Elmira College Nurse Education Program Concept Map 2 [BABY]: OB

N. DORCHESTER 1

Client

GESTATIONAL AGE:
40 W 6 D

FEMALE

-DX: RESP DISTRESS (TACHYPNEIC) AND NOT EATING WELL

Data Gaps

-NONE

Subjective Assessment (from parents)

-BREAST FED

-VAG DELIVERY

Objective Assessment

HR: 168
RR: 58
O2: 89%
TEMP: 37.1 (DEGREES C)

HEART SOUNDS: NORM, S1 S2

LUNG SOUNDS: NORM, CLEAR

SKIN: PINK

BREAST FED

7LBS 1.9OZ

APGARS: 9, 9

HEAD CIRCUM: 33 CM

LENGTH: 53.3 CM

FONTANELS: SOFT/FLAT

EARS, NOSE, MOUTH, NECK, CLAVICLES, GENITALS, ANUS, HIPS, SPINE, HANDS, FEET, AND ALL REFLEXES BUT TWO WERE NORMAL

CHEST MOVEMENT FAST

ABSENT ROOTING REFLEX
STRONG SUCK REFLEX

ABDOMEN WAS SOFT WITH BOWEL SOUNDS

BONDING/ENGROSSMENT WAS HAPPENING

Pertinent Labs

-ABG'S: PH: 7.4
PCO2: 34.3
O2: 63

-MATERNAL:
RUBELLA NON-IMMUNE
BLOOD TYPE/RH: O+

ALL OTHER LABS WERE ON FILE AT RPH

Pertinent Medications

-HEPATITIS VACCINE AT RPH

-AMPICILLIN GIVEN AT RPH

-PENICILLIN GIVEN AT RPH

-VIT K GIVEN AT RPH

-ERYTHROMYCIN OPHTHALMIC OINTMENT AT RPH

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N. DORCHESTER 2

Nursing Diagnosis: INEFFECTIVE BREATHING PATTERN R/T DIAGNOSIS OF TACHYPNEA

Goal: BY DISCHARGE THE BABY WILL MAINTAIN AN EFFECTIVE BREATHING PATTERNING WITH AN O2 SAT ABOVE 95%.

Outcomes:

THE BABY WILL MAINTAIN AN O2 SATURATION ABOVE 95% BY DISCHARGE

THE BABY WILL HAVE AN ABG PANEL THAT IS WITHIN NORMAL LIMITS BY DISCHARGE

THE BABY WILL HAVE 30-60 RESPIRATIONS WITHIN ONE MINUTE TO HAVE AN EFFECTIVE BREATHING PATTERN BY DISCHARGE

Interventions:

THE NURSE WILL MONITOR THE THE PULSE OXIMETER THROUGHOUT THE SHIFT ACCORDING TO HOSPITAL PROTOCOL

THE NURSE WILL CORRECT THE ABG PANEL WITH SUSPICION OF RESPIRATORY ALKALOSIS WITH VENTILATION PRN

THE NURSE WILL MAINTAIN THERMOREGULATION THROUGHOUT SHIFT TO MAINTAIN NORMAL BREATHING PATTERN

Evaluation: GOAL UNSURE, BUT WOULD LOOK LIKE [GOAL MET AS EVIDENCED BY EFFECTIVE BREATHING PATTERN WITH 50 RESPIRATIONS/MIN AND O2 SAT AT 98% AT DISCHARGE]

Nursing Diagnosis: IMBALANCED NUTRITION: LESS THAN BODY REQUIREMENTS R/T ADMITTING DX OF NOT EATING EFFECTIVELY AND AS EVIDENCED BY ABSENT ROOTING REFLEX

Goal: BY DISCHARGE THE BABY WILL HAVE A BALANCED NUTRITION WITH HEALTHY WEIGHT AND HAVE A PRESENT ROOTING REFLEX.

Outcomes:

THE BABY WILL HAVE A ROOTING REFLEX BY DISCHARGE.

THE BABY WILL BE FED EVERY 2-3 HOURS TO ENSURE A BALANCED NUTRITION SCHEDULE IS IN PLACE

THE BABY WILL HAVE A NORMAL WEIGHT AND GROWTH BASED ON AN INFANT GROWTH RATE CHART BEFORE DISCHARGE

Interventions:

THE NURSE WILL ASSESS THE BABY'S ROOTING REFLEX WHEN ASSESSING THE BABY ACCORDING TO THE HOSPITALS PROTOCOL

THE NURSE WILL EDUCATE THE MOTHER ON THE IMPORTANCE OF FEEDING EVERY 2-3 HRS, OR IF THE MOTHER IS NOT PRESENT FEED THE BABY EVERY 2-3 HRS TO MAINTAIN AN ADEQUATE NUTRITIONAL STATUS.

THE NURSE WILL MONITOR THE WEIGHT GAIN AND GROWTH OF THE BABY WHILE DOING REGULAR ASSESSMENTS ACCORDING TO HOSPITAL PROTOCOL

Evaluation: GOAL UNSURE, BUT WOULD LOOK LIKE [GOAL MET AS EVIDENCED BY BABY HAVING A HEALTHY WEIGHT ACCORDING TO GROWTH CHART AND ROOTING REFLEX IS PRESENT ON ASSESSMENT]

Analysis and Synthesis for Ineffective Breathing Pattern: "Tachypnea [is a] respiration rate [above] 60/min" (ATI Nursing, 2016, p. 185). The infant was admitted to the NICU because of tachypnea which is a pattern of ineffective breathing. This can then lead to poor gas exchange, collapsing of the alveoli in babies, atelectasis, and other complications with an infant (ATI Nursing, 2016, p. 185).
Rationale: (1) The nurse should be monitoring the pulse ox throughout the shift according to hospitals protocol. Nursing care for an infant in respiratory distress includes "monitor pulse oximetry" (ATI Nursing, 2016, p. 186). This will measure the babies breathing and oxygen status and will alert the nurse if any complications occur. (2) The infants ABG panel showed possible respiratory alkalosis which would require an intervention of ventilation for the infant (ATI Nursing, 2016, p. 185). Therefore the nurse should prepare oxygen for the baby on a PRN basis. (3) The baby should remain warm and this will prevent any other complications to the already depressed respiratory status. The baby should remain thermoregulated because when the baby becomes cold, the demand for oxygen increases in the the body offsetting the breathing pattern (ATI Nursing, 2016, p. 157).

Analysis and Synthesis for Imbalanced Nutrition [Less than body requirements] : "Desirable growth and development of the newborn is enhanced by good nutrition" (ATI Nursing, 2016, p. 169). Therefore the body of the infant must be receiving feedings on time, and have the proper reflexes required for feedings. This will then ensure that the infant is receiving the proper nutrition for its body requirements.
Rationale: (1) The nurse should assess the rooting reflex in a newborn assessment according to their protocol. This reflex is tested by brushing the cheek of the infant, and the newborn should then turn it's head toward the side that was stroked and being sucking (ATI Nursing, 2016, p. 159). This will ensure that the baby has the correct reflex to help with feeding which will promote balanced nutrition. (2) Newborns should be fed every 2-4 hours depending on if they are being breastfed or bottle fed (ATI Nursing, 2016, pp. 169-170). With this infant the nurse should educate the mother on the importance of breastfeeding every 2-3 hours to make sure the proper nutritional and weight status is being achieved (ATI Nursing, 2016, p. 169). (3) The nurse will be monitoring the weight and growth of the baby throughout the shift according to the hospital protocol to determine if the proper nutrients are going to the baby. "Weights are done daily in the newborn nursery." "Growth is assessed by placing the newborn's weight on a growth chart. Adequate growth should be within the 10th and 90th percentile" (ATI Nursing, 2016, p. 172). When the nurse assesses the weight and growth and places it on the growth chart, they then will be able to determine if the nutritional status is imbalanced because the baby will be below the 10th percentile if they have a poor weight gain trend (ATI Nursing, 2016, p. 172).

References

ATI Nursing. (2016). RN maternal newborn nursing review module edition 10.0. Leawood, KS: Assessment Technologies Institute, LLC