

N432 Newborn Care Plan

Lakeview College of Nursing

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## N432 Newborn Care plan

Instructions: The care plan is to be typed into a WORD document and submitted to the Newborn Dropbox 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 \_\_\_\_\_

<b>Date/time of birth</b> 09/08/19	<b>Patient Initials</b> B.L	<b>Age at time of assessment in hours.</b> 72 hours	<b>Gender</b> Male
<b>Race/Ethnicity</b> Caucasian	<b>Weight at birth</b> (gm)_2850_____  (lb.)_6lb_____ (oz.)_4.5_____	<b>Weight at time of assessment*</b> (gm) 2880  (lb.)_6____ (oz.)_5.58 or 5.6_____	<b>How old was the infant when weighed last (In hours).</b> 48 hours
<b>Length at birth</b> Cm_49.5_____ Inches_19.42 or 19.4_____	<b>Head circumference at birth</b> Cm_35.5_____  Inches_13.98_____	<b>Chest Circumference at birth</b> Cm_31.5_____ Inches12.4	

- 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\_1<sup>st</sup> day of pregnancy\_\_\_\_\_

Abnormal Prenatal labs/diagnostics \_\_ Glucose: 106, MCH: 35.7\_\_\_\_\_

Prenatal complications: Gestational hypertension \_\_\_\_\_

Smoking/Drugs in pregnancy\_\_\_\_None\_\_\_\_\_

**Labor History of Mother**

- Gestation at onset of labor\_11:15 am at 37 weeks and 6 days\_\_\_\_\_
- Length of labor\_11 hours\_\_\_\_\_
- ROM\_6 hours and 27 minutes\_\_\_\_\_
- Medications in labor \_\_N/a\_\_\_\_\_
- Complications of labor & delivery \_\_N/a\_\_\_\_\_

**Family History**

- Pertinent to infant: Gestational hypertension \_\_\_\_\_

**Social History**

- Pertinent to infant \_\_N/a\_\_\_\_\_
- Father/co-parent of baby involvement? \_Yes they are married and live together\_\_\_\_\_
- **Living situation: Live together** \_\_\_\_\_
- **Education level of parents** \_\_\_\_\_

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If applicable to parents' learning barriers or care of infant: College \_\_\_\_\_

**Birth History**

- Length of Second stage labor 1 hour and 24 minutes \_\_\_\_\_
- Type of Delivery: Induced vaginal delivery \_\_\_\_\_
- Complications of birth N/a \_\_\_\_\_
- APGAR scores 1 minute 8 \_\_\_\_\_ 5 minutes 9 \_\_\_\_\_ 10 minutes n/a \_\_\_\_\_
- Resuscitation methods beyond the normal needed: One suctioning \_\_\_\_\_

**FEEDING TECHNIQUES (8 points)**

Feeding technique type: Bottle feeding

If breastfeeding, LATCH score. N/a \_\_\_\_\_

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**). 1.05 \_\_\_\_\_ %  $(2880-2850)/2850 \times 100 = 1.05$

What is normal weight loss for this age infant? under 1.05% \_\_\_\_\_

Is this neonate's wt. loss within normal limits? yes \_\_\_\_\_

**INTAKE AND OUTPUT (8 points)****Intake**

If breastfeeding: feeding frequency, length of feeding session, one or both breasts? N/A \_\_\_\_\_

If bottle feeding: frequency and volume of formula at a session. 45 mL in 30min

If NG or OG feeding: frequency & volume 175 mL \_\_\_\_\_

If IV: then rate of flow and volume in 24 hours 158.5 mL/kg/24 hours \_\_\_\_\_

**Output**

Age (in hours) of first void 6 hours \_\_\_\_\_

Voiding patterns: ( # of times/24 hours) 8 times \_\_\_\_\_

Age (in hours) of first stool 6 hours \_\_\_\_\_

Stools: (type, color, consistency and number of times in 24 hours) moderate, soft, and green 3 times \_\_\_\_\_

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

Name of test	Why was this test ordered for this client? <b>Complete this even if these labs have not been completed.</b>	Client's results	Expected results	Interpretation of this client's results
Blood glucose levels	Gestational mother	64	70-99	Range was 70-99 average mg/dL Blood sugar should go up to normal range with continued breast feeding. (Sorenson, 2019)
Blood type and Rh factor	To find the baby's blood type	A positive		The blood type of the baby is A positive
Coombs test	To check for clonis	Negative	Negative	No Clonis was noted
Bilirubin level (all babies at 24 hours)	To check for bilirubin level in baby	8.8	Ref. range 1-15	Use <a href="http://www.bilitool.org">www.bilitool.org</a> to "plug in" your baby's 24 hour bilirubin level. Discuss baby's risk according to this website. <b>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.</b> Copy and paste the risk factor webpage stating your infant's risk status and include it at the end of this document. The baby bilirubin is not at high risk according to the bilitool
Newborn Screen (at 24 hours)	n/a	Not available until after discharge	passed	n/a
Newborn Hearing Screen	Check the functioning of the baby's ears	passed	n/a	Passed, both hearing should be intact
Newborn Cardiac Screen (at 24	Passed	n/a	The baby passed	Baby's cardiac should be functioning well. No distress or

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hours)				difficulty breathing
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**NEWBORN MEDICATIONS (15 Points)**

<b>Brand/Generic</b>	<b>Aquamephyton (Vitamin K)</b>	<b>Illotycin (Erythromycin ointment)</b>	<b>Hepatitis B Vaccine</b>	<b>n/a</b>	<b>n/a</b>
<b>Dose</b>	<b>1mg</b>	<b>20mg</b>	<b>0.5</b>	<b>n/a</b>	<b>n/a</b>
<b>Frequency</b>			<b>At birth and 6 months apart</b>	<b>n/a</b>	<b>n/a</b>
<b>Route</b>	<b>IV</b>	<b>Both eyes( ophthalmic )</b>	<b>IV</b>	<b>n/a</b>	<b>n/a</b>
<b>Classification</b>	<b>Antidote</b>	<b>Anti-effective</b>	<b>Immunizing agents</b>	<b>n/a</b>	<b>n/a</b>
<b>Mechanism of Action</b>	<b>Helps blood coagulation</b>	<b>Suppresses protein synthesis to prevent bacterial growth</b>	<b>Provides Passive Immunity to Hep B infection</b>	<b>n/a</b>	<b>n/a</b>
<b>Reason Client Taking</b>	<b>Prevention of hemorrhagic disease of the newborn</b>	<b>To prevent pink eye</b>	<b>Fight antibodies of Hep B infection</b>	<b>n/a</b>	<b>n/a</b>
<b>Contraindications (2)</b>	<b>Hypersensitivity/Impaired liver function</b>	<b>Hypersensitivity / concurrent use of pimozone</b>	<b>Hypersensitivity/ Thrombocytopenia</b>	<b>n/a</b>	<b>n/a</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Gastric problems, Rash</b>	<b>Ototoxicity/ Rash</b>		<b>n/a</b>	<b>n/a</b>
<b>Nursing</b>	<b>Monitor prothrombin(PT)</b>	<b>Give drugs as</b>	<b>Redness and</b>	<b>n/a</b>	<b>n/a</b>

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<b>Considerations (2)</b>	<b>prior to &amp; throughout Vitamin K therapy Monitor B/P</b>	<b>directed/ May obtain specimen for culture and sensitivity before initiating therapy</b>	<b>injection site/ Fever</b>		
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	<b>PT, blood pressure, and Pulse prior to administration</b>	<b>Monitor for any allergic reactions/ monitor for bowel problems</b>	<b>Monitor for allergic reaction/ Epinephrine and antihistamines may be prescribed by provider for anaphylactic reactions to the vaccine</b>	<b>n/a</b>	<b>n/a</b>
<b>Client Teaching needs (2)</b>	<b>Educate about the need for a provider follow up exam to evaluate progress. Follow exam education on signs and symptoms related to excessive coagulation</b>	<b>Larger doses can lead to second infection/ Wash hands before and after administration</b>	<b>Monitor for allergic reaction. Take vitals- B/P, respirations, pulse, temp/ skin assessment to check for rash</b>	<b>n/a</b>	<b>n/a</b>

Reference: Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Daviss drug guide for nurses*. Philadelphia: F.A. Davis Company.

**VITAL SIGNS (6 points)**

Vital Signs at Birth

T\_98 degree F \_\_\_\_\_

P\_160 \_\_\_\_\_

R\_40 \_\_\_\_\_

Vital signs 4 hours after birth

T\_98.8 degree F \_\_\_\_\_

P\_164 \_\_\_\_\_

R\_52 \_\_\_\_\_

At the time of your Assessment

T\_98 \_\_\_\_\_

P\_154 \_\_\_\_\_

R\_44 \_\_\_\_\_

**The baby's pulses went down during my assessment time but the temperature stay the same.**

**NEWBORN ASSESSMENT (25 Points)**

<b>Area</b>	<b>Your Assessment</b>	<b>Expected Variations And Findings</b> (This can be found in your book p.645)	<b>If assessment finding different from expectation what is the clinical significance?</b>
Skin		Warm, good skin color, no	

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	Normal color, no jaundice or rash	jaundice, good skin turgor	
Head	Head circumference was 35 cm Head circumference was 35 cm	SGA, LGA, preterm post term	
Fontanel	Posterior fontanelles normal size, Anterior fontanelle open, soft, and flat.	Fontanelles were firm and slightly curved inward	
Face	Molding 2-3+ with significant caput present. Large area of moderate superficial bruising over the occipital scalp	Normal defined features are WDL	Molding are normal in newborn
Eyes	Normal set, pupils equal, red reflexes present bilateral	Normal, clear, no drainage	
Nose	Nares patent, no septal deviation	Normal no deviation or displacement noted	
Mouth	Oral mucosa moist, palate normal shaped and intact	Lips are equal to defined placement on the face	
Ears	Normally set with patent canals	No abnormalities- soft, normal color and presence	
Neck	Supple, without masses, clavicles are intact to palpation	Normal alignment to the midline area of the body	
Chest	Normal equal bilateral size, no deviations	WDL	

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Breath sounds	Coarse bilateral breath sounds. Air entry 3/4	Bilateral breath sounds are intact	
Heart sounds	RRR, S1 and S2 normal, no gallops. Equal breaths sounds	Femoral pulses normal extremities	
Abdomen	Soft, non-tender. Non-distended	Palpated umbilical cord w/ 3 vessels/ protuberant contour- soft	
Bowel sounds	Normoactive in all 4 quadrants	Bowel sounds normal in all quadrants	
Umbilical cord	Dry normal color with no odor- 3 vessels seen	3 vessels confirmed	
Genitals	Term uncircumcised external genital within normal	WDL	
Anus	Appear patent	WNL x 3 since birth	
Extremities	Full range of ROM to all extremities. No joints abnormalities	Symmetrical and flexible with movement no restrictions	
Spine	Normal curvatures within spinal column	Normal aligned straight with proper form	
Safety Matching bands with parents Hugs tag Sleep position	Matching ID tags and number confirmed- baby resting comfortably.	Matching ID tags and number confirmed	

Reference: Ricci, S., Carman, S. and Kyle T. (2017). *Maternity and Pediatric Nursing*. 3<sup>rd</sup> ed. Philadelphia: Wolters Kluwer

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? \_\_AGA. The baby's weight, length and head circumference were between 10-90<sup>th</sup> percentile, which mean the baby was growing normally \_\_\_\_\_

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

\_\_Newborn is within normal limits for his gestational age so there aren't any complications\_\_\_\_\_

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**PAIN ASSESSMENT ( 2 Points)**

Pain Assessment including which pain scale you have used. Normal Infant Pain scale / Faces Legs Activity Consolability Revised Scale \_Pain was 0 No pain was expressed during examination. Newborn remained calm and slept through most of the assessment. Newborn was flexible and was able to be moved without discomfort of distress\_\_\_\_\_

UW Health. (2019). Using Pediatric Pain Scales Neonatal Infant Pain Scale (NIPS) [online] Available at <https://www.uwhealth.org/healthfacts/parenting/7711.pdf> [Accessed 14 August 2019]

**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 09/08/19 at 11:15 by normal spontaneous vaginal delivery (NSVD). Nuchal card x 1. Apgar scores 8/9. EDD 5.10.14 by US. Dubowitz revealed neonate is 37 weeks and AGA. Birth weight 6lbs 5.6ozs (2880 grams), long (49.5cms). Upon assessment all systems are within normal limits. Last set of vitals: 98/154/44.. Neonate is bottle feeding and nursing well with most feedings. Bilirubin level at 24 hours per scan was 8.8. Baby is nursing and sleeping well with no signs of distress. Neonate expected to be discharged with mother later this week with mother. Mother will be expected to follow up with pediatrician in the office for first well baby check within 48 hours of discharge from the hospital.

**NURSING CARE/INTERVENTIONS (12 Points)**

Teaching Topics (5 points)

*Include how you would teach the information & an expected outcome*

1. Baby Hygiene
2. Vitals

Nursing Interventions (5 points)

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

Nursing Interventions: Educate parents on proper techniques in regard to bathing and cleansing baby. Parents to repeat demonstration back to nurse.

Medical Treatments: Nurse will demonstrate and bath newborn with hygiene purposes and techniques to ensure proper care/and thermoregulation. Additional tools such as information packet below could be taken home.

2. Nursing interventions: Check vital signs every hour, monitor baby for any abnormalities that may occur such as jaundice or discomfort.

Medical treatments: Baby to be monitored hourly to ensure stable vital signs with proper swaddling, skin to skin with mom, and breastfeeding.

Johns Hopkins. (2019). *TakingBaby Home* [online] Available at: [https://www.hopkinsmedicine.org/howard\\_county\\_general\\_hospital/services/mothers\\_and\\_babies/taking\\_baby\\_home/baby-hygiene.html](https://www.hopkinsmedicine.org/howard_county_general_hospital/services/mothers_and_babies/taking_baby_home/baby-hygiene.html) [Accessed 14 August 2019].

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**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.</p> <p>Then write what you would do next.</p>
<p><b>Diagnosis 1.</b></p> <p><b>Deficient knowledge related to lack of exposure to information as evidence by request for information</b></p>	<p>Mother will verbalize understanding of the cause, treatment, and possible outcomes of hyperbilirubinemia            Mother will identify signs/symptoms            Mother will demonstrates appropriate care of infant</p>	<ul style="list-style-type: none"> <li>-Provide information about type of jaundice,</li> <li>-pathophysiological factors and future implications of hyperbilirubinemia.</li> <li>-Encourage to ask questions, reinforce or clarify information as needed</li> <li>-Diffused exposure to sunlight and follow up serum testing program</li> <li>-Demonstrate means of assessing infant for increasing bilirubin level( blanching the skin with digital pressure to reveal the color of skin, weight monitoring, or behavioral changes)</li> <li>-Discuss possible long-term effects of hyperbilirubinemia and the need for continued assessment and early intervention</li> </ul>	<p><b>Met/Not Met? Patient's goals are being met</b></p> <p><b>Why? Baby's mother showed interested in learning about the information that were provided to her. Mother will continue skin to skin with baby to promote bonding.</b></p>

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			<b>What next? Keep breastfeeding baby as needed. Ask mother to call if she has any questions for us</b>
<b>Diagnosis 2.</b> <b>Ineffective breastfeeding related to normal</b>	Mother will express physical and psychological comfort in breastfeeding practice and techniques Mother will show decreased anxiety and apprehension Nurse will sate at least one resource for breastfeeding support	-Monitor effectiveness of current breastfeeding efforts -Determine support systems available to mother/family -Identify cultural beliefs/ practices regarding lactation, letdown techniques, maternal food preferences -Assess mother's knowledge and previous experiences with breastfeeding -Encourage mother to drink at least 2000mL of fluid per day or 6 to 8 oz every hour	<b>Met/Not Met? Patient's goals are being met. Mother was practicing new ways to make baby comfortable so the baby can get used to being breastfed</b>  <b>Why? Goals were met because mother was doing everything right to make the baby comfortable</b>  <b>What next? Hygiene instruction given to promote clean latch pf newborn and protect mother and baby from skin breakdown</b>

Swearington, P. (2018). *All in One Nursing Care Planning Resource*. [S.I.]: Mosby. St. Louis, Missouri: Mosby, Inc.

## References:

Johns Hopkins. (2019). TakingBaby Home [online] Available at:

[https://www.hopkinsmedicine.org/howard\\_county\\_general\\_hospital/services/mothers\\_and\\_babies/taking\\_baby\\_home/baby-hygiene.html](https://www.hopkinsmedicine.org/howard_county_general_hospital/services/mothers_and_babies/taking_baby_home/baby-hygiene.html) [Accessed 09/14/ 2019].

Swearington, P. (2018). *All in One Nursing Care Planning Resource*. [S.I.]: Mosby. St. Louis, Missouri: Mosby, Inc.

Ricci, S., Carman, S. and Kyle T. (2017). *Maternity and Pediatric Nursing*. 3<sup>rd</sup> ed. Philadelphia: Wolters Kluwer

UW Health. (2019). Using Pediatric Pain Scales Neonatal Infant Pain Scale (NIPS) [online] Available at

<https://www.uwhealth.org/healthfacts/parenting/7711.pdf>

[Accessed September 14, 2019]

Sorenson, M., Quinn, L., Klien, D. (2019). *Pathophysiology: concepts of human disease*. Hoboken, Nj: Pearson, Education, Inc.

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Daviss drug guide for nurses*. Philadelphia: F.A. Davis Company.

**Ballard Gestational Age scale**

**Neuromuscular Maturity**

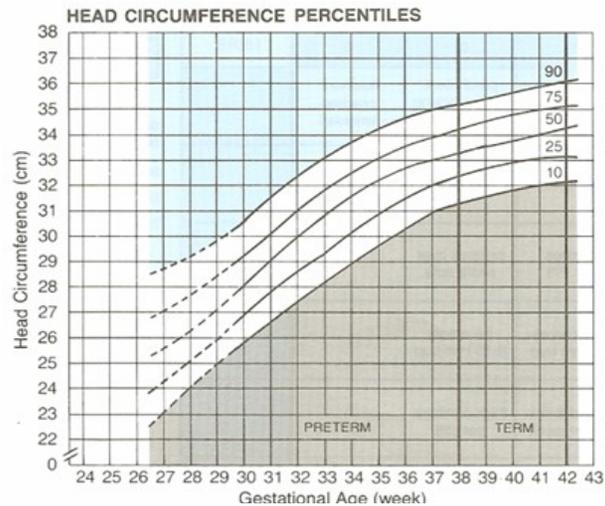
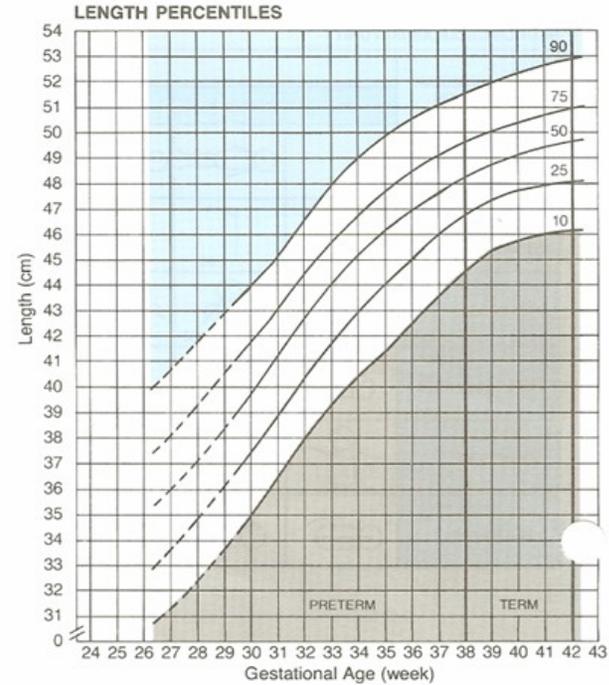
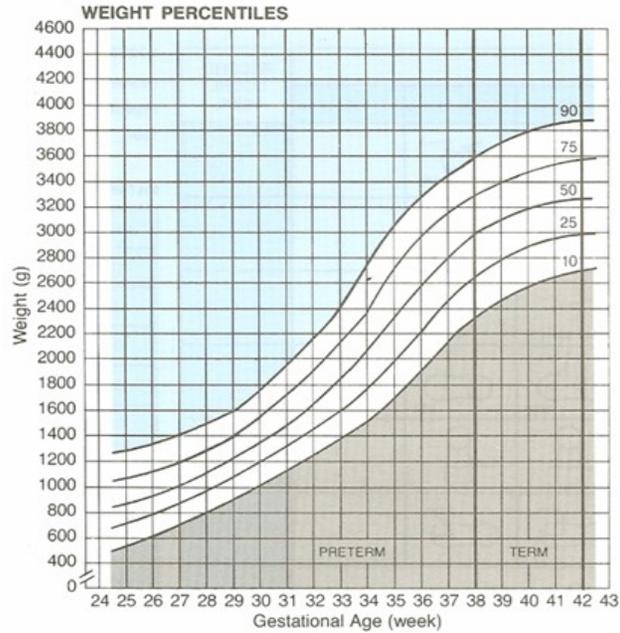
Score	-1	0	1	2	3	4	5
Posture							
Square window (wrist)							
Arm recoil							
Popliteal angle							
Scarf sign							
Heel to ear							

**Physical Maturity**

<b>Skin</b>	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
<b>Lanugo</b>	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	<b>Maturity Rating</b>
<b>Plantar surface</b>	Heel-toe 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	
<b>Breast</b>	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
<b>Eye/Ear</b>	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
<b>Genitals (male)</b>	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
<b>Genitals (female)</b>	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

**CLASSIFICATION OF NEWBORNS (BOTH SEXES)  
BY INTRAUTERINE GROWTH AND GESTATIONAL AGE <sup>1,2</sup>**

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.

**N305 Care Plan Grading Rubric: Newborn**

Student Name:

<b>Demographics</b>	<b>10 Points</b>	<b>5 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Demographics</b> <ul style="list-style-type: none"> <li>• Date/time of clinical assessment</li> <li>• Date &amp; time of birth</li> <li>• Patient initials</li> <li>• Age in hours at clinical assessment</li> <li>• Gender</li> <li>• Race/Ethnicity</li> <li>• Weight at birth and at time of assessment</li> <li>• Length at birth</li> <li>• Head circumference at birth</li> <li>• Chest circumference at birth</li> </ul>	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 not filled in correctly and therefore no Points were awarded for this section	
<b>Mother/Family Medical History</b>	<b>15 Points</b>	<b>10 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Prenatal History of the mother</b> When Prenatal care started Abnormal Prenatal labs/diagnostics Prenatal complications Smoking/Drugs in pregnancy <b>Labor History of Mother</b> <ul style="list-style-type: none"> <li>• Gestation at onset of labor</li> <li>• Length of labor</li> <li>• ROM</li> <li>• Medications in labor</li> <li>• Complications of labor &amp; delivery</li> </ul> <b>Past Surgical History</b> <ul style="list-style-type: none"> <li>• All previous surgeries should be listed</li> </ul> <b>Family History</b> <ul style="list-style-type: none"> <li>• Pertinent to infant</li> </ul> <b>Social History</b> <ul style="list-style-type: none"> <li>• Pertinent to infant</li> <li>• Father of baby involvement</li> </ul>	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	

<b>Living situation</b> <b>Education level</b> <ul style="list-style-type: none"> <li>If applicable to parents' learning barriers or care of infant</li> </ul>				
<b>Birth History</b>	<b>10 Points</b>	<b>5 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Birth History</b> <ul style="list-style-type: none"> <li>Length of second stage labor</li> <li>Complications of birth</li> <li>APGAR scores</li> <li>Resuscitation methods beyond the <i>normal needed</i></li> </ul>	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.	
<b>Feedings techniques</b>	<b>8 Points</b>	<b>4 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Latch score assessment</b>  <b>Bottle feeding technique assessment</b>  Weight loss calculation	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.	
<b>Intake and Output</b>	<b>8 Points</b>	<b>1-7 Points</b>	<b>0 Points</b>	<b>Points/Comments</b>
<b>Intake</b> <ul style="list-style-type: none"> <li>Measured and recorded appropriately—what the patient takes IN—</li> <li>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.</li> </ul> <b>Output</b> <ul style="list-style-type: none"> <li>Age in hours of first void and stool</li> </ul>	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.	One of the key components of the intake and output is missing. Difficult to determine if the student has a thorough understanding of the intake and output.	Student did not complete this section	

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<p>provided</p> <ul style="list-style-type: none"> <li>• Measured and recorded appropriately—what the client puts OUT</li> <li>• Includes: urine, stool, drains/tubes, emesis, etc.</li> </ul>				
<b>Laboratory /Diagnostic Data</b>	<b>15 Points</b>	<b>5-14 Points</b>	<b>4-0 Points</b>	<b>Points/ Comments</b>
<p><b>Normal Values</b></p> <ul style="list-style-type: none"> <li>• Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide.</li> <li>• Normal values should be listed for all laboratory data.</li> </ul> <p><b>Laboratory Data</b></p> <ul style="list-style-type: none"> <li>• Admission Values</li> <li>• Most recent Values (the day you saw the patient)</li> <li>• Prenatal Values</li> </ul> <p><b>Rational for abnormal values</b></p> <ul style="list-style-type: none"> <li>• Written in complete sentences with APA citations</li> <li>• Explanation of the laboratory abnormality in this client</li> <li>• For example, elevated WBC in patient with pneumonia is on antibiotics.</li> <li>• Minimum of 1 APA reference, no reference will result in zero Points for this section</li> </ul>	<p>All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities. 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 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 reference.</p>	
<b>Current Medications</b>	<b>15 Points</b>	<b>1-14 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<p><b>Current Medications</b></p> <ul style="list-style-type: none"> <li>• Requirements of all inpatient hospital medications given to</li> </ul>	<p>All key components were listed for</p>	<p>1 point will be lost for each medication with incomplete</p>	<p>There was noted lack of effort on the student's</p>	

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<p>the newborn</p> <ul style="list-style-type: none"> <li>• Each medication must have brand/generic name</li> <li>• Dosage, frequency, route given, class of drug and the action of the drug</li> <li>• Reason client taking</li> <li>• 2 contraindications must be listed <ul style="list-style-type: none"> <li>◦ Must be pertinent to your patient</li> </ul> </li> <li>• 2 side effects or adverse effects</li> <li>• 2 nursing considerations</li> <li>• Key nursing assessment(s)/lab(s) prior to administration <ul style="list-style-type: none"> <li>◦ Example: Assessing client's HR prior to administering a beta-blocker</li> <li>◦ Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin</li> </ul> </li> <li>• 2 client teaching needs</li> <li>• Minimum of 1 APA citation, no citation will result in loss of all Points in the section</li> </ul>	<p>each of the medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.</p>	<p>information.</p>	<p>part to complete this section or there was no APA citation listed.</p>	
<b>Physical Exam</b>	<b>25 Points</b>	<b>1-29 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<ul style="list-style-type: none"> <li>• Gestational Age assessment using Ballard scale</li> <li>• Completion of a head to toe assessment done on the students own and not copied from the client's chart</li> <li>• Safety risk assessment</li> <li>• <b>No safety risk assessment will result in a zero for the section</b></li> </ul>	<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 have a good understanding of the head to</p>	

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			toe assessment process.	
<b>Vital Signs</b>	<b>6 Points</b>	<b>3 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Vital signs</b> <ul style="list-style-type: none"> <li>3 sets of vital signs are recorded with the appropriate labels attached</li> <li>Includes a set at birth, 4 hours after birth and at the time of your assessment.</li> <li>Student highlighted the abnormal vital signs</li> <li>Student wrote a summary of the vital sign trends</li> </ul>	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	
<b>Pain Assessment</b>	<b>2 Points</b>	<b>1 point</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>Pain assessment</b> <ul style="list-style-type: none"> <li>Pain assessment was addressed and recorded once throughout the care of this client</li> </ul> It was recorded appropriately and stated what pain scale was used	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	
<b>Summary of Assessment</b>	<b>4 Points</b>	<b>2-0 Points</b>		<b>Points/ Comments</b>
<ul style="list-style-type: none"> <li>Discussion of the clinical significance of the assessment findings</li> <li>Written in a paragraph form with no less than 5 sentences</li> </ul>	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.			
<b>Nursing Care/Interventions</b>	<b>12 Points</b>	<b>2-0 Points</b>		<b>Points/ Comments</b>
<b>Nursing Interventions</b> <ul style="list-style-type: none"> <li>List the nursing interventions utilized with your client</li> <li>Includes a rationale as to why the intervention is carried out or should be carried out for the</li> </ul>	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.	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.		

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client <b>Teaching topics</b> <ul style="list-style-type: none"> <li>List 2 priority teaching items</li> <li>Includes 1 expected outcome for each teaching topic</li> </ul>				
<b>Nursing Diagnosis</b>	<b>15 Points</b>	<b>5-14 Points</b>	<b>4-0 Points</b>	<b>Points/ Comments</b>
<b>Nursing Diagnosis</b> <ul style="list-style-type: none"> <li>List 2 nursing diagnosis             <ul style="list-style-type: none"> <li>Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul> </li> <li>Appropriate nursing diagnosis</li> <li>Appropriate rationale for each diagnosis             <ul style="list-style-type: none"> <li>Explain why the nursing diagnosis was chosen</li> </ul> </li> <li>Minimum of 2 interventions for each diagnosis</li> <li>Rationale for each intervention is required</li> <li>Correct priority of the nursing diagnosis</li> <li>Appropriate evaluation</li> </ul>	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient. Each section is worth 3 Points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	
<b>Overall APA format</b>	<b>5 Points</b>	<b>1-4 Points</b>	<b>0 Points</b>	<b>Points/ Comments</b>
<b>APA Format</b> <ul style="list-style-type: none"> <li>The student used appropriate APA in text citations and listed all appropriate references in APA format.</li> <li>Professional writing style and grammar was used in all</li> </ul>	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	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

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narrative sections.		was used. Content was difficult to understand.		
			<b>Points</b>	
- Instructor Comments:	<b>Total Points awarded</b>			
<b>Description of Expectations</b>	<b>/150=      %</b>			
	<b>Must achieve 116 pt =77%</b>			