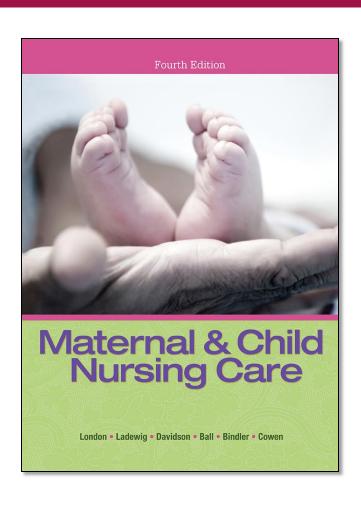
MATERNAL & CHILD NURSING CARE

FOURTH EDITION



CHAPTER 19

The Family in Childbirth: Needs and Care
Dr. Sahar Hassan

Learning Outcome 19-5

Explain the immediate needs and physical assessment of the newborn following birth in the provision of nursing care.

- Newborn on mother's abdomen
- Newborn in radiant-heated unit
- Respirations first priority
 - Newborn in modified Trendelenburg position
- Provide and maintain warmth
 - Skin-to-skin contact

- Dry
- Stimulate to Breathe
- Reposition

Dry the Baby

- Hypothermia is common
- Wet newborns rapidly lose heat
- Use a warm, dry, soft towel
- Any absorbent material:
 - Shirt
 - T-shirt
 - Socks



- Replace the wet towels
- Then let the mother hold the baby
- Her body heat will help keep the baby warm
- Cover the head to prevent heat loss

Clean the Airway

- May need to help them clear mucous & amniotic fluid from the airway
- Use a bulb syringe
- Use it gently



Cut the cord



Evaluate the Baby

- Breathing
- Color
- Heart Rate
- Tactile stimulation (rubbing) with a towel; may effectively stimulate a mildly depressed baby

Care of the Newborn

- Maintain respirations
- Provide and maintain warmth
- Apgar score
- Physical assessment
- Newborn identification
- Facilitate attachment

Apgar Score: A quick test performed on a baby at 1 and 5 minutes after birth:

- The 1-minute score determines how well the baby tolerated the birthing process
- The 5-minute score tells us how well the baby is doing outside the mother's womb

- Apgar scoring system: 5 criteria
- A = Activity (muscle tone)
- P = Pulse (heart rate)
- G = Grimace (reflex irritability)
- A = Appearance (skin color)
- R = Respiration

Scores

TABLE 22-8 The Apgar Scoring System

		Score	
Sign	0	1	2
Heart rate	Absent	Slow; less than 100 beats/min	Greater than 100 beats/min
Respiration	Absent	Slow; irregular	Good breathing with crying
Muscle tone	Flaccid	Some flexion of extremities	Active movement of extremities
Reflex response	Absent	Grimace; noticeable facial movement	Vigorous cry; coughs; sneezes; pulls away when touched
Skin color	Pale or blue	Pink body, blue extremities	Pink body and extremities
Source: Data from Apgar, V. (1966). The newborn (Apgar) scoring system, reflections and advice. Retrieved from http://profiles.nlm.nih.gov/ps/access/CPBBJY.pdf			

The Apgar score rates:

Respiration, crying

Reflexes, irritability

Pulse, heart rate

Skin color of body and extremities

Muscle tone



Apgar Score

Color

- Most newborns have acrocyanosis (body is centrally pink, but hands and feet are blue
- Cyanosis requires treatment:
- Oxygen
- Airway
- Ventilation

Question

What score would you give for the of color a newborn with acrocyanosis?

Apgar Score
Check the Heartbeat

- Normal newborn rate is >100
- Palpate umbilical cord or brachial artery
- If pulse <100, ventilate the baby, using whatever skills and equipment you have

Question

What score would you give for the pulse of a newborn 90 ?

- Newborn physical assessment by the nurse
 - Abbreviated systematic physical assessment
 - Size
 - Contour, size of head, fontanelles
 - Posture, movement
 - Inspect face, ears, neck, palate
 - Inspect skin

- Newborn physical assessment by the nurse
 - Observe nares, suction as needed
 - Inspection and auscultation of chest
 - Inspection of cord, abdomen
 - Genital area, buttocks, anus
 - Extremities
 - Reflexes

- Newborn identification
 - Mother and newborn
 - Identification codes
 - Wrist of mother, partner
 - Newborn
 - Two identification bands

- Initiation of attachment
 - Emotional time for family
 - Lights can be dimmed
 - Complete assessments with baby on mother's chest, abdomen
 - Breastfeeding encouraged
 - Enhance attachment

END