Firelands Regional Medical Center School of Nursing
Nursing Care Map

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Noticing/Recognizing Cues:

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

Assessment findings*:

- APGAR @ 1 min (4) *7lb 14oz
- APGAR @ 5 min (8)
- Nasal Flaring @ birth
- Retractions
- Weak cry
- No reflex @ birth
- Limp body @ birth
- Cyanosis @ birth
- "0" respiratory effort (CPAP)
- HR 130 @ birth
- R 0 @ birth
- T97.7 @ birth
- HR 120-reeval
- R 34-reeval
- T98.6-reeval
- SpO_2 97% RA-reeval

Lab findings/diagnostic tests*:

- DAT (neg)
- Glucose 58
- Glucose 55-reassess
- 0+ blood type
- pH 7.33(low)ABG cord blood
- CO_2 42.7 (N)ABG cord blood
- O_2 31.3 (low)ABG cord blood
- HOC_3 21.5 (low)ABG cord blood

Risk factors*:

- Breech presentation
- Caesarean section
- 2 min delayed delivery of head
- AMA Mom (geriatric)
- High BMI Mom (39.1)

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Ineffective breathing pattern
- Impaired circulation
- Impaired nutrition

Goal Statement:

Patient will display an effective breathing pattern.

Potential complications for the top priority:

- Hypoglycemia
  - Client LOC
  - Note skin changes
- Pneumothorax
  - Note rate and depth of respirations
  - Note respiratory sounds
- Respiratory arrest
  - Client alert &/able to sustain spontaneous respirations
  - Note rate and depth of respirations

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess APGAR score q5 min until > 7
   a. Assess patient's breathing efforts
   b. Ensure patient is pink all over
   c. Ensure patient HR >110/<160
   d. Evaluate baby's response to stimulation
   e. Observe muscle tone and movement
2. Assess nasal flaring q5 min until gone
   a. Assess O_3 level
   b. Ensure supplemental O_2 is being provided returns
3. Assess retractions q5 min until gone
   a. Assess O_2 level
   b. Ensure supplemental O_2 is being provided (Linnard-Palmer&HaileCoats,2025,p.244)
4. Assess weak cry q5 min until strong cry
   a. Ensure patient muscle tone is returning to normal range
   b. Change baby's position to encourage breathing
5. Assess baby's skin color q5 min until pink all over
   a. Assess O_2 level
   b. Ensure stimulation of baby
6. Assess respiration effort q1 min until RR 40-60
   a. Assess O_2 level
   b. Encourage stimulation of newborn
7. Assess muscle tone q5 min until strong
   a. Assess movement in extremities
   b. Encourage stimulation of newborn
8. Monitor ABGs q2 h until within normal range
   a. Notify HCP for this need to order
9. Monitor newborn for breathing pattern q30 sec until breathing
   a. Encourage stimulation of newborn
   b. Ensure use of CPAP/O_2 mask if necessary

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- APGAR score 8
- Nasak flaring, retractions, weak cry, absent muscle tone and reflex, RR, and skin color all return to normal on reassessment
- Breathing present with RR 34 and climbing
- T 98.6
- HR 120
- RR 34
- SpO_2 97%

*** Continue with plan of care for patient**

Reference:

Skyscape. (1998-2030). Skyscape Nurse's Pocket Guide (Version 3.3.0) [iOS iPhone]. Retrieved from http://itunes.apple.com/