University Medical Center
Newborn

Disclaimer: The is a suggested interdisciplinary plan of care. This is only a guideline. The patient problem, outcomes and interventions may be changed to meet the individual needs of the patient. Physician / Medical orders supersede all pre-printed interventions identified on the

ADDRESSOGRAPH

Newborn

Estimated LOS: 3 Days Date placed on map: _____

CRITERIA FOR REMOVING PATIENTS FROM CAREMAP®:
Remove patients from this CareMap if transferred to NICU.

Secondary Diagnosis: _____

Significant Maternal Past / Recent Medical History: _____

_____

_____

Date of Birth: _____ Time of Birth: _____ Admission Time: _____

Admitting Pediatrician: _____ Notified at: _____ am/pm Obstetrician: _____

Born by: ☐ C-Section ☐ Vaginal Instrumentation: ☐ Forceps ☐ Vacuum

RN Signature: _____ **Date/Time:** _____

CONSULTS OR DISCIPLINES INVOLVED / NOTIFIED:

1.	Discharge Planning	ext. 2299	Initials / Date / Time notified: _____
2.	Social Services	ext. 2110	Initials / Date / Time notified: _____
3.	Lactation Consultant	ext. 2458	Initials / Date / Time notified: _____
4.	Cardiology	ext. 5354	Initials / Date / Time notified: _____
5.	Nutrition	_____	Initials / Date / Time notified: _____
6.	_____		Initials / Date / Time notified: _____
7.	_____		Initials / Date / Time notified: _____

Instructions for Documentation:
OUTCOMES / INTERVENTIONS:

- Initial when met or completed
- Use notation N/A, if not applicable for the timeframe
- Initial and circle, if not met or completed

SUPPLEMENTAL DOCUMENTATION is required on the Interdisciplinary Progress Notes when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

Newborn

Signature	Title	Initial

Signature Requiring Co-Signature		
Signature Requiring Co-Signature	Date/Shift	Initial/Title

Addressograph

DOB: _____ Time: _____

Desired Outcomes

Problems/ Needs	0 –6 Hours Time: ____			6 – 12 Hours Time: ____			12 - 24 Hours Time: ____		
Knowledge deficit related to plan of care 1	Family verbalizes understanding of anticipated plan of care and participates in decision making			Family verbalizes understanding of anticipated plan of care and participates in decision making			Family verbalizes understanding of anticipated plan of care and participates in decision making		
	Provides newborn care according to instructions			Provides newborn care according to instructions			Provides newborn care according to instructions		
Pain Management 2	NIPS < 3			NIPS < 3			NIPS < 3		
Transition to Extra-uterine Life 3	Vital signs WNL			Vital signs WNL			Vital signs WNL		
	Measures & weight WNL for gestation			Weight loss not more than 10% of birth weight			Weight loss not more than 10% of birth weight		
	No evidence of respiratory distress			No evidence of respiratory distress			No evidence of respiratory distress		
	Physical & behavioral characteristics WNL			Physical & behavioral characteristics WNL			Physical & behavioral characteristics WNL		
	Demonstrates no signs of jaundice			Demonstrates no signs of jaundice			Demonstrates no signs of jaundice		
Infection / Skin Integrity 4				Cord WNL			Cord WNL		
							Circumcision WNL		
Nutrition 5	Tolerates feedings			Tolerates feedings			Tolerates feedings		
	Glucose heelstick (if done) WNL			Glucose heelstick (if done) WNL			Glucose heelstick (if done) WNL		
	Initiates breast feeding: licks, nuzzles, intermittent latch and suck			Latch Score > 7			Latch Score > 7		
Excretion 6	Passes meconium / stool			Passes meconium / stool			Passes meconium / stool		
	Voids			Voids			Voids		
Priority of Care									

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DOB: _____ Time: _____

Desired Outcomes

Problems/ Needs	24 - 48 Hours Time: _____	48 – 72 Hours Time: _____	72 - 96 Hours Time: _____
Knowledge deficit related to plan of care **1**	Family verbalizes understanding of anticipated plan of care and participates in decision making	Family verbalizes understanding of anticipated plan of care and participates in decision making	Family verbalizes understanding of anticipated plan of care and participates in decision making
	Provides or verbalizes understanding of newborn care.	Provides or verbalizes understanding of newborn care.	Provides or verbalizes understanding of newborn care.
Pain Management **2**	NIPS < 3	NIPS < 3	NIPS < 3
Transition to Extra-uterine Life **3**	Vital signs WNL	Vital signs WNL	Vital signs WNL
	Weight loss not more than 10% of birth weight	Weight loss not more than 10% of birth weight	Weight loss not more than 10% of birth weight
	No evidence of respiratory distress	No evidence of respiratory distress	No evidence of respiratory distress
	Physical & behavioral characteristics WNL	Physical & behavioral characteristics WNL	Physical & behavioral characteristics WNL
	Color WNL	Color WNL	Color WNL
Infection / Skin Integrity **4**	Circumcision WNL	Circumcision WNL	Circumcision WNL
Nutrition	Tolerates feedings	Tolerates feedings	Tolerates feedings
	LATCH score > 7	LATCH score > 7	LATCH score > 7
Excretion **5**	Passes meconium / stool	Voids after circumcision	Passes stool
	Voids	Passes stool	Voids
		Voids	
Specimens & Diagnostics **6**	Pulse Oximeter reading > 94% Predischarge assessment for the risk of Hyperbilirubinemia completed, follow-up plan identified		
Priority of Care			

Diagnosis / Procedures

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DOB: _____ Time: _____

Interventions

Problems/ Needs	0 - 6 Hours Time: _____				6 - 12 Hours Time: _____				12 - 24 Hours Time: _____			
Treatments	Assess for transition to extra uterine life Initiate the following protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose protocol				Assessment time: Resp status WNL Cardiovascular status WNL Color Pink Skin Intact Fontanel soft & flat Abdomen WNL Reflexes WNL				Assessment time: Resp status WNL Cardiovascular status WNL Color Pink Skin Intact Fontanel soft & flat Abdomen WNL Reflexes WNL			
	Pediatrician visit				Pain score with procedure at least every 8 hrs.				Pain score with procedure at least every 8 hrs.			
					Circumcision by Dr. _____				Circumcision by Dr. _____			
	Weigh Daily											
					Pediatrician visit				Pediatrician visit			
					Continue Protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose Protocol ☐ Circumcision Protocol				Continue Protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose Protocol ☐ Circumcision Protocol			
Nutrition	1st bottle feeding in nursery, water sips - formula ¼ - ½ oz. - then q 3-4 hrs.				Assist with breast Feeding as needed q 2-3 hrs.				Assist with breast feeding as needed q 2-3 hrs.			
					Finger feed if mom cannot feed or ineffective suck				Finger feed if mom cannot feed or ineffective suck			
	Encourage & assist with breast feeding q 3 hrs. - q 1-2 hrs., if exhibits ineffective suck				Assess ability to tolerate feed				Assess ability to tolerate feed			
	Observe Mom breast-feeding at least q 8 hrs.				Observe Mom breast-feeding at least q 8 hrs.				Observe Mom breast-feeding at least q 8 hrs.			
	Finger feed by staff, if needed				Refer for Nutritional Assessment if > 20 calories / oz formula							
					Assess for void & stool				Refer for Nutritional Assessment if > 20 calories / oz			
	Assess for void & stool								Assess for void & stool Notify MD if no stool or void by 24 hrs.			
Specimens / Diagnostics	Send cord blood to Lab				Blood type / RH: _____Coombs: _____ If done review labs notify MD if significant/ critical				Review labs notify MD if Significant			
					For infants receiving Hepatitis B Vaccine Hepatitas B Vaccine Information Statement Edition date: _____ Date given: _____							

Diagnosis / Procedures

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DOB: _____ Time: _____

Interventions

Problems/ Needs	0 - 6 Hours Time: ____				6 - 12 Hours Time: ____				12 - 24 Hours Time: ____			
Safety / Activity	Back to sleep				Back to sleep				Back to sleep			
	Bassinet Safety check Transport to Mom				Bassinet Safety check Transport to Mom				Bassinet Safety check Transport to Mom			
	Comfort care Provided				Comfort care Provided				Comfort care Provided			
	Bulb syringe present Parents instructed on use				Bulb syringe present				Bulb syringe present			
	Transponder in place				Transponder in place				Transponder in place			
	ID bracelet X 2				ID bracelet X 2				ID bracelet X 2			
Teaching / Psychosocial	Social Service referral As appropriate											
Discharge Planning	Assess referrals are made as necessary				Re-evaluate D/C Needs Social Service referral as appropriate				Re-evaluate D/C Needs Social Service referral as appropriate			
	Identify need for car seat observation test (< 37 weeks gestation) ☐ Yes ☐ No				Identify need for car seat observation test (< 37 weeks gestation) ☐ Yes ☐ No				Identify need for car seat observation test (< 37 weeks gestation) ☐ Yes ☐ No			
	Special Children's Health Request done if needed ☐ Yes								Car Seat Protocol Challenge Test after 12 hours			

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Interventions

Problems/ Needs	24 - 48 Hours Time: ____					48 – 72 Hours Time: ____					72 - 96 Hours Time: ____				
Assessments/ Treatments	Assessment time:					Assessment time:					Assessment time:				
	Resp status WNL					Resp status WNL					Resp status WNL				
	Cardiovascular status WNL					Cardiovascular status WNL					Cardiovascular status WNL				
	Color Pink					Color Pink					Color Pink				
	Skin Intact					Skin Intact					Skin Intact				
	Fontanel soft & flat					Fontanel soft & flat					Fontanel soft & flat				
	Abdomen WNL					Abdomen WNL					Abdomen WNL				
	Reflexes WNL					Reflexes WNL					Reflexes WNL				
	Pediatrician Visit					Pediatrician Visit					Pediatrician Visit				
	Circumcision by Dr._____					Circumcision by Dr._____					Circumcision by Dr._____				
	Pain score with procedures or at least every 8 hrs.					Pain score with procedures or at least every 8 hrs.					Pain score with procedures or at least every 8 hrs.				
	Continue Protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose ☐ Circumcision					Continue Protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose protocol ☐ Circumcision					Continue Protocols: ☐ Thermoregulation Mgmt ☐ Hypoglycemic Mgmt ☐ Skin Care Mgmt ☐ Hyperbilirubinemia ☐ Sucrose protocol ☐ Circumcision				
	Remove cord pin At discharge					Remove cord pin At discharge					Remove cord pin At discharge				
	Weight					Weight					Weight				
Nutrition	Assist with breast feeding as needed q 2-3 hrs.					Assist with breast feeding as needed q 2-3 hrs.					Assist with breast feeding as needed q 2-3 hrs.				
	Finger feed if mom cannot feed or ineffective suck					Finger feed if mom cannot feed or ineffective suck					Finger feed if mom cannot feed or ineffective suck				
	Assess ability to tolerate feed					Assess ability to tolerate feed					Assess ability to tolerate feed				
	Refer for Nutritional Assessment if > 20 calories / oz formula					Refer for Nutritional Assessment if > 20 calories / oz formula					Refer for Nutritional Assessment if > 20 calories / oz formula				
	Asses for void & stool					Asses for void & stool					Asses for void & stool				

Diagnosis / Procedures

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Interventions

Problems/ Needs	24 - 48 Hours Time: _____	48 – 72 Hours Time: _____	72 - 96 Hours Time: _____
Safety / Activity	Back to sleep	Back to sleep	Back to sleep
	Transport to Mom Bassinet Safety Check	Transport to Mom Bassinet Safety Check	Transport to Mom Bassinet Safety Check
	Provides measures to encourage sleep Keep linen clean and dry	Provides measures to encourage sleep Keep linen clean and dry	Provides measures to encourage sleep Keep linen clean and dry
	Bracelets on x 2	Bracelets on x 2	Bracelets on x 2
Specimens / Diagnostics	Review labs Notify MD if Significant/critical	Review labs Notify MD if Significant/critical	Review labs Notify MD if Significant/critical
	Biochemical screen 24 hrs. after first milk feeding or at discharge or transfer Date: _____ Time: _____ Screening Pulse Ox results_____ Screening Bilirubin Level and risk assessment completed after 24hrs		
Teaching / Psychosocial			
Discharge Planning	Assess need for Social Service Referral Referral made PRN	Re-evaluate D/C Needs Refer to Social Service PRN	Re-evaluate D/C Needs Refer to Social Service PRN
	Birth Certificate information collected & completed	Birth Certificate information collected & completed	Car Seat Observation Test testing done
	Car Seat Challenge Observation Testing done	Car Seat Observation Testing done	Assure special Children's Health Requisition is done
	Assure special Children's Health Requisition is done	Assure special Children's Health Requisition is done	
	Follow up with baby's MD within 2 days if breast-feeding and: - < 38 wks GA - Dc'd before 48 hrs. of birth		

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Initial Assessment / Transition

Weight: _____ gms. _____ lbs. _____ oz.
Length: _____ cm. _____ inches
Head: _____ cm. _____ inches
Chest: _____ cm. _____ inches
Abdomen: _____ cm. _____ inches

Bracelet# _____

Feeding:
☐ Breast
☐ Bottle

Initial Bath _____
Time / Initials

Infant removed from radiant warmer:
Date: _____ Time: _____
Temp: _____

Time	Radiant Warmer Temp	Temp	Pulse	Resp.	NIPS Pain Score	Intervention	Breath Sounds	Color	Retractions	Location	Flaring / Grunting	O_2	S_aO_2	BP	Activity	Muscle Tone	Chemstrip	Other	Initials

Pulse Oximeter Alarm On

High Limit set at _____

Low Limit set at _____

Pain Interventions: A = Sucrose B = Rocking C = Swaddling D = Noise / Light E = Distraction

Color:
A = Pink E = Plethoric
B = Pale F = Mottled
C = Dusky G = Cyanosis
D = Jaundiced H = Acrocyanosis

Muscle Tone:
I = Normal Flexion
J = Flaccidity
K = Spasticity

Activity:
L = Active stimulation P = Active with
M = Quiet, alert R = Irritable
N = Lethargic S = Hyperactive
O = Tremors T = Sleeping

Breath Sounds:
U = Equal W = Crackles
V = Clear X = Diminished

OC = Open Crib

Location: SSR = Substernal Retraction SCR = Subcostal Retration ICR = Intercostal Retraction

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Addressograph _____

SKIN

_____ Pink _____ Acrocyanosis
_____ Central cyanosis _____ Dusky
_____ Pale _____ Plethoric
_____ Mottled _____ Jaundice
_____ Abrasions Site: _____
_____ Birthmarks Site: _____
_____ Dry _____ Meconium stained
_____ Ecchymosis Site: _____
_____ Lacerations Site: _____
_____ Milia _____ Peeling
_____ Mongolian Spots Site: _____
_____ Petechiae _____ Pustules
_____ Rash describe _____
_____ Skin Tags Site: _____
_____ Vesicles Site: _____

CHEST

_____ Symmetrical _____ Asynmmetrical
_____ Barrel Chest
_____ Breast engorgement
_____ Supranummary nipples
_____ Breast discharge

RESPIRATIONS

_____ Normal
_____ Labored (see above)

BREATH SOUNDS

_____ Equal _____ Clear
_____ Crackles _____ Wheezes

CLAVICLES

_____ Straight _____ Smooth
_____ Crepitus Right Left

REFLEXES

_____ Moro _____ Suck _____ Grasp

CRY

_____ Normal _____ Weak _____ Shrill
_____ No cry, quiet, alert

HEAD

_____ Symmetrical _____ Molding
_____ Caput
_____ Cephalohematoma Right Left
_____ Forcep marks Location: _____
_____ Fontanels open & flat Other: _____

FACE

_____ Symmetrical _____ Asymmetrical

EYES

_____ Clear _____ Lid edema
_____ Discharge (describe) _____
_____ Subconjunctival hemmorhage Right Left

NECK

_____ Full ROM _____ Limited ROM

HEART

_____ Regular _____ Irregular
_____ Murmur heard _____ Displaced PMI

FEMORAL PULSES

_____ Equal _____ Unequal

EXTREMITIES

_____ Symmetrical _____ Asymmetrical
_____ Normal ROM _____ Limited ROM
_____ Symmetrical gluteal skin folds/equal leg length
_____ Extra Digits Site: _____
_____ Abnormal foot position Right Left

FEMALE GENITALIA

_____ Normal _____ Discharge
_____ Vaginal skin tag

MALE GENITALIA

_____ Normal
_____ Foreskin normal
_____ Undescended testicle Right Left
_____ Position of meatus at tip

EARS

_____ Normal _____ Low Set
_____ Sinus Right/Left _____ Skin Tags R/L

NOSE

_____ Patent _____ Discharge

MOUTH

_____ Cleft Palate _____ Cleft Lip

MUCUS MEMBRANE

_____ Pink _____ Cyanosis

CORD

_____ 3 Vessels _____ 2 Vessels

ABDOMEN

_____ Symmetrical _____ Asymmetrical
_____ Flat _____ Scaphoid
_____ Rounded _____ Distended
_____ Soft

BOWEL SOUNDS

_____ Present _____ Absent

RECTUM

_____ Patent _____ Other

SPINE

_____ Closed vertebral column
_____ Asymmetry _____ Mass
_____ Dimple _____ Tuft of hair

Refer to nutrition if:

☐ SGA
☐ Cleft lip or palate

RN Signature: _____ **Date/Time:** _____