

Perinatal Forms Guideline 8

COMMUNITY LIAISON RECORD (HLTH 1591)

INTRODUCTION

The Community Liaison Record is a form designed to facilitate and promote continuity of care between the hospital and community health nurses providing post-partum follow-up. The form is completed in hospital and provides a summary of the maternal and newborn hospital stay.

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

GENERAL OVERVIEW

- I. The Community Liaison Record should be completed in hospital. If the family has had a home birth, the midwife should complete the community Liaison Form and go through the appropriate procedure of ensuring the community care provider receives the completed form.
- II. Individual facilities will need to decide how best to utilize this form. For instance, in hospitals where there is a postpartum liaison nurse, the liaison nurse may be the appropriate person to complete the form. In other facilities the discharging nurse may complete the form. In other hospitals, the data may be computerized and faxed to the appropriate community care provider.
- III. In most instances the form will be faxed to the Community Health Unit, therefore the demographic information must be written. Addressograph stamps do not fax adequately.
- IV. Only pertinent information that may affect care in the community should be documented.
- V. The Community Liaison Record *flows* from the Maternal Postpartum Care Path and the Newborn Care Path, but should be used for *all* mothers and babies transferred to the community.
- VI. The Community Liaison Record includes a **Variance** section that is designed to track common variances seen in the postpartum and newborn periods. More information will follow in this guideline.
- VII. The white copy of the Community Liaison Record is transferred to the community care provider. The yellow copy stays with the mother’s chart. In facilities where the information is faxed to the appropriate health care provider or if the information is electronically delivered, both copies will stay on the maternal chart.
- VIII. In the event of multiple births, start a new Community Liaison Record for each newborn.

SECTION 1: DEMOGRAPHIC INFORMATION

Elements to Collect:

- *Mother's Surname, Given Name*
- *A.K.A.*
- *Birthday: YY MM DD, Age*
- *Next of Kin/Relationship*
- *Interpreter Required: Language*
- *Physician/Midwife*
- *Admitting Physician/Midwife (Document the name of the admitting physician/midwife only if different from family physician.)*
- *Consultant for Mother and/or Newborn*
- *Hospital/Place of Birth*
- *Personal Health Number*
- *Primary Address: Postal Code, Telephone Number*
- *Temporary Address: Postal Code, From & To (dates), Telephone Number (Document only if the mother and newborn are **not** being discharged to their primary address. Include the dates of how long they will be at this temporary address in the **From/To** section.)*

SECTION 2: MATERNAL INFORMATION

Elements to Collect:

- *G, T, P, A*
- *Living at Discharge, Ages of Sibs.*
- *Delivery Type: SVD, Vacuum, Forceps, VBAC, Caesarean, Breech*
- *Perineum: Intact, Tear, Degree, Epis., Sutured (Place an actual number in the "degree" box if a tear occurred.)*
- *Delivery Date, Time*
- *Discharge Date (Record as dd/mm/yy), Time*
- *Blood Group*
- *Variances: The Variances Section of the Record is designed to track variances common in the postpartum and newborn period. Variances identified on the Maternal Postpartum Care Path and Newborn Care Path that are unresolved at the time of discharge should be documented on this Record. The spaces provided with the individual assessment components are for a brief narrative description of what the variance is. Utilize the "comments" section to elaborate on each variance.*
- *EBL: 500 – 1000 cc, > 1000 cc*
- *Rubella Non-Immune: MMR Given, No, Yes*
- *Infection/Risk for Infection (specify)*
- *Antibiotics Given: No, Yes*
- *Breastfeeding Concerns*
- *Postpartum Depression Risk Identified*
- *Additional Psycho-Social Issues*

SECTION 3: NEWBORN INFORMATION

Elements to Collect:

- *Male, Female, Gestational Age*
- *APGARS: 1 min., 5 min., 10 min.*
- *Breastfeeding, Formula, Both*
- *Birth Weight, g*
- *Discharge Weight, g*
- *Discharge Date, (dd/mm/yy)Time*
- *Variances*
- *PKU Needed: All newborns should have a blood dot card collected in hospital before discharge. Repeat blood dot cards must be collected on all newborns initially screened less than or equal to 13 hours after birth. For newborns tested between 13 and 24 hours after birth, only one card needs to be collected (no repeat screening).*
- *HBIG Given, HBV Given: Dates given do not need to be recorded on the Community Liaison Record because: a) The dates are documented on the Newborn Record (HLTH 1583A) and b) HBIG and HBV are given within the first 24 hours of delivery. The date for the 2nd immunization of the HBV series can easily be determined by referring to the date of delivery. If facilities choose to document the date, there is ample room to do so.*
- *Infection/Risk for Infection (specify)*
- *Feeding Problems*
- *Weight Loss > 10%: Weight loss of >10% is only one of the factors to consider in regards to adequate hydration of the newborn. Reasons for weight loss may be obtained from the Variances Record on the Newborn Care Path and subsequently documented on the Community Liaison Record.*
- *Significant Clinical Jaundice, last bili, Date(dd/mm/yy)*
- *Blood Group (if mother Rh Neg.)*

SECTION 4: OTHER INFORMATION

Elements to Collect:

- *Other Agencies: Identify if a social worker, mental health worker, or other agency is involved with the family. Document further information in the “comments” section (i.e. name of person involved, reason).*
- *Support at Home: This section refers to who will provide physical and emotional support at home. It may include any variances from the Maternal Postpartum Care Path.*
- *Comments: This section provides space to document or elaborate on any variances or other issues pertaining to the mother, newborn, family, supports, physical & emotional needs that require follow-up in the community.*
- *Plans for Follow-Up: Document:*
 - *Any follow-up visits planned for the family physician, midwife, or specialist and indicate the date.*
 - *Any agency follow-up plans, e.g. “community health” referral or “social worker to remain involved”. If the health unit or other community agency will be involved, identify the name (if known) in the space provided.*
- *Mother informed of community resources and follow-up*

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- *Seen by Liaison RN (only applicable to facilities utilizing liaison nurses at discharge).*
- *Discharge RN/RM: Signature of the RN/RM completing the discharge assessment and Liaison Record. This may be either the postpartum RN, RM, or liaison nurse.*

REVERSE SIDE OF FORM: NURSING PRIORITY SCREENING

This screening tool is also known as the Parkyn Tool and has typically been utilized by Public Health Nurses during the home visit to determine risk status of the client. Individual communities can determine the most effective method of gathering the information for screening, e.g. some areas may wish to have public health nurses collect the information, while other areas may wish to have the process started in hospital and then have the Public Health Nurse complete the screen.

As the tool is updated to reflect current literature, the BCRCP will ensure any revisions are distributed. For further information regarding the Nursing Priority Screening tool, please contact your local Public Health Nursing Program.