Section:	Division of Nursing	**********	Index:	6170.027a
		* **PROCEDURE** *	Page:	1 of 2
Approval:	_____	**********	Issue Date:	July 16, 1990
			Revised Date:	Jan. 2010
	_____			

HACKETTSTOWN REGIONAL MEDICAL CENTER

Originator: E. Fletcher, RN
Revised by: Cathy Burns, RNC
JC Szymanski RN
S. McCarver RN, MSN
P. Swanson, RN, MSN

NEWBORN SERVICES
(Scope)

TITLE: **NURSING ASSESSMENT OF THE NEWBORN, ONGOING**

PURPOSE: To define the nursing responsibilities and care parameters in the ongoing care and assessment of all well newborns after completion of the transitional care period.

SUPPORTIVE DATA:

1. An initial assessment of all the newborn's body systems is completed by a perinatal unit staff RN soon after birth as part of the newborn's admission process.
2. Ongoing, repeated assessments of the newborn at the beginning of an eight hour nursing shift allows the perinatal nurse to detect subtle changes in the newborn's condition, identify or anticipate the development of problems, and to intervene to prevent or minimize these problems.
3. Assessment also occurs on an informal, ongoing basis during other care giving activities by the perinatal nurse, i.e. assisting with feedings, teaching parents infant care tasks.
4. Ongoing assessment allows the perinatal nurse to provide feedback regarding the newborn's status to the new parents.

EQUIPMENT:

1. Newborn size stethoscope.
2. Electronic thermometer, including appropriate probe and probe covers, lubricant, if needed.
3. Ongoing Assessment Newborn in Cerner Power Chart

CONTENT:

PROCEDURE STEPS:	KEY POINTS:
A. While newborn is in a quiet state, assess respiratory and cardio vascular status.	Normal rate: 30-60/minute
1. Observe respirations, counting for full 1 minute. **Note:** chest movement and respiration effort, i.e., grunting, retractions, if present.	Unlabored.
2. Auscultate newborn's chest.	
a. Count apical rate for 1 full minute: **note:** rate, rhythm and any extraordinary sounds.	Normal apical rate 110 – 160/min.
b. Auscultate breath sounds throughout the chest in an orderly fashion from top to bottom, comparing side to side for equality and presence of clear breath sounds.	
B. Temperature assessment: using electronic thermometer and axillary method.	
1. Thermometer probe should be placed in axilla securely and surrounded by skin. i.e. Newborn's arm should be disrobed and held gently but securely against his/her side, covering the lower ½- 1/3 of the thermometer probe.	
2. If axillary temperature reads below 35.6 C (97.7F) repeat temperature procedure above, taking extra care in procedure.	

3. If repeat axillary temperature is below 35.6 C (97.7F), take temperature using rectal method.
   A. If rectal temperature is below 37 C (98.6F), place newborn under radiant warmer with skin probe attached. Give Patient the option of placing newborn skin to skin or using radiant warmer.
      1. Explain to parent(s) what is being done and why.
      2. If parent(s) are in LDR, use radiant heater there, so parent(s) can be involved in newborn's care.
      3. Reassess temperature (every 30 minutes) rectally as long as newborn is under radiant warmer. Remove when temperature stabilizes at 37 C (98.6F).
      4. Reassess temperature via axillary method, 2 hours after newborn removed from radiant warmer.
      5. Note in Newborn Assessment Ongoing in Cerner Power chart.

C. If Skin to Skin is not effective after 30 minutes, the Radiant warmer will be used.

D. Assess Integumentary System:
   1. Note, color, bruising, cyanosis, birthmarks, jaundice, etc.
   2. Note findings in Newborn Assessment Ongoing in Cerner Power chart.

E. Neuromuscular System:
   1. Note cry, activity, symmetry of movement, abnormal or extraneous movements, ie. tremors, rhythmic clenching, stretching, etc.
   2. Note findings in Newborn Assessment Ongoing Power Chart.

F. Nutrition and Elimination:
   1. Note bowel function, bladder functioning by inspecting diapers, talking with parents. Record color, consistency and number of bowel movements, number of urination.
   2. Note Nutritional status.
      a. Formula feeding. Record type and amount taken, how tolerated, retained and/or regurgitated.
      b. Breast feeding. Direct nursing observation and assessment of newborn's latch-on, suck and swallow is the most accurate way to assess.
         1. Observe first-time breast feeding moms on a frequent basis, assist with positioning and latch-on as needed. Provide information through all learning modes: visual(demo, video), written and verbal.
         2. Observe experienced breast feeding moms on a less frequent basis. Need to assess if mom is having any problems on difficulties with this newborn. She may be reluctant to ask. Each breast feeding experience is a different, new, one.
         3. Note frequency, duration and quality of feedings.

DOCUMENTATION: Ongoing Assessment Newborn in Cerner Power chart.

Bibliography: AWHONN's Perinatal Nursing, ed Simpson, K.R and Creehan, 2001, Chapter 14-15 - Newborn Physical