Newborn, Postpartum, and Antepartum Nursing Care Tip Sheet - LMC - Supporting Document

Newborn Assessment

Baby Assessment & Vital Signs

- Initial Newborn Assessment and measurements (on admit to MB) at approximately 2-2.5 hours of life, Complete EOS
- Head-Toe Assessment at 6 hours of life & beginning of q 12° shift; focused assessment (color, respiratory status & tone) q 6-8° within 2nd half of 12° shift
- VS on admission; at 6 hours of life; beginning of every 12 hour shift. Exception: SGA, LPT & Chorio Level II—VS q 6 hrs
- 24 hour cares- TCB, CCHD, Weight and PKU drawn
- HR 100-160, R 30-60, Axillary Temp 97.7-99.3°, call MD if still >100.0 or < 97.7 after 30 minutes
- Latch Score Q Shift
- Weight check every evening. If weight loss ≥ 10%, initiate supplementation and start mother pumping.
- Hepatitis B Vaccine if >2,000 grams (usually administered in L&D)

Late Preterm Baby (LPT) (35.0-36.6 wk)

- Vital Signs q 6° X 24 hours, then Q shift; BG screen by 1° (doesn't count as part of three consecutive BG) 3 Consecutive glucose above/equal to 45. The one hour re-check is also not included in the consecutive 3 needed. A 24 hour spot check with 24 hour cares is required and needs to be above 50. If not above 50 call the provider to notify.
- Breastfeed q 2-3°, then pump x 15' after feed. Start pumping within 6°of birth. Supplement q 3 °. Encourage donor milk. Offer nipple shield if baby is uncoordinated with feedings.
- If wt loss ≥ 8% call MD. (If found at night call in the AM)
- Needs a Car Seat Challenge
- Follow-up with MD within 24- 48° after d/c is especially critical for this newborn population

Phototherapy

- Temps Q4 hours. BiliMeter Q shift. Baby is open, naked with only eye protection and a diaper. Warmer as needed to maintain temperature.

NB Blood Glucose (See guideline for newborn glucose screening)

- Initial feeding by one hour of life, obtain BS after initial feed for **babies identified at risk** and then before each feeding (Q 3 hours) for three consecutive feeds. If the infant needs a one hour re-check that one hour check doesn't count in the 3 consecutive glucose screens.
- With 24 hour cares a spot check glucose is required for the babies identified at risk, this glucose needs to be 50 or above. If <50mg/dL, notify provider to develop plan.
- If LPT or SGA with hypoglycemia treat with glucose gel and supplement with minimum of 10 ml. Refer to algorithm

Chorio Protocol

Refer to EOS calculator for recommended interventions

Transcutaneous Bili Level

- Done at 24 hours of age and then each evening with weight
- Draw serum bili if TCB > 15 or if TCB value falls above the threshold on the nomogram.

Car Seat Challenge

- If infant is < 2500 gm (at any time) or < 37 weeks.
- Set up a car seat challenge the night before discharge.

Critical Congenital Heart Disease Screening Program (CCHD)

- Obtain at ≥24 hours of age or greater (Note: not done earlier than 24 hours of age)
- Pass= Pulse ox ≥ 95% (RH or Foot) and <3% difference between RH and Foot
- Fail=Pulse ox <95% (Both RH & Foot) >3% difference between RH and Foot; Repeat in 1 hour by RT; Repeat again if needed in 1 hour by RT. If unable to pass after 3rd assessment, notify MD & obtain order for echocardiogram

Discharge to Higher Elevation

- If infant lives at an elevation of 7500 ft or higher make sure the provider knows and that respiratory is aware so we can set up home O2 prior to discharge or make a plan with families to get a pulse ox checked.

Maternal Assessment

Antepartum

- FHR monitoring, contractions, VS per orders
- Assessment q shift (12°)
- Wt q Mon AC breakfast
- Monday, if ordered: UA dip, CBC
- Rhogam, GTT & Tdap @ 24-28 weeks (f not given at office)
- Previa, Abruption: T&S q 3 days, needs IV access
- Preeclampsia: Weight q day (if ordered). Assess RUQ pain, DTR's, Neuro; Protein creatinine ratio (urine) as ordered. BPs Q 4 hours.
- PROM: Temp q 4°, assess for infection
- PTL: Notify MD if contractions > 4/hr. or as ordered
  - If BP ≤ 80/60 hold Procardia & call MD
- DM: Normal FBS < 90, normal 2° <120
  - NPH peaks 8-12°. Regular/Humalog peaks 2-4°

Vaginal Delivery

- Head-Toe assessment: Within 1 hour of admission and beginning of q 12° shift
- Focused Assessment (Uterus/lochia/perineum/bladder): One hour after initial admission assessment
- VS: Within 1 hour of admission; 1° later; q 12° shift
- If a patient has chorio or any blood pressure issues VS Q 4 hours for the entire stay.

Cesarean & Surgical

- Head-Toe Assessment: within 1 hour of admission and beginning of q 12° shift
- Focused Assessment (VS/Incision/Uterus/Lochia): One hour after initial admission assessment, then q 4° x until 24°
- Neuraxial protocol:
  - Resp & HR q 1° x 12, then q 2° x 12
  - BP q 4° x 24
  - **Pain q 1° x 6** then according to protocol (before & after interventions)
- High-Risk: VS q 4° for temp > 100.4, BP > 150/100, Risk or S/S of infection, Consider I&O
- ERAS: Remove foley after first successful ambulation.
- Walk patients to the bathroom by 6 hours after admission, thereafter 3 times a day for the entire stay.

Note: Any severe range BP of >160/110, repeat in 15." Notify provider if remains severe range.

ADOPTING SITE(S)

CO - Lutheran Medical Center

Site Department / Single Discipline Policy: Newborn Guideline for Care - LMC (MBU)	
Document Owner: Amy Dempsey (RN Educator Specialist_COFR)	**Last Review Date:** 10/13/2021
Effective Date: 10/13/2021	**Next Review Date:** 10/13/2024
Committee/Executive Approver(s): Deborah Lowery (Director Admin Womens & Infants Svc_COFR)	**Approval Date:** 10/13/2021

Purpose:

To ensure that the needs of all newborns will be met on a consistent and individualized basis, while encouraging the involvement of family members in the care of each newborn.

Scope:

This policy applies to specific roles/functions including Licensed Nursing Staff, Mom-Baby Staff, Pediatric Advanced Nurse Practitioners (ANP) and Medical Staff.

Definitions:

Late Preterm Infant — an infant born between 34 0/7 and 36 6/7 weeks gestation.

Policy:

1. This guideline provides practices to ensure safe, individualized newborn care with family involvement.

Procedure: Transition, Admission, Pediatric Assessment, Identification – LMC (MBU)

#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Refer to Transition Care for Newborns - LMC (Childbirth & Maternal Services, inc. Neonatal)	RN, ANP, MD	Refer to Newborn, Postpartum, and Antepartum Nursing Care Tip Sheet - LMC - Supporting Document.
2	Follow these admission guidelines:	RN, ANP, MD	• Infants born between less than 35 0/7 weeks and/or less than 1800 gm (3 lbs, 15 oz.) will be admitted into the NICU for care. • Infants born greater than 35 0/7 weeks may room in with the mother on the Mother/Baby unit if their condition is stable. • If infant is a Late Preterm Infant refer to Late Preterm Care Guideline - LMC (MBU) • All newborns (well-baby and transition) will be evaluated for Early Onset Sepsis utilizing the sepsis calculator and treated according to the recommendation Management of Early Onset Sepsis (EOS) for the Newborn - SCL Health (Women &

Policy Title: Newborn Guideline for Care - LMC (MBU)
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Procedure: Transition, Admission, Pediatric Assessment, Identification – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			Children Services)
3	Facilitate assessment by pediatrician or pediatric advanced practitioner.	RN, ANP, MD	All infants shall be examined within 24 hours after birth by a physician or pediatric advanced practitioner and each subsequent calendar day during their stay, including day of discharge.
4	Place on all infants as soon as possible after delivery for proper identification: an ID band on two extremities, with all information correlating to the ID bands for mother and significant other.	RN	The bands should be on the infant at all times and should be replaced immediately if necessary. Refer to Patient Identification - LMC.

Procedure: Nursing Assessment and Documentation – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Perform a head-to-toe assessment:	RN	• Within first hour of admission to Mom Baby • At six hours of life • At beginning of every 12 hour shift • Followed by a focused assessment every 6-8 hours and PRN
2	Check vital signs:	RN	• Every 30 minutes for the first two hours of life • Within first hour of admission to Mom Baby • At six hours of life • At the beginning of every 12 hour shift and PRN • Special circumstances: o SGA babies: Vital Signs every 6-8 hours with both the head-to-toe and focused assessments x 24 hours; then according to policy o Late preterm babies: Vital signs

Procedure: Nursing Assessment and Documentation – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			every 4 hours x 24 hours; then according to policy ○ Increased frequency of vital signs may be indicated based on results to Early Onset Sepsis Calculator
3	Check temperature, pulse, respirations ranges:	RN, ANP, MD	• Heart rate (100 to 160 BPM). • Respirations (30-60 per minute) • Temperature 97.7- 99.3 degrees F (36.4-37.4 C). ○ If the temperature is not within the above range, take appropriate measures to establish a normal temperature ▪ Skin-to-skin with parent ▪ Double wrap, single layer of clothes and hat ▪ Remove excess blankets and clothing (if >99.3) ▪ Place in radiant warmer up to 2 hours. ○ Recheck the infant's temperature in 30-60 minutes. ▪ If the temperature remains outside of the above range take appropriate measures again and recheck in 30-60 minutes. ▪ For specific interventions related to thermoregulation, refer to: Late Preterm Care Guideline - LMC (MBU) ○ Notify provider if the temperature is >100.0 or < 97.7 degrees after checking the temperature once at the 30-60 minute interval.
4	Obtain blood pressures as	RN, ANP, MD	Notify provider with circulatory concerns

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Procedure: Nursing Assessment and Documentation – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
	ordered by provider.		such as decreased capillary refill of <3 seconds, diminished femoral pulses, or persistent heart murmur.
5	Take note of elimination and feeding patterns.	RN, ANP, MD	Notify provider if the newborn has not had a stool or void in greater than 24 hours, or is feeding inadequately.
6	Check weight, on admission and daily- recorded in grams and pounds.	RN	Select the appropriate growth curve to evaluate weight percentile. LGA is defined as >90th percentile; SGA is defined as <10th percentile. • WHO for gestational age >37.0 weeks • Fenton for gestational age <36.6 weeks
7	Take a transcutaneous Bilimeter reading at 24 hours of age and then nightly.	RN	
8	Perform hearing screen prior to discharge.	RN	
9	Review maternal laboratory tests (syphilis, HBsAG, and HIV status) to establish individualized plans of care.	RN, ANP, MD	

Procedure: Nutrition – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Refer to Breastfeeding Assessment & Teaching and Human Milk Collection & Storage - LMC (Childbirth and Maternal Services, inc. Neonatal)	RN, ANP, MD	
2	Encourage bottle-feedings at least every three to four hours for bottle-fed infants.	RN	• Single use bottles of formula may be used for a maximum of one hour after opening. • If family has selected donor milk,

Procedure: Nutrition – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			feedings will be encouraged on demand, at least every 3 hours. • Refer to section "Procedure for use of human milk" within the "Breastfeeding Assessment and Teaching" policy Breastfeeding Assessment & Teaching and Human Milk Collection & Storage - LMC (Childbirth and Maternal Services, inc. Neonatal)
3	Develop an individualized treatment plan for infants with special nutritional needs (e.g., LGA, SGA, late preterm, premature, hypoglycemia, hyperbilirubinemia, etc.).	RN, ANP, MD	
4	Initiate gavage feedings per provider order only.	RN, ANP, MD	Infants requiring ongoing gavage feedings will be evaluated for transfer to NICU.

Procedure: Pain Management – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Refer to Guideline for Pain Assessment & Management - LMC (NICU)	RN, ANP, MD	

Procedure: Umbilical Cord Care – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Allow natural drying for cord care.	RN	This involves keeping the cord area clean and dry, without the routine application of topical agents.
2	Remove cord clamps when the cord is dry, usually about 24	RN	Clamp remover should be cleaned with alcohol after each use.

Procedure: Umbilical Cord Care – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
	hours after delivery.		
3	Perform the initial bath:	RN	• Wash umbilical area with water and soap to remove debris. • Dry thoroughly with clean absorbent cloth to remove excess moisture. • Leave umbilical area and clamped cord stump clean, dry and uncovered.
4	Take the following actions with cord care:	RN	• Keep cord area clean and dry. • Wash hands before handling umbilical stump. • Keep diaper folded down and away from umbilical stump to prevent contamination with urine/stool. • If the cord stump becomes soiled with urine or stool, cleanse the area with water and dry with clean, dry cloth. Do not reuse this cloth.

5	Differentiate normal cord healing from potential problems.	RN	• Risk factors--Delivery outside of the hospital and unclean cutting of cord
			• Normal healing
			  ○ The cord may create a “mucky appearance” or like a wet scab.
			  ○ Small amounts of cloudy mucous material are normal at the base of the cord stump.
			• <u>Characteristics of infection</u>
			  ○ Significant drainage from the stump or its base.
			  ○ Secretions that are thin and serous, sanguineous or frankly purulent and foul-smelling
			  ○ Inflammation, warmth, redness
			  ○ Fever, lethargy or poor feeding
			  ○ Blue, gray or black appearance

Procedure: Umbilical Cord Care – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			of the skin at the base of the cord
6	Complete patient education:	RN, ANP	• Cord should be kept clean as part of the normal hygiene • Moist, mucky appearance is normal • Redness, swelling and drainage are abnormal findings; notify provider • Do not pull on the cord stump; allow natural detachment to take place.

Procedure: Bulb Syringe Suctioning – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Keep a bulb syringe readily accessible in each infant's crib at all times.	RN	
2	Instruct parents on the location and use.	RN	
3	Document infant's condition before, during, and after suctioning, and amount and type of secretions if suctioning is indicated for spitting or choking,	RN	
4	Suction gently, clearing the mouth first, and then the nose.	RN	
5	Rinse bulb syringe with hot water after each use.	RN	

Procedure: Rooming In, Infant Security – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Allow the infant to remain with the mother to the extent that she desires, as long as both are	RN, ANP, MD	

Procedure: Rooming In, Infant Security – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
	physiologically stable.		
2	Explain the unit's infant security policies to the parents prior to infant rooming in.	RN	Refer to Newborn Security Guidelines - LMC (MBU) - Supporting Document
3	Transport the baby in a crib accompanied by a staff member or family wearing matching ID bands when the baby is transported outside of the mother's room.	RN	
4	Ensure the infant is in the room with a person with a matching ID band at all times.	RN	Exception: mother can designate another person to watch her baby while she is out of the room if the mother introduces the designee to the nurse in person.
5	Be sure to compare identification bands when baby is returned to the parent's room following separation.	RN	

Procedure: Routine Newborn Treatments – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Treat with Vitamin K:	RN, ANP, MD	• Single parenteral dose of Vitamin K is recommended for every newborn shortly after birth (may be delayed until after first breastfeeding in the delivery room) to prevent vitamin K-dependent hemorrhagic disease of the newborn. • Refer to Transition Care for Newborns - LMC (Childbirth & Maternal Services, inc. Neonatal)
2	Treat with Erythromycin:	RN, ANP, MD	• Erythromycin: Single dose of antimicrobial ophthalmic prophylaxis is recommended for every newborn shortly after birth (may be delayed

Procedure: Routine Newborn Treatments – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			until after first breastfeeding in the delivery room) to protect against gonococcal opthalmia neonatorum. • Refer to Transition Care for Newborns - LMC (Childbirth & Maternal Services, inc. Neonatal)
3	Treat with Hepatitis B:	RN, ANP, MD	• Early hepatitis B immunization is recommended for all medically stable infants with birth weights greater than 2kg. • For additional recommendations related to a positive or unknown maternal HBsAG status, refer to Hepatitis B Vaccine Administration for Newborns - SCL Health (Women & Children Services)
4	Offer elective circumcision of newborn male prior to discharge, providing there are no identified risk factors.	RN, ANP, MD	• Care of infants during and following circumcision is directed toward pain management, prevention of post-surgical complications, and education of parents for follow-up care. • Refer to Circumcision Care and Pain Management - LMC (MBU)

Procedure: Hyperbilirubinemia Assessment, Treatment – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Perform a transcutaneous Bilimeter (TCB) reading at 24 hours, then nightly until discharge.	RN, ANP	• TCB reading is reflective of a “Total Bilirubin.” • Recommended technique is to obtain TCB reading on sternum. • If TCB is > 15 or newborn is in the “high risk zone” (see below); obtain serum bilirubin (Total and Direct).
2	**Refer to the “BiliTool” on**	RN, ANP, MD	• Refer to Hyperbilirubinemia Management in Infants Over 35

Procedure: Hyperbilirubinemia Assessment, Treatment – LMC (MBU)

#	Required Action Step (step by step process)	Performed By	Supplemental Guidance
	weblinks.		Weeks Gestation - SCL Health (Childbirth & Maternal Services (inc. Neonatal)). • Enter hours of life and TCB (or serum) results to determine risk stratification and treatment options. • **Step 1: Determine "Risk Stratification"** ○ Plot/enter the neonate's age (hours of life) and Total Bili (using either the nomogram or the bili-tool) to determine the risk factors for developing severe hyperbilirubinemia. ○ Risk stratification is defined as low risk (green), low intermediate risk (yellow), high intermediate risk (orange) or high risk (red)**.** ○ **If baby is in "high risk stratification" (red zone), obtain serum bilirubin (Total and Direct).** • **Step 2: Determine Neurotoxicity Risk Level.** ○ Based on neurotoxicity level and age of life (at the time the TCB or serum is obtained), BiliTool will provide an approximate bilirubin level at which to initiate phototherapy. ○ Notify provider if BiliTool recommends phototherapy. ○ Once an order is obtained for phototherapy, refer to "Phototherapy" guideline. ○ Note, once phototherapy is initiated, the TCB is no longer accurate; therefore, bilirubin levels must be obtained with a

Procedure: Hyperbilirubinemia Assessment, Treatment – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			serum sample.

Procedure: Testing – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Ensure that infants of Rh-negative mothers have cord blood typed within 24 hours after birth.	RN, ANP, MD	
2	Arrange for newborn genetic screening prior to discharge.	RN	• Parents will be instructed on the need for a second newborn genetic screen between 10-14 days of age. • If the infant remains in the hospital this long, a second screening test will be completed while they are here.
3	Perform a hearing test prior to discharge.	RN	
4	Complete glucose screening per Hypoglycemia Management for Newborns - SCL Health (Women & Children Services).	RN, ANP, MD	
5	Screen for hyperbilirubinemia (see above)	RN, ANP	• Transcutaneous Bilimeter (TCB) reading at 24 hours, then nightly until discharge. ○ If TCB is > 15 or infant is in the high risk zone; obtain serum bilirubin. • If the infant appears jaundiced a transcutaneous bili level should be obtained.
6	Perform Critical Congenital Heart Disease (CCHD) Screening, involving obtaining pulse oximetry readings in the right hand and one foot, done by the baby's primary nurse with the	RN	• Refer to the Critical Congenital Heart Disease Screening - SCL Health (Childbirth & Maternal Services) , Staff Tip sheet, competency and parent education sheet for the purpose, pass/fail parameters, and

Procedure: Testing – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
	weight and TCB check after 24 hours of age.		testing algorithm. • CCHD Competency - LMC (MBU) - Supporting Document • CCHD Staff Tip Sheet - LMC (MBU) - Supporting Document • Congenital Heart Disease Screening Parent Education Form - LMC (MBU) - Supporting Document
7	Screen newborns for Early Onset Sepsis utilizing the "Early Onset Sepsis Calculator" in EMR..	RN, ANP, MD	Plan of care and recommended interventions are based on calculator risk stratification and neonate's clinical presentation at approximately 2 – 4 hours of age.
8	Perform car seat pulse-oximetry challenge test prior to discharge, as it is necessary for all infants less than 37 weeks or < 2500gms (birth weight).	RN	Refer to High Risk Car Seat Guideline - LMC (Childbirth & Maternal Services, inc. Neonatal)
9	Transport infants to another department for testing in a crib (with chart, bulb syringe, and stethoscope), with adequate thermal regulation, and accompanied by a nursing staff member.	RN, ANP	For infants being transported to another department for visitation with mom--- refer to Visitation of Infants Outside Women & Family Center (WFC) - LMC (MBU).

Procedure: Discharge Planning – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Assess family, environmental and social risk factors before discharge.	RN, ANP, MD	
2	Provide safe home environment education prior to discharge	RN	
3	Obtain an order for a care management consult If risk	RN	• Discharge should be delayed until a plan to safeguard the infant is in

Procedure: Discharge Planning – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
	factors are identified (such as history of maternal substance use disorder, mental illness, no fixed home, history of domestic violence, etc.).		place. • The plan may involve discussions with child protective services. • Refer to Screening Protocol to Detect Maternal Drug Use - LMC (Childbirth and Maternal Services, inc. Neonatal)

Procedure: Discharge Teaching – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Instruct parents of infant on the care of the mother and baby according to the items listed on the electronic medical record Discharge Teaching Sheet.	RN	
2	Encourage parents to read the patient education resource book throughout their postpartum stay.	RN	• Maternal/Newborn Discharge Teaching Sheet will be given to the mother or primary care giver at discharge. • Refer to Discharge: Infant & Mother - LMC (MBU)

Procedure: Documentation Requirements – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
1	Complete documentation as appropriate.	RN, ANP, MD	• Nursing computer documentation of assessment, feeding/output and weight • Routine newborn treatments and screening • Newborn Admission and Discharge Examination by care provider • Mother/Infant Teaching and

Procedure: Documentation Requirements – LMC (MBU)			
#	**Required Action Step** (step by step process)	**Performed By**	**Supplemental Guidance**
			Discharge Sheet • "Safety First" sheet
2	Complete "Refusal of Newborn Treatment Form" (E_0818) if parents do not consent for their newborn to have any of the following treatments or screenings: • Administration of Eye Prophylaxis • Administration of Vitamin K (Injection) • Hepatitis B Vaccine if mom is unknown or positive • Newborn Metabolic Screening • CCHD • Hearing Screen (if not completed by the hearing screen personnel)		• Parents may legally refuse treatment or newborn screening tests on the basis of religious convictions or personal objection per Colorado Statue • Parents should be provided with informed consent • Education Materials should be distributed and reviewed with parents: o Colorado Department of Public Health and Environment "Newborn Screening Program" pamphlet. o CCHD screening education form

References:

- American Academy of Pediatrics & the American College of Obstetrics & Gynecologist. (2017). 8th Ed. Guidelines of Perinatal Care.
- American Academy of Pediatrics. Clinical Practice Guideline. Subcommittee on Hyperbilirubinemia. "Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation." Reaffirmed Pediatrics. (2011). 128: 4.
- American Academy of Pediatrics. Committee of Fetus and Newborn. "Hospital stay for healthy term newborns." Pediatrics. (2015); 135:(5). http://pediatrics.aappublications.org/content/135/5/948
- Mattson, S and Smith, JE (2018). Core Curriculum for Maternal-Newborn Nursing, 5th ed.
- McGrath, A & Vohr, B.R. Hearing loss in the newborn: Early hearing detection and intervention. NeoReviews. (2017). 18: (10).

Other Related Policies:

- Breastfeeding Assessment & Teaching and Human Milk Collection & Storage - LMC (Childbirth and Maternal Services, inc. Neonatal)
- Critical Congenital Heart Disease Screening - SCL Health (Childbirth & Maternal Services)
- Circumcision Care and Pain Management - LMC (MBU)

- Discharge: Infant & Mother - LMC (MBU)
- Hepatitis B Vaccine Administration for Newborns - SCL Health (Women & Children Services)
- High Risk Car Seat Guideline - LMC (Childbirth & Maternal Services, inc. Neonatal)
- Hyperbilirubinemia Management in Infants Over 35 Weeks Gestation - SCL Health (Childbirth & Maternal Services (inc. Neonatal))
- Hypoglycemia Management for Newborns - SCL Health (Women & Children Services)
- Late Preterm Care Guideline - LMC (MBU)
- Management of Early Onset Sepsis (EOS) for the Newborn - SCL Health (Women & Children Services)
- Pain Assessment & Management - LMC (NICU)
- Patient Identification - LMC
- Screening Protocol to Detect Maternal Drug Use - LMC (Childbirth and Maternal Services, inc. Neonatal)
- Transition Care for Newborns - LMC (Childbirth & Maternal Services, inc. Neonatal)
- Visitation of Infants Outside Women & Family Center (WFC) - LMC (MBU)

Supporting Documents:

- CCHD Competency - LMC (MBU) - Supporting Document
- CCHD Staff Tip Sheet - LMC (MBU) - Supporting Document
- Congenital Heart Disease Screening Parent Education Form - LMC (MBU) - Supporting Document
- Newborn Security Guidelines - LMC (MBU) - Supporting Document
- Newborn, Postpartum, and Antepartum Nursing Care Tip Sheet - LMC - Supporting Document

Monitoring:

Nurse leadership is responsible for monitoring compliance with this policy.

Obstetrics and Newborns

MB	Mom & Baby Unit
EOS	Early Onset Sepsis
SGA	Small for Gestational Age
LPT	Late Preterm those born between 34 0/7 and 36 6/7 gestational weeks,
Chorio	Chorioamnionitis or intra-uterine inflammation is a frequent cause of preterm birth.
TCB	Transcutaneous bilirubin
CCHD	Critical Congenital Heart Disease Screening
PKU	Phenylketonuria. It is a rare disorder that prevents the body from breaking down part of a protein called phenylalanine (Phe). Phe is in all foods that contain protein, such as milk, meats, and nuts.
BG	Blood Glucose
Rhogam	RhoGAM is a shot given to pregnant people whose blood is negative for Rhesus factor (Rh) protein but who are carrying an Rh-positive fetus.
GTT	Glucose Tolerance Test
DTR	Deep Tendon Reflexes
T&S	Type and Screen determines ABO blood group and Rh type and screens for clinically significant alloantibodies in case a patient needs blood.
PROM	Premature rupture of membrane
PTL	Preterm Labor Diagnosis
Neuraxial	The term neuraxial anesthesia refers to the placement of local anesthetic in or around the CNS.
ERAS	Enhanced recovery after surgery

Neonatal Pulse Oximetry reading

- Only use the RIGHT HAND and foot due to possible interference of ductus arteriosus providing a false result.

The ductus arteriosus is a fetal vessel that allows the oxygenated blood from the placenta to bypass the fetal lungs in utero.

- At birth, a newborn inhales for the first time and the lungs fill with air, causing pulmonary vascular resistance to drop and blood to flow from the right ventricle to the lungs where it can undergo oxygenation.
- The increased arterial oxygen tension and decrease in blood flow through the ductus arteriosus causes the ductus to constrict and functionally close by 12 to 24 hours of age in healthy, full-term newborns, with permanent (anatomic) closure occurring within 2 to 3 weeks.
- In premature infants, the ductus arteriosus does not close rapidly and may require pharmacologic or surgical closure to treat unwanted repercussions.

Obstetrics and Newborns

Preeclampsia

- Preeclampsia is a pregnancy-specific hypertension syndrome.
- The American College of Obstetricians and Gynecologists defines the diagnostic criteria for preeclampsia as the measurement of hypertensive thresholds (i.e., systolic and diastolic blood pressures ≥140 and ≥90 mmHg, respectively, occurring twice, four hours apart, after 20 weeks) with either proteinuria (i.e., ≥300 mg per 24 hours) or, in the absence of proteinuria, new onset of any of the following systemic findings:
    a. thrombocytopenia (platelet count <100,000 μL);
    b. renal insufficiency (i.e., creatinine >1.1 mg/dL or two-fold increase in creatinine in the absence of underlying renal disease);
    c. abnormal liver function (i.e., hepatic transaminase levels twice the upper limit of normal);
    d. pulmonary edema; or
    e. cerebral or visual symptoms.

Urine Protein Creatinine Ratio

- UPCR is calculated by dividing the level of protein (mg/dl) in a spot urine test by the creatinine level (mg/dl)

Hyperbilirubinemia

- Hyperbilirubinemia is a common condition occurring in neonatal periods, with a prevalence of around 60% in term neonates and 80% in preterm neonates. Preterm neonates have a greater risk of severe hyperbilirubinemia, which can lead to encephalopathy

Car Seat Challenge

- The car seat challenge test is used to identify infants who are at high risk for respiratory or airway problems when in their car seats.
- Failure criteria include (1) apnea >20 seconds, (2) bradycardia <80 beats per minute for >10 seconds, and (3) desaturation <90% for >10 seconds
- Test is 90 to 120 minutes long, unless car ride home is longer.

Latch Score

- LATCH score is a simple tool to identify mothers who require breastfeeding support and counselling before discharge from the hospital to prevent early breastfeeding cessation.

Bilimeter

- The Bili-Meter is a spectroradiometer that measures the therapeutic irradiance (radiant power) of neonatal phototherapy lights.
- Bilimeters are devices that measure bilirubin transcutaneous (i.e. without drawing blood). They work by directing light into the neonate's skin and then measuring the intensity of specific wavelengths that return and using this information to calculate bilirubin level.

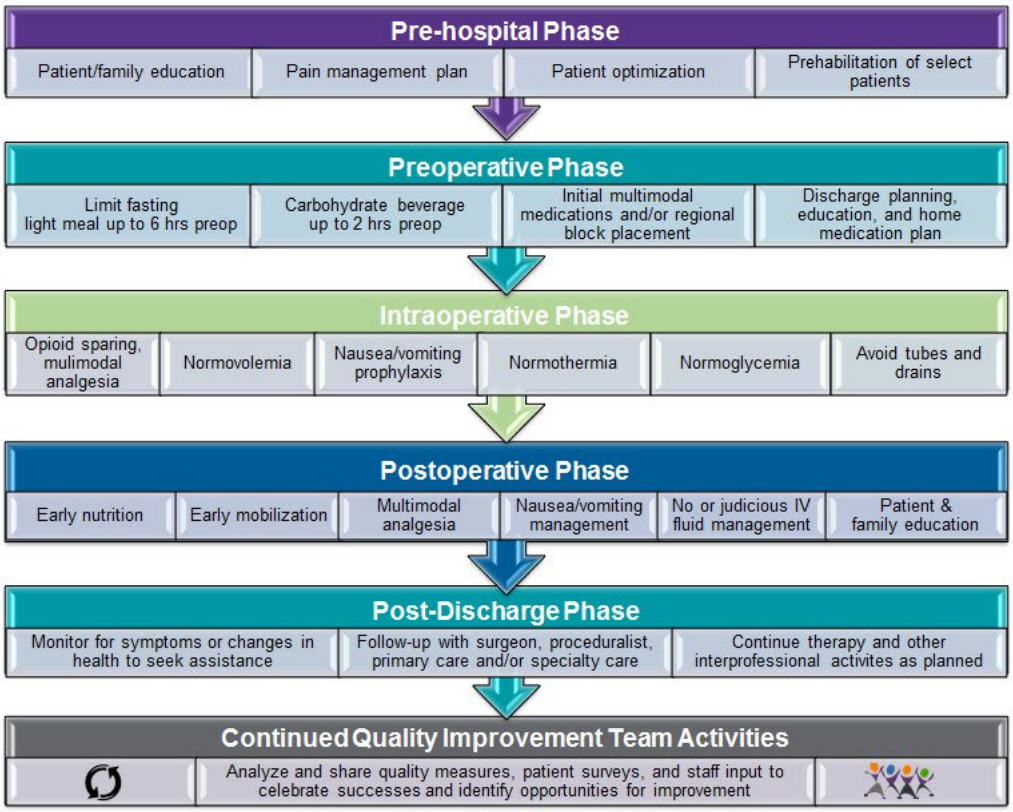
Obstetrics and Newborns

LATCH: A Breastfeeding Charting System and Documentation Tool

LATCH is a structured assessment of breastfeeding. Systematic use of LATCH can help identify which mothers and babies need additional support or referral. The use of a structured breastfeeding assessment is recommended at least twice before the newborn's discharge from the nursery. Any concerns identified by LATCH should be addressed prior to discharge, including the development of a plan for follow-up.

	0	1	2
L Latch	Too sleepy or reluctant No latch achieved	Repeated attempts Hold nipple in mouth Stimulate suck	Grasps breast Tongue down Lips flanged Rhythmic sucking
A Audible swallowing	None	A few with stimulation	Spontaneous and intermittent <24 hours old Spontaneous and frequent >24 hours old
T Type of nipple	Inverted	Flat	Everted (after stimulation)
C Comfort (Breast/nipple)	Engorged Cracked/bleeding/large blisters or bruises Severe discomfort	Filling Reddened/small blisters or bruises Mild, moderate discomfort	Soft Nontender
H Hold (Positioning)	Full assist (staff holds infant at breast)	Minimal assist Teach 1 side; mother does other Staff holds and then mother takes over	No assist from staff Mother able to position/hold infant

Obstetrics and Newborns



Obstetrics and Newborns

LOCHIA WHAT'S NORMAL & WHAT'S NOT

LOCHIA RUBRA BIRTH TO DAY 4	LOCHIA SEROSA DAY 4 TO DAY 10	LOCHIA ALBA UP TO 6 WEEKS
BRIGHT RED HEAVY FLOW BLOOD SMALL/MEDIUM CLOTS	PINKISH BROWN LESS BLOOD MORE DISCHARGE FEWER CLOTS	YELLOW/WHITE LITTLE BLOOD SOME DISCHARGE NO CLOTS

RED FLAGS

- YOUR BLEEDING SLOWS/STOPS AND THEN STARTS AGAIN
- SOAKING THROUGH A PAD IN 1 HOUR OR LESS
- PASSING CLOTS BIGGER THAN A GOLF BALL
- HAVE A FEVER OR FLU-LIKE SYMPTOMS
- ABDOMINAL PAIN THAT IS MORE THAN USUAL AFTERPAIN CRAMPS

SLOW DOWN AND CALL YOUR CAREGIVER

WHY DO YOU BLEED AFTER BIRTH?

- HEALING OF THE PLACENTA SITE IN THE UTERUS
- RELEASING EXTRA FLUIDS, BLOOD AND UTERINE LINING FROM PREGNANCY

SELF CARE

- COTTON PANTIES
- PERI-BOTTLE
- HERBAL SITZ BATH
- COOL COMPRESSES
- WITCHHAZEL
- LARGE PADS

elite doula group

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