NHS No. 2 0 0 2 0 0 2 0 0 0

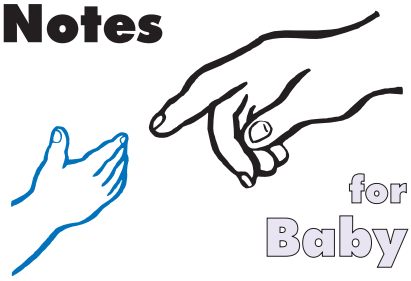
Maternity Unit A H O S P I T A L

CONFIDENTIAL

These notes should be kept safe by the mother during the postnatal period. If found, please return immediately to the owner or her midwife or maternity unit.

NHS

Postnatal Notes



Baby's name Ruby Sample

Sex Female

Address 75 Harbourne Road, Edgbaston,

Birmingham

Postcode B 1 5 3 B U

Unit No. A987654

Date of birth D D M M Y Y 1 4 0 1 1 6

Time of birth H H M M 1 1 3 8

Parents' names

Anna Sample | Peter Sample

Mother's unit/ NHS number A123456

Parents' address if different from baby

Parents' contact no. ☎ 01456 986475

Contacts If different to mother's

Named midwife		☎	
9am - 5pm contact ☎		24 hr contact ☎	
GP name		☎	
Health centre / surgery		☎	
Health Visitor/ Family Nurse Practitioner		☎	
Social worker/other multi-agency professional		☎	

First feed summary

Initial skin-to-skin contact Yes ☑ No ☐ Length of contact 1hr 20mins Reason ended mat.request

Type of first feed Breast ☑ Formula ☐ Person initiating feed baby Time feed initiated 12.05

Help offered with feed Yes ☑ No ☐ Date D D M M Y Y 1 4 0 1 1 6 Time H H M M 1 2 0 5

Duration of breastfeed / amount taken by bottle 20 mins Signature* A Midwife A MIDWIFE

Comments breast fed well

Second feed summary Breast ☑ Formula ☐ Date D D M M Y Y 1 4 0 1 1 6 Time H H M M 1 4 3 0

Comments breast fed well

Duration of breastfeed / amount taken by bottle 15 mins Signature* A Midwife A MIDWIFE

Baby care

	Discussed	Supervised	Comments	Signature*
Changing / top and tail / handling	☑	☐	Anna feels confident with all aspects	A Midwife
Bathing	☑	☐	of baby care	A Midwife
Cord care	☑	☐		A Midwife
Eye care	☑	☐		A Midwife

If you need help with any of the above aspects of baby care, please let your midwife know.

* **Signatures must be listed on page 20 for identification**

Baby alerts

Part of the assessment at each postnatal contact is to identify any additional needs your baby may have, e.g. physical, medical or developmental. In this way you can receive information about choices relating to your baby's general health and screening tests, enabling you to discuss healthy lifestyles for your baby and assess which additional services you might need to be offered.

The baby alerts below can be used by your midwife or other carers to help identify your baby's risk of developing problems in the postnatal period. The management of any problems or special features can then be documented by those health professionals on the management plan on page 3.

1	Prematurity: < 37 weeks gestation
2	Small birthweight for age: < 10th customised centile
3	Infection: spots, eyes, urinary
4	Mother with diabetes
5	Large birthweight for age: > 90th customised centile
6	Difficult delivery
7	Maternal temperature in labour : > 37.5° C
8	Rhesus incompatibility
9	Mother taking Warfarin or anticonvulsants
10	Prolonged rupture of membranes: > 24 hours
11	Mother positive for GBS** this pregnancy
12	Delayed feeding
13	Low temperature
14	Required resuscitation
15	Meconium present in labour/delivery
16	Previous baby with jaundice requiring phototherapy
17	Mother treated with beta blockers
18	Tachypnoea
19	Previous baby positive with GBS** infection
20	High temperature
21	Baby positive for GBS**
22	Feeding intolerance e.g. vomiting

< = less than; > = greater than ** Group B Haemolytic Streptococcus

☑ None identified at delivery

Key to risk

If an increased risk is identified for your baby from the prompts below, then you and your carers can be alerted to any symptoms as they develop. If your baby has one or more risk factors for any of these conditions, it does not necessarily mean that your baby is likely to develop a problem. They are prompts for your carers to initiate further investigations, treatment or referral, if necessary. Should you have concerns about any of these, contact your midwife.

Infection 1 2 3 6 7 8 10 11 15 18 19 20 21 22

Low blood sugar 1 2 3 4 5 12 13 14 17 20 22

Prolonged jaundice 1 2 3 6 8 12 16 21

Vitamin K deficiency bleeding 1 6 9

For more information on important symptoms, see pages 4 and 20.

First baby assessment

To be completed prior to: leaving a home birth, early transfer home or on admission to postnatal ward.

Date 14/01/16 Time 16:15 Temp not done Where seen del.suite Feeding method breast

Are there any concerns about the following:	No	Yes	Comments
A. Birth weight (g) 3.800g	☑	☐	
B. Activity, tone Movement, reflexes, behaviour, responsiveness	☑	☐	
C. Colour Pale, jaundiced	☑	☐	
D. Eyes Stickiness, redness, discharge, swelling	☑	☐	
E. Mouth Palate, tongue-tie, teeth	☑	☐	
F. Cord Bleeding, redness, swelling, irritation, odour, on/off	☑	☐	
G. Skin Spots, rashes, dryness	☑	☐	
H. Head Bruising, moulding, caput, fontanelles	☑	☐	
I. Urinary output Urates	☑	☐	
J. Stools Meconium, green, mucous	☑	☐	
K. Sleeping Position, bed sharing, smoking	☑	☐	
L. Security information Labels, security tags, staff identification	☑	☐	

Transitional care No ☑ Yes ☐

Management plan initiated (page 3) Yes ☑ **Key to risk reviewed above** Yes ☑

Signature* A Midwife A MIDWIFE

Date 14/01/16 Time 16:30

Vitamin K administered No ☐ Yes ☑ Dose 1mg Route I.M Batch number 123497860 Expiry date 01/12/17 Further dose required No ☑ Yes ☐

Name Ruby Sample
Unit No/ NHS No A 9 8 7 6 5 4

Feel free to ask your midwife or doctor – or look at NHS choices: **www.nhs.uk**

Special features

Type of birth	Gestation	Apgars	Birth weight	Customised Birth weight centile
vaginal	40 wks	9/1 9/5 9/10	3.800g	68.9

Key points requiring special postnatal follow-up (e.g congenital anomally, poor feeding)

Baby's blood group (if known)

Meconium stained liquor	☐
Observations initiated	☐
Additional information in mother's notes	☐
Safe sleep discussion/assessment carried out	✓
Medications	

Management plan

A management plan will outline a plan of care agreed between you and your care providers, including specialists. The aim is to keep your baby well, and to ensure that everyone involved in your baby's care is aware of individual circumstances. If any special issues have been identified from the alerts on page 2, which require further consideration they will be recorded below. This plan will be updated and amended to reflect your baby's changing needs.

Date / Time	Risk factor / Special features	Management plan	Referred to	Signed *
14 01 16	Low risk term	Breast fed baby. Observe first and		A Midwife
1235	baby	second feed.		AMIDWIFE
15.01.16	Term breast	Day 2 - breast feeding assessment carried		B Midwife
10.20am	fed baby	out. Full feed observed. Ruby alert on		B MIDWIFE
		handling. No issues or concerns today		
18.01.16	Term breast	Day 5 - breast feeding assessment carried		B Midwife
11.45am	fed baby	out. Feed observed. Ruby is correctly		B MIDWIFE
		positioned and latches on well.		
		No issues or concerns raised today.		

Investigations

eg neonatal screening test, SBR, urinalysis

Test	Explained	Accepted by mother	Date taken	Results/Actions/Comments Inc.reference number if applicable	Signed *
Newborn hearing screen	✓	✓	14 01 16		B BAKER
Blood spot test	✓	✓	18.01.16	11247596	B Midwife
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

Affix additional assessment sheets here, and number them 3.1, 3.2 etc

***Signatures must be listed on page 20 for identification**

Name Ruby Sample

Unit No/ NHS No A 9 8 7 6 5 4

General information

Information relating to baby alerts and key to risk (see page 2)

Prematurity (less than 37 weeks of pregnancy). If your baby was born early, there is an increased risk of conditions such as prolonged jaundice, infection, a low blood sugar and vitamin K deficiency bleeding. It all depends on how early your baby has been born and if admission to neonatal intensive care is required, you will be advised according to your individual circumstances.

Prolonged jaundice. This is when jaundice is still present after 2 weeks. Tests/investigations will be carried out which include testing your baby's blood and looking at their stools and urine. Your health care team will provide you with further information if your baby needs any treatment.

Infection. Some babies are at increased risk of developing infections in their eyes, umbilicus, urinary tract or on their skin, especially if the mother has:- an existing infection such as Group B haemolytic streptococcus, rupture of membranes (waters breaking) for more than 24 hours or had a raised temperature in labour. Symptoms of infections are what your health care team is looking for during the assessments of your baby. Signs of an infection are:- sticky eyes, redness around the umbilicus (cord), septic spots, high or low temperature, fast or slow breathing, poor feeding, grunting when breathing, floppy and not responsive, irritable. If you have any concerns regarding any of these signs and symptoms, contact your midwife or GP **immediately** for advice. Your baby may need treatment/medication.

Low blood sugar. A low blood sugar (hypoglycaemia) in a normally grown term baby (over 37 weeks gestation) is unusual. However, screening for hypoglycaemia may be indicated if he or she was born prematurely (less than 37 weeks gestation), is very small (growth restricted) or very large (macrosomic), has a low temperature, had a difficult delivery, you have diabetes or taken medication for high blood pressure during your pregnancy.

Vitamin K deficiency bleeding. We all need vitamin K to make our blood clot properly, so that we won't bleed too easily. Some babies have too little vitamin K. Although this condition is very rare, it can cause bleeding, which can become dangerous. This is called 'haemorrhagic disease of the newborn' or vitamin K deficiency bleeding (VKDB). To reduce the risk, your baby will be offered vitamin K after birth. It is recommended that the vitamin K is given by injection.

Baby checks

At each postnatal assessment, your midwife will check your baby's health and well-being. The following observations help to build up a complete picture of your baby and your midwife will discuss the findings with you. Please discuss any concerns you may have about your baby with your health care team.

Observations. Depending on your baby's needs, closer monitoring maybe carried out during the first 12-24 hours after birth. This may include observing your baby's breathing rate, temperature, colour, blood glucose levels and how your baby responds. Staff caring for you will explain the reason why this is being done.

Temperature. Your midwife will check how warm your baby feels to the touch, it is a good indication of how appropriate the temperature is around your baby. Your midwife can advise on the amount of clothing and bedding to use, whether in the house, car or pram. The recommended room temperature should be 16-20°C. If there are concerns about your baby's temperature your midwife will assess it using a thermometer.

Weight. Your midwife will weigh your baby at regular intervals and advise you about feeding according to your baby's weight gain. Your health visitor will give you information about local children centres/child health clinics where your baby will be weighed. They will continue assessing your baby's growth.

Tone (muscle tone - activity and reflexes). Your midwife will check to see that your baby can move both arms and legs. In the early days and weeks your baby will have some involuntary movements which are called reflexes. These include:- the root reflex which begins when the baby's cheek is stroked or touched. The baby will turn his/her head and open his/ her mouth to follow and "root" in the direction of the stroking. This helps the baby find the breast or bottle and begin feeding. Babies are born with the ability to suck and during the first few days they learn to coordinate their sucking and their breathing. The startle reflex occurs when a baby is startled by a loud sound or movement. The baby throws back its head, extends out the arms and legs, cries, then pulls the arms and legs back in. A baby's own cry can startle him/her and begin this reflex. They can also grasp things like your finger with either hands or feet and they will make stepping movements if they are held upright on a flat surface. All these responses, except sucking, will be lost within a few months and your baby will begin to make controlled movements instead.

Jaundice (yellow colour) is a common condition in newborn babies, more than half of all babies become slightly jaundiced for a few days. Babies develop a yellow colour to their skin and whites of the eyes (sclera); it is a normal process and does no harm in most cases. However, it is important to check your baby for any yellow colouring particularly during the first week of life. It will normally appear around the face and forehead first then spread to the body, arms and legs. From time to time gently press your baby's skin to see if you can see a yellow tinge developing. Check the whites of the eyes and when your baby cries have a look inside their mouth and see if the sides of the gums or roof of the mouth look yellow. Ask your midwife to show you how to check if you are not sure. If you think your baby is jaundiced contact your midwife for advice. If your baby is jaundiced, very sleepy with pale/ chalky stools or dark urine, a blood test can be taken to check the level of jaundice (bilirubin). If the level is high, treatment is recommended by using phototherapy. This is done in the hospital environment, under close supervision. Treatment may last for several days, with regular blood tests being carried out to check the level of bilirubin. You will be advised according to your individual circumstances.

Eyes. Your baby's eyes are observed for any signs of stickiness, redness or discharge. Special cleaning of your baby's eyes is not required unless your baby develops an infection. This can occur for no apparent reason and appears as a yellow discharge in one or both eyes. If this happens, your midwife may take a swab or arrange for your doctor to prescribe treatment. Your midwife will also show you how to clean the eyes properly. It is common for a newborn to have poor control of its eyes and appear cross-eyed at times but this should decrease as the eye muscles strengthen. The eyes usually look blue-grey or brown. In general, your baby's permanent eye colour will be apparent within six to 12 months.

Feel free to ask your midwife or doctor – or look at NHS choices: **www.nhs.uk**

Baby checks (continued)

Mouth. Soon after birth, the midwife will examine your baby's mouth to look for things such as tongue-tie, palate and teeth. Some babies are born with a tight piece of skin between the underside of their tongue and the floor of their mouth. This is known as tongue-tie. It can affect feeding by making it hard for your baby to attach to your breast. It can be treated; your midwife will give advice about treatment. The palate is the soft tissue and bony part of the roof of your baby's mouth. If it hasn't formed correctly it can also affect feeding. If a problem is identified, a referral to a paediatrician will be made to discuss treatment. Occasionally babies can be born with teeth. If your baby has been born with teeth, treatment will be discussed with you. At each subsequent baby check, the midwife will check your baby's mouth for thrush. Signs of thrush are redness, white spots or white coating that does not disappear between feeds. Thrush can be avoided by good hygiene. Always wash your hands before preparing bottles and after changing your baby's nappy. Wash bottles and teats thoroughly and sterilise before use. If your baby develops thrush, it may be necessary to treat with prescribed medicine from your GP (see page 16 for further information about cleaning and sterilising bottles).

Cord. After your baby is born the umbilical cord will be clamped and cut. The plastic clamp will stay on the stump of the cord until it drops off, (this usually takes 7-10 days). It usually does not require any special attention, other than careful washing and drying. It is very common for the stump to bleed slightly as it separates and your midwife will advise you how to care for this. Usually all that is required is to ensure the nappy does not rub on the area. If there is any heavy bleeding, discharge, redness or a bad smell around the cord stump you should contact your midwife or GP for advice.

Skin. Your baby's skin is very sensitive in the early weeks. Your midwife will check your baby's skin for any spots, rashes or dryness. After your baby is born it may have small amounts of vernix left in the skin folds, such as under the arms. This is the white creamy substance that protects it's skin inside your womb. It is not harmful to your baby and will disappear over the next few days, there is no need to try and remove it. Some babies have dry skin in the first few days after birth; this is common if your baby was born after their due date. It's best to bath your baby with plain water only for at least the first month. If you need to, you can also use some mild, non-perfumed soap. Avoid skin lotions, medicated wipes, or adding cleansers to your baby's bath water. After washing pat your baby's skin dry, pay special attention to skin creases. You may wish to rub some oil onto your baby's skin, ask your midwife for more information.

Urine and nappy rash. Your baby should have at least two wet nappies per day in the first two days, increasing to six or more per day by seven days. Urates are tiny orange/ pink crystals that look like brick dust that may appear in the nappy, but with regular feeding will disappear. The skin on a baby's bottom is sensitive and prolonged contact with urine or stools can cause burning or reddening of the skin. Nappies should be changed frequently, either before or after feeds to prevent this. If the skin does become sore it is better to use warm water and cotton wool rather than wipes or lotions.

Bowels (stools). The first stools are sticky, greenish-black and are called meconium. As the baby takes milk feeds, the stools become a mustard colour and sometimes have a seedy appearance. Breastfed babies will have soft, yellow stools that do not smell, while a bottle fed baby will have stools that are more formed, darker and smellier. All babies should pass at least two soft stools per day for the first six weeks regardless of feeding method. If you have any concerns, ask your midwife/health visitor or GP for advice.

Colic. A baby who cries excessively and inconsolably and either draws up his or her knees, or arches his or her back, especially in an evening, may have colic. You should tell your midwife so that an assessment can be made to rule out other causes. Your midwife will then advise you according to your individual circumstances.

The fontanelle. On the top of your baby's head near the front is a diamond shaped patch where the skull bones have not yet fused together. This is called the fontanelle. It will probably be a year or more before the bones close over it. You may notice it moving as your baby breathes. You need not worry about touching it as there is a tough layer of membrane under the skin.

Bumps and bruises. It is quite common for a newborn baby to have some swelling (caput) and bruises on the head, and perhaps to have bloodshot eyes. This is the result of the squeezing and pushing that is part of being born and will soon disappear. A cephalhaematoma is a bump, on one or both sides of the head. This is due to friction during the birth, which can last for weeks but will resolve naturally and usually no treatment is needed.

Breasts and genitals. Quite often a newborn baby's breasts are a little swollen and may ooze some milk, whether the baby is a boy or a girl. Girls also sometimes bleed slightly or have a cloudy discharge from their vagina. This is a result of hormones passing from the mother to the baby before birth and is no cause for concern. The genitals of male and female newborn babies often appear rather swollen but will look in proportion with their bodies in a few weeks.

Birthmarks and spots. Marks or spots that you notice mainly on the head and face of your baby usually fade away eventually. Most common are the little pink or red marks some people call 'stork marks'. These 'v' shaped marks on the forehead, upper eyelids and nape of baby's neck gradually fade, though it may be some months before they disappear. Strawberry marks are also very common. They are dark red and slightly raised, appearing a few days after the birth, sometimes getting bigger. These too will disappear eventually.

Early development. Newborn babies can use all their senses. From birth your baby will focus on and follow your face when you are close in front of them. They will enjoy gentle touch and the sound of a soothing voice and will react to bright light and be startled by sudden, loud noises. By two weeks of age babies begin to recognise their parents and by 4 to 6 weeks start to smile. Interacting with your baby through talking to, smiling and singing to them, are all ways of helping your baby feel loved and secure.

Excessive crying. All babies cry but some babies cry a lot. Crying is your baby's way of telling you they need comfort and care. This can be very stressful and there may be times when you feel unable to cope. This happens to lots of parents and is nothing to be ashamed of. Ask your family and friends to help and discuss this with your midwife, health visitor or GP. There is an organisation called CRY-SIS who can put you in touch with other parents who have been in the same situation. You can get further information via **www.cry-sis.org.uk** helpline number 08451 228 669. If your baby is crying and the cry doesn't sound like their normal cry and they can't be comforted it could be a sign that they are ill. If you think there is something wrong, always follow your instinct. See page 20 of this booklet - Important Symptoms section.

Date/ Time	Notes	Signed*
14/01/16 14:30	Remaining on delivery suite as mum is requesting early transfer home. Mum and baby cared for by delivery midwife. Ruby is awake and ready for second feed. Feed observed, Ruby sucking and signs of swallowing observed. Discussed with Anna "nose to nipple" technique. Support groups contact details and off to the best start leaflet given. Nappy changed by Anna, Ruby has passed urine and meconium. Physical examination of the newborn performed (as per Trust guidance) no abnormalities detected. Child health record issued and examination documented . Discussed car safety - parents have their own car seat and aware of the importance of securing the car seat correctly in their car. .	A Midwife AMIDWIFE
16.15	Anna and Ruby transferred home.	
15.01.16 10.20am	Home visit. Ruby is latching on and feeding well, settled between feeds. Safe sleeping discussed and assessment carried out.	

Assessment of baby well-being Day No. 2 Where seen home Labels checked no Method of feeding breast

Are there any concerns about the following:	No	Yes
Feeding	✓	
Weight Gain, static, loss N/W g	✓	
Activity, tone Movement, reflexes, behaviour, responsiveness	✓	
Colour Pale	✓	
Eyes Stickiness, discharge, redness, sclera colour	✓	
Mouth Colour, palate, tongue-tie, thrush	✓	
Cord On/off, bleeding, redness, swelling, smelly	✓	
Skin Spots, rashes, dryness, bruising fading/improving	✓	
Jaundice Not improving, fading, resolved	✓	
Urinary output - colour, urates no. of wet nappies per day 4-5	✓	
Stools - colour, consistency no. of dirty nappies per day 2 changing stool	✓	
Sleeping Safe sleeping discussed, position, bed sharing, smoking	✓	

Additional support required: No
Specific to individual, including referrals to social care, sure start, infant feeding specialist

Key to risk reviewed ✓ Yes

Management plan reviewed/revised ✓ Yes

Signature* B Midwife
Date/Time 15.01.16 10.25am

	Ruby alert on handling. No concerns today. Next visit planned at postnatal clinic on 18.01.16	B Midwife BMIDWIFE

Name Ruby Sample
Unit No/ NHS No A 9 8 7 6 5 4

* Signatures must be listed on page 20 for identification

Date/ Time	Notes	Signed*
180116 1145		

Assessment of baby well-being Day No. 5 | Where seen PN clinic | Labels checked no | Method of feeding breast

Are there any concerns about the following:	No	Yes
Feeding	✓	
Weight Gain, static, loss 3,750 g	✓	
Activity, tone Movement, reflexes, behaviour, responsiveness	✓	
Colour Pale	✓	
Eyes Stickiness, discharge, redness, sclera colour	✓	
Mouth Colour, palate, tongue-tie, thrush	✓	
Cord On/off, bleeding, redness, swelling, smelly	✓	
Skin Spots, rashes, dryness, bruising fading/improving	✓	
Jaundice Not improving, fading, resolved	✓	
Urinary output - colour, urates no. of wet nappies per day 6 heavy nappies	✓	
Stools - colour, consistency no. of dirty nappies per day 3 yellow soft	✓	
Sleeping Safe sleeping discussed, position, bed sharing, smoking	✓	

Additional support required: No
Specific to individual, including referrals to social care, sure start, infant feeding specialist

Key to risk reviewed ✓ Yes

Management plan reviewed/revised ✓ Yes

Signature* B Midwife
Date/Time 18.01.16 11.50am

Ruby reviewed in the postnatal clinic. Breastfeeding assessment carried out. No concerns with feeding. Ruby weighed today 50 grams weight loss - parents reassured as acceptable weight loss. Plan is to re weigh Ruby at the visit on day 10. Breastfeeding going well on demand, feeds lasting approximately 30 minutes each feed. Cord clamp in situ, cord clean and dry. Next visit scheduled for 23.01.16 Anna aware of how to contact the community midwifery team or postnatal ward if any concerns.

B Midwife
BMIDWIFE

*Signatures must be listed on page 20 for identification

Name Ruby Sample
Unit No/ NHS No A98 765 4

Date/ Time	Notes	Signed*
23/01/16 14:45	Ruby reviewed at home. Breast feeding 3-4 hourly and settled and calm between feeds.	

Assessment of baby well-being Day No. 10 Where seen home Labels checked no Method of feeding breast

Are there any concerns about the following:	No	Yes
Feeding	✓	
Weight Gain, static, loss 3.850 g	✓	
Activity, tone Movement, reflexes, behaviour, responsiveness	✓	
Colour Pale	✓	
Eyes Stickiness, discharge, redness, sclera colour	✓	
Mouth Colour, palate, tongue-tie, thrush	✓	
Cord On/off, bleeding, redness, swelling, smelly	✓	
Skin Spots, rashes, dryness, bruising fading/improving	✓	
Jaundice Not improving, fading, resolved	✓	
Urinary output - colour, urates no. of wet nappies per day 6-8 heavy nappies	✓	
Stools - colour, consistency no. of dirty nappies per day 3-4 yellow soft	✓	
Sleeping Safe sleeping discussed, position, bed sharing, smoking	✓	

Additional support required: no
Specific to individual, including referrals to social care, sure start, infant feeding specialist

Key to risk reviewed ✓ Yes

Management plan reviewed/revised ✓ Yes

Signature* B Midwife
Date/Time 23.01.16 14.45hrs

Cord off. Ruby re weighed gained 100 grams. Discharged from community midwifery care today. Postnatal notes taken from home today - ready to be filed in hospital. Contact numbers given to Anna and Peter today. Health visitor visit is planned for 26.01.16

B Midwife
B MIDWIFE

Name Ruby Sample
Unit No/ NHS No A 9 8 7 6 5 4

* Signatures must be listed on page 20 for identification

Date/ Time	Notes	Signed*
DD MM YY HH MM		

*Signatures must be listed on page 20 for identification

Name

Unit No/ NHS No

Date/ Time	Notes	Signed*
D D M M Y Y		
H H M M		

Affix additional assessment sheets here and number them 10.1, 10.2 etc

Name

Unit No/ NHS No

*Signatures must be listed on page 20 for identification

Parents' page This page is for you to write any questions or concerns that you wish to discuss with your midwife.

Name

Unit No/
NHS No

General baby care

Responsive feeding. Your baby will let you know when he/she wants to feed by becoming restless, sucking his/her fingers or making mouthing movements. Offering a feed before he/she begins to get upset and cry will make feeding easier for you both. If you are breastfeeding you can also offer baby your breast when they just want a cuddle, if you need to fit in a quick feed or if you simply wanted to sit down and have a rest. If you choose to bottle feed your baby will enjoy being held close and being fed by you and your partner rather than by lots of different people.

Skin-to-skin contact. Spending some time quietly holding him or her in skin-to-skin contact (baby naked against your bare chest) straight after the birth is very important because:- it helps to calm your baby, keeps him or her warm, steadies your baby's breathing and gives you time to bond. It also helps to get breastfeeding off to a good start. Provided you are both well, you will be able to hold your baby straight away. A blanket over both of you will help keep your baby warm. If you have had a caesarean delivery, or have been separated from your baby for a while after the birth, you will both still benefit from skin-to-skin contact as soon as you are able. If you choose to bottle feed it is lovely for you and your baby that he/she has his/her first feed given by you whilst in skin contact.

Later skin contact. Skin contact at any time will help calm and settle your baby. It can also encourage your baby to feed and help you and your partner feel close to your baby.

Keeping baby close to you. New babies have a strong desire to be close to their parents as this will help them to feel secure and loved. When babies feel secure they release a hormone called oxytocin which helps their brain to grow and develop. In hospital, providing you and your baby are well, your baby will stay in a cot next to your bed at all times so that you can get to know each other and you can respond to his/her needs for feeding and comfort. When you go home, your baby will benefit from being close by you during the day and at night. Being in the same room as you will also help protect against cot death (see page 20 for information about reducing the risk of cot death).

Safer sleep for your baby. Babies need a lot of sleep during the first few months of their lives, so it is important to make sure that your baby is sleeping as safely as possible. He/she should be placed in a separate cot, on his or her back with their feet against the foot of the cot. This is to ensure that your baby's head does not become covered by bedding, leading to overheating. This is commonly referred to as the 'feet to foot' position. The cot should be kept in the same room as you for the first 6 months of your baby's life. This means you can hear your baby and respond to his/her needs before he/she starts crying or becomes distressed. You can also reach him/her easily without having to get up. Ensure that the mattress in the cot is firm, flat, clean and in good condition.

Many breastfeeding mothers choose to feed their baby lying down in bed – please ask your midwife or health visitor to discuss safe positions for feeding. Never take your baby into bed if you or your partner are smokers, have recently drunk alcohol, taken drugs which may cause drowsiness (legal or illegal), if your baby was born prematurely or is a low birth weight. Do not put yourself in a position where you might fall asleep with your baby on a sofa or armchair as this is particularly dangerous. Avoid smoking in the house or taking your baby into smoky places. Babies exposed to cigarette smoke before and after birth are at an increased risk of cot death. It is important to not let you baby get too hot. An ideal room temperature is between 16-20°C. There is no need for your baby to wear a hat when indoors. For further information about safer sleeping advice and reducing the risk of cot death see page 20 of this booklet or visit www.lullabytrust.org.uk

Some research suggests that it is possible that using a dummy when putting a baby down to sleep might reduce the risk of cot death. If you choose to use a dummy, make sure it is part of your baby's regular sleep routine. Discuss with your midwife/health visitor if you need any further advice about using a dummy.

Ways to wake a sleepy baby. If you feel worried about how long your baby has slept you can gently wake your baby by picking him/her up and talking to him/her, changing his/her nappy, rubbing his/her hands and feet, stroking his/her back or undressing him/her and holding him/her in skin to skin contact.

Soothing and settling a crying baby. All babies cry at some time as a means of communicating with you, and will generally settle when they are picked up and cuddled. If your baby becomes very distressed this can be upsetting for you and your partner. Here are some things you can try that may help: -

- Hold your baby in skin contact
- Offer a feed
- Gently rock or sway whilst holding baby
- Speak or sing in a quiet soothing manner
- Play calming music
- Try using a sling
- Take baby out for a walk

Ask your midwife or health visitor for help if you feel the crying is making you feel anxious or agitated. If your baby is crying for long periods he/she may be ill and require a medical check.

Taking your baby out safely. Your baby is ready to go out as soon as you feel fit enough to go out yourself. Walking is good for both of you. It may be easiest to take your baby in a sling facing you. If you use a buggy, make sure your baby can lie flat on his or her back. A parent-facing buggy is best so that baby can see you and feel secure.

In a car. It is illegal for anyone to hold a baby while sitting in the back or front seat of a car. The recommended way for your baby to travel in a car is in a properly secured, backward-facing, baby seat in the back of the car. Ideally a second adult should travel in the back of the car with the baby. If you have a car with air bags fitted in the front, your baby should not travel in the front seat (even facing backwards) because of the danger of suffocation if the bag inflates. Avoid travelling for long periods of time and take regular breaks to give you a chance to take the baby out of their car seat. If your baby changes position and slumps forward, stop the car as soon as safe to do so and take the baby out of the car seat. Ask your midwife or health visitor for further information.

In cold weather. Make sure your baby is wrapped up warm in cold weather because babies chill very easily. Take the extra clothing off when you get into a warm place, including the car, so that your baby does not overheat, even if he or she is asleep.

In hot weather. Babies and children are particularly vulnerable to the effects of the sun, as their skin is thinner and they may not be able to produce enough pigment called melanin to protect them from sunburn. The amount of sun your child is exposed to may increase his or her risk of skin cancer in later life. Keep babies under six months old out of the sun altogether, by making the most of the shade such as trees or using a sunshade attached to the pram, and dressing them in loose baggy clothing. Let your child wear a floppy hat with a wide brim or a 'legionnaire's hat' that shades the face and neck. During summer, cover exposed parts of skin with a sunscreen, even on cloudy or overcast days. Use one with a sun protection factor (SPF) 50 or above and which is effective against UVA and UVB. Re-apply often.

Safety in the home. Children most at risk of a home accident are in the 0-4 age group. Speak to your health visitor for information on practical issues such as fitting smoke detectors and how to keep your baby safe generally. More information on preventing accidents relating to: choking, suffocation, burns and scalds, poisons and emergency first aid is available via www.rospa.com. A safe sleeping discussion/assessment will be carried out by your midwife and health visitor to ensure that where your baby sleeps is a safe environment. Never leave your baby alone with dogs/pets. Infant behaviour e.g crying can irritate your dog/pet. Discuss with your midwife/health visitor if you need any further information. For further information visit www.rspca.org.uk/safeandhappy

Breastfeeding ?

The value of breastfeeding
Breastfeeding provides everything your baby needs to grow and develop. Your milk is perfect and uniquely made for your growing baby's needs. Giving your milk to your baby makes a big difference to both you and your baby's health now and in the future.

Babies who are not breastfed have an increased chance of:

- Diarrhoea and vomiting
- Chest, ear and urine infections
- Allergies such as asthma and eczema
- Diabetes and other illnesses later in life
- Obesity

Breastfeeding helps mothers too:

- Reduced risk of breast and ovarian cancer
- Stronger bones for later life
- Faster weight loss after birth
- Saves money and time

If your baby was born prematurely, breastmilk is the ideal means of providing nutrients to help your baby grow whilst protecting him/her against potentially serious infections.

Protecting your baby on a daily basis
A mother will use her own immune system to protect herself from infections and viruses within her immediate environment. When breastfeeding she transfers this immunity into the milk she gives to her baby, thereby protecting him/her on a continuous basis.

Getting breastfeeding off to a good start
Holding your baby in skin to skin contact after birth and allowing him/her to spend time licking and nuzzling at your breast will help your baby instinctively 'learn' how to breastfeed. Your midwife will help you hold your baby in a way that will make it easier for him/her to feed effectively. This is important for both you and your baby as it will prevent you getting sore and will make sure your baby gets enough milk to help him/her grow. The more feeds your baby has, the more milk you will make. In the early days your baby may feed very often, particularly in the evening time. Although this can be challenging for you, it is normal for babies to do this as it sets up your milk supply for the future.

Responsive breastfeeding
Because breastfeeding is about much more than just providing food for your baby, the term 'responsive feeding' is used to describe how you can feed your baby in response to early cues (sucking fingers, mouthing or general restlessness), to comfort him/her if he/she seems lonely or upset, or if either of you just wants a cuddle and to spend some time together. Try to think about breastfeeding as an opportunity for you to take time out and rest. You can't overfeed or spoil a breastfed baby.

Expressing your milk
Your midwife will show you how to express your milk by hand. Although you may never need to do this, it is useful to know how as it can help you to soften your breasts if they become full, or if you get any red lumpy areas (a sign that one of your milk ducts may have become blocked). The milk can be expressed into a sterile bottle, covered securely and kept in the back of the fridge (never in the door), at 4 degrees or lower up to 5 days. You can freeze breast milk for 2 weeks in the freezer compartment of the fridge or for up to 6 months in a freezer. Defrost frozen milk in a fridge, once thawed use straight away. Never refreeze. If your baby prefers, you can warm the milk up to body temperature before feeding. Never heat the milk in the microwave as it can cause hot spots which can burn your baby's mouth.

Information about expression and storage of breastmilk please see **'Off to the best start'** leaflet.

Winding and posseting
Babies who are breastfed do not usually need to be winded. Sometimes babies will bring up a mouthful of milk during or just after a feed. This is called posseting and is not unusual. If you are concerned that your baby is vomiting an excessive amount please contact your midwife or doctor.

Weaning.
Exclusive breastfeeding is recommended for the first 6 months of an infant's life, as it provides all the nutrients a baby needs. Six months is the recommended age for introducing solids. When weaning your baby, carry on breastfeeding beyond the first six months.

How you and your midwife can recognise that your baby is feeding well						*This assessment tool was developed for use on or around day 5. If used at other times:
What to look for/ask about	√	√	√	√		**Wet nappies:** Day 1-2 = 1-2 or more Day 3-4 = 3-4 or more, heavier Day 6 plus = 6 or more , heavy
Your baby: has at least 8 -12 feeds in 24 hours*	✓	✓				
is generally calm and relaxed when feeding and content after most feeds	✓	✓				
will take deep rhythmic sucks and you will hear swallowing*	✓	✓				**Stools/dirty nappies:** Day 1-2 = 1 or more, meconium Day 3-4 = 2 (preferably more) changing stools
will generally feed for between 5 and 40 minutes and will come off the breast spontaneously	✓	✓				
has a normal skin colour and is alert and waking for feeds	✓	✓				
has not lost more than 10% weight	✓	✓				
Your baby's nappies: At least 5-6 heavy, wet nappies in 24 hours*	✓	✓				**Sucking pattern:** Swallows may be less audible until milk comes in day 3-4 Feed frequency: Day 1 at least 3-4 feeds After day 1 young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to your baby's need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure happy baby.
At least 2 dirty nappies in 24 hours, at least £2 coin size, yellow and runny and usually more*	✓	✓				
Your breasts:						
Breasts and nipples are comfortable	✓	✓				
Nipples are the same shape at the end of the feed as the start	✓	✓				
How using a dummy/nipple shields/infant formula can impact on breastfeeding?	✓	✓				
Date *15.01.16 18.01.16*						**Care plan commenced: Yes/No:**
Midwife's initials *BMidwife BMIDWIFE*						
Midwife: if any responses not ticked: watch a full breastfeed, develop a care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.						

General principles of breastfeeding

- Hold your baby in skin to skin contact
- Feed your baby as soon as possible after the birth
- Give only breastmilk
- Keep your baby close so you can pick up on early cues
- Breastfeed responsively
- Seek help if breastfeeding is painful
- Allow your baby to come off the breast by himself/herself and always offer your other breast although your baby may not always take this
- Avoid introducing a teat or dummy while your baby is learning to breastfeed
- Consider joining a local breastfeeding support group

Helping your baby to breastfeed

Holding your baby to feed (positioning)

- Cuddle your baby as much as possible in skin contact
- Keep your baby calm by talking and stroking him/her gently
- Hold your baby with head and body in a straight line so that he/she isn't twisted
- Look out for feeding cues
- Position your baby's nose to your nipple
- Encourage your baby to open his/her mouth by gently stroking your nipple above his/her top lip
- Make sure your baby's head is free so that he/she can tilt his/her head back as he/she takes your breast into his/her mouth
- His/her bottom lip should make contact with your breast about 2.5cm away from the nipple
- Express a little milk to tempt your baby

Close – baby has easy access to your breast
Head free – he/she can tilt his/her head back as he/she takes your breast
In line- he/she isn't twisted which would make feeding difficult
Nose to nipple – as he/she tilts his/her head your nipple will go to the back of his/her mouth

You will know your baby is 'attached' when

- It doesn't hurt although the first few sucks may feel strong or uncomfortable
- His/her chin will be firmly touching your breast
- His/her cheeks stay rounded during sucking
- If you can see dark skin around your nipple you should see more above your baby's top lip
- Your baby will take long sucks and swallows with the occasional pause

Breastfeeding mothers offered support to:

Leaflets given and discussed ☑

- Appreciate importance of closeness and responsiveness for mother/baby wellbeing
- Recognise early feeding cues
- Position and attach their baby for feeding
- Understand responsive feeding
- Hand express breastmilk
- Value exclusive breastfeeding
- Understand how to know their baby is getting enough breastmilk
- Access help with feeding when at home
- Understand the importance of healthy eating and Vitamin D supplements (Healthy Start Vitamins)

	Signature:	date: D D M M Y Y	comments:
1	B Midwife BMIDWIFE	1 5 0 1 1 6	Experienced mum, breast fed 1st baby positioning and attachment correct
2	B Midwife BMIDWIFE	1 8 0 1 1 6	Discussed exclusive breast feeding. Ruby settled between feeds
3	B Midwife BMIDWIFE	2 3 0 1 1 6	Hand expressing breast milk demonstrated Sorage of breast milk discussed

Breastfeeding assessments

These should be carried out using the breastfeeding assessment form (minimum of two in first ten days) and an appropriate plan of care made. Update management plan on page 3.

	Signature:	date: D D M M Y Y	comments:
1	B Midwife BMIDWIFE	1 5 0 1 1 6	Breasts comfortable. Baby calm during and after feeds. Feeds lasting 15-20mins
2	B Midwife BMIDWIFE	2 3 0 1 1 6	Ruby weighed - 50g loss. Full feed observed Ruby alert on handling 10-12 feeds in 24hrs
3	BMidwife BMIDWIFE	2 3 0 1 1 6	second breast offered at most feeds

Feel free to ask your midwife or doctor – or look at NHS choices: **www.nhs.uk**

Name Ruby Sample
Unit No/ NHS No A 9 8 7 6 5 4

Formula-feeding your baby

First stage milk is suitable for the first 12 months of your baby's life. If you are considering changing formula milk, please discuss this with your midwife or health visitor who can give you advice. When using formula milk to feed your baby, it is important that you prepare it in the safest way possible. Tins and packets of milk powder are not sterile even when sealed and can contain harmful bacteria, which, if the feed is prepared incorrectly can cause infections that can be life threatening.

Cleaning and sterilizing - this applies if you are breast or formula feeding.

- Wash your hands and work surfaces.
- Clean all feeding equipment in hot soapy water then rinse under running water before sterilizing. Remove all traces of milk.
- For cold water sterilizing units, follow the manufacturers instructions. Change the sterilizing solution every 24 hours. Completely immerse the bottles and teats in the solution, ensuring no air is trapped in them. Keep all the equipment under the solution by using the floating cover. It will take at least 30 minutes to sterilize the equipment.
- For steam sterilizers follow the manufacturer's instructions. Ensure the openings of the bottles and teats are facing down in the unit. Any equipment not used immediately should be re-sterilized before use.

Making up feeds - Always make up bottles fresh at each feed. Never store milk in the fridge for later.

- Use fresh tap water to fill the kettle.
- After it has boiled, let it cool for no more than 30 minutes. The optimal temperature to prepare the feed is 70 degrees centigrade. Do not use artificially softened water, or kettle water that has been repeatedly boiled. If you have to use bottled water (if you are on holiday), it will still have to be boiled.
- Shake off any excess water from the bottle and stand on a clean surface. Always pour the cooling boiled water first. Check the bottle is filled to the required level.
- Follow the formula manufacturer's instructions. Loosely fill the scoop with milk powder and level it off with the flat side of a clean knife or leveller.
- Never add extra scoops, sugar or cereals to the bottle as this can make your baby ill or choke.
- Carefully attach the teat, retaining ring and cap on the bottle and shake till all the powder is dissolved.
- Make sure the feed is not too hot; 70 degrees centigrade can still cause scalds. You may need to cool the bottle in cool water before giving it to your baby. Always test a small amount on the inside of your wrist to check it is cool enough to give to your baby.

Feeding your baby

- Sit comfortably and cuddle your baby close looking into his/her eyes.
- Tilt bottle slightly so milk reaches the end of the teat.
- Invite your baby to take the teat by gently rubbing it against his/her top lip.
- When your baby opens his/her mouth and pokes his/her tongue out - place the teat in his/her mouth and your baby will draw it in.
- Allow your baby to pace the feed by removing the teat at various times to give him/her a break.
- Never force your baby to take a full feed and throw away any unused milk left in the bottle.
- Limit the number of people who feed your baby to you and your partner, particularly in the early weeks, as this will help him/her feel safe and secure.

Bottle feeding checklist

Your midwife will complete this checklist to ensure you are given all the information needed to bottle-feed successfully.

Checklist	Yes	No	Date	Signature*
Recognise early feeding cues	☐	☐	D D M M Y Y	
Understand responsive bottle feeding and pacing the feeds	☐	☐	D D M M Y Y	
Understand how to sterilise equipment	☐	☐	D D M M Y Y	
Make up feeds safely	☐	☐	D D M M Y Y	
Choose a first formula for the first year	☐	☐	D D M M Y Y	
Appreciate the importance of closeness and responsiveness for mother/baby wellbeing	☐	☐	D D M M Y Y	
Know how to access support when you are are home	☐	☐	D D M M Y Y	
Leaflets given and discussed	☐	☐	D D M M Y Y	

Comments

Name

Unit No/ NHS No

*** Signatures must be listed on page 20 for identification**

Information about Health Professionals

Those who will take care of your baby in the postnatal period

Midwife: Your midwifery team are usually the main care providers throughout the early postnatal period. They will ensure that your care is tailored to meet your individual needs and will work in partnership with you and your family to ensure you can make informed decisions about your baby's care. Visits are arranged at home or at clinics in the local community. Care is provided by the midwifery team for a minimum of 10 days or up to 28 days following the birth. The frequency and location of visits will be decided between you and your midwife. 24-hour support is available from the midwifery service, please refer to the telephone numbers listed in this booklet. Your midwife also works in partnership with other health professionals and can refer your baby to the appropriate specialist if required.

Health visitor: These are qualified midwives/nurses who have done additional training in family and child health, health promotion and public health development work. They work as part of a team alongside your GP and other community nurses as well as midwives. Your health visitor will visit you at home after you have had your baby, and further contacts can then take place either at home, local health centre / surgery or at the local children's centre. They will ask how you are feeling and how your family is adjusting to your new baby. They will also ask if you have any questions or concerns you may have about your health or your baby's health.

Family doctor/General Practitioner (GP): Family doctors are responsible for general medical care and you will need to register your baby as soon as possible after the birth. Your doctor will follow your baby's development closely through regular assessments in partnership with the midwife and health visitor.

Specialists: Some babies with medical problems from birth may need to be followed up by a neonatologist/paediatrician. This will depend on what problem has been identified.

Child health clinics: Child health clinics are usually based in your local health centre or GP surgery and provide information and advice on all aspects of health and baby care. Your health visitor will give you all the information about where and when these clinics are held.

Child health records: The Personal Child Health Record (PCHR) or 'Red Book' will be given to you, ideally at birth. This is the main record of your child's health, growth and development and needs to be kept in a safe place.

Registering the birth

The baby's birth must be registered within 42 days from the date of birth. Your midwife will give you all the details you need to do this. If you are married, you or the father can register the birth. If you are not married you must go yourself, and if you would like the father's name to appear on the birth certificate he must go with you. You cannot claim benefits or register your baby with a doctor until you have a birth certificate and a National Health Service number, which is usually allocated at birth. For further information visit www.gov.uk

Screening

For further information visit - www.screening.nhs.uk

Physical examination of the newborn. Your midwife will complete an initial examination of your baby immediately after the birth. The first detailed examination will take place within 72 hours by a health care professional looking after you and your baby. The examination includes eyes, heart, hips and in baby boys checking if their testes are in the right place. The results will be given to you straight away. The second detailed examination will be done by your GP or health visitor when your baby is 6 to 8 weeks old. If any problems are identified during either of these examinations or at any time in between, your baby will be referred to the appropriate specialist baby doctor, such as a paediatrician or neonatologist. The checking of your baby's health and well-being is a continual process. Each time your baby is seen by your midwife, a detailed review of growth and development is carried out. If any problems are identified, a referral can be arranged. Please discuss any of the screening tests with you midwife if you have any questions or concerns.

Newborn hearing screen. A small number of babies (1-2 in every 1000) are born with permanent hearing loss. A quick screening test can be done, usually before you leave the hospital. This can identify those babies with hearing loss, so that support and information can be given to you at an early stage. In some areas, the newborn hearing screen may be done at home or at a health clinic in the first few weeks of life.

Blood spot test. All babies are offered a simple blood test to find out if they may be affected by the following serious health conditions: - sickle cell disease, cystic fibrosis, congenital hypothyroidism, PKU, MCADD, MSUD, IVA, GA1, HCU. Babies with these conditions can be given early treatment to prevent serious problems. These disorders would not be recognised in a newborn baby, even after careful examination by a doctor. Your midwife will take a small sample of blood from your baby's heel onto a card usually on the 5th postnatal day. This is then sent to a laboratory for testing. This may be uncomfortable and your baby may cry. You can help by making sure your baby is warm and comfortable. Sometimes it may be necessary to do a second blood spot test, but if this is done the reason will be discussed with you. This does not necessarily mean there is something wrong with your baby. **Getting the results -** you should receive the results by letter or from your health care professional by the time your baby is 6-8 weeks old. The results should be recorded in your baby's Child Health Record "Red Book". If you have been tested during your pregnancy, please let your midwife know so that your results can then be matched up with your baby's results. **A positive result -** the majority of results are negative. However, if your baby has one of these conditions, arrangements will be made for you to see an experienced specialist team.

Early immunisations BCG (Bacillus Calmette-Guerin). This is a vaccine offered to all babies who may be at higher than average risk from contact with TB (tuberculosis). These include babies whose families come from countries with a high incidence of TB such as Asia, Africa, South and Central America and Eastern Europe or babies born in a town or city where there is a high rate of TB. It is also offered to babies who have a relative or close contact with TB, have a family history of TB in the past 5 years or who plan to travel to a high risk country to stay for more than three months. TB is a potentially serious infection which usually affects the lungs, but can also affect other parts of the body. Treatment is with antibiotics. The BCG vaccination is usually given to the baby early in the postnatal period.

Hepatitis B. Some people carry the hepatitis B virus in their blood without having the disease itself. If a pregnant mother has hepatitis B, carries it in her blood, or catches it during pregnancy, she can pass it onto her baby. Babies born to infected mothers are at risk of getting this infection and should receive a course of vaccine. The first immunisation will be offered to your baby soon after birth and then at one, two and 12 months old and a booster before your child goes to school. Please ask your health care team if you require more information about early immunisations

PKU - Phenylketonuria, MCADD - Medium-chain Acyl - CoA Dehydrogenase Deficiency, MSUD - Maple Syrup Urine Disease
HCU- Homocystinuria (Pyridoxine Unresponsive), IVA- Isovaleric Acidaemia, GA1- Glutatic Aciduria type 1

Feel free to ask your midwife or doctor – or look at NHS choices: **www.nhs.uk**

Birth details & newborn examination

* Please place a sticker (if available) otherwise write in space provided.

Surname:

First names:

NHS number: Unit no:

Address: Sex: M / F

Post code: D.O.B:. ...../...../.....

G.P: Code:

H.V: Code:

Place of birth:

Length of pregnancy in weeks:

Type of delivery:

Mother's NHS Number:

Apgars: (1 min) (5 min)

Problems in pregnancy, birth or neonatal period:

Admitted to Neonatal Intensive Care Unit?

No ☐ Yes, for days

Significant family history:

Examination and purpose of screening explained: ☐ Accepted by parent: Yes ☐ No ☐ NSC leaflet given ☐

Newborn examination Age:.....(hours) Date:...../...../..... Time:.....

Performed by: **Signature:**

Observation – general	**Satis**	**Observe**	**Details: Comments**
Colour Pale, blue, jaundice, pigment			
Posture and behaviour Tone, responsiveness			
Respiratory Distress, cry			
Skin Mongolian blue spots, birthmarks, dry, abrasions, bruises			
Auscultation/Oximetry			
Pulse Oximetry			
*Heart Observation, heart sounds, murmur			
Lungs Breath sounds			
Abdomen Bowel sounds			

***enter final outcome page 6**

Top copy: remain in PCHR 2nd copy by midwife to postnatal notes

Continued on next page

Newborn examination continued (Affix baby label on reverse of 2nd copy if available)

Name: **DOB:** ...../...../..... **NHS number:**

Palpation and observation	**Satis**	**Observe**	**Details: Comments**
Head and skull: Features, hair, moulding, fontanelles, sutures, caput, cephalhaematoma, trauma			Head circumference enter on page 6
Face Appearance, haemangiomas, asymmetry			
Ears Dimples, position, appearance			
*Eyes: red reflex Right and left			
Eyes Appearance, squint, conjunctivitis, discharge, haemorrhage			
Mouth and palate Palate, teeth			
Neck and clavicles Clavicle fracture, mobility, sternomastoid			
Chest Shape, nipples			
Abdomen Liver, spleen, masses, tone			
Umbilicus Smell, discharge, hernia			
Upper limbs, hands Length, digits, palmar creases, syn/poly-dactyly, tone, movement, oedema			
Lower limbs, feet Length, digits, syn/poly-dactyly, tone, movement, talipes, oedema			
*Genitalia Hypo/epi-spadias, testes, hydrocoele			
Anus Position, patency			
Femoral pulses Both palpable			
Back and spine Dimples, hair tufts, naevus, abnormal skin patches			
Breech, leg problems, family history of dislocated hips			(Negative = satis) If yes do hip ultrasound
*Hips: Ortolani and Barlow			Do either
*Hips: Ultrasound if done			or both
Reflexes Grasp, Moro, rooting, stepping			
Bowels opened day 1			
Urine passed			

***enter final outcome page 6**

Signature of examiner:

Top copy: remain in PCHR 2nd copy: by midwife to postnatal notes

Baby discharge summary by midwife

***** Please place a sticker (if available) otherwise write in space provided.

Surname:
First names:
NHS number: Unit no:
Address: Sex: M / F
Post code: D.O.B:. ...../...../.....
G.P: Code:
H.V: Code:

Summary of examination on discharge

Item	Condition suspected	Referred
Hips	Yes ☐ No ☐ If yes: Left ☐ Right ☐	Yes ☐ No ☐
Eyes:	Yes ☐ No ☐ If yes: Left ☐ Right ☐	Yes ☐ No ☐
Heart:	Yes ☐ No ☐ Oximetry done: Yes ☐ No ☐	Yes ☐ No ☐
Testes/gen:	Yes ☐ No ☐ If yes: Left ☐ Right ☐	Yes ☐ No ☐
Rest of examination:	Yes ☐ No ☐	Yes ☐ No ☐

Birthweight: .....kg Head circ.:.....cm Date:...../...../..... First milk feed: breast ☐ formula ☐

Newborn Bloodspot Screening Programme: Consent given: YES ☐ NO ☐ Comment:.....

Date blood taken: ...../...../..... (results and further details page 61) Card Serial No:

BCG indicated: Yes / No If *YES* please enter details on BCG page 44

Hep B indicated: Yes / No If *YES* please enter details on separate Hep B page

Vitamin K given: Date:...../...../..... Route: ..... Further doses needed? YES ☐ NO ☐

If YES:

Dose No.	Date due	Date given
2	...../...../.....	...../...../.....
3	...../...../.....	...../...../.....
4	...../...../.....	...../...../.....

Follow-up required: No ☐ Yes ☐: GP ☐ Community Paediatrician ☐ Hospital ☐ Other: .....

Location/Clinic: ..... Date: .....

Reason: .....

Top copy: remain in PCHR 2nd copy: Child Health department /HV 3rd copy: Hospital record 4th copy: GP

Baby discharge summary by midwife 6

Newborn hearing screening programme

***** Please place a sticker (if available) otherwise write in space provided.

Surname:
First names:
NHS number: Unit no:
Address: Sex: M / F
Post code: D.O.B: ...../...../.....
G.P: Code:
H.V: Code:

NHS
Screening Programmes
Newborn Hearing

Name of NHSP Screening Programme/Site:
.....

Inpatient ☐ Outpatient ☐ Home ☐
NICU (AOAE + AABR) Protocol ☐
Well Baby Protocol ☐

Consent: Given ☐ Declined ☐ Reason .....

		1st AOAE	2nd AOAE	AABR
		Date: ...../...../.....	Date: ...../...../.....	Date: ...../...../.....
Right Ear:	Clear response:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Not Tested: Reason:	.....	.....	.....
Left Ear:	Clear response:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Not Tested: Reason:	.....	.....	.....

Further Management:

Discharge to routine child health surveillance ☐ For further screen: AOAE / AABR ☐ Refer to audiology ☐

Later follow-up at 8 months (corrected) ☐ State reason: Declined Screen ☐ Risk factor ☐ **give details below:**

Risk factor details (if family history, state exact relative): .....

Name: ..... Signature: ..... screener/nurse/HV*

* delete as applicable

Top copy: remain in PCHR 2nd copy: Child Health department /HV 3rd copy: Hospital record 4th copy: GP

Newborn hearing screening programme 7

Checklist for transfer of care to community midwife

To be completed by midwife prior to baby leaving hospital after the birth or following a home birth

Professionals informed — Community midwife ✓ — Health visitor ✓ — GP ✓ — Other ☐

	Yes	No		Yes	No
Discharge address checked	✓	☐	Registering the birth leaflet given	✓	☐
Prescription for vitamin K -if required	☐	✓	Registering the birth with GP explained	✓	☐
BCG vaccine given	☐	✓	Newborn hearing screen completed or arranged	✓	☐
Method of feeding	breast		Physical examination of the newborn completed or arranged	✓	☐
Important symptoms discussed	✓	☐	NNST blood spot test completed or arranged	☐	✓
Travel safety explained	✓	☐	Personal Child Health Record book issued	✓	☐
Cot death - leaflet given	✓	☐	Role of Health Visitor explained	✓	☐

Date D D M M Y Y: 1 4 0 1 1 6 — Time H H M M: 1 6 4 5 — Signature*: A Midwife A MIDWIFE

Important symptoms

Baby's illnesses can become serious very quickly. You know your baby best; do not wait too long if you are worried. Ask for help sooner rather than later. The following symptom checklist can help you decide whether you need to seek medical attention for your baby by contacting your midwife or doctor. Contact numbers are on page 1 of mother's notes.

- High pitched or weak cry
- Much less responsive or floppy, difficult to wake
- Pale all over
- Grunts with each breath
- Breathing faster than normal
- Not interested in feeding
- Passes much less urine
- Has a bulging fontanelle (the soft part at the top of a baby 's head)
- Is dehydrated
- High temperature or sweating
- Has blood in stools

Urgent medical attention can be obtained by dialling 999 if your baby:

- Has a fit or convulsion
- Vomits green fluid
- Has a rash that does not fade when you press it
- Stops breathing or goes blue
- Is unresponsive and shows no awareness of what is going on
- Has glazed eyes and does not focus on anything
- Cannot be woken

Reducing the risk of cot death

- Place your baby to sleep in a separate cot or moses basket in the same room with you for the first six months, even during the day.
- Use a firm, flat, waterproof mattress in good condition.
- Always place your baby on their back to sleep.
- Don't cover your baby's head or face while sleeping and place him or her in the 'feet to foot' position (see page 12 of this booklet).
- Keep your baby out of smoky areas. Don't let people smoke near your baby and keep your home, car and other places where your baby spends time, smoke free.
- Do not let your baby get too hot or too cold. The room temperature should be between 16 and 20°C.
- Do not share a bed with your baby if you or your partner smoke, drink alcohol/take drugs or are very tired.
- Do not fall asleep lying on a sofa or armchair with your baby.
- Breastfeeding your baby reduces the risk of cot death.
- Immunisation reduces the risk of cot death.

If your baby is unwell, seek prompt medical advice.

Signatures

Anyone writing in these notes should record their name and signature here

Abbreviations: CMW = Community Midwife; MW = Midwife; StM = Student Midwife; HV = Health Visitor; Ph = Phlebotomist; PS = Peer Supporter NN = Nursery Nurse; GP = General Practitioner; Con = Consultant; ST = Specialist Trainee; Reg = Registrar; FY = Foundation Year Doctor; IFC = Infant Feeding Co-ordinator, MSW = Maternity Support Worker

Name (print clearly)	Post	Signature
Amy Midwife	Midwife band 6	A MIDWIFE
Brenda Midwife	Midwife band 7	B MIDWIFE
Beryl Baker	hearing screening coordinator	B BAKER

Name (print clearly)	Post	Signature

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