

N432 Newborn Care Plan
Lakeview College of Nursing
Courtney Singleton

Demographics (10 points)

Date & Time of Clinical Assessment 01/26/2023 at 1155	Patient Initials LBB	Date & Time of Birth 01/25/2023 at 0854	Age (in hours at the time of assessment) 27 hours
Gender Male	Weight at Birth (gm) 2830 6 (lb.) 3.08 (oz.)	Weight at Time of Assessment (gm) 2593 5 (lb.) 11.65 (oz.)	Age (in hours) at the Time of Last Weight 27
Race/Ethnicity Caucasian	Length at Birth 49.5 Cm 19.488 Inches	Head Circumference at Birth 34 Cm 13.386 Inches	Chest Circumference at Birth 32 Cm 12.598 Inches

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, T¹, P¹, A⁰, L²

When prenatal care started: 07/29/2022, 10w 3d gestation

Abnormal prenatal labs/diagnostics: HBG, HCT

Prenatal complications: Complete placenta previa not otherwise specified or w/o hemorrhage, unspecified trimester.

Smoking/alcohol/drug use in pregnancy: No smoking, alcohol or drug use reported during pregnancy.

Labor History of Mother:

Gestation at onset of labor: 36w9d

Length of labor: 0h36m

ROM: Cesarean Section-Low Transverse

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Medications in labor: Acetaminophen, Cefazolin, Lactated Ringers, Reglan, Sodium Citrate-Citric Acid, Bupivacaine

Complications of labor and delivery: No complications

Family History:

Pertinent to infant: None

Social History (tobacco/alcohol/drugs): None

Pertinent to infant: None

Father/Co-Parent of Baby Involvement: Yes

Living Situation: Infant is to live at home with married parents and sibling.

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

No learning barriers are present.

Birth History (10 points)

Length of Second Stage of Labor: None

Type of Delivery: Repeat Cesarean Section

Complications of Birth: None

APGAR Scores:

1 minute: 7

5 minutes: 9

Resuscitation methods beyond the normal needed: Resuscitation did not exceed normal need.

Feeding Techniques (10 points)

Feeding Technique Type: Breast and Bottle

If breastfeeding:

LATCH score: No latch score documented.

Supplemental feeding system or nipple shield: None

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If bottle feeding:

Positioning of bottle: Upright

Suck strength: Strong

Amount: 1-6 mL

Percentage of weight loss at time of assessment: -8.4%

(Birth Weight) 2830 gm – 2593 gm (Current Weight) = 237 gm (1)

(Weight Loss) 237 g/2830 g (Birth Weight)= -0.083745583 x 100 = -8.4% (2)

****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? Yes

Intake and Output (8 points)

Intake

If breastfeeding:

Feeding frequency: Every 3-4 hours

Length of feeding session: 3-10 minutes

One or both breasts: Both Breasts

If bottle feeding:

Formula type or Expressed breast milk (EBM): Similac Advance

Frequency: Every 3-4 hours

Volume of formula/EBM per session: 10-30 mL

If EBM, is fortifier added/to bring it to which calorie content: None

If NG or OG feeding: None

Frequency: N/A

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Volume: N/A

If IV: None

Rate of flow: N/A

Volume in 24 hours: N/A

Output

Void

Age (in hours) of first void: 9 hours

Number of voids in 24 hours: 3

Stool

Age (in hours) of first stool: 18 hours

Type: Meconium

Color: Black, Tarry

Consistency: Soft, Sticky

Number of times in 24 hours: 1

Laboratory Data and Diagnostic Tests (15 points)

Name of Test	Why is this test ordered for any infant?	Expected Results	Client's Results	Interpre Res
Blood Glucose Levels	<p>Glucose serves as the primary fuel for brain growth in newborns.</p> <p>Hypoglycemia, or low blood sugar levels at birth, has been linked to brain damage, intellectual disability, and developmental difficulties. Low blood glucose is often detected in newborns at delivery and is a common and treatable condition. This patient was born at less than 37 weeks gestation, and it is protocol.</p>	Above 45 mg/dL	69 mg/dL, 58 mg/dL, 59 mg/dL, 52 mg/dL	No
Blood Type and Rh Factor	<p>Although it may appear wholly unrelated, blood type can in some circumstances be a risk factor for cerebral palsy. Blood type is used to characterize the proteins, or lack thereof, on blood cells. Ordered per protocol.</p>	A, B, AB, O	O-	No
Coombs Test	<p>This \mp test screens infant for jaundice.</p>	Negative	Negative	No
Bilirubin Level (All	<p>Jaundice results from high bilirubin</p>	>13 mg/dL	2.8 mg/dL	No

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<p>babies at 24 hours)</p> <p>*Utilize bilitool.org for bilirubin levels*</p>	<p>levels. In the first few days of life, jaundice is a common disease that typically goes away on its own.</p> <p>However, if a baby's bilirubin levels are really high, medical attention may be required to stop catastrophic issues like brain damage. Due to low birth gestational age.</p>			
<p>Newborn Screen (At 24 hours)</p>	<p>This screening checks infants for abnormalities that frequently aren't visible at birth. These conditions can be inherited, contagious, or brought on by a mother's health issue. These conditions may result in mental impairment, serious sickness, or early death if they are not identified and treated right away after delivery. Protocol at 24hours of birth prior to discharge.</p>	<p>Within normal limits</p>	<p>Results will not be available.</p>	<p>Test completed not yet</p>
<p>Newborn Hearing Screen</p>	<p>Undiagnosed hearing loss can have a significant effect on learning to speak and communicate, academic success, and social and emotional development.</p> <p>Protocol to be completed prior to discharge.</p>	<p>Pass/Fail</p>	<p>Pass</p>	<p>No</p>
<p>Newborn Cardiac Screen (At 24 hours)</p>	<p>The proportion of oxygen-saturated hemoglobin in the blood and the pulse rate are</p>	<p>Pass/Negative/In Range</p>	<p>N/A</p>	<p>No results has no</p>

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	<p>both determined by this noninvasive test. As a screening technique, pulse oximetry can be added to fetal ultrasound and physical examination to lessen the likelihood of missing critical congenital heart disease (CCHD) in infants. Protocol for infants born under 37weeks gestation.</p>			perfo
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Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. **No in text citation noted.**

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

Centers for Disease Control and Prevention. (n.d.). *NSQAP: About the program*. Retrieved January 28, 2023, from https://www.cdc.gov/labstandards/nsqap_about.html

Hearing Health Foundation. (n.d.). *Pediatric hearing loss*. Retrieved January 28, 2023, from <https://hearinghealthfoundation.org/pediatric-hearing-loss>

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

Newborn Medications (7 points)

Brand/Generic		Ilotycin	Energix B	Acetaminophe
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	Aquamephyton (vitamin k1)	(erythromycin)	(hepatitis b vaccine)	n (tylenol)
Dose	1 mg	2 mg	10 mcg	5 mL
Frequency	Once	Once	PRN	PRN
Route	Intramuscular	Eye-Ointment	Immunization	Oral
Classification	Pharmacologic Class: Phytonadione injection Therapeutic Class: Fat-soluble vitamin	Pharmacologic Class: Ophthalmic anti- infectives Therapeutic Class: Macrolide antibiotic	Pharmacological Class: Vaccines Therapeutic Class: Inactivated, Viral	Pharmacologic Class: Non salicylate, para- aminophenol derivative Therapeutic Class: Antipyretic, non- opioid analgesic
Mechanism of Action	Cofactor for gamma- glutamyl carboxylase, which converts the inactive forms of coagulation factors II, VII, IX, and X into their active forms.	Binds to and blocks the 50S subunit of bacterial ribosomes to inhibit protein synthesis, thereby stopping bacterial growth and replication.	Induces specific humoral antibodies against HBsAg. It is generally accepted that an anti-HBs titer greater than 10IU/L correlates with protection against hepatitis B virus infection.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature- regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.
Reason Client Taking	Prevention of hemorrhage caused by vitamin K deficiency	As adjunct to prevent ophthalmia neonatorum due to Neisseria gonorrhoeae or Chlamydia trachomatis	Prevention of infection caused by all known subtypes of hepatitis B virus.	To relieve mild to moderate pain
Contraindications (2)	1. Liver disease- does this infant have liver disease? 2. Hypersensiti vity to phytonadion e	1.History of hypersensitivity to erythromycin- How would we know if the infant have a history if this is a newborn? 2.Inherited blood disorder call	1. Hypers ensitivi ty to yeast- how would we know in a newbor	1. Hypersen sitivity to acetamin ophen or its compone nts 2. Severe hepatic impairme

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		porphyria	<p>n?</p> <p>2. Severe allergic reaction to a vaccine component</p>	<p>nt-How would we know in a newborn?</p>
<p>Side Effects/Adverse Reactions (2)</p>	<p>1. Hyperbilirubinemia</p> <p>2. Pain and erythema at the injection site</p>	<p>1. Minor ocular irritation</p> <p>2. Prolonged use may result in overgrowth of nonsusceptible organisms, including fungi</p>	<p>1. Reddening of the skin</p> <p>2. Difficult or labored breathing</p>	<p>1.Fever</p> <p>2.Wheezing</p>
<p>Nursing Considerations (2)</p>	<p>1. Administration is IM in the vastus lateralis</p> <p>2. Monitor for skin rash or urticaria and hypersensitivity reactions</p>	<p>1. Avoid contaminating tip of ointment tube with material from eye, fingers, or other source.</p> <p>2. When used for prophylaxis of gonococcal ophthalmia neonatorum, place specified amount of ointment into each of neonate's lower conjunctival sacs and massage gently to spread ointment; after 1 minute, wipe away excess ointment</p>	<p>1. Give IM injection in lateral side of middle 3rd vastus lateralis muscle.</p> <p>2. Document receipt of vaccine in electronic medical record and provide a card to neonate's parents for their records.</p>	<p>1. Calculate total daily intake of acetaminophen including other products that may contain acetaminophen so maximum daily dosage is not exceeded.</p> <p>2. Use acetaminophen cautiously in patients with chronic malnutrition or severe renal impairment.</p>

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<p>Key Nursing Assessment(s)/Lab(s) Prior to Administration</p>	<p>Obtain blood same for PT, INR, and aPTT labs. Assess mom history for hereditary hypoprothrombinemia.</p>	<p>with sterile cotton.</p> <p>Assess eyes for drainage or crusting, monitor for side effects after administration</p>	<p>Obtain original HBsAg laboratory results of mother for current pregnancy. Upon determining positive HBsAg status, administer HBIG and Hepatitis B single antigen vaccine within 12 hours of birth.</p>	<p>Assess client's weight prior to administering a nonopioid analgesic.</p>
<p>Client Teaching needs (2)</p>	<ol style="list-style-type: none"> Educate mom of neonate that they are unable to produce the vitamin K needed for certain coagulation factors making them at risk for bleeding. Provide comfort during and after administration. 	<ol style="list-style-type: none"> Educate mom of neonate about the purpose of the medication. Education mom of neonate about potential side effects and to avoid wiping away ointment. 	<ol style="list-style-type: none"> Educate mom of neonate to offer breast milk or formula more often. It is normal for some babies to eat less during the 24 hours after getting vaccines. Educate mom to swaddle neonate after administration of vaccines to 	<ol style="list-style-type: none"> Instruct patient to read manufacturer's label and follow dosage guidelines precisely. Explain that infants' and children's acetaminophen liquid aren't equal in drug concentration and aren't interchangeable. Teach patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.

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Medications Reference (1) (APA):

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

Osmosis from Elsevier. (n.d.). *Neonatal eye prophylaxis: Nursing pharmacology*. Retrieved January 29, 2023, from

https://www.osmosis.org/learn/Neonatal_eye_prophylaxis:_Nursing_Pharmacology

Newborn Assessment (20 points)

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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	Smooth, warm, well hydrated	Jaundice, stork bites, milia
Head	Slight bruising on infant's head, and is about 3cm larger than infant chest.	Macrocephaly, microcephaly
Fontanel	Anterior fontanel palpable at 5cm and posterior fontanel palpable at 3cm.	Enlarged Fontanel
Face	Facial features symmetric, pink color	Facial nerve paralysis, nevus flammeus, nevus vasculosus
Eyes	Eyes symmetrical, blue, random eyeball movement exhibited	Chemical conjunctivitis, subconjunctival hemorrhage
Nose	Midline and narrow	Malformation or blockage
Mouth	Soft and hard palate intact, tongue moves freely, lip movement symmetrical, suckling strong	Epstein pearls, erupted precocious teeth, thrush
Ears	Soft and pliable with quick recoil	Low-set ears, hearing loss
Neck	Moves freely, short and thick, surrounded by skin folds, holds head midline	Restricted movement, clavicular fractures
Chest	Round, symmetric, clavicles intact, nipples are prominent, well-formed and symmetrical.	Nipple engorgement, whitish discharge
Breath Sounds	Lung sounds equal and clear, normal respiratory rate, breathing appears easy	Whistling noise, hoarse cry, flaring

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Heart Sounds	No murmur present	Murmur
Abdomen	Protuberant contour, soft	Distended, only two vessels in umbilical cord
Bowel Sounds	5-12 gurgling sounds heard in all four quadrants	Reduced, intense, rippling bowel sounds
Umbilical Cord	Fleshy, not withered	Withered, thin single umbilical artery?
Genitals	Smooth glans, penile shaft is straight with intact foreskin	Edematous scrotum in males, vaginal discharge in females
Anus	Anus present, patent and not covered by a membrane. Meconium present upon diaper change.	Narrow, blocked by a thin or thick layer of tissue, imperforated
Extremities	Symmetrical	Congenital hip dislocation
Spine	Free spinal movement	Tuft or dimple on spine
Safety <ul style="list-style-type: none"> • Matching ID bands with parents • Hugs tag • Sleep position 	<input type="radio"/> Yes <input type="radio"/> Yes <input type="radio"/> Infant is laid on back, on firm surface.	

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	99 ° F	140 bpm	62 breaths/min abnormal
4 Hours After Birth	99 ° F	120 bpm	42 breaths/min
At the Time of Your Assessment	98.7 ° F	160 bpm	64 breaths/min- abnormal

Abnormal not highlighted

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Vital Sign Trends: The patient's temperature trended down .3 degrees from birth to the assessment time. The patient's pulse at birth was 140 bpm during stress. Four hours later, the patient's pulse trended down by 20 points during rest. At the time of assessment, the patient's pulse trended up 40 points from his four-hour assessment due to stress from his hearing screen. The patient's respirations trended down 20 points from his time of birth. At the time of assessment, the patient's respirations increased by 2 points from birth and 22 points from his four-hour assessment.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1115	NIPS Scale (0-7)	None pain noted on assessment	None	None	None

Summary of Assessment (4 points)

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

This neonate was delivered on 01/25/2023 at 0854 by low transverse cesarean section (LSCS). The delivery was well tolerated. The Apgar scores were 7 and 9. The EDD was 2/28/23 by US. The new Ballard scale assessment revealed neonate is 35 4/7 weeks. The prenatal history shows this pregnancy was not complicated. The birth weight was 6 lbs 3.08 ozs (2830 grams); length was 19.488" (49.5 cms); head circumference was 13.386" (34 cms); and chest circumference was 12.598" (32 cms). Upon assessment all systems are within normal limits. The last set of vitals was: 37.2/163/64-**this is not the set of vitals shown above**. Breath sounds x3 after delivery were WNL with the lowest being 42. The neonate is bottle and breastfeeding and nursing well with most feedings 20"/20" q2-3 hrs. The bilirubin level at 24 hours per scan was 2.8mg/dL. The neonate is scheduled for a car seat test prior to discharge due to 36w9d gestational delivery. The neonate is expected to be discharged home with mother and father later today. The neonate is to see the pediatrician in the office for first well baby checkup within 3-5 days.

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.
Car Seat Test (M)	Once, 24 hours after birth.	This test is required to ensure an adequate airway is maintained while sitting in a car seat due to the patient's gestation being less than 37 weeks.
Diaper Change (N)	Every two to three hours.	Without consistent diaper changes, babies risk infections, rash, and other significant health problems.
Bottle Feeding (N)	Every two to three hours.	Patient was fussy after hearing screen and showed signs of suckling. Offered bottle and patient drank 2mL of Similar Advance.

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): None

Follow up plan (include plan for newborn ONLY): This nursing student would educate the parents on car seat safety, vaccination needs, follow-up appointments, umbilical cord care,

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breastfeeding benefits, bottle feeding, shaken baby syndrome, safe sleep, SIDS risk and prevention, and how to take the infant's temperature correctly.

Education needs: This nursing student would educate the parents on self-care and adequate sleep. This nursing student would advise the parents to develop sleep habits that cater to the baby, bonding, head and neck support requirements, postpartum follow-up in 4-6 weeks, burping baby, warning signs of trouble breathing, and offer CPR refresher or resources.

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

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>Evaluation (2 pts each)</p> <ul style="list-style-type: none"> How did the patient/family respond to the nurse's actions? Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for Sudden Infant Death Syndrome related to infant being placed in a prone position to sleep as evidenced by parents asking what is the appropriate way to lay infant to sleep.</p>	<p>Education was provided to parents about proper sleeping habits for the neonate which included sleeping on his back, preventing co-sleeping, and sleeping in a space free of clutter to</p>	<p>1. Position infant on the back when placed in the crib. Incidence of SIDS is higher among infants placed prone. Rationale?</p> <p>2. Make sure infant lies on firm surface so that infant doesn't sink into the mattress, mattress cover, or blanket to decrease the risk of suffocation. Rationale?</p>	<p>The parents listened and cooperated with the teaching.</p> <p>The infant will be able to move freely without entanglement or suffocation in crib during sleep.</p>

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	include animals, large blankets and toys.		
2. Ineffective breastfeeding related to initial inadequate milk supply as evidenced by insufficient emptying of each breast per feeding.	Infant mom was provided education about breast feeding as much as possible initially to bring in her milk supply. The mother stated she wanted to pump some, allow dad to bottle feed and breastfeed at times.	<p>1. Offer information about the importance of adequate nutrition and fluid intake while breastfeeding in order to meet the infant's demand for breast milk. Rationale?</p> <p>2. Teach techniques for encouraging the letdown reflex, including warm shower, breast massage, physically caring for the neonate and holding the neonate close to the breasts. Rationale?</p>	<p>Setting up a meeting with a lactation consultant would benefit this mom.</p> <p>Neonate will feed successfully on both breasts and appears satisfied for at least 2 hours after feeding.</p>
3. Deficient knowledge related to neonate not being able to get a circumcision as evidenced by referral to urology for circumcision.	Mom and dad thought every male child could get a circumcision as the hospital prior to discharge. This neonate was referred to urology due to having a small shaft and to prevent possible injury.	<p>1. Select teaching strategies (such as discussion, demonstration, role-playing, and visual materials) appropriate for patient's individual learning style to enhance teaching effectiveness. Rationale?</p> <p>2. Provide infants mom with names, telephone numbers and resources for urologist that will provide continuity of care and follow-up after discharge. Rationale?</p>	<p>Parents expressed an understanding of next steps for infant.</p> <p>Parents responded well to teaching and were eager to review referrals.</p>
4. Deficient knowledge of car seat safety related to the infant needing a car seat test due to hospital policy	Mom and dad were unaware of the policy of the car seat test. Dad stated, "I thought you	<p>1. Provide written materials explaining the car seat safety procedure, the time required for completion and the possible outcomes. Rationale?</p>	<p>Parents expressed an understanding of the procedure with no apprehension.</p> <p>Parents stated an understanding of the</p>

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and evidence-based practice recommendations as evidenced by parents asking why did the infant need this test prior to discharge.	needed to just see a car seat he was going home in”. Education was provided and the 90 minute time frame was explained to both mom and dad.	2. Be available to answer questions and correct misconceptions for mom and dad in order to enhance learning effectiveness. Rationale?	evidence-based practice car seat procedure.
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Next time reword my suggestions of nursing diagnosis.

Other References (APA):

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

N432 Newborn Care Plan Grading Rubric

Student Name:

Demographics	10 points	5 points	0 points	Points
Demographics <ul style="list-style-type: none"> Date/time of clinical assessment Date & time of birth Patient initials Age in hours at clinical assessment Gender Race/Ethnicity Weight at birth and at time of assessment Length at birth Head circumference at birth Chest circumference at birth 	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling. 10 pts	1-2 of the key components are not filled in correctly.	3 or more of the key components are not filled in correctly and therefore no points were awarded for this section	
Mother/Family Medical History	15 points	7.5 points	0 points	Points
Prenatal History of the mother <ul style="list-style-type: none"> When prenatal care 	Includes each section completed	1-2 of the key components	3 or more of the key components	

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<p>started</p> <ul style="list-style-type: none"> Abnormal prenatal labs/diagnostics Prenatal complications Smoking/drugs during pregnancy <p>Labor History of Mother</p> <ul style="list-style-type: none"> Gestation at onset of labor Length of labor ROM Medications in labor Complications of labor & delivery <p>Past Surgical History</p> <ul style="list-style-type: none"> All previous surgeries should be listed <p>Family History</p> <ul style="list-style-type: none"> Pertinent to infant <p>Social History</p> <ul style="list-style-type: none"> Pertinent to infant Father of baby involvement <p>Living situation</p> <p>Education level</p> <ul style="list-style-type: none"> If applicable to parents' learning barriers or care of infant 	<p>correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.</p> <p>15 pts</p>	<p>is missing detailed information.</p>	<p>are not filled in correctly</p>	
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Birth History	10 points	5 point	0 points
<p>Birth History</p> <ul style="list-style-type: none"> Length of second stage of labor Type of delivery Complications of birth APGAR scores <ul style="list-style-type: none"> o 1 minute o 5 minutes Resuscitation methods beyond the <i>normal need</i> 	<p>Every key component of the birth history is filled in correctly with information.</p> <p>10 pts</p>	<p>1-2 of the key components are missing in the birth history. The birth history is lacking important information to help determine what has happened to the</p>	<p>No birth history included and/or or more of the key components are missing.</p>

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<ul style="list-style-type: none"> o Volume of formula per session • NG or OG Feeding <ul style="list-style-type: none"> o Frequency o Volume • IV Feeding <ul style="list-style-type: none"> o Rate of flow o Volume in 24 hours <p>Output</p> <ul style="list-style-type: none"> • Voiding <ul style="list-style-type: none"> o Age (in hours) of first void o Number of times in 24 hours • Age (in hours) of first stool • Stool <ul style="list-style-type: none"> o Age (in hours) of first stool <ul style="list-style-type: none"> ▪ Type ▪ Color ▪ Consistency o Number of times in 24 hours 	<p>intake and output. 8 pts</p>	<p>thorough understanding of the intake and output.</p>	
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Laboratory/Diagnostic Data	15 points	7.5 points	0 points
<p>Normal Values</p> <ul style="list-style-type: none"> • Should be obtained from the chart when possible as labs vary some. If not possible, use laboratory guide. • Normal values should be listed for all laboratory data. • Utilize bilitool.org for bilirubin levels <p>Laboratory Data</p> <ul style="list-style-type: none"> • Explanation of why the test was ordered for THIS client • Expected results • Client's results • Interpretation of results • Newborn screen results MAY NOT be available for every client as the results may not come back until after discharge <p>Rational for abnormal values</p>	<p>All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. Student had 1 reference listed with in text citations and is able to correlate abnormal laboratory findings to the patient's particular disease process.</p>	<p>1-2 of the patient's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation. Student had 1 reference listed with in text citations</p>	<p>Student did not have an understanding of laboratory values and the abnormalities. 3 or more labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference or no text citations. Source(s) utilized were greater than years old.</p>

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<ul style="list-style-type: none"> • Written in complete sentences with APA citations • Explanation of the laboratory abnormality in this patient • For example, elevated WBC in patient with pneumonia is on antibiotics. • Minimum of 1 APA reference, no reference will result in zero points for this section <ul style="list-style-type: none"> o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted 			0 pts see care pla
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Current Medications	7 points	6-1 points	0 points
<p>Current Medications</p> <ul style="list-style-type: none"> • Requirements of all inpatient hospital medications given to the newborn • Each medication must have brand/generic name • Dosage, frequency, route given, class of drug and the action of the drug • Reason client taking • 2 contraindications must be listed <ul style="list-style-type: none"> o Must be pertinent to your patient • 2 side effects or adverse effects • 2 nursing considerations • Key nursing assessment(s)/lab(s) prior to administration <ul style="list-style-type: none"> o Example: Assessing client's HR prior to administering a beta-blocker o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin • 2 client teaching needs • Minimum of 1 APA citation, no citation 	<p>All key components were listed for each of the 10 medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.</p> <p style="color: red;">7 pts</p>	<p>1 point will be lost for each medication with incomplete information.</p>	<p>There was note lack of effort of the student's pa to complete the section or there was no APA citation listed. Source(s) utilized were greater than 5 years old.</p>

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<p>will result in loss of all points in the section</p> <ul style="list-style-type: none"> o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted 			
Physical Exam	20 points	10 points	0 points
<ul style="list-style-type: none"> • Completion of a head to toe assessment done on the students own and not copied from the client's chart • Safety risk assessment • No safety risk assessment will result in a zero for the section 	<p>All key components are met including a complete head to toe assessment and safety risk assessment.</p> <p style="color: red; text-align: center;">20 pts</p>	<p>1-3 of the key components is missing from a given section.</p>	<p>4 or more of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head-to-toe assessment process.</p>
Vital Signs	6 points		3 points
<p>Vital Signs</p> <ul style="list-style-type: none"> • 3 sets of vital signs are recorded with the appropriate labels attached • Includes a set at birth, 4 hours after birth, and at the time of your assessment • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends 	<p>All the key components were met for this section (with 3 sets of vital signs) and student has a good understanding of abnormal vital signs.</p>		<p>Only 1 set of vital signs were completely recorded and/or one of the key components were missing.</p> <p style="color: red;">3 pts see care plan</p>
Pain Assessment	2 points		1 point
<p>Pain assessment</p> <ul style="list-style-type: none"> • Pain assessment was addressed and recorded twice throughout the care of 	<p>All the key components were met (1 pain assessments) for this section and student has a good understanding of the pain</p>		<p>1 of the key components is missing.</p>

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<p>this patient</p> <ul style="list-style-type: none"> It was recorded appropriately and stated what pain scale was used 	<p>assessment. 2 pts</p>	
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Summary of Assessment	4 points		2 points	
<ul style="list-style-type: none"> Discussion of the clinical significance of the assessment findings Written in a paragraph form with no less than 5 sentences 	<p>Ass of the key components of the summary are addressed. It is written in a paragraph format with no less than 5 sentences, in the student's own words. 4 pts</p>		<p>1-2 of the key components is missing. Difficult to determine if the student has a thorough understanding.</p>	<p>3 d com mis stud co</p>
Nursing Care Interventions	6 points		3 points	
<p>Nursing Interventions</p> <ul style="list-style-type: none"> List the nursing interventions and medical treatments utilized with your client Includes a rationale as to why the intervention is carried out or should be carried out for the client Differentiates between nursing interventions (N) and medical interventions (M) Include the frequency that the intervention is being performed 	<p>All of the key components are addressed. Student demonstrates an understanding of the nursing care and interventions needed/provided. 6 pts</p>		<p>1-2 of the key components is missing. Difficult to determine if the student has a thorough understanding.</p>	<p>3 d com mis stud co</p>
Discharge Planning	2 points	1 point	0 point	
<p>Discharge Planning</p> <ul style="list-style-type: none"> Discharge location Equipment needs (if applicable) Follow up plan <ul style="list-style-type: none"> o Include plan for newborn ONLY 	<p>All the key components of the discharge summary were addressed. Student demonstrated an understanding of</p>	<p>1-2 of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a</p>	<p>Student did not complete this section and/or 3 or more of the key components are missing.</p>	

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<ul style="list-style-type: none"> • Education needs 	<p>the nursing care. 2 pts</p>	<p>thorough understanding of the nursing care.</p>	
<p>Nursing Diagnosis</p>	<p>30 points</p>	<p>29-10 points</p>	<p>9-0 points</p>
<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • List 4 nursing diagnosis <ul style="list-style-type: none"> o Include full nursing diagnosis with “related to” and “as evidenced by” components • Two Nursing diagnoses are related to needed teaching topics <ul style="list-style-type: none"> o List 2 priority teaching items o Includes 1 expected outcome for each teaching topic o Includes how the information would be taught o Includes an expected outcome • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis <ul style="list-style-type: none"> o Explain why the nursing diagnosis was chosen • Minimum of 2 interventions for each diagnosis <ul style="list-style-type: none"> o Includes rationale for each intervention. o Includes source for each rationale. • Outcome/goal for each intervention is required <ul style="list-style-type: none"> o These should be specific and individualized for THIS client o These should be easily measurable • Correct priority of the nursing diagnosis 	<p>All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.</p>	<p>1-2 of the nursing diagnosis/rational/intervention/goals sections was incomplete or not appropriate to the patient. Prioritization was not appropriate. 22 pts see care plan</p>	<p>3 or more of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.</p>

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<ul style="list-style-type: none"> • Appropriate evaluation 			
Overall APA format	5 Points	2.5 Points	0 Points
<p>APA Format</p> <ul style="list-style-type: none"> • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Source(s) utilized should be 5 or less years old. <ul style="list-style-type: none"> ○ Source(s) greater than 5 years old will not be accepted. • Professional writing style, grammar, and spelling was used in all narrative sections. 	<p>APA format was completed and appropriate. Grammar, spelling, and overall writing style were professional and without errors</p>	<p>APA format was used but not correct with 1-2 errors noted. 1-2 grammar, spelling, or overall poor writing style was used. Content was difficult to understand. 2.5 pts</p>	<p>No APA format or 3 or more errors noted. Source(s) utilized were greater than 5 years old. Grammar, spelling, or writing style did not demonstrate collegiate level writing with 3 or more errors noted</p>
<p>Instructor Comments: Please make sure to follow directions on care plan and rubric. Please check work for grammar and spelling errors.</p>			
Total Points Awarded	121.5/150=81%		