

PROTOCOL FOR: Admission: NICU

DESIRED PATIENT

OUTCOME: The infant will have optimal care initiated and maintained through appropriate monitoring, assessments, planning and documentation.

CLINICAL
ASSESSMENT AND

CARE: 1. Vital signs, to include axillary temperature and blood pressure on admission. Thereafter, vital signs will be performed according to the following:

The infant's need for respiratory support or oxygen should not be the sole determining factor for the frequency of vital signs. Axillary temperatures are not needed more frequently than every 4 hours once the axillary temperature has stabilized and is well correlated with skin temperature.

- a. If intubated or receiving nasal CPAP: upon admission then every hour x 6 with hands on assessment, then every 2 hours x 9 (for total 18 hours) with hands on assessment.
- b. For infants admitted on nasal cannula or supplemental oxygen: Upon admission, then every hour x 4 with hands on assessment, then every 2 hours x 2, then every 4 hours.
- c. If admitted in room air: Upon admission then every 2 hours x 3, then every 4 hours or before feeding unless the admission diagnosis (e.g. seizures, pneumatosis intestinalis) suggests a need for more frequent vital signs.

THESE GUIDELINES ARE SUPERCEDED BY STANDARDS AND PROTOCOLS FOR HFOV, VENTILATOR AND NASAL CPAP.

- 1) Report any abnormal vital signs.
- 2) Admission weight in kilograms and pounds and ounces.
- 3) Length and head circumference (OFC) in centimeters.
- 4) Blood work and cultures as ordered.
- 5) Glucose meter on admission, then every 30 minutes until IV established. Once IV established then every hour x 2, then every 4 hours and prn. If physician/AP does not plan to start IV, do glucose monitoring on admission, every hour x 2 and then before feeds until age 12 hours or per order of physician/AP.
 - a) Report glucose meter reading < 40
 - b) Report glucose meter reading > 150
- 6) Physical assessment - initial physical assessment within 8 hours, providing infant's condition has appropriately stabilized.

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- a) Report abnormal findings on physical assessment, including increasing respiratory distress or respiratory effort, central cyanosis, and physical abnormalities.
- b) Report failure to void within the first 8 hours.
- 7) Pulse oximetry or transcutaneous CO₂ monitor as ordered.
- 8) Parent-infant interaction: parent response to admission/infant's condition.
 - a) Report questions which require communication with MD or advanced practitioner.
- 9) Medications:
 - a) Erythromycin ointment to both eyes (unless eyes fused).
 - b) Vitamin K 1mg IM unless lower dose is ordered based on weight or gestational age.
 - c) Additional medications as ordered.
- 10) Initiate pain screening per protocol.

- SAFETY:**
- 1. Ensure that bedside is adequately prepared prior to admission.
 - 2. Place ID bracelet on the infant.

- DOCUMENTATION:**
- 1. Complete nursing database (to include initial physical assessment). Database must be completed within 24 hours of admission.
 - 2. Initiate appropriate standardized care plan.
 - 3. Initiate Teaching Plan and Patient and Family Teaching Record for "Family Education of the Hospitalized Infant" and other teaching plans as appropriate.
 - 4. Document medications on MAR.
 - 5. Complete Newborn Identification Record (Footprint Sheet). All items must be completed by Labor & Delivery and NICU staff before it is filed in the chart.
 - 6. Complete parent handout containing medical record number (TO number).

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/91

REVISION DATES: 6/91, 6/92, 9/92, 5/93, 8/93, 5/94, 12/94, 3/97, 8/97, 12/97, 5/99, 10/00, 12/04, 12/06, 12/08, 7/09

REVIEWED DATES: 11/07