



DAILY ASSESSMENT CHART: GC/HC

Date:		Day of life:		IP Number:	
Name:		Date of Birth:		Gender:	
Gest. age at birth:		Current Gest. Age:		HC / GC bed:	
Nasal Prong day:		CPAP day:		UVC day:	
Birth weight:		Current weight:		Prev. weight:	
				Photo. day:	
				Last stool:	
				Loss/Gain:	

PROBLEM LIST: Include all current problems. Record resolved problems on Inpatient Support Pack cover.

REVIEW OF LAST 24HRS					
Emergency /Priority signs noted (State no. of times they were noted in the last 24hrs)			Nil Noted:	Y	N
Apnoea		Saturations <80%		Hypo/Hyperthermia	
Bradycardia <100		Cyanosis/Pallor		Glucose <2.6 or >8mmol/l	
Clinical Problems handed over:				Lethargy	
				Seizures	

FLUIDS, FEEDS AND MEDICATIONS (Previous 24hrs):					
Total output:	Urine:	Stool:	Vomitus:	Blood:	mls
Total intake:	Feeds:			Drain:	mls
ml/kg/day	IV Fluids:				
Medications:					

GENERAL EXAMINATION: To be completed <u>daily</u> by MO.			Time of MO Exam:		
Assessment of recorded vital signs:					
TSB:					
Condition (Sick Or Well)	Colour	Hydration	Skin	Pressure Areas	
Assess for priority signs	Y	Nil Noted	Y	N	Y
Hypothermia- less than 36°C		Pallor			Purulent discharge from eyes
Pyrexia- More than 37°C		Cyanosis			Red/swollen eyelids
Hypoglycaemia- less than 2.6 mmol/l		Jaundice			Rash/pustules on the skin
Hyperglycaemia- More than 8 mmol/l		Oedema			Necrotic area/wound
Umbilicus-Redness/purulent discharge		Dehydration-decreased skin turgor/sunken fontanel/ dry mouth			

RESPIRATORY SYSTEM:					
Respiratory support and settings:					
Breath Sounds	Chest Movement	Airway			
Assess for priority signs	Y	Nil Noted	Y	N	Y
Severe resp. distress: FiO ₂ > 60%		Moderate resp. distress: FiO ₂ 30-60%		Mild resp. distress: FiO ₂ <30%	
Fast breathing > 80 bpm		Fast breathing 60-80bpm		Fast breathing > 60bpm	
Severe recession or grunting		Recession or nasal flaring			
Apnoea					
Central cyanosis					

CARDIO VASCULAR SYSTEM:	Heart Sounds	Pulses	Perfusion
Assess for priority signs	Y	Nil Noted	Y N Y
Tachycardia more than 160bpm		Hypertension-MAP > 50mmHg (prem) 65mmHg (term)	Peripheries cold /pale
Bradycardia less than 120bpm		Hypotension-MAP 5-10mmHg less than Gest. age	
Abnormal heart sounds or murmur		Capillary Refill time (CRT) more than 3 secs	

CENTRAL NERVOUS SYSTEM:	Activity/Posture	Tone	Seizure Activity	Grasp
Moro	Fontanelles.			
Assess for priority signs	Y	Nil Noted	Y N Y	Y
Increased tone		Seizure activity: <u>Subtle</u> : Staring or mouthing		Bulging fontanelle
Truncal hypotonia		Fisting/ cycling movements of arms/legs		Inappropriate/reduced response to handling/pain
Decreased activity		<u>Clonic</u> : Repetitive jerking of limb/s		
		<u>Tonic</u> : Stiffness/sustained posturing		

GASTRO INTESTINAL SYSTEM:	Distension	Discolouration	Tenderness	Bowel Sounds
Organomegaly	Umbilicus			
Assess for priority signs	Y	Nil Noted	Y N Y	Y
Tense abdomen		Failure to pass meconium		Enlarged liver / spleen
Abdominal wall discolouration		Decreased / absent bowel sounds		
Abdomen tender to touch		Bile stained vomiting / drainage		

ASSESSMENT:	Note any new abnormalities and progress in listed problems

PLAN: Insert and complete a Clinical Management Checklist (C/L) for each assessed risk/ classified problem.

RESPIRATORY SUPPORT:									
Nil		Nasal prongs (NP)		NP & Head box		Nasal CPAP		High Flow Humidified O ₂	
Settings:	Flow:		FiO ₂ :		PEEP:				

Other:

FLUIDS and FEEDS: Complete Feeding and Fluids C/L. **Record orders on Intake page.**

Required fluids:	ml/kg/day	Daily total:	ml/day
Feeds:			
IV Fluids:			

MEDICATIONS:

FURTHER MANAGEMENT

INVESTIGATIONS:									
Full blood count (FBC)		C Reactive protein (CRP)		Blood Culture		LP			
Urea & Electrolytes (U&E)		Gastric aspirate		Blood gas					
Chest X-Ray		Abdominal X-Ray		Other:					
Sign:		Print:		MP No.					

SAFETY CHECKS To be completed immediately after handover by day and night staff. Record information as required.						
CHECK		PLAN	ACTION DAY	✓	ACTION NIGHT	✓
I.D	ID bands	Ensure 2 legible ID bands in situ. Location:				
		Check ID bands against incubator/cot label	Checked & correct		Checked & correct	
RESUSCITATION	Resuscitator.	Accessible to bed & checked	Checked		Checked	
	Mask: Clean.	Size 1-term, 0-prem Mask Size:				
	Suction/oxygen. At bed & checked. Respiratory equipment changed.	Maintain suction pressure at 20 KPa. Pressure:		KPa		KPa
		Size 6Fg-prem, size 8Fg-term. Catheter Size:		Fg		Fg
	Change catheter after use. Tubing/Liner/Aquapack-change daily if used.	Tubes changed Equip. changed		Tube changed Equip changed		
ALARM SETTINGS	Oxygen saturations.	Low 89% High 95%. High 100% if no oxygen. Settings:	Low:		Low:	
			High:		High:	
	Heart Rate.	Low 100bpm High 180bpm Settings:	Low:		Low:	
			High:		High:	
	Respiratory Rate.	High 80bpm Low 20bpm Settings:	Low:		Low:	
			High:		High:	
IV / ARTERIAL / GASTRIC ACCESS	Infusion/syringe pumps	Check rate/dose. Syringe (not pump) labelled.	Checked		Checked	
	Lines correctly connected.	Trace all lines/NG tube to connections.	Checked		Checked	
	Giving Set change. (See Support pack)	Change date: _____ TPN lines daily, clear fluids 72 hrs	Checked		Checked	
			Changed		Changed	
	Umbilical Catheter (See Support pack)	Removal date: _____ Depth: _____ Remove after 14 days.	Checked		Checked	
			Removed		Removed	
Naso/Oro gastric tube. (See Support pack)	Change date: _____ Change weekly	Checked		Checked		
		Changed		Changed		
Peripheral IV /Umbilical/ NG strapping.	Ensure all strapping is clean and secure. Restrap immediately if loose/soiled.	Checked		Checked		
		Restrapped		Restrapped		
HYGIENE	Baby bathed. Water/ aqueous cream only	Bath-weekly. Top and tail -daily	Bathed		Bathed	
			Top and tail		Top and tail	
	Patient care container. Cleaned & restocked.	70% alcohol changed daily. Vaseline, nappies, saline amps, aqueous cream	Restocked		Restocked	
Alcohol Based Hand Rub. (ABHR)	At foot of bed. Changed according to hosp. policy-no cracks	Present		Present		
		Changed		Changed		
EQUIPMENT	Type of bed occupied	Record if baby is nursed in a cot, closed incubator/radiant warmer				
	Radiant warmer temp. probe	Attach with reflective cover on Lt. abdomen Silver side down. Wire also secured Rt. abdom.	Secured		Secured	
	Radiant warmer Set Temp.	This is not the incubator temperature. It is the desired baby temp. Set at 36.5°C Setting:		°C		°C
	Incubator/bassinets cleaned.	Internal & external surfaces daily with soap & water. Remove tape/adhesives	Cleaned		Cleaned	
			Bed at 45°		Bed at 45°	
	Closed Incubator- Air Filter.	Check change date. Change air filter 3mthly	Checked		Checked	
			Changed			
Equipment cleaned	Syringe & infusion pumps and resp. equip. with soap & water. Remove tape/adhesives	Cleaned		Cleaned		
Phototherapy. (LED photo lights to be serviced annually)	No. of hrs. on timer: _____ Change fluorescent tubes every 1000hrs All blue tubes & all working	Checked		Checked		
		Changed		NA		
RECORDS	Previous days records filed.	To be punched and filed - admission to discharge	Checked		Checked	
	Weight (wt) plotted Plot weight daily.	Report 3 days failure to gain weight or weight loss to dietician.	Plotted		Checked	
			Reported			
	Growth plotted weekly.	Plot WT, L and COH on Growth standards chart	Plotted		Checked	
	Management Checklists (C/L)	Present, current and signed	Checked		Checked	
Weekly management	Check daily that all management given	Checked		Checked		
SIGN:						

ABBREVIATIONS IN DOCUMENT
BP= Blood pressure; bpm= beats/breaths per minute; CF=Cardiac failure; COH=Circumference of head; CPAP= Continuous positive airways pressure; EBM= Expressed breast milk; F= Female; FiO ₂ =Fraction of Inspired oxygen; GC= General Care ; Gest= Gestational; HC= High Care; IP= In patient; IV= Intravenous; kg= kilogram; LED=Light emitting diode; L=Length; LP= lumbar puncture; M=Male; MAP= Mean airway/arterial pressure; mls= millilitres; MO= Medical officer; Mx=Management; NNS= non-nutritive sucking; NPO ₂ =Nasal prong oxygen; NPO= Nil per Os, PEEP= Positive end expiratory pressure; Photo = phototherapy; Prev= Previous; Resp=Respiratory; secs= seconds; SOP=Standard operating procedure; UVC=Umbilical venous catheter; Wt=weight; < = less than; > = more than

TIME	TEMPERATURE						CARDIO- VASCULAR SYSTEM						RESPIRATORY SYSTEM						RESPIRATORY SUPPORT (BiPAP / nCPAP)						ACTION					
PLAN	<ul style="list-style-type: none"> Maintain axillary temp. 36.5-37.5°C If on radiant warmer: Apply plastic blanket in 1st week of life. Closed incubator temp 36°C on Day 1. Adjust according to baby's temp. and incub. temp. table thereafter. Check glucose if temp. low Prevent convective, conductive, radiant and evaporative heat loss Apply cap 						<ul style="list-style-type: none"> Maintain HR 120-160bpm Report any sudden change in colour Perfusion: Ensure Capillary refill time(CRT) is 3 secs. or less Tachycardia-check temp, pain, signs of sepsis Bradycardia- Call MO. Check for apnoea, low sats, seizures BP mean: Normal ± Gest. age Ensure BP cuff is not too small-check guide on cuff (causes elevated readings) 						<ul style="list-style-type: none"> Monitor resp. rate 40-60bpm Maintain Sats 90-94% in oxygen If apnoeic: stimulate, extend neck, suction, bag Ensure temp. and glucose levels are normal. Suction nasopharynx if baby apnoeic or increased respiratory distress. Use a new size 6 or 8 Fg suction catheter & sterile gloves each time. For severe distress-commence BiPAP (if available) or basic nCPAP immediately. If mild and preterm commence nCPAP. If mild & term or no CPAP available -commence nasal prong FIO₂ at 1L/min and 30% oxygen. 						<ul style="list-style-type: none"> Add head box oxygen to NP if baby not maintaining sats. on 2L nasal prong oxygen. Consult referral hospital. CPAP settings: PEEP 5. Oxygen 30% BiPAP settings: PEEP 6cm/H₂O. PIP 10cm/H₂O. Rate 40bpm. Oxygen 30% Increase/decrease oxygen by 2-5% every 5mins until sats in normal range. If not maintaining sats on 40% FIO₂ CPAP contact referral hospital. Maintain water level in humidifier chamber & empty tubes. If FIO₂ <30% wean to basic nCPAP or nasal prongs (NP). Wean NP flow if no resp. distress and maintaining sats. 						<ul style="list-style-type: none"> Call MO immediately for any change in condition Insert and complete relevant C/L for any problem identified 					
	FREQUENCY	HC		GC		ASSESS		HC		GC		ASSESS		HC		GC		ASSESS		HC		GC		ASSESS						
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	NA	3 hrly	6 hrly	3 hrly	6 hrly	3 hrly	PRN	3																						

TIME	INTAKE-FEEDS			INTAKE-IV FLUIDS						ASSESSMENT/ACTION										
PLAN / ORDERS	<ul style="list-style-type: none"> Total fluid intake includes oral and IV fluids Promote breast feeding/Donor milk if no EBM. Commence expressing breast milk within 6hrs of birth. Ensure mother empties breasts at each expression. Feed baby in skin to skin position if possible. Do not keep NPO for longer than 3 days without TPN. Observe for signs of feeding readiness: wakes for feeds, alert, rooting, sucking on hands etc. Transition slowly from NG to breast feeds. 											<ul style="list-style-type: none"> Review the need for a central/peripheral IV catheter daily. Remove as soon as possible. If infiltrated ensure IV is resited <u>within 1 hr</u>. If IV is not resited-increase oral feeds to ensure delivery of total required fluid volume. Date (on drip chamber) and change IV giving set every 72 hrs (clear fluids) or 24hrs (TPN) Record on Safety Checklist. Ensure IV dressing is clean and intact. Change if loose, soiled or wet. Total intake and output daily. 				<ul style="list-style-type: none"> Hourly, assess position & condition of insertion site & distal perfusion. Inform MO immediately of any phlebitis/swelling /absent backflow/ poor perfusion. Clean cord 3hrly with chlorhexidine if cannulated. Ensure IV dressing is clean and intact. Change if loose, soiled or wet. Scrub any access port with 70% alcohol for 15 secs & allow to dry before accessing. Record (HS) in action column. 				
	LINE No.	FEEDS			Line 1		Line 2		Bolus											
	FLUID																			
	VOL/RATE																			
	SIGN																			
	REVIEWED																			
SIGN										Line 1		Line 2		Action						
TIME	Vol	How	Tot.	Rate	Tot.	Rate	Tot.	Rate	Tot.	Site	Cond.	Site	Cond.							
0700																				
0800																				
0900																				
1000																				
1100																				
1200																				
1300																				
1400																				
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0100																				
0200																				
0300																				
0400																				
0500																				
0600																				
Totals:																				
TOTAL INTAKE:																				

TIME		GIT & RENAL SYSTEMS						OUTPUT								
PLAN		<ul style="list-style-type: none"> Keep nil per os if aspirates/vomit are blood stained, if bowel sounds are absent or decreased or if urine contains blood and protein. Place NG tube on free drainage. Monitor abdominal girth daily if baby has abdominal distention or necrotising enterocolitis Commence non-nutritive sucking as soon as possible. Report any change in sucking once oral feeding commenced. 						<ul style="list-style-type: none"> Aspirate NG tube prior to feeds to confirm location and any abnormality in type of aspirate. Return aspirates Report failure to pass stool for more than 1 day SG ≤ 1010 - \uparrow hydration SG > 1010 - \uparrow dehydration Blood and protein associated with renal damage. Test on admission if asphyxiated 								
FREQUENC	HC	3 hrly	6 hrly	PRN	6 hrly	12 hrly		PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
	GC	3 hrly	12 hrly	PRN	12 hrly	Daily		PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN	PRN
ASSESS		Sucking	Abdomen	Abdominal Girth	Bowel sounds	PH Blood	SG Protein	Glucose/ Other	Urine volume	Urine description	Stool volume	Stool description	Aspirate vol. -MIs	Aspirate description	Vomit volume	Blood -MIs
TOTAL OUTPUT:																

MOTHER				HOME LOCATION:			
Current Location:				Health check completed?	Y / N		Care of baby:
Feeding choice:	EBM		Formula	Milk production.			
Counselling given:	Yes		No	Recorded on counselling form?	Yes		No
Health Ed. given:	Yes		No	Recorded on education form?	Yes		No
Visitors:	Baby's father			Baby's siblings		Grandparents	Other-specify:
Any problems:							
Interventions:							

HANDOVER CHECKLIST	
Sign below that all the following information has been handed over.	
1. Name and Day of life	10. Specific orders
2. Gestation at birth and currently	11. Baby's current condition, colour and activity
3. Weight loss/gain	12. Any abnormal observations and action taken
4. Problem list and progress	13. Feeds given and how tolerated
5. Emergency/ Priority signs identified	14. IV fluids given
6. Respiratory Support- Mode, FiO ₂ , Saturations, Settings	15. Location and condition of IV sites
7. Daily fluid requirement	16. Urine and stools passed and any abnormality
8. IV fluids and Feeds ordered	17. Mothers condition, support required & any problems
9. Medications (Check that all have been given)	

SHIFT TIMES	NURSE RESPONSIBLE FOR CARE:				RECEIVED BY: (Handed over to)			
	SIGNATURE	NAME	SANC NO.	DESIG	SIGNATURE	NAME	SANC NO.	DESIG

