

# British Columbia Newborn Clinical Path

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

Type of birth:  SVD  Forceps  Vacuum  C/S

Meconium at delivery  Yes  No

Infant vigorous  Yes  No<sup>†</sup> Birth Weight      gms  
(<sup>†</sup> 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																					
Colour																					
Tone																					
Other																					

## 3 Feeding

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

## 4 Intake and Output Summary

	INTAKE							
	0-1h	1-24h	24-48h	48-72h				
# 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) *								
<b>Initials</b>								

BARCODE (IF USED)

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

<b>Exclusive breastfeeding</b> = Exclusive breast milk feeding including EBM, human donor milk	<b>Active feeding</b> <b>Breast</b> = Several bursts of sustained sucking at both breasts each feeding, including effective positioning, latch and evidence of milk transfer	<b>Method</b> BR = Breast      B = Bottle C = Cup          D = Dropper S = Syringe      Sp = Spoon
<b>Effective latch</b> = 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	<b>Breastmilk substitute</b> = Coordinated suck, swallow and appropriate amount	

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

## 5 Newborn Assessment

Put a check mark (✓) in the appropriate column

Document in 'N' column

N = Normal

NA = Not applicable

V = Variances/concerns

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	
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)																									
<b>Initials</b>																									

**\* Examples of feeding variances**

- Not exclusively breastfeeding at breast
- < 6 active feedings in 1<sup>st</sup> 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 \_\_\_\_\_

1<sup>st</sup> 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 \_\_\_\_\_

**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				
10. Newborn ready for hospital discharge, discharge order				
11. Knows newborn PHCP; how and when to contact				
12. Access to <i>Baby's Best Chance</i> 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 \_\_\_\_\_

