Perinatal Forms Guideline 10

NEWBORN CARE PATH (HLTH 1593)

INTRODUCTION

The Newborn Care Path is designed to be utilized in conjunction with the Maternal Postpartum Care Path (Vaginal Delivery) record and any other caesarean section documentation tool in effect in your facility. The Newborn Care Path is utilized throughout the newborn's hospitalization **providing he/she remains in stable condition.** The Newborn Care Path was developed to include some of the concepts of the time sequenced Care Path, but has been put into a check-list format. The Care Path provides legal documentation of the newborns' physiological adaptations in the first few days of life.

If the infant becomes unstable and is transferred to another unit, e.g. SCN, then these units will chart using their own format.

If the infant stays in hospital for an extended period of time and extra space is required for documenting, start another Newborn Care Path and continue charting. Upon discharge, the Care Path stays with the newborn chart.

The Care Path is an important source of learning for the mother and her family. Facilities are encouraged to review the Newborn Care Path with the mother on a daily basis.

The Newborn Care Path is a nursing record and charting should be completed by a RN.

If clarification is required under "Elements to Collect," then please refer to:
Forms Guideline 11: Abbreviations used in the Provincial Perinatal Forms.

HOW TO CHART ON THE CARE PATH

An example of charting on the Care Path is enclosed. Please refer to the example for further clarification,

The Newborn Care Path is divided into 4 areas of assessment:

1. Assessment of Physiologic Status
2. Feeding
3. Elimination – urine
4. Elimination – stools

- Beside each assessment area are specific parameters and expected outcomes that should be assessed.
- Frequency of assessment is identified throughout the Care Path.
- The assessment areas of Feeding and Elimination outline **expected outcomes for specific time lines.**
- Each assessment must have the date (dd/mm/yy) and time (24 hours clock) documented.

CHARTING NORMAL OUTCOMES

- If your assessment reveals that the newborn meets the expected outcome identified on the Care Path, initial the box beside the outcome.
- If there are several parameters that meet the outcome identified on the care path, one initial with a "}" encompassing the areas is all that is needed (see example).
- Some facilities may want to record an actual number in the spaces provided. This is acceptable as long as there is an initial beside the actual number.
- **If the assessed parameters fall into the identified outcomes, there is no need for variance charting (commonly know as narrative charting or progress notes).**

Elements to Collect (Introductory information)

- Name
- Date of Birth
- Time of Birth

1. Elements to Collect: Assessment of Physiologic Status

- *Date, Time*
- *Vital Signs*
- *Heart Rate*
- *Resp.*

For Daily Assessment:

- *Skin/Colour, 0-48 h, 48-96 h, 96 h and beyond*
- *Extremities/Tone*
- *Cry*
- *Head/Face/Neck*
- *Chest*
- *Abdomen*
- *Cord*
- *Genitalia*
- *Reflexes (The examples of reflexes are not exhaustive, but represent the more common reflexes in assessment of neurological function. It will be up to the discretion of the nurse or the standard procedure of the facility to determine which reflexes will be assessed.)*
- *Behaviour*
- *Weight (The guideline of up to 7-10% weight loss in the first few days following birth is generally accepted as normal. When assessing a 7-10% weight loss consider all factors of adequate hydration, not just weight.)*

2. Elements to Collect: Feeding *(The Feeding section of the Newborn Care Path is very closely linked to the Teaching/Discharge Planning section of the Maternal Care Path. The Adequate Hydration note does not require any documentation in that particular box. It serves as a reminder that there are many factors involved in assessing adequate intake.)*

- *Breastfeeding: Exclusively breastfed (Exclusive breastfeeding means that no other solid or liquid is given to the infant. If the infant is* ***not exclusively breastfed*****, *a variance*** *must be documented.)*

- *Skin to skin contact (this means that the mother is aware of the benefits of skin to skin contact with her infant and practices skin to skin contact with her infant at various times throughout her hospital stay.*
- *Formula Feeding: Skin to skin contact*

3. Elements to Collect: Elimination/Urine

- *1st 24 h, 24-48 h, 48-72 h*

4. Elements to Collect: Elimination/Stools

- 12-24 h, 24-48 h, 48-72 h, >4d

VARIANCE CHARTING

Variances indicate that findings are **not within the normal outcomes** identified on the Care Path. Variance charting provides an effective method for tracking both findings outside the norm, and reasons for these variances.

- Variances are charted by placing a **V** in the square beside the outcome not met.
- **If there is a variance, further documentation is required on the Variance Charting Record found on the back of the Newborn Care Path.**
- If space runs out on the Variance Charting Record found on the back of the Care Path, additional Variance Charting Records (HLTH 1594) may be utilized (these are included in the perinatal forms package).
- Variance charting must be initialed after the narrative.
- The "Focus" area on the Variance Charting Record is provided for those facilities that use Focus Charting. The "Focus" is shaded to allow charting to occur over the column in those facilities that do not use focus charting.

Elements to Collect: Variance Record

- *Page*
- *Date*
- *Time*
- *Focus*

DEFERRED OR NOT APPLICABLE

In certain situations, an identified area of assessment may not be applicable to that particular infant, e.g. if the infant is breastfeeding **only**, the area on formula feeding will not be relevant. In these cases **N/A** should be documented in the area beside the particular parameter.

In cases where a certain parameter cannot be assessed at the appropriate time, document **D** in the square beside the parameter. **If there is a deferral, further documentation is required on the Variance Charting Record.**

TEACHING

All maternal teaching in relation to the newborn is outlined on the **Maternal Postpartum Care Path (Vaginal Delivery)** and documentation for teaching should occur on the Maternal Care Path. See Perinatal Forms Guideline 9: Maternal Postpartum Care Path (Vaginal Delivery) for more information.

REFERENCES AND RESOURCES

The following references/resources were utilized in determining formatting for the **British Columbia Newborn Care Path** and identifying outcome measures on the Care Path:

Bobak, I., Jensen, M. (1997). Maternity and gynecologic care. 6th edition. St. Louis: Mosby.

British Columbia Children's & Women's Health Centre. (1997). Clinical path: vaginal birth. Vancouver: Author.

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Canadian Institute of Child Health. (1996). National breastfeeding guidelines for health care providers. Ottawa: Author.

Dickason, E., Silverman, B. & Kaplan, J. (1998). Maternal-infant nursing care. 3rd edition. St. Louis: Mosby.

Lions Gate Hospital. (1998). Postpartum/Vaginal Delivery: Coordinated Care Timeline. North Vancouver: Author.

Peace Arch Hospital. (1997). Care Path: Vaginal Delivery. White Rock: Author.

Riordan, J., Auerback, K. (1993). Breastfeeding and human lactation. Boston: Jones and Bartlett.

Surrey Memorial Hospital. (1997). Clinical Pathway: Vaginal Delivery (Postpartum). Surrey: Author.

The Simon Fraser Health Region, Royal Columbian Hospital. (1997). Clinical Path: Vaginal Birth: Postpartum. New Westminster: Author.

Vancouver Health Department, B.C. Women's Hospital & St. Paul's Hospital. (1995). Healthy Beginnings community postpartum service expansion service delivery plan: Standards and protocols. Vancouver: Author.

Wong, D., Perry, S., & Hess, Caryn. (1998). Maternal child nursing care. St. Louis: Mosby.