BCPHP
A GUIDE FOR COMPLETION OF THE NEWBORN RECORD PART 1 AND 2

Inside

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While every attempt has been made to ensure that the information contained herein is clinically accurate and current, the BCPHP acknowledges that many issues remain controversial, and therefore may be subject to practice interpretation.

MEMBERS OF THE NEWBORN RECORD REVISION COMMITTEE

The BC Perinatal Health Program (BCPHP) would like to acknowledge the committee who revised the Newborn Record Part 1 & 2. Committee members included: Viva Swanson, Project Consultant to BCPHP; Colleen Eidsness, RN & Carolyn Thibeault RM (Cranbrook); Heidi Slater RN (Victoria); Ros Derry RN (Terrace); Kate McCulloch RN & Kathy Allinott RN (Chilliwack); Colleen Upton RN & Yolanda Short RN (Vernon); Kelly Theis RN & Jane Binter RN (Fernie); Lyn Jones RN (Richmond); Anita Ballermann RN (Kamloops); Maureen Spinks RN & Sylvie Tange RN (Penticton); Heather Mash RN & MerryAnne Keane RN (White Rock); Catherine Ruskin RM (Nelson); Andrew Sear MD (Quesnel); Kirsten Duckitt MD (Prince George); Wendy Newson RN, Ann Shields RN, Heidi Dunbar RN, Melanie Basso RN & Faith Kuboniwa RN (Vancouver); Barb Campbell RN & Vanessa Pearson RN (Nanaimo); Wilma Arruda MD (Nanaimo); Sandra LaCarte RN (Surrey); Diane Sawchuck RN (Vancouver); Sheryll Dale, Kenny Der, Lily Lee & Barbara Selwood, BCPHP.

INTRODUCTION

The British Columbia Perinatal Health Program BC Newborn Record Part 1 & 2, BCPHP (HLTH) 1583A Rev. 2008/03 is a tool developed for the summary of the newborn episode of care. It is a tool to facilitate communication and continuity of care between facilities and providers of care. Specific fields in the newborn record are collected as part of a comprehensive database for the British Columbia Perinatal Database Registry (BCPDR), which includes data collection from the entire suite of Provincial Perinatal Forms. The mandate of the BC Perinatal Health Program includes the collection and analysis of perinatal data to evaluate provincial perinatal outcomes, and to improve health care initiatives.

Items collected in the database are identified with an asterisk (*).

In conjunction with the Newborn Record Part 1 and 2, several additional tools are provided to assist with assessment:

- Growth charts for assessing the evaluation of development at birth
- New Ballard Score, for assessing the gestational age from the physical examination at birth
- Nomogram for screening total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) along with a chart for response to results

The following tables provide information on the items on the Newborn Record along with a description of the items to assist documentation.

SECTION 1: DEMOGRAPHICS AND BACKGROUND INFORMATION

Item	Description
Addressograph/Label Area	Demographic information includes: patient surname, given name, address, phone number, personal health number, physician/midwife name, date.
Mother's Name*	Surname and given names of the newborn's mother.
Mother's Age	Mother's age.
Mother's Hospital ID number	Mother's hospital identification number.
Surname of Newborn	Surname of the newborn.
Partner's Name	Surname and given name of the mother's partner.
Partner's Age	Partner's age.
Gravida*	The total number of prior plus present pregnancies regardless of gestational age, type, time or method of termination/outcome. Twins or multiples are counted as one pregnancy. A blighted ovum and hydatiform mole are classified as a gravida.

Newborn Record Items

SECTION 1: DEMOGRAPHICS AND BACKGROUND INFORMATION *(CONTINUED)*

Item	Description
Term*	The total number of previous pregnancies with birth occurring at greater than or equal to 37 completed weeks gestation (includes 37^0-37^6).
Preterm*	The total number of previous pregnancies with birth occurring between 20-36 completed weeks gestation (includes 36^0-36^6).
Abortion	The total number of previous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 grams.
Living*	The total number of children the woman has given birth to, and are presently living. Does not include current pregnancy.
EDD (Expected Date of Delivery)	Expected date of birth; indicating calculation of EDD by the last menstrual period date or ultrasound from the Antenatal Record.
Mother's • Blood Group • Rh Factor • Antibodies	Mother's blood group. ABO and D (or Rh) blood typing and red blood cell antibody information from the Antenatal Record Part 1.
Risk Factors for Infant (Refer to Antenatal Record, Part 2)	Risk factors for exposure to tobacco, alcohol, and medication or specify other risks.

SECTION 2: APGAR SCORE

Item	Description
Heart Rate	Complete the Apgar scoring system by indicating the numerical score of 0, 1 or 2 points at each 1, 5 and 10 minutes (if applicable) for each category.
Respiratory Effort	
Muscle Tone	
Response to Stimuli	
Colour	
Apgar Total Score*	Total score out of 10 points per time frames.

SECTION 3: TRANSITION TO ONE HOUR OF AGE

Item	Description
Positioned	Position of the baby after birth; such as skin-to-skin, on radiant warmer or specify other.
Amniotic Fluid	Whether the amniotic fluid was clear, meconium-stained or bloody.
Suction*	Indicate if suctioning occurred; such as oropharyngeal, tracheal, for meconium below the cords or the stomach was aspirated.
Oxygen*	Indicate start and stop times that oxygen was given in minutes and seconds of the newborn's age. Indicate if additional documentation is on the Expanded Resuscitation Form.

SECTION 3: TRANSITION TO ONE HOUR OF AGE *(CONTINUED)*

Item	Description
Cord Gases	Indicate if cord gases were done.
Temperature Heart Rate Respirations*	Document first vital signs taken within the first hour of life.
Pulse Oximetry	Indicate if pulse oximetry was done.
Time to Heart Rate ≥100 bpm	Age of newborn in minutes and/or seconds when the heart rate was ≥100 beats per minute.
Time to Spontaneous Breathing	Indicate age of newborn in minutes and/or seconds when spontaneous breathing occurred.
Signatures	Signatures and professional designation of care providers present.

SECTION 4: DELIVERY

Item	Description
Birthdate and Time*	The date of birth in dd/mm/yyyy and time of birth.
Delivery Type	The type of delivery e.g. spontaneous vaginal delivery, assisted vaginal delivery or Cesarean Section.
Newborn Hospital ID Number	Newborn hospital identification number.
Identification at Birth	Signature and professional designation of care provider who identified/applied identification bands to baby at birth.
Identification at Transfer	Signature and professional designation of care provider who identified the baby at transfer if applicable.
Voided Passed Meconium	Indicate if infant voided or passed meconium at delivery.
Breastfeeding Planned	Mother's plan to breastfeed.

SECTION 5: ROUTINE PROCEDURES

Item	Description
Cord Blood	Indicate if cord blood was collected for Rh factor or other reasons.
Eye Prophylaxis	Erythromycin administered including time given, signature and professional designation. Document informed refusal.
Vitamin K	Indicate if Vitamin K was given including route, site and dosage administered, time given, signature and professional designation. Document informed refusal.

SECTION 6: EVALUATION OF DEVELOPMENT

Item	Description
Birthweight*	Admission birthweight in grams. Document the birth weight percentile as per the Newborn Growth Chart on the back of Newborn Record Part I.
Length*	The infant's length in centimeters. Document the length percentile as per the Newborn Growth Chart on the back of Newborn Record Part I.
Head Circumference*	The infant's head circumference in centimeters. Document the head circumference percentile as per the Newborn Growth Charts on the back of Newborn Record Part I.
Category for Gestational Age	The category of gestation for the infant: Preterm (≤36^{6} weeks gestation), Term (37-42 completed weeks gestation) and Post-Term (≥42^{1} weeks gestation or >294 days gestation).
Category for Size per Gestational Age	The category for size for gestational age as indicated from the growth charts (birthweight, length, head circumference) on the back of Newborn Record Part 1; such as Appropriate for Gestational Age (AGA) ≥10^{th} - ≤90^{th} percentile; Small for Gestational Age (SGA) <10^{th} percentile or Large for Gestational Age (LGA) > 90^{th} percentile.

SECTION 7: STILLBIRTH

Item	Description
Stillbirth	Condition of the stillborn, e.g. macerated, intrauterine growth restriction (IUGR), retroplacental clot, evidence of anemia, obvious anomaly (describe), umbilical cord length and if autopsy consented.

SECTION 8: PHYSICAL EXAMINATION AT BIRTH (INCLUDING STILLBIRTHS)

Item	Description
Gestational Age From Antenatal History*	The infant's gestational age from the antenatal record history.
Gestational Age by Exam*	Complete the 'gestational age by exam' by giving a numerical score of –1 to 5 points for each sign in the neuromuscular maturity and physical maturity areas using the New Ballard Score (NBS), expanded to include extremely premature infants. The total score gives the maturity rating. Refer to the back of Newborn Record Part 2 for chart and scoring.
Infant Sex*	The sex of the infant: male, female or undifferentiated where sex is not discernable.
Physical Examination	Indicate normal or abnormal for each of the areas relating to the examination of the infant. Comment as applicable. The physical examination includes: general appearance, skin, head, EENT, respiratory, cardiovascular system (CVS), abdomen, umbilical cord, genitorectal, musculoskeletal, neurological, and other.
Date, Time and Signature	The date, time, signature and professional designation of the health care provider completing the examination.

SECTION 9: HEARING SCREENING (COMPLETED BY THE NEWBORN HEARING SCREENING PROGRAM)

Item	Description
Date	The date (dd/mm/yyy) and time, (if applicable) of the hearing screen.
Screening	Indication of hearing screening done and the result: passed, passed with risk factors for delayed onset, screening declined or not applicable (e.g. non-BC resident, stillbirth/neonatal death). Comment as needed. In some facilities, screening of newborns will be done in the community setting.
Follow-Up	Follow-up to be done by the early hearing program: additional screening, diagnostic assessment or other follow-up needed. If a hearing loss is identified, the primary health care provider will be notified.
Signature	The printed name and signature of the individual completing the hearing screening.

SECTION 10: METABOLIC SCREENING

Item	Description
Date	The date (dd/mm/yyyy) metabolic screening specimens were collected.
Blood Dot Card	Indicate if the BC Newborn Screening Program blood dot card specimen was collected and the time collected. Comment as applicable.
Bilirubin Screening	Indicate if total serum bilirubin (TSB) or transcutaneous (TcB) bilirubin assessment was done; including the infant's age in hours. Comment on response to results of screening. Refer to the back of Newborn Part 2 for nomogram for evaluation and the table for response. For further information on bilirubin screening and management refer to the following website: http://www.cps.ca/English/statements/FN/FN07-02-summary.pdf

SECTION 11: PROPHYLAXIS

Item	Description
Date	The date (dd/mm/yyyy) and time that prophylaxis was given (if applicable).
Hepatitis B Prophylaxis	Whether Hepatitis B prophylaxis is required and if Hepatitis B Immune Globulin (HBIG) and / or Hepatitis B Vaccine given (HBV).
HIV Prophylaxis	Whether HIV prophylaxis is required and if prophylaxis has been given.
Group B Strep Prophylaxis	Whether mother received intrapartum antibiotic prophylaxis for Group B Strep or for other indications. Comment as needed.

Newborn Record Items

SECTION 12: NUTRITION

Item	Description
Initiation of Breastfeeding*	When breastfeeding was initiated: ≤1 hour of age, >1 hour to 2 hours of age; >2 hours to 24 hours of age, >24 hours of age or not applicable. Comment as needed.
Nutrition*	Newborn nutrition during episode of care; such as exclusive breastmilk (including expressed breastmilk by cup, bottle etc.), partial breastmilk (breastfeeding supplemented with formula, water, other); breast milk substitute (formula feeding exclusively). Document the indication if supplementation is given.

SECTION 13: PROBLEM LIST

Item	Description
Date	The date (dd/mm/yyyy) and time any problems occur.
Problem List	Document any problems identified. Indicate ACoRN sequences initiated if applicable and documentation on narrative notes.
Resolved	The date (dd/mm/yyyy) identified problems are resolved.

SECTION 14: PROGRESS NOTES

Item	Description
Date	The date (dd/mm/yyyy) of progress notes.
Progress Notes	Progress notes on the newborn as needed.

SECTION 15: DISCHARGE EXAMINATION

Item	Description
Date	The date (dd/mm/yyyy) of the discharge exam.
Newborn Age	The newborn's age at the time of discharge: ≤12 hours, 13 – 24 hours, 25 – 48 hours, 49 – 72 hours or >72 hours.
Head Circumference	The newborn head circumference (in cm) at discharge.
Discharge Weight*	The discharge weight in grams.
Weight Loss	The percentage weight loss during newborn episode of care.
Discharge Physical Exam	Indicate normal or abnormal for each of the areas relating to the infant's discharge physical examination. Comment as applicable. The physical examination includes: general appearance, skin, head, EENT, respiratory, cardiovascular system (CVS), abdomen, umbilical cord, genitorectal, musculoskeletal, neurological, and other.
Date and Signature	The date, signature and professional designation of the health care provider completing the discharge examination.

SECTION 16: STATUS AT DISCHARGE

Item	Description
Status at Discharge	Health status of newborn at discharge.
Newborn Nutrition	The newborn's feeding plan at discharge: exclusive breastmilk (feeding), partial breast milk (supplementation with formula) or exclusive breast milk substitute (formula). Comment as needed regarding feeding concerns.
Problems Requiring Follow-up	Problems requiring follow-up.

SECTION 17: DISCHARGED

Item	Description
Discharged*	Where the newborn was discharged; such as home, adoption, foster home, transfer to another hospital (specify) or other (eg. home of a family member, etc.). Indicate if a neonatal death.

SECTION 18: FOLLOW-UP

Item	Description
Follow-Up by, Date	The health care provider and/or resource identified for follow-up: such as family physician, midwife, pediatrician, consultant, public health nurse or Ministry of Children & Family Development. Space is provided to document dates for follow-up.

Space is provided at the bottom of the Newborn Record Part 1 & 2 for a barcode for facility use.

OBTAINING COPIES OF THE NEWBORN RECORD PART 1 AND 2

- Facilities may order forms through RR Donnelley. For ordering information refer to BCPHP web site link http://www.bcphp.ca/Forms.htm.
- Contact the BC Perinatal Health Program (BCPHP) at 604.875.3737 regarding any feedback or questions about any of the perinatal forms.