

N432 Newborn Care Plan
Lakeview College of Nursing
Name

Demographics (10 points)

Date & Time of Clinical Assessment	Patient Initials	Date & Time of Birth	Age (in hours at the time of assessment)
Gender	Weight at Birth (gm) _____ (lb.) _____ (oz.) _____	Weight at Time of Assessment (gm) _____ (lb.) _____ (oz.) _____	Age (in hours) at the Time of Last Weight
Race/Ethnicity	Length at Birth Cm _____ Inches _____	Head Circumference at Birth Cm _____ Inches _____	Chest Circumference at Birth Cm _____ Inches _____

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:

GTPAL:

When prenatal care started:

Abnormal prenatal labs/diagnostics:

Prenatal complications:

Smoking/alcohol/drug use in pregnancy:

Labor History of Mother:

Gestation at onset of labor:

Length of labor:

ROM:

Medications in labor:

Complications of labor and delivery:

Family History:

Pertinent to infant:

Social History (tobacco/alcohol/drugs):

Pertinent to infant:

Father/Co-Parent of Baby Involvement:

Living Situation:

Education Level of Parents (If applicable to parents' learning barriers or care of infant):

Birth History (10 points)

Length of Second Stage of Labor:

Type of Delivery:

Complications of Birth:

APGAR Scores:

1 minute:

5 minutes:

Resuscitation methods beyond the normal needed:

Feeding Techniques (10 points)

Feeding Technique Type:

If breastfeeding:

LATCH score:

Supplemental feeding system or nipple shield:

If bottle feeding:

Positioning of bottle:

Suck strength:

Amount:

Percentage of weight loss at time of assessment: _____%

****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?

Is this neonate's weight loss within normal limits?

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency:

Length of feeding session:

One or both breasts:

If bottle feeding:

Formula type or Expressed breast milk (EBM):

Frequency:

Volume of formula/EBM per session:

If EBM, is fortifier added/to bring it to which calorie content:

If NG or OG feeding:

Frequency:

Volume:

If IV:

Rate of flow:

Volume in 24 hours:

Output

Age (in hours) of first void:

Voiding patterns:

Number of times in 24 hours:

Age (in hours) of first stool:

Stool patterns:

Type:

Color:

Consistency:

Number of times in 24 hours:

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				
Blood Type and Rh Factor				
Coombs Test				
Bilirubin Level (All babies at 24 hours) *Utilize bilitool.org for				

bilirubin levels*				
Newborn Screen (At 24 hours)			(If available—these may be not available until after discharge for some clients)	
Newborn Hearing Screen				
Newborn Cardiac Screen (At 24 hours)				

Lab Data and Diagnostics Reference (1) (APA):

Newborn Medications (7 points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin Ointment)	Hepatitis B Vaccine		
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing					

Considerations (2)					
Key Nursing Assessment(s)/Lab(s) Prior to Administration					
Client Teaching needs (2)					

Medications Reference (1) (APA):

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			
Head			
Fontanel			
Face			
Eyes			
Nose			
Mouth			
Ears			
Neck			
Chest			
Breath Sounds			

Heart Sounds			
Abdomen			
Bowel Sounds			
Umbilical Cord			
Genitals			
Anus			
Extremities			
Spine			
Safety <ul style="list-style-type: none"> • Matching ID bands with parents • Hugs tag • Sleep position 			

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?

Are there any complications expected for a baby in this classification?

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth			
4 Hours After Birth			
At the Time of Your Assessment			

Vital Sign Trends:

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

Summary of Assessment (4 points)

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

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

This neonate was delivered on 5.15.14 at 0522 by normal spontaneous vaginal delivery (NSVD). Nuchal cord x1. Apgar scores 1/3/9. EDD 5.10.14 by US. Dubowitz revealed neonate is 39 2/7 weeks and LGA. Prenatal hx complicated by PIH and GDM (diet controlled). Birth weight 9 lbs 4 ozs (4440 grams), 21” long (53.34 cms). Upon assessment all systems are within normal limits. Last set of vitals: 38.4/155/48. BS x3 after delivery WNL with lowest being 52. Neonate is breastfeeding and nursing well with most feedings 20”/20” q2-3 hrs. Bilirubin level at 24 hours per scan was 4.9. Neonate expected to be discharged with mother later today and to see pediatrician in the office for first well baby check 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.

Discharge Planning (2 points)

Discharge location:

Equipment needs (if applicable):

Follow up plan (include plan for newborn ONLY):

Education needs:

Nursing Diagnosis (30 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

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 (2 pts each) <ul style="list-style-type: none"> How did the patient/family respond to the nurse's actions? Client response, status of goals and outcomes, modifications to plan.
1.		1. Rationale 2. Rationale	
2.		1. Rationale 2. Rationale	
3.		1. Rationale 2.	

		Rationale	
4.		1. Rationale 2. Rationale	

Other References (APA):

Ballard Gestational Age Scale

Neuromuscular Maturity

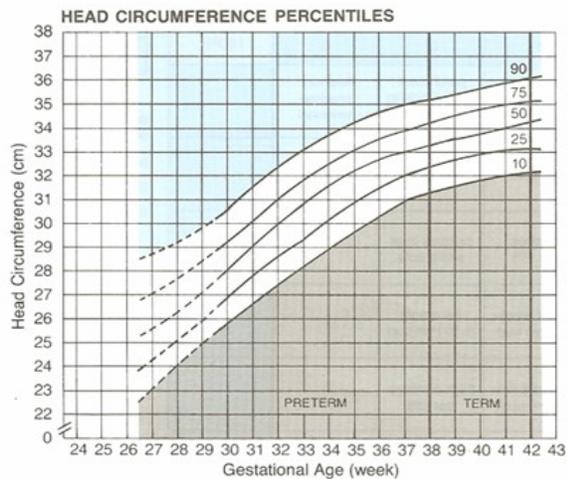
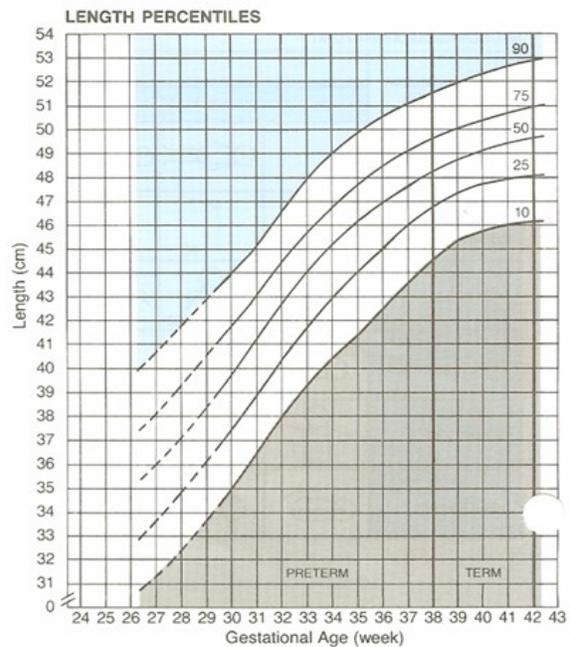
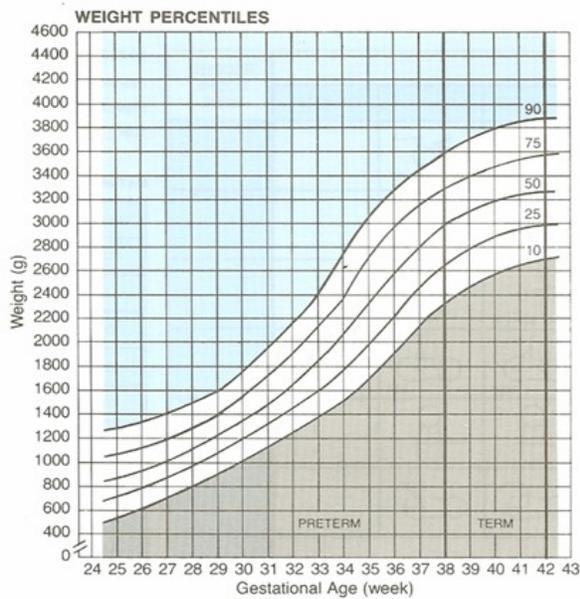
Score	-1	0	1	2	3	4	5
Posture							
Square window (wrist)	> 90°	90°	60°	45°	30°	0°	
Arm recoil		180°	140-180°	110-140°	90-110°	< 90°	
Popliteal angle	180°	160°	140°	120°	100°	90°	< 90°
Scarf sign							
Heel to ear							

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	Maturity Rating
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	-10 20
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	-5 22
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	0 24
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	5 26
							10 28
							15 30
							20 32
							25 34
							30 36
							35 38
							40 40
							45 42
							50 44

**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; 71:1-10-123