British Columbia Newborn Clinical Path

1

Birth: _____ dd _____ mm _____ yy _____ Time GA _____ Apgar score: _____ 1 min _____ 5 min _____ 10 min

Type of birth: ☐ SVD ☐ Forceps ☐ Vacuum ☐ C/S

Meconium at delivery ☐ Yes ☐ No

Infant vigorous ☐ Yes ☐ No† Birth Weight _____ gms

(† refer to Resuscitation record)

Skin-to-skin for the first hour ☐ Yes ☐ No*

Group B Strep: Exposure ☐ Yes ☐ No Hep B: Exposure ☐ Yes ☐ No Other (i.e., infection risk):

Prophylaxis protocol followed ☐ Yes ☐ No Prophylaxis protocol followed ☐ Yes ☐ No

2 Clinical Observation

Date																			
Time																			
Temperature (°C) 38.5 / 38 / 37.4 / 37 / 36.5 / 36 / 35.5																			
Respiratory rate																			
Heart rate																			
Document N = Normal, V* = Variance/Concerns: Respiratory effort																			
Circulation (SpO_2)																			
Colour																			
Tone																			
Other																			

3 Feeding

Document N = Normal, V* = Variance/Concerns: Skin-to-skin																			
Exclusive breastfeeding																			
Effective latch																			
Active feeding																			
Initials																			

4 Intake and Output Summary

	0–1h	1–24h	24–48h	48–72h			
INTAKE							
# of active feedings							
# of attempts only							
Amount EBM							
Amount donor milk							
Amount breast milk substitute							
Method							
OUTPUT							
# of voids							
# of stools							
Other (e.g. emesis) *							
Initials							

BARCODE (IF USED)

Legend (For any variance * = see Variance Record/Progress Notes)

Exclusive breastfeeding = Exclusive breast milk feeding including EBM, human donor milk

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 or distortion after feed

Active feeding

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

Method

BR = Breast B = Bottle
C = Cup D = Dropper
S = Syringe Sp = Spoon

*** = Record Variance/Concern on Variance Record/Progress Notes**

5 Newborn Assessment

Put a check mark (✔) in the appropriate column

N = Normal

V = Variances/concerns

Document in 'N' column

NA = Not applicable

X = Not assessed

***** Record variances/concerns on Variance Record/Progress Notes

Date																							
Time																							
Age in hours up to 72/ then # of days																							
	N	V	N	V	N	V	N	V	N	V	N	V	N	V	N	V	N	V	N	V	N	V	N	V
Neonatal daily classification (1a=N)																							
Head																							
Nares																							
Eyes																							
Ears																							
Mouth																							
Chest																							
Abdomen																							
Umbilicus																							
Skeletal/Extremities																							
Skin																							
Neuromuscular (reflexes)																							
Genitalia																							
Elimination – urine																							
Elimination – stool																							
Behavior (states/cues)																							
Crying																							
Other (e.g. weight)																							
Initials																							

*** Examples of feeding variances**

- Not exclusively breastfeeding at breast
- < 6 active feedings in 1st 24 hours (active feeding)
- < 8 active feedings in subsequent 24 hour periods (active feeding)
- Feeding causes nipple trauma (effective latch)
- No evidence of milk transfer (active feeding)

☐ Cord Clamp removed
Date _____
Time _____

☐ 1st Newborn bath
Date _____
Time _____

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 _____

Neonatal Daily Classification

Enter classification in the N or V box for previous 24 hours (see tool for detail)

1a – Normal newborn care

1b – Requires increased observation

2a – Requires increased observation and increased care

2b – Requires acute management

3a – Requires high acuity management

3b – Requires high acuity, multi-speciality care

6 Summary, Newborn Care/Caregiver Education and Anticipatory Guidance

☐ Interpretation req'd Language _____

EDUCATION	INITIALS	INITIALS	N/A	COMMENTS
1. Benefits of skin-to-skin				
2. Breastfeeding (cues, active feeding)				
For infants fed breastmilk substitute: 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				
10. Newborn ready for hospital discharge, discharge order				
11. Knows newborn PHCP; how and when to contact				
12. Access to *Baby's Best Chance* Parents' Handbook				
13. Aware of PHN contact/role/community resources				
14. Review of communicable diseases				
15. Weight: loss/gain				

Variances - Plan(s) including referrals	Tests/Procedures	Date
	1.	
	2.	
	3.	
	4.	
	5.	

7 Discharge

Hours/days of age at time of discharge _____ ☐ Identification bands checked ☐ Home with parent/guardian

Discharge weight (if >24 hours) _____

Hospital discharge: Date _____ Time _____ RN Signature _____

8 Variance Record/Progress Notes

Date / Time	Focus	