

## **SECTION 4: APPENDIX**



There are several types of records used in the care of newborn babies. The following records are included in this guide: general clinical record, discharge form, referral form, feedback form, and death certificate. The example records included are suggested for their content more than for their format. Additional records may be used for administrative purposes. In addition, a log book (**page A-8**) should be kept with basic information on all babies admitted.

- Ensure that the baby's name and identification number are correct on all records.
- Store clinical records according to institutional policy. Ensure that the records can be easily retrieved for the annual statistics or special investigations or studies.
- Keep clinical records for at least one year unless directed otherwise by local policy.
- Be familiar with the requirements for country reporting of diseases under surveillance (e.g. congenital syphilis).
- Analyse the hospital's statistics every 6 or 12 months:
  - Number of babies admitted;
  - Number of babies discharged;
  - Number of babies who died;
  - Main conditions by birth weight and sex of the baby;
  - Shortages of drugs, equipment, supplies, and staff on duty.

## CLINICAL RECORD

The clinical record consists of the admission record and record of ongoing care.

- The admission record (example not shown) should include the reason for admission, history, previous treatment, and other information about the mother and family. A checklist of tasks is useful.
- The record of ongoing care (e.g. **Fig. A-1, page A-2**) during hospitalization is a confidential record that is shared between the doctor and nurses involved in the baby's care:
  - Keep the record near the baby;
  - Use more than one column, if necessary, for daily recording when the baby is ill or when the baby is recovering.

**FIGURE A-1 Clinical record of ongoing care**

Record ID		Name and Sex				Birth Weight		Gestational Age		Diagnosis				Ward	
														Page #	
Date	Day														
<b>Weight</b>															
<b>Temperature</b>															
<b>Breathing</b>															
<b>Feeding instructions</b>															
<b>Feeding</b> (see key below)															
<b>Examination findings</b>															
<b>Diagnostic tests</b>															
<b>Treatment</b>															

Key for feeding: B = baby is breastfeeding. If the baby is not breastfeeding, indicate in the left column what the baby is fed (BM = expressed breast milk, S = breast-milk substitute) and the method of feeding (C = fed by cup/spoon or other device, T = fed by gastric tube), and indicate in the right column the volume of milk given.

## DISCHARGE FORM

A discharge form (e.g. **Fig. A-2**) should include information for the parents and the health care provider who will provide care after discharge.

**FIGURE A-2 Discharge form**

Number:	Date of admission:	Unit/Ward:		
Family name:		Date of birth:	Age:	Birth weight:
Parents:		Address:		
Reason for admission:		Admitted from: <input type="checkbox"/> Home <input type="checkbox"/> Institution:		
History of pregnancy and birth:				
Onset of illness:				
Hospital stay:				
Instructions for home care:				
Date of discharge:	Discharged: <input type="checkbox"/> Home <input type="checkbox"/> Institution:		If died, age at death:	
Discharge diagnoses:		Cause of death (diagnosis and code):		
Follow-up visit: Where:		When:		
		Signature:		

## REFERRAL FORM

A referral form (e.g. **Fig. A-3**) includes information that should be provided with the baby when the baby and/or mother is referred to another facility or department/unit for care.

**FIGURE A-3 Referral form**

Record number:	<b>BABY</b> name:	<b>MOTHER</b> name:
Who is referring: Name: Facility:	Birth weight:	Age:
	Date and hour of birth:	Address:
Accompanied by health care worker:	Gestational age:	
	Main reasons for referral: <input type="checkbox"/> Emergency <input type="checkbox"/> Non-emergency <input type="checkbox"/> To accompany the mother	Main reasons for referral: <input type="checkbox"/> Emergency <input type="checkbox"/> Non-emergency <input type="checkbox"/> To accompany the baby
Referred Date: Time:	Major findings (clinical and temperature):	Major findings (clinical, blood pressure, temperature, and laboratory):
Arrival Date: Time:	Treatment given and time Before referral:	Treatment given and time Before referral:
	During transfer: Last (breast)feed (time):	During transfer:
	Information given to the mother and companion about the reasons for referral:	Information given to the mother and companion about the reasons for referral:

## FEEDBACK FORM

A feedback form (e.g. **Fig. A-4**) includes information that should be provided back to the referring facility or department/unit following discharge or the death of the baby.

**FIGURE A-4 Feedback form**

Record number:	<b>BABY</b> name:	<b>MOTHER</b> name:
Who is referring: Name: Facility: Accompanied by health care worker:	Weight at discharge: Date of birth: Age (days):	Age: Address:
	Main reasons for referral: <input type="checkbox"/> Emergency <input type="checkbox"/> Non-emergency <input type="checkbox"/> To accompany the mother	Main reasons for referral: <input type="checkbox"/> Emergency <input type="checkbox"/> Non-emergency <input type="checkbox"/> To accompany the baby
Admission Date: Time:	Diagnoses: Treatment given:	Diagnoses: Treatment given:
Discharge Date: Time:	Treatment and recommendations for further care:	Treatment and recommendations for further care:
	Follow-up visit: When: Where:	Follow-up visit: When: Where:
	Preventive measures:	Preventive measures:
	If death: Date: Causes:	If death: Date: Causes:

## INTERNATIONAL MEDICAL CERTIFICATE OF CAUSE OF DEATH

- If the baby dies, fill out a death certificate and send it to the authorities according to national requirements. Use the International Classification of Disease or other coding system used in the country. Follow the instructions for coding.
- **Figure A-5 (page A-6)** is an example of the death certificate proposed by WHO. Each country has its own form and regulations for reporting a death and cause of death, which determine the content of the form and the time period within which the death must be reported. Consider adding additional information on the baby, if necessary, to the country death certificate.

**FIGURE A-5 Death certificate**

Cause of Death		Approximate Interval between Onset and Death
<p><b>I</b> Disease or condition directly leading to death*</p> <p><b>Antecedent causes</b> Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</p>	<p>(a)..... Due to (or as consequence of)</p> <p>(b)..... Due to (or as consequence of)</p> <p>(c)..... Due to (or as consequence of)</p> <p>(d).....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p><b>II</b> Other significant conditions contributing to the death but not related to the disease or condition causing it</p>	<p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p>
<p>* This does not mean the mode of dying, e.g. heart failure or respiratory failure. It means the disease, injury, or complication that caused death.</p>		

**Consider collecting the following information:**

<p><b>III</b> If the deceased is a female, was she:</p> <p><b>Antecedent causes</b> Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</p>	<p><input type="checkbox"/> Not pregnant</p> <p><input type="checkbox"/> Not pregnant, but pregnant within 42 days of death</p> <p><input type="checkbox"/> Pregnant at the time of death</p> <p><input type="checkbox"/> Unknown if pregnant or was pregnant within 42 days of death</p>
<p><b>IV</b> If the deceased is an infant and less than one month old:</p>	<p>What was the birth weight: ..... g</p> <p>If exact birth weight not known, did the baby weigh:</p> <p><input type="checkbox"/> 2.5 kg or more</p> <p><input type="checkbox"/> less than 2.5 kg</p>

## LOG BOOK

- Keep a log book with the basic information on all babies admitted:
  - identification number;
  - record ID;
  - name;
  - address;
  - sex;
  - birth weight;
  - dates of admission and discharge;
  - reason for admission;
  - diagnoses at discharge;
  - condition at discharge (alive, transferred, died);
  - next follow-up visit.
- Minimal information includes date of admission, names of the mother and the baby, main condition, outcome (discharged home, transferred, or died), and date. It is useful to include birth weight.
- It may be useful to keep a separate log book of babies who died, were transferred, or required follow-up.

## HEALTH CARE FACILITY'S LABORATORY FACILITIES

### BIOCHEMISTRY AND HAEMATOLOGY

Supplies necessary to:

- Measure blood glucose
- Measure haemoglobin (or haematocrit [erythrocyte volume fraction])
- Measure serum bilirubin
- Perform cerebrospinal fluid cell count
- Perform serologic test for syphilis

### MICROBIOLOGY

Supplies necessary to perform:

- Culture and sensitivity on samples of blood, pus, and cerebrospinal fluid
- Gram stain

### BLOOD BANK

Fresh whole blood, including type O, Rh-negative blood

Supplies necessary to perform:

- Blood type and cross-match
- Coombs test

## NEWBORN SPECIAL CARE UNIT

### NON-PATIENT-CARE AREAS

- Area for preparing IV fluid and drugs
- Refrigerator and/or freezer
- Storage space for supplies
- Torch with extra batteries and bulb

### PATIENT-CARE AREAS

- Blankets, bed linen, baby clothes (or cloth for wrapping), hats, and napkins
- Chair for mother (comfortable for breastfeeding)
- Cots for newborn babies
- Facilities for handwashing
- Heat source

Light source

Oxygen supply (e.g. from a cylinder, oxygen concentrator, or wall outlet) and a flow metre allowing flow as low as 0.5 litres per minute

Room thermometer

Wall clock

## **EQUIPMENT**

Face masks for resuscitation (sizes 0 and 1)

Incubators

IV poles

Phototherapy unit

Radiant warmers

Self-inflating resuscitation bag, newborn-size

Stethoscope

Suction apparatus

Thermometers (including a rectal thermometer that measures as low as 25 °C)

Weighing scale with 5- to 10-g increments

## **SUPPLIES**

### ***TUBES AND CATHETERS***

Gastric tubes (3.5-F, 5-F, and 8-F) with caps

Suction catheters

Umbilical vein catheter

### ***METHODS OF ADMINISTERING OXYGEN***

Head box

Nasal catheter (6-F and 8-F)

Nasal prongs (1-mm and 2-mm)

### ***IV LINE***

Butterfly sets (22- to 25-gauge)

Cannulas (22- to 25-gauge)

IV tubing

Microdropper

Stopcocks (two-way or three-way)

### ***INJECTIONS***

Needles (21- to 27-gauge)

Syringes (1- to 10-ml)

***INSTRUMENTS***

Blades and handles  
Forceps (e.g. artery, dissecting, tissue)  
Needle holder

***TESTS***

Capillary tubes  
Collection tubes appropriate for sample (blood, pus, and cerebrospinal fluid)  
Glucose paper reagent strips  
Lancet

***FEEDING AND BREASTFEEDING***

Breast-milk substitute for term and preterm babies  
Containers for storing expressed breast milk  
Cups, cups and spoons, or other devices for feeding  
Utensils and containers for preparing breast-milk substitute

***OTHER***

Adhesive strapping or thin paper tape  
Arm board  
Cord ties  
Cotton-wool balls  
Drapes  
Gauze bandage  
Splints  
Suture  
Swabs

***RECORDS***

Laboratory slips  
Log book  
Medical records, growth charts, referral and feedback forms  
Other prescribed forms

***INFECTION PREVENTION***

***FACILITIES FOR HANDWASHING***

Running/clean water  
Soap and/or alcohol-based handrub  
Towels

**GLOVES**

Clean examination gloves

Heavy rubber or latex utility gloves

High-level disinfected or sterile gloves

**SKIN PREPARATION**

Antiseptic solution (e.g. 2.5% polyvidone iodine, 4% chlorhexidine gluconate, 60% to 90% ethyl or isopropyl alcohol)

**WASTE DISPOSAL**

Leakproof container for contaminated waste

Puncture-proof container for sharps disposal

Receptacle for soiled linens and napkins

**CLEANING AND DISINFECTION**

Area for cleaning and disinfecting equipment and supplies

Disinfectant solution (e.g. 0.5% chlorine bleach, 2% glutaraldehyde)

Instrument sterilizer

**DRUGS**

0.5% gentian violet

1% tetracycline hydrochloride ointment

10% glucose solution

Ampicillin

Antitetanus immunoglobulin (human)

Arachis (or vegetable) oil

Benzathine benzylpenicillin (or procaine benzylpenicillin)

Benzylpenicillin

Oral iron preparation

Eye prophylaxis (e.g. 1% silver nitrate, 2.5% polyvidone iodine, or 1% tetracycline ointment)

Cefotaxime

Ceftriaxone

Ciprofloxacin

Cloxacillin

Diazepam

Gentamicin

Isoniazid

Lignocaine

Nevirapine

Normal saline (or Ringer's lactate)

Nystatin cream  
Oral rehydration solution  
Paraldehyde  
Phenobarbital  
Phenytoin  
Vitamin K<sub>1</sub> (phytomenadione)  
Zidovudine (AZT)

**VACCINES**

Tuberculosis (BCG)  
Diphtheria, pertussis, and tetanus (DPT)  
Hepatitis B (HBV)  
Poliomyelitis (OPV)  
Tetanus (tetanus toxoid)



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