Perinatal Forms Guideline 14

COMMUNITY NEWBORN ASSESSMENT CHECKLIST (HLTH 1597)

INTRODUCTION

Due to earlier maternity discharge, care has shifted from hospital to home. This has resulted in considerable variation in assessment parameters and how postpartum home follow-up programs are implemented in British Columbia. Several areas throughout the province have developed program guidelines and standards for their communities. However, the current literature is unclear regarding some expectations of specific assessment criteria over a specified timeframe, particularly with regards to physiological assessment during the first week postpartum. The lack of evidence at this time makes recommendations for standards of postpartum care difficult. The Community Maternal and Newborn Assessment Checklists in conjunction with the Maternal and Newborn Postpartum Care Path Outcomes, Teaching and Interventions documents are based on existing community standards and interpretation of available evidence. They were developed to assist community postpartum care providers in providing postpartum care in the home. **Each region or area will need to decide how best to utilize the Community Maternal and Newborn Assessment Checklist and the Care Path Outcomes, Teaching and Interventions documents based on regional/area variation and needs.** This is especially true for those regions that have implemented electronic charting.

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

USING THE NEWBORN ASSESSMENT CHECKLIST AND THE NEWBORN POSTPARTUM CARE PATH OUTCOMES, TEACHING AND INTERVENTIONS DOCUMENT

An example of charting on the Community Newborn Assessment Checklist is in Appendix A. Please refer to this example for further clarification.

I. THE COMMUNITY NEWBORN ASSESSMENT CHECKLIST:

- is a documentation tool for newborn care in the community up to a period of 6 weeks
- provides legal documentation of newborn physiological adaptations, safety, behavioural, and health issues during the first 6 weeks of life
- is a nursing record to be completed by a Registered Nurse (RN, PHN, or CHN)
- utilizes the principle of charting by exception: this means that if the newborn parameters fall into the norms as identified on the care path, a narrative note is not needed
- is to be utilized in conjunction with the Newborn Postpartum Care Path Outcomes, Teaching and Interventions document

II. THE NEWBORN POSTPARTUM CARE PATH OUTCOMES, TEACHING AND INTERVENTIONS DOCUMENT:

- is a guideline that provides information on the norms, variances, teaching and interventions for newborns
- is divided into postpartum time frames including: 0-24 hours, 24-48 hours, 48-72 hours, and >72 hours
- is to be utilized in conjunction with the Newborn Assessment Checklist and follows the listing of assessment parameters on the Checklist

Note that similar tools are available for the mother/family – the Community Maternal Assessment Checklist and the Maternal Care Path Outcomes, Teaching and Interventions document.

DOCUMENTATION ON THE COMMUNITY NEWBORN ASSESSMENT CHECKLIST

Elements to Collect: Introductory Information
- *Health Centre/Health Authority: locally defined*
- *Newborn Surname and Given Name(s)*
- *Mother's Surname: document only if different from newborn's surname*
- *Newborn Date of Birth: yy/mm/dd*
- *Nursing Priority Score: document only if this screening tool is used*

Elements to Collect: Left-hand Column
- *Date & Time: the date (yy/mm/dd) and time (24 hour clock) must be documented for each postpartum newborn contact*
- *P.P. Hours: document the hours since delivery up to 96 h postpartum, then document number of days*
- *Contact Type: for each newborn contact, document whether the contact occurred at a home visit, office visit, facility visit or by telephone contact*
- ***Assessment Items:*** *the assessment items listed on the Newborn Assessment Checklist follow the assessment items listed in the Newborn Care Path Outcomes, Teaching and Interventions document.*
  - *Cry (including Shaken Baby Syndrome)*
  - *Behaviour*
  - *Health Follow-up*
  - *Immunization*
  - *Safety and Injury Prevention (including SIDS)*
- ***Physiological Items***
  - *Head*
  - *Eyes*
  - *Ears/Hearing*
  - *Mouth*
  - *Chest*
  - *Umibilicus*
  - *Skeletal/Extremities*

  - *Skin*
  - *Neuromuscular*
  - *Genitalia*
  - *Elimination, Voids/Stools*
  - *Vital Signs, Temp/HR/Resp*
  - *Weight (grams)*
- ***Infant Feeding***
  - *Feeding: refers to items like positioning, hydration, frequency, duration, etc. (see Newborn Care Path) for both formula fed and/or breastmilk fed babies. Utilize the "Feeding" section in the Newborn Outcomes, Teaching and Interventions document to chart on this assessment item (just as in the above examples).*
  - *Feeding – Breastmilk 100% (Y or N) refers to the infant receiving 100% breastmilk either from breastfeeding or supplementing with expressed breastmilk. The definition of '100% Breastfeeding' includes needed medications, vitamins and minerals, but does not include any other food or fluids.*
  - *Feeding – Mixed Milk (Y or N) If the baby is getting mixed milk, e.g. some breastmilk and some other milk, document a "Y".*
  - *Feeding – Breastmilk Substitute (Y or N) refers to the infant receiving 100% formula or other artificial baby milks. This means that the infant is not receiving any breastmilk.*
- *Other Needs/Concerns (specify)*
- *Signature or Initial*

  Notice that there is one blank row at the bottom of all of the assessment items on the Checklist. This row can be utilized for local needs.

- ***Signature or Initial:*** *for each contact with the newborn, a signature or initial of the nurse completing the assessment is required. Utilize initials only if there is a central sign-in signature sheet in your facility.*

OUTCOME CODES

Each assessment item on the Newborn Assessment Checklist requires documentation of an outcome code for each contact with the newborn. The following identifies the Outcome Codes: (See table on the following page)

OUTCOME	DEFINITION
√	Assessment & teaching done and no apparent concerns or problems exist at this time. The "norm" as identified in the Newborn Care Path has been met. A variance note is NOT needed in this case.
X	Assessment item not assessed at that contact with the newborn.
***OBS**	A potential concern/problem/variance is evident – with intent to follow up by the nurse (or need to refer to district nurse). This means that the norm identified in the care path is not met.
***REF**	Referral to a different professional/agency/support.
***TRP**	Concerns are currently being handled by a professional agency or other Prevention Services Program.
***TRC**	Specific issue/condition has been addressed or treated and completed.
***UNR**	Concerns have been identified, but client unable or unwilling to take action.
YES/NO	Use for selected items where "yes" or "no" would answer a question, e.g. Formula feeding 100%. The assessment items requiring a "yes" or "no" answer are identified on the checklist.
Those items with an * asterisk require narrative explanation on the variance record.	

HOW TO CHART ON THE COMMUNITY NEWBORN ASSESSMENT CHECKLIST

Your newborn assessment begins with the information received from the place of delivery. The BCRCP Community Liaison Record (HLTH 1591) should give you the needed background information on the newborn's well being. From the Community Liaison Record, for example, you find that Baby Wilson was born May 23, 2000 at 0300 hours. The family was discharged from hospital at 1000 on May 23rd. You provide a postpartum home visit to the family at 1500 hours on the same day. One of the assessment items is newborn cry. (See sample on the following page).

1. DOCUMENTING NORMS

From the Newborn Care Path Outcomes, Teaching and Interventions document

Assessment	
Cry *Assess:* *-crying patterns, e.g. quality, duration and fussy periods.* *-parental interpreta-tion of crying and coping strategies.*	**norm:** - strong, robust - responds to consoling - parents display appropriate consoling techniques **teaching:** - crying is normal - discuss reasons that infants cry - discuss the importance of responding to infant crying - discuss signs that the baby is unwell - teach re: infant states (see Behavior section) - crying is a late feeding cue **variance:** - infant does not respond to consoling techniques - unusual, high-pitched crying (neuroligical) - no cry **intervention:** - reinforce points under teaching section - refer to appropriate health care provider prn

On the Newborn Assessment Checklist

Date (yy/mm/dd)	**00/05/23**
Time (24 hour clock)	**1500**
P.P. Hours (utilize hours to 96 h, then utilize number of days)	**12 h**
Contact Type **HV = Home Visit; TC = Telephone Call; OV = Office Visit; FV = Facility Visit**	**HV**
Cry	√
Weight (grams)	**3400**
SIGNATURE	J Doe, CHN

1. Look in the Newborn Care Path Outcomes, Teaching and Interventions document and find the assessment item "cry".
2. Look under the appropriate time frame e.g. you are assessing this baby 12 hours post-delivery. Therefore, the appropriate time frame to look at on the care path is 0-24 hours.
3. The care path identifies what you should be assessing under the word "cry".
4. If the baby meets the identified "norm" under this time frame, then the outcome code "√" is documented on the Newborn Assessment Checklist. This means that there is no apparent problem.
5. The teaching identified should be completed for all newborns. In some cases, not all teaching will be completed within the specified time frame, e.g. there may not be time to complete all teaching or the teaching item may not be appropriate for that family at that particular visit. In these cases, document on the variance record the teaching areas not completed.
6. Repeat steps 1 to 5 for all assessment parameters.
7. Once all parameters have been assessed and documented, place your initial and designation (e.g. RN, PHN, CHN) in the last row of the Checklist. If your facility does not use a signature log, then your full signature and designation is required in this space.
8. Some facilities may want to record an actual number (where applicable) in the spaces provided on the checklist, e.g. weight.

DOCUMENTING VARIANCES

From the Newborn Care Path Outcomes, Teaching and Interventions document

Assessment	0-24 HOURS
Cry *Assess:* *-crying patterns e.g. quality, duration and fussy periods.* *-parental interpreta-tion of crying and coping strategies*	**norm:** - strong, robust - responds to consoling - parents display appropriate consoling techniques **teaching:** - crying is normal - discuss reasons that infants cry - discuss the importance of responding to infant crying - discuss signs that the baby is unwell - teach re: infant states (see Behavior section) - crying is a late feeding cue **variance:** - infant does not respond to consoling techniques - unusual, high-pitched crying (neurological) - no cry **intervention:** - reinforce points under teaching section - refer to appropriate health care provider prn

Follow steps 1 to 3 above. Then:

9. If the norm is not met under this time frame, document a variance. Choose the outcome code that best describes the action that has occurred, e.g. OBS or REF
10. A variance narrative note is required. This is documented on the back of the Newborn Assessment Checklist.
11. The signature or initial of the nurse completing the assessment is needed for each contact with the family and for any variance recording.

On the Newborn Assessment Checklist

Date (yy/mm/dd)	00/05/23
Time (24 hour clock)	1500
P.P. Hours (utilize hours to 96 h, then utilize number of days)	12 h
Contact Type HV = Home Visit; TC = Telephone Call OV = Office Visit; FV = Facility Visit	HV
Assessment Items:	
Behaviour	OBS
Weight (grams)	3400
SIGNATURE	J Doe, CHN

On the Variance Record (on the back of the Newborn Checklist)

Date	Time	Focus		
00/05/23	1500	Cry	*A	Mother reports some difficulty in consoling her infant. Mother states that the baby
				"cries for hours on end and everything I try doesn't work". Newborn assessment
				done – no physical variances noted.
			* I	CHN discussed & demonstrated infant states, cues, and consoling techniques.
				Mother will try suggestions. CHN reviewed signs of abnormal cry and provided
				Newborn Hotline number.
			*P	CHN to TC tomorrow to assess progress. J Doe, CHN

VARIANCE CHARTING

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

- If space runs out on the Variance Charting Record found on the back of the Community Newborn Assessment Checklist, additional Variance Charting Records (HLTH 1594) may be utilized (these are included in the BCRCP perinatal forms package).
- The signature of the nurse completing the assessment must be documented after any variance charting.
- Regions will need to define if and how they will utilize the "Focus" area on the Variance Charting Record. For example, some regions may wish to list the assessment item in the 'focus' section (in the above example "cry" is placed in this section). Other regions may wish to identify a type of charting in this section such as DAPE charting (data, assessment, plan, evaluation), or AIP charting (assessment, intervention, plan). In the above example, AIP charting is identified in the focus section.

INFANT CARE TEACHING

- Infant care teaching is a large component in providing postpartum care. Infant care teaching in the community is crucial due to the shorter length of postpartum hospital stay.
- The Newborn Care Path Outcomes, Teaching and Interventions document outlines critical areas of newborn teaching to be completed. The teaching/anticipatory guidance topics are outlined under the "teaching" sections of the Newborn Care Path Outcomes, Teaching and Interventions document. Other postpartum teaching issues are identified in the Maternal Postpartum Outcomes, Teaching & Interventions document. The areas of identified teaching should occur for all postpartum families.
- In some cases, not all teaching will be completed within the specified time frame e.g. there may not be time to complete all teaching within that time frame or the teaching item may not be appropriate for that mother at that particular visit. In these cases, document the areas of teaching not completed on the variance record. This will provide a reminder to yourself or any other nurse following the family what teaching still needs to be completed or reinforced.
- Each facility will have their own methods of teaching, e.g. videos, classes, one to one, pamphlets, etc. Baby's Best Chance is the provincial source that may be utilized when interacting with postpartum families.

REFERENCES AND RESOURCES

The following references/resources were utilized in determining formatting, outcomes and interventions for the **British Columbia Community Newborn Assessment Checklist and the Newborn Care Path Outcomes, Teaching & Interventions document:**

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British Columbia Community Health Perinatal Documentation Committee
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The British Columbia Community Newborn and Maternal Checklists and Care Paths were developed by the British Columbia Community Health Perinatal Documentation Working Group. The Working Group:

- consisted of public health nurses chosen by public health nurses
- was chosen to ensure geographic representation
- included public health nursing leaders as well as practitioners

The process of development was facilitated by the BCRCP. The Working Group based the provincial care paths on previous community postpartum care path work done by the public health nurses of the Simon Fraser Health Region. Extensive provincial input was elicited through regional contacts throughout the province.

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