

Audit Form for Extremely Low Gestational Age (ELGA) Infants (<26 Weeks GA)

<u>CNN Case ID:</u>		<u>Date of Review:</u>		<u>Age when review done:</u>	
<u>Gestational Age:</u>		<u>Weight (g):</u>		<u>Inborn/Outborn:</u>	

Antenatal:

1. Was a formal Antenatal Consultation by Neonatology done before delivery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. Were the following antenatal interventions initiated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown/NA <input type="checkbox"/>
a. Antenatal Steroids	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown/NA <input type="checkbox"/>
b. MgSO4 for neuroprotection	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown/NA <input type="checkbox"/>

Transition Period: Resuscitation/Initial stabilization

1. What was/were the risk factors leading to preterm birth? Preterm labour <input type="checkbox"/> Gestational hypertension <input type="checkbox"/> PPRM <input type="checkbox"/> APH <input type="checkbox"/> Placental dysfunction <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Others (specify) _____	
2. Mode of delivery: Vaginal <input type="checkbox"/> Caesarean Section <input type="checkbox"/>	
3. Was an attending neonatologist present at resuscitation?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
4. Was delayed cord clamping performed?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
5. Was cord milking performed?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
6. Was nasal CPAP used as the first mode of ventilation? If yes, device used _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
7. Was intubation required?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
8. If yes to question 7, number of intubation attempts?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 <input type="checkbox"/>
9. Was there pre-medication for intubation?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
10. Was surfactant administered? If yes, age at first dose _____ hrs	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
11. Was caffeine given during this period?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
12. Was there temperature instability during this period? Temp <36.6 °C <input type="checkbox"/> >37.5 °C <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
13. Age (hours) at transfer to incubator	≤1h <input type="checkbox"/> >1h <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
14. What humidity (%) was the incubator set at?	60 – 79% <input type="checkbox"/> 80 – 89% <input type="checkbox"/> ≥90% <input type="checkbox"/> Unknown/NA <input type="checkbox"/>

NICU Management: First 6 hours

1. Was there a documented PCO ₂ <40 or pH>7.4 on blood gas?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
2. Was TPN (any form) initiated within the first 6 hours?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
3. What was the initial TFI (total fluid intake) in ml/kg/d?	60 - 79 <input type="checkbox"/> 80 - 99 <input type="checkbox"/> ≥100 <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
4. Was there evidence of hemodynamic instability? Hypotension <input type="checkbox"/> Poor perfusion <input type="checkbox"/> Metabolic Acidosis <input type="checkbox"/> Other: _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
5. Was fluid bolus given (completed within 30 minutes)? If so, how many? 1 <input type="checkbox"/> >1 <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
6. Was inotrope given?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
7. Was prophylactic indomethacin given?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>

8. Was there temperature instability during this period? Temp <36.6 °C <input type="checkbox"/> >37.5 °C <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
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NICU Management: 7-24 hours

1. What was the nursing ratio in the first 24 hours?	1:1 <input type="checkbox"/> 1:2 <input type="checkbox"/> Other: _____
2. Was there a documented PCO ₂ <40 or pH>7.4 on blood gas?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
3. Was fluid bolus given (complete within 30 minutes)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
4. If so, how many? 1 <input type="checkbox"/> >1 <input type="checkbox"/>	
5. Was enteral feeding initiated within 24 hours after birth?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
6. Was there temperature instability during this period?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
7. Temp <36.6 °C <input type="checkbox"/> >37.5 °C <input type="checkbox"/>	

NICU Management: First week

1. Did the infant require intubation or re-intubation?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
2. Was there a significant pneumothorax (requiring drainage)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
3. Was there an elective change from UVC to PICC?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
4. Did baby receive skin-to-skin care at any time?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
5. Did the baby have any skin breakdown?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
6. Did baby receive formula feed in first week?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
7. Did baby receive any narcotics or sedatives?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
8. Was there documented hyperglycemia (glucose >10 mmol/L)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
9. Was there documented hypernatremia (sodium >150mmol/L)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
10. When was sodium added to the TPN? (DOL)	< 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> >3 <input type="checkbox"/> Unknown/NA <input type="checkbox"/>
11. What was the maximum TFI at any time during the first week?	≤ 100 <input type="checkbox"/> 100 - 150 <input type="checkbox"/> 151 - 199 <input type="checkbox"/> ≥200 <input type="checkbox"/> Unknown/NA <input type="checkbox"/>

Morbidities noted in the first week:

IVH - Please complete the sentinel review form for IVH

Sepsis - Please complete the sentinel review form for Sepsis

NEC - Please complete the sentinel review form for NEC

Remarks: