

N432 Newborn Care Plan

Lakeview College of Nursing

Shawna Stewart

Instructions: The care plan is to be typed into a WORD document and submitted to the Newborn Drobox within 72 hours after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 150 points. In order to pass you must achieve at least 116 points to acquire a pass. If you do not pass, you will have one opportunity to do a newborn care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

DEMOGRAPHICS (10 points)

Date/time of clinical assessment 9/11/19 at 2:00 pm

Date/time of birth 9/8/19 11:51 am	Patient Initials A. B	Age at time of assessment in hours. 74 hrs	Gender Male
Race/Ethnicity White/ non-hispanic	Weight at birth (gm) <u>2850</u> (lb.) <u>6</u> (oz.) <u>4.5</u>	Weight at time of assessment* (gm) <u>2880</u> (lb.) <u>6</u> (oz.) <u>5.6</u>	How old was the infant when weighed last (In hours). 65 hours
Length at birth Cm <u>49.5</u> Inches <u>19.5</u>	Head circumference at birth Cm <u>35.5</u> Inches <u>13.98</u>	Chest Circumference at birth Cm <u>31.5</u> Inches <u>12.4</u>	

- There are times when the weight at the time of your assessment will be the same as at birth.

MOTHER/FAMILY MEDICAL HISTORY (15 points)

Prenatal History of the mother

When Prenatal care started 2/21/19

Abnormal Prenatal labs/diagnostics Gestational (PIH, preeclampsia)

Prenatal complications Gestational (PIH, preeclampsia)

Smoking/Drugs in pregnancy none

Labor History of Mother

- Gestation at onset of labor 37w 6d: 9/8/19 at 0100
- Length of labor (1st) 9h 27m (2nd) 1h 24m (3rd) 6m
- ROM artificial 0530
- Medications in labor dinoprostone (Cervidi), oxytocin (Pitocin), epidural
- Complications of labor & delivery Elevated blood pressure, respiratory distress of baby

Family History

- Pertinent to infant No family history on file

Social History

- Pertinent to infant Lives with both parents, large extended family involvment for support.

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- Father/co-parent of baby involvement? ___Involved in care_____
- **Living situation** ___Parents currently married, live together_____
- **Education level of parents**

If applicable to parents' learning barriers or care of infant ___ Both parents have some college education but no degree. _____

Birth History

- **Length of Second stage labor** _____ 1h 24m _____
- **Type of Delivery** _____ Induced vaginal delivery _____
- **Complications of birth** _____ Respiratory distress _____
- **APGAR scores** 1 minute 8 5 minutes 8 10 minutes NA _____
- **Resuscitation methods beyond the normal needed** _____ Supplemental oxygen and positive pressure _____

FEEDING TECHNIQUES (8 points)

Feeding technique type ___ Will breastfeed (currently baby receives breast milk via bottle or NG tube) _____

If breastfeeding, LATCH score. _____ NA _____

If bottle feeding, positioning of bottle, suck strength, amount

Percentage of weight loss at time of assessment (**Show your calculations; if today's weight is not available please show how you would calculate weight loss i.e. show the formula**). _____ 1 ___% weight gain. (subtract current weight from birth weight, then divide weight loss by birth weight and multiply that by 100 to get percentage)

What is normal weight loss for this age infant? _____ 285gm (10% of birth weight) _____

Is this neonate's wt. loss within normal limits? _____ NA _____

INTAKE AND OUTPUT (8 points)

Intake

If breastfeeding: feeding frequency, length of feeding session, one or both breasts? 45-60mL q3 hour __ (30 minutes for each session) _____

If bottle feeding: frequency and volume of formula at a session. __ Bottle feed mom's breast milk every 3 hours _____

If NG or OG feeding: frequency & volume ___ At one feed the nurse had to give 1 mL of breast milk via NG tube due to time limit. _____

If IV: then rate of flow and volume in 24 hours _____ NA _____

Output

Age (in hours) of first void _____ 6 hours _____

Voiding patterns: (# of times/24 hours) _____ 8x/day _____

Age (in hours) of first stool _____ 3 hours _____

Stools: (type, color, consistency and number of times in 24 hours) ___ 3x/day; soft, seedy; yellow-green in color. _____

NEWBORN LABS AND DIAGNOSTICS TESTS (15 Points)**Highlight All Abnormal Lab results.**

Name of test	Why was this test ordered for <i>this</i> client? Complete this even if these labs have not been completed.	Client's results	Expected results	<i>Interpretation of this client's results</i>
Blood glucose levels	To assess a baseline due to difficult delivery	61 mg/dL	30-72 mg/dL	Glucose within normal limits.
Blood type and Rh factor	To assess blood type and RH factor	A+		
Coombs test	To determine if there are markers of a reaction between mom's and baby's blood.	Negative	Negative	Baby not having a reaction to mom's blood.
Bilirubin level (all babies at 24 hours)	To test when liver starts to work properly	(26.6 hrs) 5.5 mg/dL	below 5.2 mg.dL	Use www.bilitool.org to "plug in" your baby's 24 hour bilirubin level. Discuss baby's risk according to this website. If your infant has not had a biliscan (TCB) or bili serum drawn, talk with your instructor and she will provide you with a number to use. Copy and paste the risk factor webpage stating your infant's risk status and include it at the end of this document.
Newborn Screen (at 24 hours)	Tests for certain disorders that can delay development	Not available until after discharge	Negative	NA
Newborn Hearing Screen	To test hearing	not yet performed	Normal	NA

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Newborn Cardiac Screen (at 24 hours)	To assess cardiac function and detect any congenital defects	Not yet performed	Normal	NA
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NEWBORN MEDICATIONS (15 Points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin ointment)	Hepatitis B Vaccine		
Dose	1mg	0.5% ointment	0.5mL		
Frequency	once	once	once		
Route	intramuscularly	in both eyes	intramuscularly		
Classification	vitamin	antibiotic	Vaccine		
Mechanism of Action		-Inhibits protein synthesis; usually bacteriostatic			
Reason Client Taking	Prophylaxis and treatment of vitamin K deficiency bleeding	Prophylaxis treatment of ophthalmia neonatorum caused by Neisseria gonorrhoeae or Chlamydia trachomatis.	-Immunization against infection from all known subtypes of HBV		

Contraindications (2)	-Hypersensitivity	-Hypersensitivity			
Side Effects/Adverse Reactions (2)	-low blood pressure -bluish discoloration of the skin	-Minor ocular irritations -redness			
Nursing Considerations (2)	-Monitor injection site -	-Store ophthalmic drug at room temperature. -May be flammable, keep away from heat or flame.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	PT, INR, Platelets	NA			
Client Teaching needs (2)	-Report signs of hypersensitivity. -Report signs of rash occurring after infection.	-Clean eye of any discharge before application. -Wash hands after application.			

VITAL SIGNS (6 points)

Vital Signs at Birth

T 99.7
P 164
R 40

Vital signs 4 hours after birth

T 98.9
P 164
R 52

At the time of your Assessment

T 97.9
P 116
R 40

NEWBORN ASSESSMENT (25 Points)

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Area	Your Assessment	Expected Variations And Findings (This can be found in your book p.645)	If assessment finding different from expectation what is the clinical significance?
Skin	smooth, flexible, dry no lesions or abnormal markings	Normal, smooth, flexible, good skin turgor, well-hydrated, warm	No abnormalities
Head	symmetrical, well rounded, no abnormal shape	Normal, varies with age, gender, and ethnicity	No abnormalities
Fontanel	Normal	Normal	No abnormalities or enlarged fontanel noted.
Face	symmetrical, full cheeks	Normal: full cheeks, facial features symmetrical	No abnormalities
Eyes	Pupils alert, no discharge.	Normal: clear and symmetrically placed on face; online with ears	No abnormalities, no drainage noted.
Nose	Midline placement, no septum deviation, no drainage.	Normal, small placement in the midline and narrow, ability to smell	No abnormalities noted.
Mouth	Moist, hard palate in place	Normal: aligned in midline, symmetric, intact soft and hard palate	No abnormalities
Ears	Soft, normal. quick recoil	Normal: soft and pliable with quick recoil when folded and released.	No abnormalities.
Neck	Normal, moves freely. held in midline position when baby laying in crib	Normal: short, creased, moves freely, baby holds head in midline.	No abnormalities
Chest	Symmetrical, normal rise with breathing. Normal nipple placement.	Normal: round, symmetric, smaller than head	No abnormalities
Breath sounds	Normal, respirations non -labored.	Normal respirations 30-60 bpm	No abnormalities

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Heart sounds	S1, S2 audible.	apical pulse 110-169 bpm	no abnormalities.
Abdomen	Soft, non-distended	Normal: protuberant contour, soft, three vessels in umbilical cord	No abnormalities
Bowel sounds	Active, No blockage noted. BM x3	active bowel sounds in all quads.	No blockage noted.
Umbilical cord	Normal, 3 vessels noted.	three vessels in umbilical cord	No abnormalities.
Genitals	Normal, scrotum normal size.	Normal male: smooth glans, meatus centered at tip of penis	No abnormalities.
Anus	Open, allows passage of stool.	Anus intact	No abnormalities
Extremities	Able to move all extremities	Normal extremities symmetrical with free movement.	No defects noted.
Spine	appears symmetrical and straight, no deviations noted.	aligned.	No abnormalities.
Safety Matching bands with parents Hugs tag Sleep position	All baby bands match with parents. Hugs band in place Baby sleeping on back	All bands including parents bands match with baby. Hugs band in place sleep on back	

Complete the Ballard scale grid at the end to determine if this infant is SGA, AGA or LGA (Show your work)? What was your determination? __37weeks gestation, AGA__

Are there any complications expected for a baby in this classification? (Discuss)

__Increase in bilirubin that can result in Jaundice._____

PAIN ASSESSMENT (2 Points)

Pain Assessment including which pain scale you have used. _NIPS, baby seems comfortable. _____

SUMMARY OF ASSESSMENT (4 points)

Discuss the clinical significance of the findings from your physical assessment. Note the example here:

This neonate was delivered on 5.15.14 at 0522 by normal spontaneous vaginal delivery (NSVD). Nuchal card x 1. Apgar scores 1/3/9. EDD 5.10.14 by US. Dubowitz revealed neonate is 39 2/7 weeks and LGA. Prenatal hx complicated by PIH and GDM (diet controlled). Birth weight 9 lbs 4 ozs (4440 grams), 21" long (53.34 cms). Upon assessment all systems are within normal limits. Last set of vitals: 38.4/155/48. BS x 3 after delivery WNL with lowest being 52. Neonate is breastfeeding and nursing well with most feedings 20"/20" q 2 – 3 hrs. Bilirubin level at 24 hours per scan was 4.9. Neonate expected to be discharged with mother later today and to see pediatrician in the office for first well baby check within 48 hours.

This neonate was delivered on 9/8/19 at 1151 by normal spontaneous vaginal delivery (NSVD) after induction of labor. Apgar scores 8/8. EDD of 9/23/19 reveals baby is 37 weeks 6 days and AGA. Prenatal hx complication by PIH and preeclampsia. Baby birth weight 6 lbs 4.5 oz (2850 grams), 19.5 inches long (49.5 cm). Upon assessments it was noted that the baby was having difficulty with respirations, making grunting noises, having nasal flaring and low oxygen saturation. Vitals at birth 99.7, 164, 40. Baby was transferred to the special nursery for monitoring and treatment. Respirations improved after oxygen administration and positive pressure. NG tube placed to allow for feeding of breastmilk. Baby tolerates oral feeding well. If continues to tolerate oral feedings, NG tube will be removed. Bilirubin scan at 24 hours revealed 5.5 mg/dL, however at 74 hours a bilirubin result was 14.8 mg/dL. Baby was then placed in treatment blanket. Plan of care is to continue monitoring baby, along with monitoring oral intake for possible removal of NG tube. If improvement, baby could be discharged within a few days.

NURSING CARE/INTERVENTIONS (12 Points)

Teaching Topics (5 points)

Include how you would teach the information & an expected outcome

1. Umbilical cord care. The parents will be able to properly care for and recognize signs of infection.
2. General newborn safety. The parents will be able to ensure the safety of the newborn.

Nursing Interventions (5 points)

Include a rationale as to why the intervention is being provided to client

Nursing Interventions: (1) Proper care of the umbilical cord is done to detect any bleeding or signs of infection that should be reported to the pediatrician. Medical staff should expect to remove the cord clamp approximately 24 hours after birth. However, if the cord is still moist, keep the clamp in place and ensure to refer a home health agency nurse for removal.

(2) Parents should be taught what infant abduction is and why infant security is so important. Medical staff can ensure that all newborns are not left unattended. Also that while in the room with the mother, the bassinet is between the bed and window.

Medical Treatments: (1) Avoid tub baths until the cord has fallen off and the area has healed. Also, expose the cord stump to the air as much as possible throughout the day.

(2) Place all infants on their back to sleep to prevent sudden infant death syndrome. Do not have objects, such as, pillows, heavy blankets, or stuffed toys in the crib with the child.

PRIORITY NEWBORN NURSING DIAGNOSES (15 Points)

Identified Problem or potential problem	Expected Outcomes/Goals	Interventions	Goals/Outcomes Met/Not Met
<p>Identify problems that are specific to this patient. Write 2 nursing diagnosis. In order of priority. Must include a related to (R/T) and an as evidenced by (AEB)</p>	<p>Include an expected outcome for each intervention. What do you expect to happen when you implement each intervention? Expected outcomes should be specific and individualized for THIS patient. The expected outcomes/goals MUST be measurable..</p>	<p>Include 3-5 interventions for each problem. Interventions should be specific and individualized for THIS patient. Be sure to include a time interval when appropriate, such as “Assess vitals q 12 hours”. Interventions could include assessment, client teaching, procedures and prn medications.. Include a rationale for each intervention and using APA format , list your sources.</p>	<p>Include whether the goal/outcome has been met or not met and why. Then write what you would do next.</p>
<p>Diagnosis 1. Ineffective breathing pattern related to immature respiratory system and respiratory distress as evidenced by tachypnea, nasal flaring, sternal retractions, and/or</p>	<p>Baby’s respiratory status returns to adequate level of functioning as evident by minimal to absent signs of respiratory distress.</p>	<ul style="list-style-type: none"> -Assess for gestational age and risk factors for respiratory distress to allow early detection. -Assess respiratory effort (rate, character, effort) to identify changes -Observe for cues (grunting, shallow respirations, tachypnea, apnea, tachycardia, central cyanosis, hypotonia, increased effort) to identify need of 	<p>Met/Not Met? Goals met. Why? Because baby’s oxygen remained stable with no signs of distress during visit.</p>

<p>decreased oxygen saturation (Ricci, Kyle, & Carmen, 2017).</p>		<p>additional oxygen.</p>	<p>What next? Continue to monitor baby, with possible discharge within a couple of days.</p>
<p>Diagnosis 2. Risk for imbalanced nutrition: less than body requirements to meet metabolic need related to poor sucking, lack of glycogen stores necessary to meet the newborns increased metabolic demand (Ricci, Kyle, & Carmen, 2017).</p>	<p>Baby will demonstrate adequate nutritional intake to progressively gain weight toward desired goal, remain free of signs of hypoglycemia as evident by blood glucose levels maintained above 45 mg/dL, enhanced sucking ability and appropriate weight gain.</p>	<ul style="list-style-type: none"> -Identify newborn at risk based on behavioral characteristics, body measurements and gestational age to establish a baseline and allow for early detection. -Assess blood glucose levels as ordered to determine status and establish a baseline for intervention. -Monitor tolerance of oral feedings including intake and output to determine effectiveness. -Monitor daily weight for changes to determine effectiveness of feedings. 	<p>Met/Not Met? Goals met.</p> <p>Why? Baby tolerated oral feedings well. One feeding did require remaining breast milk to be feed via NG tube.</p> <p>What next? Continue to monitor. If improvement, possible discharge within a few days.</p>

Ballard Gestational Age scale

Neuromuscular Maturity

Score	-1	0	1	2	3	4	5
Posture							
Square window (wrist)							
Arm recoil							
Popliteal angle							
Scarf sign							
Heel to ear							

Physical Maturity

Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; rare veins	Parchment, deep cracking; no vessels	Leathery, cracked, wrinkled
Lanugo	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	Maturity Rating
Plantar surface	Heel-heel 40-50 mm: -1 < 40 mm: -2	> 50 mm, no crease	Faint red marks	Anterior transverse crease only	Creases anterior 2/3	Creases over entire sole	
Breast	Imperceptible	Barely perceptible	Flat areola, no bud	Stippled areola, 1-2 mm bud	Raised areola, 3-4 mm bud	Full areola, 5-10 mm bud	-10 20
Eye/Ear	Lids fused loosely: -1 tightly: -2	Lids open; pinna flat; stays folded	Slightly curved pinna; soft; slow recoil	Well curved pinna; soft but ready recoil	Formed and firm, instant recoil	Thick cartilage, ear stiff	-5 22
Genitals (male)	Scrotum flat, smooth	Scrotum empty, faint rugae	Testes in upper canal, rare rugae	Testes descending, few rugae	Testes down, good rugae	Testes pendulous, deep rugae	0 24
Genitals (female)	Clitoris prominent, labia flat	Clitoris prominent, small labia minora	Clitoris prominent, enlarging minora	Majora and minora equally prominent	Majora large, minora small	Majora cover clitoris and minora	5 26
							10 28
							15 30
							20 32
							25 34
							30 36
							35 38
							40 40
							45 42
							50 44

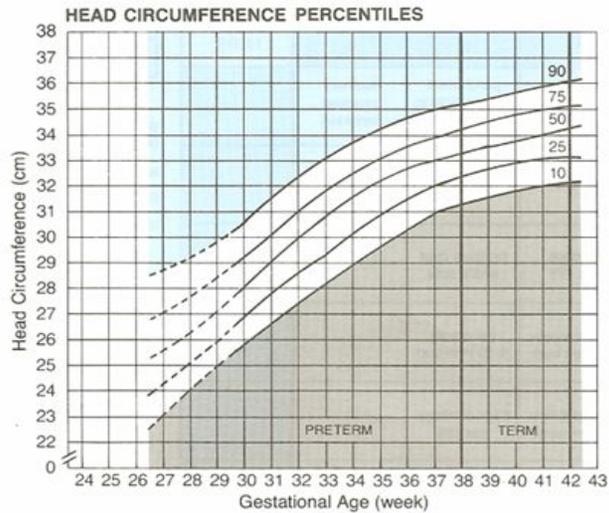
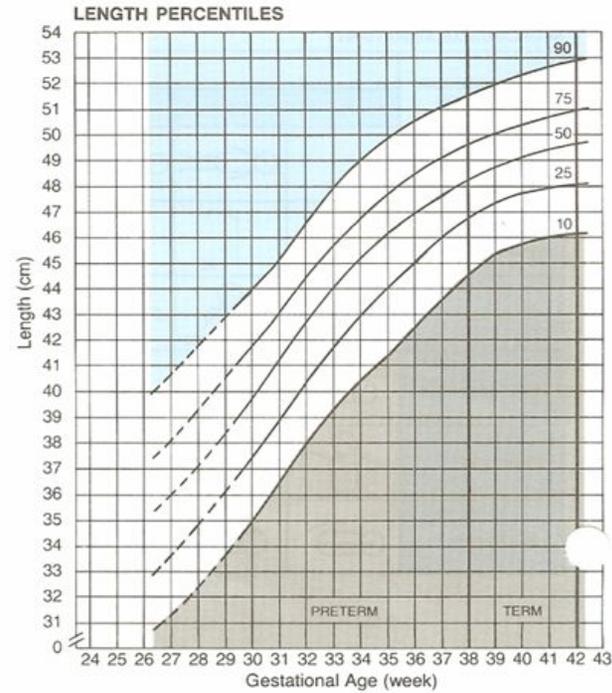
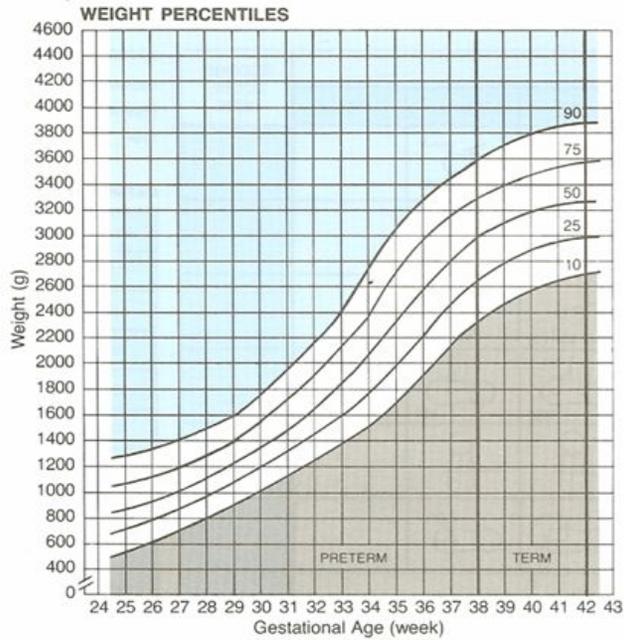
First box: score of 3+2+3+3+3+2=16

Second box: score of 2+2+3+2+2+3=15

Total score of 31

**CLASSIFICATION OF NEWBORNS (BOTH SEXES)
BY INTRAUTERINE GROWTH AND GESTATIONAL AGE ^{1,2}**

NAME _____ DATE OF EXAM _____ LENGTH _____
 HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____
 RACE _____ BIRTH WEIGHT _____ GESTATIONAL AGE _____
 DATE OF BIRTH _____



CLASSIFICATION OF INFANT*	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)			
Appropriate for Gestational Age (AGA) (10th to 90th percentile)			
Small for Gestational Age (SGA) (<10th percentile)			

*Place an "X" in the appropriate box (LGA, AGA or SGA) for weight, for length and for head circumference.

Head circumference: LGA >90th percentile

Weight: AGA (10th to 90th percentile)

Length: AGA (10th to 90th percentile)

References:

Ricci, S. S., Kyle, T. & Carmen, S. (2017). *Maternity and Pediatric Nursing*. (3rd. ed.) Philadelphia, PA: Wolters Kluwer

Woods, A.D. (2019). *Nursing Drug Handbook*. Philadelphia, PA: Wolters Kluwer

N305 Care Plan Grading Rubric: Newborn

Student Name:

Demographics	10 Points	5 Points	0 Points	Points/ Comments
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 	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	Two or more of the key components are not filled in correctly.	5 or more of the key components are	

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<ul style="list-style-type: none"> • Length at birth • Head circumference at birth • Chest circumference at birth 			not filled in correctly and therefore no Points were awarded for this section	
Mother/Family Medical History	15 Points	10 Points	0 Points	Points/ Comments
<p>Prenatal History of the mother When Prenatal care started Abnormal Prenatal labs/diagnostics Prenatal complications Smoking/Drugs in pregnancy</p> <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>	Includes each section completed 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.	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

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<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 				
Birth History	10 Points	5 Points	0 Points	Points/ Comments
<p>Birth History</p> <ul style="list-style-type: none"> • Length of second stage labor • Complications of birth • APGAR scores • Resuscitation methods beyond the <i>normal needed</i> 	Every key component of the birth history is filled in correctly with information	Two 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 patient.	No birth history included.	
Feedings techniques	8 Points	4 Points	0 Points	Points/ Comments
<p>Latch score assessment</p> <p>Bottle feeding technique assessment</p> <p>Weight loss calculation</p>	All key components are filled in correctly. The student was able to identify the effectiveness of the feeding technique Calculation of weight loss is accurate	One of the key components is missing or not understood correctly.	Student did not complete this section.	

Intake and Output	8 Points	1-7 Points	0 Points	Points/Comments
<p>Intake</p> <ul style="list-style-type: none"> Measured and recorded appropriately—what the patient takes IN— Includes: Oral intake i.e. frequency and length of breastfeeding sessions or frequency and volume of formula feeding; NG or OG feeding; or IV fluid intake. <p>Output</p> <ul style="list-style-type: none"> Age in hours of first void and stool provided Measured and recorded appropriately—what the client puts OUT Includes: urine, stool, drains/tubes, emesis, etc. 	<p>All of the key components of the intake and output were addressed.</p> <p>Student demonstrates an understanding of intake and output.</p>	<p>One of the key components of the intake and output is missing.</p> <p>Difficult to determine if the student has a thorough understanding of the intake and output.</p>	<p>Student did not complete this section</p>	
Laboratory /Diagnostic Data	15 Points	5-14 Points	4-0 Points	Points/ Comments
<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. <p>Laboratory Data</p> <ul style="list-style-type: none"> Admission Values Most recent Values (the day you saw the patient) Prenatal Values <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.</p> <p>Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.</p>	<p>1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation.</p>	<p>Student did not have an understanding of laboratory</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 client • 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 			<p>values and the abnormalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1</p>
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Current Medications	15 Points	1-14 Points	0 Points	Points/ Comments
<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"> ○ 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"> ○ Example: Assessing client's HR prior to administering a beta-blocker ○ 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 will result in loss of all Points in the section 	<p>All key components were listed for each of the medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.</p>	<p>1 point will be lost for each medication with incomplete information.</p>	<p>There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.</p>	
Physical Exam	25 Points	1-29 Points	0 Points	Points/ Comments
<ul style="list-style-type: none"> ● Gestational Age assessment using Ballard scale ● Completion of a head to toe assessment done on the students own and not copied from the client's chart 	<p>All key components are met including a complete head to toe assessment, safety risk assessment.</p>	<p>One or more of the key components is missing from a given section. Each body system is worth Points as listed on care plan</p>	<p>More than half of the key components are missing. Therefore, it is presumed that the student does not</p>	

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<ul style="list-style-type: none"> • Safety risk assessment • No safety risk assessment will result in a zero for the section 			have a good understanding of the head to toe assessment process.	
Vital Signs	6 Points	3 Points	0 Points	Points/ Comments
Vital signs <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 	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.	Only one set of vital signs were completely recorded and one of the key components were missing	Student did not complete this section	
Pain Assessment	2 Points	1 point	0 Points	Points/ Comments
Pain assessment <ul style="list-style-type: none"> • Pain assessment was addressed and recorded once throughout the care of this client <p>It was recorded appropriately and stated what pain scale was used</p>	All the key components were met (1 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete or not recorded appropriately.	Student did not complete this section	
Summary of Assessment	4 Points	2-0 Points		Points/ Comments
<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 	All the key components of the summary. It is written in a paragraph form, in the student's own words. This is developed in a paragraph format with no less than 5 sentences.			
Nursing Care/Interventions	12 Points	2-0 Points		Points/ Comments

<p>Nursing Interventions</p> <ul style="list-style-type: none"> List the nursing interventions utilized with your client Includes a rationale as to why the intervention is carried out or should be carried out for the client <p>Teaching topics</p> <ul style="list-style-type: none"> List 2 priority teaching items Includes 1 expected outcome for each teaching topic 	<p>All the key components of the summary of care (2 Points) and discharge summary (2 Points) were addressed. Student demonstrated an understanding of the nursing care.</p>		<p>One or more of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.</p>	
<p>Nursing Diagnosis</p>	<p>15 Points</p>	<p>5-14 Points</p>	<p>4-0 Points</p>	<p>Points/ Comments</p>
<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> List 2 nursing diagnosis <ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components Appropriate nursing diagnosis Appropriate rationale for each diagnosis <ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen Minimum of 2 interventions for each diagnosis Rationale for each intervention is required Correct priority of the nursing diagnosis Appropriate evaluation 	<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>One or more of the nursing diagnosis/rationale/intervention sections was incomplete or not appropriate to the patient. Each section is worth 3 Points. Prioritization was not appropriate.</p>	<p>More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.</p>	

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Overall APA format	5 Points	1-4 Points	0 Points	Points/ Comments
APA Format <ul style="list-style-type: none"> The student used appropriate APA in text citations and listed all appropriate references in APA format. Professional writing style and grammar was used in all narrative sections. 	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	
			Poin ts	
- Instructor Comments:		Total Points awarded		
Description of Expectations	/150= %			
	Must achieve 116 pt =77%			

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Hour-Specific Nomogram for Risk Stratification Links

- [Hour-specific nomogram](#)
- [Phototherapy nomogram](#)
- [Exchange nomogram](#)

Hyperbilirubinemia Risk Factors

- TSB/TcB in high-risk zone
- Jaundice in first 24 hours
- ABO incompatibility with positive direct Coombs, known hemolytic disease, or elevated ETCO
- Gestational age 35-36 weeks
- Prior sibling had phototherapy
- Cephalohematoma or bruising
- Exclusive breastfeeding, esp. with poor feeding or weight loss
- East Asian Race

Neurotoxicity Risk Factors

- Isoimmune Hemolytic Disease

- G6PD deficiency

- Asphyxia

- Significant lethargy

- Temperature instability

- Sepsis

- Acidosis

- Albumin < 3.0 g/dL

Infant age **26 hours**

Total bilirubin **5.5 mg/dl**

Risk zone

Low
Intermediate



Risk

Risk zone is one of several risk factors for developing severe hyperbilirubinemia.

Recommended Follow-up

Lower Risk

If discharge age <72 hours, follow-up according to age and other clinical concerns

(>= 38 weeks and well)

Medium Risk

If discharge age <72 hours, follow-up within 48 hours

(>=38 weeks + hyperbili risk factors
OR 35 to 37 6/7 weeks and well)

Higher Risk

If discharge age <72 hours, follow-up within 48 hours, consider TcB/TSB at follow-up

(35 to 37 6/7 weeks and hyperbili risk)

AAP Phototherapy Guidelines (2004)

Lower Risk	No	12 mg/dl
(>= 38 weeks and well)		
Medium Risk	No	10.2 mg/dl
(>=38 weeks + neurotoxicity risk factors OR 35 to 37 6/7 weeks and well)		
Higher Risk	No	8.3 mg/dl
(35 to 37 6/7 weeks and neurotoxicity risk		

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factors)

It is an option to provide conventional phototherapy in the hospital or at home at TSB levels 2-3 mg/dl (35-50 $\mu\text{mol/L}$) below those shown. Home phototherapy should not be used in infants with risk factors.

If phototherapy threshold is exceeded, please also review [AAP Guidelines for Exchange Transfusion](#).