RCNIC MANUAL	**NUMBER:** **V-1.06**
	PAGE: **1 of 4**
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SUBJECT: Respiratory Distress Syndrome (RDS), Infant with

APPROVAL

OUTCOME CRITERIA

I. The infant will attain improved and/or optimal respiratory function.

PROCESS CRITERIA

A. Assess and document infant's respiratory status.

1. Obtain infants baseline respiratory status from family/caregiver.

2. Auscultate breath sounds for quality, rhythm and rate. Observe chest wall for symmetry and effort.

3. Monitor oxygenation with pulse oximetry as ordered. Assess skin color and capillary refill.

4. Monitor blood gases and hematocrit as ordered.

5. Monitor tolerance/response to care and ventilator/oxygen weaning.

B. Use respiratory supportive measures as ordered.

1. Maintain patent airway; e.g., suctioning, positioning.

2. Administer humidified oxygen.

3. Administer pharmacologic interventions; e.g., exogenous surfactant, antibiotics, theophylline, caffeine, dexamethasone as ordered.

4. Monitor for side effects; e.g., pneumothorax, pulmonary interstitial emphysema.

5. Use assisted ventilation if applicable; e.g., CPAP, ventilator. See Standard of Care for Intubated/Ventilated Patient (V-322).

OUTCOME CRITERIA

II. The infant will attain adequate hydration.

PROCESS CRITERIA

A. Assess for fluid volume excess or deficit.

1. Maintain strict I&O.

2. Weigh daily.

3. Monitor electrolytes and renal function labs per physician order.

4. Monitor signs and symptoms of dehydration (e.g., depressed fontanelles, dry mucous membranes, poor skin turgor) or over hydration (e.g., edema, bulging fontanelles, weight gain).

5. Administer intravenous fluids per physician order.

6. Administer pharmacologic and non-pharmacologic interventions; e.g., diuretics, temperature control as ordered.

OUTCOME CRITERIA

III. The infant will achieve adequate caloric requirement.

PROCESS CRITERIA

A. Provide enteral/parenteral nutrition as ordered.

B. Assess abdomen every four hours to determine feeding tolerance.

1. Observation; e.g., distention, discoloration, stool patterns/characteristics.

2. Auscultation; e.g., bowel sounds every 4 hours.

3. Palpation; e.g., girth, loops, masses, rigidity.

C. Provide supportive measures to promote energy conservation by utilizing shared decision making with the family/caregiver.

1. Maintain neutral thermal environment.

2. Provide paced care and decrease external stimulation.

OUTCOME CRITERIA

IV. The infant will progress developmentally during the hospitalization.

PROCESS CRITERIA

A. Pace care in order to minimize noxious stimuli.

B. Monitor infant's response to care and ability to tolerate care.

C. Assess development on a regular basis; e.g., sucking, palmar grasp, responsiveness, muscle tone.

D. Provide appropriate developmental interventions; e.g., black-white pictures, tape recordings, positioning, pacifier.

OUTCOME CRITERIA

V. Family/caregiver will demonstrate attachment behaviors.

PROCESS CRITERIA

A. Explore with family/caregiver their feelings/expections about caring for their child based on ethnic background, culture and personal beliefs.

B. Provide an environment that supports participation in the child’s care, e.g. touching and holding infant, diapering, feeding and talking to infant, skin-to-skin holding.

APPROVAL

OUTCOME CRITERIA

VI. Family/caregiver will demonstrate and verbalize understanding of patient's care.

PROCESS CRITERIA

A. Assess family/caregiver's understanding of infant's condition, treatment and perception of health.

B. Provide explanations about the medical condition, procedures and treatment based on family learning styles.

C. Include family/caregiver in decision making.

D. Include family/caregiver in planning care.

REFERENCES:

Kenner, C., Lott, J. (2004) Neonatal Nursing Handbook. St. Louis:Saunders.

Wong, D., Perry, S., Hockenberry, M. (2002) Maternal Child Nursing Care. Second Edition. St. Louis:Mosby.