N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment 09/29/2021 @ 1100	**Patient Initials KB**	**Date & Time of Birth 09/21/2021 @ 1122**	**Age (in hours at the time of assessment) 192**
Gender Female	**Weight at Birth (gm) __2050_ (lb.) _4 (oz.) _8.3_**	**Weight at Time of Assessment (gm) _2025_ (lb.) _4_ (oz.) _7.4_**	**Age (in hours) at the Time of Last Weight 168**
Race/Ethnicity African-American	**Length at Birth Cm __45_ Inches __17.72__**	**Head Circumference at Birth Cm _31__ Inches _12.20_**	**Chest Circumference at Birth Cm __27_ Inches __10.63_**

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: The mother was Gravida: 3, Term: 0, Pre-term: 2, Abortion: 1, and Living: 2 upon assessment.

When prenatal care started: The mother's prenatal care began 03/08/2021 during her first trimester.

Abnormal prenatal labs/diagnostics: Abnormal prenatal labs included elevated glucose on 07/17/21 with a level of 111 mg/dL and on 07/18/21 with a level of 100 mg/dL. Her hemoglobin and hematocrit levels were low in all three trimesters. She had a urine protein level of 13.8 mg in her urinalysis and her lactate dehydrogenase was abnormally high as well.

Prenatal complications: The mother had elevated glucose levels. She also tested positive for herpes simplex virus type 2. During her entire pregnancy, she used cannabis extensively and chronically.

Smoking/alcohol/drug use in pregnancy: The mother denied tobacco and alcohol use. It was noted in her chart she used cannabis chronically, but she denied its use upon assessment on 09/29/2021.

Labor History of Mother: The mother visited the labor and delivery unit frequently due to hyperemesis secondary to chronic cannabis use. On 09/21/21 she was induced due to the fetal heart rate and rhythm abnormalities of the fetus. As a result, this caused intrauterine growth restrictions and abruptio placenta.

Gestation at onset of labor: The mother was 34 weeks and 6 days gestation.

Length of labor: I was unable to find the first and second stage lengths of labor in the chart. I did, however, find her third stage of labor was 1min as noted in her chart. I searched the mom's labor assessment flowsheet, baby's delivery assessment flowsheet, mom's event log, and baby's event log in the summary tab and was still unable to locate the length of stages 1 and 2.

ROM: Rupture of membranes was 09/21/21 at 1043. Blood clots were noted which indicated a rupture.

Medications in labor: Medications in labor included cefazolin, morphine sulfate, ondansetron, ephedrine sulfate, fentanyl, and oxytocin. Cefazolin was used as a prophylactic during her c-section, but it was not given. Morphine sulfate and fentanyl was used for her epidural for the cesarean section procedure as analgesics. Ondansetron was used for nausea and vomiting experienced by the patient. Oxytocin was used to start the

labor induction process. Ephedrine sulfate was used to maintain maternal blood pressure during an epidural anesthesia.

Complications of labor and delivery: The mother had to an urgent cesarean section due to abuptio placental rupture. During her artificial rupture of membranes (AROM), blood clots were present which indicated a rupture.

Family History: The mother stated her maternal grandfather had cancer. She also stated her maternal grandmother and aunts had diabetes mellitus type 2. No other information was given.

Pertinent to infant: Diabetes on the maternal side of the family is pertinent to the infant because it places her a risk for possible development at a later age.

Social History (tobacco/alcohol/drugs): The mother denied us of tobacco or alcohol. Nothing was indicated in her chart. Chronic cannabis was documented in chart, but upon assessment she denied any current use.

Pertinent to infant: Chronic cannabis use caused a pre-term birth including tachycardia, tachypnea, and withdrawal symptoms seen in the newborn.

Father/Co-Parent of Baby Involvement: The father is involved but was not present during assessment.

Living Situation: The father is currently in Milwaukee where he will reside until further notice. The mother currently lives in Champaign, IL with her sisters and grandmother.

Education Level of Parents (If applicable to parents' learning barriers or care of infant): The father's educational level is unknown. The mother stated she has some college credits from Parkland college. She hopes to become a social worker one day when she's able to return to school.

Birth History (10 points)

Length of Second Stage of Labor: The length of the second stage of labor was not documented. I was unable to find the length of labor in the delivery assessment, mother's flowsheets, or baby's flowsheets during the time of labor.

Type of Delivery: The mother had an urgent low transverse cesarean section.

Complications of Birth: The mother had abruptio placenta and intrauterine growth restriction.

APGAR Scores:

1 minute: The patient's APGAR score at 1 minute was 9.

5 minutes: The patient's APGAR score at 5 minutes was 9.

Resuscitation methods beyond the normal needed: No resuscitation beyond the normal was needed. The patient received normal suctioning of the mouth and nose.

Feeding Techniques (10 points)

Feeding Technique Type: The baby's current feeding type is a nasogastric tube.

If breastfeeding: N/A

LATCH score: N/A

Supplemental feeding system or nipple shield: N/A

If bottle feeding: N/A

Positioning of bottle: N/A

Suck strength: N/A

Amount: N/A

Percentage of weight loss at time of assessment: _1_ %

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

Last weight 2025 g / birth weight 2050 g = 0.9878 → 1.0 %

What is normal weight loss for an infant of this age? Normal weight loss after birth is up to 10% (Ricci et al., 2021).

Is this neonate's weight loss within normal limits? Yes, the neonate's weight loss is within normal limits because the textbook states it can be up to 10%.

Intake and Output (8 points)

<u>Intake</u>

If breastfeeding: N/A

Feeding frequency: N/A

Length of feeding session: N/A

One or both breasts: N/A

If bottle feeding:

Formula type or Expressed breast milk (EBM): The patient is receiving Similac Special Care 24 High Protein. The patient has a nasogastric tube (NG) for feedings, but she bottle feeds for the first 20 minutes as tolerated then finishes her feeding with a bolus.

Frequency: The patient receives a bolus every 3 hours.

Volume of formula/EBM per session: The patient receives 40 mL per feeding.

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

If NG or OG feeding: The patient has a 19 cm NG tube for feedings.

Frequency: The patient receives a bolus every 3 hours at 0800, 1100, 1400, and 1700.

Volume: The patient receives 40 mL per feeding.

If IV: N/A

Rate of flow: N/A

Volume in 24 hours: N/A

Output

Age (in hours) of first void: The patient was 3 hours and 38 minutes for her first void.

Voiding patterns: The patients voiding pattern was not normal, she had only 1 occurrence in the first 24 hours.

Number of times in 24 hours: The patient had 1 occurrence in 24 hours. This indicates dehydration (Ricci et al., 2021).

Age (in hours) of first stool: The patient was 13 hours old for her first stool.

Stool patterns: Her stool patterns were normal. She eliminated 1-2 stools per shift.

Type: Her stool type was normal for her age.

Color: The color of her stool was meconium green.

Consistency: The consistency of her stool was dark and tarry.

Number of times in 24 hours: She eliminated 6 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 glucose levels are normal screenings for newborns.	40 – 99 mg/dL	45	Labs within normal range.
Blood Type and Rh Factor	To ensure mom and baby's blood are compatible.	N/A	Mom was A positive.	No other labs or interventions needed for the baby.
Coombs Test	Most likely didn't do because the mother is compatible with baby's blood. This would be done if mom's Rh factor was negative. If so, the baby would be at risk for jaundice.	N/A	N/A	N/A
Bilirubin Level (All babies at 24 hours) *Utilize bilitool.org for bilirubin levels*	This is done to ensure the baby didn't have a bowel movement in the womb before birth and swallowed it.	0.3 – 8.1	8.4	This indicates the baby was at possible risk for jaundice. Prior samples were hemolyzed and did not have accurate readings. The baby's bilirubin level was done 09/23/2021.
Newborn Screen (At 24 hours)	The newborn screen was done 09/22/2021 and was sent to the Department of Health lab located in Chicago, IL.	The newborn screen should be negative for disorders.	The patient's newborn screen was negative for any disorders or deficiencies.	
Newborn Hearing Screen	Hearing screenings are done to ensure baby's hearing processes are matured and working properly.	PASS	N/A	Newborn passed her hearing screening.

Newborn Cardiac Screen (At 24 hours)	Cardiac screenings are done to ensure heart sounds are audible with no murmurs or S3 indications.	PASS	DID NOT PASS	The patient was tachycardic secondary to cannabis withdrawal.

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)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**		
Dose	**1 mg**	**1-2 cm**	**N/A The patient's parents denied the vaccine.**		
Frequency	**Once**	**Once**	**N/A**		
Route	**Intramuscular**	**Topical**	**N/A**		
Classification	**Clotting Factor**	**Antibacterial ointment**	**N/A**		
Mechanism of Action	**It provides the newborn with Vitamin K necessary for production of clotting factor and prevents Vitamin K deficiency bleeding (Ricci et al., 2021).**	**It provides bactericidal and bacteriostatic actions ot prevent Neisseria gonorrhoeae and Chlamydia trachomatis conjunctivitis (Ricci et al., 2021).**	**N/A**		

Reason Client Taking	**The Vitamin K injection ensures the baby's blood can clot effectively.**	**The ointment protects baby's eyes from pathogens in the birth canal.**	**N/A**		
Contraindications (2)	**Contraindication for this medication is hypersensitivity. No other contraindications were found.**	**A contraindication for this ointment is hypersensitivity. No other contraindications were found.**	**N/A**		
Side Effects/Adverse Reactions (2)	**The patient can have pain and erythema at the injection site Skin rash (Ricci et al.,**	**Side effects include minor eye irritations, stinging, or burning.**	**N/A**		
Nursing Considerations (2)	**Administer this medication within 1 to 2 hours after birth. Use a 25-gauge, 5/8-in needle for injection (Ricci et al., 2021)**	**Nurses should wear gloves, and open eyes by placing the thumb and finger above and below the eye (Ricci et al., 2021). Nurses should be alert for chemical conjunctivitis for 1 to 2 days (Ricci et al., 2021).**	**N/A**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Asses to ensure the baby doesn't have any congenital bleeding disorders prior to administration (Ricci et al., 2021).**	**Check mother's prenatal laboratory swabs and blood serum tests to ensure she is negative for any sexually transmitted infections or diseases.**	**N/A**		
Client Teaching needs (2)	**Advise patient's parents that this**	**Parents should be educated on**	**N/A**		

	injection is needed to prevent the baby's risk for bleeding. Also, advise parents to provide comfort before and after administration.	**the importance of using this ointment on baby's eyes to prevent an infection. They should also be advised not to rub ointment off of the baby's eyes.**			

Medications Reference (1) (APA):

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

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	**The newborn's skin was slightly tented, warm to the touch, pink, and slightly transparent. She had abundant lanugo present on her extremities. No other observations were assessment by the nursing students.**	**Typical newborn skin should have good skin turgor with no tenting. Lanugo can be seen over the shoulders or on the sides of the face and upper back.** (Ricci et al., 2021)	**The newborn's skin was consistent with her gestational age due to her pre-mature birth.**
Head	**The newborn's head was symmetric and round. She had an abundant amount of hair, but her fontanels could be easily palpated. Her head felt smooth over the fontanels.**	**A typical newborn's head should be symmetrical and round. The anterior and posterior fontanels should be palpable and smooth.** (Ricci et al., 2021)	**The newborn's head assessment was consistent with her gestational age due to her pre-mature birth.**
Fontanels	**The fontanels were palpable and smooth. The anterior fontanel was diamond shaped to the touch.**	**A newborn's fontanels should be smooth, diamond in shape, and palpable until age 18 months.** (Ricci et al., 2021)	**The newborn's fontanel assessment was consistent with her gestational age due to her pre-mature birth.**
Face	**The newborn's face was symmetrical and relatively full. There was no bruising or facial nerve paralysis caused by trauma.**	**A newborn's face should be symmetrical and full. There may be facial nerve paralysis if there were use of forceps.** (Ricci et al., 2021)	**The newborn's face assessment was consistent with normal findings indicated in the textbook.**

Eyes	**The eyes were not assessed because the nursing students was not able to observe the assessment conducted by the nurse.**	**The newborn's eyelids, lashes, conjunctiva, sclera, iris, and pupils should be assessed for color, size, and movement. The eyes should be clear and symmetrically placed. The blink reflex should be tested by brining an object close to the eye and the newborn should respond quickly by blinking. The pupillary reflex should be assessed as well. Pupils should be equal, round, and reactive to light bilaterally. The newborns gaze should track objects to the midline. Movement may be uncoordinated during the first few weeks of life. A red reflex should be seen bilaterally if using a retinoscopy.** (Ricci et al., 2021).	**The newborn's eyes were unable to be assessed due to the lack of opportunity to observe the nurse during her assessment.**
Nose	**The newborn's nose was small and narrow. The nose was placed on the midline of her face. The nose was of equal size with no drainage present. A nasogastric tube was placed in the right nostril of her nose.**	**The newborn's nose should be symmetrical with narrow nostrils. The septum should be intact with no deviation present. Some mucous drainage may be seen, but there will not be any actual**	**The outside of the baby's nose was observed, but the inside was not observed due to lack of opportunity to observe the nurse during her assessment.**

		drainage present. (Ricci et al., 2021).	

Mouth	**The newborn's mouth and lips were positioned midline. The lips were darker in color due to her ethnicity. No other observations were assessed due to lack of opportunity to observe the nurse during her assessment.**	**Typically, a newborn's mouth, lips, and interior structures should be assessed. The lips should be intact with symmetrical movements and positioned midline. The lips should encircle the examiners fingers to produce a suck. The tongue should be free-moving. The gag, swallow, and sucking reflexes should be working.** (Ricci et al., 2021).	**The external structures were observed and assessed. The interior structures and reflexes could not be assessed due to lack of opportunity to observe the nursing during her assessment.**
Ears	**The newborn's ears were darker in color which is a normal finding for her ethnicity. Her ears were soft with a well curved pinna, but ready to recoil. A hearing screen was completed and showed normal findings. A full ear assessment was not done due to lack of opportunity to observe the nurse during her assessment.**	**A newborn's ears should be inspected for shape, size, skin condition, placement, amount of cartilage, and patency of the auditory canal. A newborn hearing screening is required by law.** (Ricci et al., 2021)	**A full ear assessment was unable to be done due lack of opportunity to observe the nurse complete her assessment.**
Neck	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**A newborn's neck should be assessed for movement and ability to support the head. The neck should move freely in all directions and should be capable of**	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**

		holding the head in a midline position. (Ricci et al., 2021)	
Chest	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**The newborn's chest should be round, symmetric, and 2-3 cm smaller than the head circumference. The nipples may be engorged and secrete a white discharge. The chest is usually barrel shaped with equal anteroposterior and lateral diameters. The lung sounds should be vesicular bilaterally.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Breath Sounds	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**Normal breath sounds should be heard. Fine crackles can be heard on inspiration soon after birth due to amniotic fluid being cleared from the lungs. Diminished breath sounds might indicate atelectasis or pneumonia.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**

Heart Sounds	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**Heart sounds should be auscultated while the baby is quiet or sleeping. S1 and S2 sounds should be heard at birth. The point of maximal impulse is lateral to the midclavicular line at the 4th intercostal space. Murmurs are common and may be heard during the first few hours. Murmurs do not necessarily indicate heart disease but should be evaluated if they persist.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Abdomen	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**The abdomen should be inspected for shape and movement. Abdominal movements are synchronized with respirations because newborns are abdominal breathers.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Bowel Sounds	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**Bowel sounds should be assessed in all four quadrants starting in the lower right quadrant and moving in a clockwise manner. Absent or hyperactive bowel sounds in all four quadrants may**	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**

		indicate an intestinal obstruction. (Ricci et al., 2021)	

Umbilical Cord	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**The umbilical cord should have wo arteries and one vein. Inspect the cord for signs of bleeding, infection, inflammation, redness, swelling, purulent drainage, or erythema around the umbilicus.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Genitals	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment. Per the instructor's verbal report, the labia majora was not fully covering the labia minora. This is due to the baby's pre-mature birth.**	**Female newborn genitalia will be engorged. The labia majora is large and should cover the labia minora.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Anus	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**Passing meconium indicates patency of the anus. Abnormal findings would include anal fissures or fistulas or no meconium passed within 24 hours after birth.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Extremities	**The newborn's upper extremities appear normal and symmetric. Each hand had five digits. Each palm had three creases on**	**The newborn's upper extremities should be equal in length. There should be five digits with three palmar creases in the hands.**	**A complete ssessment was unable to be done. The student nurses were unable to observe the nurse complete her**

	them. The lower extremities were equal in length. No other assessments were done due to lack of observation of the nurse during her assessment.	**The lower extremities should be equal in length with symmetric skinfolds.** (Ricci et al., 2021)	**assessment.**
Spine	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**	**The spine should be midline and symmetric with free movement.** (Ricci et al., 2021)	**An assessment was unable to be done. The student nurses were unable to observe the nurse complete her assessment.**
Safety • **Matching ID bands with parents** • **Hugs tag** • **Sleep position**	**The baby's sleep position was on her back, swaddled in a blanket. No ID was matched with the baby. The nurse was familiar with the mother. A carseat was present near the baby's crib.**	**The mother should be always identified with the baby to ensure safety precautions.**	

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?

The Ballard Scale grid was completed with the instructor during clinical. The total score was 33 and AGA because the infant was born at 34 wks. Her gestational age during assessment was 36 weeks.

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

There are no complications for this baby in this classification. As her body matures, she will be age and develop appropriately.

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	**36.1 C**	**180**	**64**

4 Hours After Birth	**36.8 C**	**168**	**48**
At the Time of Your Assessment	**36.8 C**	**162**	**60**

Vital Sign Trends: The patient's vital sign trends indicated she was tachycardic and tachypneic secondary to withdrawal from cannabis.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	**NPASS**	**n/a**	**No pain indicated.**	**n/a**	**n/a**

Summary of Assessment (4 points)

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

This neonate was delivered on 09/21/21 at 1122 by urgent cesarean section related to abruptio placenta. Nuchal cord x1. Apgar scores 9/9. Dubowitz revealed neonate is 34 6/7 weeks and AGA. Prenatal hx complicated by chronic cannabis use, low hematocrit and hemoglobin levels, and elevated blood glucose levels in the mother. Birth weight 4 lbs 8.3 ozs (2050 grams), 17.72" long (45 cms). Upon assessment all systems are within normal limits, except her cardiac and respiratory assessment. Respiratory and cardiac assessment revealed tachypnea and tachycardia. Last set of vitals: 36.8/162/60. BS x1 after delivery WNL with lowest being 45. Neonate has NG tube with bolus feedings q3 hrs using Similac Special Care 24 cal. Bilirubin level at 48 hrs was 8.4 due to prior samples being hemolyzed. Neonate expected date to be discharged is unknown until baby's respirations and heart rate are within normal limits. The mother and father also have to show they are capable of feeding of caring for the neonate for at least 24 hours. They do not have a pediatrician selected for the first well baby check.

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

Nursing Interventions and Medical Treatments (Identify nursing interventions with	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

"N" after you list them, identify medical treatments with "T" after you list them.)		
A nursing intervention would be to support the parents and family during their adjustment with a newborn. (N)	**This intervention would be done as needed while the parents were present.**	**The parents needed to be more involved with the baby's care. They were not present frequently enough to ensure the baby could be cared for properly and thrive.**
Another nursing intervention would be to optimize nutrition and the delivery of bolus feedings. (N)	**This intervention would be done every 3 hours during the baby's feedings.**	**The baby needed to tolerate feedings to grow. Constant nursing interventions concerning the baby's optimal nutrition status should be assessed during each feeding.**
A medical treatment for this baby included bolus feedings using Similac Special Care 24 cal every 3 hours. (T)	**This intervention was done every 3 hours until discharge.**	**The baby had difficulty growing and maintaining her sucking reflex. This intervention should be assessed and monitored until discharge.**
The baby had a nasogastric tube (NG) until she was able to tolerate bottle feedings without using up too much of her energy.	**This intervention was done every 3 hours as tolerated for 20 mins.**	**The baby needed to tolerate feedings to thrive and remain healthy. She also needed to establish her sucking reflex in order to remove the NG tube.**

Discharge Planning (2 points)

Discharge location: Discharge location is unknown until parents are able to successfully feed and care for the child for 24 hours in the special nursery unit.

Equipment needs (if applicable): Equipment needed is unknown.

Follow up plan (include plan for newborn ONLY): Follow up plan includes obtaining a Pediatrician to properly care for the child.

Education needs: The parents should be educated on proper care of a newborn, reducing cannabis use around the newborn, and signs of distress or failure to thrive in the newborn.

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 (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. Failure to thrive related to a failure in the baby's sucking reflex as evidenced by the baby having an NG tube.	**This nursing diagnosis was chosen due to the baby's prematurity and failure to bottle feed effectively.**	**1.Assess sucking reflex q3h. Rationale: This will determine if the baby's sucking reflex is developing appropriately. 2.Bottle feed the baby for 20 mins q3h as tolerated. Rationale: This will ensure proper development of the sucking reflex.**	**The mother understand why the baby needed to have an NG tube place. The baby tolerated bolus feedings well. The goal is to have the parents bottle feed the baby to show they can care for her after discharge.**
2. Ineffective breathing pattern related to prematurity as evidenced by the baby's respirations of 60.	**The baby's heart rate and breathing pattern is elevated because the mother used cannabis chronically during her pregnancy.**	**1. Monitor respirations q4h. Rationale: The baby is going through cannabis withdrawals. Her respirations should be monitored to reduce complications. 2.Monitor vital signs q4h until discharge. Rationale: The baby's vitals should be monitored consistently due to her pre-maturity to ensure no complications arise.**	**The goal is for the baby to successfully tolerate withdrawal from cannabis. During my assessment, she was tachypneic and had tachycardia. There is no estimated discharge date, but if constant monitoring and assessments are done routinely the baby should have a positive outcome and her vitals should reflect such.**
3. Risk of disturbance	**The baby was born pre-**	**1. Monitor vital signs and temperature q4h.**	**Due to the baby's pre-maturity, the goal for**

in body temperature associated with immaturity as evidenced by the baby's skin having superficial peeling with visible veins on the Ballard Age Scale.	**maturely so her skin has to develop to regulate her body temperature appropriately.**	**Rationale: The baby's vital signs and temperature should be monitored to ensure she has no thermoregulation complications.** **2. Use the Ballard scale to assess the baby every shift.** **Rationale: The Ballard scale will determine if the baby is reaching the developmental milestones for her skin.**	**the diagnosis is to ensure she develops according to her gestational age.**
4. Activity intolerance related to ineffective sucking reflex as evidenced by the baby being on an energy conservation regimen.	**The baby was born pre-maturely so her sucking reflex has not developed according to her gestational age.**	**1. Bottle feed the baby q3h for 20 mins as tolerated.** **Rationale: Allowing the baby to bottle feed will help develop the sucking reflex she needs to bottle feed and develop properly.** **2. Administer a 40 mL bolus feeding q3h.** **Rationale: Administering a bolus feeding will ensure she is receiving the nutrition she needs to develop.**	**The goal is for the baby to tolerate bottle feedings so she can be discharged. The goal is also to observe the parents bottle feeding the baby to ensure they can care for her properly at home. The outcome of this diagnosis is still pending.**

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	
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]

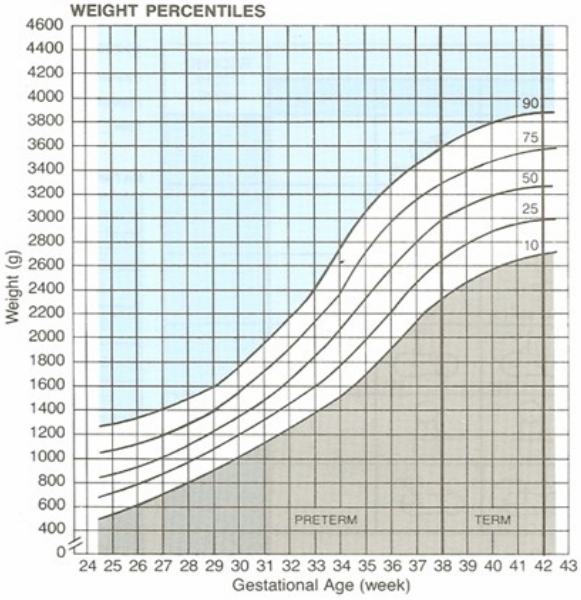
NAME _____ DATE OF EXAM _____ LENGTH _____

HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

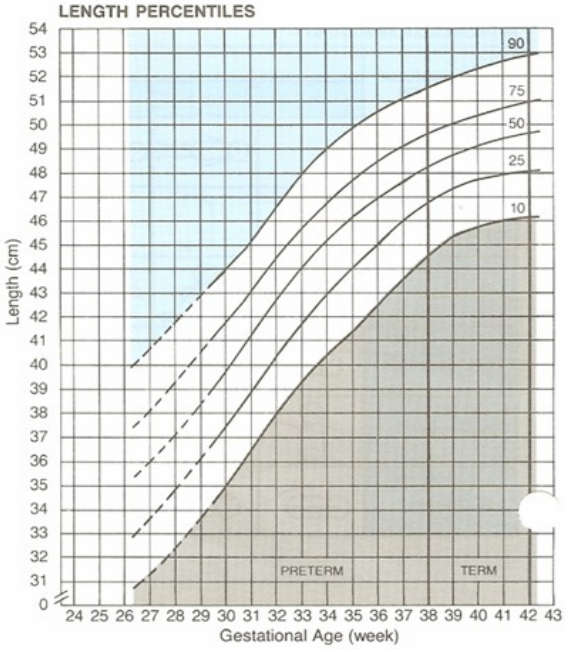
RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____

DATE OF BIRTH _____

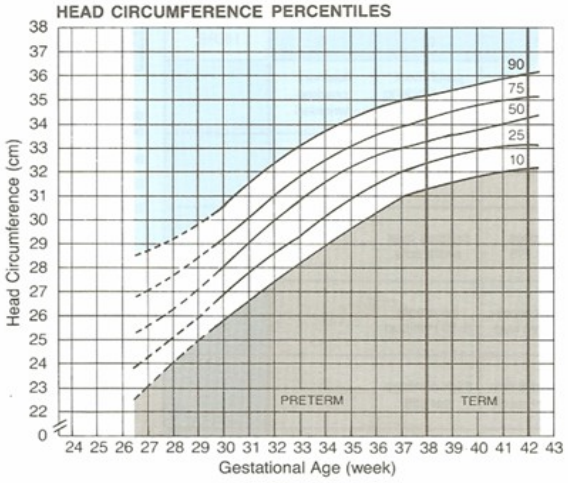
WEIGHT PERCENTILES



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