

Nursery CPN Materials

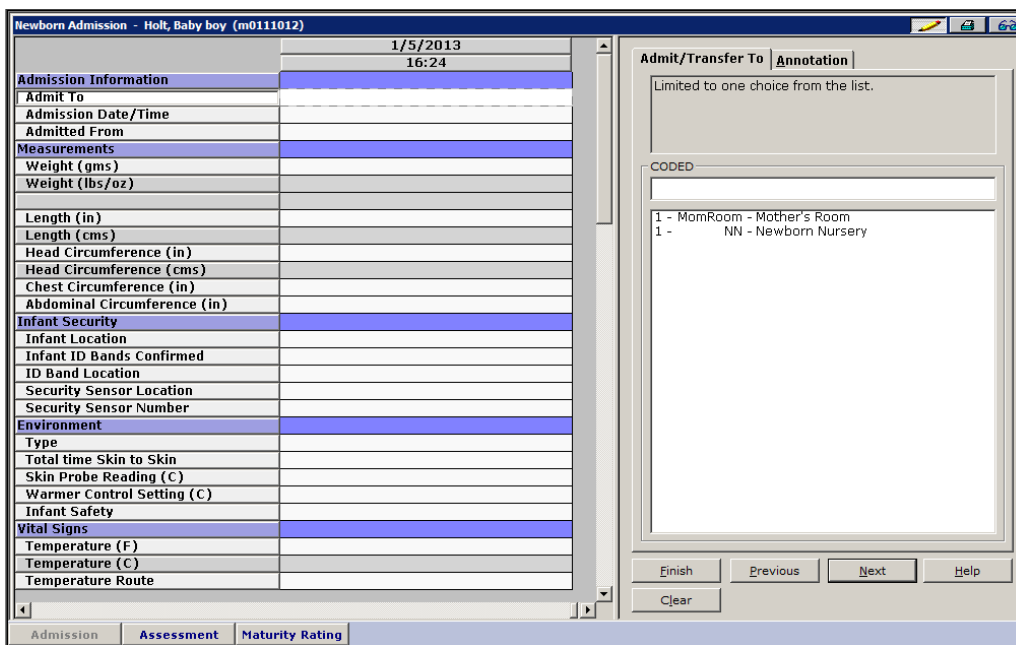
Once you are logged into CPN in the Postpartum View, change your view on the menu bar to access the newborn documentation forms by CLICKING *Nursery View*.



Once you are in the *Nursery View*, select your patient so the name appears in the Patient Banner Bar. Note that once you have accessed the *Nursery View*, the color of the patient banner bar is purple.



Admission of the Newborn

A screenshot of the 'Newborn Admission' form for patient 'Holt, Baby boy (m0111012)'. The form is dated '1/5/2013' at '16:24'. It is divided into several sections: 'Admission Information' (Admit To, Admission Date/Time, Admitted From), 'Measurements' (Weight (gms), Weight (lbs/oz), Length (in), Length (cms), Head Circumference (in), Head Circumference (cms), Chest Circumference (in), Abdominal Circumference (in)), 'Infant Security' (Infant Location, Infant ID Bands Confirmed, ID Band Location, Security Sensor Location, Security Sensor Number), 'Environment' (Type, Total time Skin to Skin, Skin Probe Reading (C), Warmer Control Setting (C), Infant Safety), and 'Vital Signs' (Temperature (F), Temperature (C), Temperature Route). On the right, there is a dropdown menu for 'Admit/Transfer To' with 'Annotation' next to it. The dropdown is currently set to 'NN - Newborn Nursery'. Below the dropdown are buttons for 'Finish', 'Previous', 'Next', 'Help', and 'Clear'. At the bottom of the form are tabs for 'Admission', 'Assessment', and 'Maturity Rating'.

1. **SBAR:** Complete the SBAR report when the baby is transferred to the nursery. For nurse to nurse report, type "Report" in the communication box. Select the nurse giving report and type in the nurse receiving report in the respective boxes. The receiving nurse's name will flow to the chalkboard to show that person as the new caregiver. See description later in this document.
2. **Admission Quick Key:** For the vaginally delivered infant, the admission assessment and initial 4 hours of care will be provided by the L&D staff. The postpartum nurse will need to ensure all items have been completed. If the baby is a c-section delivered baby, the postpartum staff will complete the admission process.
 - a. **Admission Subcomponent Button:** You will use the first subcomponent button for the first assessment completed on the baby, which includes measurements, meds, etc. Even though some measurements are documented on the delivery record, they have to be transcribed in order for the weight change calculations to occur. There are 2 items that must be documented on this flowsheet at the initial postpartum assessment: The first item Admit To MUST be

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documented on this flowsheet to tell the computer which flowsheet to place the vital signs on. The Admission Date/Time is the BIRTH date/time which starts all of the calculations for the newborn (i.e. hours of age, percentage weight loss). If you do not document these items, you will not be able to see your admission assessment documentation.

- i. *Initial care* such as lab draws, heel stick glucose, and initial bath can be documented in this chart.
 - ii. *First void and stool*: chart these as yes once the baby has had each. On subsequent voids and stools, you will chart this on the flowsheet – void/stool tab.
- b. *Assessment Subcomponent Button*: This chart will be completed every hour X 3 for the remaining hours of the newborn stabilization.
 - c. *Maturity Rating*: Complete the gestational age assessment per current policy. CPN will automatically total the maturity score and assign the corresponding weeks of gestation.
2. After the initial admission assessment, you will not need to return to this tab.

Newborn Documentation – transfer from L&D through discharge

1. *SBAR Quick Key*: This tab will be utilized when calling report to a physician or between L&D and Postpartum or shift to shift. The Situation & Background sections are pulled from the delivery record and maternal admission assessment and documents progress toward discharge: green in the history section is a negative/normal finding. Red in the history section indicates a potential health issue that may need to be addressed during the hospital stay. The Assessment section pulls the most recent data from the admission assessment and flowsheet. The Recommendation section will be updated each time you utilize this form by CLICKing the *Enter New Information* to get a clear documentation field.
 - a. If you call a physician, enter text of who was called and what was discussed in the notable communication area and any follow-up needed in the appropriate box.
 - b. For nurse to nurse report, type “Report” in the communication box. Select the nurse giving report and type in the nurse receiving report in the respective boxes. The receiving nurse’s name will flow to the chalkboard to show that person as the new caregiver.

Nursery SBAR - Holt, Baby boy (m0111012)

NURSERY COMMUNICATION TOOL

SITUATION		BACKGROUND		Discharge Checklist	
Birth Date: 01/02/13 02:00 PST	Admission Date and Time: 01/04/13 15:36 PST	Hepatitis B Vaccine Given		HBIG Given	
Method of Delivery: Vaginal	Age (Days): 0	Newborn Screening	01/05/13 12:15 PST	Hearing Screen Type	Otoacoustic Emissions
Sex: Female	Pediatrician: Garcia, A. MD	Hearing Screen Result	Right Ear Pass; Left Ear Pass	Hearing Screen Retest	
EGA: 41.0	Feeding Method: Breast Fed	Hearing Screen Status	Hearing Screen Complete	Hearing Outpatient Appointment	01/05/13 12:15 PST
Birthweight: 2678	Last Feeding: 01/04/13 15:45 PST	Pictures		Signatures Obtained before DC	Birth Certificate, Conditions of Admission, MID
Apgar 1 Min: 8	Formula Type: Enfamil Lipil				
Apgar 5 Min: 9	First Void: Yes				
MATERNAL INFORMATION	First Stool: Yes				
Gravida: 2					
Para: 1					

ASSESSMENT			RECOMMENDATION(s)	
Vital Signs			Previous Entries	1/5/2013 16:25
Respirations	55	01/02/13 09:18:00	ENTER NEW INFORMATION	
Measurements			Notable Communication:	Medications/Blood Products/Critical Labs/Treatments or Procedures Pending
Weight (gms)	2600	01/04/13 15:48:00		
Weight (lbs/oz)	5/12	01/04/13 15:48:00	Follow Up	
Weight Change (gms)	100	01/04/13 15:48:00		
Wt Change Since Birth (gms)	-78	01/04/13 15:48:00	Nurse Giving Report	Nurse Receiving Report
Head Circumference (in/cm)	12.00/30.48	01/02/13 15:54:00		
Chest Circumference (in/cm)	13.00	01/02/13 15:54:00		
	33.02	01/02/13 15:54:00		
Labs/Procedures				
Bilirubin Transcutaneous	9.8	01/04/13 15:47:00		
Age in Hours at Bili Test	61.78	01/04/13 15:47:00		
Procedures	Peripheral IV Placement	01/04/13 15:46:00		

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2. **Maternal Info:** You can review the information about the mother's history and delivery information once the mother/baby link has been updated. Remember that this quick key is a REVIEW ONLY screen and while you are able to chart, it will not change the mother's record. In order to correct or update the delivery record or maternal information, you will need to go into the mother's record, change or add the information on the appropriate chart or form, then update the baby's record through the Mother-Baby link.
 - a. *Summary* tab includes all maternal information that crossed via the Mother Baby Link.
 - b. *Pregnancy Info* shows maternal prenatal and intrapartum data up to the delivery.
 - c. *Delivery Info* subcomponent button will show all data charted on any form in the delivery record.
 - d. *Maternal History* includes information that would be found on the prenatal record, usually before admission to the hospital.

Maternal Pregnancy Information		Maternal Delivery Information	
Maternal History		Labor/Delivery Information	
Mother's Name	HOLT, JENNIFER L	Mother's Name	HOLT, JENNIFER L
Race	Caucasian	Date of Birth	01/02/13 02:00 PST
Age	40	Method of Delivery	Vaginal
Primary Language	English	Delivery Doctor	P_Nassar
Communication Barriers	None	Labor Anesthesia	IV Sedation
Cultural/Spiritual Practices	No	Delivery Anesthesia	Local
Latex Allergies	No Latex Allergies	Reason for Induction	Postdates/Postterm
Pregnancy History		Maternal Complications	None
Gravida/Para	2/1	Steroids Given	None
T/PT/AS/AI/L	1/0/0/0/1	Reason Steroids Not Admin.	Not Applicable
EDC	12/20/12	VBAC	N/A
EDC by Ultrasound	12/27/12	Born in Route	No
LMP	03/13/12	Vacuum Extraction	N/A
Number of Babies in Womb	1	Shoulder Dystocia	No
Labs (Maternal)		Presentation/Position	
Blood Type	B Positive	Fetal Presentation	Cephalic
Group Beta Strep	Negative	Cephalic Presentation	Vertex
Hepatitis B	Negative	Vertex Position	Left Occipital Transverse
Rubella	Immune	Breech Position	N/A
Gonorrhea	Negative	Infant Information	
Chlamydia	Negative	Rupture of Membranes Date/Time	12/28/12 10:38 PST
RPR/VDRL	Nonreactive	Length of Rupture (hrs)	111.37
HIV+ Exposure Test	Declined	Amniotic Fluid Color	Light Meconium
Herpes Culture	Unknown	Gestational Age	41.0
Alcohol/Smoking/Drug Use		Gestational Status	Term
Alcohol Use	Yes	Outcome	Liveborn
Consumption During Preg	<2 per day	Infant Condition	Stable
Tobacco Use	Current Everyday Smoker	Infant Sex	Female
Tobacco Use During Preg	> 10 per day	1 Minute APGAR	8
		Resuscitation Effort	Tactile Stimulation

3. **Flowsheet:** This chart replaces the yellow and green flowsheet. CLICK on the *Flowsheet* quick key.
 - a. For the initial documentation on the form, the date/time will be set as you log into the form. For subsequent charting episodes, CLICK on *Enter New Information* button and then select the time you are documenting at. This time will remain on all forms within the flowsheet tab unless you CLICK *Enter New Information* to change time.
 - b. The *Flowsheet* is built so that the documentation fields are on the top section of the screen, with a review panel on the bottom of the screen. The latest data input will appear in the chart column when you move to another tab.
 - c. *Flowsheet* subcomponent: This is a great place to chart the every 2 hour note of "baby sleeping in mom's arms, pink with good tone." – there are items available for you to continue to make that type of note using this form. On this subcomponent button, the entire flowsheet is

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available to chart on by CLICKING on the pencil, selecting the time of documentation and documenting on the pertinent items.

	01/04/13	01/04/13	01/04/13	01/04/13	01/05/13
	15:45	15:46	15:47	15:48	12:10
Oxygenation					
Preductal Oxygen Saturation (%)		95			
Feedings					
Method		Breast Fed			
Lactation Consult		Needs			
LATCH Score					
Latch		Too sleepy or reluctant, no latch achieved			
Audible Swallowing		None			
Type of Nipple		Inverted			
Comfort		Engorged, cracked, bleeding, large blisters or bruises, severe discomfort			
Hold		Full assistance needed to correctly position infant at breast			
LATCH Score Total		0			
Urine					
First Void		Yes			
Stool					
First Stool		Yes			

- d. *Environ/VS, Void/Stool* subcomponents are self-explanatory
- e. *Feedings*: This form is used for both breast and bottle feeding infants. If the patient requested to exclusively breastfeed and is given formula, you must document a reason in the “breastfeeding exception reason” text box. For breastfeeding infants, a LATCH score should be documented a minimum of once a shift. CPN will automatically tally the score once all variables are documented on.
- f. *Procedures*: This page contains all of the required tests and items that need to be completed before discharge: Hep B vaccine and HBIG, newborn screening, pictures, hearing screens, forms to be signed. Nursery nurses will document hearing tests, including if the baby needs retested while an inpatient and outpatient appointments if needed. Newborn screen date and time is a new documentation piece for staff. Some of this information is present on the chalkboard to assist in your discharge planning. It can also be found on the SBAR form and discharge checklist.
- g. *Bili/Care*: Nursery nurses will document the date and time that the transcutaneous bilirubin screen was completed as well as the numeric result. This will flow to the chalkboard. If the result is greater than 10 mg/dl, the nurse should be checking that a lab bilirubin was sent and evaluating the lab result once complete, and documenting it in CPN.
- h. *Assessment*: This is where you will document your assessment that is performed every 4-8 hours or as required by the patient’s condition.
- i. *Measurements*: This tab will be used to enter the newborn weights every 24 hours. CPN will calculate the weight loss automatically and will place the value in the patient banner bar. You can also document head, chest and abdominal circumference on this page.

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4. **Teaching:** This tab replaces the “newborn teaching record.” It includes all topics that need to be covered before discharge from the hospital. During the patient stay as you teach different topics, you will click this tab and document the topic you taught as well as the parent’s response (i.e. verbalized understanding, returned demonstration). Do not wait until day of discharge to complete this form – it is intended to document changes in the mother’s learning progress over time and you can indicate if follow-up teaching needs to be completed. By CLICKing the *Review* subcomponent button, you can review all topics with the last date/time that the topic was discussed and topics that still need to be taught.

5. **Discharge:** This tab replaces the white/yellow form that the MD signs currently on day of discharge, the appointment form (except on weekends/holidays) and the back of the newborn teaching record. The majority of the information on this form will flow from the location where it was initially documented. Review the form for completion and accuracy.
 - a. Click on the *Teaching* subcomponent button to review all of the teaching completed during the hospital stay. Review and document any missing items.
 - b. This form will be the last thing documented on before discharge as the nurse will document the date/time of discharge, how and with whom the patient left the floor and if they were discharged to a private vehicle or other mode of transport.
 - c. By CLICKing *Discharge Instructions*, you can personalize the patient instructions to provide education on warning signs and when a patient should seek medical care. Spanish instructions will also be accessible by go-live from the discharge summary or discharge instruction page.

The screenshot displays the 'Newborn Discharge' form for 'Holt, Baby boy' (ID: m0111012). The interface includes a navigation bar with tabs for Maternal Info, Admission, Flowsheet, Teaching, IDN/Consults, Graphs, I&O, SBAR, and Discharge. The 'Discharge' tab is active.

BIRTH INFORMATION

- Birthdate/Time: 1/2/2013 2:00
- Sex: Female
- Method of Delivery: Vaginal
- Gest. Age @ Delivery: 41.0
- Birthweight: 2678 Grams, 5 lbs, 14 oz
- Length: 13.00 in
- Appar Scores: Head 13.00, Chest 13.00

INFANT INFORMATION

- Blood Type: Direct Coombs
- Newborn Screen Drawn: 1/5/2013 12:15
- Hearing Screen Status: Hearing Screen Complete
- Discharge Summary: Discharge Checklist Reviewed and Appropriate Items Complete

Discharge Checklist

Hepatitis B Vaccine Given	
HBIG Given	
Newborn Screening	01/05/13 12:15 PST
Hearing Screen Type	Otoacoustic Emissions
Hearing Screen Result	Right Ear Pass; Left Ear Pass
Hearing Screen Retest	
Hearing Screen Status	Hearing Screen Complete
Hearing Outpatient Appointment	01/05/13 12:15 PST
Pictures	
Signatures Obtained before DC	Birth Certificate; Conditions of Admission, NB
Lactation Consult Done	Needs
Recorded By:	ih6465

Discharge Instructions

- Mode of DC Transport:
 - Mother's arms by wheelchair
 - Transfer Team Ambulance
 - Caregiver's arms by wheelchair
 - Other - annotation in DC comments
- Accompanied by:
 - Mom/Family Members
 - Hospital Personnel
 - Transfer Team
 - Temporary Caregiver
 - Other - annotation in DC comments

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6. *IDN/Consults*: will contain documentation on psychosocial issues, CPS referrals and newborn placement of inmates. This will be completed charge nurses or social workers. Further education will be provided before the phasing-in of this section.
7. *Graphs*: This tab will allow the nurse to review all vital signs taken and bilirubin levels. CPN also graphs this information to provide a visual overview of changes over time.
8. *I&O* will remain on paper temporarily. Further education will be provided before the phasing-in of this section.
9. Additional forms:
 - a. *Circumcision*: CLICK *Patient Progress* and then *Circumcision* just in case we perform this procedure.
 - b. *Care plans*: CLICK *Patient Progress* and then *Care Plans*. This will be phased in after go-live
 - c. *Lactation Consult*: CLICK *Patient Progress* and then *Lactation Consult*. This can be used when a lactation consultation visits the mother and needs to document on the baby.

Newborn Documentation – Where do I chart and when??

1. Receiving a newborn from L&D after vaginal delivery:
 - a. *SBAR form* – indicate date/time of transfer, select nurse giving report from drop-down box and type in receiving nurse name.
 - b. *Flowsheet* – Used for on-going assessments and care of the newborn. If newborn recovery is not complete, finish the first 4 hourly assessment on the *Admission Quick Key, Assessment subcomponent*.
 - c. *Care plans* – to be phased in after go-live. CLICK *Patient Progress* in the menu bar, then CLICK *Care Plans*

2. Receiving a newborn from C-section or an ill newborn that needs admitted:
 - a. *SBAR form* – indicate date/time of transfer, select nurse giving report from drop-down box and type in receiving nurse name.
 - b. *Admission* – complete the *Admission* and *Maturity Rating* subcomponent button for the initial assessment, then use the *Assessment* subcomponent for the remaining 3 hourly assessments.
 - c. *Care plans* – to be phased in after go-live. CLICK *Patient Progress* in the menu bar, then CLICK *Care Plans*

3. On-going care once patient is on floor:
 - a. *Flowsheet* - complete the appropriate tabs every 4-8 hours for your routine assessment
 - b. *Teaching* – document on the teaching quick key as you provide education and feedback to your patients.
 - c. *SBAR* – if you need to give report to the MD or other caregiver. Document date/time, who you reported to, the pertinent details of the conversation and what follow-up was needed or ordered.

4. To be completed once per shift
 - a. *SBAR* - indicate date/time of transfer, select nurse giving report from drop-down box and type in receiving nurse name.
 - b. *Care plans* – to be phased in after go-live. CLICK *Patient Progress* in the menu bar, then CLICK *Care Plans*. COPY previously written care plans to update or resolve individual care plans.

5. To be completed for discharge
 - a. *Teaching* quick key – *Review* to see that all topics have been covered.
 - b. *Discharge* – complete the *summary, medication reconciliation and instructions* sections. PRINT 2 copies, one for the patient and nurse to sign, and one to give to the patient.