



Author Type: NEONATAL NURSE PRACTITIONER Status: Signed

Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

^

Hide copied text

☐ Hover for attribution information

Plan of Care by Dischler, Christopher K, NNP, RN at 08/05/16 1459

Author: Dischler, Christopher K, NNP, RN Service: Neonatology
Filed: 08/05/16 1541 Date of Service: 08/05/16 1459
Editor: Dischler, Christopher K, NNP, RN (NEONATAL NURSE PRACTITIONER)

Indication for Transport: Cooling for HIE

Referring Facility and Phone Number: St. Joseph Regional Medical Center, 979-776-3777

Referring Physician: Dr. Carmicheal

Physician Covering Transport: Dr. Reyes

Social: Parents updated regarding are during transport and on arrival to TCH.

Mother's name and phone number

MATERNAL HISTORY:

Maternal Labs:
Blood Type: O + Hepatitis: negatine HIV: negative RPR: immune Rubella: immune GBS: negative HSV: negative Birth Weight: 3.530 Infant born on 8/5/16 at 0503 to a 26 year old G 2 P 1 Ab 0 (Hispanic) female

Prenatal care started: unknown

EDC: 7/31/16
Maternal history drugs/alcohol/tobacco: denies

Maternal history drugs/alcohol/tobacco: denies
Pregnancy was uncomplicated.
Maternal history uncomplicated.
Maternal Medications: none. Steroids: none.
Mother presented to th hospital on 8/4/16 for scheduled induction. AROM on 8/4/16 with meconium fluid noted. Infant delivered by repeat c-seciton secondary to failed VBAC. Instruments used: none.
Delivery complications: Non reassuring fetal heart tones
Chorioannionitis: no
Presentation included: Bag and mask ventilation. HR < 100 at 5 minutes and intubated.
Infant taken to NICU for further management.

HISTORY OF PRESENT ILLNESS AND TRANSPORT NARRATIVE.
Torm infant that was delivered we discretion of failed VIIAC and non-reasoning fetal heart tones. Infants APCAICs were 10:5 Infant was translated to NCU for further management and passive cooling infant developed a left side presumptions which was evacuated via needle aspiration (~ 70 ml). On actival infant was stable on minimal vertilator exitings. An CXIR was done prior to transferring back to TCH. ETT was pulled back 0.5 on along with UAC back by 1 cm. Needle aspiration was attempted for a right side presumptions without an results.

Referring Facility Diagnostics/Labs/Medications X-Ray ETT at T4 Latin ABO 7 33/97/94/19 5/6 4 Medicateons Ampositin and Genturicin Blood outure pending from CGH NBS Dave at CGSH 85 Hepatitis B Vaccine due PTD

PHYSICAL EXAM

General Appearance Ident, active, pink, in no abuse distress
Hydration, well hydrated, multipus membranes most, good skin turgor
Head Antaner Iontanelle open, sort, and fat, normocephatic, mist caput.
Facil taces unremarkable
Eyes clear, no issues, solera white, pupils round and reactive to light.
Ears Non dysurophic, in normal position.
Nose, parent naires bilaterally, no drainage.
Mouth, no position or graywal cyarrosis or lesions, banque is normal in appearance, ETT secured with tage.
Nose, parent naires bilaterally, no drainage.
Mouth, no position or graywal cyarrosis or lesions, back and sprise normal.
Resp Chest, buspile, insched modine, normalisms, back and sprise normal.
Resp Chest threath sounds course and equal bilaterally.
Cardovasourian normal strus shiphin, no matrims, heads counds normal, capitrefil < 3 sec. Pulse 2 × X 4 est.
Neuro ident, active, moves all 4 extremities. Mist hypertonic.
Back nortender, no deformity, no defect.
Extremises, full range of motion, and symmetrical.
Abdomen soft, without manues, organismispily or fundamens, bowel sounds normal, UVC secured with minimal biseding.
GUI, normal male external generalis.
Soin, warm, day, no rash, no lesions.
Lines, Cleansty Mistact UAC, PVI.

Category	Description
Level of Coraciouaness	Hyporatort (midd)
Sportaneous Activity	Normal (mass)
Neuromuscular Control Porture Tone	Mild distal fector (mild) Normal (mild)

8/5/2016 12:56 PM Ad

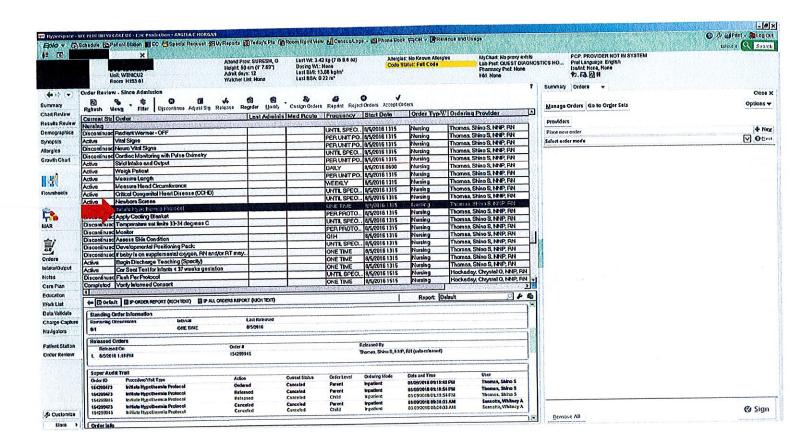
Primitive Reflexes: Suck Moro	Weak (moderate) Present (mild)	
Autonomic System: Pupils Heart Rate Respirations	Reactive (mild) Normal (mild) Normal (mild)	
Seizures:	not present	
Sarnat score:	Mild	

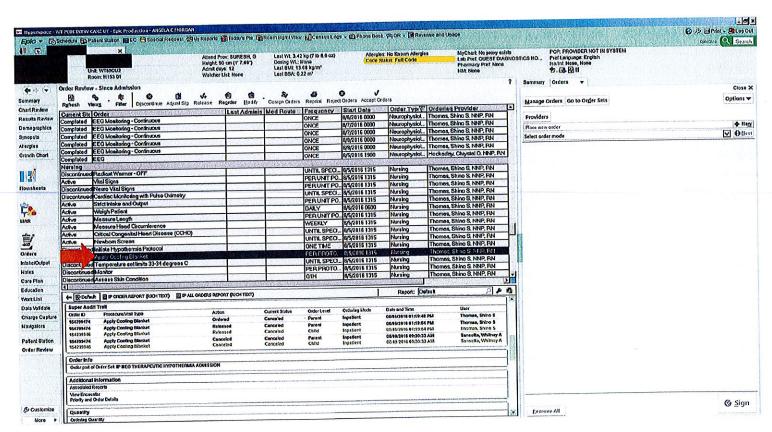
DIAGNOSIS: Respiratory Failure HIE Sepsis Evaluation Feeding Difficulity

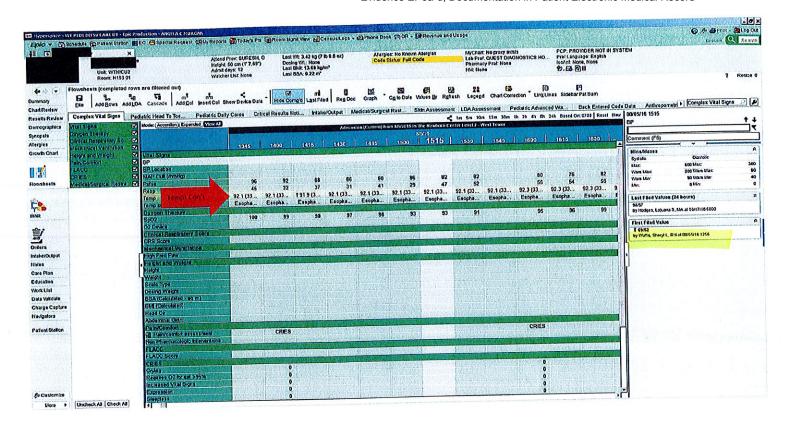
PLAN:
General: Transport to TCH. Provide neutral thermal environment
Respiratory: Continue current ventilator and wean as tolerated
CVS: Continue Morphine at 0.01 mg/kg/hour. Continue cooling per protocol.
FEN/GI: NPO, Start TPN at 45 ml/kg/day
ID: Continue Amp/Gent and follow cultures until final.

Report given to Crystal Hockaday at bedside.

Signature: Chris Dischler MSN, APRN, NNP-BC Neonatal Nurse Practitioner Volt: 33318 Pager: 2826









DOB: 8/5/2016, Sex: M Adm: 8/5/2016, D/C: 8/17/2016

8/5/2016 12.56 PM Admission Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2 Nsg/Anc Progress Note by Wallis, Sheryl L, RN at 08/05/16 1328 Author: Wallis, Sheryl L, RN Filed: 08/05/16 1329 Service: (none)
Date of Service: 08/05/16 1328 Author Type: REGISTERED NURSE Status: Signed Editor: Wallis, Sheryl L, RN (REGISTERED NURSE) 1256 pt in transport isolette arrived to NICU 4 bed 71 intubated with o2 sats 100% on cooling blanket. Pt ☐ Hide copied text accompanied by transport team. No family at bedside at this time. ☐ Hover for attribution information **Patient Information** DOB 08/05/2016 Male Home Phone Work Phone



TEXAS CHILDREN'S ROI LOCATION

DOB: 8/5/2016, Sex: M Adm: 8/5/2016, D/C: 8/17/2016

Author Type: REGISTERED NURSE Status: Addendum

Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

Nsg/Anc Progress Note by Copenhaver, Leanna D, RN at 08/05/16 1555

Author Copenhaver, Leanna D, RN
Filed: 08/05/16 1712
Editor. Copenhaver, Leanna D, RN (REGISTERED NURSE)

Service: (none)
Date of Service: 08/05/16 1555

1300) Morphine 1mg/ml concentration infusing via PIV at 0.04 ml/hr, D10 infusing via PIV at 7 ml/hr, and Heparin 1unit/ml in Normal saline infusing via

1300) Morphine 1mg/ml concentration infusing via PIV at 0.04 ml/hr, D10 iniusing via PIV at 7 ml/ml, e UAC.

UAC.

1400) CHAB done to verify UAC and ETT placement and to assess lung fields and bowel gas pattern.

1340) Labs drawn as ordered via UAC.

1500) ABG with lactate and POC glucose drawn via UAC.

1535) UVC placed per NNP, waiting on xray to verify placement.

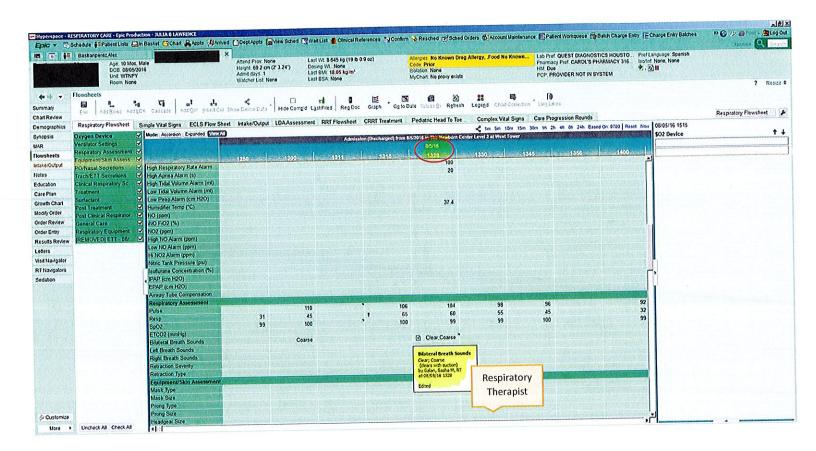
1600) POC glucose drawn via UVC.

1618) CHAB done to verify UVC placement, UVC needs repositioning.

1639) CHAB done to verify UVC placement UVC needs repositioning

1650) CHAB done to verify UVC placement UVC needs repositioning

1658) CHAB done to verify UVC placement UVC needs repositioning



Texas Children's Hospital'

TEXAS CHILDREN'S ROLLOCATION



Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

H&P by Suresh, Gautham K, MD at 08/05/16 1837

Author: Suresh, Gautham K, MD Filed: 08/05/16 2146

Editor: Suresh, Gautham K, MD (Physician)

Service: Neonatology
Date of Service: 08/05/16 1837

Author Type: Physician

☐ Hide copied text

8/5/2016 12:56 PM Admission

.Attending Neonatologist H and P

Male infant with a birth weight of 3.51 kg born at 40 5/7 weeks gestation

Referring Facility and Phone Number: St. Joseph Regional Medical Center, 979-776-3777

Referring Physician: Dr. Carmicheal

Physician Covering Transport: Dr. Reves

Mother's name and phone number:

MATERNAL HISTORY

MATERIAL DISTORT

26 year old G2P1 mom who had an uncomplicated prenatal course.

Maternal Labs: Blood Type: O + Hepatitis: negatine HIV: negative RPR: immune Rubella: immune GBS: negative HSV: negative Birth Weight: 3.530

EDC: 7/31/16

Maternal history drugs/alcohol/tobacco: denies

Maternal history uncomplicated.

Maternal Medications: none. Steroids: none.

Mother presented to th hospital on 8/4/16 for scheduled induction, VBAC. Uneventful labor (AROM with meconium stained fluid) until mother started pushing when fetal heart rate decreased and she was taken for emergent section.

DELIVERY

Infant born on 8/5/16 at 0503 by emergency Cesarean section. Repeat c-seciton secondary to failed VBAC. Instruments used: none. Delivery complications: Non reassuring fetal heart tones Chorioamnionitis: no

Presentation at delivery: Cephalic Infant delivered by Resuscitation included: Bag and mask ventilation. HR < 100 at 5 minutes and intubated.

Infant Appar Scores were 1, 2, and 5 at one, five and ten minutes respectively.

IMMEDIATE POST-DELIVERY COURSE and TRANSPORT

IMMEDIATE POST-DELIVERY COURSE and TRANSPORT
Patient was apneic on delivery with nuchal cord x2, Patient gasped, was warmed and dried but no spontaneous respiratory effort, HR 70. PPV was started at one minute of life, continued, but HR remained <100 despite increasing pressure. Patient was intubated with a 3.5 to 10 cm on first attempt at 5 minutes of life intubated on first attempt with 3mL of meconium stained fluid suctioned. HR gradually improved to >100. He began to have spontaneous respiratory effort at 7 minutes of life but did not have spontaneous movements and was limp. APGARS 1/2/5. Cord gas pH 6.8, pCO2 114, HCO3 20, BE -15. Patient placed on the ventilator SIMV/VG with tidal volume of 5mL/kg, rate 30 (with spontaneous breathing above rate), it 0.3, PEEP 6. Initial capillary blood gas with pH 6.9, pCO2 58, BE -19. Changed to SIMV PC PIP 24 (was receiving 18-20 on VG), rate 40, itime 0.3, fiO2 40%. Peripheral IV placed and initial glucose 27, received D10 bolus and started on D10 @ 50mL/kg/day, follow up glucose 78. UVC and UAC placed without complication using sterile technique, xray showed UVC curled in liver, attempted to pull to low lying but remained curled. UVC removed, UAC sutured at 20cm, confirmed placement on CXR. On XRAY a left pneumothorax was seen, 22g angiocath placed after the area was prepped with betadine and 75mL of air removed with immediate improvement in saturations.

At 45 minutes of life patient had 6 moderate encephalopathy criteria (lethargic, decreased spontaneous activity, hypotonia, absent/weak suck, incomplete moro, constricted pupils). Patient met biochemical and exam criteria for HIE. The warmer was turned off and passive cooling initiated. Transfer to TCH started for total body cooling.

On arrival of transport team infant was stable on minimal ventilator settings. An CXR was done prior to transferring back to TCH. ETT was pulled back 0.5 cm along with UAC back by 1 cm. Needle aspiration was attempted for a right side pneumothorax without an results Labs: ABG: 7.33/37/94/19.5/-6.4

Medications: Ampicillin and Gentamicin Blood culture: pending from OSH NBS: Done at OSH 8/5 Hepatitis B Vaccine: due PTD

PHYSICAL EXAM in NICU after ADMISSION

No congenital anomalies or birth injuries Orally intubated on mechanical ventilation

Heart rate low due to cooling Pale pink, skin cool to touch

Good spontaneous respiratory effort with hyperexpanded chest but symmetric breath sounds

Abdomen flat and soft Normal male genitalia Hips clinically normal

Neuro Exam (on morphine infusion):

Caput succedaneum present. . AF flat. Mild sutural overriding.

No spontaneous eye opening

Cranial Nerves:

Blinks to light

Dolls eye maneuver- sluggish movement of eyeballs. Right exotropia at rest but not fixed. Dysconjugate eye movement.

Both pupils small (around 1 mm diameter) and reactive

No spontaneous eye opening

Cranial Nerves: Blinks to light.

Dolls eye maneuver- sluggish movement of eyeballs. Right exotropia at rest but not fixed. Dysconjugate eye movement

Both pupils small (around 1 mm diameter) and reactive

No facial asymmetry. Symmetric eyelid blink to light. Bilaterally symmetric eyelid squeeze on glabellar tap.

Tongue showed fine and coarse fasciculations. Suck reflex present. Rooting absent.

Motor System:

No muscle wasting or asymmetry of muscle bulk. Resting tone low. Fisting of both hands and flexed toes. Tone increased in upper limbs and decreased in lower limbs.

Deep tendon reflexes brisk but not exaggerated

No ankle clonus.

No overt seizures, abnormal movements or limb muscle fasciculations.

Neonatal Reflexes:

Palmar and plantar grasp present and brisk

Moro not assessed

Glabellar tap present

PROBLEMS, ASSESSMENT AND PLANS

Neonatal encephalopathy due to hypoxia-ischemia
On total body cooling and morphine infusion. (Active cooling was initiated at five hours of life)

No seizures - not on anticonvulsants.
Continuous EEG monitoring to be commenced

Will obtain neurology consult
Will monitor for multi-organ dysfunction and SIADH- order LFTs and follow electrolytes and renal function

Coagulopathy
Prolonged INR, PTT and PT on admission, given FFP.

Platelet count low (93K)

No clinical bleeding

Respiratory failure due to perinatal depression and air-leak syndrome

Bilateral pneumothoraces present on CXR done on admission.

Infant on mechanical ventilation in room air on volume guarantee

Plan to not drain the pneumothorax and will wean ventilator settings to allow resorption of air in pleural spaces

If respiratory status worsens due to increase in pneumothorax will insert chest tube/s

Follow arterial blood gases

Fluids and Nutrition

Will maintain NPO

Keep on restricted IV fluids of 50 ml/kg/day

Is on started TPN

Maintain blood glucose in normal range

Risk of Sepsis

Low risk of infection

Blood cultures sent from OSH

Is on treatment with ampicillin and gentamicin

May need to stop gentamicin if renal function is poor

Parents in Bryan/College Station

Updated by NNP on phone and by transport team

Gautham Suresh, MD Pager: 14164 Phone: 61363

Revision History ∨



Home Phone Work Phone

08/05/2016





Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

MD Progress Note by Johnson, Peter W, MD at 08/05/16 2114

Author: Johnson, Peter W, MD Filed: 08/05/16 2116

Service: Neurology

Date of Service: 08/05/16 2114

Author Type: RESIDENT

Status: Signed

08/05/2016

Editor: Johnson, Peter W, MD (RESIDENT)

Neurology Phone Note

We were called regardging Babyboy an infant brn today, with HIE, now placed on cooling protocol. We will see the patient once his MRI is completed. Please call Neurology once this is completed.

Discussed with Dr. Lopez

Peter Johnson PGY-4 **BCM Neurology**

Patient Information



DOB

Home Phone

Work Phone



Texas Children's Hospital'

Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

Nsg/Anc Progress Note by Thompson, Anita L at 08/06/16 1354

Author, Thompson, Anita L Filed: 08/06/16 1355 Editor, Thompson, Anita L (TECHNICIAN)

Service: (none) Date of Service: 08/06/16 1354	
08/05/16 1914	

TEXAS CHILDREN'S ROI LOCATION

	08/05/16 1914	
EEG Questionnaire		
EEG#	16-2901 CORRECTED COPY	
CSN#	A CONTRACTOR OF THE PARTY OF TH	
Recording technologist	Anita Thompson R EEG T	
Referring MD	Shino Thomas NNP , RN	
Previous EEG?	Yes	
Repeat EEG #	BSM	
Type of study	Bedside Monitor	
Outpatient or inpatient?	Inpatient	
Inpatient room #	STAT PORTABLE NEO D 71	
Level of consciousness	Lethargic	
Reason for EEG	BSM cooling protocol	
Birth history	40 weeks	
Date of birth	08/05/16	
Pertinent medical/family history	term infant delivered via C-section due to failed BVAC and no reassuring fetal heart lones - APGARS were 1/25 - infant ransferred to NICU for further management and passive cooling - infant developed left sided pneumothorawich was evacuated - on arrival infant was stable on minim yent settings	
Description of event	arches when stimulated and crying	
Frequency of episodes	severa episodes	
Date/Time of last event	8/5	
Length of episode	several seconds	
Any preceding symptoms?	No	

Behavior after event is over	back to baseline	
Medication(s)	MORPHINE AMP, Gent	
Hand dominance	Unknown (infant)	
HV performed?	No	
Reason why HV not performed	infant	2747-274
Photic performed?	No	
Reason photic not performed	not indicated	
Eyes open/closed performed?	Yes (when stimulated)	
Events recorded?	Yes	
Events recorded description	8/5 slight arching with stm x 1	
Sleep obtained?	No	
Start time	1910	

Revision History ✓



8/5/2016 12:56 PM Admission

Author Type. TECHNICIAN
Status: Addendum

Hide copied text



Central Venous Access Procedure Note



8/5/2016 12:56 PM Admission

☐ Hide copied text

☐ Hover for attribution information

Description: Male DOB: 8/5/2016 Department: Wt Newborn Cntr Lvl 2

Procedure Report by Hockaday, Chrystal O at 08/05/16 2030

Author: Hockaday, Chrystal O Filed: 08/05/16 2035 Editor: Hockaday, Chrystal O

Service: Neonatology Date of Service: 08/05/16 2030 Author Type: NURSE PRACTITIONER

Status: Signed

Name: Babyboy DOB: 8/5/2016 Date: 8/5/2016

MRN: Bed/room: D71/01 Time: 8:30 PM

Procedure Type: UVC placement
Location procedure performed: D71/01
Indication: Difficult venous access, Prolonged IV therapy, Medication requiring CVL, Parenteral Nutrition
Pre-procedure diagnosis: HIE (hypoxic-ischemic encephalopathy)

Post-procedure diagnosis: Same as Pre-procedure diagnosis

Procedure Date/Time: 8/5/2016 @ 8:30 PM

Operator 1: CHRYSTAL O HOCKADAY, NNP, RN

Operator 2: Jessica Gomez, RN

Supervising Attending Physician: Dr. Suresh

Time Out Performed: Yes

All team members actively participated in the time out before the start of the procedure identifying the correct patient, correct site, and the correct procedure to be done.

Consent: Consent not obtained due to emergent nature of the procedure and the unavailability of the parent /guardian.

Anagelsia/Sedation/Meds: Sedation and/or analgesia provided- See MAR, Non-pharmacologic comfort measures.

Equipment:

Total catheter length (trimmed length for trimmed lines): not obtainedcm Catheter Size: 3.5French Catheter Lumens: 2

Other Catheter Details: N/A

Procedural Detail:

dural Detail:
Anatomical Side: Umbilical
Anatomical Side: Umbilical
Anatomical Side: Umbilical
Anatomical Side: Umbilical
Ultrasound used for placement: No
Placement Confirmation: Chest x-ray
Tip Position: IVC
Number of attempts: 1
Estimated Blood Loss: <1mL
Detail: hand hygiene performed, site preparation with antiseptic cleanser done, sterile field used and post-procedure site care performed, sutured in place, sterile dressing performed, flushes easily with good blood return

Complications: None

Specimens and Findings: N/A
Disposition: After procedure, the patient was returned care to primary hospital caregivers Comments: stable on mechanical ventilation, in no acute distress

Signature: Chrystal Hockaday, MSN, APRN, NNP-BC Texas Childrens Hospital NNP Service Voalte Phone 33306