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Neonatal jaundice Initial assessment

Child Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Clinical assessment

Subjective: Caregiver noticed increasing yellow skin and concerns about feeding.

Objective findings and required checks: Jaundice requires age-in-hours bilirubin assessment; feeding and hydration need review.

Physical examination and investigations: Assess bilirubin against the appropriate treatment chart, gestation, age in hours, feeding and indicated cause investigations.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Neonatal jaundice: Bilirubin accumulation may be physiological or pathological; risk depends on age, gestation and clinical factors.

Medical / surgical management

Follow neonatal bilirubin thresholds and the prescribed phototherapy or other treatment plan; support feeding and monitoring.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Phototherapy as prescribed	Reduce bilirubin through light-mediated conversion	Verify device setup, protection and monitoring
prescribed additional treatment	Manage identified severe or causal problems	Use specialist protocols.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about feeding, urine/stool pattern and caregiver observations of jaundice. Assess: Review bilirubin against age-in-hours and gestation-specific thresholds with neurological and hydration assessment.	Rising bilirubin requiring neonatal surveillance. Possible factors: bilirubin production or clearance exceeding current capacity. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Bilirubin is reviewed and treatment delivered according to the prescribed neonatal threshold pathway. Longer-term: Before the clinically approved transition or agreed follow-up: Caregiver explains feeding support, bilirubin follow-up and warning signs.	1. Verify age in hours, gestation, risk factors and the correct bilirubin treatment chart. Rationale: Treatment thresholds depend on these factors rather than appearance alone. 2. Deliver prescribed phototherapy using the correct device setup, protection and monitoring. Rationale: Effective and safely delivered light treatment supports bilirubin reduction. 3. Support the assessed feeding plan and urgently report poor responsiveness or abnormal neurological findings. Rationale: Intake affects clearance, while neurological changes may indicate serious bilirubin-related risk. 4. Follow neonatal bilirubin thresholds and the prescribed phototherapy or other treatment plan; support feeding and monitoring. Rationale: Bilirubin accumulation may be physiological or pathological; risk depends on age, gestation and clinical factors. The condition-specific plan addresses the	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
			underlying problem while response is monitored.	
Ask: Ask about feed frequency, pain, infant behaviour and caregiver concerns. Assess: Observe an entire feed when possible and assess weight, output and clinical stability.	Feeding difficulties affecting infant or caregiver well-being. Possible factors: ineffective attachment, fatigue or a clinical feeding barrier. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: A safe, supported feeding plan is demonstrated during the observation period. Longer-term: Before the clinically approved transition or agreed follow-up: Caregiver describes feeding cues, intake indicators and when to seek help.	1. Assess both infant stability and caregiver comfort before recommending changes. Rationale: Feeding difficulty can have medical as well as technique-related causes. 2. Support positioning and attachment or the prescribed alternative feeding method. Rationale: Individual support can improve comfort and effective milk transfer. 3. Arrange weight or feeding review and escalate poor intake or dehydration. Rationale: Follow-up helps identify inadequate intake early.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain bilirubin review, feeding support and follow-up; sunlight is not a substitute for prescribed treatment. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain bilirubin review, feeding support and follow-up; sunlight is not a substitute for prescribed treatment.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Poor feeding, lethargy, abnormal cry, fever or rapidly worsening jaundice requires urgent neonatal review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Bilirubin accumulation may be physiological or pathological; risk depends on age, gestation and clinical factors.

- Priority concerns: Rising bilirubin requiring neonatal surveillance; Feeding difficulties affecting infant or caregiver well-being; Insufficient fluid replacement for current losses; Learning needs about the condition and care plan.

- Poor feeding, lethargy, abnormal cry, fever or rapidly worsening jaundice requires urgent neonatal review.

- Explain bilirubin review, feeding support and follow-up; sunlight is not a substitute for prescribed treatment.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
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https://www.indiannursingcouncil.org/gazette-notification

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