Neonatal Clinical Records

INTRODUCTION

A new set of clinical records has been introduced across the province in order to:

1. Standardise record keeping processes for newborn babies;
2. Strengthen the quality of clinical records;
3. Facilitate improved care of newborn babies;
4. Increase continuity of care and team work;
5. Ensure records are appropriate for each level of care (facility and acuity);
6. Reduce the burden of multiple nursing processes and the time taken to document care;
7. Support a more effective response to medico-legal claims.

The neonatal clinical record consists of four (4) clinical bundles and a variety of supplementary forms.

CLINICAL BUNDLE

Every baby born in a public sector health facility in KwaZulu-Natal will receive at least one clinical bundle and those admitted to the nursery or NICU will receive four (4) bundles.
Each bundle is complete and comprehensive inclusive of background, medical and nursing records.

1. Newborn / Neonatal Record:
   To be issued to every baby regardless of site of birth or wellbeing of the baby. It is designed as a standalone patient record for well babies, and a history record for sick and small admitted babies. It replaces the neonatal pages in the maternity record.
   These are gender specific for a girl or a boy.
   They include:
   - History of antenatal and intrapartum events;
   - Resuscitation
   - 1st examination and risk assessment;
   - Clinical records for the first 5 days of life;
   - Discharge summary and follow-up plan.

2. Neonatal Admission Record:
   These are to be completed for babies admitted to the neonatal nursery or ICU/HCU.
   They must be completed together with the Newborn / Neonatal Record.
   The admission record forms the complete clinical record for the day of admission.
   There are two (2) admission bundles, one each for the:
   - General /High care – to be used for babies admitted to a general or high care neonatal bed;
   - Neonatal ICU – to be used for babies admitted to a regional hospital ICU bed.

   These consist of:
   - Social history;
   - Clinical assessment;
   - Nursing care plan;
   - Safety checks;
   - Observations by system and inclusive of an early warning scoring system;
   - Fluid balance sheets;
   - Multidisciplinary notes.

3. Neonatal Inpatient Support pack:
   This bundle is for inclusion in the clinical record of all babies admitted to the nursery or NICU.
   It comprises all support documents:
   - Ballard score
   - Clinical management summary
   - Invasive procedure checklist
   - Laboratory results
   - Radiological investigations
   - Weekly management checklists-nursing and medical
   - Record of Parental education
   - Record of counselling
   - Phototherapy charts
   - Abbreviations and assessment guide

4. Daily Assessment Chart:
   There are three (3) site specific charts for the daily assessment of each baby:
   - KMC bundle for babies admitted to a KMC unit;
   - General /High care Chart – for babies in general or HC beds in the neonatal nursery (regional and district hospitals);
   - ICU Chart for babies in the NICU of a regional hospital or high care bed in a district hospital.

   Each baby must have a new Daily Assessment Chart every day.
   Each chart consists of:
   - Medical assessment and management- this includes some prompts on care;
   - Safety checklist-day and night
   - Systems based assessments including norms, nursing care plans, guided assessments and an early warning scoring system;
   - Fluid balance sheets;
   - Maternal assessment
   - Assessment conclusion and action plan;
   - Multidisciplinary notes.

SUPPLEMENTARY FORMS

The clinical bundles are generic documents which cater for the routine care of babies admitted to specific components of the nursery.
Additional forms are available to support the care in specific circumstances or for specific conditions.
These include:

1. Daily and weekly weight Charts. The weekly charts are gender and gestation specific and contain percentiles.
   The daily charts cater for the following weight ranges:
   - 600 – 1450g
   - 1500 – 2350g
   - 2400 – 3250g
   - 3300 – 4150g
   - 4200 - 5050g

2. Scoring or additional Observation Charts:
   - Maternal observation form (for mothers to observe their own babies);
   - KMC Daily Score Sheet;
   - Neonatal Blood observation Chart;
   - Neonatal Blood Gas Chart;
   - Pain assessment score;

- Wound assessment chart;
- Positioning assessment tool;
- HIE Score Sheet.
- Medication chart

3. Clinical management checklists (C/L)
   A number of condition specific guides are available for use in district hospitals.
   These function as:
   - Standard treatment guidelines for the medical staff;
   - Standing orders for the nursing staff;
   - Nursing Care Plans.

   The C/L appropriate to an individual patient should be attached to the clinical file of the baby in addition to the relevant clinical bundle described above. These checklists are being developed over time. So far the following checklists are available:
   - Fluids and feeds
   - Encephalopathy
   - Surfactant
   - Assessment of readiness for oral feeding
   - Transitioning to oral feeding

4. Discharge Records
   - KMC Follow-up Form;
   - Neonatal Discharge Summary – basic for uncomplicated babies going home;
   - Neonatal Transfer / Discharge Summary – for babies being transferred to a lower /higher level of care;
   - Palliative care plan
   - Neonatal Death Summary.

PROCESS

The following sequence must be followed:

1. At birth:
   A gender appropriate Newborn / Neonatal Record and weight chart must be completed for each baby.

2. On admission to nursery:
   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.
   Each baby must be provided with:
   - A Lever Arch File:
   - 6 A4 dividers
   - Clip board

   The record must be constructed in the following sequence:
   1. Index
   2. Weight Charts
   3. Inpatient support pack
   4. Neonatal record and Admission Record
   5. Daily Assessment Charts
      Relevant C/Ls
   6. Miscellaneous: Scoring and additional observations etc
   7. Discharge and Death Summaries

   The current Daily Assessment chart, medication chart and blood gas (ICU beds only) are kept on the clip board.

3. In patient folder (In preparation for 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.