Post Birth Data Collection Form B (Baby)

INFANT STUDY

INFANT Study number: | | | | | | |

Please tick which baby this form refers to:
Baby 1 ☐ Baby 2 ☐

This form should only be completed if a baby delivered to a woman randomised in the INFANT study received a higher level of care (e.g. NICU/SCBU) for any period of time **OR** *had surgery following its birth.*

Please complete this form for care received by this baby in this hospital:

Baby's first name: _____ **Baby's surname:** _____

Category of Neonatal Care

1. **What type of higher care did this baby receive?** *(please tick all that apply)*
   - A. **Normal Care:** Care given by the mother or mother substitute with medical and neonatal nursing advice if needed. (*If this is the only care given please go to question 2*) . . . . . ☐
   - B. **Special Care:** A nurse should not be responsible for care of more than four babies receiving Special or Normal Care
     Special care is provided for all other babies who could not reasonably be expected to be looked after at home by their mother. . . . . ☐
   - C. **High Dependency Care:** A nurse should not be responsible for the care of more than two babies in this category -
     1) receiving NCPAP for any part of the day and not fulfilling any of the criteria for intensive care
     2) below 1000g current weight and not fulfilling any of the criteria for intensive care
     3) receiving parenteral nutrition
     4) receiving oxygen therapy and below 1500g current weight
     5) requiring treatment for neonatal abstinence syndrome
     6) requiring specific procedures that do not fulfil any criteria for intensive care:
        Care of an intra-arterial catheter or chest drain
        Partial exchange transfusion
        Tracheostomy care until supervised by a parent
     7) requiring frequent stimulation for severe apnoea.. . . . . ☐
   - D. **Intensive Care:** These babies have the most complex problems. They need 1:1 care by a nurse with a neonatal qualification. The possibility of acute deterioration is such that there should be the constant availability of a competent doctor
     1) receiving any respiratory support via a tracheal tube and in the first 24 hours after its withdrawal
     2) receiving NCPAP for any part of the day and less than five days old
     3) below 1000g current weight and receiving NCPAP for any part of the day and for 24 hours after withdrawal
     4) less than 29 weeks gestational age and less than 48 hours old
     5) requiring major emergency surgery, for the pre-operative period and post-operatively for 24 hours
     6) requiring complex clinical procedures:
        Full exchange transfusion

Peritoneal dialysis

Infusion of an inotrope, pulmonary vasodilator or prostaglandin and for 24 hours afterwards

7) any other very unstable baby considered by the nurse-in-charge to need 1:1 nursing: for audit, a register should be kept of the clinical details of babies recorded in this category

8) a baby on the day of death . . . . . ☐

Please give details of length of stay and reasons for admission to higher level of care:

Level of Unit *(Please give the level of unit as per the bold headings above using the appropriate letter)*	Date & time of admission	Date & time of discharge	Main reason for admission *(e.g. infection, respiratory problems)*	Treatment(s) received *(e.g. cooling, parenteral nutrition etc)*
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		

2. **Was this baby admitted to Neonatal care/Neonatal Unit (whatever level) within 48 hours of birth for a period of ≥ 48 hours?** Yes ☐ No ☐

Surgery or Referral to a Surgeon

3. **Did this baby undergo any surgery or surgery referrals following its birth (including paracentesis) before its discharge from hospital?** Yes ☐ No ☐

If Yes, please give details below:

Date of surgery/ surgical review	Type of surgery/ Nature of surgical review (state if review or if surgery conducted)	Hospital of surgery (if not hospital of birth)
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		

STUDY OFFICE USE ONLY:
First Entry: ☐ Second Entry: ☐

INFANT Study number: ☐☐☐☐☐☐

Investigations

4. **Did this baby undergo any of the following investigations after trial entry?** *(please tick all that apply)*

- Ultrasound scans ☐
  - If ticked, how many? ☐☐
- X-rays ☐
  - If ticked, how many? ☐☐
- MRI ☐
  - If ticked, how many? ☐☐
- Stand alone ECGs ☐
  - If ticked, how many? ☐☐
- CT-scan ☐
  - If ticked, how many? ☐☐
- Septic screens ☐
  - If ticked, how many? ☐☐
- EEG ☐
  - If ticked, how many? ☐☐

Conditions/diagnoses/treatments

5. **Did this baby receive any respiratory support (ventilator or CPAP)?** Yes ☐ No ☐
   If Yes, total number of days receiving respiratory support (ventilator or CPAP) (Include any part of a day as a day) ☐☐☐ days

6. **Did this baby receive any non-mechanical supplemental oxygen (e.g. nasal specs/head box)?** Yes ☐ No ☐
   If Yes, total number of days receiving supplemental oxygen days (Include any part of a day as a day) ☐☐☐ days

7. **Did this baby have seizures whilst in this hospital?** Yes ☐ No ☐
   If Yes, were they treated? Yes ☐ No ☐

8. **Did this baby have neonatal encephalopathy (NNE)?** Yes ☐ No ☐
   If Yes, please complete a NNE chart for each day of the baby's higher level of care. Please state when this form is completed how many NNE assessments are included in this form ☐☐☐

9. **Did this baby have any feeding difficulties?** Yes ☐ No ☐
   If Yes, please indicate whether any of the following were used:
   - Tube feeding ☐
   - Parenteral feeding ☐

10. **Did the baby achieve full oral sucking feeds before discharge or transfer?** Yes ☐ No ☐
    If Yes, what date did the baby achieve full oral sucking feeds? D D / M M / Y Y

STUDY OFFICE USE ONLY:
First Entry: ☐ Second Entry: ☐

INFANT Study number: ☐☐☐☐☐☐

OUTCOME – *Please complete either box A, B or C*

A) Discharge Home

11. **Was the baby discharged home?** Yes ☐

12. **Date of discharge home:** D D / M M / Y Y

B) Transfer

13. **Was the baby discharged to another hospital?** Yes ☐ No ☐

Date of transfer: D D / M M / Y Y

If Yes, please give details of where the baby was transferred to: _____

_____

_____

Please describe how the baby was transferred:

Ambulance ☐

Helicopter ☐

Other (*please specify*): _____

C) Death

14. **Did the baby die?** Yes ☐ No ☐

Date of death: D D / M M / Y Y

If Yes, has a cause of death been identified? Yes ☐ No ☐

If Yes, please provide details on what was written on the death certificate:

_____

_____

_____

_____

_____

Has a post-mortem been performed? Yes ☐ No ☐

Form completed by *(please PRINT)* _____ **Date:** D D / M M / Y Y

[redacted] [redacted] [redacted]