Using the **Newborn Care Record**

Using the Infant Care Record, and following these instructions for its use will immediately enable the improvement of the quality of care babies receive, and will make your looking after them more efficient

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**ALWAYS PRINT YOUR NAME CLEARLY**

**Newborn Care Record: 1st page (ALL live births)**
1. Birth attendant (midwife and/or doctor) to fill in all maternal and resuscitation details, marking where necessary the appropriate response boxes. Where pregnancy, labour and/or delivery problems are noted, give detail on Page 3 in the space provided
2. The apgar scores should be transposed from the table on the back page
3. Birth attendant’s name MUST appear in the bottom right corner
4. When WR is positive, write in the titre in the space provided
5. When filling in the weight scale, start in the space provided between 36 and 37 degrees. Use weight gradations of 50 grams
6. The front page becomes the daily snapshot of the clinical course
7. When babies stay longer than 14 days, use the continuation weight/temperature chart, but start the weight scale in the space provided between 34 and 35 degrees, and continue using weight gradations of 50 grams
8. The “Problem List” is to be filled in, as problems are identified (don’t use this space for clinical notes, or X-ray registers e.t.c.). Start getting into the habit of entering the ICD 10 codes as well

**2nd page (ALL live births)**
1. Birth attendant to fill in information on previous pregnancies and on the placenta, and to complete the relevant identification section
2. When urine or meconium are passed or when abnormalities are noted, these should be documented on the “Examination check list” even if they are noted at a time prior to the formal First Examination
3. First examination table to be completed by the person performing the first examination. This should be done within 24 hours of delivery. Remember to print your name and sign

**3rd page (only if problems - no matter how trivial - are encountered)**
1. Insert the referral letter here if there is one
2. Details of abnormalities during pregnancy, labour and or/delivery to be documented in the space provided
3. Clinical “First Contact” notes start below this. Doctors AND nurses can use the same pages for clinical notes
4. List the significant problems on the front page as well
5. Clinical notes continue on page 5 (using a ‘ring-binder’)

**4th page**
1. Use the “Apgar Scoring Chart” to score all babies. Transpose the totals to the space provided on page 1. Remember to print your name and sign
2. A 10 minute apgar need only be done if the baby needs ongoing resuscitation
3. On the “Discharge Check and Plan”, the “Unresolved Problems” list should only be completed at discharge

**Continuation Pages**
1. Number continuation pages starting from 5
2. Write patient registration details on each page, or use a sticker

**Referring**
When referring or transferring baby to another facility, the Newborn Care Record or a photocopy thereof should travel with the baby (this makes writing a long referral letter unnecessary). Any additional information in a referral letter should be in duplicate, the original with the patient, and the copy in the folder as a clinical record kept in chronological order with the rest of the clinical notes.