

PROTOCOL FOR: Admission: Newborn Nursery

DESIRED PATIENT

OUTCOMES: Will have optimal care initiated and maintained through appropriate monitoring, assessment, planning and documentation.

CLINICAL
ASSESSMENT AND

- CARE:
1. After admission of infants from Delivery Room, assess:
 - a. Vital signs (T, P, R, BP) on admission.
 - 1) *Report fever greater than 100°F.*
 - b. Weight on admission - record in Kg and pounds.
 - c. Length on admission - record in inches and cm.
 - d. Head circumference (OFC) on admission.
 - e. Time of first void.
 - f. Time of first stool.
 - g. Body system assessment per database.
 - 1) *Report persistent - beyond 1 hour or increasing severity of respiratory distress, central cyanosis or identified physical anomalies.*
 - 2) *Report assessment findings that are variances from the list of "expected assessment findings for the well newborn."*
 - h. Parental interaction with infant (if observed).
 - i. Initiate pain screening according to protocol. Perform screening with each hands-on vital signs during course of hospital stay.
 2. Initiate glucose screening protocol in infants at risk for hypoglycemia.
 - a. *Report glucose meter test result less than 40 or \geq 150.*
 3. Verify that information on identification bands is correct and corresponds to footprint sheet.
 4. Place security sensor on the infant if this was not done in the delivery room.
 5. Place infant under overhead servo-controlled warmer for thermoregulation.
 6. Give initial bath at no sooner than two hours of age. Infant must be stable with axillary temperature greater than 97.6°.
 7. Administer Vitamin K 1 mg IM if not given in DR (as per physician order).

PROTOCOL FOR: Admission: Newborn Nursery

8. Administer Erythromycin ophthalmic ointment if not given in DR as per physician order.
9. Initiate plan of care - Care Path for the Well Newborn.
10. Notify MD if mother is HBSAg(+) or if mother's hepatitis status is unknown.
11. Notify MD if HIV testing on mother has not been completed.
12. Initiate GBS protocol for infants at risk for Group B Streptococcal Disease (GBS).

**ADMISSION OF
INFANTS FROM**

- NICU:**
1. T, P, R and blood pressure on admission or before first feeding following transfer.
 2. Nursing physical assessment on admission or with first feeding.
 3. Place security sensor on infant (if not done in NICU).
 4. Ensure that SCP has been updated by RN transferring infant from NICU.
 5. Assess parental response to transfer (if parents are available).

- DOCUMENTATION:**
1. Nursing Database
 2. Newborn Nursery Flowsheet
 3. MAR
 4. Newborn Metabolic Screen and CF Screen Cards
 5. Newborn Identification Record (Hollister)
 6. Care Path for the Well Newborn

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/91

REVISION DATES: 6/91, 9/92, 12/94, 2/97, 8/97, 11/99, 10/00, 1/05, 12/08

REVIEWED DATES: 11/07