

**WAHT-KD-015**  
**Neonatal Key Documents**

Please attach patient sticker here or record:

Name: .....

NHS No:

Unit No:

D.O.B: .....

Male ☐ Female ☐

Consultant: .....

## COT SPACE CHECKLIST

To be completed by nursing staff preparing the cot space after discharge on the NNU. The completed form is to be placed on the patient's trolley as confirmation that the cot space was adequately prepared. Please leave the form on the cot until new patient admitted.

Please file this in the patient notes

ACTION REQUIRED		Comments
<b><u>CHECK O2 WORKING</u></b> Remove air-port if not required, place cap in outlet and perform tug-test on oxygen flow meters.		
<b><u>CHECK COT SPACE EQUIPMENT IN PLACE: All cleaned and labelled with green I am clean label</u></b> Cot side trolley cleaned and stocked -as per checklist Bag and mask/neopuff, green tubing, silicone masks x2 Suction catheters (small selection of sizes) Suitable monitoring equipment IV infusion pumps		
<b><u>SUCTION EQUIPMENT CLEAN, WORKING AND COMPLETE (All labelled with green 'I am clean')</u></b> Clear tubing Yellow tubing Canister Unused Canister insert Check filter for any colour change		
<b><u>INCUBATOR AND MATTRESS CLEAN AND FIT FOR USE:</u></b> <ul style="list-style-type: none"> <li>• Check exterior for damage which affects its integrity</li> <li>• Check exterior mattress cover for excessive staining if removable cover check interior</li> <li>• Clean mattress top and bottom as per Trust Isolation Policy.</li> <li>• Dry mattress thoroughly</li> <li>• If mattress and incubator are clean and fit for use then complete GREEN decontamination label and place inside incubator on top of bedding</li> </ul>		
<b><u>COT AREA:</u></b> All rubbish and debris removed, all stains cleaned from area Clean and restock cot side trolley as per checklist		
<b><u>PATIENT FOLDER</u></b> Clean, check for damage, replace if damaged. Complete with admission documentation		

**This is a mandatory form to be completed every time a cot space is cleaned.**

Signature of Nurse responsible:.....Date:.....

Name of Nurse responsible:.....