Maternal and Neonatal Assessments

Niomi Quinteros, BSN, RN

Fall

1

OB Sim Confidentiality Agreement

2

Course Code

ab29751bc9

3

OB Clinical Grading

- Assignments and quizzes will be worth **10%** of your overall clinical grade
  - If you are absent on your scheduled OB simulation day, you are still responsible for turning in your pre-simulation assignments. 5 points will be deducted each day they are late including the day they are due and weekends.
  - Each pre-simulation assignment will be due the Monday morning of your scheduled simulation day at 7:00 am.

4

OB Clinical Grading

- OB Clinical
  - Simulations will be evaluated as part of your Midterm and Final clinical evaluations.
    - If you are absent or late for your scheduled OB simulation time, you will not be able to make this up. This will be evaluated on your evaluation. You will be given an alternate assignment if you miss simulation.

5

Simulations

- Postpartum Assessment Simulation
- Newborn Assessment Simulation
- PIH Assessment Simulation

- You will all attend each of these simulation at least once during the semester. You will either be the nurse or play the role of a family member.

6

Pre-simulation Assignments

- To be completed prior to your scheduled OB simulation date. These will be due at 7:00 am on the Monday of your scheduled simulation day.
- If you are absent for your scheduled simulation day, you will still be responsible for submitting these assignments. 5 points will be deducted each day they are late including the day they are due and weekends.
- See D2L OB Clinical Assignments under the content section for these assignments.

7

Post Simulation Assignments

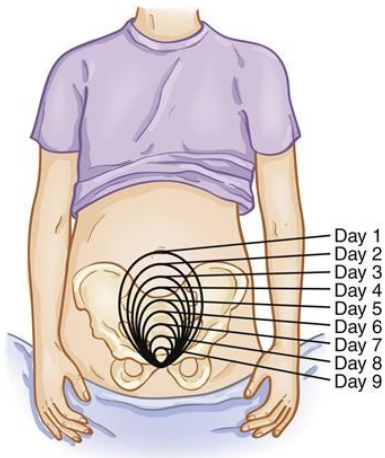
- Chartflow charting (nurse)/Self Reflecting (relative)
- Quiz

All charting, assignments, and quizzes must be done by 7:00 pm on the day of your scheduled simulation.

8

Postpartum Assessment

- Breasts
- Uterus
- Bladder
- Bowel
- Lochia
- Episiotomy
- Hemorrhoids
- Extremities
- Hygiene
- Emotions



9

Breast

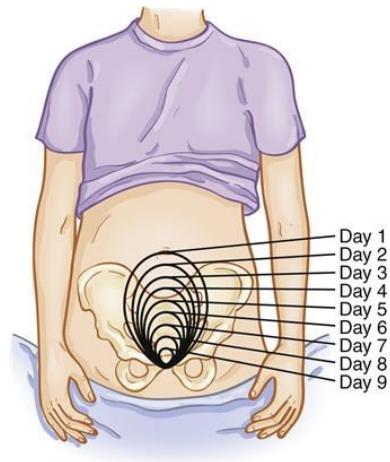
- Assess for pain/tenderness, lumps, bumps, redness or discharge
  - Colostrum
- Breastfeeding
  - Every 2-3 hours
- Bottle feeding
  - Every 3-4 hours
- Engorgement
  - Cool packs
  - Medication
  - Refrain from nipple stimulation
- Bra for support

10

Uterus

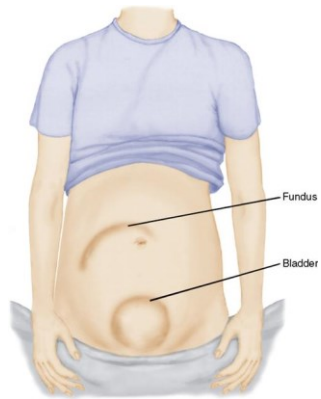
- Fundal check
  - Firmness
  - Height
  - location

Fundal Assessment



11

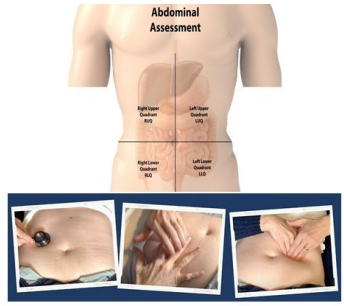
Bladder



- Palpate
  - Distended or nondistended
- Voiding
- Color
  - Maybe bloody due to lochia
- Pain
  - Burning or stinging, maybe due to vaginal trauma or episiotomy
  - Ask pain scale, location, and describe type of pain

12

Bowel

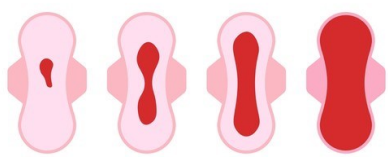


- Auscultate bowel sounds
- Ask
  - LBM
  - Consistency
  - Passing flatus (gas)
- Significant tears or episiotomy
  - Encourage fluids
  - Ambulation
  - Fiber in diet
  - Stool softeners (need an order)

13

Lochia

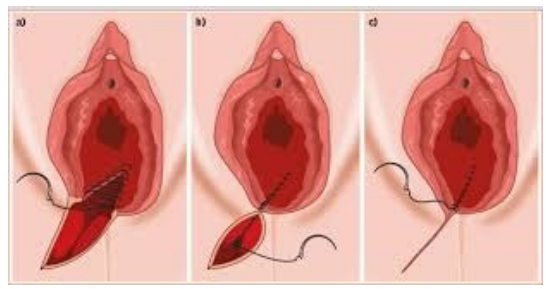
- Assess amount
  - Scant, small, moderate, large
- Lochia
  - Rubra: red, last about 3 days after birth
  - Serosa: pinkish and mucousy, last 3-7 days
  - Alba: clear and mucousy, 7-21 days
- Provide perineal care
  - Change peripad and blue pad



14

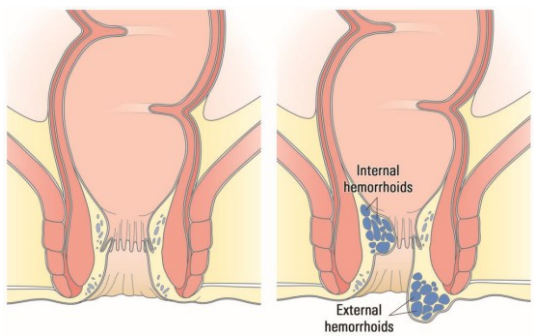
Episiotomy

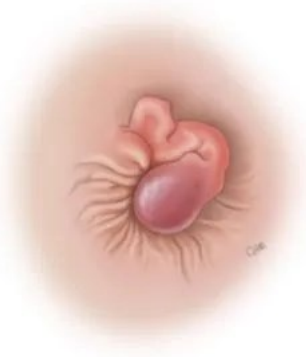
- Assess
  - Bleeding
  - Swelling
  - Bruising
  - Approximation
  - Drainage
- Offer ice pack
- Dermaplast spray (need an order)
- Stool softener (need an order)



15

Hemorrhoids

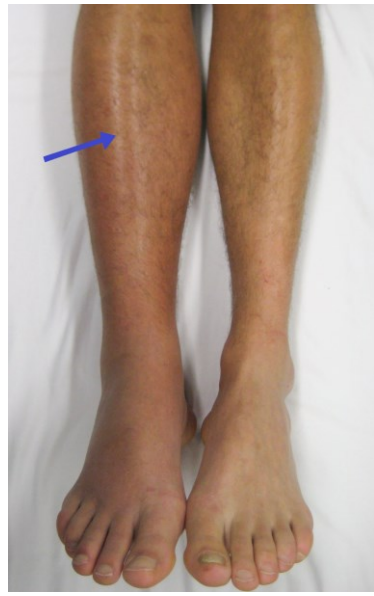




16

Extremities

- Assess
  - Capillary refill
  - Pulses
  - Edema
  - Redness
  - Swelling
  - Pain



17

Hygiene

- Education
  - Periwash bottle
  - Peripads
  - Perineal care
    - Wipe front to back

18

Emotions

19

Rubin's Psychological Adaptations

- Taking-In Phase
  - Mother is passive and willing to let others do things for her. Has interest in the newborn but prefers that others care for newborn. Has little interest in learning and focuses on food, fluids, and sleep.
- Taking-Hold Phase
  - Mother begins to initiate action and becomes interested in caring for the newborn. Becomes interested in learning how to care for self and baby.
- Letting-Go Phase
  - Mother and partner work through giving up their previous lifestyle to incorporate the newborn. They give up the fantasy child and accept the real child.

20

Postpartum Assessment

Education

- Wear a bra
- Use of peri wash bottle with each trip to the bathroom in addition to perineal care.
- Apply an ice pack to the perineal area for swelling and discomfort.
- Encourage ambulation, drinking fluids, and consuming a healthy diet with fiber.

Assess IV site

- Location, CDI, redness, swelling, pain, patent (asymptomatic), transparent dressing

Assess pain (scale, site, type) and what relieves the pain. Ex: medication, ambulation, reposition, rest, cold or heat pack

21

Postpartum Medications

- Benzocaine/Dermoplast
- Ibuprofen
- Hydrocodone/Vicodin
- Prenatal Vitamins
- Witch Hazel Pads/Tucks

22

Newborn Assessment

23

APGAR Score

- Performed at 1 and 5 minutes after birth
- Done by nurse or birth attendant
- Permits a rapid assessment of the need for resuscitation based on five signs that indicate the physiologic state of the newborn.

24

APGAR SCORES EXPLAINED

	Indicator	0 Points	1 Point	2 Points
A	Appearance (skin color)	Blue; Pale	Pink Body; Blue Extremities	Pink
P	Pulse	Absent	Below 100 bpm	Over 100 bpm
G	Grimace (reflex irritability)	Floppy	Minimal Response to Stimulation	Prompt Response to Stimulation
A	Activity (muscle tone)	Absent	Flexed Arms and Legs	Active
R	Respiration	Absent	Slow and Irregular	Vigorous Cry

Brown Trial Firm
Cerebral Palsy, HIE, & Birth Injury Attorneys

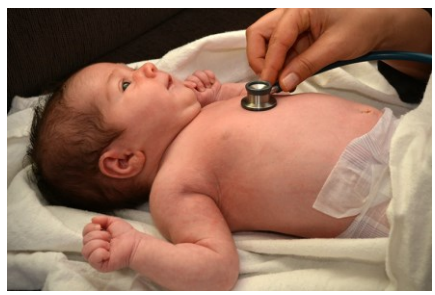
(254) 741-6200
www.browntrialfirm.com

25

Neonatal Vital Signs

1. Respirations: 30– 60 Count for 60 sec (irregular)
2. Pulse: 110 – 160 (Count apical, 60 sec.)
3. Temperature: 97.7-98.6 axillary only

- B/P – not normally taken in healthy newborn



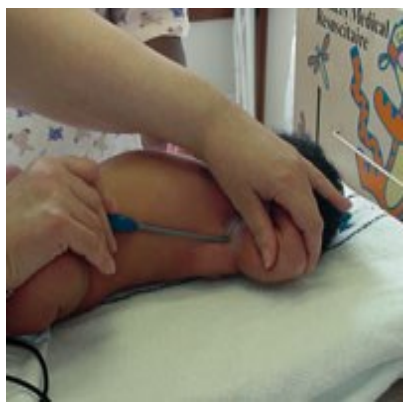
26

Newborn Assessment

- Lung sounds
- Fontanels/Overriding sutures
- Symmetry of face (ears/eyes) and hard palate
- Bowel sounds/voiding/stooling
- Spine/anus
- Reflexes (rooting, sucking, grasp, Babinski)
- Symmetry of upper and lower extremities
- Sole/palm creases
- Education: feedings and wet/dirty diapers

27

Body Temperature

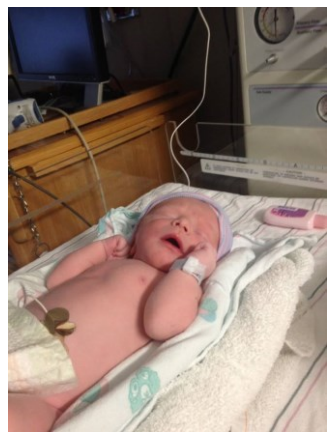


- Keep baby dry and covered, including head
- Only expose small areas at a time
- Chilling causes "cold stress" because infant cannot shiver

28

Ways a baby loses body heat

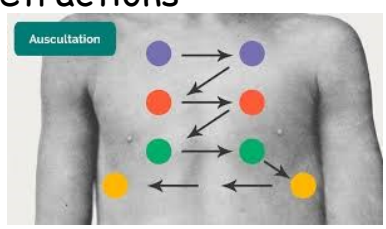
- Radiation
  - next to a window
- Convection
  - drafts
- Conduction
  - cold surface
- Evaporation
  - wet skin



29

Lung Sounds

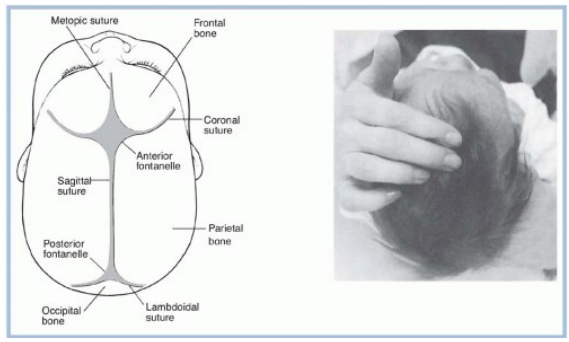
- Anterior (3 pairs), lateral (1 pair), posterior (3 pairs)
- Respiratory distress
  - Respirations ↑ than 60/min or ↓ 30/min
  - Nasal flaring
  - Grunting
  - Sternal or intercostal retractions
  - Cyanosis
  - Noisy respirations



30

Fontanels/Overriding Sutures

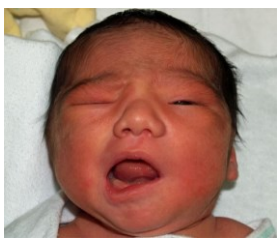
- Anterior and Posterior fontanels
  - Soft and flat
- Sutures
  - Intact
  - Overriding

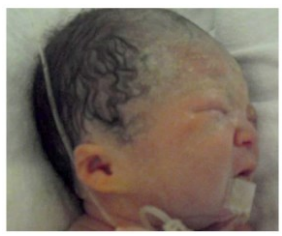


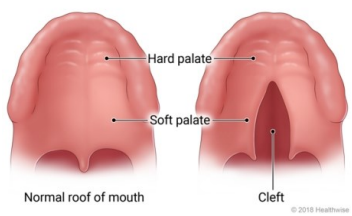
31

Symmetry of Face and Hard Palate

- Eyes and top of ears should line up
- Assess for any facial drooping
- Use pinky to feel on the roof of mouth to ensure the top palate is intact







32

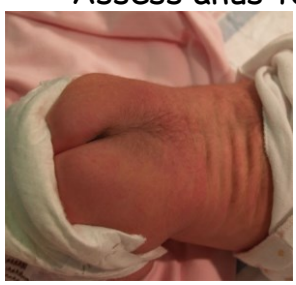
Bowel Sounds/Voiding/Stooling

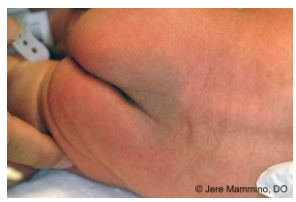
- Auscultate bowel sounds
- Ask parent if newborn had voided or had a bowel movement
- Educate parent to inform nurse when infant has wet or dirty diaper
  - Meconium stools

33

Spine/Anus

- Assess spine for any abnormalities
  - Curvatures noted
  - Openings notes
  - Ensure intactness along spine
  - Mongolian spots
  - Tuff of hair/Dimple
- Assess anus to ensure patency





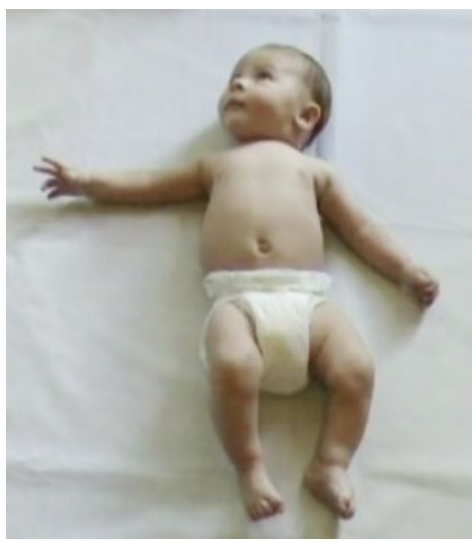
34

Reflexes

- Rooting
  - Rooting Reflex
- Sucking
  - Sucking Reflex
- Grasp
  - Grasp Reflex
- Babinski
  - Babinski Reflex

35

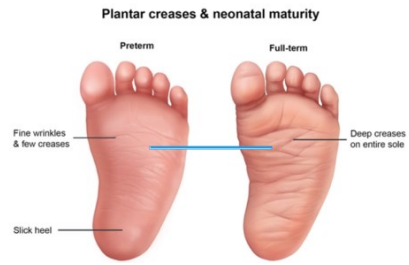
Symmetry of Upper and Lower Extremities



36

Sole and Palm Creases

- Sole creases
  - Smooth with less creases indicates prematurity
  - Wrinkled with increased creases indicates maturity
- Palm creases
  - Single lateral crease: Down Syndrome



37

Head Circumference/Weight/Length

- Head Circumference
  - Measured in cm
- Weight
  - Measured in grams
- Length
  - Measured in inches

38

Eye Prophylaxis

- Mandatory installation of eye prophylaxis as a precaution against opthalmia neonatorum.
  - Erythromycin
- Installation may be delayed to allow eye contact facilitating parent-infant attachment

39

Vitamin K Prophylaxis

- Single injection of 0.5 to 1 mg of Vit. K is given soon after birth to prevent hemorrhagic disorders.

40

Hepatitis B Vaccine

- Recommended immunization
  - At birth – given within 12 hours
  - Series of 3
  - Parental consent - Required

41

Umbilical Cord Care

- Goal of care: prevention of infection and early detection of hemorrhage or infection
- Stump and base of cord: assessed for edema, redness, and purulent drainage with each diaper change
- If bleeding observed, apply 2nd clamp below 1st one

42

Other Assessments

- Feeding
  - Breast
  - Bottle
- Bladder and bowel (meconium) function
- Observe for Eye Contact
- Blood Sugar checks on
  - Large for gestational age (↑ 8.8lb)*
  - Small for gestational age (↓ 5.5 pounds)*

* Parameters may vary by hospital policy

43

Safety

- Safety
  - Always have at least one hand on NB when on surfaces without edges (bed, table, etc.)
  - Firmly grasp a body part (ex. Leg)
  - Always support head
  - Back to sleep
  - Infant security
    - Identify self to parents
    - Name tag
    - Check baby's band with mom's armband

44

Hypertensive Disorders of Pregnancy

- Gestational Hypertension
- Preeclampsia
- Eclampsia
- Chronic Hypertension
- Preeclampsia with Superimposed Chronic Hypertension

45

Risk Factors for Preeclampsia

- First pregnancy
- Obesity
- Family history of preeclampsia
- Age more than 35 years or less than 19 years
- Multifetal pregnancy (twins)
- Chronic hypertension
- Chronic renal disease
- Diabetes mellitus
- Autoimmune disease
- History of a pregnancy interval more than 10 years

46

Magnesium Toxicity

- Absent DTR's
- Respirations > 12/minute
- Urine output > 30mL/hr
- Weakness
- Confusion
- Blurry vision

47

Nursing Management

- Monitor level of consciousness
- Obtain pulse oximetry
- Obtain clean catch urine to assess for proteinuria
- Daily weight
- Monitor VS: BP, P, R
- Observe for edema
- Check deep tendon reflexes
- I&O
- Bed rest and quiet environment
- Administer ordered medications such as Magnesium Sulfate
- Maintain seizure precautions

48

Pregnancy Induced Hypertension (PIH) Assessment

- Neurologic Assessment
  - LOC, Speech, Pupils
- Uterus
- Bowel
- Bladder
  - Foley Catheter: Assess amount of urine noted
- Lochia
- Episiotomy/Laceration/Cesarean Section Incision
  - Assess c/s dressing: CDI
- Hemorrhoids
- Lower Extremities
  - DTR's Patellar DTR
  - Clonus Clonus

49

PIH Medications

- Magnesium Sulfate
- Oxytocin
- Hydralazine
- Labetalol
- Calcium Gluconate

50

What's Next?

- Start Postpartum pre-simulation work
- View simulation videos
- Review client chart in ChartFlow

51