Perinatal Forms Guideline 10
A Guide For Completion of the British Columbia Newborn Clinical Path (PSBC 1593)

October 2013 v2

Table of Contents

Perinatal Services BC
West Tower, #350
555 West 12th Avenue
Vancouver, BC Canada V5Z 3X7
Tel: (604) 877-2121
www.perinatalservicesbc.ca

Perinatal Services BC
An agency of the Provincial Health Services Authority

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

Introduction

The revised BC Newborn Clinical Path has been developed to facilitate the assessment and documentation of pertinent information of newborns in a structured, logical and standardized manner. It is a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based newborn care. Specific fields from the entire suite of Provincial Perinatal Forms are collected as part of a comprehensive database for Perinatal Services BC (PSBC) Database Registry. Information collected for the Perinatal Database Registry is identified by an asterisk (*). In the Newborn Clinical Path, temperature and breastfeeding information is collected in the perinatal database registry and is identified with an asterisk (*) in the Guide for Completion. The mandate of PSBC includes the ongoing collection, analysis, interpretation and dissemination of perinatal data to monitor provincial perinatal outcomes, and to improve health care initiatives.

Guiding Principles

The BC Newborn Clinical Path is designed for use in conjunction with the Newborn Nursing Care Pathway, the Postpartum Nursing Care Pathway and the BC Postpartum Clinical Path.

Several key principles guided the design and development:

- Be applicable for all maternity hosptials providing healthy newborn care
- Incorporate relevant information from the birth
- Be adaptable to charting by exception or variance charting
- Minimize double charting or need for narrative notes on several forms
- Utilize standardized terminology and abbreviations
- Facilitate early recognition, timely communication and intervention for changes in newborn wellbeing
- Seamless integration of other provincial records such as the Labour Partogram, Birth Summary and Postpartum Clinical Path as much as possible
- Facilitate data collection for Perinatal Services BC Perinatal Database
- Enable electronic archiving or formatting

General Guidelines

Specific guidelines are relevant to all sections of the Newborn Clinical Path

- To determine the specifics of the normal and normal variations, variances, interventions, parent education and anticipatory guidance, and frequency of assessments, the PSBC Newborn Nursing Care Pathway is used as the foundation for documentation

- To obtain pertinent information
  - Confirm assessment data with parents/caregivers
  - Review Antenatal Record, Partogram, Labour & Birth Summary and the Newborn Record and any other significant health records
  - Perform a newborn physical, feeding, and behavioural assessment referred to as a Nursing Assessment

- For any identified variances
  - Document in the Variance Record/ Progress Notes
  - Communicate with the Primary Health Care Provider (PHCP) or designate prn:
    - Exact time of notification
    - Nature of communication
    - Responses of PHCP
    - Plan of action
    - Response or evaluation of outcomes

- A blank space or 'X' indicates that the action or assessment was not performed

The following sections provide descriptive information on the items on the Newborn Clinical Path:

- The term "Document" instructs one to write out the requested information in the space provided
- The term "Indicate" instructs one to check (√) the box provided
- Under the "Item" column fields collected in the database are identified with an asterisk (*)

1.0 Birth Summary

Item	Description
Addressograph/ label area	Demographic information includes: patient surname, given name, address, phone number, personal health number, physician/midwife name, date
Birth	Document the newborn's birth information as: date of birth (dd/mm/yy), and time of birth Refer to the BC Newborn Record Part 1, Section 4 (PSBC 1583A) or from the BC Labour and Birth Summary Record, Section 5 (PSBC 1588)
GA (Gestational Age)	Document the infant's gestational age
Apgar score	Document the infant's Apgar Score for 1, 5 min and for 10 min if applicable Refer to the BC Newborn Record Part 1, Section 2, (PSBC 1583A) or from the BC Labour and Birth Summary Record, Section 5 (PSBC 1588)
Type of birth	Indicate the type of birth as: • SVD (Spontaneous Vaginal Delivery) • Forceps (Assisted Birth) • Vacuum (Assisted Birth) • C/S (Cesarean Section) Refer to the BC Newborn Record Part 1 Section 4 (PSBC 1583A) or from the BC Labour and Birth Summary Record, Section 4 (PSBC 1588)
Meconium at delivery Infant vigorous †refer to Resuscitation record	Indicate if meconium was present at birth: yes or no If Yes, indicate if the infant was vigorous. Vigorous defined as "Strong respiratory efforts, good muscle tone (flexion/active motion) and heart rate > 100bpm" (Newborn Resuscitation Program, 2006) • Yes or no† ▪ †Refer to the Resuscitation Record to see the interventions performed
Birth Weight	Document the newborn's birth weight in grams Refer to the BC Newborn Record Part 1, Section 6, (PSBC 1583A) or from the BC Labour and Birth Summary Record, Section 5 (PSBC 1588)
Skin-to-skin for the first hour	Indicate if the infant was placed skin-to-skin following birth for the first hour of life: • Yes • No – (Variance) ▪ Document the reason on the Variance Record/Progress Notes Refer to the BC Labour Partogram, Section 14 (PSBC 1583)
Group B Strep	Indicate if the infant was exposed to Group B Streptococcus • If yes, indicate if prophylaxis protocol was followed ▪ Yes or no • No (not exposed) Refer to the BC Newborn Record Part 2, Section 11 (PSBC 1583A)
Hepatitis B Exposure	Indicate if the infant was exposed to Hepatitis B. • If yes, indicate if prophylaxis protocol was followed ▪ Yes or no • No (not exposed) Refer to the BC Newborn Record Part 1 Section 11 (PSBC 1583A)

Item	Description
Other	Indicate if the infant was exposed to other infections or risks for infection. For example HIV, Varicella or Flu Refer to the BC Newborn Record Part 1 Section 11 (PSBC 1583A)

2.0 Clinical Observation

Frequency of observations

Follow the organization's policy for Newborn Care. The suggested frequencies of observations for an infant following birth are:

Within 15 minutes in the first hour of life
At 1 and 2 hours following the initial set of vital signs and if stable
At hour 6
Once per shift until discharge

Variances

- Require more frequent observations as appropriate
- Describe any variances in the Variance Record/Progress Notes (including focus, information on the variance, nursing actions and responses to interventions/care)

Item	Description
Date/Time	Document the date and time the clinical observations/assessments were performed
Temperature* Respiratory rate Heart rate	In the appropriate date and time column, on the appropriate line document the infant's: • Axilla temperature in degrees Celsius • Respiratory rate (count for a full minute) • Heart rate (count for a full minute)
Respiratory effort Circulation Colour Tone Other	In the appropriate date and time column document as N = Normal or V = Variance, the infant's: • Respiratory effort, circulation, (chart Oxygen saturation), colour, tone and other ▪ Other significant data pertaining to the individual infant

In the appropriate date and time column document as N = Normal V = Variance

Item	Description
Skin-to-skin	Document if the infant has had the opportunity to be placed skin-to-skin with mother or significant other. Review the benefits of skin-to-skin with the parents

3.0 Feeding

Item	Description

Exclusive breastfeeding*	Document if the infant is receiving breast milk exclusively. Document
	• N = Normal
	  ▪ As per **Legend: *Exclusive breastfeeding** = Exclusive breast milk feeding including EBM (Expressed breast milk), human donor milk
	• V = Variance – Once the variance has been identified (i.e. the infant is being fed or supplemented with breast milk substitute, (i.e. formula) document
	  ▪ The infant is receiving supplementation along with breastmilk, documenting reason for variance
	  ▪ Infant who is totally artificially fed is initially marked as a variance then indicate artificially fed (which becomes the normal for that infant) on the line

Effective latch	Document if the infant is demonstrating an effective latch. As per **Legend: Effective latch =** Chest to chest, nose to nipple, wide open mouth, flanged lips, no dimpling of cheeks, may hear audible swallow, rhythmic sucking, baby doesn't easily slide off the breast, no nipple damage of distortion after feed
Active feeding	Document if the infant is demonstrating active feeding. As per **Legend: Breast** = Several bursts of sustained sucking at both breasts each feeding, including effective positioning, latch and evidence of milk transfer **Breastmilk substitute** = Coordinated suck, swallow and appropriate amount

4.0 Intake and Output Summary

Facilities may choose to use a bedside newborn intake and output record that is completed by the mother. During and at the end of each shift the nurse reviews the intake and output information with the mother and a summary of intake and output is transcribed onto the appropriate infant age timeframe (per 24 hour time frames after the first hour of life).

Item	Description
INTAKE	In the appropriate infant age timeframe column document the: • Number (#) of infant active feedings • Number (#) of attempts of breastfeeding only (tries but does not actively feed) • Amount EBM (Expressed breastmilk) in ml • Amount donor milk in ml • Amount breast milk substitute (such as formula) in ml
Method	Document the method of infant feeding. As per **Legend - Method:** BR = Breast, C = Cup, S = Syringe, B = Bottle, D = Dropper, or Sp = Spoon
OUTPUT	In the appropriate infant age timeframe column document: • Number (#) of Voids (overall N/V also included in Section 5) • Number (#) of Stools (overall N/V also included in Section 5) • Other (such as emesis)*, is a variance - document on the and Variance Record/ Progress Notes

5.0 Newborn Assessment

Refer to the timeframes in the Newborn Nursing Care Pathway for a description of the normal/normal variations, client education and anticipatory guidance, variances and interventions for each of the assessed items.

- Assessments are performed:
  - During the period of stability
  - Once per shift until discharge

Variances

- Require more frequent assessments as appropriate
- Describe any variances/concerns in the Variance Record/ Progress Notes (including focus, information on the variance, nursing actions and responses to interventions/care) is required

Item	Description
Instructions/legend	As per the instructions: Put a checkmark (√) in the appropriate column • N = Normal • V = Variance or concerns **Note:** the nurse is to document the variances/concerns on the Variance Record/ Progress Notes Document in the "N" column • NA = Not applicable • X = Not assessed
Date/Time	Document the date and time the clinical observations/assessments were performed
Age in hours up to 72 hrs then # of days	Document the age of the infant in hours. Once the infant is 72 hours old (3 days) document the age in days
Normal/Variance Columns (N/V Columns) *Assigning a Neonatal Daily Classification*	Indicate Normal or Variance for each of the areas relating to the newborn assessment as per the Newborn Nursing Care Pathway. Place a checkmark (√) in the • **N** column indicating the assessment fits the normal or normal variations for the time period as described in the Newborn Nursing Care Pathway • **V** column indicating there is a variance from the assessment for the time period as described in the Newborn Nursing Care Pathway. After completing the comprehensive assessment outlined below, use the Neonatal Daily Classification Tool to determine the classification. If the infant is classified as Level 1a (normal), place a checkmark (√) in the **N** column. Any classification beyond Level 1a (normal) should be documented explicitly in the **V** column (i.e. document as either 1b, 2a, 2b, 3a or 3b in the **V** column). **Note:** Neonatal Daily Classification is done on admission and daily at the start of each dayshift. The newborn comprehensive assessment includes: • Head • Nares • Eyes • Ears • Mouth • Chest • Abdomen • Umbilicus • Skeletal/Extremities • Skin • Neuromuscular (reflexes) • Genitalia • Elimination – urine • Elimination – stool • Behaviour (states/cues) • Crying

Item	Description
Other (e.g. weight)	Other significant assessment criteria that are not listed above are documented in this space. Put a check mark (√) in the • N column if the infant is stable • V column if the infant is unstable • Document observations in the Variance Record/ Progress Notes. For example: Weight loss concerns in a term, near term or preterm infant
Cord Clamp	Indicate cord clamp removal, include date and time of removal
First Bath	Indicate the date and time of the 1st bath
Initials	Provide legible initials

Examples of feeding variances	As per **Legend** the following are examples of feeding variances: • Not exclusively breastfeeding at breast • < 6 active feedings in the 1st 24 hours • < 8 active feedings in subsequent 24 hour periods • Feeding causes nipple trauma • No evidence of milk transfer (active feeding)
Examples of feeding plans	As per **Legend** the following are examples of feeding plans: • Improve latch and position • Hand express after feeding • Pump and top-up • Increase frequency of feeding, stimulate baby • Express/pump q 2 – 3 hours • Top up with _____

6.0 Summary, Newborn Care/Caregiver Education and Anticipatory Guidance

Item	Description
Interpretation required / Language	Indicate if interpretation is required and the language required for provision of care
Education (Item) Initials, N/A (not applicable)	Prior to discharge from the hospital, the following items are to be reviewed with the parent/newborn caregiver If the item is not applicable put a check mark (√) on the row in the column N/A (Not applicable) Space is provided for each item to be reviewed with the mother/newborn caregiver more than once (including the initials of the person performing the assessment) For variances the caregiver should be included in the plan and the PHCP and/or referrals have been contacted • Review the following: 1. Benefits of skin-to-skin 2. Breastfeeding (cues, active feeding) ▪ For infants fed breast milk substitutes: appropriate formula, preparation, storage, cue-based feeding and infant positioning ▪ Feeding plan in place 3. Behaviours – sleep/awake states 4. Infant crying – include: Shaken Baby Syndrome (SBS) prevention 5. Safe Sleeping environment – e.g.: back to sleep, tobacco use/exposure to second-hand smoke 6. Injury prevention, e.g.: baby products, car seat safety, hot liquid burns 7. Environment smoke-free 8. Newborn Care: ▪ Cord care ▪ Bathing/hygiene ▪ Tummy time, carrying infant ▪ Consoling techniques ▪ S&S of jaundice (Bilirubin level if applicable) ▪ S&S for follow-up (e.g. poor feeding, not waking to feed, cardiorespiratory changes) ▪ Vitamin D supplementation 9. Newborn Screening ▪ Hearing – completed by Hearing Screening Staff ▪ Blood spot card collected ▪ Infant Stool Colour Card – screening by parents daily for the first month to identify variances in stool colour based on BC Infant Stool Colour Card 10. Newborn ready for hospital discharge, discharge order 11. Knows newborn PHCP (Primary Health Care Provider), how and when to contact 12. Access of Baby's Best Chance Parents' Handbook 13. Aware of PHN (Public Health Nurse) contact/role/community resources 14. Review of communicable diseases 15 Weight: loss/gain
Variances – Plan(s)	Document the identified variance(s) including the plan(s) for resolving the variances; include information regarding any referrals (such as Pediatrician, clinics, etc.)
Tests/Procedures	Document and date the type of any tests and/or procedures performed on the infant

7.0 Discharge

Item	Description
Hours/days of age at time of discharge	Document the age of the infant at time of discharge. Document age in hours up to 72 hrs, then # of days
Identification bands checked	Indicate that the identification bands were checked prior to discharge
Home with parent/ guardian	Indicate if the infant was discharged home with the parent / guardian
Discharge weight (if > 24 hours)	Prior to discharge weigh the infant (if > 24hours old) and document the weight
Hospital discharge: Date/Time	Document the date and time the infant was discharged
RN Signature	Provide a legible signature

8.0 Variance Record / Progress Notes

Item	Description
Date/Time	Document the date and time the clinical observations/ assessments were performed
Focus	Document the reason or focus of documentation
Variance/ Progress Notes	Document in a chronological order any variances observed during the newborn assessment. Include pertinent data, nursing actions or plan of care, and responses or evaluations of outcomes

References

Evans, RJ, Evans MK, Brown YM, Orshan SA (2010). *Canadian Maternity, Newborn, & Women's Health Nursing*. Philadelphia PA: Lippincott Williams & Wilkins

Lowdermilk, D. L. & Perry, S. E. (2007). *Maternity & Women's Health Care* (9th ed.). St. Louis, MI: Mosby.

Society of Obstetrician and Gynaecologists of Canada. (SOGC).

Obtaining copies of the BC Newborn Clinical Path

- Individual practitioners may obtain copies of the forms from the local hospital.
- Facilities will order forms through RR Donnelley. Refer to PSBC website link **www.perinatalservicesbc.ca/NR/rdonlyres/1C039FB4-1EF0-4558-BF2E-A938FE1831EF/0/FormsOrderForm24Feb2012.pdf** for the order form.
- Contact the Perinatal Services BC (PSBC) at 604.877.2121 regarding any feedback or questions about the perinatal forms.

Revision Committee

Members of the Newborn Clinical Path Revision Committee

Perinatal Services BC (PSBC) would like to acknowledge the working committee who revised the BC Newborn Clinical Path. Committee members included:

Barbara Selwood	Project Lead, Health Promotion and Prevention, PSBC
Taslin Janmohamed-Velani	Coordinator, Knowledge Translation, PSBC
Laurie Seymour	Project Consultant
Jacqueline Koufie	Clinical Nurse Educator, St. Paul's Hospital
Radhika Bhagat	Clinical Nurse Specialist, 0-5 years, Vancouver Community
Kathy Hydamaka	Program Leader, Healthy Babies and Families, Richmond
Joan Brown	Clinical Educator for the Early Years Team, North Shore Health
Yvonne Law	Perinatal Clinical Educator – Postpartum, BC Women's Hospital
Monica Carey	Staff Nurse, BC Women's Hospital
Marina Green	Lactation Consultant, BC Women's Hospital
Tammy MacDonald	Educator, Surrey Memorial Hospital
Tanya Jansen	Clinical Nurse Educator Maternal Child Program, Ridge Meadows Hospital
Pam Munro	CNS Maternal, Infant, Child & Youth Program, Fraser Health Public Health
Elaine Klassen	Clinical Nurse Educator, Fraser Health Public Health
Bev Grossler	Patient Care Coordinator, Lillooet Hospital
Anita Gauvin	NICU Clinical Resource Coordinator, Kamloops Hospital
Patty Hallam	Public Health Nursing Program Consultant – ECD, Kamloops
Jennifer Stubbings	Team Leader, Thompson Cariboo Shuswap Public Health
Christine Moffitt	Clinical Practice Educator, Labour and Delivery, Royal Inland Hospital
Lynn Popien	Regional Perinatal Education Coordinator, Royal Inland Hospital
Tamara Kropp	Program Manager Medical & Maternity, Quesnel Hospital
Sharron Sponton	Community Health Nurse, Smithers
Grace Dowker	Maternity RN/Educator, Campbell River Hospital and Community
Amber Thomas	Public Health Nurse, Courtenay
Grace Park	Family Physician, White Rock
Wilma Aruda	Pediatrician, Nanaimo

Perinatal Services BC
West Tower, #350
555 West 12th Avenue
Vancouver, BC Canada V5Z 3X7
Tel: (604) 877-2121

www.perinatalservicesbc.ca

Perinatal Services BC
An agency of the Provincial Health Services Authority

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