CHAPTER 15

Newborns and Other Neonates with Conditions Originating in the Perinatal Period

INTERMEDIATE HEALTH RECORD

All notes

Author	Service	Author Type	Filed	Note Time
, DO	(none)	Physician	06/11/2008 1001	06/11/2008 0956

DISCHARGE SUMMARY

PRINCIPAL DIAGNOSIS: Newborn female
Additional diagnoses and complications which pertain to this admission: mom GBS positive with appropriate antibiotic treatment
Delivery Method: vaginal

REASON FOR ADMISSION: Newborn female

HOSPITAL COURSE:
Baby girl was born at 39w 4d to a 33 y.o. No obstetric history on file. mother.
OB HISTORY
Current Pregnancy: No Problems
OB/GYN History: None identified by Patient. Her prenatal labs included
PRENATAL LABS
GBS: Positive
HbsAg: Negative
HIV: (not recorded)
Blood Type: A
RH: Positive
Antibody Screen: Negative
Rubella Status: Immune
Hemoglobin: (not recorded)
VDRL/RPR: Non-reactive. Birth date was 6/9/2008.
Patient APGARS in the past 96 hrs:

	1 Minute Apgar Total	5 Minute Apgar Total	10 Minute Apgar Total
06/09/08 1513	9	9	-

Birth Weight (4165 grams):
Birth Weight (9lbs/2oz):

Patient DAILY WEIGHT in the past 96 hrs:

	Wt.	Daily Weight (grams)	Change from Previous (grams)	Change from Birth (grams)	% of Change from Birth
06/11/08 0030	3.915 kg (8 lb 10.1 oz)	3915 GRAMS	-159 GRAMS	-250 GRAMS	-6 %
06/10/08 0100	4.074 kg (8 lb 15.7 oz)	4074 GRAMS	-	-91 GRAMS	-2 %

Length (cm): 56 CM

Head Circumference (cm): 34.5 CM

Feeding preference: Breast feeding well with good latch and suck. Transitional stools and multiple wet diapers

LABS/PROCEDURES:
Metabolic Screen drawn: Yes

No results found for this basename: BILINEONATAL:* in the last 720 hours
No results found for this basename: BILIDIRECT:* in the last 720 hours
Transcutaneous Bilimeter Screening Result: 4.0

Neonatal Bilirubin Nomogram Zone: Low Risk Zone

Other labs: No
Circumcision: No
Newborn Hearing Test: Left Ear: Pass;Letter to Parents
Right Ear: Pass;Letter to Parents

PHYSICAL EXAMINATION:
GENERAL: Term female newborn
EYES: Normal
HEAD, EARS, NOSE, MOUTH, AND THROAT: Normal
NECK: Normal
CHEST/BREAST: Normal
RESPIRATORY: Normal
CARDIOVASCULAR: Normal
ABDOMEN/RECTUM: Normal
GENITOURINARY: Female: Normal
MUSCULOSKELETAL: Normal
LYMPHATIC: Normal
SKIN/HAIR/NAILS: Normal
NEUROLOGIC: Normal

Feedings (documented ability to latch, suck, and swallow with feedings): Yes

DISCHARGE PLAN:

Discharge to home..
Breast feed every 2 to 3 hours around the clock.
Usual discharge instructions provided.
Follow up in 2 days.

PERTINENT FINDINGS/RESULTS AT DISCHARGE: None

CONDITION AT DISCHARGE: stable

Total time spent on discharge: 20 minutes

6/11/2008

History and Physical

H&P Notes

All notes

Author	Service	Author Type	Filed	Note Time
DO	(none)	Physician	06/10/2008 1021	06/10/2008 1019

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS:

Baby girl was born at 39w 3d to a 33 y.o. No obstetric history on file. mother.

OB HISTORY
Current Pregnancy: No Problems
OB/GYN History: None identified by Patient. Visit history: Regular Care. Her prenatal labs include
PRENATAL LABS
GBS: Positive
HbsAg: Negative
HIV: (not recorded)
Blood Type: A
RH: Positive
Antibody Screen: Negative
Rubella Status: Immune
Hemoglobin: (not recorded)
VDRL/RPR: Non-reactive. Estimated Date of Delivery: 6/14/08.

Onset of Labor Date: 6/9/08. Time: 0500.
INTRAPARTUM EVENTS
Significant L&D Medications: ABX > 4H
Anesthesia/Analgesia: Epidural
Significant Events/Complications: None. Membranes: Date of Rupture: 6/9/08
. Time of Rupture: 1330
. Fluid Type: Thin meconium
.

Delivery Method: (not recorded)
Cesarean Birth Indications: (not recorded)
Shoulder Dystocia: (not recorded)
Forceps: (not recorded)
ForcepsType: (not recorded)
. Presentation: (not recorded)
. ROM > 18 hours: (not recorded)
. Maternal Temp > 100.4 F: (not recorded)
. Vacuum Type: (not recorded)
Total time Vacuum in use: (not recorded)
# of pop-offs: (not recorded)
. Placenta: (not recorded)
Cord: (not recorded)

History and Physical continued

Cord Vessels: (not recorded)
. Birth date was 6/9/2008. Time of Birth: (not recorded)
. Birth Weight (grams): (not recorded)
.

Resuscitation: Spontaneous respirations

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AIRWAY
Suction method: Bulb
Secretions: Thin mec.
. Blow by Oxygen (lpm): (not recorded)
. Amount of time blow by used: (not recorded)
. Bag & Mask:(lpm): (not recorded)
. Amount of time Bag & Mask used: (not recorded)
.

Patient APGARS in the past 48 hrs:

	1 Minute Apgar Total	5 Minute Apgar Total	10 Minute Apgar Total
06/09/08 1513	9	9	-

PHYSICAL EXAMINATION:

Pulse 132 | Temp 97.8 °F (36.6 °C) | Resp 32 | Wt 4.074 kg (8 lb 15.7 oz)
Head Circumference (cm): 34.5 CM

Chest Circumference (inches): 13.98 INCHES

EYES: Normal
HEAD, EARS, NOSE, MOUTH, AND THROAT: Normal
NECK: Normal
CHEST/BREAST: Normal
RESPIRATORY: Normal
CARDIOVASCULAR: Normal
ABDOMEN/RECTUM: Normal
GENITOURINARY: Female: Normal
MUSCULOSKELETAL: Normal
LYMPHATIC: Normal
SKIN/HAIR/NAILS: Normal
NEUROLOGIC: Normal

ASSESSMENT:

female infant born at 39w 3d doing well. Breast feeding with good latch.

PLAN:

Baby was admitted to the normal newborn nursery.

Begin routine nursery orders and usual cares and precautions.
Baby will be breast fed.
Observe baby for 48 hours due to Mom with positive GBS.
Obtain hepatitis B vaccine, hearing screen, and newborn screen today.

All Progress Notes

Author	Service	Author Type	Filed	Note Time
, NP	(none)	PHYS- Nurse Practitioner	06/09/2008 1517	06/09/2008 1514

NNP Note: Called to attend delivery of term infant via vaginal delivery secondary to thin meconium stained amniotic fluid. Suctioning of mouth and nares was done on perineum. Infant breathed and cried spontaneously following delivery and, therefore, was not suctioned below the cords for meconium. Infant was placed on mother's abdomen and then on warmer at approximately 3 minutes of age. Infant received gentle stimulation with drying and bulb suctioning of mouth and nares. Apgars were 9 and 9 at one and five minutes of age, respectively. Normal newborn exam, crying, pink and vigorous.
, CNNP

Progress Notes

All notes

Author	Service	Author Type	Filed	Note Time
	(none)	NURS- Registered Nurse	06/11/2008 1241	06/11/2008 1241

Newborn Discharge

Data:

Vital signs stable, assessments within normal limits.
Feeding well, tolerated and retained.
Cord drying, no signs of infection noted.
Baby voiding and stooling.
No evidence of significant jaundice, mother aware of signs/ symptoms to look for and report per discharge instructions.
Discharge outcomes on care plan met.
No apparent pain.

Action:
Review of care plan, teaching sheet and discharge instructions done with mother. Infant identification with I.D. bands done, mother verification with signature obtained. Metabolic and hearing screen completed.

Response:
Mother states understanding and comfort with infant cares and feeding. All questions about baby care addressed. Baby discharged with parents at 1240 and was secured in a car seat.

Title: Newborn Care (Resolved) continued

Initials	Name	Provider Type	Discipline
	, RN	Nurse NURS- Registered Nurse	

Medication Administration Record

All Meds and Administrations

phytonadione 1 mg injection (VITAMIN K) [140120700]

Ordered On	Ordered By	Order Status
06/09/2008 1643	DO	Completed (Past End Date/Time)

Starts	Ends	Frequency	Route	Dose
06/09/2008 1645	06/09/2008 1655	ONE TIME	Intramuscular	0.5 mL = 1 mg of 1 mg/0.5 mL

Total Doses	Remaining Doses	Rate	Duration
1			

Admin Instructions
Give within one hour of birth.

Order Comments

All Administrations

	Result	Dose	Route	Given By	Comments
06/09/2008 1610	Given Site: Left Quadriceps	1 mg	Intramuscular		

erythromycin 0.5% ophthalmic ointment 1-2 cm [140120701]

Ordered On	Ordered By	Order Status
06/09/2008 1643	, DO	Completed (Past End Date/Time)

Starts	Ends	Frequency	Route	Dose
06/09/2008 1645	06/09/2008 1643	ONE TIME	Both Eyes	

Total Doses	Remaining Doses	Rate	Duration
1			

Admin Instructions
Give within one hour of birth.

Order Comments

All Administrations

	Result	Dose	Route	Given By	Comments
06/09/2008 1610	Given	2 cm	Both Eyes		

naloxone pediatric 0.1 mg/kg injection (NARCAN) [140120703]

Ordered On	Ordered By	Order Status
06/09/2008 1643	, DO	Verified (Past End Date/Time)

Starts	Ends	Frequency	Route	Dose
06/09/2008 1642	06/09/2008 2359	ONE TIME PRN	Intramuscular	

Total Doses	Remaining Doses	Rate	Duration

Admin Instructions
Give once, PRN, to infant up to 4 hours of age with symptoms of respiratory depression whose mother received narcotics during labor if physician or NNP is not immediately available. Notify physician or NNP if dose is given. Doses will be rounded, depending on the dosage form dispensed, according to the Pediatric Dose Rounding Guidelines. This guideline is cited in the web-link below.

Order Comments

All Meds and Administrations

All Administrations
(No Admins Scheduled or Recorded for this Medication)

hepatitis B vaccine pediatric 5 mcg = 0.5 mL x 5 mcg/0.5 mL injection (RECOMBIVAX-HB) [140120704]

Ordered On	Ordered By	Order Status		
06/09/2008 1643	DO	Verified (Past End Date/Time)		
Starts	**Ends**	**Frequency**	**Route**	**Dose**
06/09/2008 1645	06/10/2008 0444	ONE TIME	Intramuscular	0.5 mL
Total Doses	**Remaining Doses**	**Rate**	**Duration**	
1	1			

Admin Instructions
Refrigerate.
Give within 12 hours of birth to all infants. Bathe newborn, wash the sites well with soap and water, prepare injection site prior to IM administration.
Obtain verbal consent from parent prior to administration.
If parent unwilling to give verbal consent, notify physician by morning rounds or prior to 12 hours of age.
Give Hepatitis B Vaccine information sheet to parent and document administration in MAR and Imm/Inj activities.

Document the necessary information in the Immunization/Injectable Activity. Mandatory: Follow VIS link from eMAR to obtain Vaccination Information Statement to give to patient. Document that VIS was given.

Order Comments

All Administrations

	Result	Dose	Route	Given By	Comments
06/09/2008 1645	Due				