NEWBORN

FOCUS ON SAFETY

Estimated Time: 30 minutes • Debriefing Time: 30 minutes

Scan to Begin

Patient Name: Noah Bailey

SCENARIO OVERVIEW

In State 1, students receive vital signs from a student nurse who reports that the father does not want to keep the baby swaddled. Upon entering the room, they discover the un-swaddled newborn near a window with a fan blowing. Students should respond with appropriate nursing actions. In State 2, students receive report from the nurse and are asked to obtain a blood glucose of the baby. Students will implement the glucose screening protocol.

LEARNING OBJECTIVES

1. Maintain a safe and effective care environment for a newborn patient
2. Integrate evidence-based practice while using the nursing process to care for a newborn
3. Provide patient education to family members

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

- Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving professional identity as a nurse committed to evidence-based practice, caring, advocacy and quality care
- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness
- Use information and technology to communicate, manage data, mitigate error, and support decision-making

NURSING FUNDAMENTALS

- Maintain a safe, effective care environment
- Use appropriate communication techniques
- Use the nursing process
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings

NURSING HEALTH PROMOTIONS

- Use principles of teaching/learning when reinforcing teaching plans
- Apply principles of family dynamics to nursing care
- Examine adaptations of nursing care for patients from infancy through adolescence

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT

Inside or outside room: Hand sanitizer or sink for hand hygiene

PATIENT PROFILE

Name: Noah Bailey

DOB: XX/XX/20XX

Age: 30 hours

MR#: 170511

Gender: Male

Height: 50 cm (20 in)

Weight: 3.68 kg (8.1 lbs)

Allergies: NKDA

Code Status: Full code

Ethnicity: Caucasian

Parents: John and Sara Bailey

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Wearing a diaper but not wrapper in blanket; security band on leg;

Monitor Settings

- No monitor
- Initial vital signs: Temp 36 C, RR 68, HR 156

Supplies

- General
    - Fan in room; place near a window or simulated window

QR CODES

START	REPORT	PARENT	FACILITATOR
FAMILY MEMBER	HEART SOUNDS	SECURITY BAND	GLUCOMETER
AXILLARY TEMP A	AXILLARY TEMP B	HEEL WITH HOT PACK	DEXTROSE IV 10%
LUNG SOUNDS	BOWEL SOUNDS	PARENT/BABY SECURITY BANDS	

TEACHING PLAN

PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the **QR Code: "Scan to Begin"** while students are in Prebrief.
- "Meet Your Patient" (on iPad) and explain how the iPad works in the simulated learning environment including:
    - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
    - Describe how a QR Code sound will work in the scenario. Show them how to use the ARISE "stethoscope" and the symbol on the QR Code that signifies when a QR Code is audio . Example: **QR Code: Heart**
    - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
    - Level tab – This tab "tells" the content in the iPad to change to what is needed for the next state of a simulation. It is used a few times in this scenario after the provider is notified to display new orders (those just given over the phone) and lab results, etc...
- Discuss the simulation "Learning Objective(s)" (on iPad) as well as any other Prebrief materials
- Get "Report" on iPad from Student Nurse
    - Possible Facilitator Questions
        - What are the normal ranges for newborn vital signs?
        - Do you have any concerns about the reported vital signs?
- View Parent video

- How will you therapeutically respond to the dad's statement that the baby doesn't like to be swaddled in a therapeutic manner?
- Evaluate the environmental conditions and identify sources of heat loss for the newborn.
- Discuss the potential adverse effects of hypothermia on a newborn.
- What type of education will you provide the parent about thermoregulation of a newborn?

- The facilitator may allow time for students to look through the information provided under the iPad tabs, which are also described below.

PATIENT PROFILE

Patient information is provided here

PROTOCOL

A glucose screening protocol is provided here. It is also available for printing in Appendix A.

Suggested Facilitator Questions

- Does this newborn qualify for glucose screening according to the information you received in report?
- Are any clinical signs present that indicate hypoglycemia at this time?

L&D RECORD

A copy of the L&D record is provided here. It is also available for printing in Appendix B.

Suggested Facilitator Question

- What important information should be noted from the labor and delivery record that might impact the care of the newborn?

GESTATIONAL AGE ASSESSMENT

Students may click on a button that links them to the MedCalc: Ballard Maturational Assessment of Gestational Age.

Suggested Facilitator Questions

- Review the neuromuscular assessments and scoring
- Review the physical maturity assessments and scoring

ORDERS

Provider Orders

Date	Time	Order
Today	On Admission	**Routine Newborn Order Set**
		Vital Signs, Monitoring and Nursing Orders: • Assess newborn and obtain temperature, heart rate and respiratory rate immediately after birth and every 30 minutes for 2 hours, then every 4 hours for 24 hours, then every shift • Maintain temperature between 36.5 and 37.5 degrees Celsius utilizing one or more of the following interventions: drying; skin to skin contact; overhead warmers; swaddling; holding newborn • If a newborn has a deviation in temperature, pulse or respiratory rate, reassess in 30 and 60 minutes. Notify physician if reassessment is outside normal limits. • After 24 hours of age, perform cardiac screening by obtaining and documenting pulse oximeter check in right arm and either foot • Document weight, length and head circumference • Document if baby is SGA (small for gestational age) or LGA (large for gestational age) • Weight infant daily • Monitor intake and output • Consult lactation for breastfeeding mothers • Provide oxygen via mask, hood, cannula or blow by for saturations less than 90%, respiratory distress or cyanosis

		• Obtain glucose according to hypoglycemia protocol; notify pediatrician if glucose is less than 40
		Prior to Discharge: • Newborn screening after 24 hours; if done before 24 hours then make arrangement for repeat screen to be done at physician's office • Car seat monitoring test on infants born prior to 37 weeks gestation; infants less than 2500 grams at time of discharge, or as ordered by physician • Transcutaneous bilirubin level PRN and prior to discharge; enter bilirubin value into bilitool to determine risk; serum bilirubin PRN • Ensure cardiac screening is documented prior to discharge • Hearing screen prior to discharge
		Notify provider for: • Infants less than 37 weeks gestation • Temperature less than 36.5 degrees Celsius after a trial of warming or greater than 38 degrees Celsius • Heart rate less than 80 beats per minute, or greater than 170 beats per minute, or abnormal cardiac rhythm • Respiratory rate less than 30/minute or greater than 60/minute; use of accessory muscles; unequal breath sounds; abnormal breathing patterns; abnormal oximetry; or changes in skin color requiring ongoing oxygen therapy • Lethargy or poor feeding • Jaundice before 24 hours; marked jaundice at any time; or bilitool risk level above "low risk" • Apnea, cyanosis, jitteriness or sluggishness • Abdominal distention • No urine or stool by 24 hours • Feeding intolerance, especially first feeding, with vomiting or aspiration • Any unusual symptoms observed by nursing
		Medications

		• Phytonadione (Vitamin K) 1 mg IM within 1 hour of birth for prevention of bleeding; if infant is less than 36 weeks give 0.5 mg • Erythromycin 0.5% ophthalmic ointment. Apply 1 cm ribbon to both eyes within one hour of birth for eye infection prophylaxis • Vitamin D 400 international units PO once daily to begin after 24 hours of age • For Hepatitis B surface Antigen negative mothers: After parental permission, give Hepatitis B vaccine 0.5 ml IM any time before discharge • For Hepatitis B surface Antigen positive mothers: Give Hepatitis B vaccine 0.5ml IM and Hepatitis B Immune Globulin 0.5ml within 12 hours of birth • Acetaminophen 15mg per kg PO every 4 hours for procedural pain. Maximum of 4 doses. • Sucrose 24%: Dose according to gestational age, administered orally, every 90 minutes as needed for procedural pain
		Diet/Nutrition: • Breastfeeding on demand • Formula feed 20 cal formula with iron on demand • If baby is less than 36 weeks, contact physician for feeding orders
		Labs: • ABO/Rh and Direct Antiglobulin Test (cord blood sample) for newborns of Rh negative mothers • Collect meconium and test for all infants who are at risk for fetal drug exposure • Obtain transcutaneous bilirubin or order fractionated serum bilirubin level on any jaundiced infant PRN
		Circumcision: Inquire regarding circumcision and notify MD if parent desires • PRE-PROCEDURE: o Have available Lidocaine 1% without epinephrine or Bupivicaine 0.25% without epinephrine

		○ 60 minutes prior to procedure: Apply 1-2 grams of EMLA to the base and distal half of penis ○ 30 to 60 minutes prior to procedure: administer Acetaminophen 15mg/kg PO • DURING PROCEDURE: ○ Have Gel Foam Silver Nitrate Sticks available at bedside ○ Administer Sucrose 24% 1 ml PO immediately prior to or during procedure PRN for discomfort ○ POST-PROCEDURE: ○ Check circumcision site for bleeding every 15 minutes x 2 then every 30 minutes x 2 ○ Apply Vaseline gauze 4x4; reapply with every diaper change x 48 hours ○ Acetaminophen 15 mg/kg PO every 6 hours PRN for discomfort x 24 hours
		---- P. Datrician, MD

MAR

Medication Administration Record

Scheduled		
Phytonadione (Vitamin K) 1 mg IM within one hour of birth	**Due**	**Last Given**
		Yesterday
Erythromycin 0.5% ophthalmic ointment. Apply 1 cm ribbon to both eyes within one hour of birth	**Due**	**Last Given**
		Yesterday
Vitamin D 400 international units PO to begin after 24 hours of age	**Due**	**Last Given**
	Now	
Hepatitis B vaccine 0.5 ml IM before discharge a	**Due**	**Last Given**
	Before discharge	
PRN		
		Last Given

Acetaminophen 15 mg/kg PO for post procedural pain	Post circumcision
Dextrose 5% minbolus or infusion per hypoglycemia protocol	**Last Given**
Sucrose 24%: 1 ml PO every 90 minutes as needed for procedural pain	**Last Given** During circumcision
Hepatitis B Immune Globulin 0.5 ml within 12 hours of birth if mother is Hepatitis B surface Antigen positive	**Last Given**
EMLA cream PRN for circumcision pre-procedure	**Last Given** Pre-circumcision

GROWTH RECORD

Growth records are available here for Head Circumference and Length and Weight for Age-Weight.

VITALS

An enterable form is available here for student input.

DAILY RECORD

Vitals	Today, 4 hrs ago				
Pulse	126				
Resp. Rate	40				
Temp (°C)	37.1 axillary				
FLACC Scale	2				

Daily Weight (kg)	Today, 4 hrs ago				
kilograms	decreased 1-2% from birth weight				

Assessments	Today, 4 hrs ago				
Respiratory Status	lungs clear bilaterally				
Cardiac Status	apical heart rate strong, slight acrocyanosis present				
Musculoskeletal	no caput, no cephalohematoma noted, clavicles intact, anterior, post fontanel present				
Neuro	awake and alert, palmer and plantar grasp noted				
Urogenital	Voided, testes descended bilaterally				
GI	meconium stool noted, bowel sound present in all four quadrants, abdomen soft				
Skin assessment	Color pink, no rashes noted				
Nutrition	Breastfed X20 minutes, with occasional swallow heard at breast				
Safety assessment	ID bracelets, safety secure band on, on back in crib				
Bonding	Mother holding infant				

LABS

Newborn Panel					
	On birth	20 hours of age		Units	Reference Range
ABO Group	A				A,B, AB, O
Rh Typing	Positive				Pos or Neg
Direct Antiglobulin Test (Coomb's test)	Negative				Negative
Transcutaneous bilirubin		4.3		mg/dl	Low risk see http://www.bilitool.org for reference ranges
Cardiac screening		97% R arm 97% R leg			

PATIENT EDUCATION

Handouts on Car Set Safety, Breastfeeding, and Safe Sleep are available here. Printable versions are located in Appendix C.

INFORMED CONSENT

A signed informed consent form for circumcision is located here.

LEVEL

Level 1 is displayed

SCANNER

Use this to scan available QR Codes.

EXIT

The message, “Are you sure you want to exit? All data will be lost? Yes/No” is displayed until the **QR Code: Facilitator** is scanned

STATE 1

ASSESSMENT

- Patient Overview
    - Students interpret the newborn's vital signs that were reported by student nurse and implement interventions immediately to raise the baby's temperature.
- Expected Student Behaviors
    - Provide appropriate hand hygiene throughout scenario
    - Introduce themselves to the parent(s)
    - Verify patient identity by scanning **QR Code: Security Band**
    - Verify matching parent/baby security bands by scanning **QR Code: Parent/Baby Security Bands**
    - (Optional) In a low fidelity environment, **QR code: Axillary temperature A or B** can be scanned to display a correct or incorrect method of assessing the axillary temperature
    - Implement interventions to warm the baby such as swaddling in a warm blanket or placing skin-to-skin with a parent
    - (Optional) Students may perform other newborn assessments by scanning **QR Code Lung Sounds, Heart Sounds** and/or **Bowel Sounds**
- Technician Prompts
    - As role play the father, continue to ask questions about jaundice:
        - "Why does he have to be swaddled? He doesn't like it."
- Suggested Facilitator Questions
    - What are the expected vital signs for a newborn?
    - What immediate interventions can be done to warm the baby?
    - When should the provider be notified?
    - What are the four different types of heat loss in newborns?
- Tabbed iPad content and changes:

- When student has performed expected behaviors, scan the **QR Code: Facilitator**. A message will appear “You have been approved to proceed” and the iPad progresses to State 2.

STATE 2

IMPLEMENTATION OF PROTOCOL

- Patient Overview
    - A video of the RN communication appears, asking the student to obtain a blood glucose on the baby. A video of the newborn is displayed demonstrating some irritability.
- Expected Student Behaviors
    - Provide appropriate hand hygiene throughout scenario
    - Obtain a blood glucose per Glucose Screening Protocol
        - Facilitator note: In a low fidelity scenario, the **QR Code: Hot Pack or QR Code: Glucometer** can be scanned to display a hot pack or bedside blood glucose results.
    - Interpret results and call lab for a STAT serum glucose
        - Facilitator note: when students tap on the Labs tab, they will be asked if they already completed a bedside glucose and if they have called lab for a STAT serum glucose before results are displayed
    - Implement appropriate interventions per Glucose Screening Protocol
    - Notify provider of assessments and interventions using SBAR format
- Technician Prompts
    - As role play the parent:
        - "Why do you have to keep poking him?"
        - "Why is his blood sugar low?"
        - "How long do we need to keep checking him?"
- Suggested Facilitator Questions
    - How can heat loss cause hypoglycemia?
    - What are the potential adverse effects of hypoglycemia in newborns?
- Tabbed iPad content and changes:

- When the student has performed the expected behaviors, scan the **QR Code: Facilitator**. A message will appear "Baby was fed and 30 minutes have passed."
    - At that point the facilitator can decide whether the blood sugar is improving, or continuing to decrease with further interventions required per the Glucose Screening protocol. Nothing further will change on the iPad, but the facilitator can verbally provide blood glucose results to the students.
        - **QR Code: IV Dextrose 10%** can be scanned to discuss how to administer this medication to an infant and perform the required math calculation. A 500 ml bag is purposefully displayed to stimulate discussion.
- When the student has performed the expected behaviors and the facilitator is ready to end the scenario, scan the **QR Code: Facilitator** again. Students will receive a message that "You have been approved to proceed. You have complete the learning objectives for this scenario and may exit."

LABS

When tapped, the student is asked, "Have you completed a bedside glucose?" If they answer yes, they will be asked, "Have you called lab for a STAT serum glucose? Yes/No"

When they tap Yes for both questions, the following results are displayed:

Newborn Panel					
	On birth	20 hours of age	Now	Units	Reference Range
ABO Group	A				A,B, AB, O
Rh Typing	Positive				Pos or Neg
Direct Antiglobulin Test (Coomb's test)	Negative				Negative
Transcutaneous bilirubin		4.3		mg/dl	Low risk see http://www.bilitool.org

					for reference ranges
Cardiac screening		97% R arm 97% R leg			
Serum glucose			34	Mg/dl	>40

Suggested Facilitator Questions

- Is the baby symptomatic for hypoglycemia?
- According to the Glucose Screening protocol, what interventions should be implemented?
- When will you repeat a bedside glucose reading?

EXIT

- When student has performed expected behaviors, scan the **QR Code: Facilitator**. A message will appear "You have been approved to proceed. You have completed the learning objectives for this scenario and may exit."
- Students may then tap on Exit and view the message, "Scenario objectives have been met. Are you sure you want to exit the game? Yes/No."

DEBRIEF

Nothing needed from the iPad.

QUESTIONS

1. How did you feel this scenario went?
2. Review learning objective: Maintain a safe and effective care environment for a newborn patient
    a. How did you maintain a safe, effective environment today?
    b. If you had not responded appropriately to the newborn's decreased temperature, what could have been the potential adverse reactions?
    c. How is blood sugar related to body temperature in newborns?
    d. Provide examples of four types of heat loss in newborns and how they can be prevented.
3. Review learning objective: Integrate evidence-based practice while using the nursing process for a newborn patient
    a. Identify 3 priority nursing problems you identified.
    b. Create a patient centered goal for each nursing problem you identified.
    c. Describe focused assessments for each nursing problem.
    d. Discuss evidence-based nursing interventions for each nursing diagnosis.
    e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?
4. Review learning objective: Provide patient education to family members
    a. Outline parent education topics about newborn cares and how to maintain appropriate newborn body temperature
5. Summarize/Take away Points: "In this scenario you cared for a newborn patient with body temperature less than 37 degrees Celsius. What is one thing you learned from participating in this scenario that you will take into your nursing practice?" (Ask each student to share something unique from what the other students share.)

NOTE: Debriefing technique is based on INASCL Standards for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
    a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
    b. This QR Code will not work in the ARIS app.

SURVEY

2. Copy and paste the following survey link into your browser.
    a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

APPENDIX A: GLUCOSE SCREENING PROTOCOL

GLUCOSE SCREENING PROTOCOL

Glucose screening is to be completed for infants in the following categories who are at **increased risk** for hypoglycemia:

- Born to mothers with gestational diabetes or diabetes mellitus
- Large for gestational age (LGA) (>8 pounds 12 ounces or >3969g)
- Small for gestational age (SGA) (<5 pounds 12 ounces or <2608g)
- Premature (<37 weeks gestation)
- Low birth weight (<2500g)
- Smaller twin when sizes are discordant
- Polycythemia (hct >70%)
- Hypothermia
- Low Apgar scores (<5 at one minute, <6 at five minutes)
- Stress (sepsis, respiratory distress, etc.)

Glucose screening is to be completed for infants with **clinical signs** consistent with hypoglycemia:

- Tremors, jitteriness, irritability
- Exaggerated Moro reflex
- High pitched cry
- Lethargy, listlessness, hypotonia
- Cyanosis, apnea, tachypnea
- Hypothermia, temperature instability
- Poor suck, refusal to feed

For an at-risk or symptomatic infant:

☐ Obtain blood sugar

- If bedside blood sugar is less than 40: order serum blood glucose

    - If bedside blood sugar is 26 to 40 mg/dL and the infant is asymptomatic: give 20cc expressed breastmilk or formula via nipple or gavage.

    - If the bedside blood sugar is less than 25 mg/dL, administer intravenous glucose minibolus 200 mg/kg (dextrose 10% at 2 mL/kg) and/or intravenous infusion at 5 to 8 mg/kg per minute (80 - 100 mL/kg/day) as needed to reach the target of 45 mg/dl.

    - Repeat bedside blood sugar 30 minutes after feeding.

        - If the level is 35 to 45 mg/dL: refeed and check again in 1 hour.

    - Feeds should be continued every 2 to 3 hours, with glucose screening taking place before each feed. The target glucose level is 45 mg/dL or higher before routine feeds.

APPENDIX B: LABOR AND DELIVERY RECORD

Patient Name: Olivia Brooks
DOB: 1/29/19xx
MR#: 12919

MNRS Maternal/Newborn Record System™

Labor and Delivery Summary

Page 1 of 2

To order call: 1.800.245.4080 Re-order No. 5712N

Labor Summary

G	T	Pt	A	L	Type and Rh	EDD
2	0	0	1	0	A neg	xx/xx/20xx

Prenatal Events

None

No Prenatal Care Late Prenatal Care
Preterm Labor (less than or equal to 37 Weeks)
Postterm Labor (greater than or equal to 42 Weeks)
Previous Cesarean
Prenatal Complications ■ Refer to Prenatal Records

Intrapartal Events Maternal

Febrile (greater than or equal to 100.4˚F/38˚C)
Bleeding—Site Undetermined
Preeclampsia (mild) (severe)
Seizure Activity See Labor Progress Chart
■ Medications **None**

Date	Time	Medication	Dose	Route
Yesterd	0830	Penicillin	5 mil	IV
Yesterd	1230	Penicillin	2.5 mil	IV
Yesterd	1630	Penicillin	2.5 mil	IV
Yesterd	2030	Penicillin	2.5 mil	IV
Yesterd	1930	Fentanyl	100 mcg	IV

Transfusion _____ units
Blood Component _____

Amniotic Fluid

■ SROM AROM Date yesterda
Time 0900
Premature ROM Prolonged ROM
■ Clear
Meconium-Stained (describe) _____
Bloody
Foul Odor
Cultures Sent _____ Time _____
Polyhydramnios
Oligohydramnios

Placenta

Placenta Previa
Abruptio Placenta

Labor

Precipitous Labor (less than 3 hrs)
■ Prolonged Labor (greater than or equal to 20 hrs)
Prolonged Latent Phase
Prolonged Active Phase
Prolonged 2nd Stage (greater than 2.5 hrs)
Secondary Arrest of Dilatation
Induction **None** Cervical Ripening
AROM Oxytocin
Augmentation **None**
AROM Oxytocin

Labor Summary (Cont'd.) Fetus

Gestational Age (Wks) 40 By Dates
40 By Ultrasound

Presentation **Position**

R	O	A

■ Vertex
Face/Brow
Breech Frank Complete
Single Footling
Double Footling
Transverse Lie Back-up Back-Down
Compound
Unknown
Cephalopelvic Disproportion (CPD)
Cord Prolapse
Dystocia _____

Monitor **None** FHR UC
External x x
Internal
Fetal Bradycardia
Fetal Tachycardia
Sinusoidal Pattern
■ Accelerations ■ Spont. Uniform
Decelerations ■ Early Late
Variable Prolonged
Scalp pH less than or equal to 7.2

FM Discontinued _____ Time _____
FHR Prior to Delivery ____ bpm Time _____

Delivery Data

Support Person Present ■ Yes No
Delivery Location
■ LDR LDRP DR OR
Birthing Center _____

Method of Delivery

■ Vaginal VBAC
Number Previous Cesareans _____
■ Vertex
■ Spontaneous
Assisted [ ][ ][ ] to [ ][ ][ ]
Manual Rotation
Forceps (type _____)
Outlet Low Mid
Vacuum Extraction Duration 10 Min.
Degree of suction _____ kg/cm²
Breech (type _____)
Spontaneous
Partial Extraction (assisted)
Total Extraction
Forceps Assist
Piper _____

Method of Delivery (Cont'd.)

Cesarean
Scheduled Emergency
Primary Repeat (x _____)
Other
Operative Indication
Previous Uterine Surgery
Failure to Progress
Placenta Previa
Abruptio Placenta
Fetal Malpresentation _____
Non reassuring FHR Pattern _____
Other _____
Uterine Incision
Low Cervical, Transverse
Low Cervical, Vertical
Classical
Hysterectomy No Yes
Tubal Ligation No Yes
Skin Incision
Vertical
Pfannenstiel

Episiotomy

None
Midline
Mediolateral L R
Laceration/Episiotomy Extension None
■ Periurethral
Vaginal
Cervical
Uterine
Perineal 1˚ 2˚ 3˚ 4˚
Repair Agent Used _____
Vagina free of sponges

Placenta

Delivery Time _____
■ Spontaneous
Expressed
Manual Removal
Adherent (type _____)
Uterine Exploration
Curettage
Configuration
Normal
Abnormal _____
Weight _____ gms
Disposition _____

Cord

■ Nuchal Cord (x 1)
True Knot Length _____ cms
2 Vessels
■ 3 Vessels
Cord Blood To Lab Refrig Discard
Lab Type + Rh Cultures Coombs
pH _____

Surgical Data

Sponge Counts Correct
N/A ■ Yes No _____
Needle Counts Correct
N/A ■ Yes No _____

Kathy Smith, RN (Signature)
Date Completed xx /xx /xx

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LABOR AND DELIVERY SUMMARY (Page 1 of 2)

2 of 2

Olivia Brooks
DOB: 1/29/19xx
MR#: 12919

MNRS Maternal/Newborn Record System™

Labor and Delivery Summary

Page 2 of 2

To order call: 1.800.245.4080 Re-order No. 5712N

Delivery Data (Cont'd.)

Surgical Data (Cont'd.)

Vaginal Pack Count Correct
☐ N/A ☐ Yes ■ No
Estimated Blood Loss 300 mL

Delivery Anesthesia

☐ None
☐ Local ☐ Pudendal ☐ General
■ Epidural ☐ Spinal

Date	Time	Medication	Dose	Effect
Yesterd		per anesthesia		

Complications ☐ None

Delivery Medications ☐ None

Date	Time	Medication	Dose	Route Site	Init
Today	1015	pitocin	10	IV	KS

Chronology

	Date	Time	Total Time Hrs/Min		
EDD	xx/xx				
Admit to Hospital	yesterday	0800			
Membranes Ruptured	yesterday	0900			
Onset of Labor	yesterday	0800			
Complete Cervical Dilatation	today	0800	24		I
Delivery of Infant	today	1000	2		II
Delivery of Placenta	today	1010		10	III
			26	10	Total Labor

Infant Data

☐ Male ■ Female
ID/Band No. 90518
Condition ■ Alive ☐ Stable ☐ Fair ☐ Critical
☐ Stillbirth ☐ Antepartum ☐ Intrapartum
☐ Neonatal Death
Birth Order 1 of 1 2 3 4
Repeat Apgar every 5 min until score greater than or equal to 7

Apgar Score	1 min	5 min	10 min
Heart Rate	2	2	
Respiratory Effort	2	2	
Muscle Tone	2	2	
Reflex Irritability	2	2	
Color	1	1	
Total	9	9	

Scored by Kathy Smith, RN

Infant Data (Cont'd.)

Airway

■ Bulb Suction
☐ Suction Catheter Size ____ Fr
☐ Mouth Pressure ____
☐ Nose millimeters Hg
☐ Pharynx ☐ At Delivery
☐ Endotracheal Tube Size ____ Fr
☐ Meconium Below Cords Times ____

Breathing

■ Spontaneous
☐ O_2 ____ Liters
☐ Free Flow Time Init. ____
☐ PPV
☐ Bag/Mask Time Init. ____
☐ ET Tube Size ____ Fr Time Init. ____
☐ CPAP ____ millimeters
____ minutes to First Gasp
____ minutes to Sustained Respiration

Circulation

■ Spontaneous
☐ External Cardiac Massage
Time Initiated ____ Time Completed ____
____ minutes for HR greater than 100
Heart Rate (bpm)
____ Time ____
____ Time ____
____ Time ____

IV Access

☐ Umbilical Catheter
☐ Peripheral Line
Person Managing Resuscitation:

Neonatal Medications ☐ None

Date	Time	Medication	Dose	Route Site	Init
Today	1030	Vitamin K	1mg	IM	KS
Today	1030	Erythromycin	0.5	eyes	KS

Lab Data ☐ None Time ____

Blood Gases	Sent	Umb Art	Umb Vein
pH			
pO_2			
pCO_2			
HCO_3			

Test	Result
Dextrostix	

Initial Newborn Exam

Weight 3742 gms 8 lbs 4 ozs ☐ Deferred
Length 50.8 cms 20 ins ☐ Deferred
Head 33 cms 13 ins ☐ Deferred
Chest ____ cms ____ ins ☐ Deferred
Abdomen ____ cms ____ ins ☐ Deferred
Temp 98.6 ☐ Rectal ■ Axillary
AP 120 Resp 44 BP n/a
■ No Observed Abnormalities

Initial Newborn Exam (Cont'd.)

☐ Abnormalities Noted
☐ Meconium Staining ☐ Cephalhematoma
☐ Petechiae ☐ Other
Describe ____

Intake ☐ None
■ Breast Fed ☐ Formula ☐ Glucose Water
Output ■ None
☐ Urine ☐ Stool (type ____)
☐ Gastric Aspirate ____ mL per hour
Examined By kathy Smith, RN
Transfer ■ With Mother
☐ To Newborn Nursery
☐ To NICU
☒ mom's room
Date ____/____/____ Time ____
Mode of Transport ____

Delivery Personnel

RN (1) Kathy Smith,RN
(2) Joe Olson, RN
Anesthesiologist/CRNA Mary Schneider
CNM ____
Physician—Attending B. Barker, MD
Physician—Assist (1) ____
(2) ____
Technician ____
Pediatric Provider ____
■ Notified ☐ Present at Birth
Others Present ____
Remarks

Kathy Smith, RN (Signature)
Date Completed xx / xx / xx

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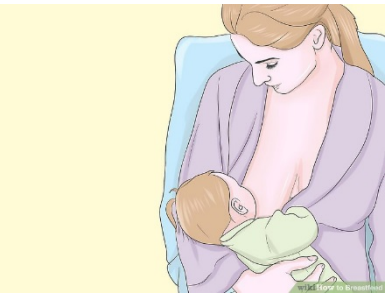
LABOR AND DELIVERY SUMMARY (Page 2 of 2)

APPENDIX C: PATIENT EDUCATION HANDOUTS

SUCCESSFUL BREASTFEEDING FOR YOU AND YOUR BABY

START WITH A CALM BABY AND MOTHER



1. Feed Regularly. Feed your newborn regularly and often. Start with a feeding in the first hour of birth. All newborn babies need to eat frequently, watch the baby not the clock. Watch for feeding cues like sucking and rooting. Bring the baby to the breast frequently. Babies vary for time they take to nurse at each feeding.

2. Positioning. Allow your baby to take the lead. Support your baby's body with your arms. Allow your breast to fall naturally and help the baby line up under your breast with your nipple toward the baby's nose.

3. Skin to Skin, Hold your baby skin to skin for the first hour after birth and have the baby in your room during the hospital stay. Skin to skin has many benefits including bonding for mothers and babies, breastfeeding success, keeping the baby warm, stabilizing blood sugar levels. Nursing and medical procedures can be completed while the infant is skin to skin. Support people can assist with skin to skin too.

4. Breast Compression is a technique that can increase milk supply and get milk to a baby that is not latching as well. Please your hand behind the nipple and areola and compress you breast in a rhythmic fashion. This technique takes practice and a

lactation consultant can assist you with this. You can do it before, during and after infant feedings.

5. Aim your nipple toward the baby's nose. The baby will then reach for the nipple. Make sure your baby's moth is open wide. The baby's upper lip should barely brush past the top of the nipple. Support the baby's upper back and shoulders with your palm. Do not put pressure on the back of the baby's head.

6. Latching on. Let your baby feed as long as he wants to on the first breast. Some babies are more "efficient" than others, some like to nurse longer. Depending on how much milk a mother makes, a baby may not take the second side. Just make sure to switch between breasts when you start a new feeding. Listen for rhythmic, regular suck/swallow pattern that will let you know the baby has latched properly and milk is being exchanged between mother and infant.

    a. When your baby feeds from your breast, it should feel like a gentle pull, not a pinch or a bite. Look at your nipple after the feeding if your nipple changes shape when in the baby's mouth your infant may be pinching the nipple. Help your baby achieve a deeper latch.
    b. Baby's need to latch onto the underside of the breast, not the nipple.
    c. When your baby is done feeding on a breast, you shouldn't pull or even yank him away. Instead, insert your finger in his mouth so that his mouth releases your breast.

7. Burp your baby (optional). This isn't always necessary. Depending on how much air the baby takes in through the nose while it is nursing, you may or may not need to burp baby. If your baby is arching his back, squirming around, and looking uncomfortable, then he may be ready to get burped. Try to burp him in one of these ways:

    a. Lift your baby toward your shoulder, with your hand on his head and neck for support. He should be facing the area behind you. Rub your baby's back with a firm and open hand to release the trapped air.
    b. Sit your baby on your lap and lean him forward, supporting his chest with the base of your hand and his chin and neck with your fingers. Massage his stomach with your front hand and gently pat his back with the hand on his back.
    c. Lie your baby on your lap with his head raised higher than his stomach. Gently pat his back until he burps.

8. Getting enough milk. A newborn baby will mostly nurse and sleep. You know when the baby is "getting enough" when there are 8-10 wet and or dirty diapers by the end of the week.

9. Maintain a healthy diet. Eat a wide variety of foods that are low in sugar, caffeine, fat and salt and be active. Foods high in iron like beans, leafy greens, and broccoli. Include high fiber foods and whole grains. Many mothers also continue to take prenatal vitamins or should take daily multivitamins to stay healthy. Eat foods with nutritional value. A

handful of veggies and dip, a bran muffin or whole wheat grains are quick healthy snacks.

10. Stay hydrated. If you want to be healthy and produce enough milk for your baby and to remain healthy, then you have to stay hydrated. Drink at least 8 oz. of water eight times a day, and add some juice, milk, or other healthy drinks into your routine

11. Avoid alcohol at least two hours before you breastfeed. The American Academy of Pediatrics view is while you are nursing; avoid drinking alcohol because it can pass through your milk to your baby. Levels of alcohol peak at approximately 30-60 minutes following ingestion then decline rapidly thereafter. Alcohol can inhibit the release of milk from the breast.

12. Avoid smoking. Smoking not only changes the amount of your breast milk supply, but it can change the taste of your breast milk, and can make it much less appealing to your baby. If you are unable to stop smoking cut down the amount of smoking you do. Do not smoke immediately before or during breastfeeding. Discuss the possibility of nicotine replacement therapy and breastfeeding with your health care provider.

13. Medications. Be careful with the medication you take. You should always check with your doctor or a lactation consultant to make sure it's okay to take any of your medications, or a new medication, while you're breastfeeding. Call the Infant Risk Center if you need more information www.infantrisk.com/

14. Consult a lactation consultant, midwife or health care provider if:

- Baby is still fussy after nursing.
- Baby is not urinating or having regular bowel movements.
- Breasts are sore, or cracked and nipples are bleeding, this may be sign that baby is not latching correctly or could indicate a more serious problem, such as mastitis.
- Baby is not gaining weight.
- Baby's skin and/or fingernail and/or toenail beds appear to have a yellowish tinge.

Images adapted from: http://www.wikihow.com/Breastfeed

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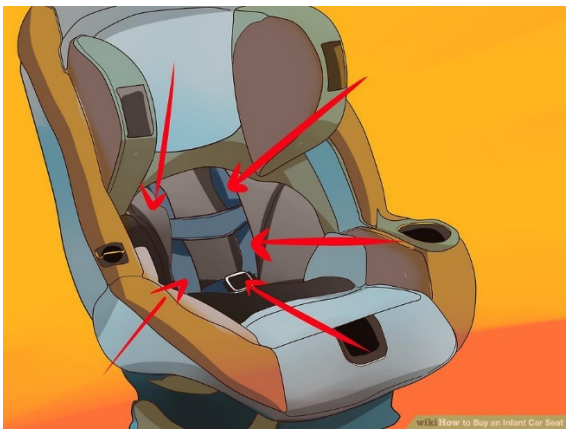
CAR SEAT TIPS

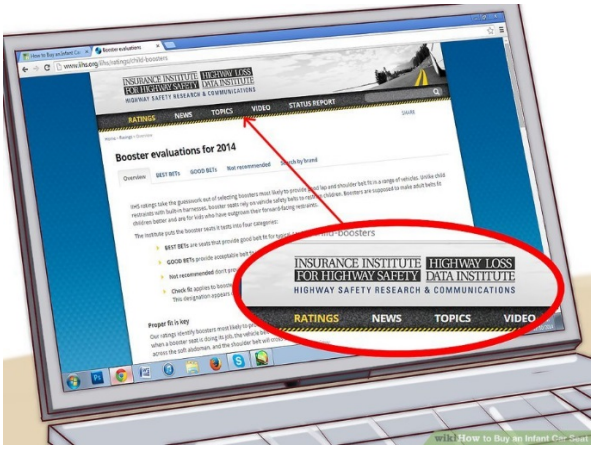
The birth of a new child brings many new things to learn, one of which is ensuring your baby stays safe. Incorrect installation of a car seat is often overlooked, resulting in putting your newborn's life in danger. By following the steps set forth in this article, you can travel while knowing that each trip your baby goes on is a safe one.

Road injuries are the leading cause of unintentional deaths to children in the United States. Correctly used child safety seats greatly reduce the risk of injury.

RIGHT SEAT

Check the label on your car seat to make sure it's appropriate for your child's age, weight and height. Check your car seat has an expiration date. Just double check the label on your car seat to make sure it is still safe. Do not buy a used car seat. If it has been in an accident you do not want to use the car seat. Register the car seat so you are updated on any recalls.



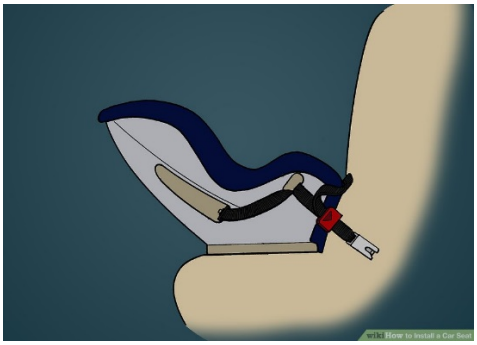


RIGHT PLACE

Kids are Very Important Persons, just ask them. And all VIPs ride in a back seat, so keep all children in a back seat until they are 13.

RIGHT DIRECTION

Keep your child in a rear-facing car seat until at least age 2. When he or she outgrows the seat, move your child to a forward-facing car seat and make sure to attach the top tether after you tighten and lock the seat belt or lower attachments (LATCH).



INCH TEST

Once your car seat is installed, give it a good shake at the base. Can you move it more than an inch side-to-side or front-to-back? A properly installed seat will not move more than an inch.

PINCH TEST

Make sure the harness is tightly buckled and coming from the correct slots (check car seat manual). Now, with the chest clip placed at armpit level, pinch the strap at your child's shoulder. If you are unable to pinch any excess webbing, you're good to go.

Source: National Institute of Health: https://www.nichd.nih.gov/sts/about/environment/Pages/look.aspx

NEWBORN SAFE SLEEP

- Put your baby to sleep on his back on a flat, firm surface, like a crib or bassinet.
- Don't bed-share. Put your baby to sleep in his own crib or bassinet.
- Safe sleep can help protect your baby from sudden infant death syndrome (also called SIDS) and other dangers
- The American Academy of Pediatrics recommends that you and your baby sleep in the same room, but not in the same bed, for the first year of your baby's life but at least for the first 6 months.
- Use a bassinet, crib or play yard that meets current safety standards. Don't use cribs with drop-side rails.
- Keep crib bumpers, loose bedding, toys and other soft objects out of your baby's crib. They put your baby in danger of getting trapped, strangled or of suffocating.
- Put your baby to sleep on his back every time until he's 1 year old. It's not safe for a baby to sleep on his side or tummy. If your baby can roll over from his back to his side or tummy and over to her back again, don't worry if he changes positions while sleeping. Give your baby tummy time every day. Tummy time helps your baby develop his neck, shoulder and arm muscles.
- Dress your baby in light sleep clothes. Remove any strings or ties from his pajamas and don't cover his head. A blanket sleeper (a kind of infant clothing used for sleeping) can help keep your baby warm without covering his head or face. Keep the room at a temperature that's comfortable for you. If your baby is sweating or his chest feels hot, he may be overheated.

Image courtesy of the Safe to Sleep® campaign, for educational purposes only; Eunice Kennedy Shriver National Institute of Child Health and Human Development, http://safetosleep.nichd.nih.gov; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.

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