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Noticing

A 12 hour-old infant was admitted to the NICU for hypoglycemia. This baby weighed 9 pounds 2 ounces at 39 & 2 weeks gestation, which could be one of the many reasons for hypoglycemia. Larger babies can sometimes have lower blood sugars because their metabolism is a bit higher and they burn more energy due to their bigger size. A couple of the nurses thought the mother of the infant may have been an undiagnosed gestational diabetic, which would also lead to these kinds of complications.
This baby also had other symptoms of hypoglycemia including a low body temperature of 97.3 degrees Fahrenheit and the patient was very irritable and hard to console. The first blood sugar reading on my shift was 50, which is right on the borderline of an acceptable result.

Interpreting

I learned that the MPM protocol for neonatal hypoglycemia is any blood sugar reading below 50. Once admitted for hypoglycemia, the infant may be put on IV fluids that contain dextrose and potentially TPN and lipids. This infant was on IV D10 fluids that started at 14 mL/hr and every time a blood sugar reading was above 50, the IV fluids could go down by 2 mL/hr. Upon my shift the IV fluids were at 7 mL/hr. We were obtaining heel stick blood sugars Q3 hrs and adjusting the fluids depending on the result. Throughout my shift the blood sugars remained above 50, so later in the day we were able to stop the fluids. At this point we had to continue to monitor the infant for signs and symptoms of hypoglycemia. We also had to have three consecutive blood sugars (while off of fluids) that were above 50, to consider the infant stable for a potential discharge.

Hypoglycemia is very serious when dealing with neonatal patients. There are many more severe symptoms including cyanosis, seizures, and apnea spells, which are life threatening. Although my patient had not had any symptoms quite that severe, I made sure to monitor the infant and teach the mother about signs that they are occurring.

Responding

Luckily, in this case the infant's blood sugars remained above 50, so he remained off the fluids. I continued to monitor the temperature and vital signs and reported my findings to the Neonatologist who was deciding if the baby was ready for discharge. My preceptor and I did a lot of teaching to the parents of the baby, to insure they know what to look for and what to do. It was important to teach the parents to keep this baby on a regular feeding schedule to make sure he is being fed every three

hours or his blood sugar could drop again. I was able to delegate the feedings and temperatures to the mother.
There were only two nurses working on this shift and no PCT's so it was hard to delegate anything else. Being in the NICU, it is very important to get the parents involved with the patients care.

We promoted breastfeeding with this mother and baby, because evidence based practice shows that breastfed infants (especially within the first hour of life) can decrease the risk of hypoglycemia. In this case, the mother has not made enough to milk to fully support the baby so we had to supplement some formula to ensure the baby was getting enough.

Reflecting

I believe I handled this situation appropriately. The mother was very upset because this was her first baby and she was not expecting him to have to be admitted to the NICU. I listened to her questions and concerns and kept her updated with every blood sugar reading.

I stayed on schedule with the Q3 blood sugars, vitals, and feedings and kept the mother updated and involved. I achieved the desired outcome by being able to discontinue the IV fluids and keep the blood sugar above 50.

I believe I did a good job keeping the mother updated on the patient's condition. I was also very good with my time management and making sure everything was done on time. I think I need to work on my confidence because I seem to know the right answers, I'm just very hesitant because these babies are so small and I don't want to mess anything up.