Well Baby Nursery Resident Handbook

NYC HEALTH+ HOSPITALS

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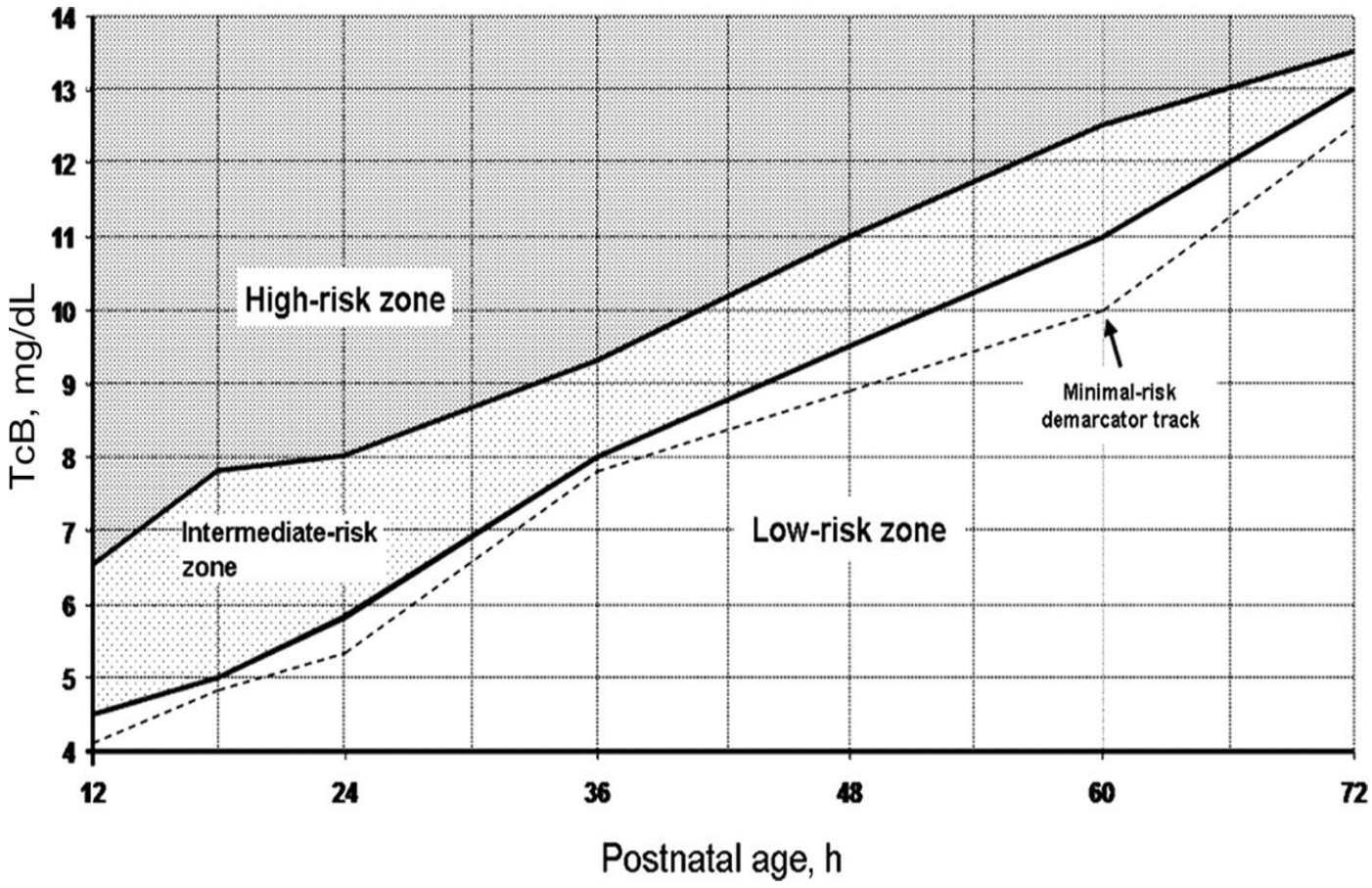
TABLE OF CONTENTS

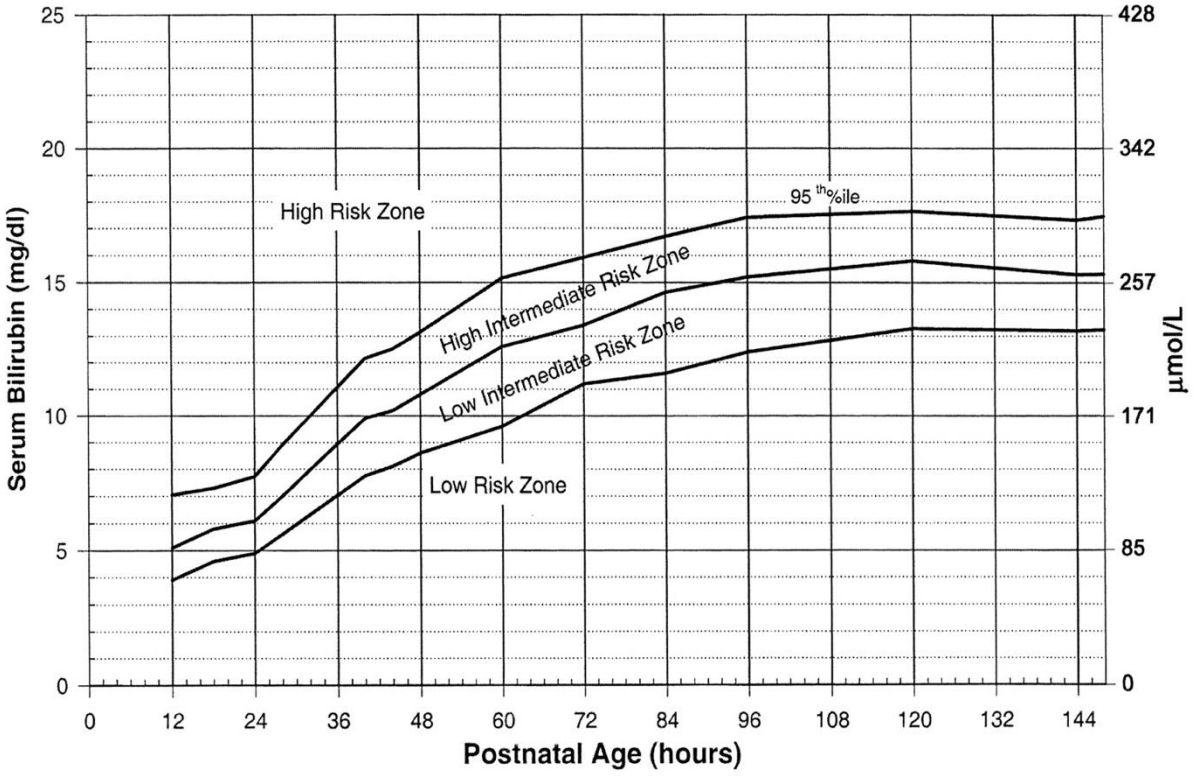
HYPERBILIRUBINEMIA

- Bilirubin must be checked for ALL newborns at 24-48 hours of life
- TSB: Total Serum Bilirubin, TCB: Transcutaneous Bilirubin, HOL: Hours of Life
- Protocols per hospital:
  - KCHC: TSB @ 30 HOL with NBS, TCB @ morning of discharge (if no bili in last 24h)
  - Downstate: TSB @ 24-48 hours of life
  - Coney Island: TCB daily at 5 AM
- Use "Bilitool" for **TSB** readings ONLY. It will show the risk zone for follow up, and the phototherapy threshold. Alternatively, refer to below nomograms for risk zones and threshold.
- Note: DO NOT use bilitool for TCB readings, refer to below nomogram.
- Tip: if TCB value is concerning (high risk zone), it is reasonable to confirm level with TSB. TCB value is usually +/- 2 from TSB.
- Note: DO NOT measure TCB for a baby under phototherapy.
- Refer to Peds in Review article for full review

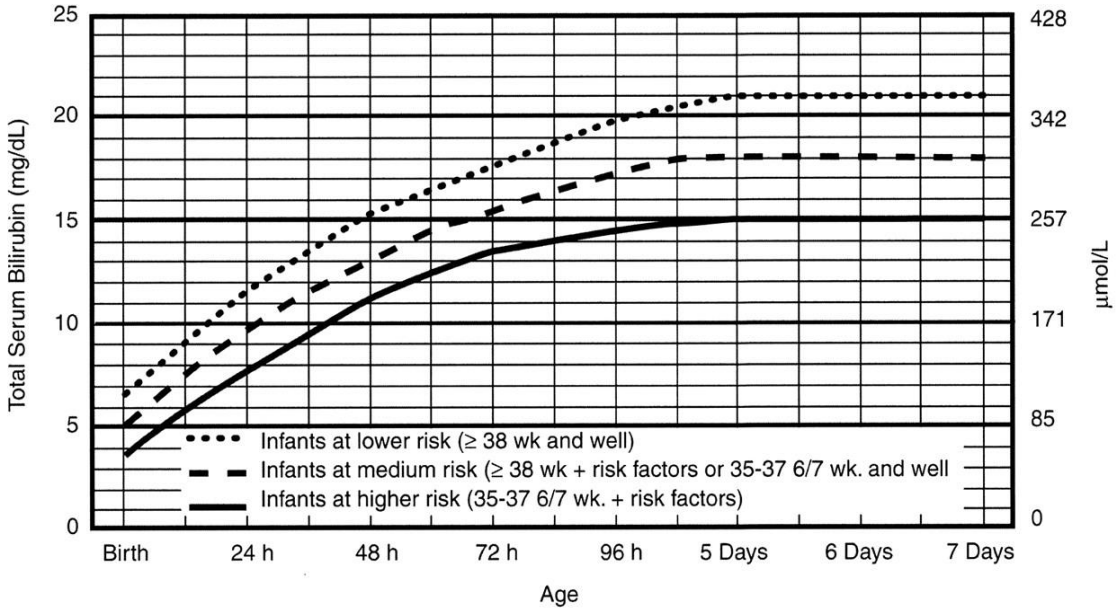
- **Risk Zones for Transcutaneous Bilirubin (TCB) (after 12 HOL)**



- **Risk Zones for Total Serum Bilirubin (TSB) (from 0 HOL)**



- **Phototherapy threshold for Total Serum Bilirubin (TSB)**



- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin.
- Risk factors = isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin < 3.0g/dL (if measured)
- For well infants 35-37 6/7 wk can adjust TSB levels for intervention around the medium risk line. It is an option to intervene at lower TSB levels for infants closer to 35 wks and at higher TSB levels for those closer to 37 6/7 wk.
- It is an option to provide conventional phototherapy in hospital or at home at TSB levels 2-3 mg/dL (35-50mmol/L) below those shown but home phototherapy should not be used in any infant with risk factors.

ABO/RH INCOMPATIBILITY

- ABO incompatibility: maternal blood is O, and baby's blood is A, B, AB
- RH incompatibility: maternal blood is NEGATIVE, baby's blood is POSITIVE
- Coombs test may be positive with Rh & ABO incompatibility, or maternal autoimmune anemia
- **For Coombs Positive blood: inform attending and monitor bilirubin level. Send total and direct bilirubin + CBC & retic at 6 hours of life and then q6-12 hours. Alternatively, serial TCB monitoring can be done (esp in CIH).**
- Monitor **"Rate of Rise" = (current bilirubin - previous bilirubin)/number of hours** between readings -- if it exceeds 0.2, or if the bilirubin level is at or above phototherapy threshold then phototherapy is indicated. Look for plasma exchange threshold if bilirubin is severely elevated.
- Order "triple phototherapy", ensure communication with the nurse about setting up the light, protect baby's eyes, and monitor I/Os closely.
- During phototherapy, monitor serum bilirubin q6-12 hours per discussion with attending. Discontinue phototherapy if rate of rise is slowing down and level is not increasing/decreasing.
- If rate of rise remains high, or bilirubin continues to increase: ensure proper feeding and I/Os, consider using radio meter to ensure optimal phototherapy spectrum (430-490 nm), otherwise consider NICU consult for exchange transfusion.
- Put a "significant event" note in the chart denoting time phototherapy was started if overnight.

RESPIRATORY DISTRESS

- If you are paged about a baby with breathing abnormality: assess baby for tachypnea, retractions, flaring, color change, chest auscultation, and other symptoms like jitteriness, problems with feeding, jaundice, or hypotonia.
- Next → if signs of respiratory distress on exam → pulse ox monitoring (ensure waveform is consistent), vitals, consider suctioning, blow by oxygen, D-stick, and call senior resident.
- If above failed or concerning exam → NICU consult, inform attending.
- Put a "significant evet" note in the chart if called/paged overnight.

GLUCOSE MONITORING PROTOCOL

- Refer to below protocol for babies born late preterm, term SGA, IDM, LGA
- If IV glucose is required per protocol: NICU consult, inform attending
- If the ranges are 25-40 (birth - 4h), or 35-45 (4-24h)
    - **In KC:** refeed (~15mL formula or breastfeed) + dextrose 40% gel (0.5 mL/kg via buccal mucosa) to be given STAT, check glucose in an hour → still low in an exclusively breastfed infant: offer formula → if still low: NICU consult, inform attending
    - **In UHB/CIH:** refeed → if still low in an hour refeed + dextrose gel → if still low: NICU consult, inform attending

- Tip: if paged about a "jittery" baby, check D-stick and assess baby.
- Refer to AAP guidelines for monitoring of glucose and Peds in review article on neonatal hypoglycemia

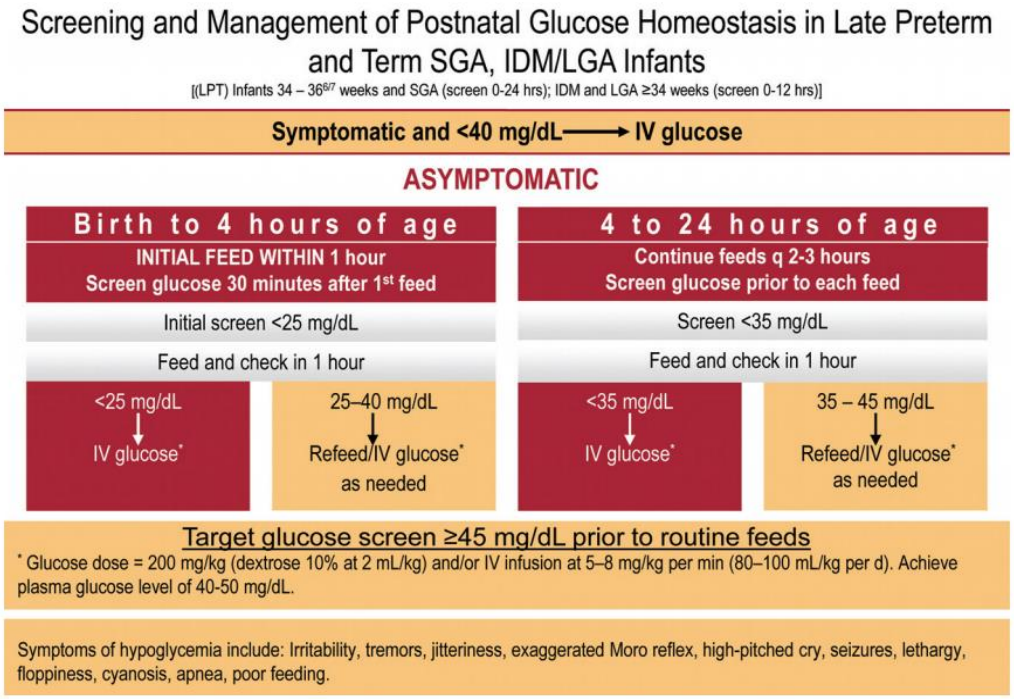


FIGURE 1
Screening for and management of postnatal glucose homeostasis in late-preterm (LPT 34–36⁶/₇ weeks) and term small-for-gestational age (SGA) infants and infants who were born to mothers with diabetes (IDM)/large-for-gestational age (LGA) infants. LPT and SGA (screen 0–24 hours), IDM and LGA ≥34 weeks (screen 0–12 hours). IV indicates intravenous.

LATE PRETERM INFANTS

- GA between 34 weeks + 0 days and 36 weeks + 6 days
- Risks: Hypothermia, Hypoglycemia, Respiratory distress, Apnea, Hyperbilirubinemia, Feeding difficulties, Low Apgar scores (<4)
- For late preterm babies: **follow above glucose monitoring protocol**
- Before discharge: perform a car seat challenge

LARGE FOR GESTATIONAL AGE INFANTS

- LGA: birth weight (BW) greater than the 90th percentile for age
- Macrosomia: BW greater than 4000 g
- Risks: hypoglycemia, birth injury, polycythemia, respiratory distress, perinatal asphyxia
- Check "Peditools" for birth percentiles, use **Olsen** or **Fenton** score (Fenton app available)
- For LGA/Macrosomic babies: **follow above glucose monitoring protocol**

SMALL FOR GESTATIONAL AGE INFANTS

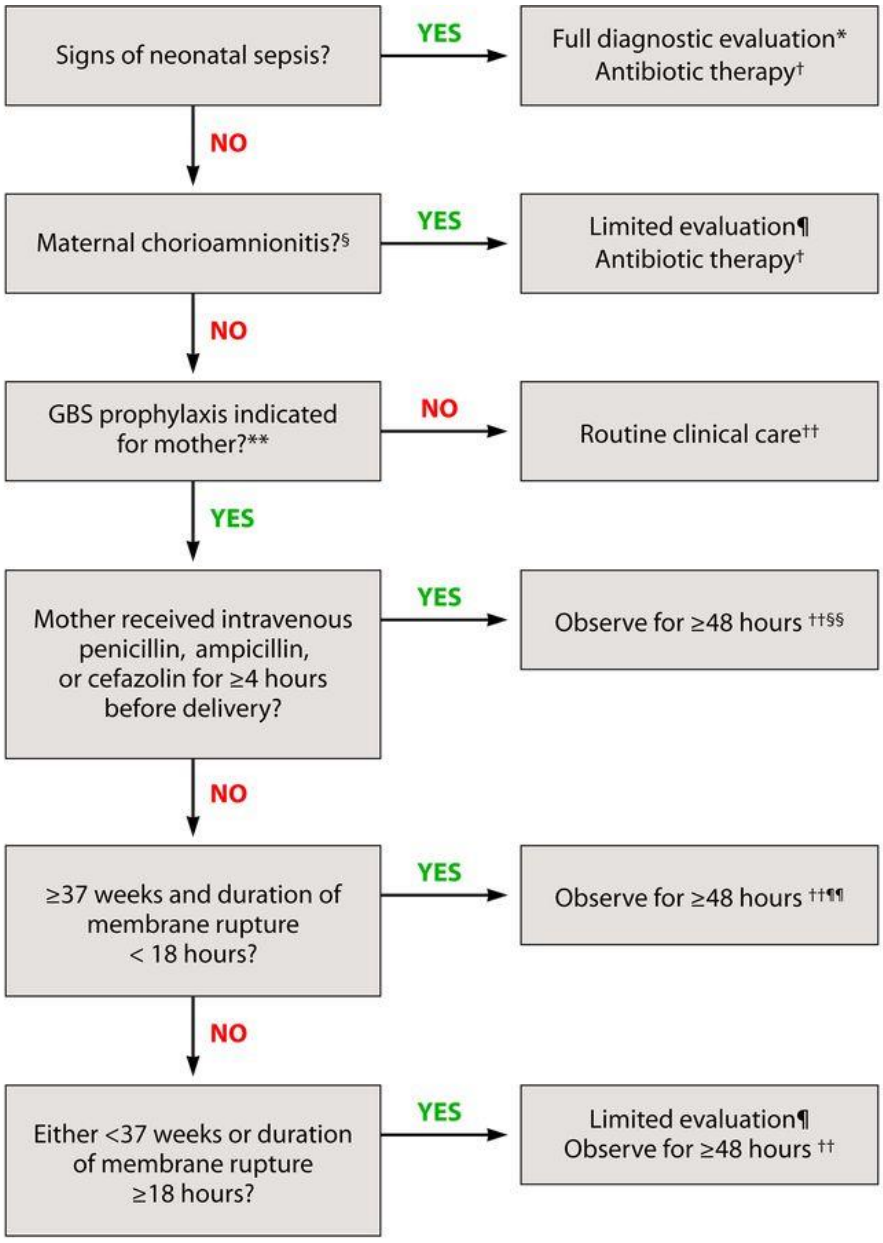
- Birth weight (BW) less than the <10th percentile or < 2500 g
- Symmetric SGA: head and body equally affected (all growth parameters: i.e. weight, length, and head circumference <10%), etiologies include genetic or chromosomal abnormalities, gestational intrauterine infections (TORCHeS), and maternal alcohol use.
- Asymmetric SGA: head larger than body size (head circumference >10%, length and weight <10%), causes include extrinsic factors that affect fetal growth later in gestation, such as preeclampsia, chronic hypertension, and uterine anomalies. Link for more information.
- Check "Peditools" for birth percentiles, use **Olsen** or **Fenton** score (Fenton app available)
- For all SGA babies & BW of <10th percentile: **follow above glucose monitoring protocol**
- For symmetric SGA/IUGR: consider sending CMV test, Toxoplasma IgM, Total IgM, Head U/S, Zika virus screen per discussion with attending

MATERNAL DIABETES

- Gestational diabetes: abnormal GCT (screening) and GTT (diagnostic) tests at 24-28 weeks gestation
- Abnormal **GCT** (50 gram one-hour glucose screen): ≥**130** mg/dL
- Abnormal **GTT** (100 gram three-hour oral glucose tolerance test): Fasting ≥**95** mg/dL, 1-hour ≥**180** mg/dL, 2-hour ≥**155** mg/dL, 3-hour ≥**140** mg/dL
- **GDMA1:** Diet-controlled, **GDMA2:** insulin or oral hypoglycemic controlled
- GDMA1 baby to be admitted to nursery, GDMA2 baby to be admitted to NICU
- IDM (infant of a diabetic mother) is at risk of LGA/Macrosomia, hypoglycemia, hyperbilirubinemia, hypocalcemia, hypomagnesemia, polycythemia, respiratory distress, or cardiomyopathy
- For IDMs babies: **follow above glucose monitoring protocol**

NEONATAL SEPSIS

- Algorithm
- Symptoms of sepsis
- Kaiser Permanente Early-Onset Sepsis (EOS) calculator. Use the **incidence of 1:1000** live births in above calculator for our population
- **See below for approach to neonate with suspected sepsis.**



- Full diagnostic evaluation includes a blood culture, a complete blood count (CBC) including white blood cell differential and platelet counts, chest radiograph (if respiratory abnormalities are present), and lumbar puncture (if patient is stable enough to tolerate procedure and sepsis is suspected).

† Antibiotic therapy should be directed toward the most common causes of neonatal sepsis, including intravenous ampicillin for GBS and coverage for other organisms (including *Escherichia coli* and other gram-negative pathogens) and should take into account local antibiotic resistance patterns.

§ Consultation with obstetric providers is important to determine the level of clinical suspicion for chorioamnionitis, Chorioamnionitis is diagnosed clinically and some of the signs are nospecific.

¶ Limited evaluation includes blood culture (at birth) and CBC with differential and platelets (at birth and/or at 6–12 hours of life).

†† If signs of sepsis develop, a full diagnostic evaluation should be conducted and antibiotic therapy initiated.

§§ If ≥37 weeks' gestation, observation may occur at home after 24 hours if other discharge criteria have been met, access to medical care is readily available, and a person who is able to comply fully with instructions for home observation will be present. If any of these conditions is not met, the infant should be observed in the hospital for at least 48 hours and until discharge criteria are achieved.

- ¶¶ Some experts recommend a CBC with differential and platelets at age 6–12 hours.

MATERNAL GBS

- Assess baby per above **sepsis algorithm**
- Group B strep is screened for in ALL mothers at 35-37 weeks gestation via vaginal culture
- Intrapartum antibiotic prophylaxis is **indicated** in:
    - Positive screening culture for GBS from either vagina or rectum **or**
    - Positive history of birth of an infant with early-onset GBS disease **or**
    - GBS bacteriuria (any colony count) during the current pregnancy **or**
    - **Unknown** antepartum culture status (culture not performed or not available) **plus**:
        - Intrapartum fever (≥100.4°F [≥38°C]) **or**
        - Preterm labor (<37+0 weeks of gestation) **or**
        - Preterm prelabor rupture of membranes **or**
        - Prolonged rupture of membranes (≥18 hours) **or**
        - Intrapartum nucleic acid amplification test (NAAT) positive for GBS
- Intrapartum antibiotic prophylaxis is **not recommended** in:
    - **Scheduled cesarean delivery** – Women with a positive GBS culture who undergo scheduled cesarean delivery (at any gestational age) before onset of labor and with intact membranes are at very low risk of GBS transmission to the fetus/neonate
    - Recent negative GBS culture
- **ADEQUATE antibiotic prophylaxis** is:
    - Antibiotic choice: Penicillin G (5 million loading dose then 2.5 million every 4 hours) or Ampicillin (2g loading dose then 1g every 4 hours)
    - Adequate duration: at least 4 hours before delivery

MATERNAL INTRAPARTUM FEVER OR PROLONGED ROM

- Assess baby per above **sepsis algorithm**
- Check GA, GBS status, highest maternal temperature, ROM, clinical appearance of infant
- Kaiser Permanente Early-Onset Sepsis (EOS) calculator
- If maternal fever in first ~24 HOL, ask if mother is being treated for chorioamnionitis, if so, then baby may need transfer to NICU based on protocol and sepsis score
- Inform senior resident, consider calling attending for NICU consult if concerned

MATERNAL SUBSTANCE USE

- Only consenting mothers would have U.tox done even if h/o use, only SW referral needed.
- Check maternal U. Tox for opiates, cocaine, phenobarb, BDZ, amphetamine, THC
- Opiate +: baby has to go to NICU for risk of NAS, SW for ACS
- Cocaine +: SW for ACS
- Phenobarb, BDZ, Amphetamine +: check maternal medication list, observe for NAS
- For all above, inform attending and only collect the infant's for U. Tox if symptomatic

MATERNAL HIV

- For HIV+ mothers, inform attending and consult peds ID immediately (usually they are aware of the upcoming delivery early on)
- Peds ID will provide a protocol for management (printed and signed requisition form -see below), fill it out when the baby is born and send it with send-out lab
- **Within first 6 hours of birth**: order medication per ID recs (Zidovudine +/- Nevirapine), send labs: CBC, CMP, HIV RNA PCR (2 tubes (lavender top) - 1 to send to hospital lab, 1 as a send out to NY DOH, ask senior or NICU resident on appropriate order in EMR, place the signed requisition form in the send-out bag) – **TIMING IS VITAL!!!**
- Be careful when performing blood test for the baby not to get a needlestick!
- **NO BREASTFEEDING!** Ensure to place order in EMR
- NYS DOH recommendations, NYS requisition form
- Guidelines for treatment

MATERNAL HEPATITIS B

- Mother who is HbsAg positive or unknown: baby has to receive Hepatitis B IG + Hepatitis B vaccine **WITHIN 12 HOURS OF LIFE!!!**
- If the maternal HBsAg test is still pending within the first 12 hours of life, CALL THE LAB, IF NO RESULT, CALL ATTENDING!
- Algorithm

MATERNAL TB

- If mother's Quant test is positive, unknown, or indeterminate and she is **asymptomatic**: maternal CXR after delivery
- If mother's Quant test is positive or indeterminate and she is **symptomatic**: SEPARATE MOTHER AND BABY, **NO BREAST FEEDING**, inform attending!
- Note: check mother's orders for chest X-ray, if not ordered, make sure to call mother's RN or OB resident

MATERNAL HERPES

- If mother is HSV 1 or 2 +, ensure she doesn't have active lesions and is on intrapartum prophylaxis with acyclovir
- If mother has active genital lesions: baby has to go to NICU
- If mother has active breast lesions: **NO breastfeeding**, express breast milk
- AAP Guidance Report, AFP Neonatal HSV

MATERNAL SYPHILIS

- If mother is positive check her titers and send baby's RPR/VDRL for titers after birth
- Inform attending, perform physical exam, consult peds ID, follow below protocol.
- CDC Guidelines for treatment

MATERNAL GONORRHEA OR CHLAMYDIA

- Check for TOC (test of cure) for mother, should be done 2 weeks after treatment
- Nothing more to do, all babies receive the ophthalmic erythromycin cream at birth
- DOCUMENT in baby's chart for follow up by PCP

MATERNAL COVID

- KCHC: Baby to be admitted to nursery and be swabbed at 24 hours of life
- Downstate: Baby to be admitted to NICU
- Full protocol for KCHC
- COVID discharge instructions for KCHC

MATERNAL LUPUS

- Babies born to mothers who have systemic lupus erythematosus, antiphospholipid syndrome, or Sjogren's syndrome are at risk of neonatal lupus
- Main features are: heart block and cutaneous manifestations
- Inform attending, consider sending labs: CBC, CMP, Anti-SSA, Anti-SSB, EKG, and peds cardio consult/OP follow up
- Immunology Article

MATERNAL HYPOTHYROIDISM OR HYPERTHYROIDISM

- Asymptomatic: check baby's TFTs after 72 hours of life (if baby remains in nursery that long)
- Symptomatic: send baby's TFTs at delivery and first 24 hours with NICU consult and transfer
- If discharged before 72 hours → mention it in the discharge summary for PCP follow up
- AAP Article

ABNORMAL BLOOD GAS

- Please follow up on cord blood gas of all new babies, if *PH<7.1* OR *BE>12*, repeat within 1 hour or immediately if associated with respiratory distress.
- The risk of neonatal morbidity is inversely related to pH, with the highest risks at the lowest pHs
- A base deficit of 12 to 16 mmol/L is associated with an increase in infant mortality, moderate to severe neonatal encephalopathy, multiorgan failure, and long-term neurologic dysfunction

Reference range for umbilical artery blood gas values in term newborns

Umbilical arterial blood	Mean	5th to 95th percentile
pH	7.27	7.15 to 7.38
PCO_2 (mmHg)	50.3	32 to 68
HCO_3 (mEq/L)	22	15.4 to 26.8
Base excess (mEq/L)	−2.7	−8.1 to 0.9

HEPATITIS B VACCINE

- Parents have the right to refuse the vaccine after extensive counseling of benefits vs risks
- Must sign a refusal form prior to discharge
- Otherwise ALL newborns must get the HepB vaccine within first 24 HOL

VITAMIN K

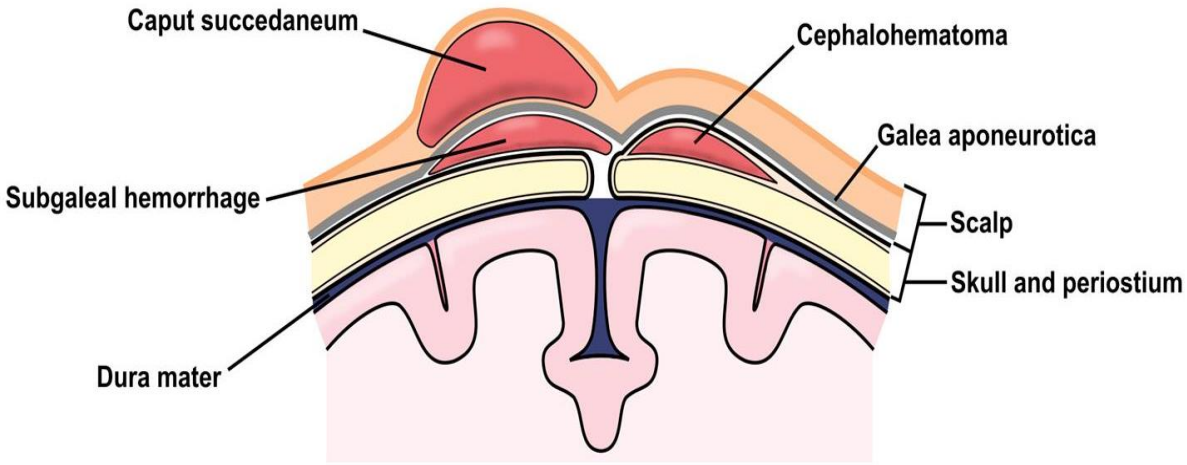
- Vitamin K is indicated in ALL newborns via IM injection, it is a requirement by New York State Law, so parents cannot refuse it.
- Guidelines for prophylaxis

NEWBORN SCREEN

- NBS to be performed at 24-48 hours of life by a licensed professional (RN or phlebotomist)
  - Downstate: 30 HOL, KCHC: 30 HOL, CIH: 24-36 HOL
- NBS is not accurate <24 hours of life, and must be repeated
- Document the NBS "number" in discharge summary, result is available in ~5-10 days
- HCS website to check results for NBS, NY State NBS information

NEONATAL EXTRACRANIAL INJURIES

- Molding: change from round to oblong head shape due to prolonged labor, and sutures may overlap, resolves in a few days.
- Caput Succedaneum: crosses suture lines, prolonged fetal head engagement in the birth canal or vacuum assisted device causes accumulation of blood above the periosteum, resolves in 4-6 days.
- Cephalohematoma: does not cross suture lines, subperiosteal vessels rupture leading to the accumulation of blood underneath the periosteum, resolves in 3-4 weeks.
- Subgaleal Hemorrhage: rupture of emissary veins, diffuse and fluctuant head swelling that can expand over time + signs of hemodynamic instability, **will require NICU evaluation**, workup with CBC & coags, and treatment with IV fluids & transfusions as necessary.



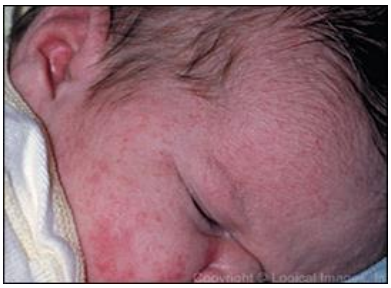
ASYMMETRIC MORO REFLEX

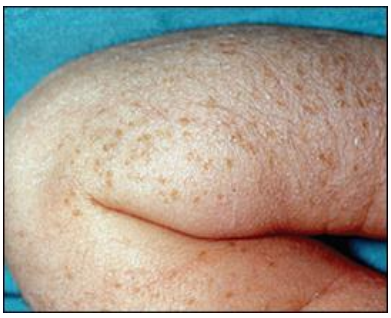
- Perform good physical exam: repeat moro reflex, palpate clavicle & extremity for “steps”, look for deformity, look for posturing (waiter’s tip posture)
- Chart review for shoulder dystocia or traumatic delivery
- Get a chest & upper extremity X-ray to look for fractures
- Consult peds neurology, set up outpatient PT/OT and neurology clinic follow up in 2-4 weeks

TONGUE TIE

- Counsel parents regarding its benign nature
- Breastfeeding consultant to help detect issues with feeding
- If persistent issues may consider frenotomy (i.e. frenulotomy)
- AAP Article

RASH



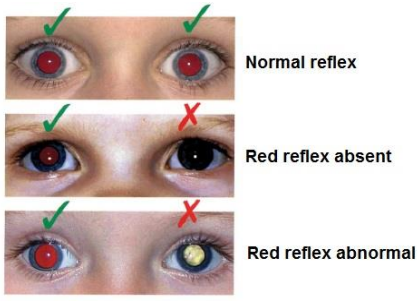


- Erythema Toxicum Neonatorum: counsel parents - the rash appears within 24 to 48 hours and usually resolves in five to seven days, although it may wax and wane before complete resolution. No treatment is needed, and the condition is not associated with any systemic abnormality.
- Transient Neonatal Pustular Melanosis: counsel parents - the rash is usually present at birth, it consists of non-erythematous hyperpigmented macules with some "popped" lesions that gradually fade over several weeks to months.
- Most neonatal rashes are benign, counseling and education is the mainstay of management. For more neonatal rashes see the AAFP article.

MONGOLIAN SPOT

- **DOCUMENT** in baby's chart--- A MUST
- Important for later in life to differentiate hematomas inflicted through NAT

ABNORMAL RED REFLEX



- Document in chart
- Follow up with ophthalmology clinic outpatient
- AAP figure

MURMUR

- Check prenatal anatomy scan or fetal echo if available for cardiac defects
- Ensure infant passed CCHD screen, has good pulses, no cyanosis, and no respiratory distress
- Consider echo per discussion with attending
- AFP Article

ABNORMAL ORTOLANI OR BARLOW TEST

- Audible "click" rather than a felt "clunk" during either maneuver is considered normal and represents snapping of soft tissue.
- Risk factors: female gender, family h/o DDH, breech presentation
- For abnormal test (i.e. "clunk" felt), or equivocal findings + risk factors for DDH:
    - Imaging with ultrasonography at age 3 to 4 weeks, or plain radiographs at 4 to 5 months if reliable ultrasonography is not available
- Referral to orthopedics:
    - Unstable hips on clinical examination
    - Abnormal findings on radiographic evaluation
- Peds in Review Article

BREECH PRESENTATION

- Ultrasonography at four to six weeks of age (adjusted for preterm birth) recommended for infants with an abnormal/equivocal hip examination or a normal examination and breech position at ≥34 weeks of gestation

CIRCUMCISION

- Ask parents whether they want circumcision performed in the nursery, the operation is optional
- Downstate: sign clearance in paper chart & place order set in HB, CIH: get consent from parents
- In Epic: place order to circumcise & in the comment section mention the baby is cleared for circumcision + lidocaine injection 20% or EMLA cream + sucrose gel
- There must be no contraindication to circumcision to clear the baby, these include:
    - Length of penis < 2-2.5 cm
    - Penile disorders: hypospadias, chordee, penile torsion, webbed penis, buried, urethral hypoplasia, epispadias, ambiguous genitalia
    - History of bleeding disorders
    - Age less than 12-24 hours
    - Known disorder of skin or connective tissue
    - Acute current illness or medical condition that requires monitoring
- After circumcision, monitor the site for bleeding for 2-4 hours.
- The baby is not required to void after the operation to be cleared for discharge.
- If parents want to circumcise later in life, refer to urology (Bellevue for KCHC & CIH and Maimonides for Downstate)
- Reference to parents
- Care for uncircumcised penis

UNDESCENDED TESTES

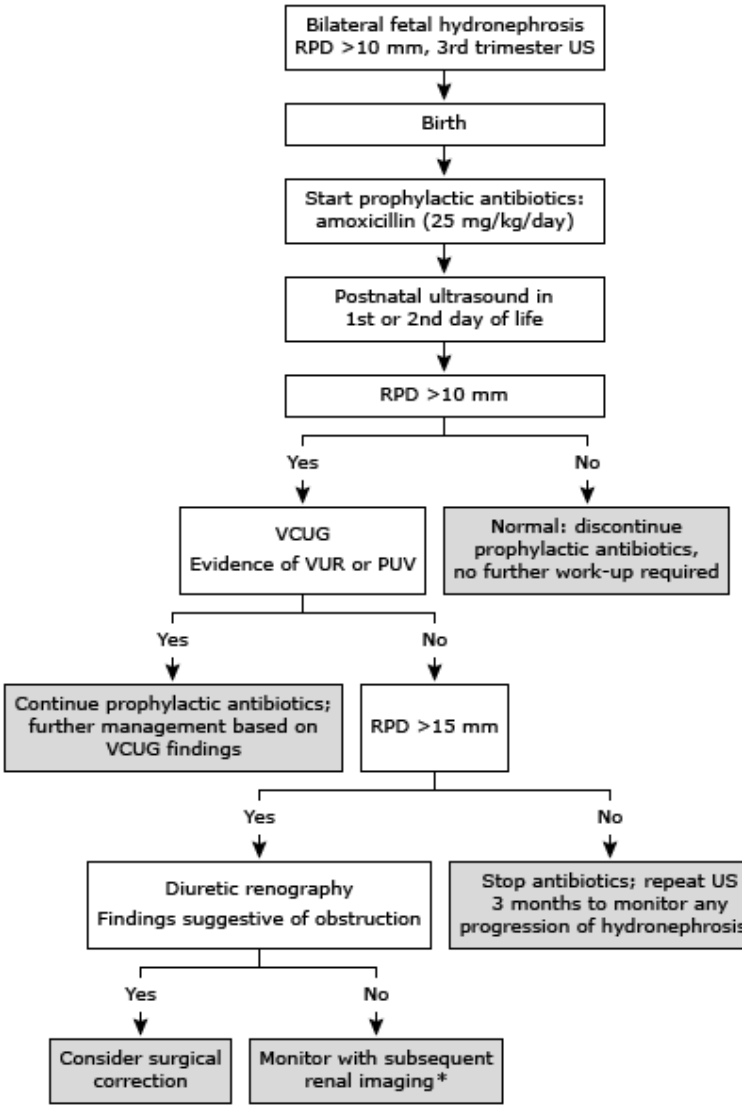
- Proper physical exam of the tests and penis
- Algorithm

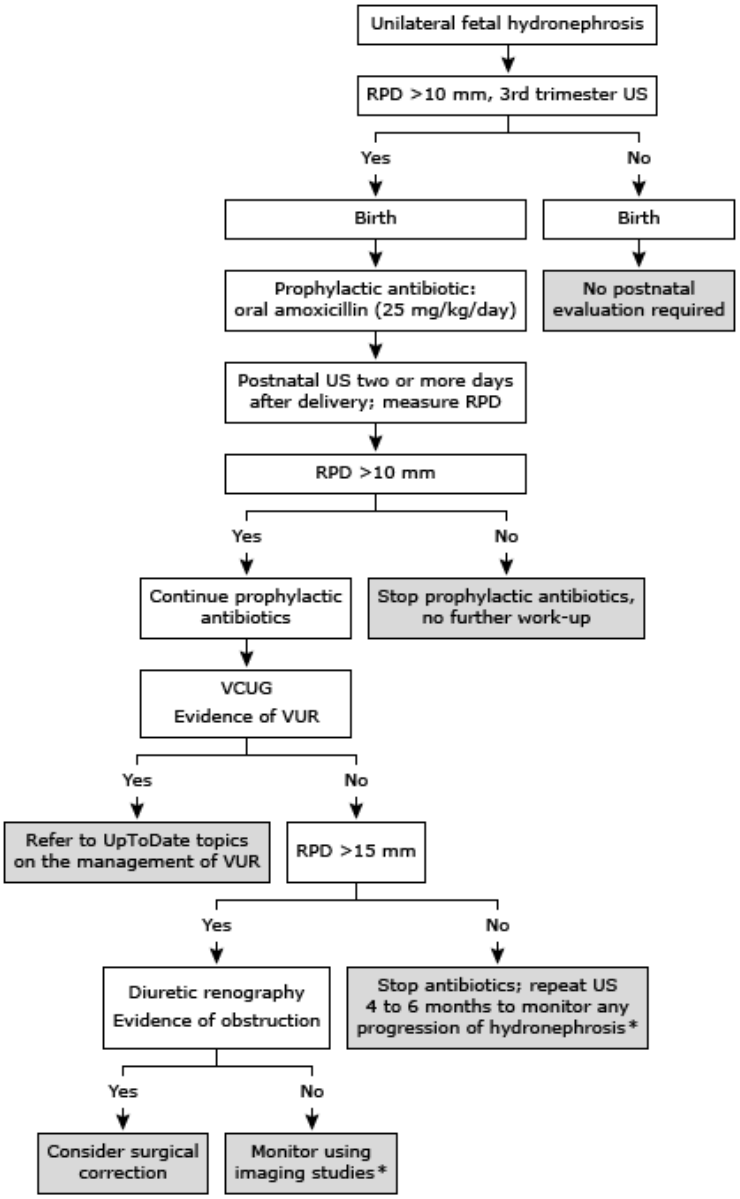
EPISPADIAS, HYPOSPADIAS, RETRACTED FORESKIN

- No circumcision
- Refer to urology outpatient: Bellevue for KCHC & CIH and Maimonides for Downstate

FETAL HYDRONEPHROSIS/PYELECTASIS

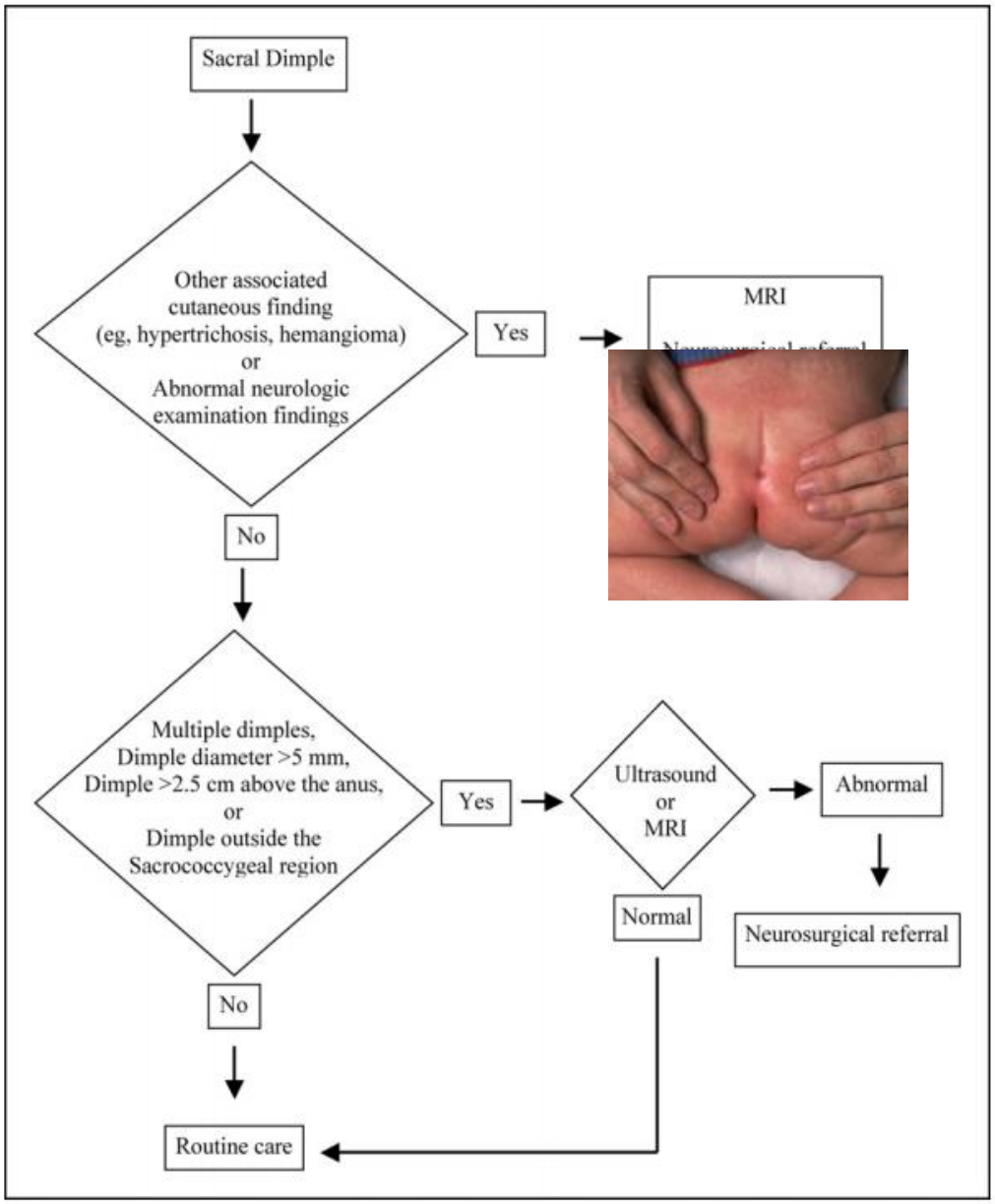
- NeoReview Article





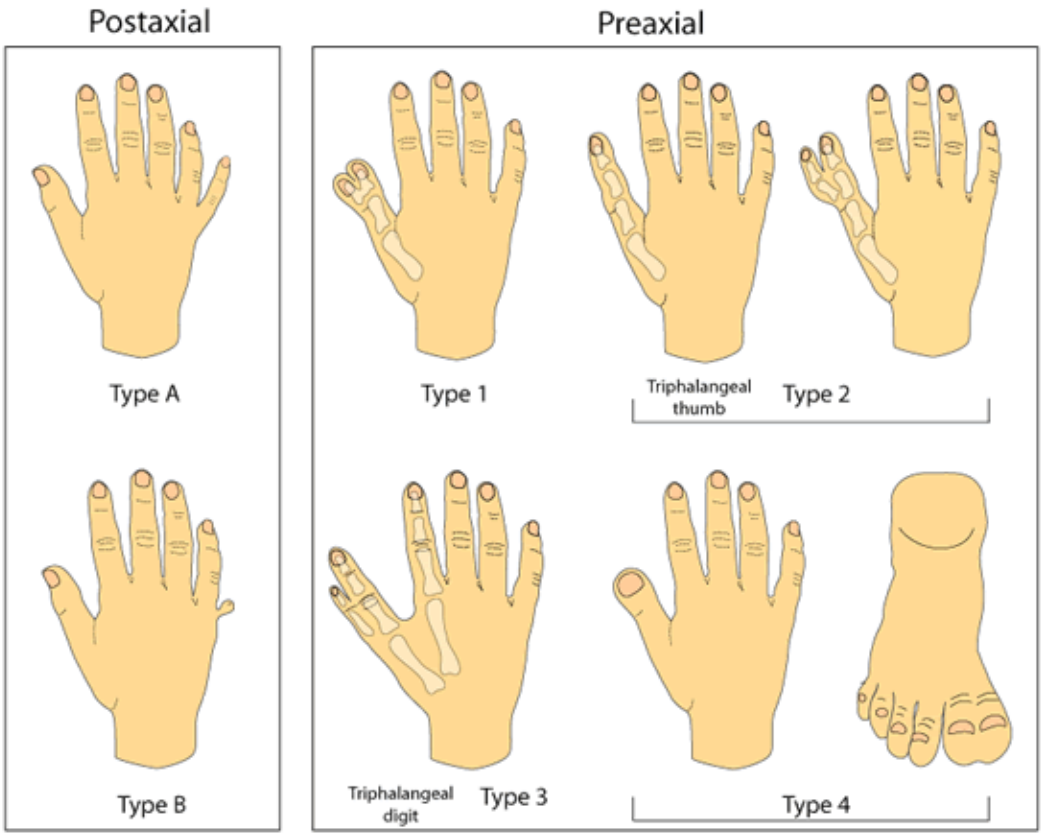
SACRAL DIMPLE

- Peds in Review Article



EXTRA DIGITS

- Speak with parent: ensure whether they want the digit(s) kept or removed
- Determine type, and whether it is post- or pre-axial, document in chart
- Inform attending, call pediatric surgery or orthopedics
- Consider X-ray of hand/foot



CLUB FOOT

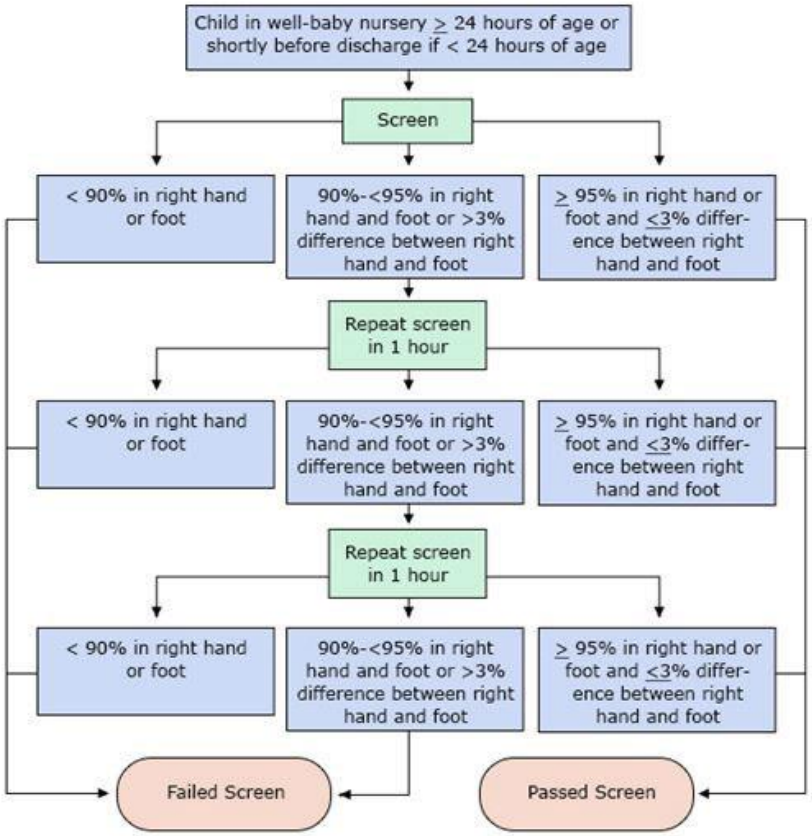
- Talipes equinovarus: Positional (ex. breech delivery) easily corrects to a normal position with manipulation, vs Congenital/Syndromic which may require it casting and bracing.
- Talipes calcaneovalgus: hyperdorsiflexion of the foot with the abduction of the forefoot. External tibial torsion is a common associated finding. spontaneously resolve. If the foot cannot be plantar-flexed below neutral, casting is indicated. Surgical treatment is not required
- Metatarsus adductus: medial deviation (adduction) of the forefoot while the hindfoot remains in a normal position is often bilateral. flexible metatarsus adductus, treatment is not necessary. Flexible metatarsus adductus resolves spontaneously over time, usually by age one year. semiflexible metatarsus adductus, we suggest observation for six months. Parents to perform passive stretching. Orthotic splints. Rigid metatarsus tends to worsen with time. require corrective casting
- Consider orthopedics consult and OP follow up
- Peds In Review Article

FAILED HEARING SCREEN

- Repeat hearing screen at nursery, either same day or next day
- While awaiting repeat screen: bag the baby for urine CMV (downstate), or swab saliva for CMV (KCHC), CMV test not required (CIH)
- If failed twice: send the CMV test, and book an outpatient audiology appointment
- Counsel mother: let mother know that repeat hearing screens are necessary and they will be done at least 2-3 more times until 6 months of age, if persistently failing, the baby will be sent to get fitted for a hearing aid.
- Healthy Children FAQ

FAILED CCHD SCREEN

- Perform thorough cardiac exam and check all pulses
- Order four limb blood pressure
- Ensure technique of CCHD screen is correct (correct placement of pulse ox leads)
- Inform attending, consider cardiac consult or outpatient follow up
- CDC Guidance



NO URINE IN 24 HOURS

- Make sure the age is correct, the diapers are documented, and feeding is appropriate.
- Palpate the bladder and gently apply pressure (bladder massage) which may induce urination.
- Consider bladder US
- Last resort is a bladder catheter, inform the attending to make a plan
- Gomela Chapter

NO STOOL IN 48 HOURS

- Make sure the age is correct, the diapers are documented, and feeding is appropriate.
- Make sure the anus is patent
- Consider digital rectal examination to stimulate bowel movement
- Inform attending, consult peds surgery, and get KUB
- Gomela Chapter

LOSS MORE THAN 7-10% OF BIRTH WEIGHT

- Determine feeding pattern, amount, and time taken on feeds
- Spend time with mother on breastfeeding education, and get breastfeeding consultant to help
- Book an early appointment within 48-hours for weight check
- You can use the Newt tool for weight as

BILIOUS EMESIS

- Determine the color and consistency of vomit, any blood, and whether it was a spit up or projectile vomiting
- Look for risk factors and associated problems such as congenital syndromes, respiratory distress, positive bowel sounds in the chest, abdominal distension, poor feeding, and excessive irritability
- **Do not feed** after episode of vomiting
- Immediate NICU consult and transfer for further workup

COFFEE GROUND EMESIS

- Likely due to ingestion of maternal blood during delivery
- Perform gastric lavage after discussion with attending
- Continue monitoring for recurrent vomiting, poor feeding, or other signs of distress, consider NICU consult if concerned

USEFUL LINKS

- Nursery Survival Guide on DownstatePeds
- KCHC Nursery Escalation Protocol
- KCHC Nursery Anticipatory Guidance "Mommy Talk"
- Bright Futures Handout to Parents
- Breastfeeding Guide for Healthcare Professionals
- Newborn Exam
- Heel Stick Instructions
- Newborn Care Videos: Swaddling , Burping , Circumcision after care , Umbilical cord care

NEONATAL RESUSCITATION PROGRAM VIDEOS

- NRP Chart
- NRP Videos: Chest Compressions , MR SOPA , Positive Pressure Ventilation , Neopuff
- Procedures: Endotracheal Intubation , IO Needle Insertion , Umbilical Venous Catheter , Needle thoracentesis