

NEWBORN CARE																																							
STABLE	UNSTABLE																																						
BLS																																							
<ul style="list-style-type: none"> • Universal Protocol #601 • Pulse Oximetry <ul style="list-style-type: none"> ○ O₂ administration per Airway Management Protocol #602 • Assess vital signs then dry thoroughly and cover head and body to maintain body heat • Position infant on back and suction as needed • Stimulate infant by vigorously rubbing the back or flicking the soles of the feet 	<ul style="list-style-type: none"> • Universal Protocol #601 • Pulse Oximetry <ul style="list-style-type: none"> ○ O₂ administration per Airway Management Protocol #602 • Respiratory distress – assist with BVM using room air (RA) • HR < 100 BPM – assist with BVM RA 40-60/min • HR < 60 BPM – BVM 100% O₂, provide chest compressions X 1 minute and reassess 																																						
ALS Standing Orders																																							
<ul style="list-style-type: none"> • None indicated 	<ul style="list-style-type: none"> • ALS resuscitation measures if indicated • Monitor EKG, and pulse oximetry in right upper extremity (preductal O₂ Sat) • Consider oxygen titrated to preductal O₂ Sat • With APGAR < 7 at 5 min check blood sugar level (treat if <40 mg/dL) 																																						
Base Hospital Orders Only																																							
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<ul style="list-style-type: none"> • Asphyxiation/respiratory distress is most common cause of neonatal arrest • Prompt warming, airway management and ventilations are the key to a successful resuscitation • A 3:1 compression-to-ventilation ratio is used for neonatal resuscitation where compromise of gas exchange is nearly always the primary cause of cardiovascular collapse • High-concentrations of oxygen may result in adverse outcomes, particularly in preterm infants • Meconium-stained infants – Routine intubation for tracheal suction is not approved. Suction oropharynx with bulb syringe and provide BLS airway management • Use proper sized equipment based on Broselow tape or equivalent • Determine APGAR at 1 minute, 5 minutes, and after any intervention 																																							
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