N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment **9/22/22** **1030**	**Patient Initials** **Female Nantz**	**Date & Time of Birth** **9/20/22** **0812**	**Age** **(in hours at the time of assessment)** **50 hours**
Gender **Female**	**Weight at Birth** **(gm) 2890_____** **(lb.) 6___ (oz.) 5.9___**	**Weight at Time of Assessment** **(gm) 2745_____** **(lb.) 6___ (oz.) 0.8___**	**Age (in hours) at the Time of Last Weight** **44 hours**
Race/Ethnicity **Caucasian**	**Length at Birth** **Cm 48.3_____** **Inches 19_____**	**Head Circumference at Birth** **Cm 35.5_____** **Inches 13.98_____**	**Chest Circumference at Birth** **Cm 32.5_____** **Inches 12.8_____**

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: 5, 3, 0, 2, 3. 2 vaginal births, 2 spontaneous abortions, 1 c-section

When prenatal care started: 2/21/22

Abnormal prenatal labs/diagnostics: There are no abnormal labs or diagnostics for this patient.

Prenatal complications: Endometriosis, ovarian cysts, positive test for HSV antibody, yeast infection, vaginitis, anemia, UTI, and bacterial vaginosis.

Smoking/alcohol/drug use in pregnancy: Patient is not a smoker, has never used smokeless tobaccos, no drug use, and currently no alcohol use.

Labor History of Mother:

Gestation at onset of labor: 39 weeks 0 days.

Length of labor: 0h 1minute

ROM: Artificial ROM 9/20/22 at 0807

Medications in labor: Anesthesia spinal, Reglan, Zithromax, ancef, and bicitra.

Complications of labor and delivery: C-section due to baby being breech, otherwise no complications.

Family History:

Pertinent to infant: No family history pertinent to the infant.

Social History (tobacco/alcohol/drugs):

Pertinent to infant: No tobacco, alcohol, or drug use that is pertinent to the infant.

Father/Co-Parent of Baby Involvement: Co-Parent involvement

Living Situation: Lives with three children and partner in a house.

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

Mom has some college

Birth History (10 points)

Length of Second Stage of Labor: None, this baby was breech and mom had a c-section.

Type of Delivery: C-section, low transverse

Complications of Birth: Baby was breech, otherwise no complications.

APGAR Scores:

1 minute: 9

5 minutes: 9

Resuscitation methods beyond the normal needed: No resuscitation methods needed beyond normal needed.

Feeding Techniques (10 points)

Feeding Technique Type: Breastfeeding

If breastfeeding:

LATCH score: 8

Supplemental feeding system or nipple shield: None used, mom has previous breastfeeding experience.

If bottle feeding: Mom is breastfeeding only

Positioning of bottle: Mom is breastfeeding information not provided

Suck strength: Mom is breastfeeding information not provided

Amount: Mom is breastfeeding information not provided

Percentage of weight loss at time of assessment: ___0.077 negative_____%

****Show your calculations; if today's weight is not available, please show how you would calculate weight loss (i.e. show the formula)** (current weight-birth weight/birth weight) (6.08-6.59/6.59)**

What is normal weight loss for an infant of this age? 10%

Is this neonate's weight loss within normal limits? Yes

Intake and Output (8 points)

<u>Intake</u>

If breastfeeding:

Feeding frequency: Feeding every 2-3 hours

Length of feeding session: Feeding sessions or between 20-30 minutes.

One or both breasts: Mom is alternating between both breasts.

If bottle feeding: Mom is breastfeeding

Formula type or Expressed breast milk (EBM): Mom is breastfeeding information not provided

Frequency: Mom is breastfeeding information not provided

Volume of formula/EBM per session: Mom is breastfeeding information not provided

If EBM, is fortifier added/to bring it to which calorie content: Mom is breastfeeding information not provided

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

<u>Output</u>

Void

Age (in hours) of first void: 1 hour 45 minutes

Number of voids in 24 hours: 4 total voids in the first 24 hours

Stool

Age (in hours) of first stool: 2 hours

Type: meconium

Color: green

Consistency: tarry

Number of times in 24 hours: 2 in the first 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 is this test ordered for any infant?	Expected Results	Client's Results	Interpretation of Results
Blood Glucose Levels	**Test not needed**	**>45**	**Test not needed**	**Test not needed**
Blood Type and Rh Factor	**To see if the baby and moms' blood are compatible, if mom is negative and baby is positive it could be dangerous to the baby if moms blood crosses the placenta.**	**(+) or (-)**	**A, positive**	**If mom's blood crosses the placenta, it could be dangerous to the baby and causing complications and destroying red blood cells.**
Coombs Test	**It is in relation to find foreign antibodies and done if baby has jaundice.**	**(+) or (-)**	**positive**	**The baby has moms' positive blood, putting baby at high risk for jaundice and possibly anemia.**
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	**To check for jaundice in babies.**	**5-6 mg/dL**	**T bili: 0.5** **Bilirubin direct:** **5.4**	**The bilirubin direct level falls in between the expected range, but baby is slightly jaundice.**
Newborn	**To identify any**	**(+) or (-)**	**Results will not**	**Results not**

Screen (At 24 hours)	**potential problems or disabilities they baby may have.**		**be available.**	**available**
Newborn Hearing Screen	**To identify if there are any hearing problems that can be diagnosed early on**	**Pass or fail**	**Pass, newborn met criteria at the time of screening. Infant was able to respond to noises and sounds being heard in one ear separately and together.**	**The infants hearing is within normal limits during the time of testing.**
Newborn Cardiac Screen (At 24 hours)	**To identify any cardiac problems that can be monitored or fixed early on**	**Positive or Negative**	**Negative at time of screening.**	**When oxygen was being monitored the infants oxygen was in the expected range and met all criteria to be negative.**

Lab Data and Diagnostics Reference (1) (APA): Pagana, K.D., Pagana, T. J., & Pagana, T. N., (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO-Elsevier.

CDC. (2022). https://www.cdc.gov/ncbddd/heartdefects/cchd-facts.html

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine (energix-B)**		
Dose	**1 Mg**	**2 gm**	**0.5 mL**		
Frequency	**1x**	**1x**	**3 dose series**		
Route	**IM**	**ophthalmic**	**IM**		
Classification	**Fat soluble vitamin**	**Macrolide Antibiotics**	**Vaccine, viral**		
Mechanism of Action	**Blood clotting vitamin.**	**Inhibits RNA-dependent protein synthesis in bacterial cells, causing them to die.**	**Causes your body to produce its own antibodies against the disease.**		
Reason Client Taking	**To help start clotting, babies don't get enough vitamin**	**All babies are given this at birth to prevent infections that**	**To protect from getting the disease.**		

	K.	**may have occurred during birth.**			
Contraindications (2)	**Hypersensitivity to the drug component, including anaphylaxis and shock.**	**No noted contraindications.**	**Anaphylactic reaction may occur, and moderate illness may occur.**		
Side Effects/Adverse Reactions (2)	**Hypotension and tachycardia**	**Rash, oral candidiasis**	**Low fever, soreness at the injection site**		
Nursing Considerations (2)	**Impaired coagulation, can lead to hemorrhage.**	**Administer within one hour after delivery, wipe away excess ointment.**	**Sensitivity to the components in the vaccine, side effects that occur and last longer than 24 hours.**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Blood tests needed: CBC, fecal occult needed for baseline labs prior to administration.**	**Assess eyes for drainage and crusting, clean eyes prior to administration, avoid contamination, no labs needed.**	**Test for Hepatitis Immune globulin.**		
Client Teaching needs (2)	**Needed due to deficient vitamin K helps blood clotting, monitor for hemorrhaging.**	**Potential side effects and purpose of medication.**	**If pain, swelling, or fever lasts longer than 24 hours contact your provider.**		

Medications Reference (1) (APA): Jones & Bartlett Learning (2021). 2021 Nurses' Drug Handbook. Burlington, MA

CDC. (2022). Hepatitis B. https://www.cdc.gov/vaccines/parents/diseases/hepb.html

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	**Skin was smooth, flexible, warm, pink, dry, and jaundice.**	**Normal: smooth, flexible, good skin turgor, well hydrated, warm Variations: jaundice, acrocyanosis, milia, stork bites, Mongolian spots.**
Head	**Head was symmetrical and aligned to face.**	**Normal: varies with age, gender, and ethnicity. Microcephaly, macrocephaly, enlarged fontanels.**
Fontanels	**Fontanels were soft and flat, no noted bulging.**	**Microcephaly- circumference more than two standard deviations below average, macrocephaly, large fontanels- more than 6cm in anterior diameter bone to bone, small or closed fontanels-smaller than normal anterior and posterior diameters or fontanels.**
Face	**Face was round, cheeks round and full, symmetrical with eyes, ears, and nose.**	**Normal: full cheeks, facial features symmetric. Facial nerve paralysis, nevus flammeus, nevus vasculosus.**
Eyes	**Eyes were symmetrical on the face to nose and ears, sclera was white, eyes were clear, infant moved eyes and eyes followed when voices were heard.**	**Normal: clear and symmetrically placed on face; online with ears. Chemical conjunctivitis, subconjunctival hemorrhages.**
Nose	**Nose is small and symmetrical on face, no signs of blockage.**	**Normal: small, placement in midline and narrow, ability to smell. Malformation or blockage.**
Mouth	**Palpated hard and soft palate and it is intact, mouth is**	**Normal: aligned in midline, symmetric, intact soft and hard**

	aligned symmetrical on the face.	**palate.** **Epstein pearls, erupted precocious teeth, thrush.**
Ears	**Ears are symmetrical on face, no signs of blockage, infant responds to noise.**	**Normal: soft and pliable with quick recoil when folded and released.** **Low-set ears, hearing loss.**
Neck	**Soft and moves freely from side to side**	**Normal: short, creased, moves freely, baby holds head in midline.** **Restricted movement, clavicular fractures.**
Chest	**Chest is symmetric and round, no discharge from nipples, no noted abnormalities, or marks on the chest.**	**Normal: round, symmetric, smaller than head.** **Nipple engorgement, whitish discharge.**
Breath Sounds	**Breath sounds are clear and audible, no wheezing noted, with 32 breaths/min.**	**30-60 breaths/min** **SGA, LGA, preterm, post-term**

Heart Sounds	**Hearts sounds are clear and audible, no murmurs or gallops were heard with 128 bpm.**	**110-160 bpm** **SGA, LGA, preterm, post-term**	
Abdomen	**Abdomen was soft, barrel shaped, three vessel umbilical cord**	**Normal: protuberant contour, soft, three vessels in umbilical cord.** **Distended, only two vessels in umbilical cord.**	
Bowel Sounds	**Bowel sounds are heard in all quadrants and active.**	**10-30 bowel sounds per minute, hyperactive, hypoactive.**	
Umbilical Cord	**Healing properly, cord is a black color, no discharge, bleeding, or drainage noted.**	**Starts drying withing hours after birth, shriveled and blackened by the second or third day.**	
Genitals	**Genitals are intact, pink, no noted discharge, swelling or rash.**	**Normal female: swollen female genitals as a result of maternal estrogen** **Normal male: smooth glans, meatus centered at tip of penis.** **edematous scrotum in males, vaginal discharge in females.**	
Anus	**Small, no lesions or cuts, no marks or bruises.**	**Passage of meconium indicate patency. Abnormal findings include anal fissures or fistulas and no meconium passed within 24 hours after birth.**	
Extremities	**Extremities moved freely, positive Babinski reflex**	**Normal: extremities symmetric with free movement.** **Congenital hip dislocation.**	
Spine	**Spine was straight and aligned.**	**Normal: extremities symmetric with free movement.** **Tuft or dimple on spine.**	
Safety • **Matching ID bands with parents** • **Hugs tag** • **Sleep**	**Infant had matching ID bands on with parents, infant sleeping swaddled in blanket on her back.**	**Abnormal findings include no identity such as bracelets that relate to mom and baby, sleeping SIDS.**	

position			

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	**97.5 F**	**132**	**92**
4 Hours After Birth	**98.6 F**	**128**	**48**
At the Time of Your Assessment	**98.2 F**	**132**	**32**

Vital Sign Trends:

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1030	**NIPS**	**Facial, cry, breathing patters, arms, legs, state of arousal.**	**0**	**Relaxed muscles, no crying, breathing patterns relaxed, legs relaxed, state of arousal infant is awake.**	**Cuddling, holding, swaddling**

Summary of Assessment (4 points)

Discuss the clinical significance of the findings from your physical assessment:
****See the example below****

This neonate was born on 9/20/22 at 08:12 AM, via planned c-section due to baby being breeched. Infant weighted 6lb. 5.9 oz, was 19 in. tall, had a head circumference of 13.98 inches, and a chest circumference of 32.5 cm. Apgar scores at 1 and 5 minutes were both 9. No further complications during labor. Records showed that prenatal complications involved include

endometriosis, cyst of ovary, positive test for HSV antibody, yeast infection, vaginitis, anemia, UTI, and bacterial vaginosis. Vitals upon assessment was a temperature of 98.2 F, pulse 132, and respiration of 32. Mom is breastfeeding the baby every 2-3 hours, with 20–30-minute feedings, and alternating breasts when feedings. This infant was born with jaundice, upon discharge mom verbalizes appointment has been set up for infant to see the doctor the following day to have bilirubin levels checked until they return to normal.

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.**
Swaddling (N)	Daily for bedtime and naps	To provide information on when and how to properly swaddle the infant to make sure that they aren't swaddled to tight and to help soothe them.
Breastfeeding (N)	Every 2-3 hours daily	To provide information to mom to make sure that the newborn is getting adequate nutrition and reduce the risk of infection to mom.
Diaper changes (N)	Every 2-3 hours daily	To provide information to mom to make sure that infant is producing wet diapers and producing stool, and to reduce rashes and infection to the genital area.

Discharge Planning (2 points)

Discharge location: Being discharged home with mom and partner

Equipment needs (if applicable): No needed equipment

Follow up plan (include plan for newborn ONLY): Infant has a follow up appoint the following day to check bilirubin levels due to them being high, and infant is to see primary doctor within one month from being discharged to home.

Education needs: Mom was given education on bathing infant, how to change the diaper to allow for adequate healing of the umbilical cord, and information on breastfeeding.

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. Deficient knowledge of jaundice related to lack of exposure to information as	This was chosen due to the infant being jaundice, and ensuring that infant gets	**1.**Demonstrate assessing the infants bilirubin levels daily. **Rationale:** Parent's understanding of the importance of this will help	Mom verbalized understanding of the information and stated she had a doctor's appointment set up for the following day from

evidenced by requestion more information.	proper care once discharged to make sure the jaundice clears up.	them cooperate more and stay on track once discharged (Swearingen & Wright, 2019). **2.** Make a follow up bilirubin testing at the lab within 24 hours of being discharged **Rationale:** Bilirubin levels need to be monitored daily until they return to normal (Swearingen & Wright, 2019).	being discharged.
2. Risk for hypothermia related to low infant body temperature as evidenced by feeling the baby's skin and taking their temperature.	Baby's temperature was 98.2 F, while that is a normal temperature, it is on the lower side as the baby was in appropriate clothing, and swaddled.	**1.** skin to skin contact **Rationale:** Body temperature adjusts to keep baby warm, putting the baby on mom/dad chest will keep baby warm and calm (Swearingen & Wright, 2019). **2.** appropriate clothing/blanket **Rationale:** monitor vital signs frequently, especially temperature (Swearingen & Wright, 2019).	Family verbalized understanding and state they would make sure the baby is bundled up in appropriate clothing, and had blankets, as well as monitoring her temperature regularly.
3. Deficient knowledge of proper umbilical cord care related to lack of information or improper instructions as evidenced by diaper being over the umbilical cord.	When assessing the infant, it was noted that the diaper was over the umbilical cord.	**1.** Provide information to patient with handouts on how to properly take care of umbilical cord. **Rationale**: This will give a guide to the patient if they have any questions, they are able to reference the information and pictures available given to them (Swearingen & Wright, 2019). **2.** Teach back method, **Rationale: H**ave the patient properly demonstrate how to take care of the umbilical cord and make sure to leave the diaper under the umbilical cord, this will	Family verbalized understanding and stated they would make sure the diaper is under the umbilical when changing the infant.

		ensure patient understands how to accurately change the diaper in regards to the umbilical cord (Swearingen & Wright, 2019).	
4.Risk for ineffective breastfeeding related to poor infant sucking, as evidenced by inadequate emptying of each breast during each feeding.	Mom is young and has two older kids, she may not have all the resources and information she needs to remember how to accurately make sure the infant is getting enough to eat.	**1.** Examine patient's knowledge and the level of education provided about breastfeeding. **Rationale:** This intervention teaches the mother the important information she needs to know about breastfeeding (Swearingen & Wright, 2019). **2.** Watch for indications of suckling issues in the baby. **Rationale:** It will assist in resolving the problem quickly, that is why it's important to watch the infant as they are feeding to make sure they are getting enough milk, or if they are having troubles suckling the nipples (Swearingen & Wright, 2019).	Family verbalized understanding and was able to communicate stating how long the infant was feeding for and making sure to rotate breasts when feeding.

Other References (APA): Swearingen, Pamela L. & Wright, Jacqueline D. All – in – One Nursing Care Planning Resource (2019). St. Louis, MO.