



**DOCUMENT TYPE: FORM**

<input type="checkbox"/> Interpretation req'd Language: _____		<b>INITIALS</b>	<b>N/A</b>	<b>COMMENTS</b>
<b>Complete Grey sections for ALL Discharges</b>				
<b>By 6 hrs</b>				
1. Benefits of skin-to-skin				
2. Infant Stool Colour Card				
3. Behaviours - sleep/wake states				
<b>By 24 hrs</b>				
4. Breastfeeding (cues, active feeding)				
5. For infants fed breastmilk substitute: appropriate formula preparation, storage, cue-based feeding and infant positioning				
6. Feeding plan in place				
7. Safe sleep environment – e.g. back to sleep, tobacco use/exposure to second hand smoke				
8. Infant crying - include; Shaken Baby Syndrome(SBS) prevention				
9. Injury prevention - e.g. baby products, car seat safety, hot liquid burns				
10. Signs and symptoms of jaundice (Bilirubin level if applicable)				
11. Signs and symptoms for follow-up (e.g. poor feeding, not waking to feed, cardiorespiratory changes)				
<b>By Discharge</b>				
18. Newborn screening				
▪ Hearing - completed by Hearing Screening Staff				<input type="checkbox"/> to be done as outpatient
▪ Blood spot card collected				<input type="checkbox"/> outpatient req. given
▪ Critical Congenital Heart Defect (CCHD)				
19. Newborn ready for hospital discharge, discharge order				
20. Knows newborn PHCP; how and when to contact				
21. Aware of PHN contact/role/community resources				
22. Weight: loss/gain				
Completed by the Public Health Nurse (post discharge)				
12. Newborn Care :				
▪ Cord care				
▪ Bathing/hygiene				
▪ Consoling techniques				
13. Tummy-time, carrying infant				
14. Environment smoke-free				
15. Vitamin D supplementation				
16. Access to Baby's Best Chance Parents' Handbook				
17. Review of communicable diseases				
<b>Variations – Plan(s) including referrals</b>		<b>Tests/Procedures</b>		<b>Date</b>
_____		1. _____		_____
_____		2. _____		_____
_____		3. _____		_____
_____		4. _____		_____
_____		5. _____		_____
<b>Discharge</b> Hours/days of age at discharge: _____		<input type="checkbox"/> Identification bands checked		
Discharge Weight (if >24 hours) _____		<input type="checkbox"/> Home with parent/guardian		
Hospital discharge: Date _____ Time _____		RN Signature _____		



## Version History

DATE	DOCUMENT NUMBER and TITLE	ACTION TAKEN
23-Jul-2019	C-06-06-60332 Newborn Education Guideline	Approved at: Perinatal Best Practice Committee
27-Mar-2020	"	Updated to reflect order sets; Approved by Maternal Newborn Interim Senior Medical Director

## Disclaimer

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