**عملي (1) اطفال (مرحلة ثالثة)**

**م.د.سالم كريم هجول/قسم التمريض /كلية المستقبل**

**Nursing Assessments**

Assessing patients is part of a nurse’s professional practice to keep patient’s safe and improve a patient’s health outcomes.

* environmental assessment
* cultural assessment
* physical assessment
* psychological assessment
* safety assessment
* psychosocial assessment

PEDIATRIC ASSESSMENT

**Airway & Appearance**

**(Open/Clear – Muscle Tone /Body Position)**

**Abnormal**: Abnormal or absent cry or speech.

Decreased response to parents or environmental stimuli.

Floppy or rigid muscle tone or not moving. A B

**Normal**: Normal cry or speech. Responds

to parents or to environmental stimuli such as

lights, keys, or toys. Good muscle tone. C

Moves extremities well.

**Circulation to Skin**

**Breathing**

**(Visible movement / Respiratory Effort)**

**Abnormal**: Increased/excessive (nasal flaring,

retractions or abdominal muscle use) or

decreased/absent respiratory effort or noisy

breathing.

**Normal**: Breathing appears regular

without excessive respiratory muscle effort

or audible respiratory sounds.

**(Color / Obvious Bleeding)**

**Normal**: Color appears normal for racial group of child. No significant bleeding

**Normal Respiratory Rate: Normal Pulse Rate: Lower Limit of Normal Systolic BP:**

Infant (<1yr): 30- 60 Infant: 100-160 Infant: >60 (or strong pulses)

Toddler (1-3yr): 24 -40 Toddler: 90-150 Toddler: >70 (or strong pulses)

Preschooler(4-5yr): 22- 34 Preschooler: 80-140 Preschooler: >75

School-age(6-12yr): 18 -30 School-age: 70-120 School-age: >80

Adolescent(13-18yr): 12 -20 Adolescent: 60-100 .Adolescent: >90

Pulses slower in sleeping child / athlete Estimated min.SBP >70 + (2 x age in yr)

**Physical Examination Of The Newborn**

**General**

Observe the entire infant at the beginning of the examination, before the assessment of specific organ systems. It is important that the infant becompletely undressed and in a warm environment

with adequate illumination.

Assess the following:

• Consciousness, alertness, general behavior

• Symmetry of body proportions and body

movements (e.g. arms and legs, facial grimace)

• State of nutrition and hydration

• Colour

• Any sign of clinical distress (e.g. respiratory)

**Vital Signs**

Average values of vital signs for newborns:

• Temperature 36.5°C to 37.5°C

• Heart rate 120-160 beats/minute

• Respiratory rate 30-60/minute, up to 80/minute

if infant is crying or stimulated

• Systolic blood pressure 50-70 mm Hg

**Growth Measurements**

Measure and record length, weight and head

circumference. If the infant appears premature or

is unusually large or small, assess gestational age

*(see Table 1-4, below, this chapter).*

• Average length at birth 50-52 cm

• Average weight at birth 3500-4400 g

• Average head circumference at birth 33-35 cm

*For additional information about growth*

*measurements, see "Well-Child Care," in chapter*

*3, "Prevention*

**Skin**

**Colour**

• Pallor associated with low hemoglobin

• Cyanosis associated with hypoxemia

• Plethora associated with polycythemia

• Jaundice associated with elevated bilirubin

**Head And Neck**

**Head**

Check for:

• Overriding sutures

• Anterior and posterior fontanels (size,

consistency)

• Abnormal shape of head (e.g. caput

succedaneum, molding, encephaloceles)

• Measure head circumference

**Eyes: Inspection**

• Check cornea for cloudiness (sign of congenital

cataracts)

• Check conjunctiva for erythema, exudate, orbital

edema, subconjunctival hemorrhage, jaundice of

sclera

**Nose: Inspection**

• Look for flaring of the alae nasi, which is a sign

of increased respiratory effort

**Ears: Inspection**

• Check for asymmetry, irregular shape, setting of

ear in relation to corner of eye (low-set ears may

suggest underlying congenital problems, such as

renal anomalies)

**Mouth: Inspection**

• Observe size and shape of mouth

**Teeth**

• Natal teeth (usually lower incisors) may be

present

• Risk of aspiration if these are attached loosely

**Chin**

• Micrognathia may occur with Pierre Robin

syndrome, Treacher Collins syndrome and

Hallerman Streiff syndrome

**Neck**

• Symmetry of shape

• Neck mass (cystic hygroma is the most common

type)

**Palpation**

• Palpate all muscles for lumps and the clavicles

for possible fracture

• Lymph nodes cannot usually be palpated at

birth; their presence usually indicates congenital

infection

**Cardiovascular System**

• Respiratory rate

• Heart rate

• Blood pressure in upper and lower extremities

*See normal values in "Vital Signs," above, this*

*chapter.*

**Abdomen**

**Inspection**

• Shape of abdomen: flat abdomen may signify

decreased tone, presence of abdominal contents

in chest or abnormalities of the abdominal

musculature

**Auscultation**

• Bowel sounds

**Palpation**

• Check for any abnormal masses

• Liver and spleen: it may be normal for the liver

. Question

1 .A nurse in a delivery room is assisting with the delivery of a newborn infant. After the delivery, the nurse prepares to prevent heat loss in the newborn resulting from evaporation by:

A. Warming the crib pad

B. Turning on the overhead radiant warmer

C. Closing the doors to the room

D. Drying the infant in a warm blanket

2.A nurse is assessing a newborn infant following circumcision and notes that the circumcised area is red with a small amount of bloody drainage. Which of the following nursing actions would be most appropriate?

A. Document the findings

B. Contact the physician

C. Circle the amount of bloody drainage on the dressing and reassess in 30 minutes

3.A nurse in the newborn nursery is monitoring a preterm newborn infant for respiratory distress syndrome. Which assessment signs if noted in the newborn infant would alert the nurse to the possibility of this syndrome?

A. Hypotension and Bradycardia

B. Tachypnea and retractions

C. Acrocyanosis and grunting

D. The presence of a barrel chest with grunting

4.A nurse in a newborn nursery is performing an assessment of a newborn infant. The nurse is preparing to measure the head circumference of the infant. The nurse would most appropriately:

A. Wrap the tape measure around the infant’s head and measure just above the eyebrows.

B. Place the tape measure under the infant's head at the base of the skull and wrap around to the front just above the eyes

C. Place the tape measure under the infant's head, wrap around the occiput, and measure just above the eyes

D. Place the tape measure at the back of the infant’s head, wrap around across the ears, and measure across the infant’s mouth

5.A postpartum nurse is providing instructions to the mother of a newborn infant with hyperbilirubinemia who is being breastfed. The nurse provides which most appropriate instructions to the mother?

A. Switch to bottle-feeding the baby for 2 weeks

B. Stop the breastfeedings and switch to bottle-feeding permanently

C. Feed the newborn infant less frequently

D. Continue to breast-feed every 2-4 hours.