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| **ACTIVITY** |
| 1. **Before you begin look through the chart, know the maternal history, observe previous exam, weight, and vital signs. Always look for opportunity to educate family and other nurses.**  * Know weight changes have happened over time. * Previous abnormal findings so you can correlate. |
| 1. **Assemble equipment required:**  * Neonatal stethoscope, measuring tape, * Thermometer * Pulse oximeter * Watch/phone with ‘second’ hand * Hand sanitizer and/or alcohol (60-70% alcohol) * Cot sheet to cover baby * Ensure that the room and equipment to be used are warm |
| 3.  **Introduce** self to mother/parents, establish rapport, and the baby’s identity. Explain what will be done, why the physical examination needs to be done and gain her/paternal consent Ask mother/father to assist in undressing baby to nappy/diaper level. Keep warm by placing the sheet. |
| 4. **Wash and dry hands. Use hand sanitizer or alcohol and gloves.**  Demonstrate hand hygiene and adopt standard precaution PPE. |
| 5. **HOW**: Perform physical examination of baby from head to toe (OBSERVATION, AUSCULTATION, PALPATION)  As the baby is undressed and before you touch the baby you can observe:   * baby’s posture (flexed, hypotonic, hypertonic) * work of breathing * Moving all extremities? Facial movement equal? * Assess colour (jaundice, plethora, pallor, peripheral cyanosis, skin mottling) |
| 6. Always begin with **“quiet”** assessments first (listening to lungs, heart and bowel sounds) Why we don’t want to make the baby cry then we lose the ability to hear murmurs, lung sounds and bowel sounds  **Cardiovascular system**  **Auscultate**: listen for quality and intensity of the heart sounds (Auscultate systematic “J” aortic, tricuspid, ventricular, ductal area)   * Capillary refill or the Perfusion <3second * Pulses (radial, femoral and pedal) |
| 7. **Chest**   * **Observe** shape of chest (barrel chested, sternum normal) Continue to observe the work of breathing (chest indrawing, nasal flaring, tracheal tug, head bobbing, respiratory rate and pattern). * Count respirations for full minute   **Auscultate**; Auscultate the lungs, anterior and posterior chest for (air entry and breath sounds e.g. crackles, grunting, stridor.) Right upper, left upper, right lower and left lower. Back upper and lower right and left. |
| 8. **Abdomen: Observe:** at umbilicus, any drainage, discoloration or openings  **auscultate:** to bowel sounds. Right upper quadrant, left upper quadrant, right lower quadrant and left lower quadrant. |
| 9**. Head** Baby lying on his/her back; Examine the head   * Inspect the head and note any abnormalities. (shape, size, bleeding and head trauma, cephalohematoma, caput and subgaleal). * Feel fontanel (gestational age dependent but normal 3-6cm anterior, posterior 1-1.5 cm) * measure head circumference (gestational age dependent normally 33-37 cm) |
| 10. **Ears**: observe for (setting, meatus, discharge, shape, asymmetry) |
| 11. **Eyes**; observe for (setting, discharge, coordination, shape, erythema, conjunctival heamorrhage) |
| 12. **Nose;** Inspect for discharge, patency, shape, setting |
| 13. **Mouth:** Inspect for: teeth, cleft lip and palate, ankyloglossia, drooling  Maxillary abnormalities  **Sucking** (with a gloved hand)  **Rooting** (Gently stroke the newborn cheek with examiner’s finger, and see baby turn toward the touch with mouth open |
| 14. **Neck, shoulders, clavicle** (webbed neck, swelling, fracture, paralysis, short neck, cysts (thyroglossal and brachial) |
| 15. **Chest and Abdomen**  **Observe:** Breast exam (normal placement, drainage)  **Palpate Abdomen:** palpate for pain or abnormalities (distension, tenderness, masses, where is the liver). |
| 16. **Limbs**  **Observe:** Open the baby’s hands, identify palmar creases, count fingers on each hand to establish number/extra digits. Amelia, polydactyly, syndactyly, talipes. **Grasp** (place finger in baby’s palm, then gently pull away examiner’s finger)  **Palpate**: Assess the feet Count toes on each foot, assess tone, and movement in both lower limb and upper limb |
| 17. **Hip Assessment -** Ortolani and Barlow tests  (**Barlow**).With baby’s knees and hips flexed to 900, steady the pelvis, move your hands to the front of the baby and push hips gently downwards and backwards; this should be smooth with no clicks  **(Ortolani)** Baby in supine position, cup the baby’s hips in the palm of your hand, gently abduct the hips through an angle of 70°\_90o, must be smooth with no ‘clunk’ sound. Do not exert force |
| 18. **Spine and Lumbar Observe** for shape of the spine, run finger through the spine and curvature for any abnormality such as Tuft of hair sacral dimple, meningocele, myelomeningocele, spina bifida occulta,   * **Galant reflex** – hold baby on by the abdomen - stroke one side of the spine (positive response is the newborn will lateral flex toward the stimulated side) |
| 19. **Skin:** Observe: rashes (erythema toxic), Mongolian spot, haemangioma. |
| 20. **Primitive Reflexes**  Elicit reflexes: Already discussed suck, root, grasp, Galant  **Moro** (Place the baby in both hands, on the soft examination mattress. Support head with dominant hand and the buttocks by the other. With the baby’s head in a midline position, the dominant hand is quickly dropped approximately 10 cm below its original supporting position. Catch the head with the dominant hand in its new position. The baby will throw out both arms and legs symmetrically in response |
| 21. **External Genitalia**  Undo the baby’s nappy/diaper.  **Observe**: appearance of genitalia and note any abnormality (position of urethra meatus, testicular swelling, absent testicles, ambiguous genitalia, vaginal discharge, bleeding, hernia, hydrocele)  **Ask**: Ask if baby has passed urine/meconium  **Palpate**: Palpate well for testes (cryptorchidism) check for the anus, delayed passage of meconium may indicate underlying cystic fibrosis or Hirschsprung disease. |
| 22. **Check the vital signs HC, Length and WT** |
| 23. **Educate the family during exam.** Especially how to feel a cold baby (feel hands and feet for cold or hot) or a baby should be active and moving all extremities. Normal vital signs. |
| 24. **Concluding the Assessment**   * Wash your hands and communicate findings to family and explain baby’s condition. * Offer to dress the baby, even though she will usually wish to do this herself.   Answer any questions he/she may have |
| 25. **Document findings** |
| 26. Please do the survey follow QRS code or the link in the chat.   * Please complete the survey at:   <https://www.surveymonkey.com/r/2JD8LZP> * Please join the Community of Neonatal Nursing Practice at: <https://www.conpcommunityofpractice.org>   Here are the upcoming educational programs to be offered until September of 2024:  January 2024: Thermoregulation – Dr. Joyce Jebet and Megan Watts JANUARY 16, 2024  March 2024: Airway management – Vicki Flanagan and Ghana nurse MARCH 19, 2024  May 2024: Nutrition and Glucose – Sue Prullage and Fauste Uwingabire MAY 21,2024  July 2024: Developmental care – Alfa and Sue (Zambia)\_JULY 23,2024  September 2024: Family centered care panel – Susan Haley, Cheryl Slater and Ethiopian nurse SEPTEMBER 17, 2024 |