

**Maternal and Child Health Home Visiting
Nursing Standards and Competencies**

Guide for Newborn Physical Assessment, Anticipatory Guidance and Health Teaching

Developed by the following *Healthy Babies* Providers:

**Vermont Assembly of Home Health Agencies
Vermont Department of Health
Vermont Regional Perinatal Program**

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Purpose

The purpose of the *Guide for Newborn Physical Assessment, Anticipatory Guidance and Health Teaching* is to describe in detail the competency *demonstrates newborn physical assessment and compares data with norms* as stated in *Maternal and Child Health Home Visiting Nursing Standards and Competencies, Postpartum Maternal and Newborn Nursing Care Competency*, Vermont Department of Health, January 1997.

It is important to note that only when physical assessment of the newborn is combined with the psychosocial and environmental assessment of the newborn as well as the physical, psychosocial and environmental assessment of the postpartum woman and her family will effective nursing interventions and positive client outcomes take place. The competencies related to the psychosocial and environmental assessment of the newborn and postpartum woman are described in the *Postpartum Maternal and the Newborn Nursing Care Competency, Maternal and Child Health Home Visiting Nursing Standards and Competencies*, January 1997. *A Guide for Postpartum Maternal Physical Assessment, Anticipatory Guidance and Health Teaching* is under development.

Priority Areas for Home Visits to Newborns Less Than 48 Hours of Age

Because important changes (e.g. jaundice) occur during the second and third days after birth, the following components of the physical assessment must be completed upon the first visit of all newborns less than 48 hours of age:

- ◆ parent(s) - infant interaction
- ◆ general health
 - sleep
 - feeding
 - elimination
 - cry
 - alertness
 - respiration
 - temperature
 - apical pulse
- ◆ newborn screening
- ◆ movement
 - muscle tone
 - symmetry
- ◆ jaundice
- ◆ hydration
- ◆ umbilicus
- ◆ circumcision

Communication with Medical Care Provider and Other *Healthy Babies* Providers

It is expected that communication between the MCH Home Visiting nurse and the postpartum woman's and newborn's medical care provider and other *Healthy Babies* providers (e.g. nutritionist or lactation consultant) takes place on an ongoing basis and includes normal and abnormal findings, assessment items not addressed, nursing interventions and client outcomes.

In the case of home visits to newborns less than 48 hours of age, it is expected that the MCH Home Visiting nurse will contact the newborn's medical care provider immediately if any abnormalities are noted.

The physical assessment of the newborn may be adapted to meet the needs of the postpartum woman and newborn. For example, if the newborn had a physical assessment by their medical care provider on the day of the home visit, then the complete physical assessment as outlined in this guide may not be necessary. Discussing the findings of the physical assessment by the medical care provider and its impact on nursing interventions is more appropriate.

Applying this Guide Locally

There may be variations in local medical practice regarding anticipatory guidance and health teaching. For example, some medical providers request parents to take a rectal rather than axillary temperature. It is important that MCH Home Visiting nurses know these local variations and incorporate, as appropriate, this information in their anticipatory guidance and health teaching so that parents receive consistent health teaching. Methods of communication between MCH Home Visiting nurses, medical care providers and other *Healthy Babies* providers will also vary at the local level. The key component of any method of communication is that it is timely, ongoing and meets the needs of the client.

Skills in Physical Assessment of the Newborn

The acquisition and maintenance of physical assessment skills of the newborn, as outlined in this guide, are best accomplished in a setting which includes theory and practice under the guidance of a skilled preceptor(s). It is the personal responsibility of the MCH Home Visiting nurse to maintain competency in newborn physical assessment as described in this guide.

Contributors to the *Guide for Physical Assessment, Anticipatory Guidance and Health Teaching*

This guide is based upon the work of Barbara Cardenas, author of *Community Health Nursing in Canada, Essential Skills: Physical and Developmental Assessment*. Many thanks for her work and providing a model of nursing care that: 1. includes a health oriented approach, 2. intertwines physical assessment with anticipatory guidance and health teaching and 3. includes the client - postpartum woman, newborn and family as a partner in assessing and planning care.

This guide articulates physical assessment of the newborn by MCH Home Visiting nurses within the context of maternal and child health nursing; community health nursing; home visiting of newborns less than 48 hours of age as well as newborns over 48 hours of age; and nursing care that complements, rather than substitutes for the newborn's primary medical care.

The contributors to this guide are listed below; many thanks for your expertise and time.

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Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
A. Parent(s)-Infant Interactions	-signs of affection or mutual responsiveness between parent/newborn	-excessively negative feelings	-observe closely for other signs of bonding -reinforce importance of verbal and non-verbal interaction -introduce concept of temperament & each child’s uniqueness in responding to people, events & conditions	-Assess parent-infant interaction, refer to medical provider if abnormality observed
B. General Health - sleep	-12-16 hours of sleep/24 hours -pattern variable		-reinforce sleep position/connection to SIDS -reinforce crib safety: space slats no more than 2 3/8” apart, snug mattress, no decorative Cutouts or corner post extensions, crib located away from window w/cords	
- feeding (refer to breastfeeding competency)	-on average 8-12 breast feedings in a 24 hr period -14-31 oz formula in 24 hr period -feeding with interest and without difficulty	-less than normal intake -poor skin turgor -dissatisfaction after feeding -patterns vary: observe for dissatisfied, constantly hungry baby and haggard mother	-breastfed babies feed on average 8-12 feedings in 24 hr period; both breast & formula fed babies work up to the average no. of feedings over the 1st week -colostrum to milk changes between 2nd & 5th days postpartum ; assess breastfeeding technique, newborn’s ability to latch on, suckle and swallow -recommend breastfeeding mothers drink whenever baby is nursing or to thirst as she recognizes it -discuss ongoing breastfeeding supports -if formula feeding, discuss formula preparation	-Assess feeding, refer to medical provider if abnormality observed -Baby may not awaken on own to feed. If intake less than recommended over a 24 hr period (6-8 feedings in 24 hrs on day 1-2 is not unusual), parent may need to wake baby. Be sure to give this information to the newborn’s medical care provider

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
-elimination	<p>-newborn should pass urine w/in 1st 12-24 hrs after birth</p> <p>-1 wet diaper every 8 hr on day 2; 4-6 wet diapers in 24 hr on day 3 & 4; by day 5 should have 6-8 wet diapers/24 hr period</p> <p>-newborns should pass 1st stool w/in 48 hrs after birth (called meconium)</p> <p>-stools progress from thick, tarry, black (meconium) to thin brown to green (transitional stools) to yellow, gold, soft or mush for breastfed babies or pale yellow, formed & pasty for formula fed babies</p> <p>-breastfed newborn should have 3-4 stools/day or more & the formula fed newborn may have 1-2 stools/day</p>	<p>-abnormal elimination pattern</p> <p>-skin turgor dry and non-elastic</p> <p>-depressed fontanel</p>	<p>-teach re urination: fewer wet diapers may indicate inadequate fluid intake</p> <p>-teach re stools: appearance, frequency, signs of constipation or diarrhea; for breastfed babies, elimination patterns vary in the 1st week depending on when the mother's milk comes in</p> <p>-super-absorbent disposable diapers make it difficult to assess wetness. If there is a concern and wet diapers must be counted, suggest the parent place a folded facial tissue in the diaper to assess wetness</p>	<p>-Assess elimination, refer to medical provider if abnormality observed</p> <p>-Important that parent monitor elimination, patterns until feeding & hydration are stable & to contact medical provider when abnormal or when parent(s) has questions</p>
<p>B. General Health</p> <p>-well being</p>	<p>-alert, responsive to environment</p> <p>-cry is lusty & vigorous</p> <p>-feeding well (refer to General Health, feeding section)</p> <p>-respirations normal (refer to Chest, respiratory section)</p> <p>-temperature stable (refer .to General Health, temp. section)</p> <p>-apical pulse normal (refer to Chest, cardiovascular section)</p>	<p>-minimal or no response to environmental stimuli</p> <p>-cry is high-pitched, weak or absent</p>	<p>-reinforce that periods of alertness tend to be short the 1st 2 days after birth to allow the baby to recover from the birth process</p> <p>-teach parent(s) re signs & symptoms of illness and when to call their medical provider</p>	<p>-Assess well being, refer to medical care provider if abnormality observed</p>

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
-temperature	-axillary: 36.5-37.5C (97.8-99.5F) degrees & stable	<p><u>neonatal sepsis</u>:(at present gram negative organisms Group B Streptococcus are the most common causative agents):</p> <p>-early onset occurs w/in 7 days of life; late onset occurs one week to 3 mos</p> <p>-early symptoms are vague & frequently nonspecific but include; apnea, tachypnea, temperature instability, tachycardia, lethargy and poor feeding</p> <p>-later symptoms; petechiae, seizures, enlarged liver & spleen and conjugated hyperbilirubinemia</p>	<p>-teach parents re: axillary temp when signs of illness are present</p> <p>-reinforce that newborns have little fat & can't at first readily regulate their own temp. Avoid excessive layers of clothing when surrounding temp. is warm. A rule of thumb is to dress infant 1 extra thin layer more than parent(s) is wearing</p>	-Assess temperature, refer to medical care provider if abnormality observed
B. General Health - sleep	-32 to 37 cm (12.5.14.5 in) -molding may last several days & cause the head circumference to be smaller immediately after birth; returns to normal w/in 2-3 days after birth			
-weight (if monitoring needed)	-2,500 to 4,000 gin (5lb 8oz - 8lb 13oz) -10% weight loss over 1st 3 days of life is normal	-weight loss > 15%	-assure that the same calibrated scale is used if the newborn's weight requires monitoring	
-tactile stimulation	-consolable; quiet when held	-continuous irritability or irritability on tactile stimulation		

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
<p>C. Movement</p> <p>-tonic neck reflex</p> <p>-muscle tone</p> <p>-symmetry</p>	<p>-tonic neck reflex (fencer position): extremities on same side as head is turned extend & on opposite side flex; present at birth or appears at 1-2 mos. of age</p> <p>-partially flexed extremities w/knees up toward abdomen; active, uncoordinated symmetrical bilateral movements of the extremities.</p>	<p>-a tonic neck reflex which is much stronger on the head side than the other should be referred</p> <p>-muscles flaccid; little flexion; movements are absent, minimal or obviously asymmetric</p>	<p>-assure that the baby has time to move extremities freely</p> <p>-ask parent how baby lies</p>	<p>-Assess muscle tone & symmetry, refer to medical care provider if abnormality observed</p>
<p>D. Skin</p> <p>-color</p>	<p>-pink; cyanosis of hands and feet (acrocyanosis is seen in the 1st 24-48 hrs of life & may last up to 10 days); mottling</p> <p>-circumoral cyanosis with crying, possibly with feeding</p> <p>-no pallor</p> <p>-physiologic jaundice occurs after the 1st 24 hrs of life:</p> <p><u>onset</u>: by end of second, beginning of third day & ending around seventh day</p> <p><u>progression</u>: jaundice first appears on the head and face, progressing downward to the trunk and extremities & finally to the sclera of the eyes</p> <p><u>course</u>: intensity decreases</p> <p><u>symptoms</u>: none</p>	<p>-cyanosis: at rest/quiet, cyanosis of torso is persistent</p> <p>-pallor</p> <p>-jaundice:</p> <p><u>onset</u>: before second day; after 7th day in full-term newborn. & 14th day in pre-term newborn</p> <p><u>course</u>: intensity persists or increases</p> <p><u>symptoms</u>: poor suck, eating less, irritable, vomiting, decreased activity, sleeping long periods</p>	<p>-inform parent(s) that 50% of newborns develop jaundice on the 2nd, 3rd, or 4th day of life but very important to inform their medical care provider if jaundice develops</p> <p>-teach parent(s) physiologic course of jaundice and how to assess for jaundice by observing the color of skin & sclera for yellow tinge & if yellow tinge present note its depth</p>	<p>-Assess skin color; refer to medical care provider if abnormally observed</p> <p>-if jaundice appears during the 1st 24 hrs of life, it may indicate the presence of an underlying illness. Notify medical care provider immediately</p>

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
D. Skin -hydration	-falls quickly into place w/o residual marks after gently lifting up a fold of skin -localized edema may be noted in a presenting part due to trauma -swelling of breasts, genitals common (due to hormones)	-tenting of skin (dehydration) -edema (generalized or localized other than in a presenting part)		-Assess skin hydration, refer to medical care provider if abnormality observed
-general appearance	-normally skin is dry & peeling <u>vernix caseosa</u> -cheesy white layer of skin formed in uterus and lubricates the skin of the newborn; <u>milia</u> - multiple yellow/pearly white papules, located on face due to retained sebum; disappear in a few weeks <u>miliaria</u> (heat rash) -superficial grouped vesicles w/o erythema or red grouped papules; usually found in forehead skin, scalp, creases or groin area caused by obstruction of sweat ducts from excessively warm & humid environment <u>erythema toxicum</u> - blotchy, red papule w/ central yellow/white elevations; located generally on face, trunk or extremities; appear suddenly on 1st-2nd day & disappear in a few hrs to a few days; often called newborn rash or fleabite dermatitis.	-petechiae, other than on presenting part -diaper rash that persists or gets worse after following steps (listed under anticipatory guidance & health teaching) to alleviate the problem -skin breakdown and infection; redness and rashes (other than norms described), blotches or drainage	-skin of the term or post-term newborn has less vernix and is frequently dry; peeling is common, especially on the hands & feet -give guidance re diaper rash: keep affected area dry by changing diaper frequently, clean baby well & air drying area; changing disposable diaper brands may help. Baby powder (or cornstarch) is not recommended since it may cake with urine and irritate the skin. Ointments that provide a barrier such as zinc oxide, A&D ointment, or petroleum jelly may be helpful -assure parents that erythema toxicum is normal & appears suddenly on the 1st - 2nd day of life and can disappear in a few hours to a few days	

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
<p>(Continued): D. Skin -general appearance</p>	<ul style="list-style-type: none"> - <u>forcep marks</u> on face, cheeks, jaw, usually disappear in a day or two - <u>stork bites</u> (telangiectatic nevi): pale pink or red spots found on the eyelids, nose, lower occipital bone & nape of neck; usually fade by 2nd birthday - <u>Strawberry Mark</u> (nevus vasculosus): raised, clearly delineated, dark red, rough surfaced birthmark commonly found in head region. Grow (often rapidly) for several mos and become fixed in size by 8 mos. Then begin to shrink & resolve spontaneously. About 90% cases resolved by 9 yrs of age - <u>Mongolian spots</u> dark blue or purple, bruise-like spots usually over sacrum, found in darker complexioned infants, gradually fade during 1st or 2nd year of life - <u>Port wine stain</u> (nevus flammeus): non-elevated, red to purple area (in infants of African descent it may appear as purple-black stain) & commonly appears on the face. It does not grow in size, does not fade w/ time and does not blanch as a rule. 	<p>-large size or location</p>	<p>-birthmarks are frequently a cause of concern for parents. The mother may be especially anxious, fearing that she is to blame; provide appropriate information about the cause and course of birthmarks and dispel any misconceptions</p> <p>-birthmarks may rarely be subject to trauma with ulceration and bleeding. -reassure Mongolian spot in non-Caucasian is normal</p>	

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
I. Parent(s) – Infant Observation and Discussion				
E. Newborn Screening	<p>-typically a sample is drawn before hospital discharge regardless of the baby's age</p> <p>-conditions screened for in Vermont are: hypothyroidism, biotinidase deficiency, PKU, galactosemia, homocystinuria, maple syrup urine disease, hemoglobinopathies</p> <p>Refer to Vermont Newborn Screening Program's "Newborn Screening for your Baby's Health" Manual for more detailed information, or contact Dr. Carol Walters, Vermont Newborn Screening Program at: 802- 860-7540.</p>	-newborn screen not done or repeat not done when indicated	-reinforce to parent(s) the importance of having repeat screens completed when indicated by their medical care provider	<p>-Assess if newborn screening was done before hospital discharge; if not, refer to medical care provider</p> <p>-newborn screening done <24 hrs of age must be repeated: If indicated, assure a sample is drawn by the newborn's health care provider system or draw sample for repeat newborn screening</p>

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
A. Head -symmetry	-minor asymmetry is common and should equalize by approximately 4 mos -cephalohematomas emerge between the 1st & 2nd day, may be unilateral or bilateral and do not cross suture lines -caput succedaneum (the fluid in a caput) is reabsorbed w/in 12 hrs or a few days after birth	-refer major asymmetry	-reassure parent(s) re minor asymmetry- explain that skull bones are not fixed at birth so that: (a) baby's head can adjust to birth passage during labor; (b) during infancy the skull grows rapidly to accommodate the brain; (c) discuss changing baby's position, when awake, because lying in one position over a period of time will cause flattening. Baby should always sleep on back. -if baby has a cephalohematoma, reassure parent(s) that they are relatively common on vertex births and may disappear w/in 2-3 weeks or slowly over subsequent months	
-fontanels (assess when newborn not crying)	-anterior: 2-3 cm wide, 3-4 cm long, closes 9-24 months (1 yr average) -posterior: 1-2 cm, may be almost closed at birth, closes 6-8 weeks -sutures felt as depressed ridges; in a newborn with molding (an overriding of the cranial bones) the suture lines become palpable within a few days after birth when this overriding diminishes	-refer if fontanel: -bulging (increased intracranial pressure) -depressed (dehydration) -sutures spread or prematurely closed	-ask mother what she was taught in hospital re fontanel and if she is worried washing baby's head -explain the fontanel allows for brain growth; she can't hurt it in washing as it is covered by a tough membrane (nothing but a direct blow can hurt it); washing well w/soap & rinsing well will prevent development of cradle cap -explain shouldn't compare size of fontanel w/another baby as they are different sizes at birth & close accordingly-should notify medical care provider if parent(s) notices fontanel bulging or depressed (tell why)	

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
A. Head (Cont.) -condition of scalp -cradle cap	-clean scalp -native lanugo; hair growth: Asian, African, Native American	-cradle cap; refer if persistent; if does not respond to treatment it could be eczema	-if cradle cap is present, advise parent(s) to use an oil to soften, remove dry skin with a comb, then wash off and rinse well	
-ears -appearance -response to sound	-responds to sounds & voice -normally ears are placed with the top of the ear (pinna) in line with inner and outer canthi	-malformations -discharge -reddened ear -ear tags or low-set ears	-ask parent(s) if baby reacts to sounds such as voices, music, etc. Discuss risk factors for hearing loss & preventive measures. If at any time they suspect a problem w/ hearing recommend they discuss with their medical provider -teach: sponge outer ear only; never put anything in canal	
-eyes -appearance	-bruised &/or puffy eyelids are normal -sclerae white to bluish white; slightly brownish frequent in newborns of African descent -small conjunctival, scleral & retinal hemorrhages are common -erythromycin & tetracycline are now frequently used prophylactically instead of silver nitrate. If silver nitrate drops are used, it may cause edema & chemical conjunctivitis which may appear a few hrs after instillation and disappear in 1-2 days	-jaundice (scleral) -opacity -anomalies; such as eyes wide apart (spacing)	-reassure parent(s) that puffy and/or bruised eyelids are normal after birth	
-visual acuity	-blinks -response to face or object: should be alert with decrease in random activity; a focus on object in the line of vision; follows an arc; brightens (change in facial expression), widens eyes, jagged respirations	-absence of blink -failure to fixate on face or object	-inform parent(s) that newborns prefer faces, geometric designs and black & white to colors	

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
A. Head (Cont.) -eyes -discharge		-excessive tearing or discharge -infection: sore, red swollen lids, conjunctivitis, purulent discharge -blocked tear duct; unilateral tearing with chafing of cheek	-tearing begins after 2-3 mos of age -ask what parent(s) was taught in hospital re eye care, explain no need to wash out baby's eyes with any solution; wash gently over eyes with cotton ball, using separate balls for each eye to remove any secretions on outside -if needed, demonstrate to parent(s) how to massage a blocked tear duct	
-nose -shape -patency of nares -discharge	-breathes easily through either nostril with lips closed -may have temporary plugging -sneezing is a natural reflex which clears nostrils	-obvious discharge -constant nasal blocking	-sneezing is not a cold; simply a way of cleansing nostril-wipe off only visible secretion. Not to use Q-tips. -ask mother what she was taught in hospital re bulb syringe & if she is comfortable using the bulb syringe; instruct if necessary	
-facial skin (also refer to skin-general appearance section)	-smooth-pink/white milia (pinhead-sized raised areas on nose, cheeks, forehead, immature sebaceous glands)	-refer if reddened and itchy (eczema) -refer if suspicion of impetigo (spreading of vesicular lesion)	-explain that milia are normal in infants; pores are not yet mature and not secreting fully-these white spots will disappear in about 2 weeks	
-mouth -hard & soft palate	-chin is poorly developed in relation to face -intact soft/hard palate	-cleft palate -thrush (whitish patches which spread rapidly & don't rub off w/o causing redness or bleeding)	-explain small chin enables a baby to fit the breast comfortably -glassy white look to roof of mouth is normal (cartilage)	

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
A. Head (Cont.) -lips, buccal mucosa	-sucking callus on lips -whitish appearance on roof of mouth (cartilage)			
-tongue-frenulum	-allows good mobility of tongue	-tongue tied	-suggest parent(s) discuss w/ their medical care provider if baby tongue-tied (if they have concerns)	
-smile	-smile 3-4 weeks	-no smile by 10 weeks	-smile may be seen as early as 1st 2 wks	
-rooting & sucking reflex	-present at birth, disappears 6 weeks - 4 months	-absence of rooting & sucking reflex		
B. Neck -traction response -appearance	-contraction of the shoulder & arm muscles, followed by flexion of the neck and minimal head lag when pulling infant from a supine to sitting position	-more than 45 degree lag -anomaly present e.g. web neck	-explain that you are testing the baby's neck and shoulder muscle tone. - reassure parent(s)	
C. Hands -palmar grasp reflex	-fingers grasp adult finger when palm is stimulated & holds momentarily -palmar grasp reflex lessens at 3-4 months of age	-weak or absent grasp		

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
D. Chest -nipples -breast: position, size	-two nipples -may have, some enlargement		-explain breast enlargement is normal & reason why it occurs: mother's hormone which stimulates her breast milk prior to birth transfers through placenta to baby - temporary; never massage or squeeze	
-cardiovascular	-apical pulse normal range for neonate 100-160 beats per minute -refer to "Skin Color" section	-apical pulse rate <100 or > 160 -irregular rhythm -refer to "Skin Color" section		-Assess cardiovascular, refer to medical care provider if abnormality observed
-respiratory	-normal range for neonate 30-60 breaths per minute	signs & symptoms of respiratory distress: -tachypnea -grunting respirations -retractions -nasal flaring -cyanosis	-explain: newborns show more abdominal breathing than chest-breathing: irregular & noisy breathing is normal -explain risks to infant from 2nd hand smoke -instruct parent(s) on signs & symptoms of respiratory distress if baby is at risk	-Assess respiratory, refer to medical care provider if abnormality observed
-rooting & sucking reflex	-present at birth, disappears 6 weeks - 4 months	-absence of rooting & sucking reflex		
E. Back -spine	-spine straight	-scoliosis		
-gluteal folds	-symmetrical	-congenital hip dysplasia		

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
F. Legs and Feet	-legs same length & free movement	-anomalies, e.g. feet clubbed	-explain that shoes not needed other than for warmth -reassure that infant's legs often remain bowed until about 18 months	
G. Umbilicus	-dried cord remnant up to 2-3 weeks of age -occasional small amounts of bloody discharge	-infection: purulent discharge, redness/induration, fetid odor -discharge continuing after 3 weeks	-teach re cord care and warning signs that would suggest the presence of infection. During the first few weeks keep the umbilicus clean and dry; fold diapers so cord doesn't become soiled and apply alcohol at the base of the cord once a day	-Assess umbilicus, refer to medical care provider if abnormality observed
H. Genitalia (male) -scrotum	-2 testes felt in scrotum; hydrocele, a collection of fluid surrounding the scrotum, is common in newborns -genitalia may have edema due to maternal hormones which should decrease in a few days	-undescended testes	-hydrocele is common and usually resolves by 6 months of age	
-penis	-foreskin normally adherent; cannot be completely retracted until 2 years and sometimes not until puberty		-give guidance regarding bathing/cleansing the non- circumcised penis	
-circumcision		-infection: purulent discharge, redness/induration, fetid odor	-teach re circumcision care & possible signs of infection; answer questions -instruct parents to apply bacitracin ointment liberally on the penis with each diaper change for at least 24-48 hrs to keep the diaper from adhering to the site. Note this is not indicated when a Plastibell is used	-Assess circumcision, refer to medical care provider if abnormality observe

Assessment Items	Norms	Abnormalities	Anticipatory Guidance and Health Teaching	Priority Areas for Home Visits to Newborns <48 Hrs of Age
II. Head to Toe Examination and Discussion				
H. Genitalia -female -hymen -discharge	-hymenal tag is a common neonatal variation that usually disappears in a few weeks -during the 1st week of life the baby may have vaginal discharge composed of thick whitish mucus which can be tinged with blood	-continuing vaginal discharge	-ask re vaginal discharge, blood tinged; same explanation as enlarged breasts, i.e. is caused by maternal hormone; resolves by the 1st week of life -cleansing of all perineal folds should be done gently when bathing and at diaper change	
I. Moro Reflex	-this reflex is a response to the sensation of loss of support and is present at birth and disappears 2-4 months -symmetric extension and abduction of arms w/ fingers extended; then return to normal relaxed flexion and closing of the fists; spine & legs are extended with the knees flexed; an audible cry may accompany this reflex -disappears 2-4 months	-if no reflex or asymmetrical movements -if occurs after 6 months may indicate neurological disease	-reassure mother before testing -parent(s) may feel they have a very nervous baby, explain that it is normal for baby to startle with noise or sudden movement, is a natural reflex and all babies do this at this stage	