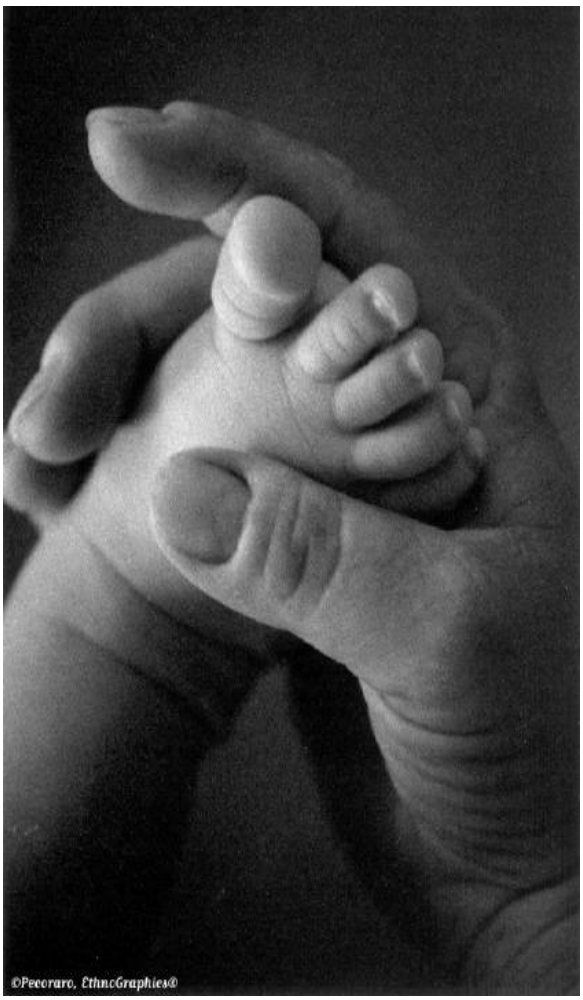
Connecticut Department of Public Health



Connecticut Newborn Screening Program

Electronic Reporting
Hospital User's Manual
Version 1.5.1

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INTRODUCTION

About Newborn Screening

Connecticut newborns are also screened for over forty genetic or metabolic disorders through a few drops of blood collected from a heelstick bloodspot specimen. The specimen should be collected by day 4 of life, prior to transfusion, TPN, transfer, or discharge, and/or as soon as practical after death. Approximately 2,100 of those babies screened, or 5%, will have a positive lab screen result that needs more testing.

Additionally, each year more than 40,000 babies born in Connecticut are screened for hearing loss before hospital discharge. Approximately 1-2% of the babies screened will have a permanent congenital hearing loss.

The Newborn Screening Program at the Connecticut Department of Public Health (DPH) receive screening results on all CT births and strive to assure that each child who screens positive receives Testing, Tracking and Treatment.

About E-Forms System

The Department of Information Technology and the Office of Policy and Management are the lead agencies for the implementation of electronic forms in state government. The objective of this initiative is to replace the paper forms with electronic forms to expedite the transmission and processing of information and follow up of results.

The Newborn Screening Program was chosen by the Department of Information Technology (DoIT) and the Office of Policy and Management (OPM) to be an early pilot program for electronic forms processing. This process obviates the need for hospital staff to manually complete newborn screening forms that are sent to the DPH. It is hoped that this system will help ensure the accuracy of the data by reducing the opportunities for errors to be introduced through manual data entry.

About This Manual

This User's Guide was designed as a reference tool to help a new user become familiar with the *Newborn Screening System v1.5.1*.

This is an update of the originally released manual and includes instructions for using new functionality that has been added to allow the transfer of a newborns record in NSS from one hospital to another, and includes information about the new fields that have been added to the NBS Lab Screening panel.

I. Logging on to the Extranet Virtual Private Network (VPN)

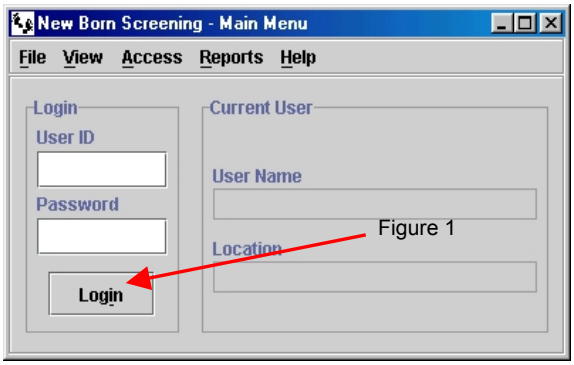
To access the Newborn Screening System you must login to the Extranet through a virtual private network (VPN). This is a secure means of transmitting electronic data to the Department of Public Health (DPH). Your facility has been issued a security key fob, which displays numbers that are to be used as your password. The numbers change every 60 seconds. The number of bars displayed on the key fob indicates the amount of time that you have left to enter the password numbers before they change.

- Enter your Login USER ID.
- Enter the password as displayed on the key fob. The password will be the numbers that are displayed on the security key fob/token.

II. Logging in to the Newborn Screening System (NSS)

Once you have established the Extranet connection, double click on the Newborn Screening icon on your desktop. The NSS system is password protected and will prompt the user for both a ***USER ID*** as well as a ***Password***. Your System Administrator, normally the Nurse Manager or other designee, can assign a you a USER ID and Password for you to access the system.

- Enter the appropriate information in the ***USER ID*** and ***Password*** fields then click on the Login button. (Figure 1)



Once you are logged in, your User Name and Location will be displayed on the Main Menu screen shown above.

- Click on ***Access*** located on the top toolbar as shown in *Figure 2.*
- Select ***Hospital Entry*** as shown below.

Figure 2

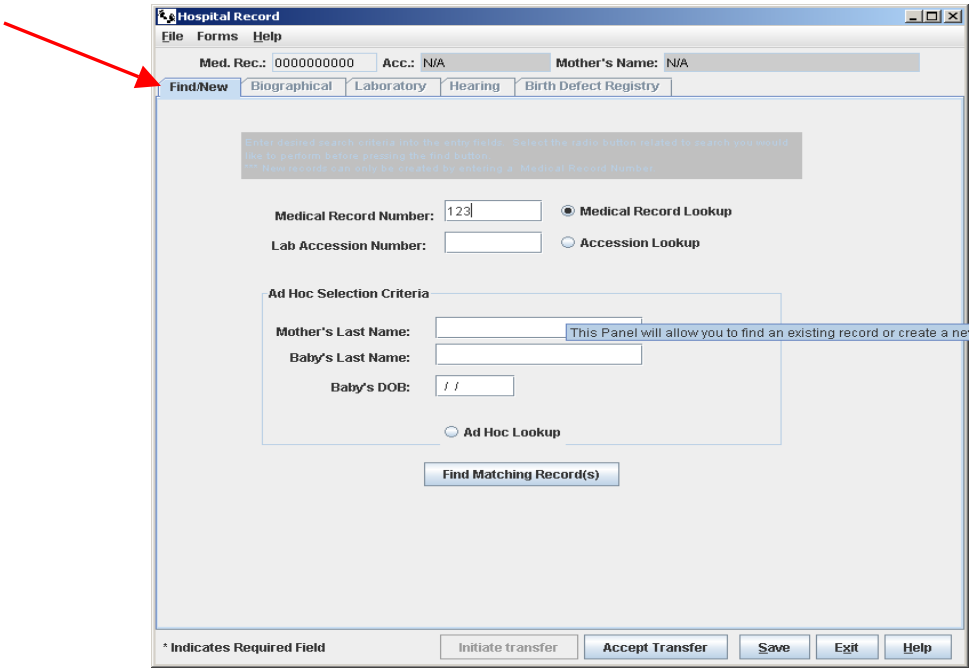
Manage Security launches a series of screens where user access is defined and/or restricted by the hospital's system administrator and will be discussed later in this manual.

Hospital Entry allows access to the lookup panel for the newborn data entry screens.

Public Health Access is restricted to DPH use only.

II. Find/New Panel

Once you are logged in to the NSS, the following panel will be displayed. You can either ***create*** a new record, or ***find*** an existing record from the ***Find/New*** panel.

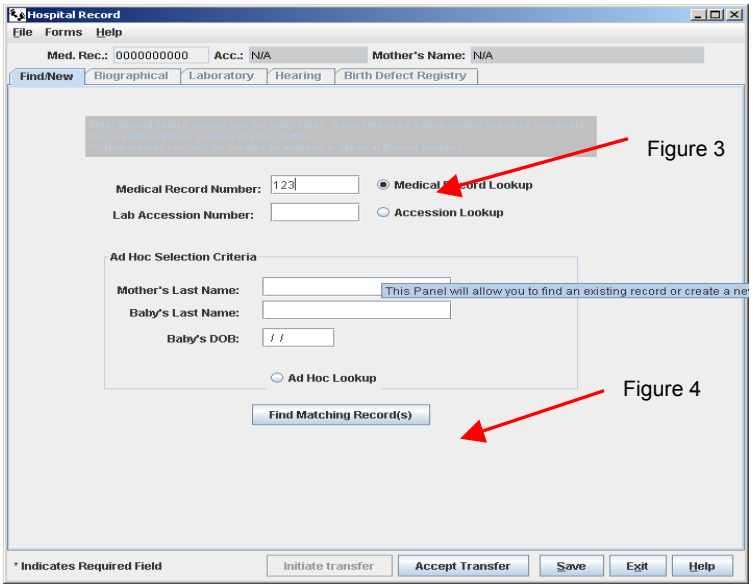


A. *Creating a New Record*

The electronic record is always **created by the facility of birth** and should be created for ***all infants born Connecticut birth facility.*** Enter the child's medical record number from your hospital, up to 10 characters in length.

To create a new record:

- Enter the baby's medical record number in the designated field.
- Click the radio button (●) located to the left of *Medical Record Lookup* as shown below in *Figure 3.*
- Select ***Find Matching Record(s)*** *as displayed in Figure 4.*



The Newborn Screening System was designed to search for the medical record number that was entered before allowing the user to create a new record, using that same number. This is a validation process to prevent duplicate records from being created for the same infant.

If the Medical Record that you searched for does not exist in the system, a dialog box will appear telling you that the record was not found *(Figure 5).*

Figure 5

To continue entry of a new record, select ***OK***.

Next, you will see a prompt that asks if you would like to create a record for that Medical Record Number? *(Figure 6)*

Figure 6

- Select ***Yes*** to continue.

The new record will open to the child's Biographical panel and the system will automatically generate an eight-digit Accession number. The Accession Number is a unique identifier for that child and can be found on the top toolbar of each electronic record.

B. How to Find an Existing Record

To retrieve a record that has already been created you can search for it by the *Baby's Medical Record Number, Accession Number, or Ad Hoc features including Mother's Last Name, Baby's Last Name or Baby's Date of Birth.*

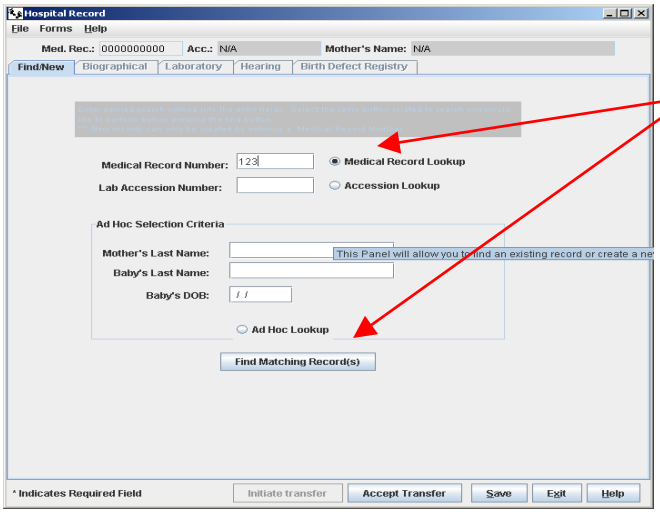


Figure 7

Be sure to select the radio button (●) next to the search criteria that you are using as shown in *Figure 7.* Radio button selections include ***Medical Record Number***, ***Accession Number*** or ***Ad Hoc*** Lookups.

C. Duplicate Records

In the event that the wrong medical number was entered and two records were created for a child, contact the CT Department of Public Health at **T- (860) 509-8057** and ask for the Newborn Hearing Screening Program staff. DPH staff will take the necessary information required to delete the duplicate record.

III. Transfers

A. In-State Transfers

The Newborn Screening System allows the electronic transfer of a baby's record from one Connecticut hospital to another. This is helpful when an infant is transferred to another facility before the lab and/or hearing screenings have been conducted. NSS records cannot be transferred to a facility out-of-state. ** Remember, the **birth hospital always creates the baby's record**, which generates the Accession Number.

The birth hospital should always try to collect the bloodspot specimen before the baby is transferred, whenever possible. In the event that an infant's medical condition is such that it is impossible to collect the specimen before the transfer, the birth hospital should send the CT bar-coded filter paper form and the mailing envelopes along with the baby to the transfer facility and transfer the infant's electronic record.

B. How to Transfer a Record

The transfer is a simple, two-step process.

- Open the baby's record that you want to transfer.
- Complete the Biographical panel and *Save* or *Commit and Save* the panel.
- Select ***'Initiate Transfer'*** from the bottom of the screen (*Figure 8*).

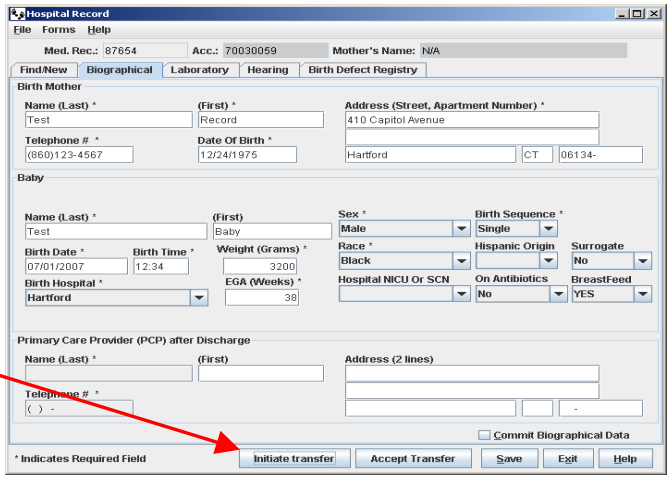


Figure 8

- Select the hospital that the baby is being transferred to from the dropdown list as shown *(Figure 9*).
- Next select ***'Process Transfer'.***

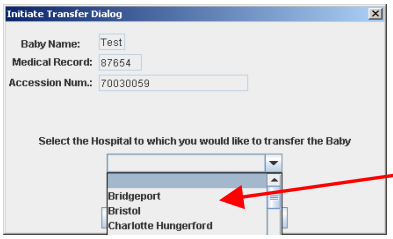


Figure 9

A dialogue box will open and list the baby's last name, medical record and facility of transfer *(Figure 10).*

Figure 10

- If the information in the dialogue box is not the record you wish to transfer, select ***'No'*** and repeat the *'Initiate Transfer'* steps outlined on page 4.
- If the transfer information is correct, select ***'Yes'.***

Upon successful completion of the transfer a dialog box will appear *t*hat indicates the transfer was successful *(Figure 11).* Select **OK** to continue.

Figure 11

C. Accepting a Transfer

The facility of transfer must ***'Accept'*** the transferred record to complete the process.

- Go to The ***FIND/NEW*** panel *(Figure 12).*
- Select ***'Accept Transfer'*** at the bottom of the panel as shown in *Figure 13.*

Figure 12

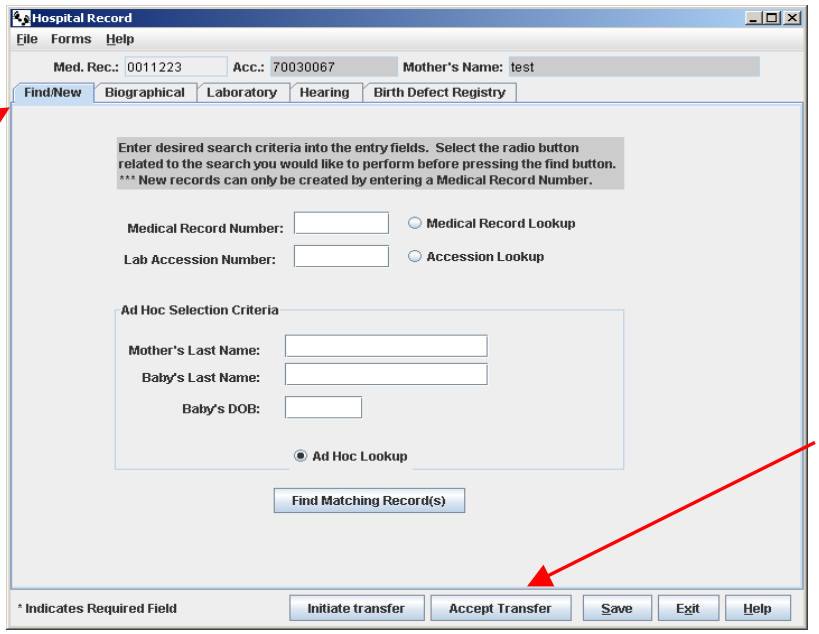


Figure 13

Once you select the ***Accept Transfer*** box, the dialog box shown in *Figure 14* will appear.

- Click on the **(▼)** to view the list of records waiting to be accepted
- Select and click on the name of the record that you want to accept. Records must be accepted one at a time.

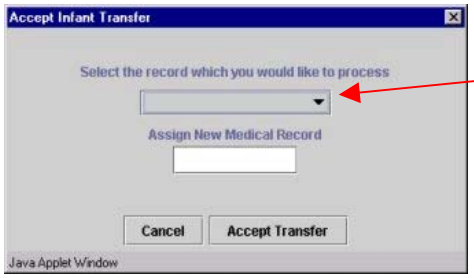


Figure 14

- In the '***Assign New Medical Record'*** field enter the baby's medical record number that was assigned by your facility.
- Select ***'Accept Transfer'*** *(Figure 15)*.

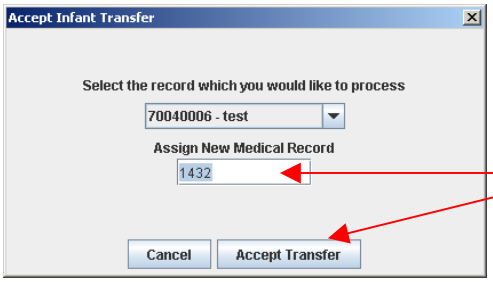


Figure 15

You will receive the following prompt which confirms that you successfully accepted the record *(Figure 16)*.

- Select OK

Figure 16

To access the record that you have just accepted, go to the FIND/NEW panel and look up the record by medical record number, Accession number, name, or date of birth.

D. Out-of-State Transfers

When a Connecticut born infant is transferred to an out-of-state hospital it is important to collect the Newborn Lab Screening specimen before the baby is transferred, whenever possible. In the event that an infant's medical condition is such that it is impossible to collect the specimen before the transfer, the birth hospital should send the CT bar-coded filter paper form and the mailing envelopes along with the baby to the facility of transfer.

The NSS electronic record cannot be transferred out-of-state and must remain at the birth facility. *Document all information related to the CT Newborn Screenings that need to be performed on the Inter-Agency Transfer Report and on the infant's Discharge Summary.*

The out-of-state hospital should **collect the CT NBS specimen on the CT filter paper form** and mail it to the CT State Laboratory. The facility of birth should contact the out-of-state hospital within four days of the infant's birth and confirm that the CT NBS Lab screening was conducted and that the specimen was collected on the CT filter paper form. The collection information should then be entered into the NSS.

The out-of-state hospital should **conduct the hearing screening** on the infant prior to discharge. The facility of birth should contact the out-of-state hospital to confirm that the NBS Hearing screening was conducted and enter the screening results into the NSS.

E. Out of State Births

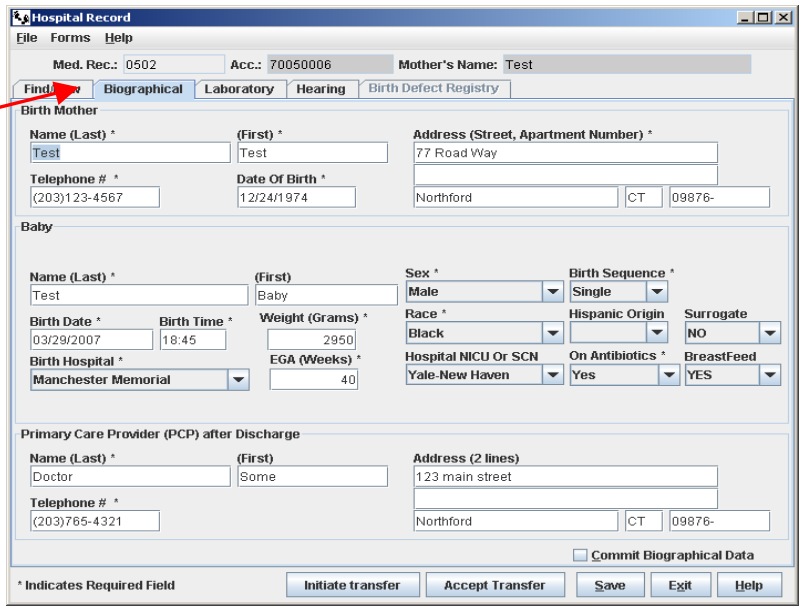
All states bordering CT screen newborns for genetic/metabolic conditions, and hearing loss at birth. It is important to note that the number of tests in the NBS Lab panel varies from state to state. CT state law requires each institution caring for newborns to administer the test for newborn screening. When an infant who was born in another state is transferred to a CT hospital, ideally the specimen should have been collected by the out of state birth facility. If the infant's screening status is unknown, the CT facility should contact the birth facility and confirm whether the specimen was collected in that state. If a specimen was NOT collected, the specimen should be collected on a CT filter paper form and sent to the CT state lab for testing. ***Out-of-state births DO NOT get entered into the Newborn Screening System.***

- Collect the heelstick specimen on the CT filter paper form.
- Handwrite the collection information on the filter paper form and **indicate the name** of the infant's facility of birth.
- Mail the specimen to the CT State NBS Lab in the appropriate envelope.
- Conduct the hearing screen and fax the results to the DPH on the ***'Hearing Screening Reporting Form'*** (See Appendix A, Hearing Screening Reporting Form).

IV. The Biographical Panel

To access the Biographical panel select the Biographical tab as shown in *Figure 17*. Text can be manually entered into each of the white fields. Any field with a (▼) next to it indicates that the response must be selected from a pre-set dropdown list. Those fields marked with an asterisk (*) are required fields that must be completed in order to commit the record and send it to the DPH.

Figure 17



A. Biographical Panel Fields

Mother's Name
This is always the name of the mother who gave birth to the baby. Enter the **birth mother's** last name, then first name in the designated fields. Each field will allow up to 25 characters to be entered. Note: This information is the minimum required data to allow further entry in either the Lab or the Hearing panels.

Mother's Telephone
Enter the mother's 10-digit phone number including area code.

Mother's Date of Birth
Entry Format is MMDDYYYY.

Mother's Address
Enter the mother's home address in the fields as shown. Note that the second address field is for an optional address such as a PO Box number or Apartment.

Baby's Last Name
Enter baby's last name, as it will appear on the birth certificate. If unknown, always enter the last name of the birth mother. The field will allow up to 25 characters to be entered.

Baby's First Name
Enter baby's first name, if known. If no name has been decided upon yet, enter ***Baby***. **Do not use quotation marks** in this, or any other field. The field will allow entry of up to 25 characters.

Baby's Birth Date
Entry format is MMDDYYYY.

Birth Time
Enter the baby's time of birth in *military time*.

Birth Hospital
This field will default to the hospital that created the record. If necessary, the Birth Hospital location can be changed by selecting the correct facility from the dropdown list.

Weight
Enter baby's birth weight in grams. The birth weight entered must be between **200 and 7000 grams**.

EGA
Estimated gestational age in weeks. The EGA entered must be between **18 and 45 weeks.**

Birth Sequence
A single birth should always be entered as *Single*. In the event of multiple births, enter the birth sequence with the corresponding letter (A-G). **Do not use A or 1 to indicate the sequence of a single birth.**

Race
Select Baby's race from the dropdown selection menu. The options include:

- Black/African American
- White
- American Indian
- Other
- Asian

Hispanic Origin
If the Baby is of Hispanic origin, select the specific origin from the dropdown selection menu. The options include:

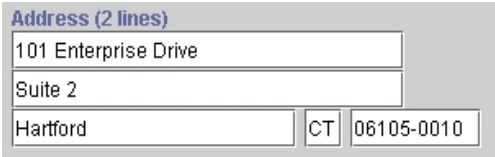
- Puerto Rican
- Cuban
- Mexican
- Other

Hospital in NICU or SCN
If the baby was transferred to a NICU/SCN, select the hospital name from the dropdown selection. The option list includes the following **in-state** hospitals only:

- Bridgeport Hospital
- Danbury Hospital
- Greenwich Hospital
- CT Children's Medical Center
- Hospital of St. Raphael
- Lawrence & Memorial
- Middlesex Hospital
- Midstate Medical Center
- The Hospital of Central CT (NBG)
- Norwalk Hospital
- Stamford Hospital
- St. Francis Hospital
- St. Mary's Hospital
- UCONN Health Center
- Waterbury Hospital
- Yale New Haven Hospital

Physician After Discharge
Enter the name of the primary care provider (PCP) that will care for the baby after discharge. If the child is a pre-term baby and is expected to be in the hospital for a significant period of time, and the PCP after discharge is unknown, enter the name of the NICU/SCN attending physician who is overseeing the care of the infant. Each name field (last, first) allows up to 25 characters to be entered.

Physician's Address
Enter the PCP's Address in the fields as shown. Note that the second address field is for additional address information such as a Suite, Room Number, etc.



Physician's Telephone
Enter the PCP's ten-digit phone number including area code.

On Antibiotics
If the Baby is currently being treated with antibiotics, select ***Yes*** from the dropdown list. If not, the default for this field is ***No*** and no entry is required.

Surrogate

Indicate if the mother who delivered the baby was a surrogate by selecting *Yes* or *No* from the dropdown box. The default for this field is *No*. Refer to page 25 for more information about Surrogate Births and Gestational Agreements.

V. Saving a Record

Data can be entered into a baby's record at different intervals and *Saved*. This feature allows the user to access the record at a later time and complete the necessary data entry.
To save a record, select the ***'Save'*** feature located on the bottom of any screen *(Figure 18)*.
You can then exit out of the system by selecting the 'Exit' feature.

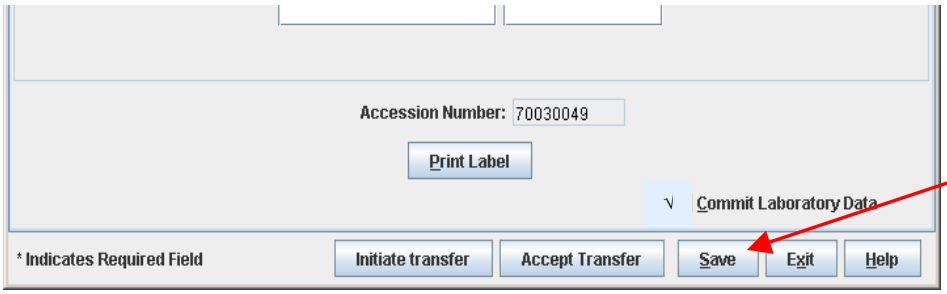


Figure 18

VI. Committing a Record

Once all of the required (*) data fields have been entered on <u>any</u> single panel, the panel should immediately be ***COMMITTED***, and then ***SAVED***. To commit a panel click on the box in the bottom right corner of the screen so that the box is checked *(Figure 19)*.

Committing a panel means that it is complete, and the information can be extracted by the DPH.
*** Note: The Biographical screen <u>must be committed</u> prior to committing the Lab, Hearing or Birth Defect panels. This assures that any information, which is extracted by the DPH has the proper identifying information found on the biographical panel.

Panels can be committed independently from one another. Once a panel has been committed, the data fields turn gray.

Figure 19

VII. Correcting A Record After It Has Been Committed

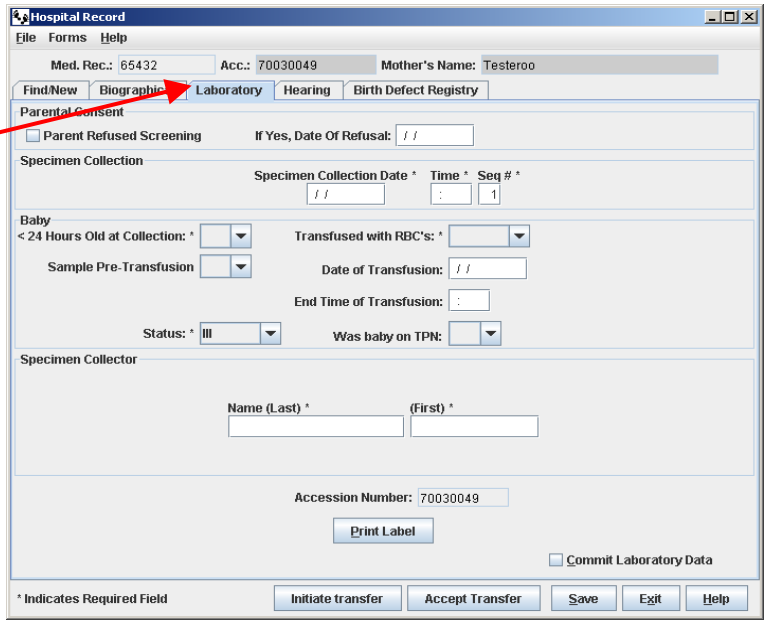
If the commit box ☑ *(Figure 19)* is still present in the bottom right corner of the panel, you can click on the check and 'uncommit' the panel. This is useful if you find that there was a data entry error that requires correcting.

If the commit box is no longer visible on the panel, then DPH has extracted the record and only the DPH staff can correct data entry errors. Call the **DPH Help Desk at 860 509-7777** or Newborn Hearing Screening staff at **860 509-8057** and give them the information that you would like changed. Please be prepared with the baby's Accession Number and Date of Birth and corrected information when you call.

VIII. The NSS Laboratory Panel

To access the Laboratory panel select the Laboratory Tab as shown in *Figure 20.*
A heelstick specimen must be collected by day 4 of life, prior to transfusion, TPN, transfer, or discharge, and/or as soon as practical after death, per CT State law. You must complete the required fields on the Biographical and Laboratory panels and commit the screens <u>before the filter paper leaves the hospital.</u>

Figure 20



It is extremely important that all requested information on the specimen card and in the electronic Newborn Screening System (NSS) be filled out completely and accurately. This information is critical to interpreting the test results and facilitating rapid communication of results to health care providers. Prompt *follow-up* of an *abnormal screening result* depends upon the ability of DPH to identify the infant's primary health care provider after discharge, such as a pediatrician, rather than the provider who cared for the child after birth, such as a neonatologist, house staff, etc. Every effort should be made to ensure that the ***pediatric healthcare provider after discharge*** information is accurate and complete.

A. Laboratory Panel Fields

Specimen Collection Date
Enter the date that the 1st specimen was collected in format equivalent to MMDDYYYY.

Time
Enter the time that the specimen was collected in military time format.

Seq #
Enter the sequence number of the specimen collected. The default data for this field is 1. Only the 1st sequence can be entered into NSS.

Less than (<) 24 Hours Old at Collection
Was the baby less than 24 hours old at the time the specimen was collected? Select options Yes/No from the dropdown box.

Sample Pre-Transfusion
Newborn screening bloodspot specimens should be collected prior to a red blood cell (RBC) transfusion. DPH now collects the date and end time of a transfusion to ascertain whether the specimen was collected before the transfusion, or if another specimen will be required. Was the bloodspot specimen collected before the baby was transfused with RBCs? Select options Yes/No from the dropdown box.

Transfused with RBCs
If the Baby has been transfused with RBCs before the collection, select Yes from the dropdown list. If not, the default for this field is No and no entry is required.

Date of Transfusion
Enter the date that the baby was transfused in the MMDDYYYY format.

End Time of Transfusion
Enter the end time of the transfusion that was **closest to the collection of the specimen**. Enter the time in military time.

Status
Select the appropriate Status of the Infant from the following options on the dropdown list:
1-Well (default)
2-Ill
3-Expired

Baby Ever on TPN?
TPN infusions can alter the amino acid newborn screening results. The NBS specimen should not be collected while the TPN is running. Each facility should have policies in place regarding the NSS collection for infant's receiving a TPN infusion. Refer to your facility's policy and the physician's orders before suspending a TPN infusion.
Did the baby ever receive a TPN Infusion? Select options Yes/No from the dropdown box. The default for this field is 'No'.

Specimen Collector
Enter the specimen collector's last name in the first field, and the first name in the second. Each field allows up to 25 characters to be entered.

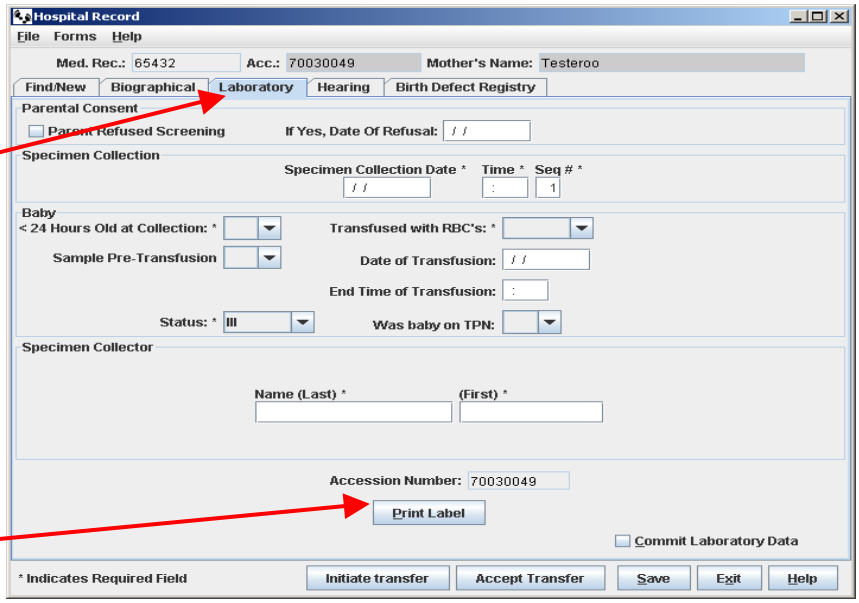
B. Bar Code Label

A bar code label should be affixed to each filter paper form, prior to specimen collection. The bar code has the required CLIA identifying information that is needed for the submission of the child's specimen to the State Lab. The bar code printers are supplied to the birth facilities by the Connecticut Department of Public Health. You must have a **Zebra TLP 2844** bar code printer installed on the same computer operates the Newborn Screening System and it should be set as your default printer in order to print the bar code labels.

You must complete required fields on the Biographical panel and save and/or commit and save the data before you can print a bar code label.
The bar code labels are printed from the Laboratory panel in the Newborn Screening System. Click on Laboratory tab to access the panel as shown in *Figure 21*.

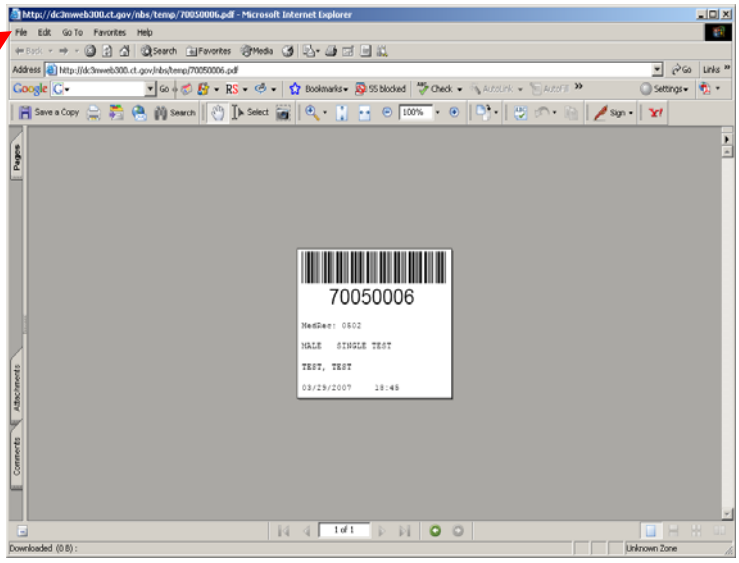
Figure 21

Figure 22



Select *the **'Print Label'*** feature located in the bottom center of the screen as shown above in *Figure 22*. Adobe Acrobat will open and the bar code label will be displayed on the screen.

Figure 23

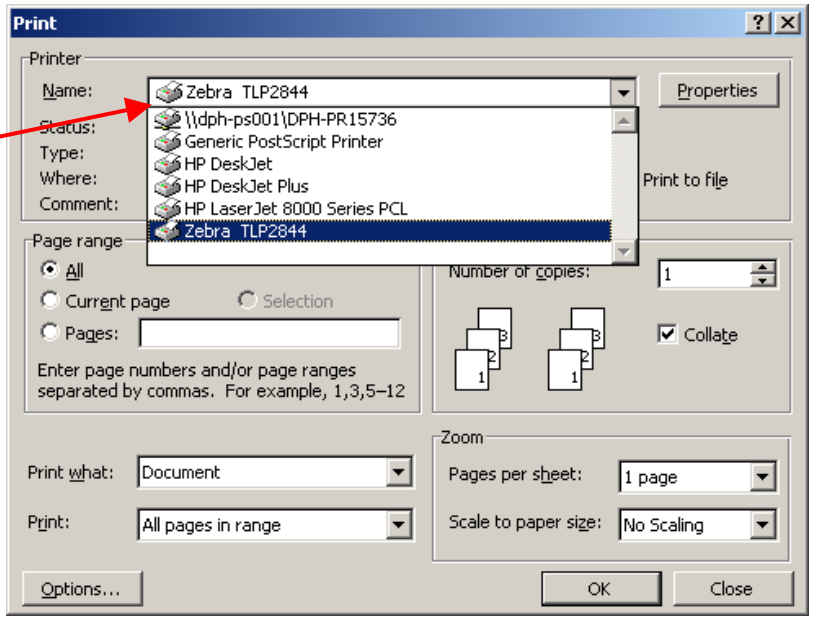


To print the label click on ***'File'*** in the upper left corner of the screen *as shown in Figure 23.*
Next select ***'Print.'***

C. Printer Settings

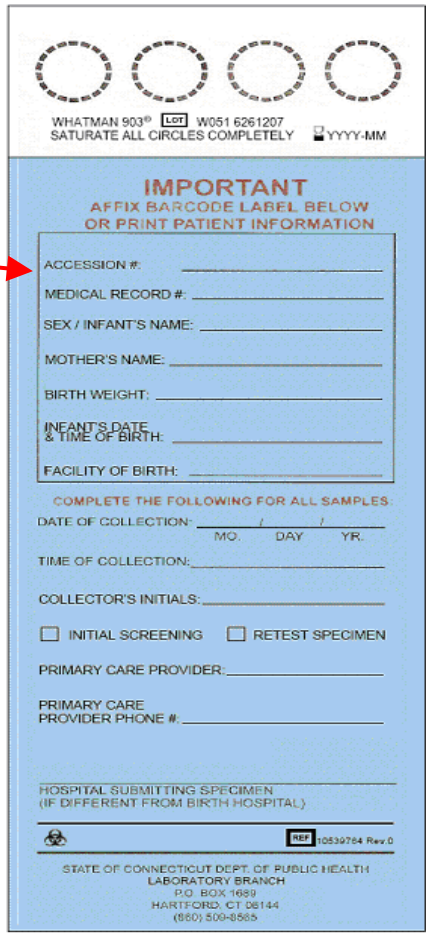
Be sure that the printer selected in the *Printer Name* field is the **Zebra TLP 2844** printer as shown in *Figure 24.* If the Zebra TLP2844 printer is not listed in the *Printer Name field*, click on Zebra TLP2844 from the dropdown box as shown in *Figure 24* and it will move the selected printer field.
Select ***OK*** to print.

Figure 24



The bar code label will print out on the Zebra bar code printer. The label size should remain set at **2 ¼" x 2"**. Affix the bar code label to the filter paper form in the box beneath the collection circles *(Figure 25)*. The filter paper form is then ready for the specimen to be collected.

Figure 25

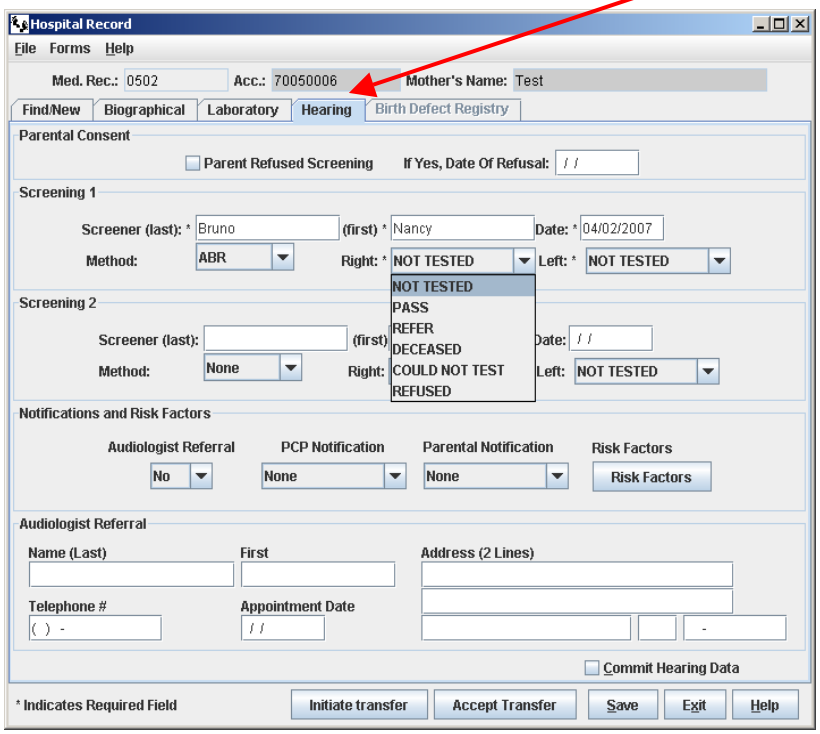


IX. The Hearing Screening Panel

Connecticut General Statutes, **Section 19a-59** mandates universal hearing screening of all newborns as a standard of care, unless the responsible party objects to hearing screening as being in conflict with their religious tenets and practice (See Appendix B, Hearing Screening Regulations). The results and/or refusal of the hearing screening are entered into the NSS on the Hearing panel.

To access the hearing panel click on the tab labeled *Hearing (Figure 26*). A hearing screening should be conducted on each newborn, unless the parent refuses due to religious tenets.

Figure 26



A. Hearing Panel Fields

Screener
Enter last name, then first name of the person who conducted the hearing screen.

Date
Enter the date of the first hearing screen in format equivalent to MMDDYYYY.

Method
The first screening method for infants who are **<u>not "at risk"</u>** can be **OAE or ABR**. Infants **who are at high risk** for hearing loss **should have an ABR** screening conducted. (See Appendix C, Risk Indicators for Hearing Loss)
Select the equipment used for the first hearing screening from the dropdown list. Options include:
OAE
ABR

Results
Select the hearing screening results specific to each ear, from the dropdown menu. Options include:
Not Tested: Baby was not screened before discharge

Pass: Baby was screened and passed the 1st screen
Refer: Baby did not pass the first screening **or baby was born with atresia** and could not be tested.
Deceased: Baby was born live but expired.
Could Not Test: Equipment malfunctioned or other reason.
Refused: Responsible party refused screening and signed the *Hearing Screening Refusal Waiver.*

Screener- Second Screening
Enter last name, then first name of the person who conducted the 2nd hearing screen.

Date – Second Screening
If the baby did not pass the *1st* hearing screening a *2nd* screening must be conducted before discharge, using **ABR**. Enter the date of the *second* hearing screen in format equivalent to MMDDYYYY.

Method – Second Screening
If any baby did not pass the 1st hearing screening, the 2nd screening method must be **ABR**.

Results- Second Screening
Select the hearing screening results specific to each ear, from the dropdown menu. Options include:
Not Tested: Baby was not screened before discharge
Pass: Baby was re-screened and passed the 2nd screen
Refer: Baby did not pass the first screening and was rescreened and did not pass the second screen, or the baby has atresia. You must enter a 2nd screen result into the system if the baby has atresia in order to commit the panel.
Deceased: Baby was born live but expired.
Could Not Test: Equipment malfunctioned or other reason.
Refused: Responsible party refused screening and signed the *Hearing Screening Refusal Waiver.*

PCP Notification
Select the method by which the PCP is to be notified of the results of the hearing screening from the dropdown list. Follow your facility policy on physician notification. The options include the following:
Verbal
Written
Verbal & Written
None (default)

Parental Notification
Select the method by which the Parent/Responsible Party was notified of the results of the hearing screening from the dropdown list. Follow your facility policy on notifying the parent/responsible party of the screen results. The options include the following:
Verbal
Written
Verbal & Written
None (default)

Audiologist Referral
Is the patient being referred to an Audiologist for follow-up testing? Select *Yes* or *No* from the dropdown list.

Audiologist Name
Enter the name of the **audiology center** that the infant was referred to, or the audiologist's last and first names. Each field allows up to 25 characters to be entered.

Audiologist Address
Enter the address of the audiology center in the fields. Note that the second address field is for additional address information such as group practice name or a PO Box number.

Audiologist Telephone #
Enter the Audiologist's telephone number including area code.

Date of Appointment
Enter the date of the patient's appointment with the audiologist if known, in the MMDDYYYY format.

B. Risk Factors

Children with risk indicators for hearing loss require ongoing audiological monitoring. DPH collects risk factor information for each newborn.
To report a risk factor, select the ***'Risk Factor'*** feature located on the hearing panel. Select the appropriate risk factor from the dropdown box selection as shown in *Figures 25 and 26.*

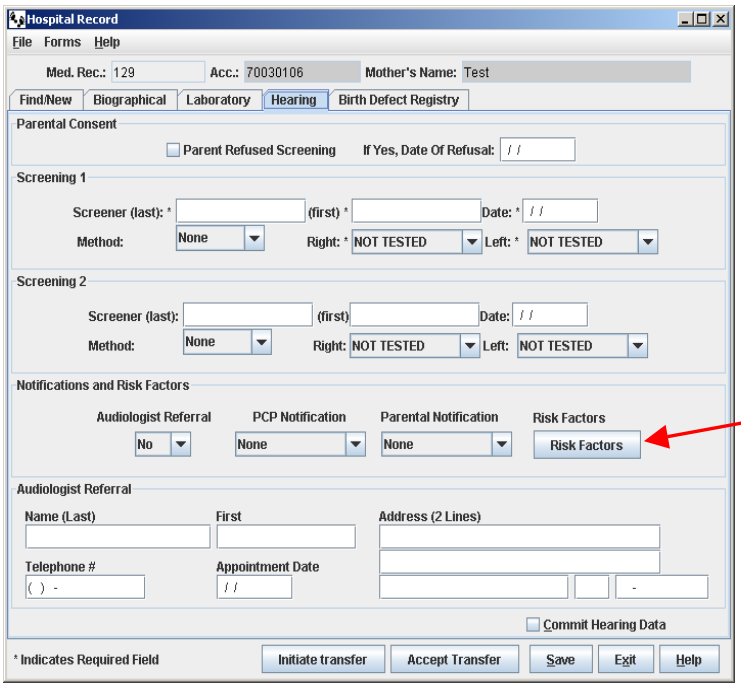


Figure 25

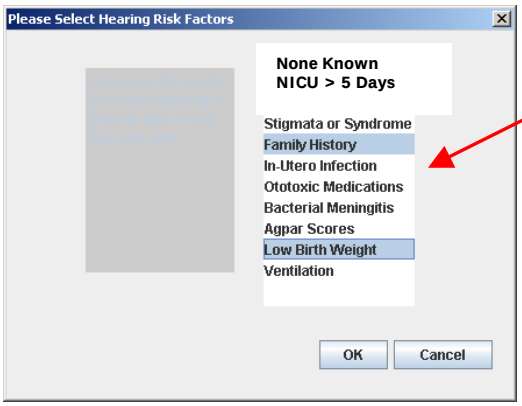


Figure 26

- To report more than one risk factor, hold the *'Control'* key located in the bottom left corner of your keyboard, and click on the appropriate risk factor. The risk factors that you selected will be highlighted in blue as shown above.
- Click *'OK'* when you have finished selecting the Risk factors and the box will close.
- Save and Commit the Hearing panel once all data has been entered.

X. The Birth Defect Registry Panel

Select the Birth Defect Registry tab to access the e Birth Defect Registry panel as shown in *Figure 27.*

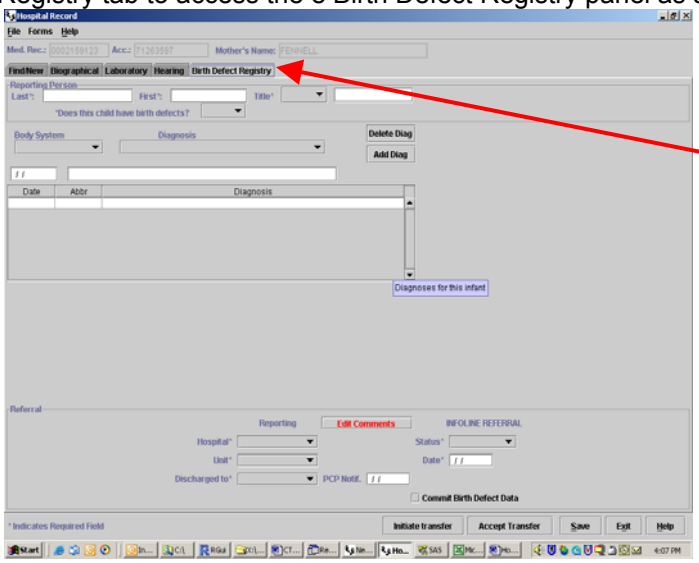


Figure 27

A. Birth Defect Panel Fields

Reporting Person

- Enter information on reporting person, including Last Name, First Name, and Title (select from the dropdown box, and do the free text entry in the next blank box if 'Other' is selected)

Does this child have birth defects?

- Select the ***'YES'*** or ***'NO'*** from the dropdown box.
- If ***'NO'*** birth defect is selected for this child, then check ***'Commit Birth Defect Data'*** to submit the record; if ***'Yes'*** is selected for this child, continue to enter other information on diagnoses and referral.

Adding a Diagnosis

- Select the appropriate **'Body System'** from the dropdown box.
- Next select the appropriate diagnosis from the corresponding dropdown box.
- Enter the date the birth defect was diagnosed in the format as MM/DD/YYYY.
- Click the ***'Add Diag'*** button to add a diagnosis to the diagnosis panel below.
- If the child has more than one birth defect diagnoses, repeat the steps to select 'Body System' and 'Diagnosis', and click 'Add Diag' to add diagnosis to the diagnosis panel.
- When the ***'Body System'*** list does not include a diagnosis that you want to report, select the category of ***'Other'*** from the ***'Body System'*** list.
- Next select ***'Condition/Syndrome Not Mentioned'*** from the 'Diagnosis' list and select 'Edit Comments'.

Deleting a Diagnosis

- To delete a diagnosis, select the diagnosis in the Diagnosis Panel, and then click *'**Delete Diag**'.*

Referral

- Select the reporting hospital from the dropdown box for *'**Hospital**'*.
- Select the reporting unit from the dropdown box for *'**Unit**'*.
- Select the discharge information from the dropdown box for *'**Discharge to**'.*
- Enter the date of *'**PCP Notif.**'* in the format as MM/DD/YYYY, if PCP is notified.
- Select the referral *'**Status**'* from the dropdown box for *'**INFOLINE REFERRAL**'*.
- Enter the date of referral in the format as MM/DD/YYYY.
- Click on the *'**Commit Birth Defect Data**'* box then select ***'Save'***.

XI. Validation Errors

The Newborn screening system has built in validations that help assure the integrity of the data that is sent to the Department of Public Health. You may see a validation error when you attempt to commit a panel with incomplete or incorrect format of data.

A. *Common Errors*

Common examples of data entry errors that will cause a validation error message include:

- A required field was not entered
- Baby's DOB is before the Mother's DOB.
- Baby's birth weight is outside of the specified parameters
- Baby's EGA is outside of the specified parameters
- Lab specimen date of collection is **prior** to the Baby's birth date
- A required field (*) was not entered
- The wrong date format was used. It should be (mm/dd/yyyy).

The data entry field(s) that caused the validation error(s) will be highlighted in red as shown in *Figure 28*. The validation may be on any of the panels, so it is important to check them all until you find the field or fields that are highlighted in red.

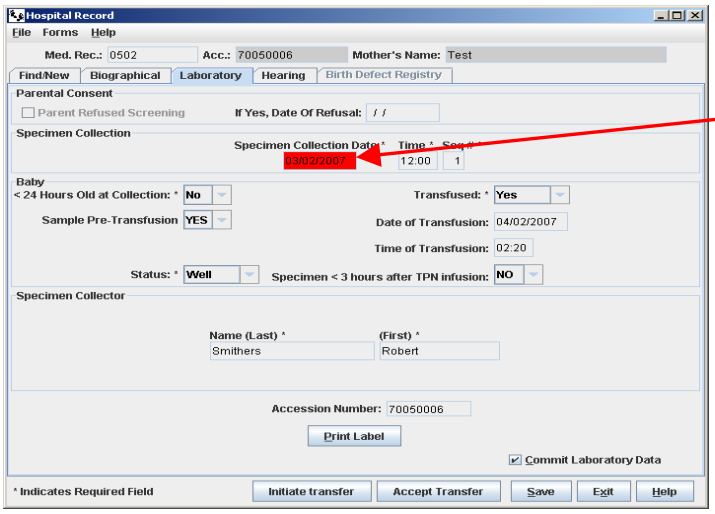


Figure 28

B. *How To Correct A Validation Error*

- Find the panel that has the field highlighted in red.
- Hold the mouse cursor over the highlighted field and a message will be displayed that explains the reason for the error.
- Click on the *'Commit'* checkbox located in the bottom right of the panel and 'uncommit' the record so the fields turn white.
- Delete the incorrect information in the field and add the correct data.
- Commit and Save the panel once completed.

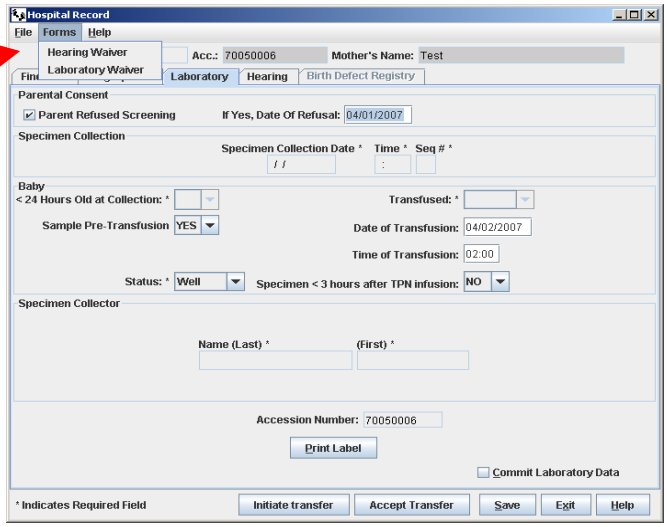
XII. Refusal Waivers

Although CT State Statute 19a-55 mandates Newborn Lab screening, and 19a-59 mandates Newborn Hearing screening, both regulations allow a family to refuse either screening if it is in conflict with their religious tenets or beliefs. The parent or responsible party must sign a refusal waiver for each Newborn Screen refused. *(See Appendix D, CT NBS Lab Refusal Waiver).*

A. How to Access a Waiver

- Enter the child's electronic record.
- Select ***'Forms'*** from the top menu bar and select the appropriate waiver *(Figure 29)*. The form will open in the Adobe Acrobat pdf format.
- To print out the waiver select ***'File'*** in the upper left corner of the panel.
- To avoid the waiver from being printed on the bar code label printer, change the printer setting to your desktop printer as explained in VIII. C. on page 14.
- Go to ***'File'*** in the upper left corner of the screen and select ***'Print'***.

Figure 29



B. Laboratory Refusal Protocol

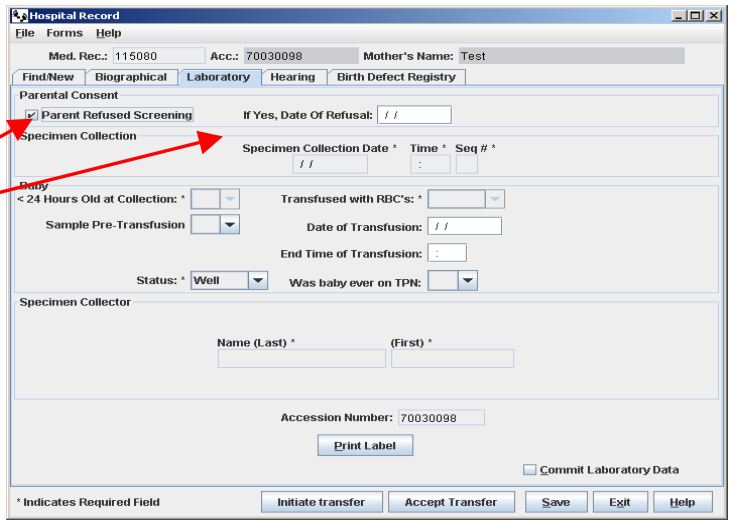
- Print out the ***Laboratory Refusal Waiver*** as explained above.
- Complete the form and have the parent or responsible party **sign** it.
- Place the **original** signed waiver in the child's medical record.
- Affix the **bar code** to the unused filter paper form.
- Write ***'Refused'*** on the filter paper form.
- **Mail** a photocopy of the signed waiver, along with the **unused filter paper form** to the State Lab in the envelopes provided by the DPH.

C. Documenting NBS Lab Refusals in the NSS

When a parent or responsible party refuses the Laboratory screen you must enter the results in the NSS.

- Open the child's electronic record in the NSS.
- Go to the *'Laboratory'* panel.
- Check off the *'Parent Refused Screening'* box as shown below in *Figure 30*.
- Enter the date of the refusal.
- Commit the panel.
- Notify the child's pediatric healthcare provider of the refusal.

Figure 30

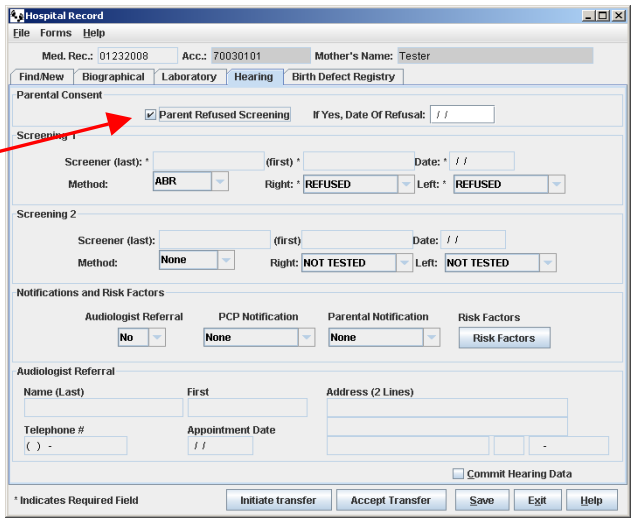


E. The Hearing Screen Refusal Waiver

When a parent or responsible party refuses the hearing screen you must enter the results in the NSS.

- Open the child's electronic record.
- Go to the ***'Hearing'*** panel.
- **Print** out the *Hearing Refusal Waiver* as explained above.
- Complete the form and have the parent or responsible party **sign it**.
- Place the **original waiver** in the child's medical record.
- **Fax** a copy of the signed waiver to the DPH fax number listed on the form: **Fax: 860 509-8132.**
- Notify the child's primary healthcare provider of the refusal.

Figure 30



F. Documenting Hearing Screen Refusals in the NSS

When a parent or responsible party refuses the hearing screen you must enter the results in the NSS.

- Open the child's electronic record.
- Go to the ***'Hearing'*** panel.
- Check off the *'Parent Refused Screening'* box as shown above in *Figure 30*.
- Enter the screening method.
- The *Right* and *Left* ear result fields will default to *'Refused'.*
- Enter the date of the refusal.

- ***'Commit'*** the hearing panel by checking the box in the lower right corner of the panel and then select ***'Save'***.
- Document the refusal in the infant's medical record.
- Notify the child's primary healthcare provider of the refusal.

XXV. Administrative Rights & User Access

Each hospital or birth facility should designate one or two nursing staff members as the Administrator(s) of the system. Administrative rights allow the designated staff person to:

- Add/remove users from the system.
- Control what panels the users can access.
- Determine who can generate report.

A. Adding a New User

To add a new user to the Newborn Screening System the person with ***Administrative rights*** must log onto the system using their User ID and Password. Once you are in the system and on the Main Menu page select:

- *'Access'* from the top toolbar as shown in *Figure 31.*
- Next select '*Manage Security'.*

Figure 31

The ***'Info Panel'*** will be displayed as shown in *Figure 32*. Add the information required for the new user, including a User ID and Password, Last Name and First Name.

- Assign panel access options by checking off the panel boxes located under ***NBS Access.***
- If you want the user to be able to generate reports, select the ***Report Access*** box.
- Once the information has been added, select ***'Insert'*** at the bottom of the screen.
- ***'Save'*** the panel when prompted.
- To verify that the new user access has been added, log out, and then log in as the new user.

****NOTE: The USER ID cannot be duplicated in any of the 31 hospitals using NSS. For example, if two hospitals have a nurse by the name of K. Smith, only one can use ksmith for the USER ID. The second user will have to use smithk, or another unique User ID.**

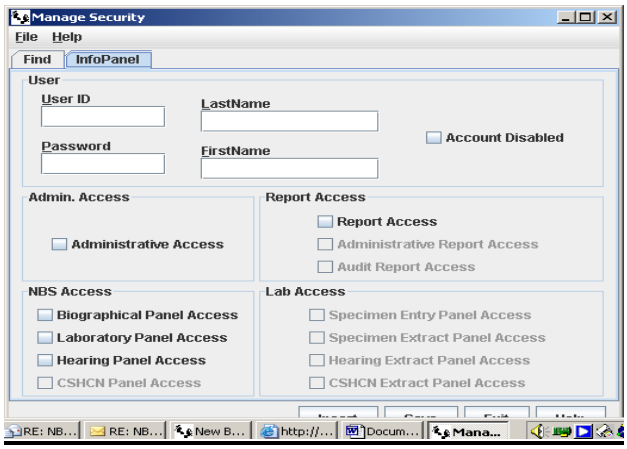
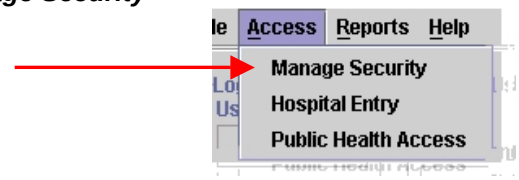


Figure 32

B. Disabling User Access

To remove a user from the Newborn Screening System the person with Administrative rights must log onto the system using their User ID and Password. Once you are in the system and on the Main Menu page select

- ***'Access'*** from the top toolbar as shown below
- Next select ***'Manage Security'***



- The ***'Find'*** panel will be displayed as shown below in *Figure 33*.

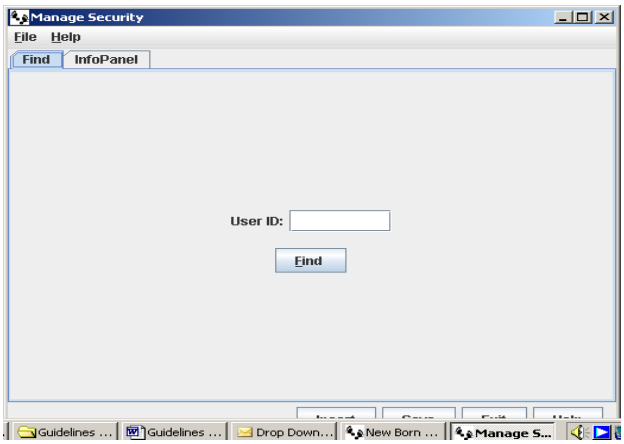


Figure 33

- Type in the ***User ID*** of the person you want to remove from the system. The User ID is normally the first initial and last name of the user.
- Select ***Find***
- The ***'Info Panel'*** for that person will open.
- Select the ***'Account Disabled'*** box as shown in *Figure 34.*
- *Select* ***'Insert'***
- Save the panel when prompted.
- To verify that user access has been removed, log out of the Newborn Screening System and try to log in as the disabled user. If the account is disabled you should not be able to log in as the user.

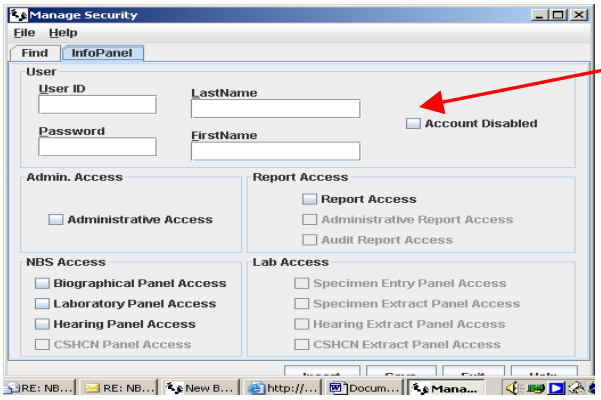


Figure 34

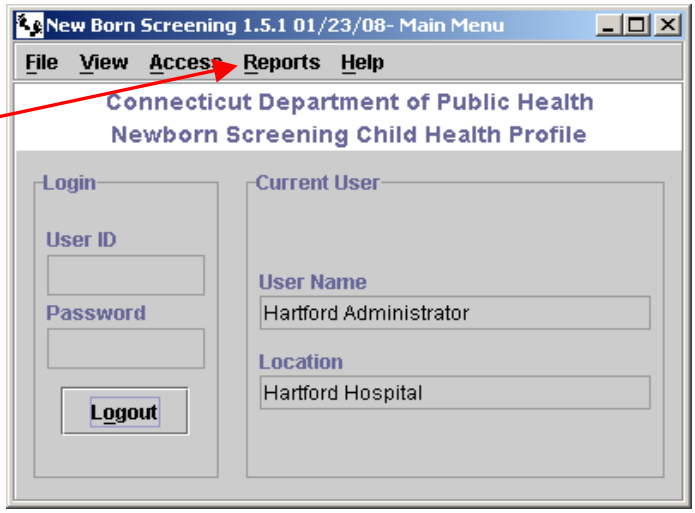
XXVI. Reports

A. *Exception Reports*

Only users with that have been given '*Report Access*' by the Administrator can generate or view reports. Normally the Administrator is your Nurse Manager, or other designated person. To access the report options go to the '*Main Menu*' screen.

- Select ***'Reports'*** from the top toolbar (Figure 35).

Figure 35



- Select ***'General Reports'*** from the dropdown list (Figure 36).

Figure 36

There are three useful report options in General Reports:

1. **Lab Data Exception Report:**
   Requires entry of a **date range**, then lists all records that have had the Biographical data committed, but not the Lab data.

2. **Hearing Data Exception Report:**
   Requires entry of a **date range**, then lists all records that have had the Biographical data committed, but not the Hearing data.

3. **Birth Defect Exception Report:**
   Requires entry of a **date range**, then lists all records that have had the Biographical data committed, but not the Birth Defect Registry panel.

B. How to Run an Exception Report

Select the Report that you want to generate from the list shown in *Figure 36*. The following screen will appear *(Figure 37)*.

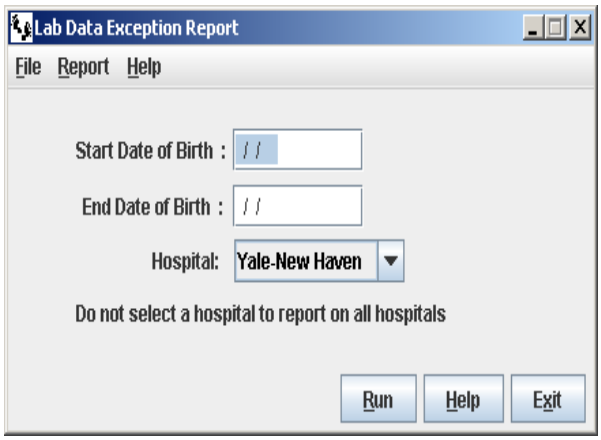


Figure 37

- Enter the start and end birth dates of the time period that you want to view. Dates must be entered in the MM/DD/YYYY format.
- Select your hospital/facility name from the dropdown box. You can only view reports from your facility.
- Select ***'Run'***
- The report will open in an Adobe Acrobat pdf file.
- Review the list records with uncommitted panels.
- Promptly commit any panel in a newborn's record if the screening has been completed.

XXVII. Surrogate Births

Hospitals are required by law to enter the name of the birth mother on the child's official Birth Certificate. This is the actual person who delivered the baby. Often with a surrogate birth, the surrogate mother and parent who will take the baby after delivery have entered into a *'Gestational Agreement'*. This is a legal contract that is often in place before the delivery of the baby.

If it is a surrogate birth, indicate 'Yes" on the Biographical panel as shown in *Figure 38*.

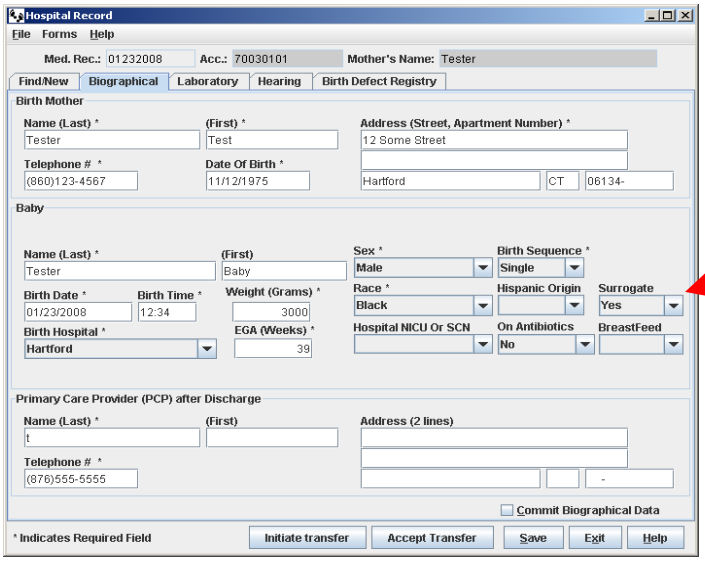


Figure 38

IF there is a *Gestational Agreement* in place, the necessary paperwork is sent to the Department of Public Health, State Office of Vital Records by the birth facility. The State Office of Vital Records will issue a new birth certificate for the baby, with the "legal" parent's name.

Once the gestational agreement is in place and there is a legal name change, as required by law, all records of the birth mother's identity must be removed from the birth certificate and any other databases.

- If the birth mother is a surrogate, **enter the name of the birth mother** in the NSS.
- Select ***'Yes'*** from the Surrogate dropdown box on the Biographical panel as shown in *Figure 38.*
- Complete the data entry and commit the panel.

If there is NOT a *Gestational Agreement* in place, the mother's name should remain as the name of the person who delivered the baby. Under no circumstances is the birth mother's name changed at the birth facility or DPH without a legal Gestational Agreement in place. Often times there are only verbal agreements between the surrogate and mother who will take the baby. In this case, the name must stay as the birth mother, the person who delivered the baby.