Alliance University
Newborn Assessment

Student Name __SL_____ Date of care _2/24_____ Infant initial_NB__ Gender__M__

Date & time of birth __2/22/23 0822_____Type of delivery__VD_____

Complications/ resuscitation measures _____

Apgar 9__/_9_ Blood type _O+_____ Coombs __negative_____ TCB/ bili levels___7.3_____

Newborn screening: □ yes Hearing screen: □ yes results:__pass_____

Medications

Medication name	Dose/ Route/Frequency	Use/Action
erythromycins	5mg/gram(0.5%) ophthalmic ointment. 1 apply each eye once. 1hr after birth.	prevent and treat infections. It's a bacteriostatic antibiotic, it prevents the further growth of bacteria
hepB vaccine	IM, 0.5mL, give once within 24hrs of birth	It's a hepatitis B vaccine. It's action is prevent infection by the hepatitis B virus. The vaccine works by causing your body to produce its own protection (antibodies) against the disease.
Phytonadione (vitK)	1mg/0.5mL, IM injection, give once within 6hrs of birth	Babies born with small amount of vitK which is risk for bleeding and death. Vitamin K helps to make various proteins that are needed for blood clotting and the building of bones.

Assessment

Vital Signs: Temp___98.4_____ Pulse__134_____ Resp__45_____ BP_____ O_2 sat_____ Weight__7.97_____ Birth weight __7.11_____ % change_0.9_____ Length__19.8_____ Head___34.5_____ Chest__33_____
Skin

Turgor: ☐ good Condition: ☐ smooth ☐ dry, cracked Color: ☐ pink
TCB_____
Variations: (rashes, lesions, birthmarks etc)__milla(nose), rash(eyelids), no lesons/birthmarks_____

Head & Neck

Shape: ☐ normocephalic Fontanelles: Anterior: ☐ flat Posterior: ☐ flat

Sutures: ☐ open Variation:

Facial: ☐ symmetrical

Eyes (symmetry, conjunctiva, sciera, eyelids, PERL): ☐ normal

Ears (shape, position, auditory, auditory response): ☐ normal

Nose (patency): ☐ normal

Mouth (lip, mucous membranes, tongue, palate): ☐ normal

Neck (ROM, symmetry): ☐ normal

Chest- Respiratory/ Cardiovascular

Appearance (shape, breasts, nipples):__full areola, 1cm bud_____

Breath sounds: ☐ clear

Heart sounds: HR135 (AM)

S/S of respiratory distress ☐ no

Clavicles: ☐ normal

Brachial/femoral pulse (compare strength, equality): ☐ normal

Femoral pulse equal bilateral, strong +2

Abdomen

Appearance (shape, size): ☐ normal

Umbilical cord condition:___dry, intact, AVA_____

Bowel sounds: BS: ☐ hypoactive Date/Time of Last BM:_0200, 2/24_____ How many BM in last 24hrs:__2_____

Describe BM during shift_____none_____

Genitalia

Male (circumcision, urethral meatus, scrotum, testes):__testest descended, palpable_____

Circumcision: ☐ yes

Femoral pulses: ☐ normal

Urine output: ☐ Number of output in last 24hrs:__3 wet, 2 dirt_____

Anal patency: ☐ normal

Musculoskeletal

Posture: ☐ upper and lower flexed ROM all extremities: ☐ normal

Neurological Reflexes

(normal: positive, symmetrical)
(abnormal: absent, weak, assymetrical)

Blink: ☐ normal

Moro: ☐ normal

Grasp: ☐ normal

Tonic neck: ☐ normal

Sneeze: ☐ normal

Rooting: ☐ normal

Suck: ☐ normal

Swallow: ☐ normal

Gag reflex: ☐ normal

Stepping: ☐ normal

Babinski: ☐ normal

Behavior (Sleep/Activity Pattern 24hrs)

Sleep/ wake patterns: ☐ normal
Consolability: ☐ normal

Nutrition

Breast Milk: frequency _as needed, Q2-3hrs_____ Positioning: ☐ correct Latch: ☐ correct Audible swallow: ☐ yes Expressed breast milk in bottle: ☐ yes
Notes:uses bottled breastmilk to feed_____
Satiation: ☐ yes
Regurgitation: ☐ yes
Pacifier use: ☐ no

Stool (number per day, color, consistency)___2 drt in 24 hrs_____
Urine output (number per day/ color)____3 wet__

Bonding

Describe interaction between mother and infant
__mother expressed bonding with her newborn and no concern after lactation consultation_____

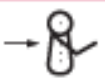
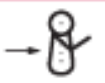
Client Education Topic	**Patient verbalize or demonstrate understanding**	**Additional information**

	or needs reinforcement	
(in postpartum AS paper)		

Maturational Assessment of Gestational Age

(New Ballard Score)

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 UB

HOSPITAL NO.

RACE UK

DATE OF BIRTH 21/2/23

DATE OF BIRTH

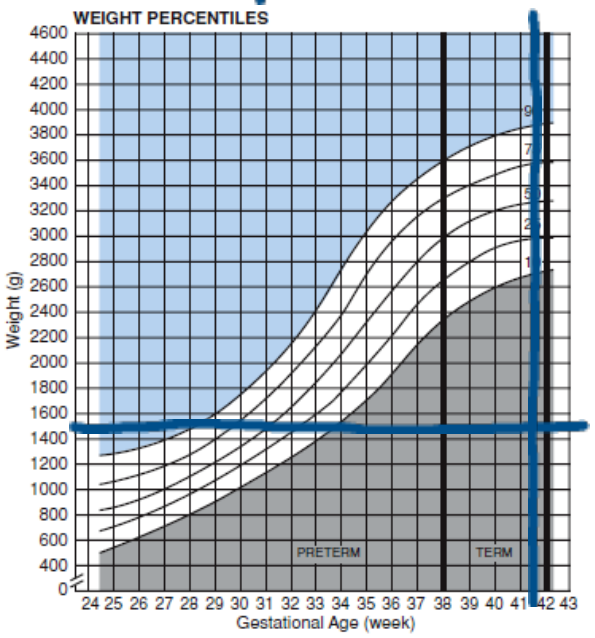
SEX M

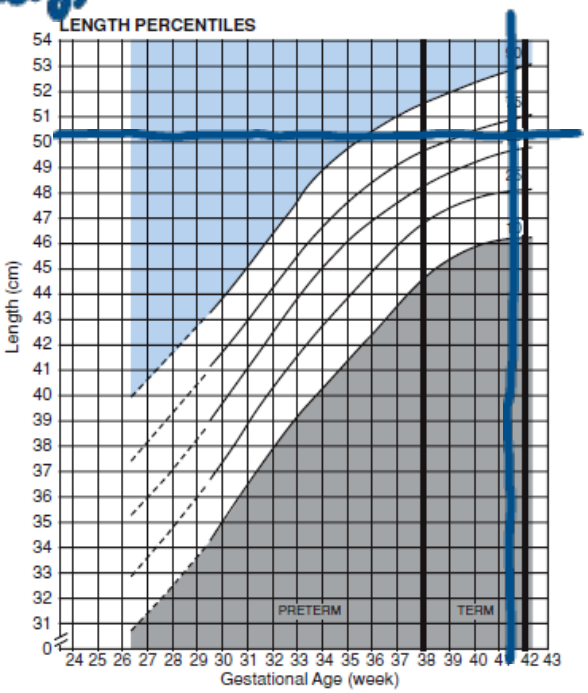
BIRTH WEIGHT 7lb 15oz (3566g)

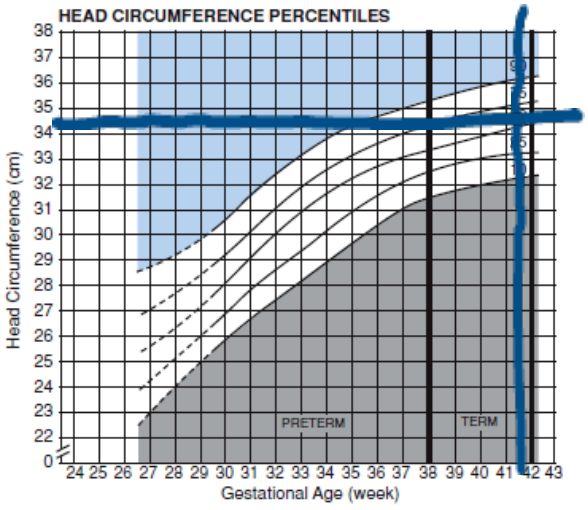
LENGTH 19.8 (50cm, 20in)

HEAD CIRC. 34.5

GESTATIONAL AGE 41+5.







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; 71:159-163.
2. Lubchenco LO, Hansman C, Boyd E: Intrauterine growth in length and head circumference as estimated from live births at gestational ages from 26 to 42 weeks. *Pediatrics* 1966; 37:403-408.

Abbott Nutrition
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Abbott Nutrition

Alliance University
Postpartum Assessment

Student Name __SL_____ Date of care _2/24_____

Patient's initials _NB__ Age _26__ Marital status _Single LMP _11_/29__/_22_ EDC _2_/_24_/23__

Gravida/ Para1_/ _1___ TPAL 1__ _0_ _0_ _1_ Blood Type ___A+___ Allergies __no__

Date, time and type of delivery 2/22/23 0822___ Induction/ Augmentation__none_____

Complication__none__ EBL _300mL_____ Anesthesia _____none_____

Religion __Christian__ Educational level _n/a_____ Occupation _____n/a_____

Medications

Medication name	Dose/ Frequency	Use/ Action
Benzocaine 20%	Topic spray, 1 time PRN	Skin itchiness, numbing spray, skin tear/prevent transmission of impulses along nerves
Docuate 100mg	PO 2times/day	Helps constipation, lowers surface tension, at oil water feces, allow water and lipids penetrate to stool
Ferrous sulfat 25mg	PO, 1 time/day	Postpartum anemia, replenishes iron, iron supplement
Glycerin-witch hazel pads	Q4hrs	Skin tear irritation, reduce swelling, repair, barrier
Ibuprofen 600mg	PO Q6hr PRN (4-6pain)	Pain relieve/anti-inflammatory, analgesic through inhibit coxi isotons
Prenatal iron supplement, 800mg	PO daily	Pregnancy volume blood increase, iron need increase, supply oxygen
Lanolin cream topical	Topical Q4hr PRN	Dry skin, nipple cream/treatment for sore/cracked nipples

Assessment

Vital Signs: Temp__97.8(oral)_____ Pulse__58_____ Resp__16_____ BP__92/64_____ O_2 sat__99_____

LOC/ orientation___AO*4_____ Activity_up with limb, bathroom privilege_____
Pain (scale, location, etc)_abdo cramping 2/10, motrin given, 1-2mg

Skin
Color_matches with ethnicity, gray_____ texture_smooth, dry_____
tugor: □ good integrity __smooth_____
variations_no_____
IV- location, fluid & rate____disconnected on 2/22/23_____

Chest- Respiratory/ Cardiovascular
Breath sounds___regular_____ Heart sounds:
□ lactating
Breasts: □ soft □ filling in
Nipples: □ erect □ intact □ sore
Notes___left nipples pain, soreness_____

GI/ Abdomen
Diet__regular_____ BS: □ hypoactive Diastasis recti: □ absent
Hemorrhoids _____none_____
Incision: □ None
Fundal assessment: □ firm □ midline
Fingerwidths/ fingerbreaths: _2fingers below umbilicus_____

Genitalia
Perineum: □ intact : □1°
Condition: □ approximated Lochia: color__rubra_____
amount__scant<2.5cm_____ odor___none_____
Note:_____normal to mild edema_____

Extremities
Varicosities__none_ pedal pulses___+2_ homan's sign _negative Edema: □ none

Elimination
Voiding pattern: □ normal Last BM__2/22 on DV_____

Psychological
Stage: □ taking hold □ Edinberg depression scale score_3/10_____

Bonding
Describe interaction between mother and infant
Baby rooming and bonding with mom

Client Education Topic	**Patient verbalize or demonstrate understanding or needs reinforcement**	**Additional information**
Needs assist with positioning,lactating, deeplying, feeding on depend	Pt verbalized subsidided pain on initial latch education	Watch wet/dirty diaper when documenting feeding log

promoted, assisted left breast		
Infant latch-on verified	Pt verbalized understanding	
Lactation counseling, seperation minimized, encouraged eye-contact with infant	Pt verbalized understanding	
Encouraged to feed Q2-3hrs and on dmand	Pt verbalized initiating actions	

Alliance University

Cheryl Phenicie School of Nursing

NURSING CARE PLAN

DYAD #2 - Newborn CP#1

Student's Name: Siohn Lee

Nursing Diagnosis **Patient's Initials:** NB's boy

P Risk for infection **Date:** 02/24

E r/t surgical procedure opened a portal of entry

Expected Outcomes	Nursing Interventions	Rationales	Evaluations
Patient's circumcision site remains clean and free of infection during 12 hours shift	1. Administer pain medicine as ordered by PCP 2. Provide comforts such as swaddling and skin-to-skin contact 3. Monitor the circumcision site for infection (bleeding, swelling, malodor, change of color) 4. Educate parents on circumcision site care, and verbalize the contents 5. Protect the surgical site with petroleum gauze 6. Avoid soaps, clean only with water on the penis, and avoid alcohol when caring for the umbilicus	1. Helps reduce discomfort and inflammation and allows the pt to recover quickly 2. Reduce stress and promote relaxation and recovery 3. Identifies early s/s of infection to prevent complications 4. Educate the parent to ensure the newborn is appropriately cared for and prevent complications 5. Protects against adherence to a diaper and in direct contact with urine 6. Soap and alcohol may	Patient's circumcision site remained clean and free of infection during 12 hours of shift

		irritate and may cause the umbilical cord clamp to fall off early	

Alliance University
Cheryl Phenicie School of Nursing
NURSING CARE PLAN
DYAD #2 - Newborn CP#2

Student's Name: Siohn Lee
Nursing Diagnosis **Patient's Initials:** NB's boy
P Risk for hyperbilirubinemia **Date:** 02/24
E r/t accumulation of blood as evidenced by serum bilirubin level 10mg/dL within 48 hours of born

Expected Outcomes	Nursing Interventions	Rationales	Evaluations

Newborn's serum bilirubin levels will be decreasing from 10 to 7 during 12 hours of shift	1. Check serum bilirubin level every 12 hours 2. Educate the parent about feeding every 2-3 hours and closely monitor input 3. Monitor stool output and weight twice a day 4. Educate parents on the importance of adequate breastfeeding to manage neonatal jaundice 5. Assist mother with positioning and latch techniques if needed 6. Provide emotional support and encouragement to the mother and family	1. Increasing bilirubin levels indicate neonatal jaundice and may need phototherapy 2. Feeding helps eliminate excess bilirubin from the body 3. Weight and stool output ensure the liver processes bilirubin effectively 4. Educate the parent to ensure the newborn is appropriately cared for and prevent complications 5. Improper positioning and latch decrease intake 6. Reduce anxiety and enhance coping strategies that promote the newborn's healing	The newborn's serum bilirubin levels decreased to 7 during 12 hours of shift

NURSING CARE PLAN
DYAD #2 - Mother CP#1

Student's Name: Siohn Lee
Nursing Diagnosis **Patient's Initials:** NB
P Risk for ineffective breastfeeding **Date:** 02/24
E r/t lack of direct breastfeeding and potential for difficulty transitioning to direct breastfeeding as evidenced by frequent using of bottled breast milk

Expected Outcomes	Nursing Interventions	Rationales	Evaluations

Mother reports increased comfort during direct breastfeeding with no pain or nipple trauma upon education at 1000	1. Assess the mother's comfort level with direct breastfeeding 2. Consult with a lactation consultant 3. Provide emotional support and encouragement 4. Encourage skin-to-skin contact during pumping 5. Provide education on proper storage and handling of breast milk 6. Assess knowledge and understanding of the breastfeeding technique	1. Helps identify the mother's need for support 2. Lactation consultants can provide information about proper breastfeeding techniques without experiencing nipple trauma 3. Give confidence and motivation to direct breastfeeding 4. Promote mother and baby bonding 5. Prevent contamination of breast milk and safety of the baby 6. Helps identify the mother's difficulty in direct breastfeeding	The mother verbalized increased comfort during direct breastfeeding with no pain or nipple trauma upon education at 1030

Dyad Concept Map

Past medical Hx
+B Thalassemia
AS mom: AAO*4, VS within normal range, pain 2/10 abdo cramp, VD, perineum intact 1degree laceration, rubra scant lochia, no odor, soft filled breast, left nipple pain on breastfeeding, 2+pedal pulse bilaterally, taking hold phase
AS baby: VS within normal range, breastfed with bottle, weight/length/head size AGA 10th-90th percentile, ballard score 42, all reflexes positive/symmetrical/circumcised, erythromicin, vitK

Medications
Mom:
Benzocaine 20%Topic spray, 1 time PRN
Docuate 100mg PO 2times/day
Ferrous sulfat 25mgPO, 1 time/day
Glycerin-witch hazel pads Q4hrs
Ibuprofen 600mg PO Q6hr PRN (4-6pain)
Prenatal iron supplement, 800mg PO daily
Lanolin cream topical Topical Q4hr PRN
Baby: erythromycins 5mg/gram(0.5%) ophthalmic ointment. 1 apply each eye once. 1hr after birth.

Nursing Diagnosis
Risk for infection Related to the circumcision procedure
Expected outcome: the baby will be free of infection until the discharge on 2/24
Nursing Interventions:

Monitor the circumcision site for signs of infection, including redness, swelling, and drainage.

Administer appropriate pain meds as ordered

Take vital signs every 3-4hours, document intake and output, and signs of infection at site or change of behavior

Nursing Diagnosis: Acute pain related to the circumcision procedure
Expected Outcomes: the baby will show decreased pain behaviors such as crying and fussiness during my shift
Nursing Interventions

Administer pain meds (acetaminophen, ibuprofen, anesthetic cream) as ordered

Encourage mom to breastfeed to help soothe and comfort the baby

Provide a quiet and dimly lit environment to help the infant rest and relax

Use non-pharmacological pain relief such as gentle rocking, swaddle, massage,

Nursing Diagnosis: Knowledge deficit related to post-circumcision care after education on 1300 2/24
Expected outcome: Parents will demonstrate understanding of post-circumcision care instructions.
Interventions:

Educate parents about post-circumcision care, proper hand hygiene, including water only cleaning, petroleum gauze on surgical site, give antibiotic

Educate mom about signs of infection including site redness, swelling, drainage, malodorous, change of baby's behavior,