N432 Newborn Care Plan

Lakeview College of Nursing

Peyton Luesse

Demographics (10 points)

Date & Time of Clinical Assessment:

Date & Time of Birth 09/22/2020 0143	**Patient Initials** MB	**Age** **(in hours at the time of assessment)** 31 hours	**Gender** Female
Race/Ethnicity African American	**Weight at Birth** **(gm) ___3445____** **(lb.) _7_ (oz.) _9.5_**	**Weight at Time of Assessment** **(gm) __3310___** **(lb.) _7__ (oz.) __4.8_**	**Age (in hours) at the Time of Last Weight** 25 hours
Length at Birth **Cm __50.01____** **Inches __19.69____**	**Head Circumference at Birth** **Cm ___33____** **Inches ___12.99____**	**Chest Circumference at Birth** **Cm ___33____** **Inches __12.99____**	

There are times when the weight at the time of your assessment will be the same as birth

Mother/Family Medical History (15 Points)

Prenatal History of the Mother:

When prenatal care started: 9 months before birth- December

Abnormal prenatal labs/diagnostics: None

Prenatal complications: None

Smoking/alcohol/drug use in pregnancy: None

Labor History of Mother:

Gestation at onset of labor: 38 weeks and four days

Length of labor: 1 hour

ROM: Spontaneous natural rupture of membranes

Medications in labor: Oxytocin

Complications of labor and delivery: None

Family History: None

Pertinent to infant: None

Social History (tobacco/alcohol/drugs): Mother did not partake in any drinking, smoking, or drugs during pregnancy

Pertinent to infant: None

Father/Co-Parent of Baby Involvement: Father is involved in the child's care and life

Living Situation: Lives in a house with mom, dad, and three other children

Education Level of Parents (If applicable to parents' learning barriers or care of infant): Mother is in college, and the father graduated high school, and there are no learning barriers.

Birth History (10 points)

Length of Second Stage of Labor: 2 minutes

Type of Delivery: Natural vaginal birth

Complications of Birth: None

APGAR Scores:

1 minute: 9

5 minutes: 9

Resuscitation methods beyond the normal needed: None

Feeding Techniques (10 points)

Feeding Technique Type: Breastfeeding

If breastfeeding:

LATCH score: 10

If bottle feeding:

Positioning of bottle:

Suck strength:

Amount:

Percentage of weight loss at time of assessment: ___4___%

3310/3445=0.96 1-0.96=0.04

****Show your calculations; if today's weight is not available, please show how you would calculate weight loss (i.e. show the formula)****

What is normal weight loss for an infant of this age?

A 7-10% weight loss within the first 5-7 days of life is normal

Is this neonate's weight loss within normal limits?

Yes- at one day old, it lost 4%, and within the next few days, it will fall into normal limits.

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency: Every 4 hours

Length of feeding session: 15-20 minutes

One or both breasts: Both breasts

If bottle feeding:

Frequency:

Volume of formula per session:

If NG or OG feeding:

Frequency:

Volume:

If IV:

Rate of flow:

Volume in 24 hours:

Output

Age (in hours) of first void: 8 hours

Voiding patterns:

Number of times in 24 hours: 6

Age (in hours) of first stool: 8 hours

Stool patterns:

Type: meconium

Color: light brown

Consistency: sticky

Number of times in 24 hours: 5

Laboratory Data and Diagnostic Tests (15 points)

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Name of Test	Why was this test ordered for THIS client? *Complete this even if these labs have not been completed*	Expected Results	Client's Results	Interpretation of Results
Blood Glucose Levels	To make sure the infant can control its blood sugar levels	30-60 mg/dL	N/A	N/A

Blood Type and Rh Factor	To check the infant's blood and double-check data gathered before birth. Also, check and see if the baby needs medication/blood products.	B+	B+	The baby should have had the same blood type as both mother and father.
Coombs Test	It detects antibodies that act against the baby's RBCs. It can indicate hemolytic anemia.	0.3-5.7	N/A	N/A
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	To check if the circulating amount of bilirubin is normal or not. This test, in turn, checks the liver function of the infant.	0.3-5.7	0.6	The bilirubin level is within normal limits, and so the baby's liver is functioning correctly.
Newborn Screen (At 24 hours)	This checks for any birth defects an infant may have.	No abnormalities	N/A	N/A
Newborn Hearing Screen	It is to determine if the ears are working correctly on the newborn or detect malfunctions like deafness.	Hearing intact	Baby's hearing was intact on the left side but not the right.	The baby can normally hear out of the left ear but will have to go through further testing to determine if she can hear out of the right ear properly. This test shows she cannot.
Newborn Cardiac Screen (At 24 hours)	This test is to test the infant for congenital heart defects.	Passes screen	N/A	N/A

Lab Data and Diagnostics Reference (APA):

ATI. (2019). *RN maternal newborn nursing* (11th ed.). Assessment Technologies Institute.

Ricci, S., Kyle, T., Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.) Lippincott, Williams & Wilkins.

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**	**Sucralose Solution**	**N/A**
Dose	1 mg	One drop per eye	N/A	0.5 mL	
Frequency	Once	Once	N/A	PRN	
Route	IM	Ophthalmic drop	N/A	Oral	
Classification	Vitamin	Antibiotic	N/A	analgesic	
Mechanism of Action	Synthesis of clotting factors	"Binds to ribosomal subunit and inhibits RNA dependent protein synthesis in bacterial cells, causing them to die" (Jones & Bartlett, 2019).	N/A	Taste stimulation to cell membrane receptors in the brain helps to reduce pain.	
Reason Client Taking	To prevent hemorrhagic disease	Prevents conjunctivitis	N/A	Prevent or reduce pain from procedures	
Contraindications (2)	Hypersensitivity and liver dysfunction/disease	Hypersensitivity and hepatic disease	N/A	Suspected enterocolitis Altered gag reflex	
Side	Flushing,	Fever	N/A	Hyperglycemi	

Effects/Adverse Reactions (2)	hypotension	Jaundice		a Choking on solution	
Nursing Considerations (2)	You must administer 1-2 hours after birth (Ricci et al., 2017). Administer in the upper leg.	Apply from the inner canthus out. Close the eye to make sure the medication spreads throughout the eye.	N/A	Has to be stored in a refrigerator Monitor the amount the infant receives	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for bleeding and monitor the platelet count	Monitor heart rate and rhythm	N/A	Monitor blood glucose levels and vital signs	
Client Teaching needs (2)	Bleeding precautions and side effects of medication	Educate the mother not to touch the ointment Notify provider if the infant experiences and side effects	N/A	Inform the parents of the purpose of the medication Inform them that it should only be used in the hospital setting, not at home.	

Medications Reference (APA):

Jones & Bartlett. (2019). *Nurse's drug handbook (*18th ed.). Jones & Bartlett Publishers, Inc.

Kendrick, A. (2018). Sucrose(oral) for procedural pain management in infants. The Royal Children's Hospital Melbourne. https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Sucrose_oral_for_procedural_pain_management_in_infants/#:~:text=Definition%20of%20Terms,be%20effective%20in%20pain%20reduction.

Ricci, S., Kyle, T., Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.) Lippincott, Williams & Wilkins.

Newborn Assessment (20 points)

Area	Your Assessment	Expected Variations and Findings *This can be found in your book on page 645*	If assessment finding different from expectation, what is the clinical significance?
Skin	Skin color appropriate for ethnic background. No jaundice or rashes noted. Skin turgor is good, less than 3 seconds. Temperature is within normal limits.	Smooth, flexible, good skin turgor, well-hydrated, warm	Findings within normal limits
Head	Normocephalic and symmetric. No abnormalities present.	Symmetrical and normocephalic	Findings within normal limits
Fontanels	The anterior fontanelle is palpable and soft. The posterior fontanelle is palpable and triangular.	Diamond-shaped anterior fontanelle triangular-shaped posterior fontanelle	Findings within normal limits
Face	Full cheeks with symmetric facial features. No abnormalities present.	Full cheeks, facial features symmetric	Findings within normal limits
Eyes	Baseline set, pupils are equal. Eyes are clear and symmetrically positioned. The red reflex is present bilaterally. No eyelid edema or discharge was noted.	Clear and symmetrically placed on the face, in line with ears	Findings within normal limits
Nose	Nares are patent, no septal deviation. The nose is midline.	Small, midline, narrow, sense of	Findings within normal limits

	Sense of smell intact.	smell intact	
Mouth	Oral mucosa moist, pink and intact. Palate baseline shape and undamaged.	Aligned in the midline, symmetric, intact soft and hard palate	Findings within normal limits
Ears	Ears are soft and pliable with quick recoil. They are symmetrically positioned on the head.	Soft and pliable with quick recoil when folded and released	Findings within normal limits
Neck	The neck is short and creased. It holds the head at the midline.	Short, creased, moves freely, baby holds head in midline	Findings within normal limits
Chest	The chest is round and symmetric, with no abnormalities noted.	Round, symmetric, smaller than head	Findings within normal limits
Breath Sounds	Vesicular breath sounds heard in all lobes. Symmetric and regular.	Bilateral lung sounds. No diminished breath sounds noted.	Findings within normal limits

Heart Sounds	S1 and S2 heard upon auscultation. No extra heart sounds present. Regular rate and rhythm.	S1, S2, and no S3	Findings within normal limits
Abdomen	The abdomen is protuberant and soft. There are three vessels present in the umbilical cord.	Protuberant contour, soft, three vessels in the umbilical cord	Findings within normal limits
Bowel Sounds	Normoactive bowel sounds auscultated in all four quadrants	Bowel sounds are auscultated in all four quadrants.	Findings within normal limits
Umbilical Cord	Umbilical vein and arteries are seen, and the vein seems to be larger than the arteries.	Umbilical vein larger than two arteries.	Findings within normal limits
Genitals	Labia is midline and intact. Folds are intact.	Labia midline and intact. All parts are intact.	Findings within normal limits
Anus	Normal position and patency indicated by the passing of meconium	Normal position and patency indicated by the passing of meconium	Findings within normal limits
Extremities	Extremities symmetric with free movement	Extremities symmetric with free movement	Findings within normal limits
Spine	Spine symmetrical and palpable along the entire length. No lateral curvature	Spine symmetrical and palpable along the entire length. No lateral curvature	Findings within normal limits
Safety • **Matching bands with parents** • **Hugs tag** • **Sleep position**	Matching parental bands and hug tags present. The newborn is swaddled and sleeping on their left side.	Matching parental bands, hugs tag on the ankle, and swaddled.	Findings within normal limits

Complete the Ballard Scale grid at the end to determine if this infant is SGA, AGA, or LGA—be sure to show your work

What was your determination? AGA- Age appropriate for gestational age

Are there any complications expected for a baby in this classification? No

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**
Birth	99.2 F – 37.3 C	160 bpm	42
4 Hours After Birth	98.6 F- 37 C	156 bpm	52
At the Time of Your Assessment	98.0 F- 36.7 C	156 bpm	52

Vital Sign Trends: Heart rate and temperature decreased from birth but are remaining stable post-birth. Respirations increased. Vital signs are within the normal range.

Pain Assessment, 1 set (2 points)

Time	**Scale**	**Location**	**Severity**	**Characteristics**	**Interventions**
0800	FACES	N/A	N/A	N/A	N/A

Summary of Assessment (4 points)

Discuss the clinical significance of the findings from your physical assessment:

****See the example below****

This infant was delivered on 9/22/2020 at 0143 by normal spontaneous vaginal delivery (NVSD). Apgar scores 2/2/2/2. EDD 10/2/2020. It is revealed that the infant is 38 4/7 weeks LGA. Prenatal hx is not complicated by anything. Birth weight was 7 pounds 9.5 ounces (3445 grams), 19.69 inches long (50.01 cm). Upon assessment, all systems are within normal limits besides the right ear of the infant. The right ear did not pass the hearing exam and will be tested further. Last set of vitals: 36.7/156/52. BS not available. The infant is breastfeeding and nursing well with all feedings 20" 20" q4 hours. The bilirubin level at 24 hours per scan was 0.6. infant expected to be discharged with the mother later today at 2 pm to see the pediatrician in the office for the first well-baby visit within 48 hours.

Nursing Interventions and Medical Treatments for the Newborn (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	**Frequency**	**Why was this intervention/ treatment provided to this patient? Please give a short rationale.**
Swaddled (N)	PRN	This intervention was provided to ensure the baby stays warm and comfortable. Swaddling helps the baby stay comfortable by providing a confined space like the womb.
Hearing screening (N)	Once	This intervention is done to determine if the infant has normal hearing abilities and if their auditory function is intact.
Vital signs (N)	Q4	This intervention is performed to monitor the newborn and recognize any issues within heart rate, blood pressure, oxygen level, or respiratory rate.
Administration of sucralose solution (T)	PRN	This treatment is given to comfort the infant in uncomfortable procedures like the hearing exam or a heel prick.

Discharge Planning (2 points)

Discharge location: Home with mother and father

Equipment needs (if applicable): None

Follow up plan (include plan for newborn ONLY): See pediatrician in 48 hours (9/25/2020) for the first well-baby visit and receive the Hepatitis B vaccination.

Education needs: The mother and father need to receive information on the results of their child's hearing exam and the steps to take moving forward. They have to be educated to be tested again at the well-baby visit.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client."

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (1 pt each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk of infection due to young age and minimal immune response as evidenced by the newborn's	There is always a chance an infant could get sick because they have little to no immune	1. Everyone will perform hand hygiene before touching the infant. Rationale: Measures for infection prevention include thorough handwashing hygiene for all staff (Ricci et al., 2017).	The mother was receptive and understood the importance of hygiene for the infant to prevent infection.

immune system deficiency.	system, which is always a concern.	2. Mother and father will receive education on the importance of keeping pathogens away from the infant to avoid infection. This education could be taught by giving the parents pamphlets about different infections and what the outcomes of each could be. Rationale: By promoting a better understanding of newborn infections and appropriate actions, nurses can lower the mortality rate (Ricci et al., 2017).	
2. Risk of tissue damage due to invasive procedures, as evidenced by the heel prick wound.	This diagnosis was chosen because the heel prick done by the medical team could potentially cause tissue damage because it is an invasive procedure at a very young age.	1. The wound will be kept clean and free of debris. Rationale: Any break in the skin is a portal of entry for bacteria. Keeping the wound clean will decrease the chance of damage (Ricci et al., 2017). 2. The parents will be educated on the importance of hygiene and keeping the wounds clean to avoid any tissue damage. This education could be taught by showing the parents how to properly clean the wound and asking them to demonstrate the next time. Rationale: By promoting a better understanding of newborn infections and appropriate actions, nurses can lower the mortality rate (Ricci et al., 2017).	The mother was receptive to the information and understood the importance of cleaning the wound periodically.
3. Potential risk of altered nutrition due to raised metabolic rate	This diagnosis was chosen because if the infant does not eat enough, she	1. Infant will be offered milk every 2-4 hours. Rationale: A mother is encouraged to feed the newborn every 2 to 4 hours	The mother was receptive to the information and understood the importance of frequent

as evidenced by weight loss in the first day of life.	could become malnourished because she cannot keep up with her new body needs.	during the day (Ricci et al., 2017). 2. Assure the infant is fed on demand when it acts hungry. Rationale: Most newborns are on-demand feeding schedules and are allowed to feed when they awaken (Ricci et al., 2017).	feedings and ensuring the infant gets enough milk to satisfy its appetite.
4. Potential for fluid volume deficit related to increased insensible water loss, as evidenced by the infant's vital signs.	This diagnosis was chosen because the infant cannot express or realize what thirst is, and it could become dehydrated from that which could lead to a fluid volume deficit.	1. Assure the infant is receiving milk every 2-4 hours to replenish the baby's fluid. Rationale: A mother is encouraged to feed the newborn every 2 to 4 hours during the day (Ricci et al., 2017). 2. Assure the infant is getting an adequate amount of milk with every feeding to maintain fluid volume. Rationale: Fluid requirements for the infant range from 100-150 mL/ daily (Ricci et al., 2017).	The mother was receptive to the information and understood the importance of adequate fluid intake.

Other References (APA):

Nanda Nursing Diagnosis (2020). Newborn nursing diagnosis. Nanda nursing diagnosis list. http://www.nandanursingdiagnosislist.org/newborn-nursing-diagnosis/

Ricci, S., Kyle, T., Carmen, S. (2017). Maternity and pediatric nursing (3rd ed.) Lippincott, Williams & Wilkins.

Ballard Gestational Age Scale

Neuromuscular Maturity

Score	−1	0	1	2	3	4	5
Posture							
Square window (wrist)	 > 90°	 90°	 60°	 45°	 30°	 0°	
Arm recoil		 180°	 140–180°	 110–140°	 90–110°	 < 90°	
Popliteal angle	 180°	 160°	 140°	 120°	 100°	 90°	 < 90°
Scarf sign							
Heel to ear							

Physical Maturity

Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; rare veins	Parchment, deep cracking; no vessels	Leathery, cracked, wrinkled
Lanugo	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	
Plantar surface	Heel-toe 40–50 mm: −1 < 40 mm: −2	> 50 mm, no crease	Faint red marks	Anterior transverse crease only	Creases anterior 2/3	Creases over entire sole	
Breast	Imperceptible	Barely perceptible	Flat areola, no bud	Stippled areola, 1–2 mm bud	Raised areola, 3–4 mm bud	Full areola, 5–10 mm bud	
Eye/Ear	Lids fused loosely: −1 tightly: −2	Lids open; pinna flat; stays folded	Slightly curved pinna; soft; slow recoil	Well curved pinna; soft but ready recoil	Formed and firm, instant recoil	Thick cartilage, ear stiff	
Genitals (male)	Scrotum flat, smooth	Scrotum empty, faint rugae	Testes in upper canal, rare rugae	Testes descending, few rugae	Testes down, good rugae	Testes pendulous, deep rugae	
Genitals (female)	Clitoris prominent, labia flat	Clitoris prominent, small labia minora	Clitoris prominent, enlarging minora	Majora and minora equally prominent	Majora large, minora small	Majora cover clitoris and minora	

Maturity Rating

Score	Weeks
−10	20
−5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

4,4,4,4,4,4

Abundant, creases over entire sole, full areola 5-10 mm bud, formed and firm instant recoil, majora cover clitoris, and minora

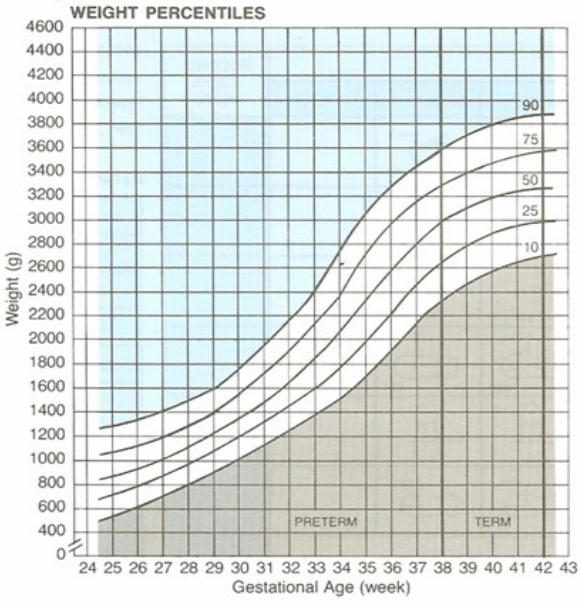
CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE [1,2]

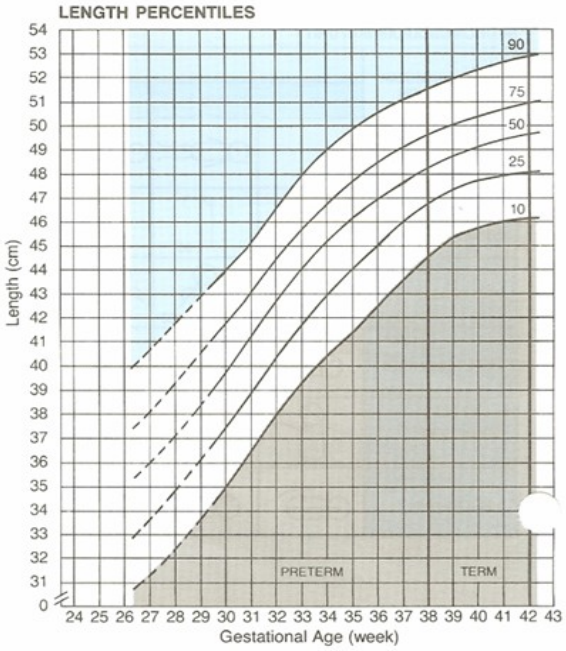
NAME _____ DATE OF EXAM _____ LENGTH _____

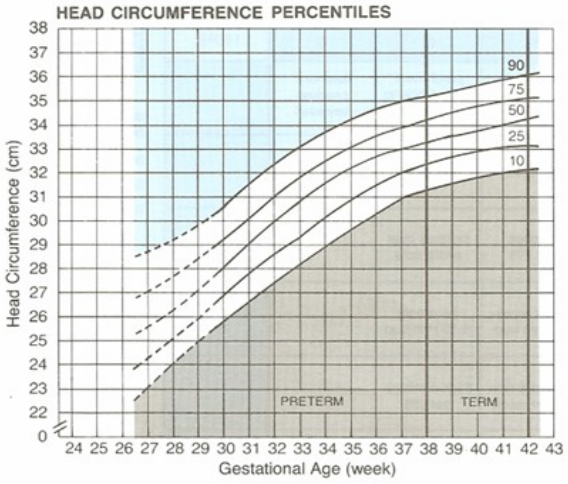
HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____







CLASSIFICATION OF INFANT*	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)			
Appropriate for Gestational Age (AGA) (10th to 90th percentile)			
Small for Gestational Age (SGA) (<10th percentile)			

*Place an "X" in the appropriate box (LGA, AGA or SGA) for weight, for length and for head circumference.

References
1. Battaglia FC, Lubchenco LO: A practical classification of newborn infants by weight and gestational age. J Pediatr 1967; 71:159-163

Weight: 3445 g
Length: 50.01 cm
Head Crc: 33 cm
All in the AGA range