PURPOSE:

- To ensure that all hospital staff/volunteers and outside agencies are notified appropriately, with the goal being to locate and reunite the infant or child and his/her family as quickly as possible.

- Effective crisis management, immediately following an infant or child abduction, requires close cooperation between physicians, nurses, administration, security, other hospital staff/volunteers, law enforcement staff and the media. Given the urgent nature of an infant or child abduction and time-critical decisions that must be made, this cooperation becomes vital.

POLICY:

- At no time during the early stages of an abduction shall any person, without a valid need to know, be told that an infant or child is missing. The law enforcement agency(ies) and Community Relations Department shall make that determination in conjunction with the administration of the hospital.

- No hospital employee or volunteer shall be authorized to make a public statement concerning this incident or communicate with a member of the media without prior clearance from the Chief Executive Officer, Community Relations Director or designee.

PROCEDURE:

- When a staff member/volunteer has suspicion that an infant or child is missing or has been abducted, he/she shall immediately notify the Charge Nurse or Unit Nurse Manager. A search shall be conducted of the unit. The unit staff/volunteers shall follow the following response program **STORK**:
  - S = Search the unit for infant/child and Secure the scene.
POSITION DESCRIPTION / PERFORMANCE EVALUATION

Job Title: Nursery RN
Prepared by: ____________________________  Approved by: ____________________________
Date: ________________________  Date: ________________________

Supervised by: Nurse Manager

Job Summary: Provides direct and indirect patient care in the Nursery setting. Provides assessment and planning for individualized patient care. Communicates with physicians about changes in patient’s clinical condition including results of diagnostic studies and symptomatology. Responds quickly and accurately to changes in condition or response to treatment. Performs general nursing duties in all Maternal-Child Health departments with supervision. Participates in performance improvement activities.

DUTIES AND RESPONSIBILITIES:

Demonstrates Competency in the Following Areas:

<table>
<thead>
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<th>3</th>
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<tr>
<td>Ability to perform a head-to-toe assessment on infants, adolescents and adults and perform reassessments as per policy.</td>
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<td>Ability to assess neonate at delivery and perform neonatal resuscitation.</td>
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<td>Ability to adequately assess and reassess pain. Utilizes appropriate pain management techniques. Educates the patient and family regarding pain management.</td>
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<td>Ability to revise plan of care as indicated by the patient’s response to treatment and evaluate overall plan daily for effectiveness.</td>
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<td>Ability to perform waived testing (point-of-care testing) per Clinical Laboratory’s and the resident care unit’s policies and procedures.</td>
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<td>Ability to interpret results of waived tests; take appropriate action on waived tests results.</td>
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<td>Performs patient care responsibilities considering needs specific to the standard of care for infants.</td>
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<td>Knowledge of medications and their correct administration based on age and weight of the patient and his/her clinical condition.</td>
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<td>Follows the seven (7) medication rights and reduces the potential for medication errors.</td>
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<td>Formulates a teaching plan based upon identified learning needs of the parents/caregivers and evaluates effectiveness of learning.</td>
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<td>Demonstrates an ability to assist physicians with procedures and performs services requiring technical and manual skills in the Nursery and Postpartum units.</td>
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<td>Demonstrates ability to perform treatments and provide services to level licensure.</td>
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<td>Treats patients and their families with respect and dignity. Identifies and addresses psychosocial, cultural, ethnic and religious/spiritual needs of patients and their families. Functions as liaison between administration, patients, physicians and other healthcare providers.</td>
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<td>Communicates appropriately and clearly to Nurse Manager, charge nurse, co-workers and physicians.</td>
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<td>Consults other departments as appropriate to provide for an interdisciplinary approach to the patient’s needs.</td>
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**DEFINITION:**

An infant is classified as large for gestational age (LGA) if their birth weight is greater than 90% for gestational age. LGA infants may be term, post-term or premature.

**POLICY:**

- _________________ (organization name) shall use _________________ tool to evaluate the gestational age of each newborn within two (2) hours of birth.

- LGA infants shall be assessed and monitored every _____ hours.

- LGA infants shall transition on Mom/Baby utilizing the following procedure as long as their vital signs and physical assessment are within normal parameters.

**RISK FACTORS:**

- Conditions associated with LGA infants include, but are not limited to:
  - Maternal conditions, including genetic predisposition, large weight gain during pregnancy, diabetes, Beckwith-Wiedemann Syndrome and hydrops fetalis
  - Physical conditions, including potential for, but not limited to:
    - Facial nerve damage
    - Brachial plexus injury
    - Clavicular or humeral fractures
OBJECTIVE:
To assist in the identification of Rh sensitization and prevent the possibility of Rh hemolytic disease related to future pregnancies and deliveries.

POLICY:
- The prevention of antibody development in an Rh-negative mother, who has conceived an Rh-positive infant will be initiated through the use of the Rh immune globulin vaccine (RhIG), to prevent sensitization related to future pregnancies.
  - Based on the results of the Rh factor, the physician shall order the RhIG vaccine and the dose for the mother who has not been previously sensitized.
  - RhIG is given intramuscularly.
  - RhIG may be given to unsensitized pregnant women at 28 weeks of gestation.
  - RhIG shall be administered by a member of the Nursing staff within 72 hours after term or preterm delivery, when appropriate.
  - RhIG shall be administered if infant is Rh-positive after an induction, or spontaneous abortion and immediately following amniocentesis to prevent maternal sensitization from possible transplacental hemorrhage during procedure.
  - If mother refuses the RhIG, the RhIG Refusal Release Form shall be obtained and incorporated into the patient’s medical record. The physician shall be notified.

- Management of the Neonate:
  - For the Rh-positive baby with antibodies:
    - Frequent monitoring of bilirubin level, as needed.
    - If bilirubin level rises to serious levels, exchange transfusion may be necessary.
    - Phototherapy and increased fluid intake may be used to reduce jaundice.
POLICY:

Mother and parents/legal guardians shall receive instruction and verbalize understanding of infant care throughout hospitalization in preparation for discharge.

GUIDELINES:

• Breast Feeding, Breast Care:
  • Frequency/duration:
    ■ Infant shall breast feed on demand 8 to 12 times in a 24-hour period, nursing at both breasts.
    ■ Infant shall breast feed until satiated and comes off breast.
    ■ Emphasis is on equal stimulation to both breasts throughout each day, not each feeding.
  • Releasing infant from breast:
    ■ Break suction with finger before removing infant from breast. Failure to do so may contribute to sore nipples.
  • Supplements:
    ■ Supplementation shall not be recommended for normal term newborns unless per physician order.
  • Nursing positions:
    ■ Varying positions such as sitting, lying down, football hold or cradling may help prevent sore nipples. Use pillows to support a comfortable position and bring infant to mother.
  • Breast support/breast care:
    ■ Wear supportive bra.
    ■ Do not use plastic liners in bra.