INDEX:

PTO For Instructions

Instructions:

Every Baby cared for in the neonatal unit must be admitted with an inpatient number. Their records must be filed separately from their mothers in medical records.

Inpatient File

1. Each baby should have a full set of the above records including weight charts, Inpatient support pack, neonatal record, admission pack, daily assessment packs etc in a lever arch inpatient file with 6 dividers as indicated above.
2. Weight is the best indicator of whether a baby is thriving –they are therefore the first notes in the file. They must remain in the lever arch file until the baby is discharged.
   - Use the charts relevant for baby's weight/ gender.
   - The pink/blue percentile charts should be completed weekly.
   - The weight charts should be completed daily. Choose the chart appropriate for the baby's birth weight.
3. The Inpatient support pack contains records for the whole multidisciplinary team used throughout the inpatient stay. They must remain in the lever arch file until the baby is discharged.
4. The Neonatal notes are issued in Labour ward. They contain the history for the baby. The First examination should be completed on admission otherwise the record is only used as a reference during the baby's stay. Do not complete any other sections-these are for Labour ward and Post-natal.
5. An admission pack is used for the day of admission only. It contains the social history for the mother. It must remain in the lever arch file until the baby is discharged. An admission pack is not required for KMC unit as the baby will be a transfer in from the neonatal unit.
6. Use a new Daily assessment chart pack each day. Choose between KMC, GC/HC, or ICU. These are used by the whole multidisciplinary team –there are no separate doctors and nurses notes.eg
7. A Standard Operating Procedure (SOP) must be inserted for each identified problem-prematurity, hypothermia etc.
   - Should a resolved problem reoccur eg hypoglycaemia- a new SOP must be inserted for that day.
   - Ensure all SOPs have been completed prior to discharge.
8. Current Daily assessment chart, medication chart and Blood gas chart (ICU) should be located on a clip board at the baby's bedside.
9. Daily-Old Daily assessment charts should be filed in the lever arch file, once reviewed by MO/Consultant.
10. Weekly- file previous weeks Daily assessment charts in the inpatient folder issued by admitting department
11. **NB-Records must be filed from admission to discharge at all times. (They should be able to be read like a book)**

Inpatient folder-on discharge

This is the folder issued by the Admitting department containing the baby's inpatient number. It is most commonly a brown paper folder. It is crucial that notes in this folder are neatly filed in order from admission to discharge to facilitate replication and review of the records in future.

1. There should be 6 folding silver paper fasteners for each folder. The paper fasteners must secure the notes from each section in the lever arch file.
2. Insert paper fasteners through the punch holes in the records.
3. The paper fasteners must face downwards and new notes should be added from the bottom. This ensures notes are still in order from admission to discharge.
4. 4 copies of the discharge summary must be made
   - one for the clinical record
   - one for road to health book
   - one for mother to be inserted in the paediatric outpatient file if baby is readmitted
   - one for the unit discharge file (in case the other copies are mislaid)
5. Copies of the percentile chart, discharge summary and KMC follow up must be stapled into the Road to Health Book before the baby is discharged.
6. Ensure all notes have been properly filed including the discharge summary before sending the file to medical records
7. Should the baby have been diagnosed with HIE-the maternal and neonatal notes should be scanned and an electronic and hard copy made and stored in the unit for 21 years.