Waikato District Health Board

Guideline

Documentation Standards in the Neonatal Intensive Care Unit (NICU)

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Neonatal Intensive Care Unit (NICU)
Document Facilitator Name	Phil Weston
Document Facilitator Title	Neonatologist
Document Owner Name	Jutta van den Boom
Document Owner Title	Clinical Director
Target Audience	NNPs, CNSs, Registrars, SMOs & Nurses
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
01	Phil Weston	August 2020	New guideline, new template
1.1	Jutta van den Boom	August 2021	Updated discharge sign off, whanau discussion

Documentation Standards in the Neonatal Intensive Care Unit (NICU)

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Documentation Standards in the Neonatal Intensive Care Unit (NICU)

1 Overview

1.1 Purpose

Documentation is held to be of high importance in the clinical care of babies in the Neonatal Intensive Care Unit (NICU). As a priority it sits below some other responsibilities of the clinical care team, including making good clinical decisions, undertaking necessary practical procedures, meeting the emergency needs of babies, and information sharing with parents, however it still sits within the group of highly important activities, and this guideline seeks to provide clarity about how much documentation is expected, given the time availability to do so.

Waikato District Health Board (DHB) recognises that the clinical record is the primary document for recording clinical care and that it has clinical and medico-legal significance for the patient/client, staff members and the Waikato DHB. An accurate clinical record is necessary to support informed and co-ordinated decision making, evaluation of the care provided, achievement of effective healthcare outcomes, and retrieval of data for management information, research and medico-legal reference. Record keeping is an integral part of practice and good record keeping is the mark of a skilled and safe practitioner. Clinical records may be used for supporting evidence in investigations: clear documentation assists with the understanding of what occurred.

Although Waikato DHB is increasingly storing clinical information electronically, at this stage the record is a hybrid of paper and electronically held information with the combination providing the comprehensive view.

This guideline should be read in conjunction with:

- Clinical Records Management policy (Ref. 0182)
- Standing Order Documentation – Process and Documentation procedure (Ref. 2524)
- Electronic Record Keeping Metadata policy (Ref. 0150)

1.2 Scope

Waikato District Health Board (DHB) medical staff working in NICU.

1.3 Patient / client group

Neonates.

1.4 Definitions and acronyms

CNS	Clinical Nurse Specialist
CPAP	Continuous positive airway pressure
CUL	Clinical Unit Leader
CVAD	Central Vascular access device
HiFlow	High Frequency Ventilation
HiFreq Vent	High Frequency Ventilation
LISA-MIST	Less invasive surfactant administration - Minimal Invasive Surfactant Therapy
LoFlow	Low Frequency Ventilation
MDT	Multi-disciplinary team
NIPPV	Nasal Intermittent Positive Pressure Ventilation
NNP	Neonatal Nurse Practitioner
NNS	Neonatal Nurse Specialist
SIMV	Synchronised Intermittent Mandatory Ventilation
SMO	Senior Medical Officer

2 Clinical management

2.1 Roles and responsibilities

Senior Medical Officer

The adherence to or deviation from the documentation standards guideline on any particular day is the responsibility of the duty SMO on that day. If, due to workload pressures, it proves unreasonable to meet these expectations on any particular day, every effort must be made to retrospectively document. A Datix entry would be desirable to monitor workload.

2.2 Guideline

2.2.1 Level 3

There should be a daily entry for each baby which reflects the status of the baby and the planned changes in therapies. A pre-formatted stick-in entry will be used for documentation of ward rounds and MDT meetings or may be used at some other time

The minimum required components of the entry are:

a) Date and time.

b) The name of the senior person (usually the duty SMO) who is taking responsibility for the decisions made.

c) The name of the resident (Registrar / NNP / NNS) who is caring for the baby.

d) Presence of caregivers during ward rounds

e) The status of the current nutrition.

f) The status of the current respiratory support.

g) The status of current cardiovascular condition.

h) A list of the currently active health issues that are affecting the treatment decisions.

i) A list of the current medications, including doses.

j) A plan for the day, which must specify as a minimum what the respiratory and nutritional expectations are for the day, and laboratory work for the day.

k) Clinical examinations should be undertaken at least daily, but should be tailored to have regard for the age, gestation, and stability of the baby. Findings should be written in the clinical notes. This would be expected to be undertaken at the time of cares to avoid unnecessary handling of these infants. However, the SMO/delegated decision maker may examine relevant systems at the time of ward round to assist with making management plans.

The “age-related task sheet” to be initiated at admission for babies <34/40, and reviewed daily.

2.2.2 Level 2

There should be at least a twice - weekly entry which reflects the status of the baby and the planned direction of therapies. These entries will be made by the resident, as part of the formal ward rounds by SMOs on Monday and Friday.

The required components of the entry are as above for Level 3.

a) There should be an examination recorded weekly, and more often if clinically indicated.

b) Focus of documentation should be towards discharge process.

2.2.3 <u>All significant procedures</u> (whether successful or not)

- These should be documented with date and time including:

  a) Intubation / reintubation / LISA-MIST.

  b) Extubation.

  c) Transitions between SIMV, HiFreq Vent, CPAP, NIPPV, HiFlow, LoFlow

d) Intercostal drain insertion.

e) CVAD insertions (separate checklist is available for this).

f) Peripheral artery catheterisation.

g) Urinary catheterisation.

h) Lumbar puncture.

i) Ventricular tap.

j) Institution of non-routine medications.

k) Exchange transfusion.

l) Head Ultrasound/Echo

- In all cases where an unexpected change in management or investigation occurs, i.e. any deviation from the daily written plan, an additional note is to be made in the records by either SMO or resident which explains what the change is, and why it is being made. The timing of the change is to be recorded.
- If asked to review a baby there should be a record made of appropriate observations and interpretations at the time of the assessment.
- In all cases where the SMO is called to assist in the clinical management of a baby due to a baby-specific problem, a clinical note is to be made by the SMO about what the problem was, and what the SMO decision was. Such notes are to be accurately timed, and if the recording of such a note is necessarily delayed by more than 1 hour then the note is to be titled “retrospective note”, with reference back to the time of the actual call.
- Formal family meetings should be documented in the clinical notes by SMO or delegated resident compiled under the section ‘Whānau Discussions’ for easier reference (pink clinical notes paper)
- Discussions with other specialist teams (e.g. Starship Hospital) are to be documented by the person initiating the consultation.
- Discussions of advanced care plans should be documented on the Waikids Advanced Careplan form and placed in the front of the clinical record.

2.2.4 Discharge summaries

- Discharge summaries are to be completed prior to baby leaving the unit and a printed copy should accompany the baby.
- Discharge summaries are to be updated regularly (at least weekly) by resident staff and all relevant information added prior to discharge.
- NNP/RMO will complete the discharge letter in CWS ready for discharge, esp in anticipation of discharges over the weekend. These should be reviewed by the service SMO prior to the weekend.

- NNP/RMO will inform respective service SMO (not the admitting SMO) that letter is ready for discharge.
- SMO will review (and if satisfactory sign off) letter in CWS and inform NNP/RMO this is done.
- Letter now ready to be printed by discharging staff.
- Exception to this are discharges overnight back to postnatal wards – these should be reviewed the next day.

3 Audit

3.1 Indicators

- There is documented evidence of daily records for all babies in Level 3
- There is documented evidence of no less than twice weekly records for all babies in level 2
- The content of the record meets the minimal requirements for clinical records as per 2.2.1 and 2.2.3.

4 Evidence base

4.1 Associated Waikato DHB Documents

- Clinical Records Management policy (Ref. 0182)
- Standing Order Documentation – Process and Documentation procedure (Ref. 2524)
- Electronic Record Keeping Metadata policy (Ref. 0150)