Nurses Content
Downloaded from nursescontent.com

Newborn Care and Assessment

Child Health Nursing

Characteristics of a normal newborn, immediate newborn care, APGAR scoring, newborn reflexes, physical assessment, thermoregulation, cord care, eye care and essential newborn care.

For educational purposes only.

CHAPTER 03 / CHILD HEALTH NURSING 03. Newborn Care and Assessment

1. Normal newborn characteristics

Neonatal period is birth through first 28 completed days; term birth is 37+0 to 41+6 weeks. Typical term birth weight approximately 2.5-4 kg; variations reflect gestation and growth. Normal quiet newborn respiratory rate about 30-60/min, heart rate often 100-160/min, axillary temperature 36.5-37.5 C. Assess in context, using neonatal ranges and trends.

NURSE'S CONTENT / CHILD HEALTH NURSING 5

B.SC. NURSING / CHAPTER-WISE STUDY NOTES

2. Essential immediate care

Prepare warm area and resuscitation equipment; dry thoroughly, assess breathing, support skin-to-skin and thermal care, delay cord clamping when appropriate (often at least 60 seconds if stable), and initiate breastfeeding within one hour if possible. No routine suction of a vigorous newborn. Identify with approved bands, give vitamin K and birth vaccines per protocol, examine and document. A newborn who is apnoeic/gasping needs immediate neonatal resuscitation, not waiting for Apgar.

3. Apgar scoring at 1 and 5 minutes

Sign	0	1	2
Appearance	Pale/blue	Body pink, extremities blue	Completely pink
Pulse	Absent	<100/min	>= 100/min
Grimace	None	Grimace	Cry/cough/active response
Activity	Limp	Some flexion	Active movement
Respiration	Absent	Slow/irregular	Good breathing/cry

Score 0-10; repeat at 5-min intervals up to 20 min when 5-min score <7 according to protocol. Colour assessment has limitations across skin tones. Apgar describes status and response, not a standalone diagnosis of asphyxia or guide to delay resuscitation.

4. Newborn reflexes and examination

Rooting (turn toward cheek stimulation), sucking, Moro (symmetrical startle), palmar/plantar grasp, stepping and asymmetric tonic neck are primitive reflexes. Assess fontanelles, red reflex per trained examiner, palate, chest, heart, abdomen, genitalia, anus, hips, spine and limbs. Note respiratory distress, central cyanosis, absent movement, abnormal tone, jaundice in first 24 h, poor feeding or temperature instability.

Nurses Content
Downloaded from nursescontent.com

5. Thermal, cord and eye care

Prevent heat loss by evaporation, conduction, convection and radiation; dry, use warm linens/skin-to-skin, delay bath at least 24 h when feasible, avoid overheating. Keep cord clean/dry according to local policy; do not apply unapproved substances. Eye prophylaxis follows national/local policy. Teach safe sleep supine on firm flat separate surface without loose bedding.

6. Important Examination Questions

Long Answer Questions

1. 1. Describe immediate and essential newborn care with Apgar scoring.

Short Answer Questions

1. 1. Explain newborn reflexes, thermoregulation and physical assessment.

Very Short Answer Questions (with answers)

1. 1. Maximum Apgar? - 10.
2. 2. What is neonatal period? - First 28 days of life.

7. Quick Revision

- Resuscitation is based on breathing and heart rate.
- Warmth and early feeding are essential.

NURSE'S CONTENT / CHILD HEALTH NURSING 6

B.SC. NURSING / CHAPTER-WISE STUDY NOTES

- Early jaundice or poor feeding requires clinical assessment.

8. Conclusion

Resuscitation is based on breathing and heart rate. Warmth and early feeding are essential. Early jaundice or poor feeding requires clinical assessment.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. A newborn turns toward stimulation of the cheek. Which reflex is being assessed?

A. Moro
B. Stepping
C. Rooting
D. Palmar grasp

2. Which Apgar component is assessed by observing limb flexion and movement?

A. Appearance
B. Grimace
C. Respiration

Nurses Content
Downloaded from nursescontent.com

D. Activity

3. Which newborn finding requires clinical assessment for possible pathology?

A. Jaundice in the first 24 hours
B. Symmetrical startle response
C. Turning toward cheek stimulation
D. Palmar grasp on stimulation

4. A newborn is breathing well but is wet and exposed after birth. Which routine action helps prevent heat loss?

A. Dry the baby and support appropriate warm skin-to-skin care
B. Delay drying until the next examination
C. Place the baby beside an open cold window
D. Give a cold bath to stimulate activity

Nurses Content
Downloaded from nursescontent.com

Answer key and explanations

1. C - Rooting

Rooting is turning toward cheek stimulation.

2. D - Activity

Activity ranges from limp to some flexion to active movement.

3. A - Jaundice in the first 24 hours

Early jaundice is a warning sign.

4. A - Dry the baby and support appropriate warm skin-to-skin care

Evaporation from wet skin causes heat loss. Drying and appropriate thermal care, including skin-to-skin when suitable, support newborn temperature.

Source and attribution

Online chapter: https://nursescontent.com/learn/child-health-nursing/unit-03-newborn-care-and-assessment/

Downloaded from Nurses Content. Branding identifies the delivery website. Original author credits, third-party licences and applicable rights remain unchanged.