N432 Newborn Care Plan

Lakeview College of Nursing

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Demographics (10 points)

Date & Time of Clinical Assessment 10/19/2022 1800	**Patient Initials BL**	**Date & Time of Birth 10/13/2022 at 10:28 am**	**Age (in hours at the time of assessment) 151 hours**
Gender male	**Weight at Birth (gm) 2580_____ (lb.) __5___ (oz.) __11___**	**Weight at Time of Assessment (gm) ____2520_____ (lb.) __5___ (oz.) __8.9___**	**Age (in hours) at the Time of Last Weight 146 hours**
Race/Ethnicity White/Caucasian and African-American	**Length at Birth Cm ____47cm_____ Inches _____18.5_____**	**Head Circumference at Birth Cm _____33_____ Inches ___12.9_____**	**Chest Circumference at Birth Cm _____30_____ Inches ___11.8_____**

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: G2P1102

When prenatal care started: 4/7/2022

Abnormal prenatal labs/diagnostics: HSV type 1 and type 2 antibodies on 5/20/2022, syphilis IgG ang IgM are positive on 5/202/2022, gonorrhea and chlamydia are positive on 10/12/2022

Prenatal complications: bacterial vaginosis and STD panels are positive, antepartum mild preeclampsia, threatened labor at term, non-immune to varicella

Smoking/alcohol/drug use in pregnancy: the mother tested positive for marijuana antepartum

Labor History of Mother:

Gestation at onset of labor: 35 weeks and 5 days

Length of labor: 8 hours and 39 minutes

ROM: artificial

Medications in labor: iron, Pitocin, Penicllin G XIII

Complications of labor and delivery: preterm labor at 35 weeks and 5 days

Family History:

Pertinent to infant: history of asthma in father

Social History (tobacco/alcohol/drugs):

Pertinent to infant: new born was affected by maternal use of cannabis which tested positive antepartum on 10/12/2022

Father/Co-Parent of Baby Involvement: UTA

Living Situation: the patient will be going home with mother

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

Birth History (10 points)

Length of Second Stage of Labor: 2 minutes

Type of Delivery: spontaneous, vaginal

Complications of Birth: respiratory failure

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: N/A

Feeding Techniques (10 points)

Feeding Technique Type: Nasogastric

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: ____2.32_____%

2580g-2520g = 60g, 60g/2580g = 0.02326 X100 = 2.32

****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? 7-10%

Is this neonate's weight loss within normal limits? The infant has lost significantly less than the expected weight loss.

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: N/A

Formula type or Expressed breast milk (EBM): N/A

Frequency: 1 time

Volume of formula/EBM per session: 6mL

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

If NG or OG feeding:

Frequency: Q3 hours

Volume: 138mL

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: 11 hours

Number of voids in 24 hours: 5

Stool

Age (in hours) of first stool: 7 hours

Type: small

Color: green

Consistency: tarry, meconium

Number of times in 24 hours: 6

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	Newborns may be at a higher risk for hypoglycemia so it is crucial to assess blood glucose levels immediately.	45-99mg/dL	10/17/2022, 99	Normal
Blood Type and Rh Factor	Blood typing and Rh factor are done in order to see whether the mother will need Rhogam for her next birth.	AB, A, B, O, Rh(- or +)	A, Rh (+)	Normal
Coombs Test	UTA	UTA	UTA	UTA

Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	Infants can present with elevated bilirubin levels, which can cause brain damage if within toxic levels.	<12.0mg/dL	10/14/2022, 8.5	normal
Newborn Screen (At 24 hours)	Newborn screens are done in order to determine whether the newborn has genetic abnormalities.	Negative for genetic abnormalities	Results will not be available.	UTA
Newborn Hearing Screen	Hearing screen is a routine screening done in order to identify any hearing impairments in	normal	UTA	UTA

	the newborn.			
Newborn Cardiac Screen (At 24 hours)	Cardiac screens are done in order to identify any cardiac issues in the newborn.	normal	UTA	UTA

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

Newborn Medications (7 points)

Brand/Generic	**Aquamephyton (Vitamin K)**	**Illotycin (Erythromycin Ointment)**	**Hepatitis B Vaccine**		
Dose	1mg	N/A	0.5mL		
Frequency	once	once	Once, PRN		
Route	IM	ophthalmic	IM		
Classification	Vitamin supplement	Macrolide, antibiotic	Vaccines, inactivated viral		
Mechanism of Action	Vitamin K is an important vitamin needed for clotting functions in the blood.	Erythromycin is a drug which kills bacteria by binding to ribosomal units, which inhibits essential protein synthesis in bacterial cells (Jones & Bartlett Learning, LLC, 2021).			
Reason Client	Infants can	This is taken in			

Taking	bleed out easily and Vitamin K is administered prophylactically to reduce the risks of adverse hemorrhagic outcomes.	order to prevent eye infections in the newborn.			
Contraindications (2)	Hypersensitivity to Vitamin K, thrombocytosis	Hypersensitivity to erythromycin and other macrolide antibiotics, eye abnormality			
Side Effects/Adverse Reactions (2)	Respiratory arrest, shock	Erythema, pruritus			
Nursing Considerations (2)	Vitamin K should be protected from light (Jones & Bartlett Learning, LLC, 2021). Administer Subq when possible due to fatal toxic syndrome (Jones & Bartlett Learning, LLC, 2021).	- Monitor the infant for any signs of vomiting or diarrhea (Jones & Bartlett Learning, LLC, 2021). - Assess the newborn for any signs of hearing impairment (Jones & Bartlett Learning, LLC, 2021)			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Vitamin K levels should be assessed and the patient's vital signs should be taken prior to administration.	The patient's vital signs should be taken prior to administration to track whether he develops any sensitivity reaction.			
Client Teaching needs (2)	Educate the client's parents of the purpose	Any allergic reactions should be immediately			

	of Vitamin K administration. The parents must be instructed to report any signs of renal or respiratory impairment (Jones & Bartlett Learning, LLC, 2021).	reported to the provider or nurse (Jones & Bartlett Learning, LLC, 2021). Educate the patient's mother and father on the purpose of the medication.			

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). *Nurse's drug handbook* (20th ed). Jones & Bartlett Learning, LLC.

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	**Pink, warm, dry and flexible, skin turgor of normal mobility**	**Smooth, flexible, warm, good skin turgor**
Head	**Head is atraumatic and symmetrical**	**Symmetrical**
Fontanels	**Anterior and posterior fontanels not closed**	**Anterior and posterior fontanels not closed**
Face	**Facial features are symmetric and no bruises or lesions**	**Face is symmetric and atruamtic**
Eyes	**Clear, symmetrical, and no presence of purulent drainage**	**Clear and symmetrical**
Nose	**Small, no abnormal drainage, midline, NG tube placed**	**Normal and midline**
Mouth	**Palates are midline, symmetric and soft and hard palates are intact**	**Intact hard and soft palates, symmetric and midline palates**
Ears	**No drainage, clear, quick recoil**	**Soft and pliable with quick recoil**
Neck	**No distensions noted, midline**	**Midline, and moves freely**
Chest	**Round, symmetric, and smaller than baby's head**	**Round, symmetric, and smaller than baby's head**
Breath Sounds	**clear**	**clear**

Heart Sounds	**S1 and s2 auscultated, no gallops, murmur or bruit auscultated**		
Abdomen	**No organomegaly noted, soft**	**Protuberant contour, soft, three vessels in umbilical cord**	
Bowel Sounds			
Umbilical Cord	**Not completely off, dry**	**Dry, no drainage**	
Genitals	**Foreskin intact, unable to visualize glans at this time, no cuts or rash**	**Meatus centered on penis, glans are smooth**	
Anus	**Pink, no drainage or cuts noted**	**Pink, atraumatic**	
Extremities	**Symmetric, strength equal bilaterally in both upper and lower extremities**	**Symmetric, free movement**	
Spine	**Symmetric and no abnormal shapes noted**	**Symmetric and moves freely**	
Safety • **Matching ID bands with parents** • **Hugs tag** • **Sleep position**	**Matching ID bands with parents was unable to be assessed; the baby does have hug tags; the neonate sleeps on his back with railings on 4 sides up**	**Matching ID bands with parents should be present and confirmed. Hugs tag should be present and the baby should be sleeping on his back to prevent suffocation.**	

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**

Birth	**97.9F**	**140**	**46**
4 Hours After Birth	**98.2F**	**140**	**88**
At the Time of Your Assessment	**98.1F**	**128**	**48**

Vital Sign Trends:

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	**rFLACC**	**0**	**0**	**0**	**0**

Summary of Assessment (4 points)

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

The neonate was born on 10/13/2022 at 2580 grams birth weight. His head circumference was measured to be 33cm and his length was 47cm. The neonate was born premature at 35 weeks and 5 days gestation. The patient is currently under continuous pulse oximetry because he experienced acute respiratory distress a few hours after birth. His APGAR score at 1 minute is 8; and his APGAR score at 5 minutes is 9. During assessment, the patient was able to suck for a little bit, but shows signs of underdevelopment in this aspect. His ears are pliable and recoils quickly after being folded and released, which shows that his ear is more developed than his gestational age. His skin is warm and pink and shows adequate tissue perfusion. His heart sounds are normal, and no physical abnormality was assessed at this time.

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.
Oxygen therapy (N)	Once/PRN	This treatment is ordered to keep the

		patient's oxygen saturation from 85% to 93%. This is also ordered to combat central cyanosis.
Vital signs (N)	Q 8 hours	Vital signs are ordered in order to keep track of the patient's health status.
Pulse oximetry (N)	Continuous, change sites every 6 hours	The newborn had respiratory distress a few hours after he was born. Pulse oximetry monitors the patient's respiratory status.
STAT glucose administration (N)	PRN for glucose less than 30dL/mL	Hypoglycemia can be fatal to newborns, so it is important to be able to administer glucose when possible.

Discharge Planning (2 points)

Discharge location: home with mother

Equipment needs (if applicable): N/A

Follow up plan (include plan for newborn ONLY): The patient must go to a pediatric specialist or primary care provider to keep track of the patient's health after birth and to get necessary vaccinations.

Education needs: The mother needs to be educated on feeding.

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	Explain why the nursing diagnosis	Interventions should be specific and individualized	• How did the patient/family

this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	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.	respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
Ineffective breathing pattern related to preterm delivery as evidenced by respiratory distress.	Newborns do not have a lot of energy reserves and so extra energy spent on breathing labor can be catastrophic. This should be addressed quickly.	1. Administer oxygen as ordered. Rationale Oxygen administration relieves the patient's respiratory labor and distress, and reduces hypoxemia (Phelps, 2020). 2. Perform chest physiotherapy such as cupping of the upper back. Rationale Percussion aids in the elimination of airway secretions and alleviates respiratory distress by reducing respiratory labor (Phelps, 2020).	The patient's oxygen saturation levels should remain above 93% and should not show signs of labored respirations. The patient's respirations should also remain within normal range.
Ineffective thermoregulation related to preterm delivery as evidenced by premature development.	Neonates are not able to thermoregulate effectively and will need support from caregivers. Neonates can die from overheating or hypothermia.	1. Monitor the patient's temperature every 4 hours or as ordered. Rationale Frequent assessment helps in determining the effectiveness of intervention and whether the patient's health status has not changed from baseline (Phelps, 2020). 2. Instruct and educate the patient's parent about the signs and symptoms of altered body temperature. Rationale This intervention allows the parent to become an active player in the patient's health	The parent should understand and verbalize the signs and symptoms of an altered body temperature. The parent should know that she is to contact the baby's primary care provider for evaluation when altered body temperature is identified.

		maintenance (Phelps, 2020).	
Deficient knowledge related to infection prevention as evidenced by the mother testing positive for STDs antepartum.	Sexually transmitted infections can be fatal to newborns whose immune systems are still developing.	1. Assess the parent's knowledge level related to sexually transmitted infections. Rationale Through effective assessment, the nurse can provide appropriate information based on the parent's level of knowledge. 2. Do not place overbearing demands and expectations on the patient's parent. Rationale The parent may feel a sense of inadequacy and anxiety due to the nurse's demands in teaching. Therefore, it is important that the nurse limits his or her own expectations Phelps, 2020).	The patient's mother should understand that HSV infections can be spread through contact with ruptured vesicles during flare up. The parent should be cautious during these times so that the baby does not contract the infection.
Deficient knowledge related to breastfeeding as evidenced by mother planning for formula feeding.	Breastfeeding helps the baby's immune system as the mother provides immunoglobulins through breastmilk.	1. Assess and identify the patient's mother's level of cognitive and perceptual development. Rationale Identifying the parent's level of development can help with establishing learning goals when it comes to breastfeeding (Phelps, 2020). 2. Establish rapport with the patient's mother. Rationale In order to effectively teach and relay information, it is important that the nurse shows consistency, and	The parent should be able to verbalize and understand the importance of breastfeeding, especially for neonates. The parent should also not feel compelled to breastfeed if she follows through with formula feeding.

		truthfulness so that the parent becomes more receptive to the nurse's teaching (Phelps, 2020).	

Other References (APA):

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

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