Care of High-Risk Newborns

Systematic Assessment

A thorough systematic physical assessment is an essential component in the care of high-risk infants (see Nursing Care Guidelines box). Subtle changes in feeding behavior, activity, color, oxygen saturation (SaO_2), or vital signs often indicate an underlying problem. Low birth weight (LBW) preterm infants, especially very low birth weight (VLBW) or extremely low birth weight (ELBW) infants, are ill equipped to withstand prolonged physiologic stress and may die within minutes of exhibiting abnormal symptoms if the underlying pathologic process is not corrected. Alert nurses are aware of subtle changes and react promptly to implement interventions that promote optimum functioning in high-risk neonates. Changes in the infant's status are noted through ongoing observations of the infant's adaptation to the extrauterine environment.

Nursing Care Guidelines

Physical Assessment

General Assessment

Using an electronic scale, weigh daily, or more often if indicated.

Measure length and head circumference at birth.

Describe general body shape and size, posture at rest, ease of breathing, presence and location of edema.

Describe any apparent deformities.

Describe any signs of distress—poor color, hypotonia, lethargy, apnea.

Respiratory Assessment

Describe shape of chest (barrel, concave), symmetry, presence of incisions, chest tubes, or other deviations.