

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 10/14/19

Date/time of birth 10/14/19 at 1158	Patient Initials CS	Age at time of assessment in hours. 4 hours	Gender Male
Race/Ethnicity Caucasian	Weight at birth (gm) 3,435.96 (lb.) 7 (oz.) 9.2	Weight at time of assessment* (gm) 3,435.96 (lb.) 7 (oz.) 9.2	How old was the infant when weighed last (In hours). 4 hours
Length at birth Cm 52.7 Inches 20.8"	Head circumference at birth Cm 36 Inches 14.1"	Chest Circumference at birth Cm 33 Inches 13"	

- 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: April 12, 2019

Abnormal Prenatal labs/diagnostics: Herpes Simplex Virus

Prenatal complications: Herpes Simplex Virus, baby was transverse, and mitral valve prolapse

Smoking/Drugs in pregnancy: N/A

Labor History of Mother

- Gestation at onset of labor: 39 weeks 0 days
- Length of labor: 4.5 hours

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- ROM: Full ROM
- Medications in labor: Reglan, Zofran, Zithromax, lactated Ringer's
- Complications of labor & delivery: N/A

Family History

- Pertinent to infant: Sibling had shoulder dystocia

Social History

- Pertinent to infant: Mother is a former smoker
- Father/co-parent of baby involvement? Father is involved
- **Living situation:** The patient lives with her significant other
- **Education level of parents**

If applicable to parents' learning barriers or care of infant: High school degree

Birth History

- **Length of Second stage labor:** N/A, the patient had a scheduled C-section
- **Type of Delivery:** C-section
- **Complications of birth:** N/A
- **APGAR scores: 1 minute: 10**_____ **5 minutes: 10**_____ **10 minutes: 10**_____
- **Resuscitation methods beyond the normal needed:** N/A

FEEDING TECHNIQUES (8 points)

Feeding technique type: Breastfeeding

If breastfeeding, LATCH score. : 9

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**). 0%

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?__One breast, 30 minutes, every 2-3 hours

If bottle feeding: frequency and volume of formula at a session.: N/A

If NG or OG feeding: frequency & volume: N/A

If IV: then rate of flow and volume in 24 hours: N/A

Output

Age (in hours) of first void___N/A, patient did not void during the clinical day

Voiding patterns: (# of time/24 hours): N/A

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Age (in hours) of first stool: 4 hours

Stools: (type, color, consistency and number of times in 24 hours): Meconium, black, sticky, and once throughout the clinical day

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	If mother has Diabetes mellitus or Gestational Diabetes	N/A	N/A	
Blood type and Rh factor	To know baby's blood type	A+	N/A	Negative compatibility to mother's blood type. The mother's blood didn't mix with baby's blood.
Coombs test	To check baby for clonis	N/A	N/A	
Bilirubin level (all babies at 24 hours)	To check the baby's bilirubin level	N/A	N/A	Use www.bilitool.org to "plug in" your baby's 24 hour bilirubin level. Discuss baby's risk according to this website. If your infant has not had a biliscan (TCB) or bili serum drawn, talk with your instructor and she will provide you with a number to use. Copy and paste the risk factor webpage stating your infant's risk status and include it at the end of this document.
Newborn Screen (at 24 hours)	To test for disorders not apparent at birth	Not available until after discharge	N/A	
Newborn	To test for hearing	N/A	N/A	

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Hearing Screen	issues in the newborn			
Newborn Cardiac Screen (at 24 hours)	To test the baby's cardiac function	N/A	N/A	

Reference

Ricci, S., Kyle, T. and Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins.

NEWBORN MEDICATIONS (15 Points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin ointment)	Hepatitis B Vaccine		
Dose	1 mg	N/A	0.5 mL		
Frequency	once	once	vaccine		
Route	IM	Both eyes	IM		
Classification	Fat soluble vitamin	Macrolide	Vaccine or immune globulins		
Mechanism of Action	Catalyzes the posttranslational	Inhibits RNA-dependent protein	An immune gamma-globulin		

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	gamma-carboxylation of glutamic acid in hepatic precursors of coagulation factors II, VII, IX, X.	synthesis, resulting in blockage of transpeptidation.	fraction contains high titers of antibodies to the hepatitis B surface antigen.		
Reason Client Taking	To prevent bleeding	Prevents transmission of infection	To prevent Hepatitis B		
Contraindications (2)	Hypersensitivity to vitamin K. Hypersensitivity to benzyl alcohol.	Hypersensitivity to erythromycin. Hypersensitivity to erythromycin's components.	Hypersensitivity to immune globulins. Hypersensitivity to glycine or thimerosa.		
Side Effects/Adverse Reactions (2)	Rash, hyperbilirubinemia, and hemolytic anemia.	Minor ocular irritation and redness.	Pain, swelling, tenderness, and erythema at IM site.		
Nursing Considerations (2)	Monitor for frank and occult bleeding.	Avoid touching the eye or lid. Pull the lower	Give vaccine within 12 hours of		

	Know neonates may be more sensitive than older children.	eyelid down and squeeze a drop in each eye.	birth. Do not give intravenously.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess heart rate and blood pressure and monitor prothrombin time.	Assess eyes prior to administration	Assess for cardiopulmonary compromise		
Client Teaching needs (2)	Advise patient's family to report any symptoms of bleeding or bruising. Emphasize the importance of frequent lab tests to monitor coagulation factors.	Educate the patient's family about the signs of significant reaction. Patient may experience eye redness.	Advise patient's family swelling and redness may occur at site. Advise patient's family not to touch the site.		

Reference

Vallerand, A. H., Sanoski, C. A., & Quiring, C. undefined. (2019). *Davis's Drug Guide for Nurses* (16th ed.). Philadelphia, PA: F.A. Davis Company.

VITAL SIGNS (6 points)

Vital Signs at Birth

T 97.9

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Vital signs 4 hours after birth

T 97.7

At the time of your Assessment

T 97.7

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P_156 _____

R_60 _____

P _____ 160 _____

R _____ 64 _____

P _____ 160 _____

R _____ 64 _____

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	Skin is warm, pink, and dry. No signs of jaundice or discoloration. No rashes, wounds, or drains present. Skin turgor rebounds within 3 seconds.	Skin should be warm, pink with no signs of jaundice or discoloration with rapid skin turgor to show the newborn is not dehydrated.	N/A
Head	Head is normocephalic. Molding is 3+, No bruises or indentation, sutures are palpable, soft spot on the back of the head is noted.	Sutures are well defined and palpable, No abnormalities. SGA, LGA, Preterm and Post term.	N/A
Fontanel	Anterior and posterior fontanel are open allowing for growth and development. Both are normal size.	Fontanel should be open allowing for maturation of the newborn. These should be normal, curved, and firmness should be palpable.	N/A
Face	Facial features are intact, no abnormalities.	Facial features should be within defined limits. No abnormalities noted such as drooping of one side of the face.	N/A
Eyes	PERRLA. No drainage or vision loss apparent.	PERRLA	N/A
Nose	No purulent drainage, or polyps, no septum deviation noted.	Should be in place with no standard deviation, no purulent drainage, or abnormalities.	N/A

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Mouth	Oral mucosa is pink, and moist. Soft palate rises and falls.	Oral mucosa is pink, and moist. No abnormalities to the mouth or lips such as a cleft palate.	N/A
Ears	Tympanic membrane is pearly grey bilaterally, no excessive drainage, ears are symmetrical. Auricles are pink and soft.	Auricles are pink and soft, no rigidity, no abnormalities to the shape or color, TM are pearly grey and symmetrical.	N/A
Neck	Neck is supple, clavicles are bilaterally symmetrical.	Normal alignment of the neck with the proportion of the midline of the body.	N/A
Chest	No excessive work of breathing noted. Chest rises and falls with ease upon inspiration and expiration. Nipples are erect.	Chest is well defined with no abnormalities such as a barrel chest or pigeon chest. Newborn is using the chest to breathe instead of accessory muscles.	
Breath sounds	Clear to auscultation. No increased work of breathing, SOB, wheezes, or rhonchi noted. No signs of respiratory distress.	Newborn is able to breathe on their own with no increased work of breathing. Newborns are nose breathers. No adventitious breath sounds noted.	
Heart sounds	S1 and S2 heard upon auscultation, no gallops or murmurs noted. pulses are strong and palpable, capillary refill returns quickly within 3 seconds.	No abnormal heart sounds noted such as a gallop or a murmur with S4 or S3 heard upon auscultation. Cap refill is within 2-3 seconds, and pulses are strong and palpable.	N/A
Abdomen	Normoactive bowel sounds, abdomen is soft and nontender with no distension or masses noted. 3 vessels noted upon palpation of the umbilical cord.	Umbilical cord is palpated to find it is soft and has 3 vessels. No masses or distension noted.	N/A
Bowel sounds	Normoactive bowel sounds in all 4 quadrants. Last BM was 10/14/19 with	Normoactive bowel sounds.	N/A

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	meconium stool noted.		
Umbilical cord	Umbilical cord is dry and intact. 3 vessels noted, the clamp is in place.	3 vessels are noted upon palpation.	N/A
Genitals	Normal genitalia, testes are descended. Circumcision is to be scheduled for tomorrow.	No abnormalities to the genitalia with testes descended.	N/A
Anus	Last BM was 10/14/19 has meconium stool. The anus is dry and intact.	Normal bowel movements noted, no masses noted. Meconium stool is passed within the first couple of stools until feeding regularly.	N/A
Extremities	Full ROM noted, strong peripheral pulses upon palpation, no dislocation of the shoulder or hips.	No shoulder dystocia or dislocation of the hips. Able to move all extremities.	N/A
Spine	Spine is midline and intact. No abnormalities noted.	Proper alignment of the spine with no abnormal curvatures such as scoliosis.	N/A
Safety Matching bands with parents Hugs tag Sleep position	Hugs tag present, matching maternal band present, sleeps supine.	ID number is identified and documented, Hugs tag should be placed at the time of birth and documented once placed. Newborn needs to be consistently turned when sleeping to prevent abnormalities of the occipital region of the head.	N/A

Reference

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? Patient is AGA for his weight and head circumference. Patient is LGA for his length.

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

___No complications. Newborn was in the 75th percentile for weight, above the 90th percentile for length, and the 25th percentile for head circumference.

PAIN ASSESSMENT (2 Points)

Pain Assessment including which pain scale you have used: NIPS 0/10 pain noted.

Facial expression: Occasional frown. Cry: Absent. Breathing: Relaxed. Arms: Relaxed. Legs: Relaxed. Alertness: Sleeping/calm.

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SUMMARY OF ASSESSMENT (4 points)

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

This newborn was delivered on 10.14.19 at 1158. Patient came in for a scheduled C-section. Apgar scores was 10 at 1/5/10 minutes. EDD 10.14.19 . Neonate is 39 weeks and LGA. Prenatal hx complicated by Herpes Simplex Virus. Birth weight 7 lbs 9.2 ozs (3435.96), 20.75” long (52.71cm). Upon assessment all systems are within normal limits. Last set of vitals: was at 1358. Vitals were temperature 97 pulse was 160, and respirators were 64. BS x1 after delivery WNL at 64. Neonate is breastfeeding every 2 hours with strict I/O ordered. Bilirubin level at 24 hours per scan was 4.5. Neonate expected to be discharged with mother in 2 days and to see a pediatrician in the office for first well baby check within one week after delivery date.

NURSING CARE/INTERVENTIONS (12 Points)

Teaching Topics (5 points)

Include how you would teach the information & an expected outcome

1. Benefits of breastfeeding is an essential teaching topic for new mothers. Breastfeeding should be taught in a discussion form with a breastfeeding consultant. An expected outcome would be for the mother to learn how to get the baby to latch properly and for the mother to know the benefits of breastfeeding.
2. Skin to skin contact can be taught in a discussion form with the nurse or the care provider. The expected outcome would be for the mother to choose to have skin to skin contact after giving birth and throughout the stay. The mother will also identify any questions she has for the nurse.

Nursing Interventions (5 points)

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

Nursing Interventions: The interventions for this mom since the mom identified how sore her nipples are and the newborn is not able to suck very well. A few interventions for this mom would be assisting the mother with guiding the infant to the nipple and emphasizing the need to allow fresh air to the nipple in between feedings. When the nipples are sore providing key interventions and teaching for how to alleviate the soreness would be applying aloe vera or vitamin E to promote healing of the tissue. The nurse should explain to the mom the need for a follow up appointment with her primary care provider to ensure these interventions have worked since discharge. A nursing intervention for skin to skin contact is to provide proper education upon the subject. When the nurse provides this intervention and helps the mom perform the task it allows a resting period for the mom to decrease her anxiety level.

Medical Treatments: Vitamin K, erythromycin to prevent an infection within the eyes, and the Hepatitis B vaccine to prevent the transfer of the pathogen. Consulting a lactation consultant, and recommending follow up with the primary care provider for a well-baby visit 48 hours after discharge or 1 week after delivery.

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	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	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,	Include whether the goal/outcome has been met or not met and why. Then write what you would do next.

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evidenced by (AEB)	for THIS patient. The expected outcomes/goals MUST be measurable..	client teaching, procedures and prn medications.. Include a rationale for each intervention and using APA format , list your sources.	
Diagnosis 1. Imbalanced nutrition: less than body requirements related to poor sucking as evidenced by multiple feedings.	<ul style="list-style-type: none"> • Patient will latch properly for most feedings • Patient's sucking ability will improve by the time of discharge • Patient will not lose more than 10% of his body weight by the time of discharge 	<ul style="list-style-type: none"> • Educate mother how to get baby to latch properly <ul style="list-style-type: none"> ◦ When the mother knows how to get her baby to latch properly, the baby's sucking will improve • Consult breastfeeding specialist <ul style="list-style-type: none"> ◦ The specialist will give mom tips to improve baby's sucking ability • The patient's weight will be monitored throughout his stay <ul style="list-style-type: none"> ◦ Monitoring his weight will tell the nurse if he is losing weight 	<p>Met/Not Met? The goal was not met.</p> <p>Why? The patient was not discharged by the end of the clinical day.</p> <p>What next? Breastfeeding consultant will schedule a follow-up with the mother to ensure the patient is sucking properly</p>
Diagnosis 2. Risk for infection related to inadequate primary defence as evidenced by immature immunity.	<ul style="list-style-type: none"> • Patient will not have a hospital acquired infection • Patient will not have signs or symptoms of infection • Vaccines and ointment will prevent infections 	<ul style="list-style-type: none"> • CBC will be monitored throughout the patient's stay <ul style="list-style-type: none"> ◦ WBC count will indicate an infection • Patient will be monitored for signs and symptoms of infection <ul style="list-style-type: none"> ◦ Catching an infection early will prevent further complications • Vaccines and Erythromycin ointment will be administered to the patient <ul style="list-style-type: none"> ◦ The vaccine and ointment will prevent infections 	<p>Met/Not Met? Goal was met</p> <p>Why? Patient did not have signs or symptoms of infection.</p> <p>What next? Patient education to the mother and father about the signs and symptoms of infection.</p>

References

Ricci, S., Kyle, T. and Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins.

Vallerand, A. H., Sanoski, C. A., & Quiring, C. undefined. (2019). *Davis's Drug Guide for Nurses* (16th ed.). Philadelphia, PA: 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							

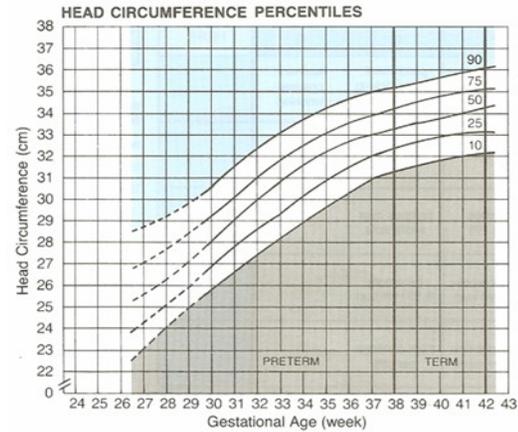
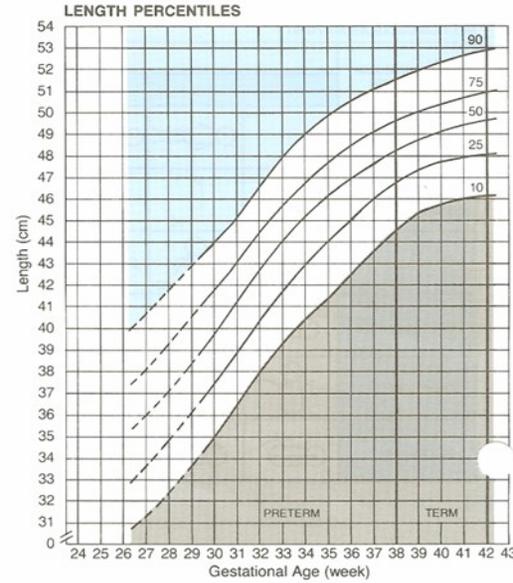
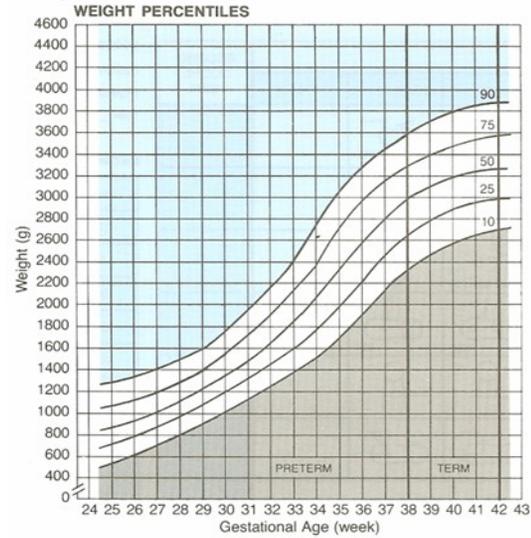
Physical Maturity

Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; rare veins	Parchment, deep cracking; no vessels	Leathery, cracked, wrinkled
Lanugo	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	Maturity Rating
Plantar surface	Heel-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	-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
							0 24
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	5 26
							10 28
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	15 30
							20 32
							25 34
							30 36
							35 38
							40 40
							45 42
							50 44

Neuromuscular maturity: Posture: 4. Square window: 3. Arm recoil: 4. Popliteal angle: 5. Scarf sign: 2. Heel to ear: 2.
Physical Maturity: Skin: 1. Lanugo: 1. Plantar surface: 2. Breast: 3. Eye/Ear: 3. Genitals (male): 3.

**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.

References
 1. Battaglia FC, Lubchenco LO: A practical classification of newborn infants by weight and gestational age. *J Pediatr* 1967; 71:160-163

Patient is AGA for his weight and head circumference. Patient is LGA for his length.

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 ● Chest 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 and the therefore no Points were awarded</p>	

			ard ed for this sec tio n	
Mother/Family Medical History	15 Points	10 Points	0 Points	Points/ Comments
<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 ● 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 	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	

<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 				
Birth History	10 Points	5 Points	0 Points	Points/ Comments
<p>Birth History</p> <ul style="list-style-type: none"> ● Length of second stage labor ● Complications of birth ● APGAR scores ● Resuscitation methods beyond the <i>normal needed</i> 	Every key component of the birth history is filled in correctly with information	Two of the key components are missing in the birth history. The birth history is lacking important information to help determine what has happened to the patient.	No birth history included.	
Feedings techniques	8 Points	4 Points	0 Points	Points/ Comments

<p>Latch score assessment</p> <p>Bottle feeding technique assessment</p> <p>Weight loss calculation</p>	<p>All key components are filled in correctly. The student was able to identify the effectiveness of the feeding technique</p> <p>Calculation of weight loss is accurate</p>	<p>One of the key components is missing or not understood correctly.</p>	<p>Student did not complete this section.</p>	
<p>Intake and Output</p>	<p>8 Points</p>	<p>1-7 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 	<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>puts OUT</p> <ul style="list-style-type: none"> ● Includes: urine, stool, drains/tubes, emesis, etc. 				
<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> <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 	<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 ab</p>	

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<ul style="list-style-type: none">● 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			normalities. More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format	
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			with a minimum of 1 reference.		
Current Medications		15 Points	1-14 Points	0 Points	Points/ Comments
Current Medications <ul style="list-style-type: none"> ● Requirements of all inpatient hospital medications given to the newborn ● Each medication must have brand/generic name ● Dosage, frequency, route given, class of drug and the action of the drug ● Reason client taking ● 2 contraindications must be listed <ul style="list-style-type: none"> ○ Must be pertinent to your patient ● 2 side effects or adverse effects ● 2 nursing considerations 		All key components were listed for each of the medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.	1 point will be lost for each medication with incomplete information.	There was noted lack of effort on the student's part to complete this section or there was no APA citation listed.	

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<ul style="list-style-type: none"> ● 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 				
Physical Exam	25 Points	1-29 Points	0 Points	Points/ Comments
<ul style="list-style-type: none"> ● Gestational Age assessment using Ballard scale ● Completion of a head to toe assessment done on the students own and not copied from the client's chart ● Safety risk assessment ● No safety risk assessment will result in a zero for the section 	<p>All key components are met including a complete head to toe assessment, 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 toe assessment process.</p>	

Vital Signs	6 Points	3 Points	0 Points	Points/ Comments
<p>Vital signs</p> <ul style="list-style-type: none"> ● 3 sets of vital signs are recorded with the appropriate labels attached ● Includes a set at birth, 4 hours after birth and at the time of your assessment. ● Student highlighted the abnormal vital signs ● Student wrote a summary of the vital sign trends 	<p>All the key components were met for this section (with 3 sets of vital signs) and student has a good understanding of abnormal vital signs.</p>	<p>Only one set of vital signs were completely recorded and one of the key components were missing</p>	<p>Student did not complete this section</p>	
Pain Assessment	2 Points	1 point	0 Points	Points/ Comments
<p>Pain assessment</p> <ul style="list-style-type: none"> ● Pain assessment was addressed and recorded once throughout the care of this client <p>It was recorded appropriately and stated what pain scale was used</p>	<p>All the key components were met (1 pain assessments) for this section and student has a good understanding of the pain assessment.</p>	<p>One assessment is incomplete or not recorded appropriately.</p>	<p>Student did not complete this section</p>	
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 	<p>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</p>			

	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” 	All key components were addressed. The student demonstrated an appropriate	One or more of the nursing diagnosis/rational/intervention sections was	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is	

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<p>and “as evidenced by” components</p> <ul style="list-style-type: none"> ● 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>understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.</p>	<p>incomplete or not appropriate to the patient Each section is worth 3 Points. Prioritization was not appropriate.</p>	<p>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	

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