N432 Newborn Care Plan 1

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 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_____9/25/19 0730_____

Date/time of birth 9/23/19 12:11	**Patient Initials** AH	**Age at time of assessment in hours.** 44 Hours	**Gender** Male
Race/Ethnicity Caucasian	**Weight at birth** (gm)____3076_____ (lb.)__6____ (oz.)__13___	**Weight at time of assessment*** (gm)____3027_____ (lb.)___6___ (oz.)_67____	**How old was the infant when weighed last (In hours).** 9/25/19 0415 44 Hours
Length at birth Cm___52.07_____ Inches__20.50_____	**Head circumference at birth** Cm___34_____ Inches__13.39_____	**Chest Circumference at birth** Cm____31____ Inches___12.20_____	

- **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: G4 P3 003

When Prenatal care started_9/23/19 0829_____
Abnormal Prenatal labs/diagnostics ___No abnormal prenatal lab/diagnostics_____
Prenatal complications: Cord Prolapse upon delivery resulted in emergent cesarean section_____
Smoking/Drugs in pregnancy: Patient denies smoking and drug use during pregnancy_____

Labor History of Mother

- Gestation at onset of labor__39 weeks 2 days_____
- Length of labor_104 minutes_____
- ROM__1027_____
- Medications in labor: Propofol, Emulsion, succinylcholine, phenylephrine oxytocin, ondansetron, morphine
- Complications of labor & delivery: Cord prolapse during labor resulted in emergent cesarean section_____

Family History

- Pertinent to infant_ __Mother has history of asthma, diabetes mellitus, stroke, epilepsy_____

Social History

- Pertinent to infant_ No pertinent information to infant _____
- Father/co-parent of baby involvement? __Yes_____
- **Living situation:** Lives with other children and father of the baby_____

- **Education level of parents**
  If applicable to parents' learning barriers or care: Information not available. _____

Birth History

- **Length of Second stage labor** Did not have access to this information in chart_____
- **Type of Delivery** Primary cesarean section_____
- **Complications of birth:** Cord Prolapse_____
- **APGAR scores__1 minute__7_____5 minutes_____9____10 minutes:** Information not charted____
- **Resuscitation methods beyond the normal needed**: Suction_____

FEEDING TECHNIQUES (8 points)

Feeding technique type: Breastfeeding_____

If breastfeeding, LATCH score. _____6 – Repeated attempts, newborn grasp breast, takes a few sucks then lets go_____

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**). __-1.59_____% birthweight (3076) – assessment weight (3027) = 49 divided by birthweight (3076) = 0.01592 x100 =1.59% weight loss

What is normal weight loss for this age infant? _10%_____

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? _25mL of mom's milk, left breast, feeds as long as baby tolerates_____

If bottle feeding: frequency and volume of formula at a session. _____NA_____

If NG or OG feeding: frequency & volume: NA_____

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)___yellow in color, 2 times in first 24 hours, first void at 1810 9/23/19_____

*Age (in hours) of first stool*____24 hours_____
Stools: (type, color, consistency and number of times in 24 hours) _____black in color, meconium, 1x, 0002 9/24_____

NEWBORN LABS AND DIAGNOSTICS TESTS (15 Points)

Highlight All Abnormal Lab results.

Name of test	**Why was this test ordered for *this* client? Complete this even if these labs have not been completed.**	**Client's results**	**Expected results**	***Interpretation of* this *client's results***
Blood glucose levels	Not ordered, newborn is stable. Blood glucose levels may be ordered if the mother had poor nutrition or uncontrolled diabetes. Another reason this may be drawn is if the mother and baby had incompatible blood types (Stanford Children's Health, 2018).	NA	45-125 (Stanford Children's Health, 2018).	NA
Blood type and Rh factor	Blood type and Rh factor are ordered to determine the compatibility of the mother and baby's blood. This was ordered for this patient as it is a routine assessment for all newborns to determine any risks associated with it (Stanford Children's Health, 2018).	O-	O-	The mother and her baby have compatible blood, resulting in no Rh disease.
Coombs test	Test not ordered. A Coombs test is performed in the presence of jaundice in the baby. It assesses foreign antibodies that may be on red blood	NA	Negative (Stanford Children's Health, 2018).	NA

	cells causing cell lysis. It also assesses the potential of hyperbilirubinemia and anemia in neonates (Stanford Children's Health, 2018).			
Bilirubin level (all babies at 24 hours)	This test was ordered for the patient to assess how much bilirubin is in the blood. It can determine if red blood cells are breaking down correctly and that liver function is not impaired. Although the neonate was not jaundice, it was ordered as a routine blood draw to determine the risk of the patient developing hyperbilirubinemia (Stanford Children's Health, 2018).	4.3 mg/dl Low Risk	Low risk for developing severe hyperbilirubinemia	Low risk for developing severe hyperbilirubinemia. Risks include: gestational age between 38-39 weeks, male gender, TSB or TcB level in low risk zone, discharge from hospital after 72 hours (Management of Hyperbilirubinemia I the Newborn Infant 35 or More Weeks of Gestation, 2004).
Newborn Screen (at 24 hours)	Newborn screening collected at 9/24/19 at 1345. This screening was done to the patient to screen for serious conditions via a heel stick blood sample. This is a routine assessment to prevent the development of the condition and treat earl if necessary (Stanford Children's Health, 2018).	Not available until after discharge	Negative for any conditions (Stanford Children's Health, 2018).	Newborn is at no serious risk of harmful diseases.
Newborn Hearing Screen	Newborn screening collected at 9/24/19. The hearing test was done to the patient to assess for any hearing abnormalities and	Pass Left Pass Right	Pass left Pass right (Stanford Children's Health, 2018).	Newborn has no hearing abnormalities and is developing normally.

	evaluate the development of their range. This is a routine assessment to prevent the development of the condition and treat earl if necessary (Stanford Children's Health, 2018).			
Newborn Cardiac Screen **(**at 24 hours)	Newborn screening collected at 9/24/19. This is a routine assessment to prevent the development of the condition and treat earl if necessary (Stanford Children's Health, 2018).	Pass Right Foot: 100 Right Hand: 100	Pass > 95% in right hand and right food and <3% difference Fail sp02 of 90% in right hand and right foot (Stanford Children's Health, 2018).	Newborn has no cardiac defects and effective oxygen perfusion.

NEWBORN MEDICATIONS (15 Points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin ointment)	Hepatitis B Vaccine	Zinc Oxide	No other medications prescribed
Dose	1mg=0.5mL	0.25 in in both eyes	10mcg = 0.5mL	1 gram	NA
Frequency	once	once	Once	PRN	NA
Route	IM	Ophthalmic	IM	Topical	NA
Classification	Fat-Soluble Vitamin	Anti-Infective Macrolide	Immune Globulins Vaccination	Protectant agent	NA
Mechanism of Action	Hepatic synthesis of blood coagulation factors II (Prothrombin), VII, IX, and X	Suppresses protein synthesis at the level of 50S bacterial ribosome. Active against	An immune gamma-globulin fraction containing high titers of antibodies to the hepatitis B surface antigen. Confers	Promoted healing of the skin by providing a protective barrier from chafing, has	NA

	(Ciccone, 2018).	gram positive cocci and gram-positive bacilli (Ciccone, 2018).	passive immunity to hepatitis B infection (Ciccone, 2018).	antiseptic properties (Zinc Oxide Topical, 2018).	
Reason Client Taking	Prevents hemorrhagic disease of newborn	Treat bacterial eye infection	Immunization against Hepatitis B	Diaper rash	NA
Contraindications (2)	Hypersensitivity Liver impairment	Allergy Viral infection of eye	Immunocompromised Cancer Febrile	Allergy to Zinc Oxide Allergy to petroleum Jelly	NA
Side Effects/Adverse Reactions (2)	Facial flushing Gastric Upset	Eye redness Mild irritation	Weakness Pruritus	No reports of side effects	NA
Nursing Considerations (2)	Apply pressure to venipuncture site for 5 minutes after injection Monitor for blood in stool, urine, and unusual bleeding	Assess for eye infection Monitor bowel function such as diarrhea or bloody stools	Administer into anterolateral thigh Monitor respirations Shake well before use Assess for signs of anaphylaxis	Do not use around eyes Put on for each dry diaper and keep diaper area clean and dry	NA
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Asses allergy Assess vitals Q15 minutes in first hour Determine	Tilt head and pull down on lower lid. Do not contaminate the lid	Epinephrine available and ready to use prior to administering vaccine Monitor antibody levels	Assess skin for any lesions, redness, or warmth Assess urine	NA

	coagulation labs	Monitor liver function test and CBC		color and odor for baseline before applying	
Client Teaching needs (2)	Call doctor if unusual bleeding occurs or if bruising on skin Call doctor if trouble breathing or has weak, rapid pulse	Call doctor if pain, swelling, discomfort, or fever occurs Call doctor if yellow discoloration of the skin or eyes occurs	Call doctor if site is red and swollen and accompanies by facial flushing, wheezing, and vomiting Call doctor if infant has difficulty breathing	Discontinue if rash becomes red and blisters or if fever, diarrhea, or strong urine occurs Apply with each diaper change and keep diaper area clean and dry	NA

VITAL SIGNS (6 points)

Vital Signs at Birth
T_36.2_____
P__178_____
R__63_____

Vital signs 4 hours after birth
T___36.5_____
P___115_____
R_____30_____

At the time of your Assessment
T__36.2_____
P__ 150_____
R___50_____

NEWBORN ASSESSMENT (25 Points)

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	Pink, well profuse, No jaundice, cyanosis or rash, normal capillary refill of <2 seconds, no edema	Normal: smooth, flexible, good skin turgor, warm <2 second capillary refill	Assessment findings meet the expectations.
Head	Normocephalic, anterior fontanel open, soft, flat, no	Normocephalic, varies with age, gender, ethnicity	Assessment findings meet the expectations.

	masses		
Fontanels	Anterior fontanel open, soft, flat	Anterior fontanel open, soft, flat (Ricci et al., 2017)	Assessment findings meet the expectations.
Face	No anomalies noted, awake, alert, vigorous, good tone	Normal: full cheeks, facial features symmetric (Ricci et al., 2017)	Assessment findings meet the expectations.
Eyes	Normal in size and patient, no conjunctivitis, pupils respond to light, red reflex bilaterally	Normal: clear and symmetric on face (Ricci et al., 2017)	Assessment findings meet the expectations.
Nose	Normal in size and patient, no nasal flaring, nares patent bilaterally	Normal: small, placement in the midline and narrow, ability to smell (Ricci et al., 2017)	Assessment findings meet the expectations.
Mouth	Oral cavity and tongue normal, no cleft or lip palate, no natal teeth	Normal: aligned in midline, symmetric, intact soft and hard palate (Ricci et al., 2017)	Assessment findings meet the expectations.
Ears	Normal in patient and shape, external canals present, no ear pits or tags	Normal: clear and symmetrically located, soft and pliable with a quick recoil when folded and released (Ricci et al., 2017)	Assessment findings meet the expectations.
Neck	Normal, no masses, no torticollis	Normal: short, creased, moves freely, baby holds head midline (Ricci et al., 2017)	Assessment findings meet the expectations.
Chest	Symmetrical, clavicles intact	Normal: round, symmetric, smaller than head (Ricci et al., 2017)	Assessment findings meet the expectations.
Breath sounds	No rhonchi, normal respiratory effort, no grunting, nasal flares, retraction	Normal: clear breath sounds absent of rhonchi, normal respiratory effort (Ricci et al., 2017)	Assessment findings meet the expectations.
Heart sounds	Regular respiratory and rate, normal S1S2	Normal rate and rhythm, no murmurs or gallops, S1S2 sounds noted (Ricci et al., 2017)	Assessment findings meet the expectations.
Abdomen	Soft, nondistended, color is normal, no masses	Normal: protuberant contour, soft, three vessels in umbilical cord (Ricci et al., 2017)	Assessment findings meet the expectations.
Bowel sounds	Normal, active in all 4 quadrants, normal stool and void	Present in all four quadrants (Ricci et al., 2017)	Assessment findings meet the expectations.
Umbilical cord	Drying, normal	Three vessels, dry (Ricci et	Assessment findings

		al., 2017)	meet the expectations.
Genitals	Tanner 1 male, normal for gestation age, tested descended bilaterally, plast-bell intact	Normal male: smooth glans, meatus centered a tip of penis (Ricci et al., 2017)	Assessment findings meet the expectations.
Anus	Patent and normally positioned	Patent, positioned midline of body (Ricci et al., 2017)	Assessment findings meet the expectations.
Extremities	Normal upper and lower extremities, normal number of digits, normal hands, hips normal and symmetrical	Normal: extremities symmetric with free movement (Ricci et al., 2017)	Assessment findings meet the expectations.
Spine	Normally formed, sacral pit closed	Normal: sacral pit closed (Ricci et al., 2017)	Assessment findings meet the expectations.
Safety Matching bands with parents Hugs tag Sleep position	Matching bands with parents, hugs tag on right lower ankle, sleep position supine	Sleep supine, matching bands (Ricci et al., 2017)	Assessment findings meet the expectations.

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 neonate weights between 2500g and 4000 g at full term and is between the 10th and 90th percentile. _

Are there any complications expected for a baby in this classification? (Discuss)
__None –appropriate gestational age _____

PAIN ASSESSMENT (2 Points)

Pain Assessment including which pain scale you have used: FLACC score 0_____

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.

Newborn male delivered via stat cesarean section for prolapsed cord at 39 weeks and 2 days gestation to 22-year-old G4 now P4 mother. Initial assessment indicated the patient's skin is pink in color, head normocephalic fontanelles and sutures, eyes normal, nostrils equal, strong suck and good cry, responsive to sound and movement. Baby was in breech wen mom arrived at hospital on 9/23/19. External version performed successfully. Range of motion performed at 1027 9/23. Baby delivered at 1211 Apgar's 7 and 9. Birth weight 2076 grams. Upon assessment all systems are within normal limits. Last vitals at 36.2C/152/50. BSx4. Neonate breastfeeding. Bilirubin 4.3. Neonate expected be discharged with mom tomorrow and see PCP for first well baby check within 48 hours.

NURSING CARE/INTERVENTIONS (12 Points)

Teaching Topics (5 points)

Include how you would teach the information & an expected outcome

1. Instruction on the topic of circumcision care would be through the method of verbal instruction. The outcome is that the patient understands that Vaseline needs to be applied with each diaper change to prevent breaking off the skin. The newborn will remain free of pain and infection.

2. Instruction on the topic of rear facing infant only car seat would be through method of verbal instructions. The outcome is that the client understands how to properly install car seat into car and buckle neonate in to prevent injury. The application will be assessed and approved if correctly positioned.

Nursing Interventions (5 points)

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

Nursing Interventions: Vital signs of the neonate were obtained twice before discharge papers started to ensure he was healthy enough to go home. An assessment of the baby and mother were performed to ensure that each were healthy and responding appropriately postpartum.

Medical Treatments: No medical interventions were done by the student nurse as the patient was preparing for discharge.

PRIORITY NEWBORN NURSING DIAGNOSES (15 Points)

Identified Problem or potential problem	Expected Outcomes/Goals	Interventions	Goals/Outcomes Met/Not Met
Identify problems that are	Include an expected outcome for each	Include 3-5 interventions for each problem.	Include whether the goal/outcome has

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)	**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..**	**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.**	**been met or not met and why.** **Then write what you would do next.**
Diagnosis 1. Risk for ineffective thermoregulation related to immature temperature control and decreased subcutaneous fat as evidenced by axillary temperature of 36.2 degrees Celsius (Swearingen, 2016, p. 166)	The newborn's body temperature will remain stable between the ranges of 36.5-37 degrees Celsius. The parents will be able to verbalize an understanding of interventions to prevent cold stress on the baby by discharge.	1. Monitor body temperature and vital signs every 8 hours via axillary temperature. Rationale: Frequent assessment of thermoregulation will identify trends of improvement. The axillary location has the best indicator of body temperature in newborns (Swearingen, 2016, p. 166). 2. Assess need for warming incubator, skin to skin contact or swaddling. Rationale: Skin to skin contact helps promote paternal-baby bonding and heat retention. Additionally, placing the baby in a warming incubator will physically show an improved temperature change that can be regulated (Swearingen, 2016, p. 166). 3. Educate family on cold stress and ways to prevent it, such as maintaining a thermoregulated environment to prevent cold stress during baths or changing. Also includes swaddling and skin to skin contact while at home. Rationale: Family education on maintaining a warm environment will prevent heat loss from the baby during stress. This also helps the family feel more confident at discharge (Swearingen, 2016, p. 166).	**Met/Not Met?** The goal was met. **Why?** The newborn demonstrates improved body temperature by discharge. The family verbalized risk factors of heat loss and how to prevent this by discharge. The family also demonstrated interventions to provide to promote heat retention. **What next?** The next step is continuing to educate the family on how to promote thermoregulation of the baby. By taking a hands-off approach, the parents can implement the interventions. They will prepare for discharge and continue to practice these techniques at home. Their physician can reassess the temperature at the 48-hour well baby assessment.
Diagnosis 2. Risk for infection related to plast-bell circumcision (Swearingen, 2016, p. 596).	The newborn exhibits wound healing without signs of infection (drainage, erythema, increased pain, fever). Additionally, the parents demonstrate an understanding to prevent infection by discharge.	1. Educate parents on proper care of circumcised infant. This includes applying a layer of Vaseline over past-bell with each diaper change. Rationale: A lubricant prevents the diaper from adhering to the penis and possibly irritating the site (Swearingen, 2016, p. 596). 2. Educate family on the importance of hand hygiene before and after handling the baby. Rationale: Hand hygiene is the leading prevention of spreading bacteria. By doing this, the parents will minimize the risk of infection (Swearingen, 2016, p. 596). 3. Monitor the patient for any signs of swelling, purulent drainage and pain from the plast-bell. Other signs of infection include fever, restlessness, anxiety, grunting, and tachypnea. Rationale: Early recognition facilitates prompt treatment and a less severe infection (Swearingen,	**Met/Not Met?** The goal was met. **Why?** The family verbalized an understanding of precautions to take to prevent infection. The newborn demonstrated would healing that is free of signs of infection. The parents were able to list manifestations to be aware of that could indicate infection. **What next?** The next step is continuing to educate the family on how to prevent infection. By taking a hands-off approach, the parents can implement the interventions. They will prepare for discharge and continue to practice these techniques at

		2016, p. 596).	home. Their physician can follow up on the plast-bell at the 48-hour well baby assessment.

Resources:

Ciccone, C. D. (2018). Davis's Drug Guide for Rehabilitation Professionals. Retrieved from https://fadavispt.mhmedical.com/book.aspx?bookid=1873.

Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation. (2004). 114(1) 297-316; DOI: 10.15/peds.114.1.297

Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation. (2004). Retrieved from http://www.bilitool.org/index.php?page_id=8

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and Pediatric Nursing*.

Stanford Children's Health. (2018). Retrieved from https://www.stanfordchildrens.org

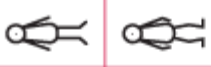
Swearingen, P.L. (2016). *All-in-one nursing care planning resource* (4th ed.). St. Louis, Missouri: ELSEVIER.

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Davis's Drug Guide for Nurses* (14 ed.). Philadelphia, PA: F.A. Davis Company.

Zinc Oxide Topical. (2019, September 28). Retrieved from https://reference.medscape.com/drug/desitin-diaparene-diaper-rash-zinc-oxide-topical-999354#10.

Ballard Gestational Age scale

Neuromuscular Maturity

Score	−1	0	1	2	3	4	5
Posture							
Square window (wrist)	 > 90°	 90°	 60°	 45°	 30°	0°	
Arm recoil		 180°	 140–180°	 110–140°	 90–110°	 < 90°	
Popliteal angle	 180°	 160°	 140°	 120°	 100°	 90°	 < 90°
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	
Plantar surface	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	
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	
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	
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	
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	

Maturity Rating

Score	Weeks
−10	20
−5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

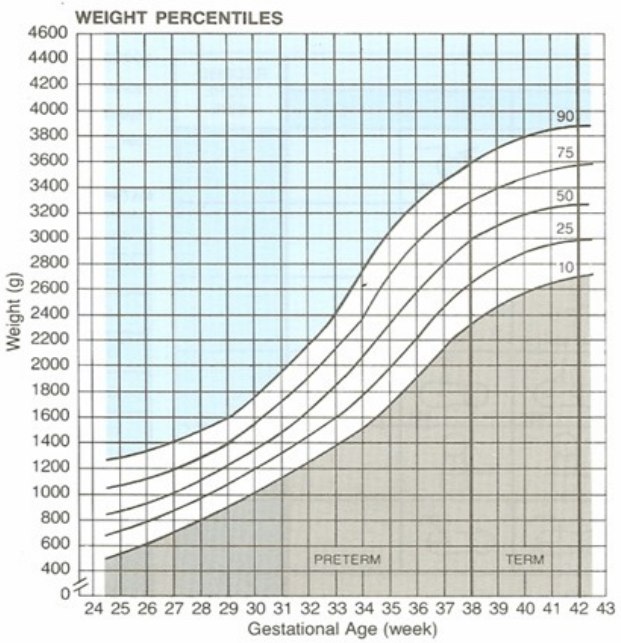
CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE [1,2]

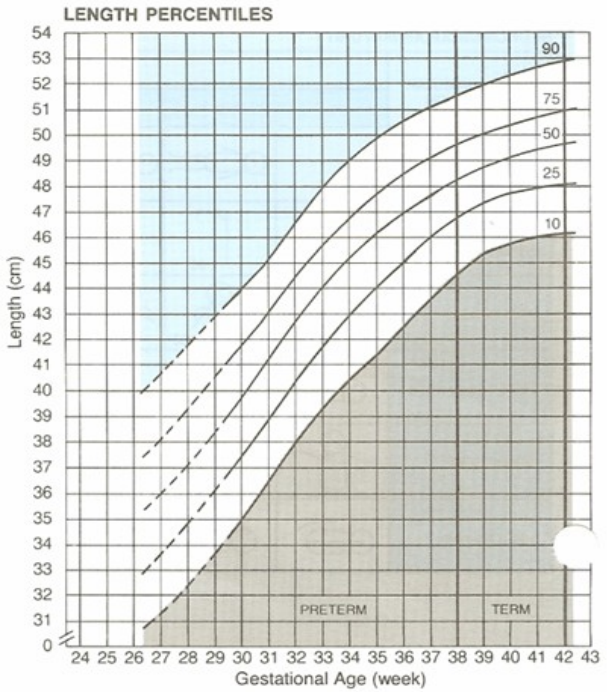
NAME _____ DATE OF EXAM _____ LENGTH _____

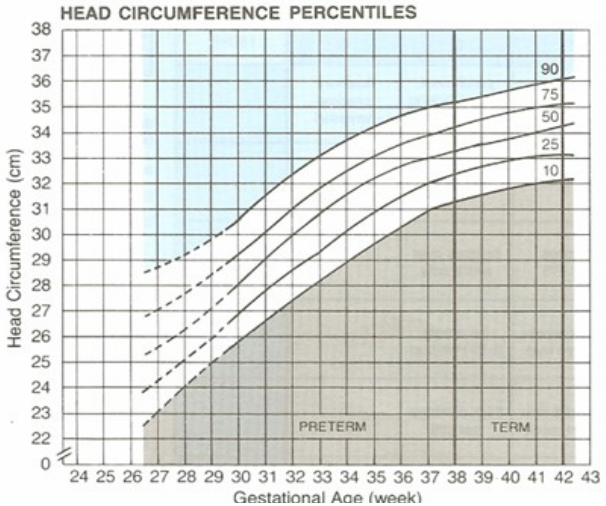
HOSPITAL NO. _____ SEX _____ HEAD CIRC. _____

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.

N305 Care Plan Grading Rubric: Newborn Student Name:

Demographics	10 Points	5 Points	0 Points	Points/ Comments
Demographics • 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.	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	
Mother/Family Medical History	**15 Points**	**10 Points**	**0 Points**	**Points/ Comments**
Prenatal History of the mother When Prenatal care started Abnormal Prenatal labs/diagnostics Prenatal complications Smoking/Drugs in pregnancy **Labor History of Mother** • Gestation at onset of labor • Length of labor • ROM • Medications in labor • Complications of labor & delivery **Past Surgical History** • All previous surgeries should be listed **Family History** • Pertinent to infant **Social History** • Pertinent to infant • Father of baby involvement	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	

Living situation **Education level** • If applicable to parents' learning barriers or care of infant				
Birth History	**10 Points**	**5 Points**	**0 Points**	**Points/ Comments**
Birth History • Length of second stage labor • Complications of birth • APGAR scores • Resuscitation methods beyond the *normal needed*	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**
Latch score assessment **Bottle feeding technique assessment** 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.	
Intake and Output	8 Points	1-7 Points	0 Points	Points/Comments
Intake • 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. **Output**	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	

• 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.				

Laboratory /Diagnostic Data	15 Points	5-14 Points	4-0 Points	Points/ Comments
Normal Values • 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. **Laboratory Data** • Admission Values • Most recent Values (the day you saw the patient) • Prenatal Values **Rational for abnormal values** • 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	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.	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.	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.	

Current Medications	15 Points	1-14 Points	0 Points	Points/ Comments
Current Medications	All key components	1 point will be lost for	There was noted	

• 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
  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
  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 will result in loss of all Points in the section
	were listed for each of the medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.	each medication with incomplete information.	lack of effort on the student's part to complete this section or there was no APA citation listed.	

Physical Exam	**25 Points**	**1-29 Points**	**0 Points**	**Points/ Comments**
• Gestational Age assessment using Ballard scale • Completion of a head to toe assessment done on the students own and not copied	All key components are met including a complete head to toe assessment, safety risk	One or more of the key components is missing from a given section. Each body system is worth Points	More than half of the key components are missing. Therefore, it is	

from the client's chart • Safety risk assessment • **No safety risk assessment will result in a zero for the section**	assessment.	as listed on care plan	presumed that the student does not have a good understanding of the head to toe assessment process.	
Vital Signs	**6 Points**	**3 Points**	**0 Points**	**Points/ Comments**
Vital signs • 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 • Pain assessment was addressed and recorded once throughout the care of this client 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	

Summary of Assessment	**4 Points**	**2-0 Points**	**Points/ Comments**
• 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
Nursing Interventions • 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 **Teaching topics** • List 2 priority teaching items • Includes 1 expected outcome for each teaching topic	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.	

Nursing Diagnosis	15 Points	5-14 Points	4-0 Points	Points/ Comments
Nursing Diagnosis • List 2 nursing diagnosis o Include full nursing diagnosis with “related to” and “as evidenced by” components • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis o 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	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.	

• Appropriate evaluation				
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	**Points/ Comments**
APA Format • 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.	

		Points
- Instructor Comments:	**Total Points awarded**	
Description of Expectations	**/150= %**	
	Must achieve 116 pt =77%	