Nb assessment essay

Table 21-2 SUMMARY OF NEWBORN ASSESSMENT *MCH pages 479-473| NORMAL| ABNORMAL (POSSIBLE CAUSES)| NURSING CONSIDERATIONS| Initial AssessmentAssess for obvious problems first. If infant is stable and has no problems that require immediate attention, continue with complete assessment. | Vital Signs| TemperatureAxillary: 36. 5– 37. 5°C (97. 7 – 99. 5°F). Axilla is preferred site. | Decreased (cold environment, hypoglycemia, infection, CNS problem). Increased (infection, environment to warm). | Decreased: Institute warming measures and check in 30 minutes. Check blood glucose. Increased: the excessive clothing.

Check for dehydration. Decreased or increased: look for signs of infection. Check radiant warmer or incubator temperature setting. Check thermometer for accuracy if skin is warm or cool to touch. Report abnormal temperature to physician. | PulsesHeart rate 120 – 160 BPM. (100 sleeping, 180 crying). Rhythm regular. PMI at 3rd-4th intercostal space lateral to mid-clavicular line. Brachial, femoral, and pedal pulses present and equal bilaterally. | Tachycardia (respiratory problems, anemia, infection, cardiac conditions). Bradycardia (asphyxia, increased intracranial pressure).

PMI to right (dextrocardia-heart situated to right of body, pneumothorax). Murmurs (normal or congenital heart defects). Dysrhythmias. Absent or unequal pulses (coarctation of the aorta). | Note location of murmurs. Refer abnormal rates, rhythms and sounds, pulses. | RespirationsRate 30 -60 (AVG 40 -49) BrPM. Respirations irregular, shallow, unlabored. Chest movements symmetric. Breath sounds present and clear bilaterally. | Tachypnea, especially after the first hour (respiratory distress). Slow respirations

(maternal medications). Nasal flaring (respiratory distress). Grunting (respiratory distress syndrome).

Gasping (respiratory depression). Periods of apnea more than 20 seconds or with change in heart rate or color (respiratory depression, sepsis, cold stress). Asymmetry or decreased chest expansion (pneumothorax). Intercostal, xiphoid, supraclavicular retractions or see-saw (paradoxical) respirations (respiratory distress). Moist, coarse breath sounds (crackles, rhonchi) (fluid in the lungs). Bowel sounds in chest (diaphragmatic hernia). | Mild variations require continued monitoring and usually clear early hours after birth. If persistent or more than mild, suction, give oxygen, call physician, and initiate more intensive care. Blood Pressure Varies with age, weight, activity, and gestational age. Average systolic 65-95 mm Hg, average diastolic 30-60 mm Hg. | Hypotension (hypovolemia, shock, sepsis). BP 20 mm Hg or higher in arms than legs (coarctation of the aorta). | Refer abnormal blood pressures. Prepare for intensive care and very low. | Measurements| Weight2500-4000 g (5 lbs. 8 oz. to 8 lbs. 13 oz.). Weight loss up to 10% in early days. | High (low gestational age LGA, maternal diabetes). Low (small for gestational age SGA, preterm, multifetal pregnancy, medical conditions and mother that affected fetal growth).

Weight loss above 10% (dehydration, feeding problems). | Determine causeMonitor for complications common to cause. | Length48-53 cm (19-21 inches)| Below normal (SGA, congenital dwarfism). Above normal (LGA, maternal diabetes). | Determine causeMonitor for complications common to cause. | Head Circumference32-38 cm (12. 5-15 inches). Head and neck are approximately ? of infants body surface. | Small (SGA, microcephaly,

anencephaly-absence of large part of brain or skull). Large (LGA, hydrocephalus, increased intracranial pressure). | Determine causeMonitor for complications common to cause. | Chest Circumference30-36 cm (12-14 inches).

Is 2 cm less than head circumference. | Large (LGA). Small (SGA). | Determine causeMonitor for complications common to cause. | Posture Flexed extremities move freely, resist extension, return quickly to flexed state. Hands usually clenched. Movements symmetric. Slight tremors on crying. Breech: extended, stiff legs. “ Molds” body to caretaker’s body when held, responds by quieting when needs met. | Limp, flaccid, floppy, or rigid extremities (preterm, hypoxia, medications, CNS trauma). Hypertonic (neonatal abstinence syndrome, CNS injury). Jitteriness or tremors (low glucose for calcium level).

Opisthotonos- extreme hyperextension of body, seizures, stiff when held (CNS injury). | Seek cause, refer abnormalities. | CryLusty, strong. | High-pitched (increased intracranial pressure). Week, absent, irritable, cat-like “ mewing” (neurologic problems). Hoarse or crowing (laryngeal irritation). | Observe for changes in report abnormalities. | Skincolor pink or tan with acrocyanosis (cyanotic discoloration of extremities). Vernix caseosa in creases. Small amounts of lanugo (fine, soft downy hair) over shoulders, sides of face, forehead, upper back. Skin turgor good with quick recoil. Some cracking and peeling of skin.

Normal variations: Milia (tiny white bumps). Skin tags. Erythema toxicum (flea bite” rash). Puncture on scalp (from electrode). Mongolian spots. |

Color: cyanosis of mouth and central areas (hypoxia). Facial bruising (nuchal cord). Pallor (anemia, hypoxia). Gray (hypoxia, hypotension). Red, sticky, transparent skin (very preterm). Greenish brown discoloration of skin, nails, cord (possible fetal compromise, postterm). Harlequin color (normal transient autonomic imbalance). Mottling (normal or cold stress, hypovolemia, sepsis). Jaundice (pathologic if first 24h). Yellow vernix (blood incompatibilities). Thick vernix (preterm).

Delivery Marks: bruises on body (pressure), scalp (vacuum extractor), or face (cord around neck). Petechiae (pressure, low platelet count, infection). Forceps marks. Birthmarks: Mongolian spots. Nevus simplex (salmon patch," stork bite"). Nevus flammeus (port-wine stain). Nevus vasculosus (strawberry hemangioma). Cafe au lait spots (6+) larger than 0. 5cm in size (neurofibromatosis). Other: excessive lanugo (preterm). Excessive peeling, cracking (postterm). Pustules or other rashes (infection). " Tenting" of skin (dehydration). | Differentiate patient bruising from cyanosis. Central cyanosis requires suction, oxygen and further treatment.

Refer jaundice in first 24 hours or more extensive than expected for age. Watch for respiratory problems in infants with meconium staining. Look for signs and complications of preterm or postterm birth. Record location, size, shape, color, type of rashes and marks. Differentiate Mongolian spots from bruises. Check for facial movement with forceps marks. Watch for jaundice with bruising. Point out and explain normal skin variations to parents. | Head Sutures palpable with small separation between each. Anterior fontanel diamond shaped, 4-5 cm, soft and flat. Many bulge slightly with crying. Posterior fontanel triangular, 0. 5-1 cm.

Hair silky and soft with individual hair strands. Normal variations: overriding sutures (molding). Caput succedaneum or cephalohematoma (pressure during birth). | Head large (hydrocephalus, increased intracranial pressure) or small (microcephaly). Widely separated sutures (hydrocephalus) or hard, ridged area at sutures (craniosynostosis- birth defect that causes one or more sutures on a baby’s head to close earlier than normal). Anterior fontanel depressed (dehydration, molding), full or bulging at rest (increased intracranial pressure). Woolly, bunchy hair (preterm). Unusual hair growth (genetic abnormalities). | Seek cause of variations.

Observe for signs of dehydration with depressed fontanel; increased intracranial pressure with bulging of fontanel and wide separation of sutures. Refer for treatment. Differentiate Caput succedaneum from cephalohematoma, and reassure parents of normal outcome. Observe for jaundice with cephalohematoma. | Ears Ears well-formed and complete. Area where upper ear meets head even with imaginary line drawn from outer canthus of eye. Startle response to loud noises. Alerts to high-pitched voices. | Low set ears (chromosomal disorders). Skin tags, pre-auricular sinuses, dimples (may be associated with kidney or other abnormalities).

No response to sound (deafness). | Check voiding if ears abnormal Look for signs of chromosomal abnormality if position abnormal. Refer for evaluation if no response to sound. | FaceSymmetric and appearance and movement. Parts proportional and appropriately placed. | Asymmetry (pressure imposition in utero). Drooping of mouth or one side of face,” one-sided cry” (facial nerve injury). Abnormal appearance (chromosomal abnormalities). | Seek cause of variations. Check delivery history for possible cause of injury

to facial nerve. | Eyes Symmetric. Eyes clear. Transient strabismus. Scant or absent tears.

Pupils equal, react to light. Alerts to interesting sights. Doll’s eye sign- reflex movement of the eyes in the opposite direction to that which the head is moved, the eyes being lowered as the head is raised, and the reverse (Cantelli sign); an indication of functional integrity of the brainstem tegmental pathways and cranial nerves involved in eye movement. Red reflex present- reddish-orange reflection of light from the eye’s retina. May have subconjunctival hemorrhage or edema of eyelids from pressure during birth. | Inflammation or drainage (chemical or infectious conjunctivitis). Constant tearing (plugged lacrimal duct).

Unequal pupils. Failure to follow objects (blindness). White areas over pupils (cataracts). Setting sun sign- downward deviation of the eyes so that each iris appears to “ set” beneath the lower lid, with white sclera exposed between it and the upper lid; indicative of increased intracranial pressure or irritation of the brain stem. (hydrocephalus). Yellow sclera (jaundice). Blue sclera (osteogenesis imperfecta- condition causing extremely fragile bones). | Clean and monitor any drainage; seek cause. Reassure parents that subconjunctival hemorrhage and edema will clear. Refer other abnormalities. NoseBoth nostrils open to air flow. May have slight flattening from pressure during birth. | Blockage of one or both nasal passages (choanal atresia). Malformations (congenital conditions). Flaring, mucus (respiratory distress). | Observe for respiratory distress. Report malformations. | Mouth Mouth, gums, tongue pink. Tongue normal in size and movement. Lips and palate intact. Sucking pads. Sucking, rooting, swallowing, gag reflexes present.

Normal variations: precocious teeth, Epstein’s pearls-Multiple small white epithelial inclusion cysts found in the midline of the palate in most newborns. Cyanosis (hypoxia). White patches on cheek or tongue (candidiasis). Protruding tongue (Down syndrome). Diminished movement of tongue, drooping mouth (facial nerve paralysis). Cleft lip, palate or both. Absent or weak reflexes (preterm, neurologic problem). Excessive drooling (tracheoesophageal atresia). | Oxygen for cyanosis. Expect loose teeth to be removed. Obtain order for antifungal medication for candidiasis. Check mother for vaginal or breast infection. Refer anomalies. | Feeding Good suck/swallow coordination. Retains feedings. | Poorly coordinated suck and swallow (prematurity).

Duskiness or cyanosis during feeding (cardiac defects). Choking, gagging, excessive drooling (tracheoesophageal fistula, esophageal atresia). | Feed slowly. Stop frequently if difficulty occurs. Suction and stimulate if necessary. Refer infants with continued difficulty. | Neck/Clavicles Short neck turns head easily side to side. Infant raises head when prone. Clavicles intact. | Weakness, contractures, or ridgidity (muscle abnormalities). Webbing of neck, large fat pad at back of neck (chromosomal disorders). Crepitus, lump, or crying when clavicle or other bones palpated, diminished or absent arm movement (fractures). Fracture of clavicle more frequent in large infants with shoulder dystocia at birth. Immobilize arm. Look for other injuries. Refer abnormalities. | Chest Cylinder shape. Xiphoid process may be prominent. Symmetric. Nipples present and located properly. May have engorgement, white nipple discharge (maternal hormone withdrawal). | Asymmetry (diaphragmatic hernia, pneumothorax). Supernumerary nipples. Redness

(infection). | Report abnormalities. | Abdomen Rounded, soft. Bowel sounds present within first hour after birth. Liver palpable 1-2cm below right costal margin. Skin intact. 3 vessels in cord. Clamp tight and cord drying.

Meconium passed within 12-48hr. Urine generally passed within 12-24h. Normal variation: “ Brick dust” staining of diaper (uric acid crystals). | Sunken abdomen (diaphragmatic hernia). Distended abdomen or loops of bowel visible (obstruction, infection, and large organs). Absent bowel sounds after first hour (paralytic ileus). Masses palpated (kidney tumors, distended bladder). Enlarged liver (infection, heart failure, hemolytic disease). Abdominal wall defects (umbilical or inguinal hernia, omphalocele, gastroschisis, exstrophy of bladder). Two vessels in cord (other anomalies). Bleeding (loose clamp). Redness, drainage from cord (infection).

No passage of meconium (imperforate anus, obstruction). Lack of urinary output (kidney anomalies) or inadequate amounts (dehydration). | Refer abnormalities. Assess for other anomalies if only two vessels in cord. Tighten or replace loose cord clamp. If stool and urine output abnormal, look for missed recording, increase feedings, report. | Genitals| Female Labia majora dark, cover clitoris and labia minora. Small amount of white mucus vaginal discharge. Urinary meatus and vagina present. Normal variations: Vaginal bleeding (pseudomenstruation). Hymenal tags. | Clitoris and labia minora larger than labia majora (preterm).

Large clitoris (ambiguous genitalia). Edematous labia (breech birth). | Check gestational age for immature genitalia. Refer anomalies. | Male Testes within scrotal sac, rugae on scrotum, prepuce nonretractable. Meatus at tip of

penis. | Testes in inguinal canal or abdomen (preterm, cryptorchidism). Lack of rugae on scrotum (preterm). Edema of scrotum (pressure in breech birth). Enlarged scrotal sac (hydrocele). Small penis, scrotum (preterm, ambiguous genitalia). Empty scrotal sac (cryptorchidism). Urinary meatus located on upper side of penis (epispadias), underside of penis (hypospadias, or perineum.

Ventral curvature of the penis (chordee). | Check gestational age for immature genitalia. Refer anomalies. Explain to parents why no circumcision can be performed with abnormal placement of meatus. | Extremities| Upper and Lower ExtremitiesEqual and bilateral movement of extremities, Correct number and formation of fingers and toes. Nails to ends of digits or slightly beyond. Felxion, good muscle tone. | Crepitus, redness, lumps, swelling (fracture). Diminished or absent movement, especially during Moro reflex (fracture, nerve injury, paralysis). Polydactyly (extra digits). Syndactyly (webbing) Fused or absent digits.

Poor muscle tone (preterm, neurologic injury, hypoglycemia, and hypoxia). | Refer all anomalies, look for others. | Upper ExtremitiesTwo transverse palm creases. | Simian crease (normal or Down syndrome). Diminished movement (injury). Diminished movement of arm with extension and forearm prone (Erb-Duchenne paralysis). | Refer all anomalies, look for others. | Lower Extremities Legs equal in length, abduct equally, gluteal and thigh creases and knee height equal, no hip “ clunk”. Normal position of feet. | Ortolani and Barlow tests abnormal, unequal leg length, unequal thigh or gluteal creases (developmental dysplasia of the hip).

Malposition of feet (position in utero, talipes equinovarus). | Refer all anomalies, look for others. Check malpositioned feet to see if they can be gently manipulated back to normal position. | BackNo openings observed or felt in vertebral column. Anus patent. Sphincter tightly closed. | Failure of one or more vertebrae to close (spina bifida), with or without sac with spinal fluid and meninges (meningocele) or spinal fluid, meninges, and cord (myelomeningocele), enclosed. Tuft of hair over spina bifida occulta. Pilondial dimple or sinus. Imperforate anus. | Refer abnormalities.

Observe for movement below level of defect. If sac, cover with sterile dressing wet with sterile saline. Protect from injury. | Reflexes See table 21-3. | Absent, asymmetric or weak reflexes. | Observe for signs of fractures, nerve injury, or injury to CNS. | TABLE 21-3 SUMMARY OF NEONATAL REFLEXES *MCH page 493| REFLEX| METHOD OF TESTING| EXPECTED RESPONSE| ABNORMAL RESPONSE/POSSIBLE CAUSE| TIME REFLEX DISAPPEARS| Babinski| Stroke lateral sole of foot from heel to across base of toes. | Toes flare with dorsiflexion of the big toe. | No response. Bilateral: CNS deficit. Unilateral; local nerve injury. 8-9 mos| Gallant (trunk incurvation)| With infant prone, lightly stroke along the side of the vertebral column. | Entire trunk flexes toward side stimulated. | No response: CNS deficit. | 4 mos| Grasp reflex (palmar and plantar)| Press finger against of infant’s fingers or toes. | Fingers curl tightly; toes curl forward. | Weak or absent: neurologic deficit or muscle injury. | Palmar grasp: 2-3 mos. Plantar grasp: 8-9 mos| Moro| Let infant’s head drop back approx. 30?. | Sharp extension and abduction of arms followed by flexion and adduction to “ embrace” position. | Absent: CNS dysfunction.

Assymetry: brachial plexus injury, paralysis, or fractured bone of extremity. Exaggerated: maternal drug use. | 5-6 mos| Rooting| Touch or stroke from side of mouth toward cheek. | Infant turns head to side touched. Difficult to illicit if infant is sleeping or just fed. | Weak or absent: prematurity, neurologic deficit, depression from maternal drug use. | 3-4 mos| Stepping| Hold infant so feet touch solid surface. | Infant lifts alternate feet as if walking. | Asymmetry: fracture of extremity, neurologic deficit. | 3-4 mos| Sucking| Place nipple or gloved finger in mouth, rub against palate. | Infant begins to suck.

May be weak if recently fed. | Weak or absent: prematurity, neurologic deficit, maternal drug use. | 1 yr| Swallowing| Place fluid on the back of the tongue. | Infant swallows fluid. Should be coordinated with sucking. | Coughing, gagging, choking, cyanosis: tracheoesophageal fistula, esophageal fistula, esophageal atresia, neurologic deficit. | Present throughout life. | Tonic neck reflex| Gently turn head to one side while infant is supine. | Infant extends extremities on side to which head is turned, with flexion on opposite side. | Prolonged period in position: neurologic deficit. | May be weak at birth; disappears at 4 mos|