HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Neonatal Intensive Care Unit (NICU)		
Document:	Multidisciplinary Policy and Procedure		
Title:	Admission of Neonates to NICU		
Applies To:	All NICU and Pedia ER Staffs		
Preparation Date:	January 05, 2025	**Index No:**	NICU-MPP-002
Approval Date:	January 19, 2025	**Version :**	5
Effective Date:	February 19, 2025	**Replacement No.:**	NICU-DPP-002 (4)
Review Date:	February 19, 2028	**No. of Pages:**	18

1. PURPOSE:

1.1 To provide consistent process for admission to the neonatology department units and ensure cost effective utilization of resources.
1.2 To establish system and set responsibilities for NICU admissions.

2. DEFINITIONS:

2.1 It delineates the steps taken for admitting infants to the neonatal intensive care unit.
2.2 ED: Emergency Department,
2.3 PNW: Postnatal Ward
2.4 SOD: Specialist On Duty
2.5 ROP: Retinopathy Of Prematurity
2.6 DR: Delivery Room
2.7 ROD: Resident On Duty
2.8 PRN: Per Required Needs
2.9 OR: Operation Room

3. POLICY:

3.1 The unit follows this policy in accordance with the Maternity and Children hospital policy for admission "Admission to Maternity and Children Hospital" and the neonatology unit policies for admission to the neonatology/ isolation, observation room, well baby and admission from the delivery room and OR.
3.2 Admissions to the neonatology department are accepted from DR, OR, ED, ED-DR, obstetric postnatal and caesarean wards and referrals from other hospitals.
3.3 Consultant, specialist and resident who process admissions to the neonatology department are assigned according to a monthly-prepared schedule approved by head of the department.
3.4 At the time of admission, responsible (primary) consultant is clearly identified for all patients.
3.5 Patients are admitted to the proper neonatology department's unit according to admission and discharge criteria and scope of work of the neonatology department "Admission and Discharge Criteria of the Neonatology Department".
3.6 Complete assessment of patients and developing a plan of care is done for all patients on admission by the admitting team.
3.7 The specialist on duty informs the on call consultant about all admissions as soon as possible and according to severity of illness within a maximum of 24 hours.
3.8 Identification of all admitted babies is secured on admission.
3.9 Patients not eligible for treatment are informed by administrative office representative about expected costs before admission.

4. PROCEDURE:

4.1 The neonatology bed capacity (level 3A+3B+ 2A+ 2B+ 1A+ Isolation) is 40 beds.
4.2 Responsible (primary) consultant is clearly identified on all admissions as follows:

4.2.1 All neonates are admitted under the care of the on call consultants covering all neonatology units 24 hours a day according to a monthly prepared schedule approved by HOD.

4.2.2 Assigning the responsible consultant is according to:

4.2.2.1 Date and time of birth for neonates admitted from the OR, DR and ED-DR.

4.2.2.2 The time of opening the file for neonates admitted from the post natal ward and emergency Department.

4.2.2.3 When no bed is available and the patient requires either intensive or intermediate care:

4.2.2.3.1 If the patient is delivered in the hospital delivery rooms (including ED-DR), he/she is admitted to the observation room under the responsibility of the consultant on duty covering NICU and observation room.

4.2.2.3.2 If the patient is admitted in the emergency room: he/she is admitted under the responsibility of the consultant covering the NICU and emergency room.

4.2.2.3.3 In situations when two different consultants arc covering NICU and observation room:

4.2.2.3.3.1 If the patient requires management in the observation room for 6 hours or more, he/she is admitted under the consultant covering observation room.

4.2.2.3.3.2 If the patient requires management in the observation room for less than 6 hours, he/she is admitted under the consultant covering NICU.

4.3 Referred patients:

4.3.1 Referred patients from other hospitals are accepted by the on duty consultant according to the admitting status of the unit:

4.3.1.1 Open : > 2 beds are available
Restricted : 1 or 2 beds are available
Closed: 0 beds are available

4.3.1.2 For restricted status the accepted referred cases are limited to those problems for which Maternity and Children Hospital have special expertise.

4.3.2 If no bed is available, neonatology SOD should:

4.3.2.1 Inform the on call consultant/department bed manager and parents.

4.3.2.2 Consider referral of the patient to another hospital, where facilities are available for such patient if the patient fulfils the criteria for referral i.e. patient is stable, eligible and does not require any of the subspecialty services available in MCH hospital and not in the receiving hospital and parents agree for the referral.

4.3.2.3 Referral is done through the hospital referral system. SOD/ROD writes the fax with updated medical information and informs the on duty hospital manager/medical coordination office.

4.3.2.4 Critical patients should be immediately stabilized whether in observation room or ED.

4.3.2.5 If the patient is in the DR, OR, postnatal or post caesarean wards, the patient is observed until result of the referral is received.

4.3.2.6 If the patient is in the ED, clerking by neonatology on call SOD/ROD should be done within a maximum of 2 hours.

4.3.2.7 If referral of the patient is accepted, an arrangement for patient's transfer by ambulance accompanied by a physician and a nurse is done through the hospital on duty manager and hospital medical coordination office.

4.3.2.8 If the patient referral is not accepted, or no reply in 2 hours, neonatology SOD follows the results of the referral with the hospital on duty manager to locate a bed in another hospital where facilities are available for such patient.

4.4 For admissions from ED:

4.4.1 The ED physician examines the baby and informs neonatology SOD. They order and interpret results of required preliminary investigations that would help in making decision of admission.

Neonatology SOD decides the need for admission, after consultation with the on call consultant. If needed, and arranges bed in neonatology department.

4.4.2 For critical patients e.g. requiring resuscitation, hemodynamically unstable, etc. the ED team starts the resuscitative management and immediately calls the neonatology SOD, who also examines the patient in ED. SOD calls the consultant on duty if needed. The team urgently stabilizes the patient then shifts him/her to the neonatology department as quickly as possible, in a transport incubator, accompanied by neonatology physician and ED nurse.

4.5 Criteria when to call the consultant:

4.5.1 Any time a specialist wishes to share the responsibility of decision making, he/she should not hesitate to communicate with the assigned consultant, regardless of the time of day or night.

4.5.2 Time of calling consultant for new admissions:

4.5.2.1 Inform the on call consultant as soon as possible within 30 minutes for emergency cases that need admission to intensive care e.g. critically ill neonates who require cardiopulmonary and or multi-system monitoring and support for complicated medical and/or surgical disease, lifesaving conditions, encephalopathy, seizures, diaphragmatic hernia" infants in blood exchange transfusion levels, etc.

4.5.2.2 Inform within 4 hours for moderately ill patients who require intermediate care level IIB i.e. patients with a low risk of, but potential for significant deterioration and who require frequent monitoring of vital signs e.g. mild to moderate respiratory distress of any etiology requiring ± 40% FiO2 to maintain acceptable SpO2, hemodynamically stable congenital heart disease,

4.5.2.3 Inform within a maximum of 24 hours for infants with stable vital signs who require intermediate care level II admission e.g. for conventional phototherapy,

4.5.2.4 Within 30 minutes for all requests for admission from other hospitals.

4.5.2.5 Call the consultant once the need for urgent consultation with another subspecialty is suggested.

4.6 Patients not eligible for treatment are informed by admission office representative about expected costs

4.7 Neonatology SOD shall fill and sign the admission request form, assess all new admissions with ROD and approves/makes the management plan after consultation with the consultant on duty if needed.

4.8 SOD/ROD shall fill and sign the Physician Newborn Assessment Form, New born Maturity Rating and Classification form as soon as possible, within a maximum of 2 hours. He/she shall document all procedures or events in the progress notes e.g. lines inserted, lumber puncture, intubation, etc.

4.9 Patients not eligible for treatment are informed by admission office representative about expected costs

4.9.1 For infants admitted from Emergency Department (ED):

4.9.2 While in the emergency room, the ED nurse prepares identification bands that indicate the infant's name(four names for Saudi/ complete name for Non-Saudi), sex, medical record number, date of admission and nationality and secures one to the infant's wrist and the second to his/her ankle.

4.9.3 When the neonate is taken to his/her neonatology bed, both the ED nurse and the admitting nurse match the baby's identification bands with his/her medical record identification information.

4.9.2 For infants delivered in the hospital, securing identification in the delivery and operating rooms is according to the neonatology Identification of neonates in the delivery and operating rooms"

4.9.3 On admitting infant delivered in the hospital i.e. from the delivery or operating rooms or from postnatal wards:

4.9.3.1 Both the assigned obstetric nurse and the admitting nurse match the babies' identification bands with his/her medical record information (the two ID bands carry the mother's medical record number and another ID carries a number according to the origin; either from DR or OR)

4.9.3.2 The ID bands with infant's medical record number, his/her mother's name, sex, date and time of birth, date of admission and nationality are used for identification before any medication or procedure all through the infant's hospital stay.

4.9.4 The ward clerk/nurse fills out the incubator identification card with the infant's medical record number, his/her mother's name, date and time of birth and the neonatology responsible

consultant. The nurse assigned to admit the baby checks it and attaches it to the neonate's incubator.

4.10 The admitting specialist or consultant discusses the status and immediate plans and expectations for the neonate with the parents.

4.11 COD/SOD/ROD obtains informed consent from the father/patient guardian "General consent / Consent for "Surgical and Medical Interventional procedure".

4.12 ROD documents the parents/patient's guardian phone number on the " Physician New born Assessment Form.

4.12.1 The order sheet must have the patient name (four name for Saudi and complete name for Non-Saudi), medical record number, sex, age and nationality on it.

4.12.2 Indicate date, time and place of admission i.e. admit to NICU.

4.12.3 Monitoring:

4.12.3.1 Vital signs: Required frequency for measurement of temperature, pulse, respiratory rates and BP, with acceptable limits and when to notify the physician. e.g. acceptable SpO2 for cyanotic heart disease, temperature during therapeutic hypothermia, etc.

4.12.3.2 Weight on admission and then daily, head circumference on admission and then biweekly and at the time of discharge, length on admission and then weekly (except in certain circumstances) and at discharge.

4.12.3.3 Strict intake & output for intensive care patients (including urine, all drains, catheters, etc.)

4.12.3.4 If the patient needs oxygen therapy, indicate its required percentage, mode of administration, flow & target range for SpO2.

4.12.3.5 For nasal CPAP and mechanically ventilated babies indicate machine parameters.

4.12.4 Blood Work

4.12.4.1 Indicate time and frequency for required blood work.

4.12.4.2 Order only required chemistry individually and specifically.

4.12.5 Radiological Investigations

4.12.5.1 Indicate type and time for required investigation.

4.12.6 Medications

4.12.6.1 Handwriting and numbers on the physician order sheet and the medication record form must be very clear. Do not use abbreviations other than abbreviations approved by the hospital.

4.12.6.2 Indicate weight used to calculate doses and fluids.

4.12.6.3 Indicate generic drug name, dose, route and frequency

4.12.6.4 Whenever possible, specify volume of dilution.

4.12.6.5 If medications are to be given STAT, make sure that the order is immediately seen and acted upon by the assigned nurse.

4.12.6.1 Handwriting and numbers on the physician order sheet and the medication record form must be very clear. Do not use abbreviations other than abbreviations approved by the hospital.

4.12.7 Per Required Needs (PRN) orders:

4.12.7.1 Should clearly specific the condition under which the medication can be administered, the dose and maximum frequency.

4.12.8 Nutrition

4.12.8.1 Indicate type of feeding, volume and frequency or nothing per oral (NPO).

4.12.8.2 Intravenous fluids or total parenteral nutrition.

4.12.9 Verbal or telephone communications:

4.12.9.1 Follow hospital policy for verbal orders.

4.12.9.2 Limit verbal orders as much as possible to situations in which it is difficult or impossible to write order or enter it in the computer by yourself e.g. during a sterile procedure, emergency or resuscitation.

4.12.11 Patients admitted to NICU through the emergency department:

4.12.11.1 Admit to NICU isolation rooms

4.12.11.2 The assigned nurse will:
- 4.12.11.2.1 Collect surface swabs (nasal, axillary, throat, umbilical and perineal) in addition to other ordered cultures.
- 4.12.11.2.2 Give the baby chlorhexidine 1% bath

4.12.11.3 They can be moved to other level in NICU (after consulting neonatology bed manager/infection control) if:
- 4.12.11.3.1 Cultures taken on admission are not growing pathogenic organisms.
- 4.12.11.3.2 After the infecting organism is successfully treated, and cultures taken after 48 hours of stopping the antibiotics are negative (for some cases, two negative cultures results, 48 hours apart, taken 48 hours after stopping antibiotics are needed before moving the patient to regular rooms).
- 4.12.11.3.3 Before moving the baby, give him/her an antiseptic bath with chlorhexidine 1% and place in a clean incubator.

4.12.12 Move infants to NICU (isolation) if cultures show infection or colonization with:
- 4.12.12.1 Any of the following organisms regardless of susceptibility pattern: Acinetobacter species, Stenotrophomonas Maltophilia, Serratia species, Citrobacter, Flavobacteria, Burkholderia cepacia.
  - 4.12.12.1.1 Any multidrug resistant organism (MDRO) e.g.
    - 4.12.12.1.1.1 MRSA (Methicillin-resistant Staphylococcus aureus), VISA (Vancomycin-intermediate Staphylococcus aureus), VRSA Vancomycin-resistant Staphylococcus aureus), VRE (Vancomycin resistant enterococci), GISA (glycopeptide-intermediate Staphylococcus aureus).
    - 4.12.12.1.1.2 Extended Spectrum Beta-Lactamase [ESBL]-producing (e.g. Klebsiella E Coli).
    - 4.12.12.1.1.3 Any gram negative organism resistant to all third generation cephalosporin and gentamicin is considered MDRO.

4.12.13 Patient and family:
- 4.12.13.1 The admitting office officer will inform/give parents a copy of Bill of patient/family rights and responsibilities at registration or admission to the hospital.
- 4.12.13.2 The assigned physician will ensure that the parent/patient guardian knows about the patient's diagnosis, plan of care and his/her treating team.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physicians in NICU and Pedia ER
6.2 Nurses in NICU and Pedia ER

7. APPENDICES:

7.1 Admission request form
7.2 Physician newborn assessment form
7.3 NICU assessment form
7.4 New Ballard score form

8. REFERENCES:

8.1 Guidelines for Perinatal Care. American Academy of pediatric, The American college of obstetricians and gynaecologists. Fifth edition.

8.2 Joint Commission international Accreditation Standards for hospitals. Access to Care and Continuity of Care. Sixth Edition. 2017.

8.3 Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI). Third edition.20l6

9. APPROVALS:

	Name	Title	Signature	Date
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Prepared by:	Dr. Falah Nabhan Al Shammari	NICU Quality Coordinator		January 05, 2025
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 07, 2025
Reviewed by:	Dr. Sarhan Hamdan Al Shammari	NICU Head of the Department		January 08, 2025
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	QM&PS Director		January 09, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam Al - Shammari	Hospital Director		January 19, 2025

KINGDOM OF SAUDI ARABIA

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

ADMISSION REQUEST FORM

Mobile Number:

ADMITTING CONSULTANT _____

SOURCE OF REFERRAL: ☐ Emergency Department ☐ Outpatient Clinics ☐ Day Care

☐ Others, please specify; _____

Category of Admission : ☐ Emergency ☐ Urgent ☐ Elective within _____ weeks (choose from 1 to 52)

Current Medical Problem? ☐ None ☐ Yes,: _____

_____

Current Medication? ☐ None ☐ Yes,: _____

_____

ADMISSION DIAGNOSIS: _____

_____

PLANNED SURGICAL PROCEDURE: ☐ None _____

_____

ESTIMATED BLOOD NEED: ☐ None ☐ Yes, _____ **Number of Units** _____ **Unit (s)**

Date of Admission (if Available): _____ **Estimated Length of Stay: (L.O.S)** _____ **days**

Date of Procedure (if Available): _____ **Expected Duration of procedure:** _____ **mins**

Admitting Officer: _____ **Signature:** _____ **Date:** ____/____/____

Admitting Consultant: _____ **Signature:** _____ **Date:** ____/____/____

ANESTHESIA CLINIC

PRE-OPERATIVE ASSESSMENT:

☐ Medically Fit and Ready for Surgery ☐ Needs further investigations ☐ Needs Referral

Plan: _____

_____

Anesthesiologist: _____ Signature: _____ Date: ____/____/____

Paid Treatment: Name: _____ Signature: _____
(Admitting Officer Team)

BED MANAGEMENT

Date of admission: ____/____/____ Time: _____ Department: _____

Ward/ Bed Number: _____ Name of Bed Manage. Officer: _____ Sign.: _____

OR COOR/ ADMISSION OFFICER

DONATION: ☐ Yes, Date____/____/____ ☐ No, (why) _____

Name of OR Coordinator / Admission Officer: _____ Signature: _____

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Name: _____ الاسم	MRN: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] رقم الملف الطبي

(Psychosocial history) (home environment, occupation of father anf mother, problems, family support system, etc.....)

(Labor) (spontaneous, induced, PROM, fetal distress, etc.....)

☐ ***Infant*** ☐ Apgar score: ☐ 1 min. ☐ 5 mins. ☐ 10 mins.

☐ Delivery: ☐ SVD ☐ C/S ☐ Forceps ☐ Vacuum

Resuscitation (initial steps, IPPV, intubation, cardiac massage, medications,, volume, surfactant)

Physical examination: Weight _____/_____ % Length _____/____ % HC _____/_____%

Ballard assessment: Dates: ___/___/___Exam _____

Temperature: _____ PR: _____ RR: _____ BP: _____

General: Color: _____ O^2 saturation: _____ Posture: _____

Skin:

Head, face dysmorphism:

Eye, red reflex:

ENT:

Neck:

Chest/ Lungs:

CVS:

Abdomen and genetalia:

CNS (TONE, POWER, DTR, etc.....)

Name: الاسم	MRN: رقم الملف الطبي
Musculoskeletal:	
Hips	
Assessment/Diagnosis	
Investigation	
Procudures: Intubation, umbilical line catheterization, ect....)	
Plan of care	
Patient care (lab, consults, ect...)	
Communication with family (reason for admission, medical or surgical management, education ect...)	
Name:	*Stamp&Signature:* *Date:____/____/____*
Comments: Specialist/consultant	
Name:	*Stamp&Signature:* *Date:____/____/____*

Appendices 7.2

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PHYSICIAN ADMISSION ASSESSMENT FORM

Date: ___/___/___ **Time:**.....

History Taken From: ☐ **Patient** ☐ **Family; Specify:**..... ☐ **Others; Specify:**.....

Present Complaint and Duration:

Allergies:

History Of Present Illness:

Review of Systems:

Endocrine:.....

Respiratory:.....

CVS:.....

GI:.....

GU:.....

Musculo Skeletal:.....

Neurology:.....

Others:.....

Past Medical History:.....

Past Surgical History:.....

Drug History and Current Medications:.....

Adverse drug Reaction:.....

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Name:_____ الاسم	MRN: رقم الملف الطبي:
Psychiatric History:	
Socio Economic History:	
Illicit drug abuse: ☐ No ☐ Yes Detail:_____	
Smoking: ☐ No ☐ Yes Detail:_____	
Alcohol: ☐ No ☐ Yes Detail:_____	
Educational Level:	
Language Barrier: ☐ Yes ☐ No	
Language Spoken: ☐ Arabic ☐ English ☐ Others_____	
Current and Past Occupation:	
Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced	
Family History:	
Obstetric and Gynecologic history:	
Physical Examination:_____ **Appearance:**_____	

Vital Signs:	☐ Temperature	☐ Pulse Rate	☐ Respiratory Rate	☐ BP	☐ O_2 Saturation	☐ Pain Score

Weight:_____ Height:_____ BMI:_____ Mobility:_____

Head and Neck:
Chest:
Cardiovascular:
Abdomen:
Neurological:
Musculoskeletal:
Investigation and Radiology:

Name: _____ الاسم:	MRN: ☐☐☐☐☐☐☐☐☐☐ رقم الملف الطبي:

Provisional Diagnosis:

1.

2.

3.

Plan of Care:

1.) Goals:

2.) Medication:

3.) Investigation:

4.) Consultation:

5.) Expected Length of Stay: _____ days

6.) Nutrition and Diet:

Education of patient and Family:

Discharge Planning:

Discharge Needs:

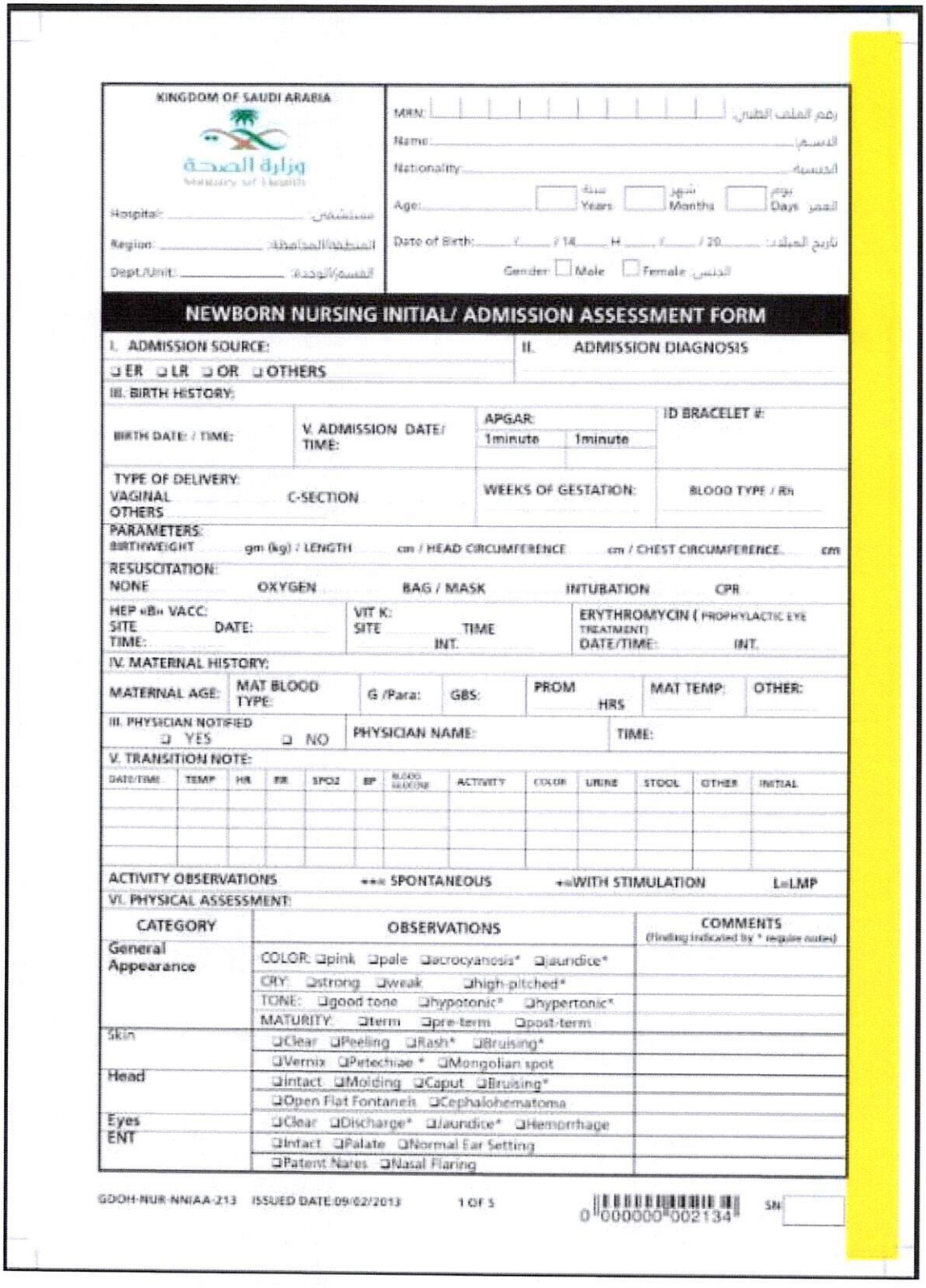
Physician Name: _____ **Stamp&Signature:** _____ **Date:** ___/___/___

Consultant Notes: :

Assistant Consultant: _____ **Stamp&Signature:** _____ **Date:** ___/___/___

Consultant Name: _____ **Stamp&Signature:** _____ **Date:** ___/___/___

Appendices 7.3



KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: مستشفى

Region: المنطقة/المحافظة

Dept./Unit: القسم/الوحدة

MRN: رقم الملف الطبي

Name: الاسم

Nationality: الجنسية

Age: سنة Years شهور Months يوم Days العمر

Date of Birth: / / 14 H / / 20 تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس

NEWBORN NURSING INITIAL/ ADMISSION ASSESSMENT FORM

I. ADMISSION SOURCE:
❑ ER ❑ LR ❑ OR ❑ OTHERS

II. ADMISSION DIAGNOSIS

III. BIRTH HISTORY:

BIRTH DATE / TIME:	V. ADMISSION DATE/ TIME:	APGAR: 1minute	1minute	ID BRACELET #:
TYPE OF DELIVERY: VAGINAL C-SECTION OTHERS		WEEKS OF GESTATION:		BLOOD TYPE / Rh

PARAMETERS:
BIRTHWEIGHT gm (kg) / LENGTH cm / HEAD CIRCUMFERENCE cm / CHEST CIRCUMFERENCE cm

RESUSCITATION:
NONE OXYGEN BAG / MASK INTUBATION CPR

HEP «B» VACC: SITE DATE: TIME:	VIT K: SITE TIME INT.	ERYTHROMYCIN (PROPHYLACTIC EYE TREATMENT) DATE/TIME: INT.

IV. MATERNAL HISTORY:

MATERNAL AGE:	MAT BLOOD TYPE:	G /Para:	GBS:	PROM HRS	MAT TEMP:	OTHER:

III. PHYSICIAN NOTIFIED ❑ YES ❑ NO	PHYSICIAN NAME:	TIME:

V. TRANSITION NOTE:

DATE/TIME	TEMP	HR	RR	SPO2	BP	BLOOD GLUCOSE	ACTIVITY	COLOR	URINE	STOOL	OTHER	INITIAL

ACTIVITY OBSERVATIONS ***= SPONTANEOUS +=WITH STIMULATION L=LMP

VI. PHYSICAL ASSESSMENT:

CATEGORY	OBSERVATIONS	COMMENTS (finding indicated by * require notes)
General Appearance	COLOR: ❑pink ❑pale ❑acrocyanosis* ❑jaundice*	
	CRY: ❑strong ❑weak ❑high-pitched*	
	TONE: ❑good tone ❑hypotonic* ❑hypertonic*	
	MATURITY: ❑term ❑pre-term ❑post-term	
Skin	❑Clear ❑Peeling ❑Rash* ❑Bruising*	
	❑Vernix ❑Petechiae * ❑Mongolian spot	
Head	❑Intact ❑Molding ❑Caput ❑Bruising*	
	❑Open Flat Fontanels ❑Cephalohematoma	
Eyes	❑Clear ❑Discharge* ❑Jaundice* ❑Hemorrhage	
ENT	❑Intact ❑Palate ❑Normal Ear Setting	
	❑Patent Nares ❑Nasal Flaring	

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Name: الاسم	MRN: رقم الملف الطبي

Thorax	❑Symmetrical ❑Clavicle (intact / fractured)	
Lungs	❑Clear ❑Equal Expansion Bilaterally ❑Retractions*	
	❑Grunting* ❑Coarse ❑Breath Sounds*Abd. ..... cms ❑Abdomen Soft / Distended*	
Heart	❑Regular Rate ❑Peripheral Pulses Bilaterally (Y/N)	
Abdomen	Abd. ..... cms Abdomen ❑Soft / Distended*	
	Umbilical cord ❑Bowel Sounds (present / diminished*/ absent*)	
Genitalia	❑Male ❑Female ❑Ambiguous*	
	Testes: L ..... R ..... Discharge*	
Anus	Patent ❑Meconium (present* / absent*)	
Trunk – Spine	Gluteal Folds (equal/unequal*) ❑Hip Click (R/L)	
Extremities	Symmetrical ❑Extra Digits* ❑Syndactyly	
Reflexes (noted)	Moro ❑ Grasp ❑Suck ❑Swallow	

VII. NUTRITIONAL ASSESSMENT:

FIRST FEED: ❑Breast Feed ❑Bottle Feed: Time ..... Type ..... Amount .....

VIII.PAIN ASSESSMENT: CRIES NEONATAL PAIN SCALE

- Any score above 4 indicates pain and infant should receive pain management intervention.

CATEGORY	PARAMETERS	SCORE	PATIENT'S SCORE
Crying	No	0	
	High Pitched (Consolable)	1	
	Inconsolable	2	
Requires O_2 for Sat greater than 95%	No	0	
	Less than 30%	1	
	greater than 30%	2	
Increased vital signs	HR, BP within 10% of Pre-Op value	0	
	11% to 20% greater than Pre-Op values	1	
	greater than 21% of Pre-Op values	2	
Expression	None	0	
	Grimace	1	
	Grimace/Grunt	2	
Sleeplessness	No	0	
	Wakes at frequent intervals	1	
	Constantly awake	2	
	TOTAL PATIENT'S PAIN SCORE		

SCORING: ❑0- 3 No pain ❑4- 6 Moderate pain ❑7- 10 Severe pain

Note: Grimace consists of lowered brow, eyes squeezed shut, deepening nasolabial furrow, and open eyelids.
Non-audible grunt - only heard with a stethoscope

IX."HUMPTY DUMPTY"FALL RISK ASSESSMENT: (Write & sum up the appropriate answer from "a" to 'g' to get the total)
SCORE: (If score is 12 or above at risk for falls) Minimum Score = 7 Maximum Score = 23

Parameters	Criteria	Score	Patient's Score
a) Age	Less than 3 years old	4	
	3 to less than 7 years old	3	
	7 to less than 13 years old	2	
	13 years and above	1	
b) Gender	Male	2	
	Female	1	
c) Diagnosis	Neurological Diagnosis	4	
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3	
	Psychological/Behavioral Disorders	2	
	Other Diagnosis	1	
d) Cognitive Impairments	Not aware of Limitation	3	
	Forgets Limitations	2	
	Oriented to own ability	1	

Name: الاسم	MRN: (رقم الملف الطبي)		
e)Environmental Factors	History of falls or Infant-Toddler placed in bed	4	
	Patient uses assistive devices or Infant-Toddler in crib or Furniture/Lighting (Tripled room)	3	
	Patient placed in bed	2	
	Outpatient Area	1	
f) Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3	
	Within 48 hours	2	
	More than 48 hours/None	1	
g) Medication Usage	Multiple usage of : Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotics	3	
	One of the medication listed above	2	
	Other medications/None	1	
	TOTAL PATIENT'S FALL RISK SCORE		

X. **SKIN RISK ASSESSMENT: NEONATAL / INFANT BRADEN Q SCALE (NIBQS)**
(Write number adjacent to descriptor; add for total score)

Parameters	Criteria	Score	Patient's Score
a) Gestational age	Less than 28 wks.	1	
	greater than 28- Less than 33 wks.	2	
	greater than 33- Less than 38 wks.	3	
	greater than 38wks.	4	
b) Mobility	Completely immobile	1	
	Very limited	2	
	Slightly limited	3	
	No limitation	4	
c) Activity	Bedfast	1	
	Very limited	2	
	Slightly limited	3	
	No limitation	4	
d) Sensory perception	Completely limited	1	
	Very limited	2	
	Slightly limited	3	
	No impairment	4	
e) Moisture	Constantly moist	1	
	Very moist	2	
	Occasionally moist	3	
	Rarely moist	4	
f) Friction/ Shear	Significant problem	1	
	Problem	2	
	Potential problem	3	
	No apparent problem	4	
g) Nutrition	Very poor	1	
	Inadequate	2	
	Adequate	3	
	Excellent	4	
h) Tissue perfusion & oxygenation	Extremely compromised	1	
	Compromised	2	
	Adequate	3	
	Excellent	4	
	TOTAL PATIENT 'S SKIN RISK SCORE		

Score: If Less than 20At risk for skin breakdown

Diaper Dermatitis risk:* (identification of one or more risk factors+ enteral feeding = dermatitis risk.)

❑Frequent stool ❑ Bowel surgery ❑ Short gut ❑Hyper-caloric feeding ❑PGEs ❑On Antibiotics ❑ Prolonged NPO status

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Name:_____ الاسم: | MRN: رقم الملف الطبي

Interventions: ❑Skin cleansing/protection ❑Gel pillow ❑Sheepskin ❑Scheduled turning ❑Tegaderm
❑Reduce friction /shear ❑Petroleum jelly ointment ❑Desitin ointment ❑Citric acid ointment ❑Other:
Comments:

XI.OTHERS: (oral and nasogastric tubes, dressing, restraint (splint), umbilical catheter)

XII.SAFETY:
❑Cardio-respiratory audible alarms at 70% volume ❑Oximeter alarm settings: Low High
❑Bag/mask/suction@ bedside: FiO2 ❑ IV fluids/rate verified ❑High risk medication infusion dose/rate verified
❑Bed appropriate for developmental level
❑Radiant warmer ❑Incubator; NTE ❑Bassinette ❑NICU Crib ❑Pedi Crib
❑I.D Band x 2 ❑I.D. band location:1 2 MR#

XIII. PSYCHOSOCIAL :
Patient / family express or demonstrate coping: ❑Yes ❑No
Family active in care: ❑Yes ❑No Detail:
Support needs identified:
❑Emotional support ❑Interpreter ❑Social worker ❑Chaplain ❑Lactation consultant

XIV. DISCHARGE PLANNING

SOCIOECONOMIC NEEDS:		
Lack of needed caregiver; family support	❑Yes	❑No
At risk of abuse or neglect	❑Yes	❑No
Inadequate resources: insurance, financial	❑Yes	❑ No
Foster parent, guardian etc.	❑Yes	❑No
PHYSICAL NEEDS:		
Metabolic Screening	❑Yes	❑No
ENVIRONMENTAL NEEDS:		
Change in living arrangements	❑Yes	❑No
In-home care or equipment	❑Yes	❑No
REFERRAL INDICATED:		
Referral sent to:		
Social Services	❑Yes	❑No
Home Care	❑Yes	❑No
Others	❑Yes	❑No
High risk indicated but no referral sent, why?	❑Yes	❑No

XIII. EDUCATIONAL / GENERAL NEEDS:

Repeated, unscheduled admissions	❑Yes	❑No
Newly diagnosed chronic/ terminal illness	❑Yes	❑No
Family education needed for in-home care	❑Yes	❑No
Immunization awareness	❑Yes	❑No

PHYSICAL DEFICITS

Cardiovascular	❑Yes	❑No
example		
Respiratory	❑Yes	❑No
example		
Neurological	❑Yes	❑No
example		
Sensory/Speech	❑Yes	❑No
example		
Gastrointestinal/Nutritional	❑Yes	❑No
example		
Genitourinary	❑Yes	❑No
example		
Musculoskeletal/Mobility	❑Yes	❑No
example		
Skin/Wound	❑Yes	❑No
example		
Cognitive/Mental	❑Yes	❑No
example		
Endocrine	❑Yes	❑No
example		
Language Barrier	❑Yes	❑No
example		
Other Concerns:		

RN NAME (Assessor) Signature Designation Job number Date & Time

Note: Please fill-up the data required completely and legibly. Put check ( ) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.

Name: الاسم	MRN: رقم الملف الطبي

XV. PROBLEM SUMMARY LIST
"ACTION : REFER TO MULTIDISCIPLINARY PLAN OF CARE FORM"

SERIAL NUMBER	ASSESSMENT / PATIENT NEEDS FINDINGS

RN NAME | Signature | Designation

Job number | Date (dd/mm/yy) | Time

NOTE: Please fill-up the data required completely and legibly. Put check (√) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.

Appendices 7.4

KINGDOM OF SAUDI ARABIA

Ministry of Health

Hospital: _____ مستشفى

Region: _____ المنطقة/المحافظة

Dept./Unit: _____ القسم/الوحدة

MRN: | | | | | | | | | | رقم الملف الطبي

Name: _____ الاسم

Nationality: _____ الجنسية

Age: _____ Years سنة ___ Months شهور ___ Days يوم العمر

Date of Birth: ___/___/14__ H ___/___/20___ تاريخ الميلاد

Gender: ☐ Male ☐ Female الجنس

MATURATIONAL ASSESSMENT OF GESTATIONAL AGE (New Ballard Score) FORM

Date/Time of Exam: _____ Age when Examined: _____

Birth weight: _____ Length : _____ Head circumference: _____

NEURO MUSCULAR MATURITY:

NEUROMUSCULAR MATURITY SIGN	SCORE -1	0	1	2	3	4	5	RECORD SCORE
POSTURE								
SQUARE WINDOW (wrist)								
ARM RECOIL								
POPLITEAL ANGLE								
SCARF SIGN								
HEEL TO EAR								
TOTAL NUROMUSCULAR MATURITY SCORE:								

SCORE:
Neuromuscular: _____
Physical: _____
TOTAL: _____

SCORE	weeks
-10	20
-5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

PHYSICAL MATURITY:

PHYSICAL MATURITY SIGN	SCORE -1	0	1	2	3	4	5	RECORD SCORE	GESTATIONAL AGE (weeks)
SKIN	Sticky friable transparent	Gelatinous red translucent	Smooth pink visible veins	Superficial peeling &/ or rash, few veins	Cracking pale areas veins	Parchment deep cracking no vessels	Leathery cracked wrinkled		By dates:
LANUGO	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald			
PLANTAR SURFACE	Heel-toe 40-50mm: -1 <40mm: -2	>50mm no	Faint red marks	Anterior transverse crease only	Creases anterior 2/3	Creases over entire sole			
BREAST	Imperceptible	Barely perceptible	Flat areola no bud	Stippled areola 1-2mm bud	Raised areola 3-4mm bud	Full areola 5-10mm bud			By ultrasound:
EYE/ EAR	Lids fused Loosely: -1 Tightly: -2	Lids open Pinna flat stays folded slight	Slight curved pinna; soft but ready recoil	Well- curved pinna; soft but ready recoil	Formed & firm	Thick cartilage ear stiff			
GENITALS (Male)	Scrotum flat, smooth	Scrotum empty faint rugae	Testes in upper canal rare rugae	Testes descending few rugae	Testes down good rugae	Testes pendulous deep rugae			By examination
GENITALS (Female)	Clitoris prominent & labia flat	Prominent clitoris & small labia minora	Prominent clitoris & enlarging minora	Majora & minora equally prominent	Majora large minora small	Majora cover clitoris & minora			
TOTAL PHYSICAL MATURITY SCORE									

PHYSICIAN NAME: _____ Stamp&Signature: _____ Date: ___/___/___

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