N432 Newborn Care Plan

Lakeview College of Nursing

Name: ADELE MOANDA

Demographics (10 points)

Date & Time of Clinical Assessment **09/13/2021** **1535**	**Patient Initials** **A S**	**Date & Time of Birth** **09/12/2021** **2110**	**Age** **(In hours at the time of assessment)** **18 hours and 25 minutes**
Gender **F**	**Weight at Birth** **(gm) 3730** **(lb.) 8 (oz.) _____**	**Weight at Time of Assessment** **(gm) 3730**	**Age (in hours) at the Time of Last Weight** **15 hours**
Race/Ethnicity **Write/Caucasian**	**Length at Birth** **53.3 Cm** **21 Inches**	**Head Circumference at Birth** **34 Cm** **13 Inches**	**Chest Circumference at Birth** **Cm: none in the file** **Inches: none in the file**

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: 10001

When prenatal care started: 03/03/2021

Abnormal prenatal labs/diagnostics:

There are no abnormal prenatal labs or diagnostics noted in the file.

Prenatal complications: The baby's mother has those illnesses:

Right ovarian cyst, Hypertension, obesity, chlamydia infection, Bacterial vaginosis, acute pelvic inflammatory, no immune measles, no immune rubella.

Smoking/alcohol/drug use in pregnancy:

Smoking cigarettes: 1 pack a year

Drug: Marijuana

Labor History of Mother:

Gestation at onset of labor: 39 weeks and 5 days.

Length of labor: 25 hrs.

ROM: spontaneously at home, the time has not been documented in the file.

Medications in labor:

- **Fentanyl (Sublimize) injection 25 mcg every 2 hours PRN**
- **Lactated ringers 1,000 mL Iv bolus 500 mL/hr. IV.**
- **Oxytocin (Pitocin) in NS premix 30 units 500 mL**
- **Penicillin G potassium IVPB 3 milli units 100 mL/hr. every 4 hrs.**

Complications of labor and delivery: There was not any complications during labor and delivery of the baby.

Family History:

Pertinent to infant: There is no family story pertinent to the infant.

Social History (tobacco/alcohol/drugs):

Pertinent to infant: the baby's maternal grandfather smokes a cigarette, and the baby's maternal grandmother used marijuana.

Father/Co-Parent of Baby Involvement: boyfriend

Living Situation: renting an apartment with the boyfriend. They live together.

Education Level of Parents (If applicable to parents' learning barriers or care of infant): The mother and the father of the baby have a high school diploma.

Birth History (10 points)

Length of the Second Stage of Labor: 12 hours

Type of Delivery: vaginal spontaneous

Complications of Birth: There are no complications in the file

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: N/A

Feeding Techniques (10 points)

Feeding Technique Type: The mother uses two feeding techniques breastfeeding and bottle-feeding formula.

If breastfeeding:

LATCH score: 9

Supplemental feeding system or nipple shield: it is not used

If bottle feeding:

Positioning of the bottle: the baby is placed in the mother's arms/ cradling position with the head of the newborn raised slightly.

Suck strength: strong in the left breast, but poor in the right breast.

Amount: Approximately 20 mL reported by the mother.

Percentage of weight loss at time of assessment: 0%

****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?

This baby does not lose weight yet. According to Ricci et al. (2021), newborns can lose up to 10 % of their initial birth weight by 3-4 days of age due to the elimination of meconium. It is normal to observe that this newborn does not lose weight yet since her birth; she is only in her 15 hours of birth.

The formula of % of weight loss is:

birth weight – current weight divided by birth weight* 100

Intake and Output (8 points)

<u>Intake</u>

If breastfeeding:

Feeding frequency: every 2 hrs.

Length of feeding session: 30 – 60 minutes

One or both breasts: two breasts, but mostly the left breast.

If bottle feeding:

Formula type or Expressed breast milk (EBM): Similac

Frequency: every 3 hrs.

Volume of formula/EBM per session: 15 mL

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

If NG or OG feeding: N/A

Frequency: N/A

Volume: N/A

If IV:

Rate of flow: N/A

Volume in 24 hours: N/A

Output

Age (in hours) of the first void: the baby was 2hrs age when she avoided for the first time because the first void was at 2315.

Voiding patterns:

Number of times in 24 hours: 2

Age (in hours) of first stool: 10 minutes because the baby has her first meconium at 2120

Stool patterns:

Type: meconium

Color: green

Consistency: tarry

Number of times in 24 hours: 2

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	The blood glucose test Helps to monitor glucose level to the newborn whom the mother has diabetes. It helps to assess for neonatal diabetes.	>45	They are not completed currently.	The blood glucose level test is not completed for this baby because her mother is not a diabetic patient. The baby is not at risk of developing neonatal diabetes (Ricci et al., 2021).
Blood Type and Rh Factor	The blood type and Rh factor	A, B, AB, O	O+	The baby and the mother have the

	determine Rh status and any incompatibility of the newborn.			**same blood type O+. Therefore, she does not present any blood incompatibility (Ricci et al., 2021).**
Coombs Test	**The Coombs's test is used to identify hemolytic disease of the newborn. Positive results indicate that the newborn's red blood cells have been coated with antibodies (Ricci et al., 2021).**	**Positive/ negative**	**Negative**	**The baby has negative results that mean that the baby does not have any hemolytic disease (Ricci et al., 2021).**
Bilirubin Level (All babies at	**The Bilirubin level test is used**	**12-15 mg/dL**	**It is not completed**	**The bilirubin level test is not completed**

24 hours) ***Utilize bilitool.org for bilirubin levels***	**to determine the risk of jaundice in the newborn (Ricci et al., 2021).**		**currently.**	**at this time, and there is no sign of jaundice in her skin and eyes due to the increase in bilirubin level (Ricci et al., 2021).**
Newborn Screen (At 24 hours)	**The newborn screen helps to identify an inborn error of metabolism and to check the genetic issue. It helps to prevent death or future disability to the baby.**	**PKU: normally 0.5 mg**	**(If available—these may be not available until after discharge for some clients)** **They are not completed currently.**	**According to Ricci et al. (2021), a PKU test is done between 24 - 48 hours after birth to detect any genetic issue. The newborn is 18 hr. and 25 minutes age from birth. The newborn screen is not done yet.**
Newborn Hearing Screen	**The hearing screen determines**	**>140**	**Pass** **Right: 220** **Left: 171**	**The newborn passed the hearing screening test on**

	hearing loss to the newborn who might need a further evaluation.			**both sides, left and right ear. She does not show a sign of hearing loss (Ricci et al., 2021).**
Newborn Cardiac Screen (At 24 hours)	**A cardiac screen helps the early detection and management of critical congenital cardiac failure. So, the newborn can receive the treatment sooner (Ricci et al., 2021).**	**Normal pulse oximetry > 93%**	**They are not completed currently.**	**The baby's pulse oximetry is 98%. It is usual for her age; she does not show any sign of congenital heart failure (Ricci et al., 2021).**

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

Ricci, S. S., Kyle, T., & Carman, S. (2021). ***Maternity and pediatric nursing*** **(4th ed.). Wolters Kluwer.**

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)** **(Skidmore-Roth, 2018, p. 797-798).**	**Illotycin (Erythromycin Ointment)** **(Skidmore-Roth, 2018, p. 377-379).**	**Hepatitis B Vaccine Engerix-B, Recombivax HB virus** **(Skidmore-Roth, 2018, p. 1140).**		
Dose	**0.5 mg**	**5 mg/g**	**0.5 mL**		
Frequency	**Once**	**Once**	**Once**		
Route	**IM**	**Eyes**	**IM**		
Classification	**Fat soluble vitamin**	**Antibiotic**	**Immune globulin Vaccine**		
Mechanism of Action	**It needed for adequate blood clotting (factors II, VII, IX, X) by increasing the synthesis of**	**Inhibits CNS neuron uptake of serotonin but not of norepinephrine.**	**Provides passive immunity to hepatitis B**		

	prothrombin by the liver.				
Reason Client Taking	**It provides clotting factors that help to prevent bleeding in newborn.**	**Prevent Neisseria gonorrhea and chlamydia trachomatis conjunctivitis, Prevents ophthalmia neonatorum**	**It helps to protect the neonate from any exposure to the hepatitis B virus infection.**		
Contraindications (2)	**1. Severe hepatic disease. 2. hypersensitivity.**	**1. Hypersensitivity to this product. 2. Bleeding 3. Renal/ hepatic disease**	**1. Hypersensitivity to immune globulins. 2. Coagulation disorder. 3. IgA deficiency**		
Side Effects/Adverse Reactions (2)	**Anemia and bronchospasm**	**Seizures, tachycardia, pupil dilation and eye discomfort.**	**1. Swelling at injection site. 2. Vomiting**		

Nursing Considerations (2)	**1. Assess for bleeding, bruising, hematuria, black tarry stools, and hematemesis.** **2. Monitor Vital signs.**	**1. Assess for eye itching and rash** **2. Monitor B/P, pulse q4hr.**	**1. Assess for dysphagia and vomiting.** **2. Assess for anaphylaxis: inability to breath, fever, flushing, and bronchospasm.**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor PT/INR**	**1. Monitor blood studies: CBC, leukocytes, and platelets.** **2. Monitor liver function: AST, ALT, bilirubin, and creatinine (Skidmore-Roth, 2018).**	**1. Monitor electrolytes: potassium, sodium, calcium, and magnesium,** **2. Monitor BUN, ABGs, blood pH, and CBC.**		
Client Teaching	**1. Advice the**	**1. Teach the mother**	**1. Give the mother**		

needs (2)	**mother of the baby to report a sign of elevated temperature to the baby.** **2. Advise the mother of the baby to report symptoms of bleeding, bruising, blood in urine, or black tarry stools (Skidmore-Roth, 2018).**	**to report signs of urinary retention immediately in the baby, difficulty breathing, or swelling on the baby's face.** **2. Teach the mother to report any swelling or drainage from the baby's eyes (Skidmore-Roth, 2018).**	**a list of adverse reactions that need to report immediately: wheezing, sneezing, and vomiting.** **2. Advice the mother of the baby that a minor rash and swelling at the injection site can be expected (Skidmore-Roth, 2018).**		

Medications Reference (1) (APA):

Skidmore-Roth, L. (2018). *Mosby's drug guide for nursing students*. St. Louis, MO: Elsevier.

Newborn Assessment (20 points)

Area	Your Assessment	Expected Variations and Findings *This can be found in your book on page 622 in Ricci, Kyle, & Carman 4th ed 2020.	If assessment finding different from expectation, what is the clinical significance?
Skin	**Pink color on trunk and extremity, the skin is intact without any drainage. The ski has a small scratch on its feet from birth.**	**Findings: smooth pink with visible veins.** **Variations: jaundice, Milla, and Mongolian spots.**	**Appropriate color as expected for newborn.**
Head	**Normal head size without not abnormally size or a presence of a cephalohematoma.**	**Findings: average size compared to the chest.** **Variations: macrocephaly/ microcephaly**	**The size of the head is appropriate to the baby's chest size and age.**
Fontanels	**Both fontanels,**	**Findings: open anterior and**	**The expectation**

	anterior, and posterior are open to touch.	**posterior frontals** **Variation: enlarged fontanels**	**is normal for this baby age.**

Face	**equal cheeks on both sides of the face,**	**Finding: full cheeks, facial features symmetric.** **Variation: facial nerve paralysis.**	**There is no dropping on one side of the face, and the cheeks are equally on both sides without any mouth deviation.**
Eyes	**Normally set ant present bilateral. Eyes placed symmetrical to the face, and there is no drainage observed from both eyes,**	**Finding: both eyes are symmetrically placed on the face.** **Variation: chemical conjunctivas.**	**Both eyes appropriately place each other in perfect position as expected for newborn. There is no drainage from the eyes.**
Nose	**Nares patent bilaterally, no septal deviation noted.**	**Small, placement in the midline and narrow, ability to smell**	**Intact septum with patent nares. A small nose in the midline and expected for her**

			age.

Mouth	**Moist oral mucosa and intact palate with symmetry lips.** **The baby has swallow and sucking reflexes present.**	**The mouth is aligned in the midline, symmetric, intact soft and hard palate.** **The presence of sucking, swallowing, and working gag reflexes.**	**The baby can suck the finger, and the reflexes are present.** **There is not a lesion in the mouth, and the oral mucosa is pink and moist.**
Ears	**Regular size with a patent canal with firm cartilage bilaterally.**	**Soft and pliable with quick recoil when folded and released.**	**The ears are soft with normal size and shape.**
Neck	**The neck Moved freely in all directions, solid and stable neck without mass in palpation.**	**The neck is short and can easily move freely.**	**The neck supports the head, and it is moving in all directions. Baby can hold her head.**
Chest	**Round chest with two nipples in place without drainage.**	**The chest is symmetric, small than the head, without any discharge from**	**No nipple engorgement noted. Normal**

		the nipples.	**chest size of the chest.**
Breath Sounds	**Auscultation reveals a regular and clear breath sounds bilaterally without distress or crackles.**	**Normal breath sounds bilaterally in auscultation.**	**The patient is breathing normally in room air. Clear lungs sound bilaterally with no distress or excessive muscles used.**

Heart Sounds	**Regular S1 and S2, no extra sound or murmur heard when auscultating.**	**S1 and S2 present with the PMA accentuated in the midclavicular line, fourth intercostal space. Murmur can be present during the first hours of birth.**	**The baby has a regular S1 and S2 in auscultation.**
Abdomen	**Soft abdomen with active bowel sound on auscultation.** **There are no masses and tenderness during palpation of the abdomen.**	**Findings: protuberant contour, soft with three vessels in the umbilical cord. There are no masses.** **Variations: Abdomen distension and only two vessels on the umbilical cord.**	**The baby's abdomen is soft, with a normal protuberant contour expected for a newborn. The newborn's belly does not show a sign of enlarged abdominal organ or distention on palpation.**

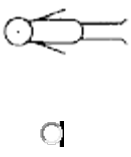
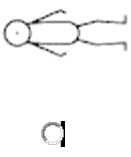
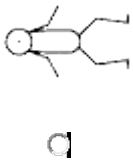
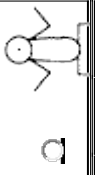
Bowel Sounds	**Active bowel sounds during auscultation in all four quadrants, no masses and tenderness during palpation of the abdomen.**	**Findings: bowel sounds are present in all four quadrants. Absence of hyperactive bowel sounds.**	**Bowel sounds are present in all four quadrants as expected.**
Umbilical Cord	**The umbilical cord is dry and intact without visible masses.**	**The umbilical cord has three vessels.**	**There are no masses or drainage from the umbilical site. It has three vessels as expected.**
Genitals	**The baby genial has a small swollen genital with vernix present.**	**Swollen female genitals because of maternal estrogen.**	**Swollen female genitals and wright secretion are normal findings to this newborn due to**

			maternal estrogen.

Anus	**Normal patent with small meconium**	**Normal patent**	**Normal patent with small green tarry bowel movement.**
Extremities	**Normal range of motion without deformity**	**Extremities symmetric with free movement.**	**The baby is moving hands and feet without any issue. There is no hip dislocation noted.**
Spine	**Intact without any deformity, the spine line is visible during observation.**	**Intact without any deformity.**	**There is no dimple on the spine. The spine is intact without deformity.**
Safety • **Matching ID bands with parents** • **Hugs tag**	**Always match the baby bracelet with the mother by comparing the number.** **Hugs tags are the alert tag that**	**For the newborn's safety, always compare the parents' ID bands with the newborn to ensure the correct newborn is brought to the right mother.** **The alert tug remains all the time**	**The staff member respects the safety measure in the hospital, everyone checks the mother and baby ID bands to ensure that it matches, and the hugs tag is present, intact, and attached**

• **Sleep position**	**confirms that the baby is in the safe area.** **Place the baby on the back position**	**on baby's ankle when he is in the hospital.** **Advice the mother to place the baby in supine position while sleeping or napping.**	**to the baby's ankle.**

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

SIGN	NEUROMUSCULAR MATURITY					TOTAL SCORE	WEEKS
	-1	0	1	2	3	-10	
Posture						-5	
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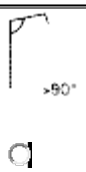
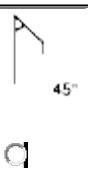
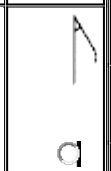
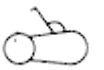
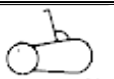
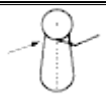
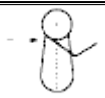
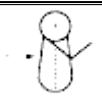
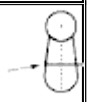
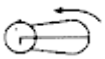
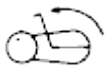
Square Window						10	
						15	
						20	
						25	

Arm Recoil						30 35
Popliteal Angle						40 45 50
Scarf Sign						TOTAL NEUROMUSCULAR MATURITY SCORE
Heel To Ear						TOTAL PHYSICAL MATURITY SCORE TOTAL SCORE WEEKS

SIGN	PHYSICAL MATURITY SCORE					
	-1	0	1	2	3	
Skin	Sticky, friable, transparent	gelatinous, red, translucent	smooth pink, visible veins	superficial peeling &/or rash, few veins	cracking, pale areas, rare veins	deep cracking,

Lanugo	none ○	sparse ○	abundant ○	thinning ○	bald areas ◉		○
Plantar Surface	heel-toe 40-50mm: -1 <40mm: -2 ○	>50 mm no crease ○	faint red marks ◉	anterior transverse crease only ○	creases ant. 2/3 ○		creases over ○
Breast	imperceptible ○	barely perceptible ○	flat areola no bud ○	stippled areola 1-2 mm bud ○	raised areola 3-4 mm bud ○		5-10 mm bud ◉
Eye / Ear	lids fused loosely: -1 tightly: -2 ○	lids open pinna flat stays folded ○	sl. curved pinna; soft; slow recoil ○	well-curved pinna; soft but ready recoil ○	formed & firm instant recoil ○		thick cartilage ◉
Genitals (Male)	scrotum flat, smooth ○	scrotum empty, faint rugae ○	testes in upper canal, rare rugae ○	testes descending, few rugae ○	testes down, good rugae ○		◉
Genitals (Female)	clitoris prominent & labia flat	prominent clitoris & small labia minora	prominent clitoris & enlarging	majora & minora equally prominent	majora large, minora small		majora cover

			minora			

Patient scores are:

- **Total neuromuscular maturity = 25**
- **Total physical maturity = 17**

What was your determination? The total score is 42.

It placed the baby in the maturity of 40 weeks six days.

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

The newborn is LGA (large for gestational age). She weighs more than 90% on average growth. She can place her at risk of obesity; according to the score, she is neurologically and physically mature.

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**
Birth	**98.5**	**142**	**40**
4 Hours After Birth	**98.4**	**140**	**40**
At the Time of Your Assessment	**98.9**	**140**	**40**

Vital Sign Trends:

There are not trending vital signs because all vital signs recorded from birth until now are stable and within normal range. The baby does not have is any abnormal vital signs

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1420	FLACC	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****

A female neonate named A S was delivered on 09/12/2021 at 2110 by spontaneous vaginal delivery without any abnormal prenatal complication. The neonate was born with an 8 lbs. (3730 grams) and length of 53.3 cm long. The Apgar scores show 8 in 1 minute and 9 in 5 minutes; her latch score is 9. The Ballard scale is 42 and placed the neonate on 40 weeks, and six days, she is LGA. At birth, the neonate has all vital signs within the normal range: 98.5 T, 142 P, BP: 62/35, and R 40. She has a last void and bowel movement today, 09/13/2021, at 1617 during bathing. The neonate was bottle feeding and ate 15 ml. She is

also breastfeeding her mother every 2 hours, and she passes a hearing screen test. There is not a plan of discharge yet for this neonate.

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.
Promoting relaxation and comfort by swaddling the newborn "N".	As needed	Swaddling helps to decrease anxiety, crying to the newborn because it provides comfort and good sleep. Swaddling reduces the baby's colicky and abdominal fussiness and helps the newborn to calm down.
Promoting adequate nutritional intake" N".	Every 2 hours.	Promoting adequate nutritional intake to the newborn by giving formula or educating the mother to supply breast milk will help the baby maintain calorie intake.

Preventing the newborn's injury "N".	**All the time**	**Never leave the newborn unattended in the bed. Always keep the baby in the crib. Advice the mother to never co-sleep with the baby to avoid the newborn's injury or death.**
Administrating Vitamin K "T"	**Once**	**A fat-soluble vitamin K is administrated IM to help to reduce the risk of bleeding in newborns.**

Discharge Planning (2 points)

Discharge location: Home probability by 09/14

Equipment needs (if applicable): N/A

Follow up plan (include a plan for newborn ONLY):

- **Schedule the baby first visits within 2 to 4 days after discharge,**

- **Schedule the four weeks and two months visit of the baby with the health care provider.**
- **Provide the mother information on immunizations that the baby needs to receive.**
- **Reinforce breastfeed technique by demonstrating the correct latching technique to the baby's mother.**
- **Discuss safety concerns and home environment with the baby's primary caregiver.**

Education needs:

It is the first time for the mother to give birth and take care of the newborn; she needs education about the appropriate position during latching and how to help to baby fall asleep. Those are some educations that can help this new mother to promote comfort to the baby and to reduce her anxiety about being a first-time mother:

- **Position the newborn with the head elevated to prevent choking, especially during and after breastfeeding.**
- **Always place the baby on her back when sleeping or napping.**
- **Change diapers and clothes to make the baby comfortable.**
- **Schedule a bath with a gentle massage before bedtime to help the baby gets to sleep.**
- **Wrap the baby snugly in a blanket and gently rock her to help with fussy or crying and calm her down.**

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)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Knowledge deficit related to first-time mother status as evidence mother does not know	**The mother verbalizes that she never takes care of a newborn before.**	**1. Assess the baby voiding/ stool patterns at least six voids per day and >1 stool per day. Rationale: At least one stool ped day and six voids per day confirm the regular pattern for breastfeeding the baby**	**The goal is not met yet. However, the patient shows motivation to learn about the newborn by asking questions about the newborn's growth and development. She is offering effort in the**

how properly change her baby's diaper.		**(Ricci et al., 2021).** **2. Teach to increase the skin-to-skin contact at least every 2 hours if possible.** **Rationale: Skin-to-skin contact increase bonding between the baby and her primary caregiver (Ricci et al., 2021).**	**care process of the baby by placing the baby in her chest.**
2. Risk of infection related to skin integrity at umbilical site as evidence loosened cord clamp.	**The baby's cord clamp appears loosened.**	**1. Assess for bleeding, redness, and drainage from the cord stump every hour.** **Rationale: Any signs of infection in the umbilical site must be reported to the physician immediately (Ricci et al., 2021).** **2. Fold the diaper below**	**The baby's diaper is placed below the cord stump all the time to prevent contamination. The nurses are changing the baby's diaper, and the primary care must receive education to promote healing in the baby's umbilical site**

		the cord any time after a diaper change or every hour. **Rationale: folding the diaper below the cord will prevent contamination of the umbilical and promote air-drying of the umbilical (Ricci et al., 2021).**	**and avoid infection.**
3. Inadequate knowledge on latching technique related to poor infant sucking and maternal anxiety as evidence baby cannot suck the right breast.	**The mother states that the baby is unable sucking the right breast.**	**1. Assess breast and nipple structure q 8 hours to detect breast abnormalities and the mother's breast position during breastfeeding.** **Rationale: This will help support breastfeeding because the correct position enhances suitable attachment and ensures effective milk transfer (Ricci et al., 2021).**	**The mother of the baby is positively engaging in breastfeeding education. She places the baby in the right breast every two hours for sucking. The mother of the baby understands the benefit of breastfeeding for her baby.** **There is not an**

		2. Evaluate and record the baby's suckling and swallowing pattern at the breast every 2 hours to stimulate milk production on the right breast. Rationale: The milk supply equals demand; the more sucking, the baby will produce more milk (Ricci et al., 2021).	**outcoming modification of this plan. Keep continuing to monitor for effective breastfeeding.**
4. Risk of altered body temperature related to bathing and newborn's metabolism as evidence the baby is shaking	**The baby shows a sign of shills after bathing.**	**1. Place the newborn under a radiant heater after show and monitor the baby's temperature every 8 hours. Rationale: bathing a newborn under radiant warmer helps preventing heat loss (Ricci et al., 2021).**	**After bathing, the baby was placed under a radiant warmer to maintain a temperature within normal range and avoid hypothermia. The nurse swaddles the baby, and the mother holds the baby by hand**

during and after bathing.		**2. Swaddle the baby in a warm blanket and encourage the mother to maintain the temperature within the normal range. Rationale: The baby's blanket or swaddle underneath the newborn for warmth and comfort (Ricci et al., 2021).**	**to keep the body's temperature. It shows that the mother of the baby responds positively to the nurse's action.**

Other References (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). ***Maternity and pediatric nursing*** **(4th ed.). Wolters Kluwer.**

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

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

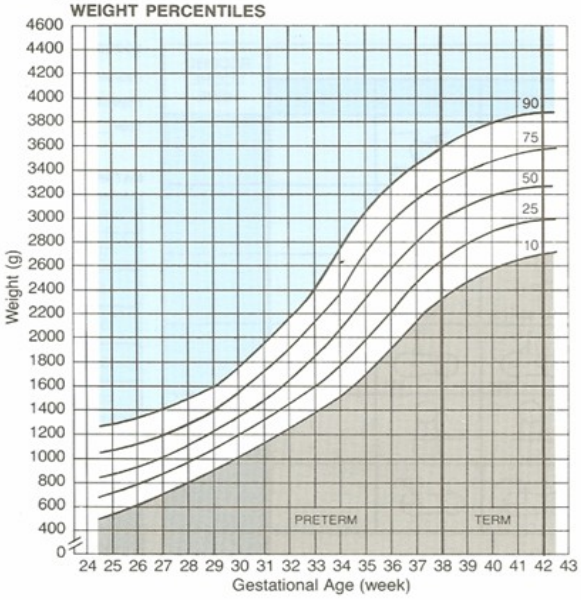
NAME _____ DATE OF EXAM _____ LENGTH _____

HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

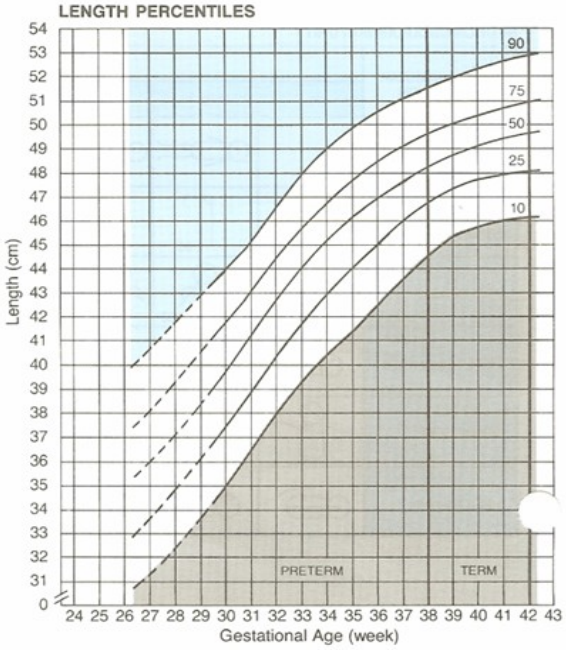
RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____

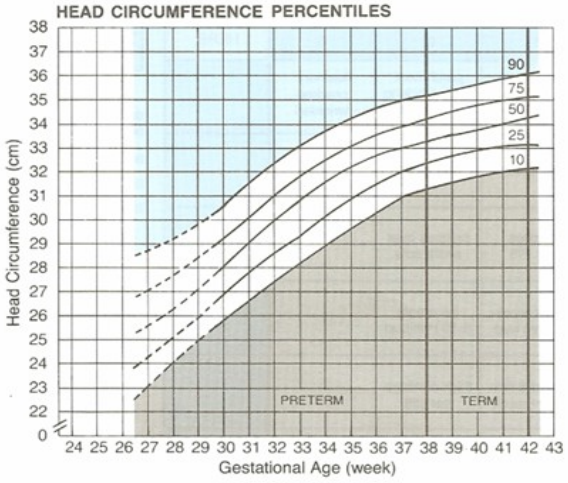
WEIGHT PERCENTILES



LENGTH PERCENTILES



HEAD CIRCUMFERENCE PERCENTILES



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