KINGSBOROUGH COMMUNITY COLLEGE
DEPARTMENT OF NURSING

N/A – Not Applicable
NIC – Not in Chart
UTD – Unable To Determine
Ø – None

NURSING ASSESSMENT NEWBORN

STUDENT ____________
INSTRUCTOR _______________
AGENCY/SECTION _____________

CLIENT INITIALS ______________
ROOM NO ___________________
DATES OF CARE _______________

DATA COLLECTION: HISTORY & HEALTH ASSESSMENT

Birth History:
Age ________________
Sex ________________

Type of Delivery____________ Date _________ Time________
Birth Weight _______________ Length ________________
Gestational Age ______________________
Apgar: 1 min _________ 5 min ______ 10 min _______
Obvious Anomalies ___________________________________

Significant Labor Findings (length of labor, presentation, drugs given to mother, complications, etc.)
Describe:

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Social History:

Support System ____

Family's pertinent cultural practice ____

Maternal – Newborn Interactions ____
(Bonding) ____

Infant's Developmental Task ____

Family's Development Task ____

Discharge Planning:

Intended Destination post Discharge ____________________________________

Referrals: Clinic ____________________ Social Service ______________
Foster care __________________ Other/comments ____________________
Private Pediatrician ______________________

Teaching Needs (caregiver/parent's readiness to learn/barriers to learning)
(for the newborn)

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____
____
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Newborn's Laboratory/ Diagnostic Studies

Blood Type: __________________________

Rh Factor: __________________________

Blood Glucose: __________________________

Bilirubin: __________________________

Coomb's Test: Direct ____________
Indirect ____________

P.K.U: ______________________

Urine: ______________________

DATA COLLECTION	PHYSICAL	ASSESSMENT
	Day 1	Day 2
Systemic Assessment **A. Neurological:** Alert/reflexes: mono, tonic neck, babinski, blink, grasp, sleep wake cycle, cry, activity		
B. Cardiovascular:		
Apical Pulse: rate/rhythm/quality		
Respirations: rate/labored/nasal flaring		
Capillary refill (< 3 sec/color/ movement)		
Chest Symmetry: equal/unequal/chest circumference.		
C. Integumentary: Skin: Temperature: Axillary Rectal		
color/turgor/texture Jaundice/cyanotic		
fontanels/ head circumference rashes/erythema/Mongolian spots milia/lanugo/intergrity		

DATA COLLECTION	PHYSICAL	ASSESSMENT
	Day 1	Day 2
C. Integumentary: Cont……		
Umbilical cord: drainage/bleeding/ Odor/color clamped		
mucous membrane: lips/tongue/cheeks palate		
D. Gastrointestinal:		
Present weight		
Type of Feeding: Breasts/formula (specify) amounts tolerance		
Reflexes: root/suck Swallow/ gag		
Bowel sounds: present/absent		
Abdomen: soft distended		
Bowel movements: color (meconium, transitional, soft -yellow) odor/consistency		

DATA COLLECTION	PHYSICAL	ASSESSMENT
E. Genitourinary: Voiding: color/odor #wet diapers	Day 1	Day 2
Vaginal/ penile discharge		
Circumcision: discharge odor dressing		

TEXTBOOK PICTURE (definition, Major S/S, Tx)

PHARMACOLOGY DATA ANALYSIS

Trade Name	Generic Name	Classification	Normal Dosage	Action	Side Effects

DATA COLLECTION: PHYSICIAN ORDERS	
Date:	**ORDERS:**
Diet:	
Activity:	
Lab/Diagnostic Tests:	
Treatment/Therapies:	
Medications:	

DATA ANALYSIS:	NURSING DIAGNOSIS	
DATA SOURCE	**SIGNIFICANT FINDINGS**	**NURSING DX:**
1. Nursing History		
2. Physical Assessment		
3. Diagnostic/Lab Assessment		
4. Physician's Orders		

KINGSBOROUGH COMMUNITY COLLEGE
OF
The City University of New York

Student ______________________________ Date (s) Experience ______________________________

Client's Initials ______________________________

NURSING CARE PLAN

Nursing Diagnosis	**Expected Outcome & Criteria for Measuring**	**Nursing Actions**	**Rationale**	**Evaluation of Outcome**
Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

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Student’s Nurses Progress Note Day 1

Student’s Nurses Progress Note Day 2

STUDENT SELF-EVALUATION

Directions: Take time to do a realistic evaluation of your abilities in the areas listed below. Reflect on your overall performance for the course. What can you identify as support/barriers to your performance? Cite specific examples form your clinical experiences.

1. NURSING PEOCESS

A. Assessment –

What was your ability to gather data? Did you assess the client's cultural, developmental, emotional, physical, psychological, and spiritual needs? Did you use all sources ex. Client, family, staff, medical record etc.

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____

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B. Analysis/Diagnosis –

Did you identify significant findings and cluster the data to arrive at diagnosis? Did you use your Nursing Diagnosis book to select the diagnostic label? Did you identify contributing/risk factors for your patient? Did you use the PES format?

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____

C. Planning –

Did you prioritize your diagnoses? Were outcomes stated with specific criteria for measurement? Were nursing actions clear, did you include patient medications and teaching needs?

____

____

____

D. Implementation –

Did you carry out the plan, maintain a safe environment, provide patient/family teaching, collaborate with others?

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____

____

E. Evaluation -

Were the outcomes met, how? Did you state specific outcome criteria? Does the plan need to be continued or changed?

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____

2. THERAPEUTIC INTERVENTIONS

What psychomotor skills did you perform? What do you need improvement with? What skills would you like to perform?

____

3. COMMUNICATION ABILITIES

Did you use therapeutic techniques? How effective was your verbal/non-verbal communication with the client/family, staff, peers, instructor? How would you describe your participation and contributions to pre and post conference? Was your written documentation organized clear, concise and complete? Did you complete the flow sheet, I & O, Medex etc?

4. MANAGEMENT

Did you manage your time well? Was all care given? Were your priorities correct?

5. CRITICAL THINKING

Did you apply theoretical knowledge? Can you explain and support the thinking behind the actions you chose? Did you consider . . . What if something goes wrong? or What if we try . . . ? Did you recognize your biases? What would you do differently? Did you have self-confidence? Did you demonstrate good clinical judgment?

NURSING ASSESSMENT AND CARE PLAN EVALUAITON CRITERIA

Please note: All elements of nursing process must be completed in order to receive a satisfactory grade of 75.

ASSESSMENT	**(20)**
Data is logically summarized:	
a) History and Health Assessment	4
b) Physical Assessment	4
c) Physician's Orders	2
d) Textbook Picture	2
e) Pharmacology Data Analysis	4
f) Diagnostic and lab tests	4
DIAGNOSING (DATA ANALYSIS)	**(25)**
Clusters Data	5
Identifies **ALL** Significant Findings	10
Identifies **ALL** relevant nursing diagnoses using the PES format	10
PLANNING	**(15)**
(Develops Plan for 4 highest priority diagnoses-3 physiological/1 psychosocial)	
Prioritizes all identified diagnoses as HI-MED-LOW	5
Identifies appropriate client goals/desired outcomes	5
States criteria for evaluation of client goals/outcomes	5
IMPLEMENTATION	**(30)**
Identifies independent interventions to accomplish the top priorities for care (Including teaching when appropriate)	7
Identifies interdependent interventions to accomplish the top priorities of care (Including medications when appropriate)	7
Cites preferences for intervention	2
Explains scientific rational for each intervention	7
Documents nursing activities on appropriate flow sheets and nurses' notes	7
EVALUATION	**(10)**
Evaluates outcomes for 4 top priority diagnoses using sates criteria for evaluation	5
Evaluates (self) performance of care	1
Correct grammar is used throughout document	2
Paper is legible	2
Total Points possible	**100**