HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Neonatal Intensive Care Unit (NICU)		
Document:	Departmental Procedure and Procedure		
Title:	Neonatal Care Admission and Discharge Criteria		
Applies To:	All NICU Staff		
Preparation Date:	January 05, 2025	**Index No:**	NICU-DPP-001
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Effective Date:	February 19, 2025	**Replacement No.:**	NICU-DPP-001 (1)
Review Date:	February 19, 2028	**No. of Pages:**	20

1. PURPOSE:

1.1 To provide a unified consistent format that will be followed for admission and discharge to neonatal intensive care unit.

1.2 To ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her heath care needs and to facilitate the achievement of optimal outcomes.

2. INTRODUCTION:

2.1 The guideline set out the standards required of the hospital to ensure that a high standard of neonatal care at all levels continues to be provided in its Neonatal Intensive Care Unit (NICU).

2.2 Neonates are specialized cohort of patients requiring an individualized approach in nursing care.

2.3 Goals of care include minimizing stress, conserving energy, enhancing recovery, promotion of growth and wellbeing and protecting sleep pattern.

2.4 All healthy inborn more than 35 weeks of gestation and appropriate for gestational age should be rooming in with their mothers.

2.5 For neonates who required a lengthy birth hospitalization, shortening the duration of neonatal hospitalization as much as possible is beneficial because it decrease the risk of hospital acquired neonatal morbidity, shortens the period of separation of the parents from the infant and lower medical costs.

2.6 **Well Baby Unit** – the unit for accommodating otherwise healthy babies with no medical problem staying in the hospital because of Maternal (Post C/S for short period according to mother condition, Mother in the ICU, etc.) or social reason.

3. ADMISSION CRITERIA & LEVELS OF NEONATAL CARE

Level	Capabilities	Admission Criteria	Health Care Provider Type
I	➢ Provide neonatal resuscitation at every delivery. ➢ Evaluate and provide postnatal care to stable term infants ➢ Stabilize and provide care for infants born 35-37 weeks GA who remain physiologically stable	➢ Infant with mild respiratory distress does not required oxy gen supplementation can be watched for 1-2 hours as per a Senior Doctor's Order ➢ Requiring support with feeding ➢ Minor anomalies that may need further investigations but don't compromise the	➢ Paediatrician, family physicians, Nurse Practitioners, and other advance practice registered nurses.

Level	Capabilities	Admission Criteria	Health Care Provider Type
I	➢ Stabilize newborn infants who are ill and those born at < 35 wks. Gestation until transfer to a higher level of care.	infant's health in the neonatal period such as unilateral hydronephrosis, feature of Down Syndrome ➢ Large of Gestational Age (LGA) with birth weight >4kg ➢ Infant of Diabetic Mother (IDM) to monitor blood sugar as per hypoglycemia algorithm ➢ Term ≥ 37 weeks with PROM > 18 hours who is asymptomatic and without history of chorioamnionitis	
II	Level I capabilities plus: ➢ Provide care for infants born ≥ 1500g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. ➢ Provide care for infants convalescing after intensive care ➢ Provide Mechanical ventilation for brief duration (<24h) or continuous positive airway pressure or both. ➢ Stabilize infants born before 32 weeks gestation and weighing < 1500 grams as per standard of care.	➢ Infants born ≥ 32 and less than 35 wks. GA and weighing ≥ 1.5kg and less than 2 kg with problems that are expected to resolve rapidly ➢ Continuous Positive Airway Pressure (CPAP), either transitional or extended stable CPAP ➢ Mechanical ventilation for conditions expected to resolve within 24 hours. ➢ Growing preemie who is stable and who requiring oxygen during the feeding. ➢ Stable neonatal from level III with a corrected over 30 weeks, and over 1.2 kg and does not requiring invasive ventilation, ➢ subspecialty support, surgical support, advanced treatments and investigations (transfer should be reviewed on a case-by-case basis between the tertiary and receiving sites) ➢ Temperature Instability ➢ Transient tachypnea of new-born ➢ Transient problems requiring cardiorespiratory monitoring/ Laboratory investigation	Level I health care providers plus: ➢ Pediatric specialist who has an experiences in Neonatology

Level	Capabilities	Admission Criteria	Health Care Provider Type
	Continuation:	➢ Jaundice new-borns requiring cardiorespiratory monitoring /laboratory investigation. ➢ Jaundice new-borns requiring peripheral IV fluids therapy and closer monitoring and intensive Phototherapy. ➢ Septic work and administration of Antibiotics ➢ Gastrointestinal Problems; A. Such as feeding problems severe enough to cause clinical concern. B. Hypoglycemia CNS Problems Convulsion, Mild Birth Asphyxia ➢ **Malformations** Congenital anomalies that may require intervention unavailable on level I, or an initial period of observation, e.g. Pierre Robin Syndrome Family History of inborn errors of Metabolism	
	Level II Capabilities Plus: ➢ Provide sustained life support ➢ Provide comprehensive care for infants born < 32 weeks of gestation and weighing < 1500g and born at all GA and birth weights with critical illness ➢ Provide prompt and readily available access to full range of pediatric medical subspecialists, and pediatric ophthalmologist	➢ Meconium aspiration syndrome requiring mechanical ventilation. ➢ Persistent pulmonary hypertension of the newborn ➢ Air leaks syndrome require intervention ➢ Moderate and severe Hypoxic Ischemic Encephalopathy for cooling therapy ➢ Surgical conditions such as omphalocele, meningomyelocele, gastroschisis, imperforate anus and tracheoesophageal fistula.	➢ Level II health care providers plus: Certified Neonatologist Pediatric Medical, Subspecialist Pediatric Anesthesiologist, Pediatric Surgeons, Pediatric Ophthalmologist and Neonatal Nurse Practitioners

Level	Capabilities	Admission Criteria	Health Care Provider Type
III	Continuation: ➢ Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide ➢ Perform advanced imaging with interpretation on an urgent basis, including computed tomography, MRI and echocardiography	➢ Invasive diagnostic test/procedures e.g. diagnostic laryngoscopy, ventricular tap, intravitreal injections, thoracentesis. ➢ Hemodynamic instability and Cardiac arrhythmia such as supraventricular tachycardia or congenital heart block ➢ Hyperbilirubinemia requiring exchange transfusion ➢ Persistent Hypoglycemia (Refer to Hypoglycemia guideline) ➢ Any other baby whose clinical condition cannot be appropriately cared for in Level 2 (as per consultant decision)	➢

4. DISCHARGE CRITERIA

4.1 Discharge planning should be developed and implemented by a multidisciplinary team consisting of physician, nurses, respiratory therapist, occupational and/or physical therapists, and social workers. The process can begin soon after an infant is admitted to the NICU and is continued through regularly scheduled planning sessions during hospitalization.

4.2 The following are the components of discharge planning

4.2.1 **Neonatal Medical Readiness:**

4.2.1.1 Neurophysiological stable

4.2.1.2 There is no specific weight is required to discharge preterm infants, however most infants do not fulfill these criteria before they can reach 1.6 – 1.8 kg.

4.2.1.3 Maintain normal body temperature in an open crib with normal temperature (24 to 25 °C) for at least 24 hours.

4.2.1.4 Demonstrate mature oral feeding skills (breast or bottle) that will allow enough nutritional intake to promote appropriate growth.

4.2.1.5 Demonstrate a consistent pattern of appropriate weight for 3 days.

4.2.1.6 Patient should be discharged from NICU to other facilities in the hospital if he reached 4 months of age in terms babies and 6 months corrected age in preterm babies.

4.2.1.7 A plan of nutritional support and monitoring of growth also should be established

4.2.1.8 Neurodevelopmental follow-up with a special program should be arranged for extremely preterm and other high-risk infants.

4.2.1.9 A visit should be scheduled within two to four days of discharge and arrangements made for on-going care, including subspecialty care, if needed.

4.2.1.10 Dietician consultation can help Infants with chronic disease, such as chronic lung disease, short bowel syndrome, cholestasis jaundice or osteopenia.

4.2.2 **Vaccination and Screening and Care:**

4.2.2.1 Medically stable preterm infants ≥ 1800 grams and ≥ 28 days old should receive full immunization based upon their chronological age consistent with the schedule and dose recommended for normal full-term infants.

4.2.2.2 Palivizumab (prophylaxis for Respiratory Syncytial Virus) should be given to eligible infants during respiratory syncytial virus season according to the guideline eligibility.

4.2.2.3 All newborn require routine screening for metabolic screening, critical congenital heart disease, and hearing screening.

4.2.2.4 Infants at risk for developing retinopathy of prematurity (ROP) should have routine ophthalmologic screening.

4.2.2.5 Screening for intraventricular haemorrhage, imaging may be recommended prior to discharge to detect periventricular leukomalacia or white matter injury in at-risk infants.

4.2.3 **Parental Readiness and Education:**

4.2.3.1 The parents should demonstrate consistent involvement in their infant's care, and readiness and competency to provide home care (feeding techniques, positioning, medication administration, and respiratory treatments, training in gastrostomy and/or tracheostomy care and in the use of cardiorespiratory monitoring equipment if needed).

4.2.3.2 Cardiopulmonary resuscitation training is advisable to all parents.

4.2.3.3 Parents also should be counselled about importance of supine sleeping.

4.2.3.4 Special medical equipment and services needed at home should be arranged (oxygen, cardiorespiratory monitoring, on feeding pumps for trans abdominal enteral nutrition).

4.2.3.5 A social worker evaluation should be performed in order to assist with social or financial needs.

4.2.4 **Follow Up:**

4.2.4.1 A full review of the infant's hospital course should be summarized and documented in infant's medical record.

4.2.4.2 For healthy newborn in post-natal ward discharge less than 48 hours after delivery, three additional postnatal contacts are recommended for all mothers and newborns, on day 3 (48-72 hours), one month old at 2 months old.

4.2.4.3 For infants with a complicated hospital course and on-going health issues, review the results of diagnostic studies, such as cranial ultrasound examination and echocardiograms and Subspecialty consultants who will provide follow-up care should see the infant prior to hospital discharge.

4.2.4.4 Follow up arrangements can be made for primary care, specialty care (e.g. pulmonology, cardiology, surgery), and neurodevelopmental follow up.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

5.1 Physician

5.2 Nurse staffs (NICU, CCHD)

7. APPENDICES:

7.1 Admission request form

7.2 Physician newborn assessment form

7.3 NICU assessment form

7.4 New Ballard score form

7.5 CCHD Form

7.6 Vaccination Form for PHC

8. REFERENCES:

6.1 Level of Neonatal Care/ From the American Academy of Pediatrics ... pediatrics.aappublication.org/content/130/3/587

6.2 Level III neonatal intensive care units (NICU) – Floyd Medical Center www.floyd.org/services/pages/nicu.aspx

6.3 NW Newborn Clinical Guidelines – NICU Admission, Discharge and www.adhb.govt.nz/newborn/.../admissionsdischargesandtransfers

6.4 Neonatal Admission/ Great Ormond Street Hospital www.gosh.nhs.uk>healthprofessional>clinicalguidelines

6.5 Selection criteria in the NICU: who should get effective critical care? https://www.ncbi.nlm.nih.gov/pubmed/19517656

6.6 Admission to NICU CA40668v3 www.nnuh.nhs.uk/publication/download/admission-to-nicu-ca4068v3

6.7 Discharge Criteria for the NICU / NICU Discharging Information www.mercydesmoines.org/childrenshospital/variety-nicu-discharge

6.8 Hospital Discharge of the High-risk neonate / From the American.Pediatrics.aapublications.org/content/122/1119

6.9 NW Newborn Clinical Guideline – NICU Admission, Discharge, and www.adhb.govt.nz/newborn/.../NICUadmissionsDischargesandtransfer.htm

6.10 Going home: Facilitating discharge of the preterm infants- NCBI – NIH https://www.ncbi.nlm.noh.gov>NCBI>Literature>PubmedCentral(PMC)

6.11 NICU Discharge Guidelines – Health Net https://www.healthnet.com/static/general/unprotected/NICUdischargeGuidelines.pd

6.12 Neonatal Discharge Checklist afhsr.med.sa/cqi-web/web/cqi-docs/3.Documents/.../7540%20761%201522.pdf

6.13 Download – Mid Essex Hospital Services NHS Trust www.meht.nhs.uk/easysiteweb/getresources.axd?assetID=6454&type=full

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Afrah Saud Al Shammari	NICU Head Nurse		January 05, 2025
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

Appendices 7.1

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:____/____/____*

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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: .....

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2.) Medication: .....

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3.) Investigation: .....

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4.) Consultation: .....

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5.) Expected Length of Stay: _____ days

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6.) Nutrition and Diet: .....

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.....

Education of patient and Family:

Discharge Planning:

Discharge Needs:

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

Consultant Notes: : .....

.....

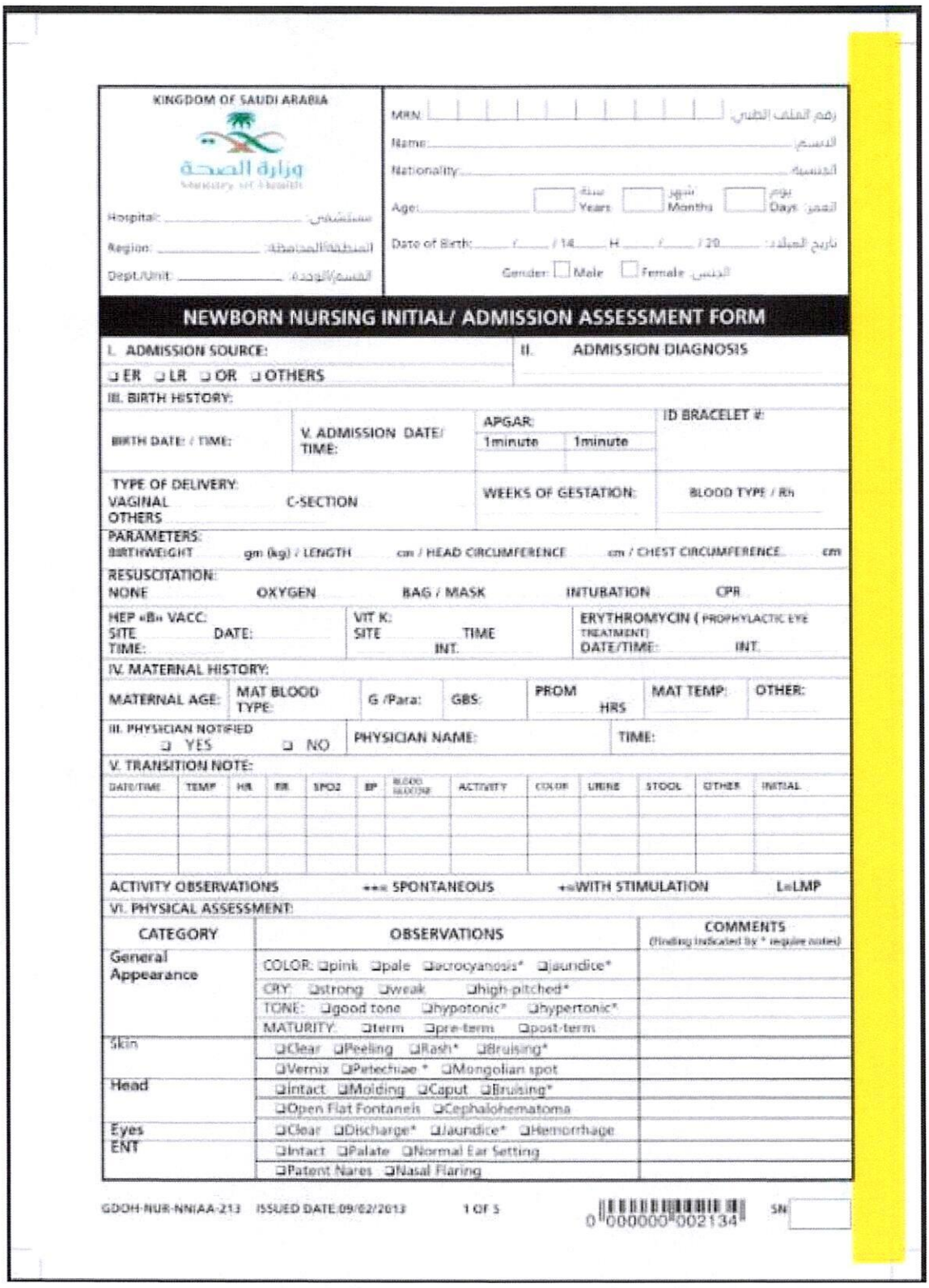
.....

.....

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	APGAR: 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 0_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

0 000000 002134 SN

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
	❑Yes	❑No
	❑Yes	❑No
Others		
High risk indicated but no referral sent, why?		

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

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

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:

MATURITY RATING	
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 red veins	Parchment thick 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; slow 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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Appendices 7.5

Maternity and Children's Hospital
Kingdom of Saudi Arabia
Hafer Al - Batin

وزارة الصحة
Ministry of Health

CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING

NAME_____ AGE_____

NATIONALITY_____ FILE NUMBER_____

DIAGNOSIS_____

DOA_____ DATE OF SCREENING_____

NAME OF SCREENING STAFF_____ PHYSICIAN_____

INITIAL SCREENING

TIME		SPO_2	PI	RESULT		COMMENTS
	RT. HAND-			MET	NOT MET	NOT MET * FOR REPEAT SCREENING AFTER ONE HOUR. * MONITOR SIGNS & SYMPTOMS OF CARDIAC & RESPIRATORY DISSTRESS
	FOOT-					

SECOND SCREENING

TIME		SPO_2	PI	RESULT		COMMENTS
	RT. HAND-			MET	NOT MET	NOT MET * FOR REPEAT SCREENING AFTER ONE HOUR. * MONITOR SIGNS & SYMPTOMS OF CARDIAC & RESPIRATORY DISSTRESS
	FOOT-					

THIRD SCREENING

TIME		SPO_2	PI	RESULT		COMMENTS
	RT. HAND-			MET	NOT MET	NOT MET * NOTIFY PHYSICIAN IMMEDIATELY * TO BE SEEN BY CARDIOLOGIST FOR ECHOCARDIOGRAM PRIOR TO DISCHARGE * MONITOR SIGNS & SYMPTOMS OF CARDIAC & RESPIRATORY DISSTRESS
	FOOT-					

THIRD SCREENING RESULT NOT MET. TO BE FILL UP MOTHER'S DATA BELOW:

MOTHER'S NAME_____ AGE_____
MOTHER'S MRN:_____ NATIONALITY_____ PARITY NUMBER:_____
FATHER'S NAME_____ NATIONALITY_____
TELEPHONE NUMBER_____ MOBILE NUMBER_____
IS MOTHER HAS HISTORY ILLNESS DURING PREGNANCY: ☐ YES ☐ NO
IF YES PLEASE WRITE WHAT TYPE(S) OF DISEASE(S):_____
HYPERTENSIVE MOTHER: ☐ YES ☐ NO IS FAMILY HAS HISTORY OF HEART DISEASE: ☐ YES ☐ NO
KNOWN DIABETIC: ☐ YES ☐ NO GESTATIONAL DIABETIC MOTHER: ☐ YES ☐ NO
CONSANGUINEOUS PARENTS: ☐ YES ☐ NO
DATA TAKEN BY:_____

M.K.10/08/16

Appendices 7.6

Maternity and Children Hospital Hafar Al Batin, KSA

VACCINATION REPORT TO PHC تقرير التطعيم إلى المراكز الصحية

NAME:

MEDICAL RECORD NUMBER : NATIONALITY:

ROOM NO: BED NO: AGE:

GENDER: □ MALE □ FEMALE

CONSULTANT IN – CHARGE:

DEPARTMENT: UNIT:

DELIVERY: BCG AND HEPATITIS B

DAY	MONTH	YEAR	يوم	شهر	عام

MEDICAL RECORD NUMBER	رقم السجل الطبي

MOTHER'S COMPLETE NAME	اسم الأم الكامل

FATHER'S COMPLETE NAME	اسم الأب الكامل

PRIMARY HEALTHCARE CENTER THE MOTHER IS RELATED TO	مركز الرعاية الصحية الأولية, ترتبط الأم ب

MOBILE NUMBER	TELEPHONE NUMBER	رقم هاتف	رقم الهاتف الجوال

OUTCOME OF PREGNANCY — نتيجة الحمل

ABORTION	STILLBIRTH	LIVE BIRTH	ولادة حية	لا تزال ولادة	الإجهاض

TYPE OF DELIVERY — نوع الطلبية

NORMAL	INSTRUMENTAL DELIVERY	CESAREAN SECTION	العملية القيصرية	التسليم الفوري	عادي

GENDER	MALE	FEMALE	WEIGHT OF THE BABY	وزن الطفل	الذكر	انثى	جنس

VACCINES GIVEN (IF GIVEN, PLEASE GIVE THE DATE) — اللقاحات التي أعطيت (إذا أعطيت ، يرجى ذكر التاريخ)

BCG	HEPATITIS B	التهاب الكبد ب	الدرن

NAME OF RECORDER	اسم المسجل

SIGNATURE	التوقيع

DOC-PC-015 Page 1 of 1 VACCINATION REPORT TO PHC تقرير التطعيم إلى المراكز الصحية