N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment **10/6/22 @ 0920**	**Patient Initials** **A. M.**	**Date & Time of Birth** **10/5/22 @ 1400**	**Age** **(in hours at the time of assessment)** **19**
Gender **Male**	**Weight at Birth** **(gm)** **___3110__________** **(lb.) __6___ (oz.)** **__13.7___**	**Weight at Time of Assessment** **(gm)** **___2940__________** **(lb.) __6___ (oz.)** **__7.7___**	**Age (in hours) at the Time of Last Weight** **19**
Race/Ethnicity **Black / African American**	**Length at Birth** **Cm** **____49.5__________** **Inches** **____19.5________**	**Head Circumference at Birth** **Cm** **____34__________** **Inches** **___13.4_________**	**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: G2 T2 P0 A1 L2

When prenatal care started: 4/15/22

Abnormal prenatal labs/diagnostics: 31.8 Hct and 10.9 Hgb during first trimester, 34% and 11.2 Hgb during third trimester, Potassium 3.3, BUN 22, Albumin 3.4, Alkaline phosphatase 146, LDH 255.62

Prenatal complications: Gestational hypertension and preeclampsia

Smoking/alcohol/drug use in pregnancy: No history of alcohol, drug, or tobacco use

Labor History of Mother:

Gestation at onset of labor: 37 weeks 5 days

Length of labor: Procedure was 2 hours and 43 minutes long

ROM: Yes

Medications in labor: Clindamycin, azithromycin, ancef, gentamycin, reglan, labetalol

Complications of labor and delivery: C-section for preeclampsia that could not be managed

Family History:

Pertinent to infant: Mother claims that she and her siblings had heart murmurs after being born, which disappeared over time

Social History (tobacco/alcohol/drugs):

Pertinent to infant: No use of tobacco, alcohol, or drugs

Father/Co-Parent of Baby Involvement: Father is involved

Living Situation: Infant will live in a house with both parents, a 4 year old brother, and the father's younger brother

Education Level of Parents (If applicable to parents' learning barriers or care of infant): Patient's mother has a CMA certification and is a phlebotomist, so she has a better understanding of healthcare of other patients.

Birth History (10 points)

Length of Second Stage of Labor: Patient did not go through second stage of labor

Type of Delivery: C-section

Complications of Birth: Preeclampsia

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: Deep suctioning

Feeding Techniques (10 points)

Feeding Technique Type: Breastfeeding

If breastfeeding:

LATCH score: Not documented

Supplemental feeding system or nipple shield: Breast milk given through syringe

If bottle feeding:

Positioning of bottle: N/A

Suck strength: Normal during assessment

Amount: 10 mL (once)

Percentage of weight loss at time of assessment: ___-5.47________%

[(Current weight - Birth weight) / Birth weight] x 100

[(2940 - 3110) / 3110] x 100

What is normal weight loss for an infant of this age? 5-10%

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

Intake and Output (8 points)

<u>Intake</u>

If breastfeeding:

Feeding frequency: Every 2-3 hours

Length of feeding session: About 5-10 minutes

One or both breasts: Both

If bottle feeding:

Formula type or Expressed breast milk (EBM): Similac 360 total care

Frequency: Once

Volume of formula/EBM per session: 10 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: N/A

Rate of flow: N/A

Volume in 24 hours: N/A

<u>Output</u>

Void

Age (in hours) of first void: 5

Number of voids in 24 hours: 4

Stool

Age (in hours) of first stool: 5

Type: Breastfed

Color: Yellow-green

Consistency: Soft

Number of times in 24 hours: 4

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	**A blood glucose test is typically performed on infants if they are at risk of hypoglycemia with 30-60 mg/dL (Pagana, 2019).**	**A neonate is expected to have a blood glucose reading of 30-60 mg/dL (Pagana, 2019).**	**Not tested**	**Not tested**

Blood Type and Rh Factor	**A blood typing test is used to determine the antibodies in the blood of the infant to know what blood is compatible if there needs to be an infusion, if the mother needs Rhogam, and for performing a Coombs test (Pagana, 2019).**	**Blood type is expected to be type A, B, AB, or O with a positive or negative based on the presence of an Rh factor.**	**B +**	**The blood of the patient has B antigens and antibodies against type A blood. They also have Rh factor protein present in their blood.**
Coombs Test	**A Coombs test is performed on infants to detect the presence of foreign RBCs for antibodies that could lead**	**A Coombs test is expected to be negative with no agglutination caused by foreign**	**Negative**	**The patient does not have foreign blood from the mother that would put them at risk of hemolytic anemia.**

	to hemolytic anemia (Pagana, 2019).	**incompatible blood in the body (Pagana, 2019).**		
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	**A test for bilirubin level is performed on infants to assess for jaundice (Pagana, 2019).**	**Total bilirubin in newborns should be from 1.0-12.0 mg/dL (Pagana, 2019).**	**Test not complete at this time**	**Test not complete at this time**
Newborn Screen (At 24 hours)	**A newborn screen is early testing of an infant for genetic, endocrine, and metabolic disorders (Centers for Disease Control, 2021).**	**A newborn screen is expected to have no results that indicate disorders.**	**Results will not be available.**	**Results not available**
Newborn Hearing Screen	**A newborn**	**A newborn**	**Test not**	**Test not complete at**

	hearing screen is done to see if an infant has to be referred to an audiologist to determine if there is hearing loss (Centers for Disease Control, 2022).	**hearing test is expected to show no signs of hearing loss.**	**complete at this time**	**this time**
Newborn Cardiac Screen (At 24 hours)	**A newborn cardiac screen is performed to identify congenital heart defects (Centers for Disease Control, 2022).**	**A newborn cardiac screen is expected to show no signs of congenital heart defects.**	**Test not complete at this time**	**Test not complete at this time**

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

Centers for Disease Control and Prevention. (2021, November 29). *Newborn screening portal*. Centers for Disease Control and Prevention. Retrieved October 11, 2022, from https://www.cdc.gov/newbornscreening/index.html

Centers for Disease Control and Prevention. (2022, July 29). *Newborn hearing screening*. Centers for Disease Control and Prevention. Retrieved October 11, 2022, from https://www.cdc.gov/ncbddd/hearingloss/parentsguide/understanding/newbornhearingscreening.html

Centers for Disease Control and Prevention. (2022, January 24). *Critical congenital heart defects*. Centers for Disease Control and Prevention. Retrieved October 11, 2022, from https://www.cdc.gov/ncbddd/heartdefects/cchd-facts.html#:~:text=Newborn%20screening%20for%20critical%20CHDs%20involves%20a%20simple%20bedside%20test,placed%20on%20the%20baby's%20skin.

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Newborn Medications (7 points)

Brand/Generic	**Phytonadione (Vitamin K)**	**Romycin (Erythromycin Ointment)**	**Recombivax HB (Hepatitis B Vaccine)**	**LMX (Lidocaine 4% cream)**	
Dose	**1 mg**	**Not specified**	**0.5 mL**	**Not specified**	
Frequency	**Once**	**Once**	**Once**	**prn for IV or blood draws**	
Route	**Intramuscular**	**Opthalmic**	**Intramuscular**	**Topical**	
Classification	**Pharmacological:**	**Pharmacological:**	**Pharmacologic**	**Pharmacol**	

	Fat soluble vitamin **Therapeutic: Vitamin**	**Macrolide** **Therapeutic: Antibiotic, bacteriostatic**	**al: Inactivated vaccine** **Therapeutic: Vaccine**	**ogical: Amide anesthetic** **Therapeuti c: Local anesthetic**	
Mechanism of Action	**This vitamin is essential in producing clotting factors II, VII, IX, and X by the liver during the first week of life for the infant until they can produce them on their own.**	**Provides bactericidal and bacteriostatic actions to prevent *Neisseria gonorrhoeae* and *Chlamydia trachomatis* conjunctivitis.**	**Antibodies are produced after exposure to a non-infectious subunit of the hepatitis B virus.**	**This medication inhibits the conduction of nerve impulses and causes temporary loss of feeling where it is applied to the skin.**	
Reason Client Taking	**The patient is taking this medication to prevent bleeding that can result from a deficiency of vitamin K.**	**The patient is taking this medication to prevent eye infections.**	**The patient is given this drug to prevent hepatitis B infection.**	**The patient is prescribed this medication to reduce pain during a blood draw.**	
Contraindications (2)	**Hypersensitivity to phytonadione, hereditary hypoprothrombine mia**	**Hypersensitivity to erythromycin, hypokalemia or hypomagnesemia**	**Celiac disease or hypersensitivit y to yeast, hypersensitivit y to component of Hep B vaccine**	**Hypersensi tivity to amide-type anesthetics , impaired respiratory function**	
Side Effects/Adverse Reactions (2)	**Dyspnea, anaphylaxis leading to cardiac arrest**	**Inflammation, increased irritation and sensitivity**	**Fever, pain at injection site**	**Tendernes s or burning at site of application**	
Nursing Considerations (2)	**Administer 1-2 hours after birth. Assess for bleeding at the injection site after administration.**	**With gloved hands, place ointment in between eye and lower eyelid. Make sure the patient's eye are closed for about 1-2 minutes to ensure medication stays within the eye.**	**The hepatitis B vaccine is administered intramuscularl y into the vastus lateralis. Monitor for allergic reaction after administration .**	**Apply medication to skin that will be used as site for IV or blood draw. Apply the lowest dosage possible that still has a therapeuti c effect.**	
Key Nursing Assessment(s)/Lab(s	**Monitor injection site and assess baseline vitals.**	**BMP to assess potassium and magnesium. Assess**	**Assess injection site and signs for**	**Assess baseline vitals.**	

) Prior to Administration		**bilirubin as it may be increased with this medication.**	**allergic reaction.**		
Client Teaching needs (2)	**Educate the family on the importance of the injection to promote clotting. Inform the family that this is needed because the infant will not be able to make clotting factors until a week of life.**	**Inform the family on the purpose of the medication to prevent eye infections. Educate the family on adverse effects to report such as inflammation.**	**Educate the family on the importance of vaccines for building immunity. Inform the family on this being the first administration in a series of 3 Hep B shots.**	**Educate the family on reporting pain, swelling, and difficulty with breathing. Inform the family on the use of this drug for pain relief.**	

Medications Reference (1) (APA):

Hodgens A, Marathi R. Hepatitis B Vaccine. *StatPearls*. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554400/

Ingold CJ, Sergent SR. Phytonadione (Vitamin K1). *StatPearls*. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK557622/

Kizior, R. J. (2021). *Saunders Nursing Drug Handbook 2021*. 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 2021.
Skin	**The skin of the patient was smooth, warm, and no tenting was present. There was no cyanosis noted. A mongolian spot was present midline above the patient's buttocks. No rashes or bruising were present.**	**Skin should be smooth, warm, and flexible and color should match with genetic background. Skin is often blotchy. Acrocyanosis of the hands and feet are normal but any change in color should be assessed over time. Mongolian spits are blue or purple spots that appear on the buttocks, legs, shoulders, or back that occur in dark-skinned newborns. A harlequin sign is redness on a side of the body due to dilated blood vessels. Variations include rashes, bruising, and petechiae that should be monitored (Ricci et al., 2021).**
Head	**The patient's head was symmetric, round, and had a normal circumference. There was no molding present since the patient was born through a C-section and did not go through the birth canal. No edema was present.**	**The head should be symmetric and round. Microcephaly is a below average head circumference. Macrocephaly is a head circumference that is bigger than 90% of normal size. Molding is shaping of the head that can be noticed as an effect of passage through the birth canal. Caput succedaneum is edema on the scalp that occurs from the pressure of birth (vacuum). A strawberry mark (nevus vasculosus) can be found on the head (Ricci et al., 2021).**
Fontanels	**The anterior and posterior fontanels were open and palpable during assessment. Fontanels were regularly shaped and soft on palpation.**	**The anterior fontanel is diamond shaped. The posterior fontanel is triangular and smaller the the anterior fontanel. Fontanels should be soft, flat, and open in a**

		newborn but should feel a bit fused and smooth. Fontanels could be longer than 6 cm and can be caused by malnutrition or congenital disorders (Ricci et al., 2021).

Face	**The patient's face was symmetrical and cheeks had full appearance. There was no signs of paralysis noted.**	**The newborn's face should be symmetric and cheeks should appear full. Asymmetry could indicate paralysis (Ricci et al., 2021).**
Eyes	**Eyelids and sclera were clear and conjunctiva was pink. There was no edema present in the eyelids. The patient opened their eyes in reaction to touch but were mostly closed with no evidence of involuntary eye movements. Unable to assess for a strabismus.**	**Conjunctiva, eyelids, and sclera should be clear. Edema could be present in the eyelids from pressure of birth. Pupils should be PERRL. Involuntary eye movement could be repeated along with strabismus due to immature muscles. Red light reflex should be present (Ricci et al., 2021).**
Nose	**Nose was small, narrow, midline, and had no lesions. Nostrils were equal size. No discharge was present. There was no nasal flaring or signs of respiratory distress. No other markings were noted.**	**The nose should be small, narrow, midline, and free of lesions. Nostrils should be equal size. Mucous discharge is normal but no actual drainage. Nasal flaring is a sign of impaired respiratory function. Milia is a white or yellow unopened sebaceous gland that can be found on the nose (Ricci et al., 2021).**
Mouth	**Lips were symmetric and without lesions. Sucking reflex was present during assessment to calm the patient. Soft and hard palate of the mouth are intact. Mucous membranes are pink and moist. No teeth were present. No signs of infection or other markings were observed during assessment.**	**Lips should be intact and symmetric. There should be no lesions. Lips should be pink and moist. Sucking reflex should be present. Cleft upper lip and thin upper lip are abnormal findings. The soft and hard palate of inside the mouth should be intact Mucous membrane should be pink and moist. Epstein pearls are unopened sebaceous glands similar to milia in the mouth. Teeth could be present and should be removed to prevent aspiration. White plaque in the mouth is a sign of thrush (Ricci et al., 2021).**
Ears	**Ears were normally shaped and aligned on the head. Skin on ears was without lesions or**	**Ears should be soft and pliable. Ears should be aligned with the outer corner of the eyes but low**

	bruising. No abnormalities were present and ear canals were patent.	**set ears that are shaped differently could be from abnormalities. Ears should appear patent and skin should be clear (Ricci et al., 2021).**
Neck	**The patient's neck was short and midline. Neck allowed slight movement of the head in all directions. No edema was present or markings such as stork bites and salmon patches.**	**The neck appears short but should be able to move in all directions. The neck should be midline along with the clavicle. Edema could appear if there is a fracture. Stork bites or salmon patches are vascular areas that can be found on the neck (Ricci et al., 2021).**
Chest	**Chest was normal size and symmetrical. No signs of respiratory distress with chest retractions were present. Nipples were free of discharge and only two were present.**	**The chest should be symmetrical and 2-3 cm smaller than the head circumference. Chest retractions indicate respiratory distress. Nipples could secrete white discharge and is a result of high estrogen while in the womb. Extra nipples could be present (Ricci et al., 2021).**
Breath Sounds	**Breath sounds were clear throughout. No rhonchi, crackles, wheezing, or stridor was noted.**	**Clear breath sounds should be heard. Diminished breath sounds is associated with pneumonia or atelectasis. Labored breathing and adventitious breath sounds like rhonchi, crackles, wheezing, or stridor are abnormal findings (Ricci et al., 2021).**

Heart Sounds		**Normal S1 and S2 heart sounds. Apical pulse was located in the expected site. A slight heart murmur was auscultated after 19 hours of age.**	**Normal S1 and S2 sounds should be heard. The apical pulse is located in the fourth intercostal space. An apical pulse head elsewhere could mean there is a tension pneumonthorax or cardiomegaly. A heart murmur is common during the first few hours of life but should be monitored (Ricci et al., 2021).**
Abdomen		**No distention was present in the abdomen. Abdomen had normal rise and fall with breathing. No masses or tenderness was palpated during the assessment.**	**Abdomen should be pronounced but not distended. Infants are abdominal breathers and should rise and fall with breathing. There should be no palpable masses or tenderness (Ricci et al., 2021).**
Bowel Sounds		**Bowel sounds were present throughout. No signs of intestinal obstruction was present.**	**Bowel sounds should be present in all four quadrants. Absent or hyperactive bowel sounds could be a result of obstruction in the intestines (Ricci et al., 2021).**
Umbilical Cord		**The umbilical cord was free from bleeding, redness, drainage, or rash.**	**The umbilical cord should have two arteries and one vein. The vein is larger than the arteries. A single**

			artery could be due to a congenital problem. Abnormal findings include bleeding, inflammation, redness, swelling, drainage, or rash (Ricci et al., 2021).

Genitals		**Patient is not circumcised and foreskin covered the glans of the penis. The meatus was centered on the tip of the glans. Scrotum was normal size with rugae present. No edema or discoloration was noted. The testes were descended and palpable.**	**The glans is smooth and the meatus is centered. Foreskin covers the glans in uncircumcised infants. An abnormal findings is the meatus on the ventral surface of the glans is called hypospadias and on the dorsal surface is called epispadias. The scrotum should be relatively large and have rugae. Edema and discoloration are abnormal findings of the scrotum. The testes should be palpable and feel firm and smooth in the scrotal sac. Undescended testes is an abnormal finding (Ricci et al., 2021).**
Anus		**The anus was patent and the patient was free from abdominal distention.**	**The anus should be patent. A reflex could be triggered by stimulating perianal skin to constrict the anus to ensure nerve function (Ricci et al., 2021).**
Extremities		**Arms were equal length and legs were equal length. Hands had normal structure. Normal position and number of fingers. Creases were**	**The hands should have a normal structure and creases with normal range of motion. A single crease is related to Down syndrome.**

		present on hands. Normal range of motion. No inward turn of the foot was present in the patient. No cyanosis was noted.	**Extremities should have equal lengths. An inward turn of the foot is called a clubfoot (Ricci et al., 2021).**
Spine		**Spine was normal, straight, and midline. No cysts, masses, or other variations were present.**	**The spine should be straight, flat, and able to flex when prone. Abnormal findings are cysts, masses, a midline dimple, and hair (Ricci et al., 2021).**
Safety ● **Matching ID bands with parents** ● **Hugs tag** ● **Sleep position**		**Patient had a matching ID band with the mother. The patient slept in a supine position.**	**The mother, newborn, and father or other support persons have matching ID bands. Electronic devices sound an alarm of a newborn is taken beyond a certain point (Hugs tag). Infants should sleep supine (Ricci et al., 2021).**

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**
Birth	**97.8** °F	**132**	**40**
4 Hours After Birth	**98** °F	**142**	**44**
At the Time of Your Assessment	**98.9** °F	**144**	**40**

Vital Sign Trends: Pulse and temperature are trending upwards based on the last three sets of vitals. Respirations are not demonstrating a trend.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0920	0 on the NIPS scale	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****

The patient was delivered on 10/5/22 at 1400 through a Cesarean section due to risks associated with preeclampsia. APGAR score after 1 minute was 8 and after 5 minutes was 9. The patient's birth weight was 6 lbs 14 oz (3110 g) and they were measured at 49.5 in (19.5 cm) with a head circumference of 13.4 in (34 cm). Last weight was 2940 g (6 lbs 8 oz) at 19 hours of age. Last set of vitals were also taken at 19 hours of age with temperature of 98.9 degrees F axillary, pulse 146 bpm, and 40 respirations/min. An full body assessment found no abnormal findings except for a heart murmur. Patient is currently only breastfeeding every 2-3 hours for about 10-15 minutes. Patient has voided 5 times and had 5 bowel movements. A blood typing test determined that the patient has B+ blood. The newborn is expected to be discharged on 10/7 and come back for a follow-up visit after 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.
Assess vital signs of the patient (N)	Q4H until 24 hours of age and then change frequency to Q8H	The purpose of assessing vital signs is to monitor for abnormal findings to investigate and provide nursing interventions or notify the provider.

Blood draw for newborn metabolic screening (N)	**Once**	**Blood is drawn from a heel stick and this sample will be important in determining if there is a congenital problem that the infant has a metabolic disorder.**
Swaddling (N)	**PRN when the patient is resting**	**Swaddling is done when the patient is at rest to promote comfort and reduce stress.**
Weigh the patient (N)	**Every 6-8 hours**	**The weight of the patient is more closely monitored because they have recently shown that they are underweight.**

Discharge Planning (2 points)

Discharge location: Home on 10/7

Equipment needs (if applicable): N/A

Follow up plan (include plan for newborn ONLY): Follow-up visit after 2 days

Education needs: Feeding, importance of follow-up visits

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	**Rational (1 pt each)** Explain why the nursing	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be specific and individualized	**Evaluation (2 pts each)** • How did the patient/ family respond to

this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	diagnosis was chosen	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.	the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Knowledge deficit related to feeding as evidenced by low weight of newborn patient	**The mother of the patient should be informed about feeding practices to help with the growth of their newborn who has been determined to have a low weight.**	**1. Assess the mother's knowledge of feeding techniques and how often they would feed the baby and if they will use formula.** **Rationale: If there is any misconceptions about feedings, then the patient's family could be informed to eliminate the knowledge deficit (Phelps, 2020).** **2. Inform the mother to record the amount of time in which she breastfeeds or bottlefeeds.** **Rationale: This will help the mother monitor and be more aware of caloric and fluid intake (Phelps, 2020).**	**The patient's family is expected to understand and demonstrate feeding techniques to support the growth of the patient. The goal is to get the patient to a healthy weight and modify the plan based on the progress that they make shown through assessment.**
2. Knowledge deficit related to importance of follow-up visits as evidenced by mother's reluctance to come to appointment in 2 days	**The patient denied that they would come in for a follow-up visit 2 days after being discharged, which is a standard of care at this facility. It is even more significant that the patient is seen soon because of their low**	**1. Communicate with the patient in a nonjudgemental way and encourage regular visits to monitor the health of the infant.** **Rationale: The nurse should always build trust with patients and family to promote comfort and compliance to plans of care (Phelps, 2020).** **2. Consider what barriers there may be in preventing the patient from coming to a follow-up visit.** **Rationale: Considering**	**The family of the patient will understand the importance of follow-up visits to monitor the health of the newborn and prevent complications. The goal is to get the family of the patient to bring them in within 48 hours after discharge from the hospital and encourage compliance with coming to future appointments.**

	weight and heart murmur, so the patient should be taught the importance of follow-up appointments.	**life experiences in patient interaction makes it easier to communicate and encourage learning information (Phelps, 2020).**	
3. Risk for imbalanced nutrition related to feeding as evidenced by low birth weight	**The patient was assessed and there is a concern for a nutritional deficit due to a weight that is below normal expectations. To promote growth of the patient, it is important to perform early interventions.**	**1. Refer the mother of the patient to a specialist in pediatric diet. Rationale: A referral with a nutritional specialist can help the patient and individualize a plan to support the mother in feeding the newborn (Phelps, 2020). 2. Set a goal for weight and monitor for changes. Rationale: An accurate reading of weight will help in tracking the progress of feedings for the patient (Phelps, 2020).**	**The patient's family is expected to understand the importance of feeding techniques in supporting the growth of the infant. Feeding habits will be improved and the infant will exhibit a healthy weight during the next assessment.**
4. Risk for decreased cardiac output related possible heart defect as evidenced by audible heart murmur	**The patient has a slight heart murmur that can be heard on auscultation during assessment at 19 hours of age. While it is not uncommon for newborns to have a heart murmur after the first few hours within being born, it is worth**	**1. Monitor heart rate and rhythm every 4 hours. Rationale: Assessment of cardiac function will provide an indication on whether there are still complications present in the patient (Phelps, 2020). 2. Educate the patient's family on symptoms of a cardiac problem such as nausea and vomiting, weakness, or impaired respiratory function. Rationale: Informing the family of the patient on what signs to report will increase compliance and provide better control over the situation of the**	**The patient's family will understand the importance of monitoring for signs of cardiac problems. The heart murmur will hopefully resolve itself over time but will be monitored to see if there needs to be interventions made to maintain the health of the patient.**

	monitoring in this patient because there could be a heart defect.	**patient if they have any health complications (Phelps, 2020).**	

Other References (APA):

Phelps, L.L. (2020). ***Sparks and Taylor's nursing diagnosis reference manual*** **(11th ed.). Wolters Kluwer.**

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