N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment 09/08/2022 0800	**Patient Initials** E.M	**Date & Time of Birth** 09/08/2022 0400	**Age (in hours at the time of assessment)** 4 hours old
Gender Female	**Weight at Birth** **(gm)** 2480 **(lb.)** 5 **(oz.)** 7.5	**Weight at Time of Assessment** **(gm)** 2480 **(lb.)** 5 **(oz.)** 7.5	**Age (in hours) at the Time of Last Weight** 4 hours old
Race/Ethnicity White Non Hispanic	**Length at Birth** **Cm** 18.7 **Inches** 7.38	**Head Circumference at Birth** **Cm** 33 **Inches** 12.99	**Chest Circumference at Birth** **Cm** 29.5 **Inches** 11.61

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: G2 T0 P1 A1 L1

When prenatal care started: February 18, 2022

Abnormal prenatal labs/diagnostics: Failed 1-hour glucose but passed the 3hr, decreased RBC, decreased HCT and decreased HCB.

Prenatal complications: HSV-2 positive and preterm premature labor

Smoking/alcohol/drug use in pregnancy: Previous use of vaping and drinking of alcohol (social), mother stated that she has stopped and it has been about a year since.

Labor History of Mother

Gestation at onset of labor: 36 weeks

Length of labor: 11 hours

ROM: 09/05/2022 1000

Medications in labor: The patient received IV pain medication through her IV but then received 2 epidurals because the first one failed.

Complications of labor and delivery: Fetal did not tolerate leading to labor not progressing normally.

Family History

Pertinent to infant: None

Social History (tobacco/alcohol/drugs)

Pertinent to infant: None

Father/Co-Parent of Baby Involvement: Father of baby was present

Living Situation: Living with partner

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

Birth History (10 points)

Length of Second Stage of Labor: Second stage of labor was not reached due to complications

Type of Delivery: Cesarean birth

Complications of Birth: Babies heart rate dropped leading to cesarean birth

APGAR Scores:

1 minute: 9

5 minutes: 9

Resuscitation methods beyond the normal needed: None

Feeding Techniques (10 points)

Feeding Technique Type: Mother expressed that she wants to breastfeed but has not been able to get the baby to take so she will use bottles for now of colostrum and breast milk.

If breastfeeding:

LATCH score: Not available due to circumstances

Supplemental feeding system or nipple shield: Not available due to circumstances

If bottle feeding:

Positioning of bottle: Baby is cradled while parents are holding bottle (semi-upright position).

Suck strength: Not available due to circumstances (baby is preterm and is struggling to eat).

Amount: 10 mL colostrum

Percentage of weight loss at time of assessment: N/A

****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? N/A

Is this neonate's weight loss within normal limits? N/A

If I was able to do this I would use the formula, Current weight-birth weight/birth weight. This value will be negative if the infant has had weight loss or positive if the infant has happened to gain. After I use the formula I will multiply by 100 to get my percent (%).

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency: Every 3 hours

Length of feeding session: This baby has not set length of feeding, we are pushing just to get the baby to eat.

One or both breasts: Not applicable she has not latched

If bottle feeding:

Formula type or Expressed breast milk (EBM): No formula is being used, only colostrum.

Frequency: Every 3 hours

Volume of formula/EBM per session: Not applicable

If EBM, is fortifier added/to bring it to which calorie content: Not applicable

If NG or OG feeding:

Frequency: Not applicable

Volume: Not applicable

If IV:

Rate of flow: Not applicable

Volume in 24 hours: Not applicable

Output

Void

Age (in hours) of first void: Baby has not had first void.

Number of voids in 24 hours: Not applicable

Age (in hours) of first stool: Baby has not had first void.

Type: Not applicable

Color: Not applicable

Consistency: Not applicable

Number of times in 24 hours: Not applicable

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 is this test ordered for any infant?	Expected Results	Client's Results	Interpretation of Results
Blood Glucose Levels	Showing signs of hypoglycemia	>45	44	Baby glucose is below the normal range. The baby is showing signs of hypoglycemia.
Blood Type and Rh Factor	This is tested to find out the blood type of the newborn and if the blood lacks the Rh antigen making the newborn Rh-negative or if the newborn has the antigen making it Rh-positive (Pagana et al., 2019).	(+) or (-)	A+	The mother's blood was O so this means there an antigen
Coombs Test	This is a routine test that helps detect any foreign antibodies that have attached to the newborn's RBCs (Pagana et al., 2019).	(+) or (-)	(-)	No foreign antibodies have affected the newborns RBC
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	Bilirubin levels are checked to screen for jaundice in the newborn (Pagana et al., 2019)	1-15	No test baby was 4 hours old	N/A
Newborn Screen	This screening helps to identify	All results should be	Results will not be available.	N/A

(At 24 hours)	if there are any rare conditions the newborn has, this could reduce or eliminate the condition if treated early on (Pagana et al., 2019).	normal		
Newborn Hearing Screen	This is a routine test to analyze if the newborn has any hearing issues and should be evaluated further (Pagana et al., 2019).	Pass	No test baby was 4 hours old	N/A
Newborn Cardiac Screen (At 24 hours)	This test screens for critical congenital heart defects and can help identify if they have any concerns with their heart before being discharged (Pagana et al., 2019).	Normal results no positive findings	No test baby was 4 hours old	N/A

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th ed.). Elsevier.

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**	**Glucose gel (Dextrose)**
Dose	1 mg	2 g	0.5 mL	0.6 g
Frequency	1X	1X	1X	PRN

Route	IM	Ophthalmic	IM	Oral
Classification	Fat-soluble vitamin	Antibiotic	Immunization	Glucose elevating agent
Mechanism of Action	Produces adequate clotting factors	Routine for prevention of ophthalmia neonatorum	Prevents infection of Hepatitis B by making the body produce its own antibodies	Ingested to orally to rapidly increase levels through blood to intestine
Reason Client Taking	Provides the newborn with Vitamin K during the first week of birth until they can make their own	Preventative care	Prevent infection of Hepatitis B.	Pt blood glucose is below normal range
Contraindications (2)	Hypersensitivity to Vitamin K Hereditary hypoprothrombinemia	Minor ocular irritation Hypersensitivity to ilotycin	Severe allergic reaction Belimumab which decreases effects of hepatitis b vaccine by immunosuppressive effects	Allergy to sulfonamides Anticoagulants
Side Effects/Adverse Reactions (2)	Cyanosis Dyspnea	Rash Trouble breathing	Light headedness Tachycardia	Allergic reaction Dizziness or passing out
Nursing Considerations (2)	Must be given IM or IV diluted Light exposure	Avoid heat Protect from freezing	Latex allergy Patient with a weak immune system	Assess orientation and reflexes before Monitor levels every 1hr after each dose
Key Nursing Assessment(s)/Lab	This is a mandatory injection the baby	Routine for newborns	This injection is highly	Blood glucose

(s) Prior to Administration	must get in the first hour of birth. None.	following birth. None.	recommended to get. None	check
Client Teaching needs (2)	Pay attention to symptoms of deficiency of this vitamin such as bruises that appear on their own, nose and gum bleeds, presence of blood in urine or stool. Newborns injection site may be sore afterwards.	Avoid contamination of the tip of the applicator. Given once after birth.	Watch for signs of anaphylaxis. Tenderness at the injection site	Store at room temperature Follow the recommended dose

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2022 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning

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 2021.
Skin	Normal color, no jaundice or rash.	Normal color no jaundice no rash soft and smooth normal turgor with a small amount of hair covering surface of skin.
Head	Sutures mobile, 33 cm.	Round symmetrical moves easily 32-37cm around.
Fontanels	Normal size fontanelles.	Anterior fontanelle 3-4 cm long by 2-3 cm wide diamond-shaped and flat Posterior fontanelle 1-2 cm at triangle shaped and flat.
Face	Symmetrical.	Symmetrical movement of all facial features normal facial hair.
Eyes	Normally set, red reflexed present bilateral.	Same level bright and clear move in all directions.
Nose	Nares patent, no septal deviations.	Nostrils equal in size small narrow in midline even placement to eyes and mouth.
Mouth	Moist mucus membrane, palate intact, swallowing and sucking reflexes are delayed caused by preterm.	Strength and symmetry of motion Gag, swallowing, and sucking reflexes in sync. Adequate salivation Hard palate dome-shaped Uvula midline with symmetrical soft palate movement Palate intact, sucks well when stimulated.
Ears	Normal shape and placement.	Without tumors, cysts, or module placement of pinnae parallel with eye canthi bilaterally Attends to sounds; sudden or loud noise provokes Moro reflex Absence of all hearing risk factors passed Algo hearing test bilaterally.

Neck	No lumps, clavicles are intact upon palpitation.	Short, straight, creased with skin folds Posterior neck lacks loose extra folds of skin.
Chest	29.5 cm bellow average, normally shaped.	Circumference: 32 cm, 1-2 cm Less than the circumference of the head Wider than it is long Normal shape without a depressed or conspicuous sternum Lower end of the sternum (xiphoid cartilage) may protrude; this becomes less noticeable after a few weeks.
Breath Sounds	No respiratory distress, rise and falls bilaterally.	Breath sounds are louder in infants Chest and axilla clear on crying Bronchial breath sound (heard where trachea and bronchi closest to chest wall, above sternum and between scapulae): bronchial sounds bilaterally Air entry clear Rales may indicate normal newborn atelectasis Cough reflex absent at birth, appears in 2 or more days.

Heart Sounds	S1 and S2 are normal, no murmurs.	Regular rhythm and rate.
Abdomen	Soft nontender, non-distended, no masses or organomegaly.	No documented norms for circumference Cylindrical with some protrusion, appears large in relation to pelvis, some laxness of abdominal muscles No cyanosis, few vessels seen.
Bowel Sounds	Active bowel sounds.	Soft bowel sounds heard shortly after birth every 10-30 seconds Diastasis recti.
Umbilical Cord	Normal in color and no bleeding present.	There is no protrusion of the umbilicus. Cutis navel, granulation tissue presents in the navel, two arteries and one vein visible, starts drying 1-2 hours after birth There is no bleeding.
Genitals	Normal female external genitals.	Normal swollen female genitals as a result of maternal estrogen.
Anus	Appears patent.	Normal colorization, no rashes.
Extremities	Moves all extremities well.	Short and generally flexed, extremities move symmetrically through range of motion but lack full extension All joints move spontaneously; good muscle tone, of

		flexor type, birth to 2 months.
Spine	Intact without deformities.	C-shaped spine Flat and straight when prone Slight lumbar lordosis Easily flexed and intact when palpated At least half of back devoid of lanugo Full-term infant in ventral suspension should hold head at 45-degree angle, back straight.
Safety • **Matching ID bands with parents** • **Hugs tag** • **Sleep position**	Matching ID bands Hugs tag present Sleeping on back, swaddled in baby bed	ID bands should match, hugs tag should be present and baby should be sleeping safely.

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**
Birth	92.2 degrees Fahrenheit Axillary	124 bpm	50
4 Hours After Birth	97.3 Fahrenheit Axillary	120 bpm	44
At the Time of Your Assessment	97.2 Fahrenheit Axillary	124 bpm	44

Vital Sign Trends: Vital signs are trending the same, with the temperature trending on the low side. These temperatures are not alarming yet but need to implement interventions to raise her temperature.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:45 am	NIPS	N/A	0	N/A baby is comfortable	N/A

Summary of Assessment (4 points)

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

This neonate was delivered on 09/08/2022 at approximately 0400 by cesarean birth. The mother reached 7 cm dilated, and the neonate's heart rate dropped, leading to an emergency cesarean. The Apgar scores were both 9. The estimated delivery date was October, so the neonate was 36 weeks premature. One complication of prenatal history was the mother tested positive for HSV-2 and premature rupture of her membranes. The birth weight was 5 lb 7.5 oz (2480 g); length 7.38in (18.7 cm); head circumference 12.99 in (33 cm); chest circumference 11.61 in (29.5 cm). Upon assessment, all systems are within normal limits. The last set of vitals was:97.2 axillary, 124 pulse, and 44 respirations. Neonate blood glucose was 44, and after a dose of glucose gel, it did not rise. Breath, heart, and bowel sounds were all WNL. The neonate is struggling to latch and suck. The mother wants to breastfeed but has not produced milk yet, and the neonate is not latching, so she is feeding colostrum from the bottle. Mother is trying to feed every 3 hours with little success. There was no bilirubin test completed because the neonate was not old enough. The neonate is expected to be discharged to home with her mother and father once she tolerates feeding and gets her glucose to rise. Neonate will follow up in 24-48 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 "M" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Blood glucose checks (N)	Re check every 1hr after receiving	This is provided because her glucose was low and we are trying to get her into

	glucose gel and feedings.	the normal range.
Vital signs checks (N)	Every 4 hours	This is provided to see what her vital trends are as well as her temperatures were running low and exhibiting signs of hypoglycemia.
Swaddle (N)	As needed	This is provided to try and keep her warm and raise her temperature.
Warming bed (T)	As needed	This was provided because she was unable to keep her temperature regulated with being swaddled in multiple blankets.

Discharge Planning (2 points)

Discharge location: Baby will be discharged to home with mom and dad.

Equipment needs (if applicable): No equipment will be needed for this discharge.

Follow up plan (include plan for newborn ONLY): Baby will be seen for a check-up in 24-48 hours.

Education needs: Mother should be educated on breastfeeding as well as infant signs of distress as a first time mother.

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)	Rational (1 pt each)	Intervention/Rational (2 per dx) (1 pt each)	Evaluation (2 pts each)

Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	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.	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for hypoglycemia related to feeding as evidence by low blood sugar.	The newborns blood sugar was 44 and after glucose gel is dropped to 42.	**1.**Oral glucose gel **Rationale** - Efforts to raise the blood glucose levels (Phelps, 2020). **2.**More frequent feedings **Rationale** -Efforts to raise the blood glucose levels (Phelps, 2020).	The mother was understanding of why her daughter was given this glucose gel and understands that she needs to try and feed more often. Her daughter did not tolerate the gel and was unable to suck and swallow.
2. Risk for hypothermia related to low temperature (inability to manage thermoregulation) as evidence skin cold to touch.	The newborn was unable to keep her temperature even being swaddled in 3 blankets.	**1.** Heat lamp bed **Rationale** - Quick warming technique (Phelps, 2020). **2.** Adjust the temperature of the environment **Rationale** -Keep baby comfortable after heat lamp bed end help prevent hypothermic episode (Phelps, 2020).	The mother understands that the warming bed will help raise her daughter's temperature but refuses to turn up the heat in her room because she is sweating. The baby responded well to the warming bed but was not kept warm after that due to the noncompliance of the mother.
3. Risk for knowledge deficit related to feedings as evidence by newborn low blood sugar.	The mother is unable to get her daughter to latch on breast or bottle so she is not eating.	**1.** Educate mother in breast feeding techniques. **Rationale** - This enhances proper nutrition of neonate (Phelps, 2020). **2.** Offer information about the importance of adequate nutrition and fluid intake. **Rationale** -This enhances information	The mother is comfortable and the neonate will feed successfully on both breaths and will be satisfied for 2 hours.

		to meet infants demand of breast milk (Phelps, 2020).	
4. Risk for knowledge deficit related to newborn cues as evidence by irritability.	As a new mother it is important to know the cues of a newborn so the baby will gain trust in her caregiver.	**1.** Discuss with parents how their actions can help modify infants behavior but make it known maturation isn't completely within their control. **Rationale** **-** This may help decrease the parents feeling of incompetence (Phelps, 2020). **2.** Assist parents in exploring ways to cope with stress imposed by the infants behavior. **Rationale** **-**This will help them develop better and healthy coping skills (Phelps, 2020).	The parents understand the infants behavioral cues and will find appropriate ways to respond. They will also find healthy ways to cope with their stress.

Other References (APA):

Phelps, L.L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th ed.). Wolters Kluwer.