N432 Newborn Care Plan

Lakeview College of Nursing

Name

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Demographics (10 points)

Date & Time of Clinical Assessment 1100 10/26/22	**Patient Initials** C.A.K	**Date & Time of Birth** 700 10/26/22	**Age (in hours at the time of assessment)** 4 hours
Gender Male	**Weight at Birth** **(gm)** 1985 g_____ **(lb.)** 4 lb_____ **(oz.)** 6 oz_____	**Weight at Time of Assessment** **(gm)** 1985 g_____ **(lb.)** 4 lb_____ **(oz.)** 6 oz_____	**Age (in hours) at the Time of Last Weight** 0 hours
Race/Ethnicity African American	**Length at Birth** **Cm** 43 cm_____ **Inches** 16.93 in_____	**Head Circumference at Birth** **Cm** 31.5 cm_____ **Inches** 12.4 in_____	**Chest Circumference at Birth** **Cm** 28 cm_____ **Inches** 11.02 in_____

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: G1T0P1A0L1

When prenatal care started: Prenatal care started on 6/16/22

Abnormal prenatal labs/diagnostics: Acute cystitis

-RBC-> 3.29 (3.5-5.2)

-Hgb-> 9.6 (11-16.8)

-Hct-> 28.8% (34%-47%)

-Platelets-> 110,000 (140,000-400,000)

-WBC-> 12,500 (4,000-11,000)

Prenatal complications: N/A

Smoking/alcohol/drug use in pregnancy: The patient smoked marijuana daily

Labor History of Mother:

Gestation at onset of labor: 35 weeks and 1 day

Length of labor: 1 minute

ROM: Artificial

Medications in labor: N/A

Complications of labor and delivery: Placental Abruption

Family History: N/A

Pertinent to infant: N/A

Social History (tobacco/alcohol/drugs): The patient is a smoker and used marijuana at a daily basis.

Pertinent to infant: Smoking can increase the chances of bleeding during pregnancy. Marijuana use can cause low birth weight and abnormal neurological development in the infant.

Father/Co-Parent of Baby Involvement: The father is involved in care

Living Situation: The father lives with his girlfriend. The infant will be living at home with his parents.

Education Level of Parents (If applicable to parents' learning barriers or care of infant): The mother has her high school diploma

Birth History (10 points)

Length of Second Stage of Labor: 1 minute

Type of Delivery: C-section

Complications of Birth: Placental abruption/Transient tachypnea in newborn

APGAR Scores:

1 minute: 7

5 minutes: 9

Resuscitation methods beyond the normal needed: The patient received 4L of oxygen on a high flow nasal cannula. The patient was tachypneic.

Feeding Techniques (10 points)

Feeding Technique Type: N/A (The newborn will not be breastfed or given bottle-feeding until

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: 0_____%

****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) x 100

The answer needs to be in negative

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

7-10%

Is this neonate's weight loss within normal limits?

Yes, because the patient had no weight loss

Intake and Output (8 points)

Intake

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: N/A

Volume of formula/EBM per session: N/A

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:

Rate of flow: Ampicillin-8.8 mL/hr, Dextrose 10%-5.8 mL/hr, Gentamacin-2 mL/hr

Volume in 24 hours: 66.4 mL

Output

Void

Age (in hours) of first void: 5 hours

Number of voids in 24 hours: 1

Stool

Age (in hours) of first stool: N/A

Type: N/A

Color: N/A

Consistency: N/A

Number of times in 24 hours: N/A

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	The test is ordered to assess for signs of hypoglycemia	40-99 mg/dL	60	The result is within normal limits; blood glucose levels for the newborn is normal.
Blood Type and Rh Factor	The test is used to determine the blood type of the newborn and if the blood lacks the Rh antigen. The antigen is responsible for making the blood type positive or negative (Pagana et al., 2019).	A, B, AB, O (+) or (-)	O+	The newborn's blood type is O+ indicating O blood with a (+) Rh factor.
Coombs Test	The test helps detect foreign antibodies that may be attached to the newborn's	(+) or (-)	N/A	N/A

	RBCs (Pagana et al., 2019).			
Bilirubin Level (All babies at 24 hours) ***Utilize bilitool.org for bilirubin levels***	Bilirubin levels are used to screen for jaundice in newborns (Pagana et al., 2019).	1-15	**N/A**	The patient is less than 24 hours old
Newborn Screen (At 24 hours)	The newborn screen helps to identify any rare conditions in the newborn (Pagana et al., 2019).	Results identify no conditions	**Results will not be available.**	The patient is less than 24 hours old
Newborn Hearing Screen	The newborn hearing screen helps assess any hearing issues (Pagana et al., 2019).	Pass	N/A	N/A
Newborn Cardiac Screen (At 24 hours)	The screening helps to detect for any critical congenital heart defects (Pagana et al., 2019).	SpO2 >95% No positive findings	N/A	The patient is less than 24 hours old

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**		
Dose	1 mg	0.5%	N/A- the patient did not get the Hep B vaccine		

Frequency	Once	Once	N/A- the patient did not get the Hep B vaccine		
Route	IM	Ophthalmic	IM		
Classification	Pharmacologic class: Hemostatic Therapeutic class: Vitamins	Pharmacological class: Macrolide Therapeutic class: Antibiotic	Pharmacologic class: Immune globulins Therapeutic class: Vaccine		
Mechanism of Action	Vitamin K is a cofactor of gamma-carboxylase. Gamma carboxylase attaches carboxylic acid functional groups to glutamate, allowing precursors of factors II, VII, IX, and X to bind calcium ions. Produces active coagulation factors.	It binds with the 50S ribosomal subunit of the 70S ribosome in many types of aerobic, anaerobic, gram-negative, and gram-positive cells. It blocks bacterial ribosomes to inhibit protein synthesis, stopping bacterial growth and replication.	It induces specific humoral antibodies against HBsAg. It stimulates the immune system to product anti-HBs without exposing the newborn to risks of active infection.		
Reason Client Taking	Taken to promote normal blood clotting	Helps to prevent eye infection	Prevents infection by the hepatitis B virus		
Contraindications (2)	-Hypersensitivity to Vitamin K or any components -Contraindicated in patients with hypoprothrombinemia	-Hypersensitivity to erythromycin -Contraindicated in patients taking	-Contraindicated in patients with an anaphylactic allergy to yeast -Hypersensitivity		

		simvastatin	to immunoglobulins, glycine, pr thimerosal		
Side Effects/Adverse Reactions (2)	-Hyperbilirubinemia -Cyanosis	-Pruritis -Eye redness	-Low-grade fever -Tachycardia		
Nursing Considerations (2)	-Protect medication from the light -Apply pressure to the injection site to prevent bleeding	-Protect the medication from heat - Avoid touching the eye or eyelids with the ointment tip	-Assess for allergy to latex -Give vaccination and immune globulin at separate sites		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Obtain consent from caregivers and educate them prior to administration	-Assess for signs of infection prior to administration	-Assess for any allergic reactions as they are at risk for a hypersensitivity reaction		
Client Teaching needs (2)	-Provide comfort during and after the medication administration, as the injection site may get sore -Record the presence of any rashes	-Provide education about how the medication can cause blurriness, stinging, and itching -Educate that it needs to be administered from the inner canthus to the outer canthus	-Assess for tenderness at the site of the injection -Monitor for signs of anaphylaxis		

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	Skin is warm, dry, intact, and elastic. No signs of redness	Expected Findings (Normal): Smooth, flexible, good skin turgor, well hydrated, warm (Ricci et al., 2021) Expected Variations: Jaundice, acrocyanosis, milia, Mongolian spots, stork bites (Ricci et al., 2021)
Head	Head is normocephalic. No bruising or lacerations	Expected Findings (Normal): Varies with age, gender, and ethnicity (Ricci et al., 2021) Expected Variations: Microcephaly, macrocephaly, enlarged fontanels (Ricci et al., 2021)
Fontanels	Normal size fontanels	Expected Findings (Normal): The anterior and posterior (Ricci et al., 2021) Expected Variations: Enlarged fontanels (Ricci et al., 2021)
Face	Facial features are symmetric	Expected Findings (Normal): Full cheeks, facial features symmetric (Ricci et al., 2021) Expected Variations: Facial nerve paralysis, nevus flammeus, nevus vasculosus (Ricci et al., 2021)
Eyes	Sclera is clear bilaterally. Eye size appropriate for age. Pupils are equal, round, and reactive to light. Red reflex present bilaterally	Expected Findings (Normal): Clear and symmetrically on face; aligned with ears (Ricci et al., 2021) Expected Variations: Chemical conjunctivitis, subconjunctival hemorrhage (Ricci et al., 2021)
Nose	Externally normal, nares without obvious obstruction	Expected Findings (Normal): Small, placement in the midline and narrow, ability to smell (Ricci et al., 2021)

		Expected Variations: Malformation or blockage (Ricci et al., 2021)
Mouth	The mouth is symmetrical to the head and face. Hard and soft palate intact	Expected Findings (Normal): Aligned midline, symmetric, intact soft and hard palate (Ricci et al., 2021) Expected Variations: Epstein pearls, erupted precocious teeth, thrush (Ricci et al., 2021)
Ears	The external ear shape and placement appropriate for age	Expected Findings (Normal): Soft and pliable with quick recoil when folded and released (Ricci et al., 2021) Expected Variations: Low-set ears, hearing loss (Ricci et al., 2021)
Neck	There are no lumps palpable. Clavicles are intact upon palpation	Expected Findings (Normal): Short, creased, moves freely. Baby holds head midline (Ricci et al., 2021) Expected Variations: Congenital Torticollis, clavicle fracture, neck masses, congenital anomaly (Ricci et al., 2021)
Chest	Appropriately shaped chest for age. Chest circumference measures 28 cm	Expected Findings (Normal): Round, symmetric, and smaller than head (Ricci et al., 2021) Expected Variations: Nipple engorgement, whitish discharge
Breath Sounds	Breath sounds are present in all fields. There appears to be signs of respiratory distress. The patient's respiratory rate is 86 breaths/min. There is a rise and fall of the chest bilaterally	Expected Findings (Normal): Lung sounds should be clear bilaterally. No wheezes, stridor, or retractions. There should be no signs of respiratory distress (Ricci et al., 2021) Expected Variations: Unequal breath sounds, asymmetric chest movement, respiratory distress (Ricci et al., 2021)

Heart Sounds	Heart sounds are regular, appropriate rhythm with no murmurs. S1 and S2 sounds present; PMI at mid-sternal border	Expected Findings (Normal): Normal heart rate, rhythm, regularity, normal heart sounds, and no murmurs (Ricci et al., 2021) Expected Variations: Abnormal pulses, pediatric murmur, and absent S2 sound (Ricci et al., 2021)
Abdomen	The abdomen is soft, nontender, non-distended, round, and symmetrical. There are no masses palpable and no organomegaly upon assessment	Expected Findings (Normal): Protuberant contour, and three vessels in the umbilical cord (Ricci et al., 2021) Expected Variations: Distended, only two vessels in umbilical cord (Ricci et al., 2021)
Bowel Sounds	Audible and normoactive bowel sounds present bilaterally	Expected Findings (Normal): Normoactive bowel sounds in all 4 quadrants (Ricci et al., 2021) Expected Variations: Distal bowel obstruction, hypoactive bowel sounds (Ricci et al., 2021)
Umbilical Cord	Umbilical cord is normal in color and there is no bleeding present	Expected Findings (Normal): Three vessels in the umbilical cord (Ricci et al., 2021) Expected Variations: Single umbilical artery (Ricci et al., 2021)
Genitals	Normal male genitalia. The penis is straight, and foreskin is not retracted. The testes are descended, and the scrotum has a deep rugae color	Expected Findings (Normal): Smooth glans, meatus centered at tip of penis (Ricci et al., 2021) Expected Variations: Edematous scrotum (Ricci et al., 2021)
Anus	The anal opening is patent and is in midline position	Expected Findings (Normal): Patent opening of anus (Ricci et al., 2021) Expected Variations:

		Imperforate anus without fistula (Ricci et al., 2021)
Extremities	The patient moves all extremities well. The extremities are symmetric	Expected Findings (Normal): Extremities are symmetric with free movement (Ricci et al., 2021) Expected Variations: Congenital hip dislocation (Ricci et al., 2021)
Spine	The spine is intact without deformities	Expected Findings (Normal): Spine is symmetrical (Ricci et al., 2021) Expected Variations: Tuft or dimple on spine (Ricci et al., 2021)
Safety • Matching ID bands with parents • Hugs tag • Sleep position	The newborn has matching ID bands with Mom and Dad. Infant wears two separate hug tags. Newborn sleeps on back	Expected Findings (Normal): The newborn has matching ID bands with Mom and Dad. Infant wears two separate hug tags. Newborn sleeps on back (Ricci et al., 2021)

Vital Signs, 3 sets (6 points)

Time	**Temperature**	**Pulse**	**Respirations**
Birth	97.0 F (Axillary)	124 bpm	86 breaths/min
4 Hours After Birth	98.6 F (Axillary)	122 bpm	52 breaths/min
At the Time of Your Assessment	98.6 F (Axillary)	122 bpm	52 breaths/min

Vital Sign Trends:

The patient's temperature increases slightly after 4 hours from birth. The pulse remains stable.

The respirations significantly decrease after 4 hours from birth.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	NIPS	N/A	0	No cry, relaxed	Pain goal met

Summary of Assessment (4 points)

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

The neonate was delivered on 10.26.22 at 0700 through a C-section. The nuchal cord was loose and around the neck x1. The Apgar scores were 7 and 9. The EDD was 11/26/22 by US. The new Ballard scale assessment revealed the neonate is 35 weeks and 1 day, and SGA. The prenatal history shows that this pregnancy was complicated by acute cystitis. The birth weight was 4 lbs. and 6 oz (1985 grams); length was 16.93 inches (43 cm); head circumference was 12.4 inches (31.5 cm); and chest circumference was 11.02 inches (28 cm). The patient received a Vitamin K injection and erythromycin ointment. Upon assessment all systems are within normal limits besides the patient's breath sounds. The last set of vitals were Temp: 98.6F, HR: 122, Resp: 52. Breath sounds x3 were not WNL. The highest was 86 breaths/min with the lowest being 52 breaths/min. The neonate is not currently breastfeeding or bottle-fed since he is less than 24 hours old. No bilirubin test was performed on the patient. There is currently no expected discharge date. The patient has not met with a lactation consultant regarding breastfeeding. The neonate will follow up with the pediatrician at appropriate times.

This neonate was delivered on 5.15.14 at 0522 by normal spontaneous vaginal delivery (NSVD). The nuchal cord was around the neck x1. The Apgar scores were 1/3/9. The EDD was 5/10/14 by US. The new Ballard scale assessment revealed neonate is 39 2/7 weeks and LGA. The prenatal history shows this pregnancy was complicated by PIH and GDM (diet controlled). The birth weight was 9 lbs 4 ozs (4440 grams); length was 21" (53.34 cms); head circumference was 13" (33 cms); and chest circumference was 12" (30.5 cms). Upon assessment all systems are within normal limits. The last set of vitals was: 38.4/155/48. Breath sounds x3 after delivery were WNL with the lowest being 52. The neonate is breastfeeding and nursing well with most feedings 20"/20" q2-3 hrs. The bilirubin level at 24 hours per scan was 4.9. The neonate is expected to be discharged with mother later today and to see the pediatrician in the office for first well baby check within 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 the patient's vital signs continuously. N	Continuously	It is important to check the infant's vital signs every continuously to assess for signs of infection and other health-related problem. The patient was tachypneic, so it is important to assess the patient's respiratory rate continuously. The infant was preterm, and they can face complication, so continuous monitoring is important.
Check the patient for diaper change as needed. Infants do not provide indication to do so, so it is important to assess the patient frequently. N	As needed (PRN)	Checking the diaper for urine and stool and changing it on a timely manner helps to prevent infection. It also helps to prevent diaper rash.
It is important to warm and dry the patient after birth and allow	Once/continuous	Warming the patient immediately after birth prevents the risk hypothermia,

skin-to-skin contact. N		knowing the infant's temperature drops right after birth. The risk can be reduced by drying the infant. Swaddling can also ensure warmth and raise the temperature of the newborn.
Educate the patient on the importance of breastfeeding and how to properly hold the patient during breastfeeding. N	Once	Educating the mother on different breastfeeding positions helps to promote breastfeeding without any interruptions. The goal is to ensure the mother is aware of the benefits of breastfeeding. Breastmilk helps keep the healthy by preventing them from diseases.

Discharge Planning (2 points)

Discharge location: Home with parents

Equipment needs (if applicable): N/A

Follow up plan (include plan for newborn ONLY): The newborn will remain in the NICU until further evaluation. The newborn should have regular checkups with their pediatrician after discharge.

Education needs: It is important to teach the mother the importance of breastfeeding and the importance of attending scheduled appointments for the infant. The mother and father will also be educated on the basics of infant care like diaper change, bathing, and swaddling.

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. Ineffective breathing pattern related to transient tachypnea of the newborn as evidenced by rapid breathing of 86 breaths per minute	Upon delivery, the neonate had a respiration of 86 breaths per minute. The patient was diagnosed with transient tachypnea.	1. Assess the infant's vital signs and characteristics of respirations at least every 30 to 60 minutes within the first 4 to 6 hours of life. Rationale: It is important to monitor the patient's vital signs continuously. The patient's respiration needs to be checked and be monitored for any improvements (Phelps, 2020). 2.Administer oxygen with a high flow nasal cannula. Discontinue the oxygen if the oxygen levels continue to improve throughout time. Rationale: The goal is to increase the oxygen level and achieve SpO2 value within the targeted range (Phelps, 2020).	The parents were aware that the patient's respirations will be monitored continuously. The parents were informed of the patient's vital signs. The patient was given oxygen continuously until their oxygen levels improved.
2. Risk for hypothermia related to cesarean	The patient was delivered via a c-section. They are at	1. It is important to warm the patient immediately after birth and allow for skin-to-skin contact.	The environment was maintained at a good temperature. The nurses assessed the patient for

section as evidenced by skin cold to touch	risk for hypothermia. Hypothermia can always be a complication for all newborns	Rationale: It is important that mother's do skin-to-skin contact with the infant immediately after birth knowing it helps to prevent heat loss (Phelps, 2020). 2. Adjust the temperature and provide a comfortable and warm delivery room. All the supplies should be planned and warmed ahead of time. Rationale: Adjusting the rooms temperature prior to delivery can prevent excessive hypothermia in the infant. Preparing the supplied beforehand can allow hypothermia to get treated instantly (Phelps, 2020).	any signs of hypothermia upon delivery. They made sure that all the equipment was readily available to the patient. Also, the mother was aware that she needed to maintain skin-to-skin contact with the newborn after delivery.
3. Knowledge deficient related to breastfeeding as evidenced by mother expressing concern	The mother is unsure if she wants to breastfeed or bottle-feed the child. This is the mothers first pregnancy, so she has no knowledge on breastfeeding. The patient needs to be given education on the benefits of breastfeeding.	1. Demonstrate effective breastfeeding positions such as cradle hold, cross-cradle hold, and football hold. Rationale: Informing the patient on different breastfeeding positions helps them to increase their knowledge and skills. This can allow them to practice different skills and develop a positive attitude towards it through hands on practice (Phelps, 2020). 2. Offer the patient information on the importance of breastfeeding and the nutritional benefits. Rationale: The information	The mother demonstrates that she is comfortable with the responsibilities of breastfeeding. She was provided with education on the importance of it. Also, she understood that breastfeeding can provide nutritional benefits and prevent disease.

		will help the patient gain further insight on the importance of breastfeeding. The nutritional benefits will be discussed, and they will be aware that breastmilk provides the ideal vitamins and nutrients to build the child's immunity (Phelps, 2020)	
4. Readiness for enhanced knowledge related to the mother's expression of her desire to learn about neonatal care as evidenced by the mother's first pregnancy	The mother is willing to learn more about neonatal care as this is her first pregnancy.	1. Educate the mother to cooperate with the NICU team and the baby's pediatrician. Rationale: Since infants are admitted to the NICU after birth, the mother needs to maintain contact with the nurses and doctors from the NICU. This allows the parents to be aware of any changes in the patient's condition (Phelps, 2020). 2. Educate the mother on the importance keeping the infant healthy by maintaining proper hygiene in the infant. Rationale: Even when the newborn is discharged from the hospital, their immune system will not develop fully. It is necessary to take proper precautions like hand hygiene and bathing the infant daily. These strategies help to reduce infection and prevent disease (Phelps, 2020).	The mother was aware that she needed to maintain communication with the staff members in the NICU to obtain information about the infant's care and any changes. The mother was also educated on the necessary precautions to take to prevent infection in the newborn.

Other References (APA):

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