KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DAILY ASSESSMENT CHART: GC/HC (2°)

Date:			Day of life:		IP Number:		
Name:			Date of Birth:		Gender:		
Gest. age at birth:		Current Gest. Age:		HC / GC bed:		Photo. day:	
Nasal Prong day:		CPAP day:		UVC day:		Last stool:	
Birth weight:		Current weight:		Prev. weight:		Loss/Gain:	

PROBLEM LIST: Include all current problems. Record resolved problems on Inpatient Support Pack cover.

REVIEW OF LAST 24HRS							
Emergency /Priority signs noted (State no. of times they were noted in the last 24hrs)					**Nil Noted:**	**Y**	**N**
Apnoea		Saturations <80%		Hypo/Hyperthermia		Lethargy	
Bradycardia <100		Cyanosis/Pallor		Glucose <2.6 or >8mmol/l		Seizures	
Clinical Problems handed over:							

FLUIDS, FEEDS AND MEDICATIONS (Previous 24hrs):					
Total output:	Urine:	Stool:	Vomitus:	Blood: mls	Drain: mls
Total intake:	**Feeds:**				
ml/kg/day	**IV Fluids:**				
Medications:					

GENERAL EXAMINATION: To be completed daily by MO.	**Time of MO Exam:**	
Assessment of recorded vital signs:		
TSB:		
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	Perfusion	
CENTRAL NERVOUS SYSTEM:	Activity/Posture	Tone	Seizure Activity	Grasp
Moro	Fontanelles.			

GASTRO INTESTINAL SYSTEM:	Distension	Discolouration	Tenderness	Bowel Sounds
Organomegaly	Umbilicus			

ASSESSMENT:	Note any new abnormalities and progress in listed problems

PLAN:	Ensure a comprehensive plan is made to manage every listed problem**.** Insert relevant Clinical Management Checklist (C/L)		
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:			
FURTHER MANAGEMENT			
INVESTIGATIONS:			

Sign:		**Print:**		**MP No.**	

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**	Ensure 2 legible ID bands in situ **Location:** Check ID bands against incubator/cot label				
			Checked & correct		Checked & correct	
RESUSCITATION	**Resuscitator.**	Accessible to bed & checked	Checked		Checked	
	Mask: Clean.	Size 1-term, 0-prem **Mask Size:**				
	Suction/Oxygen. At bed & checked. Respiratory equipment changed.	Maintain suction pressure at 20 KPa. **Pressure:** Size 6Fg-prem, size 8Fg-term **Catheter Size:** Change catheter after use. Tubing/Liner/Aquapack-change daily if used.	KPa		KPa	
			Fg		Fg	
			Tubes changed		Tube changed	
			Equip. changed		Equip changed	
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/ARTERIAL/ GASTRIC ACCESS	**Infusion/syringe pumps**	Check rate/dose. Syringe (not pump) labelled.	Checked		Checked	
	Lines correctly connected.	Trace all lines/NG tube to connections.	Checked		Checked	
	Giving Set change. (See Support pack)	**Change date**: _____ TPN lines daily, clear fluids 72 hrs	Checked		Checked	
			Changed		Changed	
	Umbilical Catheter (See Support pack)	**Removal date:** _____ Remove after 14 days.	Checked		Checked	
			Removed		Removed	
	Naso/Oro gastric tube. (See Support pack)	**Change date:** _____ Change weekly	Checked		Checked	
			Changed		Changed	
HYGIENE AND STRAPPING	**IV /Umbilical/ NG strapping.**	Restrap immediately if loose/soiled. **Depth:** _____	Checked		Checked	
			Restrapped		Restrapped	
	Baby bathed. Water/ aqueous cream only	Bath-weekly. Top and tail -daily	Bathed		Bathed	
			Top and tail		Top and tail	
	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**	
	Incubator/bassinet cleaned.	Internal & external surfaces daily with soap & water. Remove tape/adhesives	Cleaned		Cleaned	
			Bed at 45°		Bed at 45°	
	Closed Incubator- Air Filter.	Check change date. Change air filter 3mthly	Checked		Checked	
			Changed			
	Equip. cleaned & checked	Recorded on daily equipment checklist	Recorded		Recorded	
	Phototherapy.	**LED** photo. lights to be serviced **annually** Change **fluorescent** tubes every **1000hrs** All blue tubes & all working	**Hrs. on timer:**		Checked	
			Changed		NA	
RECORDS	**Previous days records filed.**	To be punched and filed - admission to discharge	Checked		Checked	
	Weight (wt) plotted Plot weight daily.	Report 3 days failure to gain weight or weight loss to dietician.	Plotted		Checked	
			Reported			
	Growth plotted weekly.	Plot WT, L and COH on Growth standards chart	Plotted		Checked	
	Management Checklists (C/L)	Present, current and signed	Checked		Checked	
	Weekly management	Check daily that all management given	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; F= Female; FiO_2=Fraction of Inspired oxygen; GC= General Care ; Gest= Gestational; HC= High Care; IP= In patient; IV= Intravenous; kg= kilogram; LED=Light emitting diode; L=Length; LP= lumbar puncture; M=Male; MAP= Mean airway/arterial pressure; mls= millilitres; MO= Medical officer; Mx=Management; NPO_2=Nasal prong oxygen; NPO= Nil per Os, PEEP= Positive end expiratory pressure; Photo = phototherapy; Prev= Previous; Resp=Respiratory; secs= seconds; SOP=Standard operating procedure; 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 <u>nasal perfusion</u>. 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 <1.5mmol/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: ○ Complete enceph. 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 saline or water and apply Vaseline • Apply veg. oil to dry skin and Vaseline or barrier cream to the buttocks every nappy change. • Position baby head up and <u>prone</u> (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 <u>off</u> when taking blood for a Total Serum Bilirubin (TSB) • If receiving phototherapy, cover eyes with phototherapy eye shield and open the nappy.	• Shield eyes from light • Ensure baby is in foetal position -shoulders curved, all joints flexed and midline positioning of head and limbs • Cluster care/monitoring activities to optimise sleep • Respond promptly to crying. • Give pain management prior to painful procedures - sucrose, NNS, swaddling or analgesia • Allow parents and siblings to visit 24hrs/day. Other identified visitors during visiting hours.

FREQUENCY	Condition	Eyes	Skin	Mouth	Cord	Perineum	Nasal perfusion	Wound	Glucose mmol/l < 2.6	Glucose mmol/l 2.6 - 8	Glucose mmol/l > 8	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	Pain Mx	Visitors
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	3hrly	PRN	3hrly	3hrly	3hrly	6 hrly	6 hrly	6 hrly	3hrly	3hrly	3hrly PRN	PRN	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	6 hrly	PRN	6 hrly	6 hrly	3 hrly	6 hrly	6 hrly	6 hrly	3hrly	3hrly	Continuous	PRN	PRN
ASSESS																													

 Name: _____ IP No._____ Date: _____ Chart No. _____

TIME	TEMPERATURE	CARDIO- VASCULAR SYSTEM	RESPIRATORY SYSTEM	RESPIRATORY SUPPORT (Advanced/Basic 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 respiratory distress: If preterm-commence advanced mode (if available) or basic **nCPAP** immediately. **If no CPAP** available or baby has infection or cong. Abnormality-commence nasal prong FIO_2 at 1-2L/min.	• **Add** head box oxygen to NP if baby not maintaining sats. on 2-3L nasal prong oxygen. Consult referral hospital. • **Optimise PEEP at 4-8 cm/H_2O & PIP 4-5 above PEEP.** • **Rate must be set at 30.** • Optimise FiO_2 by monitoring saturations continuously and adjusting FiO_2 in order to maintain sats. in normal range • If not maintaining sats on 30% FIO_2 CPAP contact referral hospital. • Maintain water level in humidifier chamber & empty tubes. • 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																															
	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	**nCPAP only** 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			**Colour / Perfusion**	**Heart Rate** bpm			**BP** mmHg	**Mean** mmHg	**Resp. Rate** bpm			**Saturations**			**Respiratory distress**	**Apnoea**	**Oxygen method**	**FiO_2**%	**Flow** L/min	**MAP/PEEP** cm/H_2O	**PIP** cm/H_2O	**Humidifier temp.**	**Water refill/Bag check?**	**Empty tubes?**	**Suction Vol./description**	
				<36 .5	36.5-37.5	>37.5		<100	100-160	>160			< 40b	40-60	> 60	< 90%	90-100% -No Oxygen	90-94% -On oxygen	> 94% -On Oxygen												

Name: _____ IP No._____ Date: _____ Chart No. _____

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 a central/peripheral IV catheter daily. 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 (on drip chamber) and change IV giving set every 72 hrs (clear fluids) or 24hrs (TPN) Record on Safety Checklist.
- Ensure IV dressing is clean and intact. Change if loose, soiled or wet.
- 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												

 Name: _____ IP No._____ Date: _____ Chart No. _____

TIME	GIT & RENAL SYSTEMS	OUTPUT
PLAN	• Keep nil per os if aspirates/vomitus are bile stained, if bowel sounds are absent or decreased or if urine contains blood and protein. Place NG tube on free drainage. • Observe for signs of feeding readiness: wakes for feeds, alert, rooting, sucking on hands etc • 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	Sucking	Abdomen	Bowel sounds	PH / Blood	SG / Protein	Glucose/ Other	Urine	Urine description	Stools	Stool description	Aspirates -Mls	Aspirate description	Vomitus	Blood -Mls
HC	3 hrly	6 hrly	6 hrly	12 hrly			PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
GC	3 hrly	12 hrly	12 hrly	PRN			PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
ASSESS														
TOTAL OUTPUT:						mls								

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	
Any problems:													
Interventions:													

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 and currently	11. Baby's current condition, colour and activity
3. Weight loss/gain	12. Any abnormal observations and action taken
4. Problem list and progress	13. Feeds given and how tolerated
5. Emergency/ Priority signs identified	14. IV fluids given
6. Respiratory Support- Mode, FiO_2, Saturations, Settings	15. Location and condition of IV sites
7. Daily fluid requirement	16. Urine and stools passed and any abnormality
8. IV fluids and Feeds ordered	17. Mothers condition, support required & any problems
9. Medications (Check that all have been given)	

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: _______________ Chart No. ________