Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____Abigail Foote_____ Date ___9/24/25_____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Nasal Flarring
- Respiratory retractions
- APGAR score at 1 minute of 4
- Weight of 7lbs 14oz
- Head circumference of 14 inches
- Chest circumference of 13 inches
- Height of 19 inches
- Low temperature of 36.4 Celsius
- Respiratory distress needing mechanical ventilation
- Spontaneous respiratory delay
- Heart rate of 130 bpm
- Respiratory rate of 0: no respiratory effort

Lab findings/diagnostic tests*:

- Glucose of 58
- DAT was negative
- O positive blood

Arterial Cord Gases

- pH of 7.33
- CO2 of 42.7
- O2 of 31.3
- Bicarb of 21.5

Risk factors*:

- Breech position at time of birth
- Cesarian birth
- 2-minute delay birth of head
- Geriatric pregnancy
- Mothers BMI of 39.1

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Ineffective breathing pattern
- Ineffective airway clearance
- Respiratory distress
- Thermoregulation
- Impaired glucose tolerance
- Impaired gas exchange
- Imbalanced nutrition

Goal Statement: Newborn displays an improvement in breathing pattern.

Potential complications for the top priority:

- Neonatal death
  - No respiratory rate
  - No heart rate
  - Cyanosis
  - Unresponsive to stimulation
- Pneumothorax
  - Shortness of breath
  - Rapid respiratory rate
  - Chest pain
  - Tracheal shift
  - Fatigue
  - Cyanosis
- Hypoglycemia
  - Weakness
  - Cool and clammy skin
  - Fatigue
  - Irritability

Responding/Taking Actions:

Nursing interventions for the top priority:

- Provide baby with warmth by putting them under the warmer at birth and as needed.
  - To provide baby with comforting temperatures to maintain a stability because they cannot maintain their own temperature.
- Assess respiratory rate and heart rate immediately after birth.
  - To assure infants stability and help intervein with infants needs to live,
- Perform suction of infant at birth.
  - To clear all secretions from infant's airway.
- Stimulation of infant after birth.
  - To help infant become responsive.
- Perform mechanical ventilation with c-pap as needed until stable.
  - Ro help assist infant with breathing and oxygen until they can on their own.
- Perform continuous monitoring of infant's pulse oximetry for the first 4 hours until stable.
  - To help monitor for sudden decreases in pulse oximetry, ruling out sudden infant death and long-term complications. Also to maintain a stable reading of the pulse oximetry.
- Assess vital signs every 15 minutes for the first 4 hours, then every 30 minutes for the next 2 hours, after that 1 every 4 hours and then Q8hrs.
  - To check the stability of the infant.
- Perform complete newborn assessment of infant on admission and Q8hrs.
  - To identify any new findings needing interventions and determining infants' health through their stay.
- Perform glucose checks on admission and Q4hrs until infant passes 4 glucose checks in a row.
  - Performing glucose checks can help determine if they have a blood sugar issue that could relate to low temperature readings and respiratory distress.
- "Review laboratory data, such as ABGs (determines degree of oxygenation and carbon dioxide retention), drug screens, and pulmonary function studies" (Doenges, Moorhouse, & Murr, 2022, para. 23)
  - To determine what gases infant is lacking in to provide care to stabilize their labs.
- Perform focused respiratory assessments at birth and every hour.
  - To identify any abnormal findings.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority: Continue Plan of Care

- Respiratory rate of 34- improved.
- Temperature of 98.6 Fahrenheit- improved.
- Glucose of 55 which was maintained in normal range.
- Arterial cord gases were not repeated.
- APGAR score at five minutes was 8- improved.
- Mechanical ventilation discontinued and infant was able to breath on her own- improved.
- Spontaneous respirations within normal limits- improved.
- No sign of nasal flaring- improved.
- No sign of retractions and unlabored breath occurred- improved.

Reference: Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2022). *Nurses' pocket guide: Diagnoses, prioritized interventions, and rationales* (16th ed). F. A. Davis Company: Skyscape Medpresso, Inc.