KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DAILY ASSESSMENT CHART: ICU/HC

Date:		Day of life:		IP Number:	
Name:		Date of Birth:		Gender:	

Gest. age at birth:		Current Gest. Age:		HC / ICU bed:		Photo. day	
Post Op. Day:		CPAP day:		Vent. day:		NPO Day:	
Umbil. Day A/V:	/	PICC day:		CVC day:		TPN Day:	
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:		**Total Intake:**		**Positive/Negative balance:**		
Output:	Urine: mls	Stool:	Vomitus:	Blood: mls	Drain: mls	
Intake:	**Feeds:**					
	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 (Including OI):		
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:	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:			
FURTHER MANAGEMENT:			
INVESTIGATIONS:			

Sign:		Print:		MP No.	

IPC CARE BUNDLES CHECKLIST:	NB. Record for each central line present. Record Yes (Y) or No (N) for each question.						
VAP Bundle	Ready for extubation?		**CLABSI Bundle**	Type of line: UAL/UVL/PICC/CVP			
	In-line suction in use?			Date inserted:			
	Circuit changed if soiled?			Central line still required?			
	No water in circuit?			Line dated and changed appropriately?			
CAUTI Bundle	Date inserted:			Dressing clean & intact (CI)?			
	Catheter still required?			Insertion site healthy?			
	Catheter secured?			Hubs scrubbed before accessing?			
	Closed drainage system?			Dedicated lumen/line for TPN?			
	Bag below bladder & emptied?			No unused /superfluous ports?			
	Catheter/tubing not kinked?		**Response**	Clinical signs of infection?			
	Catheter care given 3hrly?			Positive blood culture?			
				Device associated infection suspected?			
				Baby entered in HAI register?			
				Action taken:			

 Name: _____ IP No._____ Date: _____ Chart 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. In-line suction in use Resp. equipment changed.	Maintain suction pressure at 20 KPa. **Pressure:** Size 6Fg-prem, size 8Fg-term **Catheter Size:** Change in-line catheter weekly. Tubing/Liner/Aquapack-change daily if used.	KPa Fg Cath. changed Equip. changed		KPa Fg Cath. changed Equip changed	
ALARM SETTINGS	**Oxygen saturations.** Check monitor & set alarms	Low 89% High 95%. High 100% if no oxygen **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Heart Rate. Check monitor & set alarms	Low 100bpm High 180bpm **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Respiratory Rate. Check monitor & set alarms	High 80bpm Low 20bpm **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Peak Inspiratory Pressure (PIP) On ventilator	Set 2 above and below current settings **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Positive End Expiratory Pressure (PEEP) On vent.	Set 2 above and below current settings **Settings:**	**Low:** **High:**		**Low:** **High:**	
	Expired tidal volume On ventilator	High 7ml/kg (Term 9ml/kg) Low 3ml/kg **Settings:**	**Low:** **High:**		**Low:** **High:**	
ETT / IV / ARTERIAL / NGT (See Pg 4 in Support pack)	**Infusion/syringe pumps**	Check rate/dose. Syringe (not pump) labelled.	Checked		Checked	
	Lines correctly connected.	Trace all lines/NG tube to connections.	Checked		Checked	
	Endo tracheal tube.	**Depth:** _____. Securely strapped? Restrap immediately if loose/soiled	Checked Restrapped		Checked Restrapped	
	Giving Set change.	**Change date**: _____ TPN lines daily, clear fluids 72 hrs	Checked Changed		Checked Changed	
	Umbilical Catheter/s	**Removal dates:** V _____ / A_____ **Depths:** V _____cm / A_____ cm	Checked Removed		Checked Removed	
	Naso/Oro gastric tube.	**Change date:** _____ Change weekly	Checked Changed		Checked Changed	
	IV /Umbilical/ NG strapping.	Ensure all strapping is clean and secure. Restrap immediately if loose/soiled	Checked Restrapped		Checked Restrapped	
HYGIENE	**Baby bathed**. Water/ aqueous cream only	Bath-weekly. Top and tail -daily	Bathed Top and tail		Bathed 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 Changed		Present Changed	
EQUIPMENT	**Type of bed occupied**	Record radiant warmer / closed incubator				
	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 the desired baby temp. Set at 36.5°C	**°C**		**°C**	
	Incubator /warmer cleaned.	Internal & external surfaces daily with soap & water. Remove tape/adhesives	Cleaned Bed at 45°		Cleaned Bed at 45°	
	Closed Incubator- Air Filter.	Check change date. Change air filter 3mthly	Checked Changed		Checked	
	Equip. cleaned & checked	Recorded on daily equipment checklist	Recorded		Recorded	
	Phototherapy. All blue tubes & all working	**LED** photo. lights to be serviced **annually** Change **fluorescent** tubes every **1000hrs**	**Hrs. on timer:** Changed		Checked NA	
RECORDS	**Previous days records filed.**	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 Reported		Checked	
	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 was given	Checked		Checked	
		SIGN:				

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

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/ 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 / 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	3hrly	**Action** Insert and complete relevant C/L for any problem identified
ASSESS	**Condition**	**Eyes**	**Skin**	**Mouth**	**Cord**	**Perineum/ Buttocks**	**Wound**	**Eye care**	**Cord care**	**Mouth care**	**Skin care**	**Buttock care**	**Position change**	**Probe change**	**Eyes shielded**	**Midline/ flexed**	**KMC**	**Signs of stress**	
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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: _____ IP No._____ 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 2-5ml/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			
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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
Su	Sunken	M	Midazolam			5% D	5% Dextrose	LA	Local anaes.
L	Large	P	Phenobarbitone					E	Epidural

Name: _____ IP No._____ 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 and saturations if temp. 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**
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**	Insert and complete relevant C/L for any problem identified
					<36.5	36.5- 37.5	>37.5	<120	120-160	>160				**LR** / **LF**	**RR** / **RF**			
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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: _____ IP No._____ 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: Optimise PEEP 4-8. PIP 4-5 above PEEP** • **Vent: Start PEEP 4-6, PIP 16-20** • Monitor saturations continuously Adjust FiO_2 in order to maintain 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		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**	**Action** 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**
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EFFORT / DISTRESS	
N	Nil
SS	Substernal R.
SC	Subcostal R.
IC	Intercostal R.
TT	Tracheal tug
NF	Nasal flare
G	Grunting
M	Mild
MD	Moderate
S	Severe
R.	Recession

CHEST MOVEMENT	
B/E	Bilateral & equal
↓	Reduced
R	Right
L	Left
PERFUSION	
W	Warm
P	Pink
Pa	Pale
Pr	Pressure area
N	Necrosis

AIR ENTRY	
B/E	Bilateral & equal
↓	Reduced
LLL	Lt. lower lobe
LUL	Lt. upper lobe
RLL	Rt. lower lobe
RUL	Rt. upper lobe
RML	Rt. middle lobe
SOUNDS	
CL	Clear
CR	Crackles
W	Wheezes
RH	Rhonchi
S	Stridor
B	Bubbling

BREATHING On Oscillator	
S	Spontaneous
AP	Apnoea
AC	Active
ACTION	
S	Spontaneous recovery
FiO_2↑	Oxygen increased
FiO_2↓	Oxygen decreased
FL↑	Flow increased
ST	Stimulated
B	Bagged
C	Compressions

MODE	
NP	Nasal prongs
HB	Head box
nCPAP	Continuous positive airways pressure (nasal)
HFOV	High frequency oscillatory ventilation
PCV	Pressure control vent.
SIMV PC	Synchronised intermittent mandatory vent. Pressure control
VCV	Volume control vent.
VGPS	Volume Guarantee pressure support
AC	Assist control
FCAC	Flow cycled AC

ABBREVIATIONS	
FQY	Frequency
P_{AW}	Airway pressure
MAP	Mean Airway Pressure
IE	Inspiratory: Expiratory
TV	Tidal volume
PIP	Peak Inspiratory Pressure
PEEP	Positive End Expiratory Pressure
AMP ΔP	Amplitude/Change in pressure/Power
FiO_2	Fraction of inspired oxygen
SaO_2	% Haemoglobin (Hg) saturated with O_2

Name: _____ IP No._____ 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**
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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: _____ IP No._____ 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
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														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: _____ IP No._____ 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.
- 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															
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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: _____ IP No._____ 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. Remove catheter. • 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. • 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																
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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		

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

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, oedema; normal urinary output; passing stools	**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**		**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, oedema; normal urinary output; passing stools	**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**		**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, oedema; normal urinary output; passing stools	**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**		**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, oedema; normal urinary output; passing stools	**Y**	**N**
General /Metabolic- Temp. & Glucose normal. No jaundice.	**Y**	**N**		**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 over page 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. Mothers condition, support required & any problems
3. Weight loss/gain	12. Baby's current condition, colour and activity
4. Problem list and progress	13. Any abnormal observations and action taken
5. Emergency/ Priority signs identified	14. Urine and stools passed and any abnormality
6. Respiratory Support- Mode, FiO_2, Saturations, Settings	15. Feeds given and how tolerated
7. Daily fluid requirement	16. IV fluids given
8. IV fluids and Feeds ordered	17. Location and condition of IV sites
9. Medications (Check that all have been given)	

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

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

MULTIDISCIPLINARY NOTES 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: ___________________________ IP No.__________________ 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: __________________________ IP No.__________________ 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.**

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.**

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; LED=Light emitting diode; 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, OI= Oxygen Index; P_{aw}-Airway Pressure; PEEP= Positive end expiratory pressure; Photo = phototherapy; PIP=Peak Inspiratory Pressure; Prev= Previous; Resp=Respiratory; secs= seconds; 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: __________________ Chart No. ____