leg/foot	PICC	Peripherally inserted central catheter	PH	Phlebitis (heat/tracking)	LRE	Line resited
UAC	Umbilical arterial catheter			I	Infiltrated	HS	Hub scrubbed
UVC	Umbilical venous catheter	SL	Short line	B	Blocked / ↑IV pressure	LS	Limb splinted
S	Scalp			WPM	Warm, pink, mobile	LE	Limb elevated
				DS	Dressing soiled		

Assessment summary and Action Plan- 0700-1300: (ICU: 6hrly. HC: 12hrly)					**Time:**	
1. Baby is stable with no abnormal observations or emergency signs.					**Y**	**N**
Neurological-Responsive, no seizures, fontanelle's normal	**Y**	**N**	Respiratory-SPO_2 90-94%, FIO_2 not increasing		**Y**	**N**
CVS- Pink; Heart rate, BP and perfusion normal	**Y**	**N**	GIT/Renal-No vomiting, abdom. distention,		**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**	oedema; normal urinary output; passing stools		**Y**	**N**
2. All strapping secure and lines patent	**Y**	**N**	3. Alarms set and all equipment functional		**Y**	**N**
4. Mother is healthy, updated on baby's condition and caring well for baby.					**Y**	**N**
Action Plan:						
Assessment summary and Action Plan- 1300-1900:					**Time:**	
1. Baby is stable with no abnormal observations or emergency signs.					**Y**	**N**
Neurological-Responsive, no seizures, fontanelle's normal	**Y**	**N**	Respiratory-SPO_2 90-94%, FIO_2 not increasing		**Y**	**N**
CVS- Pink; Heart rate, BP and perfusion normal	**Y**	**N**	GIT/Renal-No vomiting, abdom. distention,		**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**	oedema; normal urinary output; passing stools		**Y**	**N**
2. All strapping secure and lines patent	**Y**	**N**	3. Alarms set and all equipment functional		**Y**	**N**
4. Mother is healthy, updated on baby's condition and caring well for baby.					**Y**	**N**
Action Plan:						
Assessment summary and Action Plan- 1900-0100:					**Time:**	
1. Baby is stable with no abnormal observations or emergency signs.					**Y**	**N**
Neurological-Responsive, no seizures, fontanelle's normal	**Y**	**N**	Respiratory-SPO_2 90-94%, FIO_2 not increasing		**Y**	**N**
CVS- Pink; Heart rate, BP and perfusion normal	**Y**	**N**	GIT/Renal-No vomiting, abdom. distention,		**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**	oedema; normal urinary output; passing stools		**Y**	**N**
2. All strapping secure and lines patent	**Y**	**N**	3. Alarms set and all equipment functional		**Y**	**N**
4. Mother is healthy, updated on baby's condition and caring well for baby.					**Y**	**N**
Action Plan:						
Assessment summary and Action Plan- 0100-0700:					**Time:**	
1. Baby is stable with no abnormal observations or emergency signs.					**Y**	**N**
Neurological-Responsive, no seizures, fontanelle's normal	**Y**	**N**	Respiratory-SPO_2 90-94%, FIO_2 not increasing		**Y**	**N**
CVS- Pink; Heart rate, BP and perfusion normal	**Y**	**N**	GIT/Renal-No vomiting, abdom. distention,		**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**	oedema; normal urinary output; passing stools		**Y**	**N**
2. All strapping secure and lines patent	**Y**	**N**	3. Alarms set and all equipment functional		**Y**	**N**
4. Mother is healthy, updated on baby's condition and caring well for baby.					**Y**	**N**
Action Plan:						

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

 Name: _____ Date: _____ Chart No. _____

MULTIDISCIPLINARY NOTES-Continued. Consultant, doctor, nurse, rehab team, social worker, dietician etc

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

Name: ___________________________ Date: __________________ Chart No. ___________

MULTIDISCIPLINARY NOTES-Continued. Consultant, 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: ________________________ Date: ________________ Chart No. __________