Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ___Olivia Arthur_____ **Date** ____08/31/23_____

Noticing/Recognizing Cues:

Highlight all related/relevant data from the Noticing boxes that support the top priority problem

Assessment findings*:

Acrocyanosis
T 98.9 before bath; 97.7 after bath under warming light
P 122
R 48
Newborn Rash on right side of chest
NIPS score 6
Right testes higher than left
Witnessed circumcision- penis beefy red, light bleeding
Milia across nose
Has not eaten since 0900
Length: 50.80cm
Birth weight: 3.42kg (7lbs 9oz)
Head Circumference: 34 cm
Baby not wearing a hat
Congenital Heart Screen: negative

Lab findings/diagnostic tests*:

- IgG specific: negative
- Rubella: immune
- Antibody screen: negative
- Chlamydia: negative
- HBsAG: negative
- Bilirubin: 6.6
- Blood Type: O+
- Hearing Screening: failed
-

Risk factors*:

Leaving Hospital before recommended time
Inappropriately dressed
Limiting time under warming lamp
Uneducated parents
Baby's age: 1 day old
Other young children in house
No pediatrician follow-up
Low Birth Weight
Premature Delivery

-

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

Nursing priorities*: *Highlight the top nursing priority problem*

- 1. Risk for Ineffective Thermoregulation
- 2. Impaired Skin Integrity r/t Circumcision and Newborn Rash
- 3. Risk for Infection r/t Circumcision
- 4. Knowledge Deficit r/t Newborn Management

Potential complications for the top priority:

- 1. Hypothermia: cool/pale extremities, poor feeding, T<97.7
- 2. Hypoglycemia: Tremors, lethargy, weak/high-pitched cry
- 3. Shock: low BP, tachycardia, tachypnea/apnea

(Linnard-Palmer et al., 2021)

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ___Olivia Arthur_____ Date ____08/31/23_____

Responding/Taking Actions:

Nursing interventions for the top priority:

1. 1. Assess vital signs (Temperature, Pulse, Respirations) Q4-8H for 24 HR – To assess for any changes that may indicate newborn is in distress
2. 2. Assess Skin for integrity, color, temperature, moisture (Q4H or PRN with diaper change) – To ensure that the newborn is not losing too much heat; to ensure umbilical cord is drying and intact; to ensure circumcision site does not show signs of infection or excessive bleeding; to ensure newborn rash is not getting worse or causing other symptoms; to assess for presence of milia
3. 3. Reassess NIPS score (Q4H or PRN) – To assess for signs/symptoms of pain or distress
4. 4. Reassess testicular placement (Q4H or PRN with diaper change) – To assess for placement of right testicle; is it still high or is it normalizing?
5. 5. Assess feeding regimen (Q2H) – To assess how often and duration of nursing to assess for adequate nutrition intake
6. 6. Assess weight (Once Daily) – To assess for weight gain or weight loss to indicate efficiency of nutrition intake
7. 7. Assess length (Once Daily) – To assess for any growth
8. 8. Assess Head circumference (Once Daily) – To assess for signs of dehydration or increased ICP
9. 9. Wrap/swaddle baby in extra blankets (PRN)- To warm newborn if temperature drops below 97.7
   10. Cover head with a hat (Daily unless fever is present)- To prevent heat loss through head (greater surface area)
10. 11. Utilize warming lamp when bathing and performing Newborn Assessment (Daily/Q4H/PRN)- To ensure baby's temperature is regulated when unclothed/unswaddled
11. 12. Promote skin-to-skin contact between mom and baby and breastfeeding (PRN/anytime in room) – To promote bonding and proper breastfeeding
12. 13. Repeat hearing screening using double ear cuffs (After initial failed screening) – to ensure a referral is not needed for potential hearing problems
13. 14. Change diapers immediately after soiled and apply Vaseline to front portion of diaper (PRN)- to prevent infection of circumcision site and promote proper healing
14. 15. Sponge bathe (Q2days or PRN)- Until umbilical cord has fallen off
15. 16. Schedule Lactation Consult (PRN) – to Ensure that baby has a proper latch and is receiving adequate nutrition
16. 17. Educate Parents on thermoregulation and risks of leaving hospital early (Upon Discharge) – To ensure that parents know what possible complications to look for and how to take care of postpartum mom and newborn baby; prevent hypothermia
17.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- T 98.0 (Before 2nd assessment)
- P 117
- R 42
- Acrocyanosis still present
- NIPS score: 0
- Breastfed around 1300
- Daily Weight: 3.42kg
- Length: 50.80cm
- Head Circumference: 34 cm

Baby Still not wearing a hat
Hearing Screening with double Ear cuffs: Passed
Newborn rash still present, but not worsening
Right testes still higher than left
Milia still present across nose

Recommendation:

Some improvement in assessment findings.

Discontinue care. Pt requesting discharge to home.

Provide discharge education and papers.

Linnard-Palmer, L., Coats, G. H., Linnard-Palmer, L., & Linnard-Palmer, L. (2021). *Safe maternity and pediatric nursing care. second edition ; study guide for safe maternity and pediatric nursing care. Second edition*. F.A. DAVIS.