

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 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 09/25 0900

Date/time of birth 09/12/19 07:12 am	Patient Initials JR	Age at time of assessment in hours. 312 hours (13days)	Gender Female
Race/Ethnicity African American	Weight at birth (gm) 1700 (lb.) 3 (oz.) 12	Weight at time of assessment* (gm) 1818 (lb.) 4 (oz.) 2	How old was the infant when weighed last (In hours). 312 hours (13 days)
Length at birth Cm 42.5 Inches 16.7	Head circumference at birth Cm 29.5 Inches 11.6	Chest Circumference at birth Cm 27 Inches 10.6	

- 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 **March 2019**

Abnormal Prenatal labs/diagnostics **Urine ketones 2+ mg/dL**

Prenatal complications **Placental abruption/delivered**

Surgical History **C-section**

Smoking/Drugs in pregnancy **No drugs or smoking during pregnancy**

Labor History of Mother

- Gestation at onset of labor **31 weeks 4 days**
- Length of labor **37 hours and 15 minutes**
- ROM **09/12 @ 01:25 am**
- Medications in labor **Oxytocin 30U/500 mL, Fentanyl 02.mg/1 mL**
- Complications of labor & delivery **No complications of labor and delivery**

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Family History

- Pertinent to infant **No pertinent family history related to the infant.**

Social History

- Pertinent to infant **No social history pertinent to infant.**
- Father/co-parent of baby involvement? **Father and Mother married**
- **Living situation** Live in a home.
- **Education level of parents**

If applicable to parents' learning barriers or care of infant **No learning barriers of parents.**

Birth History

- **Length of Second stage labor** 7 minutes
- **Type of Delivery** VBAC spontaneous
- **Complications of birth** No complications of birth
- **APGAR scores 1 minute** 8 **5 minutes** 8 **10 minutes** NA
- **Resuscitation methods beyond the normal needed** None

FEEDING TECHNIQUES (8 points)

Feeding technique type **Breast Milk via bottle**

If breastfeeding, LATCH score. **NA**

If bottle feeding, positioning of bottle, suck strength, amount: baby cradled in arm drinking 35-40 mL every 3 hours, strong suck strength

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**). _____% (**infant was born early and has gained weight since birth**) To calculate subtract current weight from birth weight, divide weight loss by the birth weight then multiply by 100 to get the percent. $1700g-1880g=-180/1700=-0.12*100=-10.5\%$

What is normal weight loss for this age infant? **7-10%**

Is this neonate's wt. loss within normal limits? **Infant gained weight and had negative weight loss.**

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

If breastfeeding: feeding frequency, length of feeding session, one or both breasts? **Infant drinking breast milk from bottle**

If bottle feeding: frequency and volume of formula at a session. **35-40 mL q3hr**

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 **5 hours**

Voiding patterns: (# of times /24 hours) **15 times/24 hours**

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Age (in hours) of first stool **7 hours**

Stools: (type, color, consistency and number of times in 24 hours) **meconium, green, thick, 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? Complete this even if these labs have not been completed.	Client's results	Expected results	Interpretation of this client's results
Blood glucose levels	Infants born premature and may have hypoglycemia	9.4	8.6-10.3	The infant's blood glucose level is within normal limits.
Blood type and Rh factor	To compare the baby's blood type to the mothers.	B +	B +	The baby's blood type matches the mother's blood type.
Coombs test	The coombs test is used to test for autoimmune hemolytic anemia.	pt mother B+		The infant and mother have matching blood types and no hemolytic reaction will happen.
Bilirubin level (all babies at 24 hours)	To monitor liver development or to check if red blood cells are being destroyed quicker than normal due to hemolysis	5.9	0.3-5.7	See end of care plan
Newborn Screen (at 24 hours)	This is a screening performed shortly after birth to detect birth conditions that are not evident in newborns.	Not available until after discharge	Not completed	Patient not discharged yet so screening has not been performed.
Newborn Hearing Screen	To ensure fully functional hearing at birth	pt premature test not yet performed	Hearing intact	Test not performed
Newborn Cardiac	This is used to detect	pt premature	Passes screen	Test not performed

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Screen (at 24 hours)	congenital cardiac defects	test not yet performed		
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NEWBORN MEDICATIONS (15 Points)

Brand/Generic	Aquamephyton (Vitamin K) (Jones & Bartlett Learning, 2018)	Illotycin (Erythromycin ointment) (Jones & Bartlett Learning, 2018)	Hepatitis B Vaccine (Jones & Bartlett Learning, 2018)		
Dose	1 mg	0.5 %	0.5 mg		
Frequency	Once	Once	Once		
Route	Intramuscular	Topical (ointment)	Intramuscular		
Classification					

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	Vitamin	Antibiotic	Vaccine		
Mechanism of Action	Vitamin used for the synthesis of clotting factors	Binds to bacterial ribosome. Used for prophylaxis of conjunctivitis	Hepatitis B antigen is given to provide immunity		
Reason Client Taking	Prophylactic hemorrhage of newborn	Prophylactically used to prevent conjunctivitis.	Hepatitis B prevention		
Contraindications (2)	Hypersensitivity Concurrent use of blood thinners	Hypersensitivity Concurrent use of astemizole	Hypersensitivity Yeast allergy		
Side Effects/Adverse Reactions (2)	Metabolic acidosis Cardiac arrest	Diarrhea Anaphylaxis	Injection site irritation Fever		
Nursing Considerations (2)	Use NS for dilution Takes 1-2 hours to take effect	Use 1cm ribbon for each eye Don't administer directly into eye with tip	Don't mix with other vaccines Shake before use		
Key Nursing Assessment(s)/Lab(s)	Monitor	Monitor for hypersensitivity	Monitor for		

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) Prior to Administration	bleeding Monitor platelets	y Monitor heart rate and rhythm	fever Monitor injection site		
Client Teaching needs (2)	Report rashes Teach side effects	Monitor for SE Review why we use ointment	Review vaccine schedule Monitor fever		

VITAL SIGNS (6 points)

Vital Signs at Birth
T 97.7 F rectal
P 140
R 96

Vital signs 4 hours after birth
T 98.4 axillary
P 120
R 34

At the time of your Assessment
T 98.7 axillary
P 160
R 50

NEWBORN ASSESSMENT (25 Points)

Area	Your Assessment	Expected Variations And Findings (This can be found in your book p.645) (Ricci, Kyle, & Carman, 2017)	If assessment finding different from expectation what is the clinical significance?
Skin	Normal color, no jaundice or rashes noted	Smooth & flexible with color consistent with genetic background	No abnormal findings
Head	Normocephalic, diamond shaped anterior fontanelle and no abnormalities	Varies with gender, age, and ethnicity. Symmetrical and normocephalic	No abnormal findings
Fontanels	Anterior fontanelle open, soft, and flat. Posterior fontanelle opened and triangular.	Diamond shaped anterior fontanelle, triangular shaped posterior fontanelle.	No abnormal findings
Face	Full cheeks with no abnormalities	Full cheeks, symmetrical facial features	No abnormal findings

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Eyes	Normally set, pupils equal, red reflex present bilaterally	Clear and symmetrical, may have uncoordinated movement or strabismus	No abnormal findings
Nose	Nares patent, no septal deviation	Small, midline, narrow and able to smell.	No abnormal findings
Mouth	Oral mucosa moist, palate normal shape and intact	Intact with symmetrical movement. Gums pink, moist, natal teeth may be present	No abnormal findings
Ears	Normally set with patent canals	Soft, pliable and recoil quickly. Aligned with outer canthus of eye	No abnormal findings
Neck	Supple, without masses	Supple, without masses.	No abnormal findings
Chest	Symmetrical with no abnormalities	Barrel shaped, symmetric	No abnormal findings
Breath sounds	Vesicular breath sounds in all fields. Symmetric and slightly irregular.	Vesicular breath sounds in all fields. Symmetric and slightly irregular.	No abnormal findings
Heart sounds	Normal S1 and S2, no S3 noted. Heart Rate within normal range	Normal S1 and S2, no S3 noted. Heart Rate within normal range	No abnormal findings
Abdomen	Protuberant contour, soft, three vessels in umbilical cord	Protuberant contour, soft, three vessels in the umbilical cord.	No abnormal findings
Bowel sounds	Bowel sounds heard in all quadrants	Bowel sounds heard in all quadrants	No abnormal findings
Umbilical cord	Umbilical vein larger than two arteries	Umbilical vein larger than two arteries	No abnormal findings
Genitals	Swollen genitals as a result of estrogen, no bleeding or redness.	Swollen genitals as a result of estrogen, no bleeding or redness.	No abnormal findings
Anus	Normal position and patency indicated by the passing of meconium.	Normal position and patency indicated by the passing of meconium.	No abnormal findings
Extremities	Extremities symmetric with free movement.	Extremities symmetric with free movement.	No abnormal findings
Spine	Spine symmetrical and palpable along entire	Spine palpable along entire length with not lateral	No abnormal findings

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	length.	curvature.	
Safety Matching bands with parents Hugs tag Sleep position	Matching parental bands, hug tag present, sleeping position supine, side rails of radiant warmer raised, incubator and portholes secured, wheels locked, ID band, electronic transponder on bag/mask, oxygen, suction readily available	Matching parental bands, hugs tag on foot, baby sleeps on back and swaddled	No abnormal findings

Reference:

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. 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

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

There are no complications expected for this baby. The baby is developing appropriately for gestational age.

PAIN ASSESSMENT (2 Points)

Pain Assessment including which pain scale you have used: NIPS scale score of 0. No pain or facial cry, no movement of arms or legs.

SUMMARY OF ASSESSMENT (4 points)

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

The neonate was delivered on 9.12.19 at 0712 by VBAC spontaneous vaginal delivery. Nuchal cord *1. Apgar scores 8/8/NA. EDD 11/19. Neonate is 31 weeks 4 days and AGA. Prenatal hx of placental abruption. Birth weight 3lbs 4oz (1700 grams), 16.7 in (42.5cm). Upon assessment all systems are within normal limits. Last set of vitals 98.7 axillary, pulse 160, respirations 50. BS * 3 within normal limits with lowest being 50. Neonate is bottle fed breast milk 35-40 mL every 3 hours. Bilirubin level at 24 hours was 5.9. Neonate remains in the hospital with anticipation of discharge on day 15. Neonate will see a pediatrician in the office for first well bay check within 48 hours of discharge.

NURSING CARE/INTERVENTIONS (12 Points)

Teaching Topics (5 points)

Include how you would teach the information & an expected outcome

1. Teach pt parents signs and symptoms of nutritional deficiency
2. Teach pt parents signs and symptoms of infection

Nursing Interventions (5 points)

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

Nursing Interventions:

It's important for premature babies to gain weight since they are usually born at a low birth weight. Teach patients signs and symptoms of nutritional deficiency which include pale skin, fatigue, weakness, breathing problems, sleeplessness, general fussiness, lack of weight gain.

Infants that are born early are more prone to infection due to underdevelopment and lack of immune system. Parents of premature infants must be taught the signs and symptoms of infection so they can identify changes in the infant. Signs and symptoms of infection include temperature, poor feeding, excessive sleeping, rapid breathing or change in behavior.

Medical Treatments:

Parents of infant should seek treatment for nutritional deficiency right away because there could be an underlying cause such as absorption issues, or vitamin deficiencies, or problems with the infant intake of food.

Treatment of infection for infants includes antibiotics. In more serious cases hospitalization may be needed for IV fluids or tube feedings.

PRIORITY NEWBORN NURSING DIAGNOSES (15 Points)

Identified Problem or potential problem	Expected Outcomes/Goals	Interventions	Goals/Outcomes Met/Not Met
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)	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..	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.	Include whether the goal/outcome has been met or not met and why. Then write what you would do next.
Diagnosis 1. Eating disorder related to insufficient sucking or swallowing reflexes as evidenced by infant spitting out breast milk when bottle fed	Infant will consume all 35-40 mL of breast milk via bottle without spitting it out by the time of discharge in two days.	Perform assessment every 3 hours (per infant feeding schedule) on latching to bottle to ensure infant is feeding properly Teach parents signs and symptoms of nutritional deficiencies so they can identify any feeding problems. Weight infant daily at the same time to ensure steady weight gain.	Met/Not Met? Partially met Why? Infant has improved feeding and has consistently eaten between 35-40 mL at feedings with only minimal regurgitation after What next? Infant will show continued improvement and will follow up with pediatrician within 2 day of discharge

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<p>Diagnosis 2.</p> <p>Risk for infection related to premature birth as evidenced by low birth weight and immature immune system</p>	<p>Infant will show no signs of infection by the time of discharge in two days.</p>	<p>Monitor vitals especially temp every three hours with feedings</p> <p>Perform and monitor prescribed labs for infant to assess for change in condition</p> <p>Protect infant from any unnecessary exposure to infection to decrease changes of infection.</p>	<p>Met/Not Met?</p> <p>Partially met</p> <p>Why?</p> <p>Infant has shown no signs of infection and will continue to do so by discharge in two days</p> <p>What next? Infant will follow up with pediatrician within 48 hours of discharge in 2 days</p>
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Reference:

Swearingen, P. L. (2016). *All-in-one care planning resource: medical-surgical, pediatric, maternity & psychiatric nursing care plans*. Philadelphia, PA: Elsevier/Mosby.

Ballard Gestational Age scale

Neuromuscular Maturity

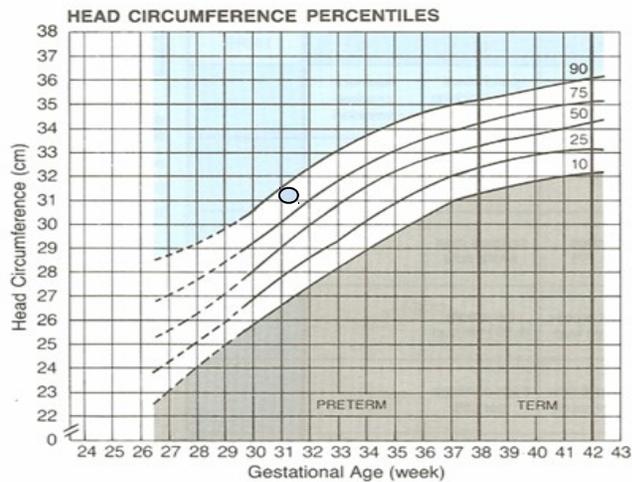
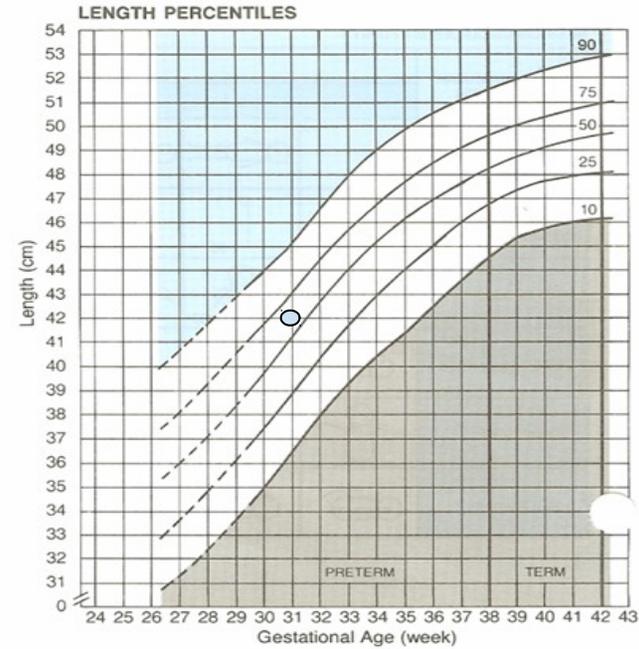
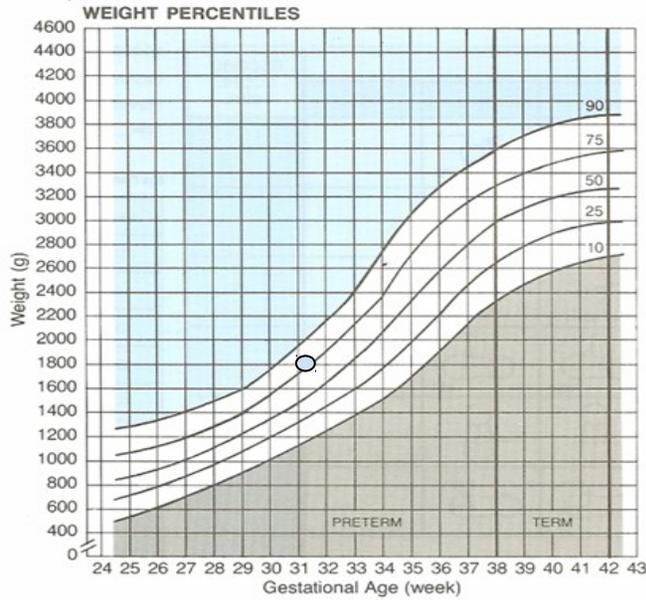
Score	-1	0	1	2	3	4	5
Posture							
Square window (wrist)							
Arm recoil							
Popliteal angle							
Scarf sign							
Heel to ear							

Physical Maturity

Category	-1	0	1	2	3	4	5	Maturity Rating	
Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; few 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		Score	Week
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 usually 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 ^{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)	X		
Appropriate for Gestational Age (AGA) (10th to 90th percentile)		X	X
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.

References
 1. Battaglia FC, Lubchenco LO: A practical classification of newborn infants by weight and gestational age. *J Pediatr* 1967; 71:169-183

N305 Care Plan Grading Rubric: Newborn

Student Name:

Demographics	10 Points	5 Points	0 Points	Points/ Comments
<p>Demographics</p> <ul style="list-style-type: none"> ● Date/time of clinical assessment ● Date & time of birth ● Patient initials ● Age in hours at clinical assessment ● Gender ● Race/Ethnicity ● Weight at birth and at time of assessment ● Length at birth ● Head circumference at birth 	<p>Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.</p>	<p>Two or more of the key components are not filled in correctly.</p>	<p>5 or more of the key components are not filled in correctly</p>	

<ul style="list-style-type: none"> ● Chest circumference at birth 			<p>and the reference points were awarded for this section</p>	
<p>Mother/Family Medical History</p>	<p>15 Points</p>	<p>10 Points</p>	<p>0 Points</p>	<p>Points/ Comments</p>
<p>Prenatal History of the mother</p> <ul style="list-style-type: none"> When Prenatal care started Abnormal Prenatal labs/diagnostics Prenatal complications Smoking/Drugs in pregnancy <p>Labor History of Mother</p> <ul style="list-style-type: none"> ● Gestation at onset of labor ● Length of labor 	<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</p>	<p>1 or more of the key components is missing detailed information.</p>	<p>More than two of the key components are not</p>	

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<ul style="list-style-type: none"> ● ROM ● Medications in labor ● Complications of labor & delivery <p>Past Surgical History</p> <ul style="list-style-type: none"> ● All previous surgeries should be listed <p>Family History</p> <ul style="list-style-type: none"> ● Pertinent to infant <p>Social History</p> <ul style="list-style-type: none"> ● Pertinent to infant ● Father of baby involvement <p>Living situation</p> <p>Education level</p> <ul style="list-style-type: none"> ● If applicable to parents' learning barriers or care of infant 	<p>chart.</p>		<p>filled in correctly</p>	
<p>Birth History</p>	<p>10 Points</p>	<p>5 Points</p>	<p>0 Points</p>	<p>Points/ Comments</p>

<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. Student demonstrates an understanding of intake and output.</p>	<p>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.</p>	<p>Student did not complete this section</p>	
<p>Laboratory /Diagnostic Data</p>	<p>15 Points</p>	<p>5-14 Points</p>	<p>4-0 Points</p>	<p>Points/ Comments</p>
<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>	<p>All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities.</p>	<p>1 or more of the client's labs were not reported completely with normal values or patient results. Lab correlation</p>	<p>Student did not have an under</p>	

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<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> <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>Student had 1 reference listed and is able to correlate abnormal laboratory findings to the client's particular disease process.</p>	<p>did not completely demonstrate student's understanding of correlation.</p>	<p>standing of laboratory values and the abnormalities. More than 2 labs were excluded. Student did not discuss</p>	
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			<p>the abnormal findings in AP A format with a minimum of 1 reference .</p>		
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 	<p>All key components were listed for each of the medications, along with the most common side effects, contraindications</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>		

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<ul style="list-style-type: none"> ● 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>and client teachings.</p> <p>Student had 1 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 	All key components are	One or more of the key components is	More than half of the key	

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<ul style="list-style-type: none"> ● Completion of a head to toe assessment done on the students own and not copied from the client's chart ● Safety risk assessment ● No safety risk assessment will result in a zero for the section 	met including a complete head to toe assessment, safety risk assessment.	missing from a given section. Each body system is worth Points as listed on care plan	components are missing. Therefore, it is 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 <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 	All the key components were met (1 pain assessments) for this section and student has a	One assessment is incomplete or not recorded appropriately.	Student did not complete this section	

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It was recorded appropriately and stated what pain scale was used	good understanding of the pain assessment.			
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 	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
<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/rational/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>	
Overall APA format	5 Points	1-4 Points	0 Points	Points/ Comments

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

N432 Newborn Care plan

Infant age 23 hours

Total bilirubin 5.9 mg/dl

Risk zone **Low Intermediate Risk**

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

Recommended Follow-up

Lower Risk

(>= 38 weeks and well)

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

Medium Risk

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

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

Higher Risk

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

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

AAP Phototherapy Guidelines (2004)

N432 Newborn Care plan

Lower Risk (\geq 38 weeks and well)	No	11.5 mg/dl
Medium Risk (\geq 38 weeks + neurotoxicity risk factors OR 35 to 37 6/7 weeks and well)	No	9.7 mg/dl
Higher Risk (35 to 37 6/7 weeks and neurotoxicity risk factors)	No	7.8 mg/dl

It is an option to provide conventional phototherapy in the hospital or at home at TSB levels 2-3 mg/dl (35-50 μ 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](#).