Nairobi Newborn Study
Standard Operating Procedure 4.1 [SOP4.1]: Data entry from maternal admission register

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This standard operating procedure aims to provide guidance to the team abstracting and entering data from the maternal admissions register during the Nairobi Newborn study. This survey targets all patient population admitted to the facility for deliveries. Admissions starting from date 30th June 2015 moving backwards in time will be abstracted until either 500 registers have been entered or the date 1st July 2014 has been reached.

You may require information from a referral book at the facility in addition to the admission register to complete this data entry. Please refer to SOP 4.0 for guidance.

1. **Unique ID:** This is an eight digit number that acts as a unique identification number for each record. It is composed of the hospital ID, the data clerk ID, and then the first record to be entered at each facility proceeds from 0001. You will only have to enter this number for the first record at each hospital, starting with [hospital ID][clerk ID][0001], RedCap will then auto-generate the unique ID for subsequent records ([hospital ID][clerk ID][0002] and so forth).

2. **Hospital ID:** From the dropdown list, select the name of the hospital in which you are entering the record.

3. **Data entry person ID:** From the dropdown list, select your name.

4. **Patient number (IP No.)**: This is the patient number (IPNO) as found to be written on the register. If the year is added to the end of the IPNO (e.g. 1234/15), enter the year but no symbols such as / or - (e.g. 123415). This number is used in case we need to relocate individual records/patients to confirm data.

5. **Today's date:** This is today's date, i.e. the date of data entry. The 'Today' button should be pressed and the field will automatically be generated. The date should be formatted as YYYY-MM-DD, e.g the 3rd of February 2015 would be '2015-02-03'.

6. **Date of admission:** This is the date on which the patient was admitted. The date should be formatted as YYYY-MM-DD. If the date is missing from the register than enter 1915-01-01.

7. **Data of discharge/death:** This is the date on which the patient was discharged. The date should be formatted as YYYY-MM-DD. If the date is missing from the register than enter 1915-01-01. This date should not be earlier than the date of admission, however, if it is recorded as such then enter the date that is on the record and include a note in the comment box.

8. **Residency: Location:** Using the lookup list select the estate/location from which the patient comes. If the estate/location is not available on the lookup list, then enter 'Empty' which is an option on the lookup list. If residency locations are available, but whether they are sub-locations or location is not specified, check to see if you can find them on this location lookup list and the sub-location lookup list below. If they are unavailable on the lists, then enter one of the locations as though it is a 'location' (below under 'specify location not on lookup list') and the other as though it is a sub-location (below under 'specify sub-location not on look up list'). If only one location is available and not found on either look-up list then enter it as a 'location'.

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9. **Location not on lookup list?** If you are unable to find the estate/location on the lookup list then select 'not on list'. This field will disappear if the location has been entered above based on the lookup list.

10. **Specify location not on lookup list:** If you select that you are unable to find the estate/location on the lookup list, then this field will appear. Please enter the information here.

11. **Residency: Sub-location:** Using the lookup list, select the village/sub-location from which the patient comes. If the village/sub-location is not available on the lookup list, then enter 'Empty' which is an option on the lookup list.

12. **Sub-location not on lookup list?** If you are unable to find the village/sub-location on the lookup list then select 'not on list'. This field will disappear if the sub-location has been entered above based on the lookup list.

13. **Specify sub-location not on lookup list:** If you select that you are unable to find the village/sub-location on the lookup list, then this field will appear. Please enter the information here.

14. **Referred IN from another facility before delivery?** Please indicate if the patient has been referred to this facility from another facility. Some facilities might have a dedicated referral book. If this is the case, then check this book. Using the IPNO as an identifier, locate the patient in the referral book to obtain this information. If there is no reference made to referral INTO the facility then presume that there was no referral in and select 'No'. If the patient came from home or self-referred, then select 'no'.

15. **Where was she referred FROM? (Name of facility):** Using the lookup list, select the facility from which the patient was referred. If the name of the facility is not recorded then enter 'Empty' which is an option on the lookup list.

16. **Facility referred from not on lookup list?** If you are unable to find the referring facility on the lookup list then select 'not on list'. This field will disappear if the facility has been entered above based on the lookup list.

17. **Specify facility not on lookup list:** If you select that you are unable to find the referring facility on the lookup list, then this field will appear. Please enter the information here.

18. **Referred OUT to another facility before delivery?** The admission register will also have discharge information. Check this discharge information to see if the patient was referred out of the facility before she gave birth. If she has been referred to another facility BEFORE delivering her baby, then select 'yes'. If (a) there is information about the delivery of the patient's baby (even if stillbirth) OR b) there is no reference to referring out of the facility during discharge, then select 'No'. Some facilities might have a dedicated referral book. If this is the case, then check this book. Using the IPNO as an identifier, locate the patient in the referral book to obtain this information. If you are unable to locate the patient, then select 'no'.

19. **Where was she referred TO? (Name of facility/location):** If the patient was referred out of the facility to another facility before giving birth, using the lookup list, select the name of the facility to which she was referred. If there is no information available on where the patient was referred to then enter 'Empty' which is an option on the lookup list.

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20. **Facility referred to not on lookup list?** If you are unable to find the facility to which she was referred on the lookup list then select 'not on list'. This field will disappear if the facility has been entered above based on the lookup list.

21. **Specify facility not on lookup list:** If you select that you are unable to find the facility to which she is referred on the lookup list, then this field will appear. Please enter the information here.

22. **HIV status:** Indicate the patient's/mother's HIV status. Reactive=positive, non-reactive=negative. If the status is indicated to be unknown/indeterminate, or there is no information available on HIV status, then select 'Unknown/Empty'.

23. **Singleton or multiple births:** Please indicate if the patient delivered one baby/singleton birth or more than one baby/twins/triplets/etc i.e. multiple births. *This field does not appear if the patient was referred out before giving birth.*

24. **Outcome of delivery:** Please indicate what the outcome of the birth (or first birth in the case of multiple births) was. If there are several births then it does not matter which you define as 'first', 'second', and 'third' but be consistent and be sure to maintain the same order when entering the sex (field below) of the babies. For live-births, there are two categories, we are primarily interested to know if the baby has been admitted for inpatient care either in this or another facility. Therefore, if there is an indication that the newborn is critically ill/admitted/sent for further investigation etc, then indicate 'Live birth – newborn admitted to inpatient care'. Otherwise, if it is a live-birth, then indicate 'live birth- health newborn', even if minor conditions not requiring further attention are recorded. If you are unsure about your selection, make a note in the comment bubble with the query. For stillbirths, there are three options, (1) intrapartum is equivalent to 'fresh' and not-macerated, (2) macerated is equivalent to 'in uterus' and 'not fresh'. If miscarriage is noted then indicate 'unknown/empty' and make a note in the comment bubble. *This field does not appear if the patient was referred out before giving birth.*

25. **Outcome of delivery (second birth):** Please refer to 'outcome of delivery', the details are the same. *This field only appears if 'multiple births' was selected.*

26. **Outcome of delivery (third birth, where relevant):** Please refer to 'outcome of delivery', the details are the same. If there are more than three deliveries, please select the first three babies to be reported and make a comment in the comment bubble. *This field only appears if 'multiple births' was selected.*

27. **Sex of newborn:** Indicate the sex of the newborn (or first newborn if multiple births). If there are multiple births, the order is not important, however, the order must correspond to that chosen for the 'outcome of delivery' fields. *This field does not appear if the patient was referred out before giving birth.*

28. **Sex of newborn (second birth):** Please refer to 'sex of newborn', the details are the same. *This field only appears if 'multiple births' was selected.*

29. **Sex of newborn (third birth, where relevant):** Please refer to 'sex of newborn', the details are the same. *This field only appears if 'multiple births' was selected.*