

[Newborn Care Manual: Contents](#)

WRITING GOOD CLINICAL NOTES

Good clinical notes, which form the patient record, should be accurate, brief and easy to read. In addition, they must be systematic. Therefore, they should be written in an orderly, logical way so that all staff members can understand them.

20-A THE DATE AND TIME.

Whenever notes are written it is important to give the date and the time that the record is made. It is then possible to know when the observation was made or care was given.

20-B ALWAYS SIGN YOUR NOTES.

Every time you write clinical notes you should sign (and write) your name. The rest of the health team then knows who wrote the notes.

20-C THE "SOAP" METHOD OF WRITING NOTES.

When an infant is examined for the first time the clinical notes should include:

1. The STORY (i.e. the history).
2. The OBSERVATIONS (i.e. the physical examination and investigations).
3. The ASSESSMENT.
4. The PLAN.

In order to remember these important steps in writing clinical notes, remember the word "SOAP". The letters in SOAP stand for Story-Observations-Assessment-Plan.

20-D THE STORY.

Good notes should always start with the history (i.e. the history of the pregnancy, labour, delivery and events after delivery). A history should always be taken before examining an infant.

20-E THE OBSERVATIONS.

The observations include the findings of the physical examination and the results of any additional investigations done, e.g. packed cell volume or chest X-ray.

20-F THE ASSESSMENT.

Once you have recorded the results of the history, the physical examination and the investigations, you must make an assessment of the infant's condition. For example, you should ask yourself:

1. Is the infant sick or well?
2. Is the infant at high risk or low risk for clinical problems?
3. What clinical problems does the infant have at present?

The assessment must not be forgotten as a carefully recorded history and examination are of little value if you are unable to assess what the results mean. The management depends on an accurate assessment of the infant's problems. If you cannot identify the problems you will not be able to plan the correct treatment. Assessing an infant's problems correctly takes a lot of practice.

20-G THE PROBLEM LIST.

When the assessment is made, it is very helpful to compile a problem list. Each clinical problem that you identify from the story and observations must be listed separately. A typical problem list looks like this:

1. Unmarried, teenage mother.
2. Preterm delivery.
3. Jaundice.

You now have a good idea of the clinical problems that require management.

Read the following case history and draw up your own problem list:

After a normal vaginal delivery at 40 weeks, an infant has Apgar scores of 3 and 8 and requires mask ventilation. The birth weight is 2300 g. The infant is not put to the breast after delivery and at 45 minutes after birth the blood glucose concentration, measured with a reagent strip, is 1,5 mmol/l. While starting an intravenous infusion, the infant's skin temperature falls to 34,5°C.

You should be able to identify at least 4 problems. Each will have to be managed.

20-H THE MANAGEMENT.

Finally the management of the infant must be planned. The management consists of the nursing care, the observations needed, the medical treatment, and the management of the parents.

20-I AN EXAMPLE OF GOOD "SOAP" NOTES.

14-1-2005. 10:30.

S: 18 year old primip. Booked. Spontaneous preterm labour. 35 weeks by dates and palpation. No signs of fetal distress. NVD 06:15. Apgar scores 4 and 9. Intubation and ventilation needed for 3 minutes. Thereafter infant moved to nursery.

O: Male infant. Weight 2000 g.
 Assessed gestational age 36 weeks.
 Active. No congenital abnormalities.
 Skin temperature 36°C.
 RS -Respiratory distress with recession and a respiratory rate of 65 breaths per minute. Infant needs 50% head box oxygen to remain pink.
 CVS -Heart rate 150/min. Well perfused.
 GIT -Abdomen normal.
 CNS -Appears normal. Fontanelle flat.
 Blood glucose 3,0 mmol/l. PCV 60%.

A:

1. Preterm delivery.
2. Neonatal asphyxia.
3. Respiratory distress.

P:

1. Incubator.
2. Neonatalyte IVI at 4 dpm.
3. Nasogastric tube. Nil per mouth.
4. Routine observations.
5. Head box oxygen.
6. Speak to parents.
7. Arrange transfer to level 2 hospital.

Signed: Sr. Mowtana

These brief notes give all the important information in a simple and systematic manner. Try to write your notes using the SOAP method.

20-J AN EXAMPLE OF POOR NOTES.

No antenatal care. Antepartum haemorrhage.
 Normal delivery. 2000 g. Female, term infant.
 Good Apgar scores. Vitamin K given.
 Temp. 36°C. Infant looks pale. Blood glucose normal.
 No respiratory distress. Heart rate 200/min.
 Abdomen normal. Sucks poorly.
 Keep nil per mouth. Neonatalyte infusion started at 5 dpm.
 Hb. 10 g/dl. Blood taken for cross match.
 Nurse in incubator.

Although most of the information is given, these notes are not systematic and, therefore, they are difficult to understand. Notice how the history, examination and investigations are mixed up in a disorganised way. There is no problem list so that the reader is not sure what problems have been identified. There is also no date or signature. Try to rewrite these notes using the SOAP method. Do not forget to draw up a problem list.

20-K PROBLEM ORIENTATED PATIENT RECORD.

When writing follow up notes, the SOAP system can be applied to each problem in turn. This method is known as the problem orientated patient record. It is very useful in a nursery where infants may need ongoing care for days or weeks. Each day the problem list of the previous day is examined. You must decide which problems remain unresolved and, therefore, must be carried over to the next day. Resolved problems can be dropped from the list. After reviewing the record for the past 24 hours and examining the infant, any new problems are added to the previous list.

For example, on day 2, the infant described in 20-I is doing well. The respiratory distress has improved slightly but the infant has developed a mild conjunctivitis. The problem list for day 2 should, therefore, be:

1. Preterm infant.
2. Respiratory distress.
3. Conjunctivitis.

The problem of neonatal asphyxia has been removed from the problem list, as it has resolved and no longer has any effect on the infant, while the new problem of conjunctivitis has been added to the list.

Again the SOAP system can be used, but now it is applied to each problem in the problem list. For example:

15/1/05 09:00

1. Preterm infant.

S: No problems during the night. Passed meconium. No apnoea.
 O: Active. Abdomen normal. Not pale. Blood glucose and temperature normal.
 A: No change.
 P: 1. Keep in incubator.
 2. Start 2 x 12 feeds of expressed breast milk.
 3. Continue Neonatalyte at 4 dpm.

2. Respiratory distress.

S: Oxygen requirements came down slightly during the night.
 O: Mild recession. Respiratory rate 55/min. Chest clear with good air entry. Pink with normal oxygen saturation in 40% head box oxygen. Blood gases normal.
 A: Improving. Diagnosis probably hyaline membrane disease.
 P: 1. Continue head box oxygen.
 2. Repeat blood gas analysis at lunch time.

3. Conjunctivitis.

- S: Eyes became sticky during the night. Swabbed with saline.
 O: Mild purulent discharge from both eyes. Eyelids not swollen.
 A: Probably Gonococcal conjunctivitis.
 P: 1. Pus swab for laboratory.
 2. Clean eyes every 2 hours.
 3. Chloromycetin eye drops 2 hourly.
 4. Ceftriaxone 100 mg IMI.

Signed: Dr. A.Smith.

This example shows how simple, short, problem orientated notes can give a very clear record of the patient's progress. This is far better than pages and pages of jumbled notes. Each day, after the infant has been carefully examined and the observations chart read, the problem list should be drawn up and the SOAP method used to write notes under each problem.

20-L A COMMON PATIENT RECORD.

It is far more efficient if both the medical and nursing staff use the same patient notes. In all clinics and hospitals the records should be shared. All members of the health team should learn how to keep systematic patient records.

20-M ABBREVIATIONS.

To save time and space, abbreviations are often used in the patient record. A list of the commonly used abbreviations in your nursery should be drawn up and displayed in the nursery. Below is a list of some of the commonly used abbreviations in the notes of newborn infants:

AFIS	Amniotic fluid infection syndrome, i.e. chorioamnionitis
AGA	Appropriate weight for gestational age
CNS	Central nervous system
CPAP	Continuous positive airways pressure
CVS	Cardiovascular system
EBM	Expressed breast milk
FAS	Fetal alcohol syndrome
GIT	Gastro-intestinal tract
Hb	Haemoglobin
HC	Head circumference
HMD	Hyaline membrane disease.
IDM	Infant of a diabetic mother
IMI	Intramuscular injection
IV	Intravenous
LBW	Low birth weight
NEC	Necrotizing enterocolitis
PCV	Packed cell volume
PDA	Patent ductus arteriosus
RDS	Respiratory distress syndrome
RS	Respiratory system
TSB	Total serum bilirubin
UGA	Underweight for gestational age

RECORDING ROUTINE OBSERVATIONS

20-N THE OBSERVATION CHART.

Routine observations made on sick infants by nurses or doctors must be recorded on a special chart. The usual observations are:

1. Heart (pulse) rate.
2. Respiratory rate.
3. Skin or axillary temperature.
4. Incubator temperature (if the infant is in an incubator).
5. Percentage oxygen given (FiO₂).
6. Pattern of respiration (recession, grunting, shallow or irregular).
7. Colour.
8. Apnoea.
9. Blood glucose concentration.

20-0 USING AN OBSERVATION CHART.

The names of the different observations are listed along the top of the chart at the head of separate columns. Each time an observation is made, the date and time must be recorded as well as the observer's name. The result of the observation is then recorded in the correct column. A column is also available for comments to be written. It is very important that the person recording the observation knows whether the result is normal or abnormal. Some people prefer to write abnormal results in red. The record on the observation chart is started when observations on a sick infant begin. Usually a new page is started each day, most commonly in the morning when the day staff take over duty from the night staff.

Different observation charts are used in different hospitals. However, they all use the same principle for recording clinical observations.

Figure 20-A. An example of a chart used for the routine observations of sick infants.

Newborn Observation Chart																									
Name:	Hospital No.														Weight:				Date:						
	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00	1:00	2:00	3:00	4:00	5:00	6:00	
Respiratory rate																									
Grunting																									
Recession																									
Apnoea																									
Heart rate																									
Temp: infant																									
incubator																									
Colour																									
Oxygen %																									
Oxygen saturation																									
Blood glucose																									
Remarks:																									

RECORDING FLUID INTAKE AND OUTPUT

The total amount of fluid given to a sick infant (the intake) and lost by a sick infant (the output) should be carefully recorded on an intake and output chart so that the fluid balance can be calculated each day.

20-P RECORDING FLUID INTAKE.

The fluid may be given by mouth, nasogastric or orogastric tube, or by intravenous infusion. The type, volume and time of each oral or tube feed must be noted on the chart by the nurse who has given the feed. The type of intravenous fluid given, together with the time it was started, the time it was completed and the volume received, must also be carefully recorded.

The daily volume of each type of fluid intake is recorded separately and then added together to give the total intake for the 24 hour period.

It is essential that clear instructions are given each day for both milk and intravenous fluids. The type of oral or tube feed to be given, together with the volume and frequency of feeds, must be clearly written on the intake chart. In addition, the type of intravenous fluid and the drip rate must also be stated.

20-Q RECORDING FLUID OUTPUT.

Fluid may be lost in the urine, stool, vomitus or may be aspiration from a nasogastric or orogastric tube. Less commonly, fluid may be lost via a drain from the chest or other site. Some forms of fluid loss, such as in the stools and from the lungs and skin, cannot be measured easily and therefore are not routinely recorded. If necessary, they can be measured or calculated. Even very small volumes of fluid loss may be important in a small infant.

Urine has to be collected in a urine bag, aspirated via a catheter and measured with a plastic syringe if an accurate record of urine output is to be kept. This is often difficult, especially in a female infant, as the urine tends to leak out of the bag. In addition, removing a urine bag may damage the infant's skin. Therefore, an accurate record of the volume of urine passed is only kept when there is a clinical indication, e.g. possible dehydration or renal failure. Most infants pass about 2 ml/kg/hour. Oliguria in a newborn infant is defined as a urine output of less than 1 ml/kg/hour.

In many small infants, only a record of the frequency of wet nappies is kept. Most infants have about 8-10 wet nappies a day.

The number of vomits, and whether they are large or small, must be carefully recorded. If the stomach is aspirated before feeds, an accurate record of the volume of fluid aspirated should also be kept.

The number and appearance of stools passed is recorded. Loose stools may contain a lot of fluid and, therefore, must be recorded carefully.

Each type of fluid loss is recorded separately and then added up at the end of the 24 hour period to give the total measured output. The difference between the intake and the output over 24 hours is called the daily fluid balance.

Figure 20-B. An example of an intake and output chart.

DOCTOR'S ORDERS INSTRUCTIONS INTRAVENOUS INTAKE		DROPS PER MINUTE	SIGNATURE		INSTRUCTIONS ORAL/TUBE FEEDING	
1.						
2.						
3.						
4.						
5.						
6.						

TPN ORDERS					TIME	ORAL INTAKE OR FEED TYPE	VOLUME PUT UP GIVEN		POSITION CHECKED	FLUSHED	TIME	GASTRIC ASPIRATE	VOMITUS	URINE VOL S.G.		OTHER DRAINAGE	B.A.	SIGN.
					07H00						07H00							
					08H00						08H00							
					09H00						09H00							
NURSES RECORD INTRAVENOUS INTAKE					10H00						10H00							
					11H00						11H00							
TYPE OF FLUID	TIME PUT UP	TIME COMPLETED	VOLUME GIVEN	SIGN.	12H00						12H00							
					13H00						13H00							
					14H00						14H00							
					15H00						15H00							
					16H00						16H00							
					17H00						17H00							
					18H00						18H00							
					19H00						19H00							
					20H00						20H00							
					21H00						21H00							
					22H00						22H00							
NURSES RECORD T.P.N. INTAKE					23H00						23H00							
					00H00						00H00							
					01H00						01H00							
					02H00						02H00							
					03H00						03H00							
					04H00						04H00							
					05H00						05H00							
					06H00						06H00							
TOTAL INTRAVENOUS (I.V.)					TOTAL PER	MOUTH TUBE				TOTALS								