

Introduction to Newborn Physical Assessment Curriculum

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About the Author



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Sarah Schulze is a board-certified pediatric nurse practitioner. She earned her BSN from Indiana State University in 2011 and her MSN from University of Illinois at Chicago in 2014. As an RN, she has experience in a variety of settings including critical care, surgery, and pediatrics. As an NP she has worked in primary care pediatrics and adolescent mental health. Her special interests include breastfeeding, nutrition, and adolescent mental health. She has extra certifications as a lactation counselor and a pediatric mental health specialist.

This curriculum and accompanying Infant Vital Signs Trainer will help students learn about the assessment of newborns, fontanelle, and cord care according to the American Academy of Pediatrics.

Curriculum Structure

The *Introduction to Newborn Physical Assessment* curriculum is composed of the following parts. Approximate times are included.

Lesson	Title	Approximate Time
One	FOCUS: Part 1 – Focus on APGAR	10 minutes
One	FOCUS: Part 2 – Focus on Fontanelle	10 minutes
One	LEARN: Introduction to Newborn Physical Assessment	20 minutes
One	REVIEW: Practice and Assessment of Assessing Newborns	35 minutes
	Total	1½ hours

Lesson Structure

Each lesson begins with a Lesson Overview, Lesson Objectives and a Lesson at a Glance table which lists the lesson activities, materials required, suggested preparation steps, and approximate class time.

Lesson Sections

The actual lesson follows the overview, which will contain some of the sections described below.

FOCUS

Every lesson begins with a FOCUS activity intended to capture participants' attention. This may be in the form of a small or large class discussion, a game, a review of previous lesson information, or a demonstration. During this activity, participants are introduced to the topic of the lesson.

LEARN

The LEARN activity in each lesson varies in its presentation mode. It may be a slide presentation, group activity, or demonstration.

REVIEW

The majority of lessons end with a REVIEW activity intended to briefly review the lesson's key messages or main points.

Lesson One – Introduction to Newborn Physical Assessment

Lesson Overview

In this lesson, students will learn about the assessment of newborns, their fontanelle, and cord care according to guidelines from the American Academy of Pediatrics.

Pre-Lesson Knowledge

- How to assess an apical pulse
- How to document vitals
- How to convert measurements from grams/kg to lbs or inches to cm

Lesson Objectives

After completing this lesson, participants will be able to:

- Explain infant assessment in relation to APGAR scores
- Demonstrate how to collect weight, height, and head circumference on infants
- Identify sutures and fontanelles on a normal infant skull
- Identify common abnormalities with the infant skull following birth
- Demonstrate care of the umbilical cord
- Explain normal umbilical cord appearance in the weeks following birth

Lesson at a Glance

Activity	Materials	Preparation	Approximate class time
FOCUS – Part 1	• <i>Introduction to Newborn Physical Assessment (Focus on APGAR) worksheet</i> • <i>Introduction to Newborn Physical Assessment (Focus on APGAR) Instructor Resource</i>	1. Print/photocopy <i>Introduction to Newborn Physical Assessment (Focus on APGAR) worksheet</i> (one per participant)	10 minutes
FOCUS – Part 2	• <i>Introduction to Newborn Physical Assessment (Focus on Fontanelle) worksheet</i> • <i>Introduction to Newborn Physical Assessment (Focus on Fontanelle) Instructor Resource</i>	1. Print/photocopy <i>Introduction to Newborn Physical Assessment (Focus on Fontanelle) worksheet</i> (one per participant)	10 minutes
LEARN	• <i>Introduction to Newborn Physical Assessment slide presentation</i> • <i>Infant Vital Signs Trainer</i>	1. Prepare <i>Introduction to Newborn Physical Assessment slide presentation</i> for viewing	20 minutes
SUMMARIZE	• <i>Introduction to Newborn Physical Assessment Check-Off Instructor Resource</i> • <i>Introduction to Newborn Physical Assessment Check-Off</i> • <i>Infant Vital Signs Trainer</i> • <i>Introduction to Newborn Physical Assessment Test</i> • <i>Introduction to Newborn Physical Assessment Test – Answer Key</i>	1. Print/photocopy <i>Introduction to Newborn Physical Assessment Check-Off</i> for each participant 2. Get the supplies ready for the lesson 3. Print/photocopy <i>Introduction to Newborn Physical Assessment Test</i> (one per participant)	35 minutes

Lesson One – Introduction to Newborn Physical Assessment

FOCUS: Part 1 – Focus on APGAR

10 minutes

Purpose:

To help participants understand the assessment of newborns in the immediate birth period and the significance of this assessment on the overall health of the newborn.

Materials:

- *Introduction to Newborn Physical Assessment (Focus on APGAR) worksheet*
- *Introduction to Newborn Physical Assessment (Focus on APGAR) Instructor Resource*

Facilitation Steps:

1. Distribute the *Introduction to Newborn Physical Assessment (Focus on APGAR) worksheet* prior to or at the start of the class.
2. Have the *Introduction to Newborn Physical Assessment (Focus on APGAR) Instructor Resource* page available.
3. Have participants read through the information and complete the worksheet.
4. Have participants pair up upon completion and share answers.

Introduction to Newborn Physical Assessment

(Focus on APGAR) Instructor Resource

Read each of the newborn scenarios below and, using the APGAR info table, assign the infants an APGAR score. Reflect on the significance of the score and what you think this means for the immediate health of the infant. Discuss these thoughts with a partner.

APGAR info table

Criteria	0 points	1 point	2 points
Appearance (skin color)	Blue, pale	Pink body, blue extremities	Pink
Pulse	Absent	<100 bpm	>100 bpm
Grimace (reflex irritability)	Absent	Grimace	Active motion, coughs, grimaces, or pulls away
Activity (muscle tone)	Flaccid	Arms and legs flexed	Active motion
Respiration	Absent	Slow, irregular	Vigorous cry

Gracie is a 39-week infant born via normal spontaneous vaginal delivery. At 1 minute of life, she is noted to be pink with blue extremities, actively moving extremities, grimaces with reflex stimulation, is crying vigorously, and has a heart rate of 158. What APGAR score would you assign this infant and what does this score indicate about how she tolerated the birthing process?

Score of 8. A score above 7 indicates the infant tolerated the birthing process well.

What if, at 5 minutes, Gracie is less responsive, breathing more slowly and irregularly, and now has an APGAR score of 6. What does this indicate about how Gracie is responding to life outside the womb?

This indicates the infant may be experiencing some distress, either from breathing difficulties, low oxygen levels, trouble with temperature regulation, or other issues. This infant needs, special attention to locate the cause of her distress and address it as quickly as possible.

Connor is a 37-week infant born via emergency c-section after some non-reassuring fetal heart tones during a long, difficult labor. At 1 minute of life, Connor is pale, with a heart rate of 98 bpm, some weak flexion of his extremities, grimace when stimulated, and irregular breathing rate with some grunting but no cry. What APGAR score would you assign this infant and what does this score indicate about him?

APGAR score of 4. This infant is in distress, most likely from low oxygen levels leading up to birth. He is briefly given respiratory resuscitation with oxygen and once stable transferred to the NICU for further observation.

At 5 minutes of life, Connor is now pink except for his hands and feet, heart rate of 154, actively moving and coughs with stimulation, and vigorously crying. What is his APGAR score now and what does this indicate about his adjustment to life outside the womb?

Score is now 9. This indicates he responded very well to the respiratory resuscitation and oxygen and is now doing well.

Name: _____ Class: _____

Introduction to Newborn Physical Assessment (Focus on APGAR)

Read each of the newborn scenarios below and, using the APGAR info table, assign the infants an APGAR score. Reflect on the significance of the score and what you think this means for the immediate health of the infant. Discuss these thoughts with a partner.

APGAR info table

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What if, at 5 minutes, Gracie is less responsive, breathing more slowly and irregularly, and now has an APGAR score of 6. What does this indicate about how Gracie is responding to life outside the womb?

Introduction to Newborn Physical Assessment

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At 5 minutes of life, Connor is now pink except for his hands and feet, heart rate of 154, actively moving and coughs with stimulation, and vigorously crying. What is his APGAR score now and what does this indicate about his adjustment to life outside the womb?

Lesson One – Introduction to Newborn Physical Assessment

FOCUS: Part 2 – Focus on Fontanelle

10 minutes

Purpose:

To help participants understand the purpose and anatomy of the fontanelles and sutures on a newborn's skull as well as expected or problematic variations.

Materials:

- *Introduction to Newborn Physical Assessment (Focus on Fontanelle) Instructor Resource*
- *Introduction to Newborn Physical Assessment (Focus on Fontanelle) worksheet*

Facilitation Steps:

1. Distribute the *Introduction to Newborn Physical Assessment (Focus on Fontanelle)* worksheets prior to or at the start of the class.
2. Have the *Introduction to Newborn Physical Assessment (Focus on Fontanelle) Instructor Resource* available for reference.
3. Have participants read through the information and complete the worksheet.
4. Have participants pair up upon completion and share answers.

Introduction to Newborn Physical Assessment

(Focus on Fontanelle) Instructor Resource

Match the word with its definition

- | | |
|--|---|
| 1. Anterior fontanelle f | a. Edema, or fluid accumulation over the bones of the skull after birth. Crosses suture lines |
| 2. Posterior fontanelle c | b. 1-2 months |
| 3. Typical age at closure of anterior fontanelle g | c. Opening between parietal and occipital bones at the back of the skull |
| 4. Typical age at closure of posterior fontanelle b | d. Overlapping of the bony plates of the skull that is normal after birth |
| 5. Caput succedaneum a | e. A collection of blood between a bone of the skull and its membrane after birth. Does not cross suture lines. |
| 6. Cephalhematoma e | f. Opening between frontal and parietal bones at the front of the skull |
| 7. Overriding sutures or ridge d | g. 9-18 months |

Name: _____ Class: _____

Introduction to Newborn Physical Assessment (Focus on Fontanelle)

Match the word with its definition

- | | |
|---|---|
| 1. Anterior fontanelle _____ | a. Edema, or fluid accumulation over the bones of the skull after birth. Crosses suture lines |
| 2. Posterior fontanelle _____ | b. 1-2 months |
| 3. Typical age at closure of anterior fontanelle _____ | c. Opening between parietal and occipital bones at the back of the skull |
| 4. Typical age at closure of posterior fontanelle _____ | d. Overlapping of the bony plates of the skull that is normal after birth |
| 5. Caput succedaneum _____ | e. A collection of blood between a bone of the skull and its membrane after birth. Does not cross suture lines. |
| 6. Cephalhematoma _____ | f. Opening between frontal and parietal bones at the front of the skull |
| 7. Overriding sutures or ridge _____ | g. 9-18 months |

Lesson One – Introduction to Newborn Physical Assessment

LEARN: Introduction to Newborn Physical Assessment Slide Presentation

20 minutes

Purpose:

Participants will receive a thorough introduction to assessment of the newborn, fontanelle and normal variations after birth, and care of the umbilical cord.

Materials:

- *Introduction to Newborn Physical Assessment* slide presentation
- Stethoscope
- Infant Vital Signs Trainer
- Tape measure
- Newborn scale and stadiometer

Facilitation Steps:

Slide 1: Intro

Slide 2: There are many measurements and assessments for newborns.

They serve to assess the immediate health of the newborn and recognize the need for intervention or specialty care.

Abnormalities may be recognized immediately or not until a closer assessment is done.

And even in the absence of abnormalities, initial assessments are useful as they can be used as a baseline for future measurements and help track the infant's growth and development.

Slide 3:

APGAR is an initial assessment of infants immediately after birth. This isn't something you will usually need to do unless you are working in a birthing department, but it is important to understand how the scores are calculated and what their significance is. APGARs are an important part of a birth history during an infant's first few days and weeks of life.

The first assessment is at one minute and reflects how well the infant tolerated the birthing process.

The second assessment is at 5 minutes and reflects how well the infant is adjusting to life outside of the womb.

APGAR is scored 0-10, with anything greater than 7 considered a reassuring score. Less than 7 but greater than 4 is acute and requires attention and possible intervention. Anything less than 4 is life threatening.

Slide 4:

APGAR is made up of 5 criteria, with a possible 2 points for each category.

Appearance is skin color and can either be recorded as blue or pale (0), pink except for extremities (1), and pink all over (2). This reflects how well the infant is oxygenating during birth and after.

Pulse can be absent (0) which would require resuscitation, <100 bpm (1), and >100 bpm (2). Pulse should be assessed via apical impulse with a stethoscope (which is covered further in a previous lesson).

Grimace (or reflex irritability) is how an infant responds to stimuli such as a heel flick or vigorous drying with a towel. A nonresponsive infant gets a score of (0), some grimace or flexion of extremities gets a score of (1), and actively pulling away, coughing, sneezing, or crying gets a (2).

Activity (or muscle tone) is assessed as flaccid (0), arm and leg flexion (1), or active motion (2).

And respiration is assessed as absent (0) which requires resuscitation, slow and irregular breathing or grunting (1), or vigorous cry (2).

Each category is given a score and added together for a total of 0-10.

Slide 5:

Newborns are weighed naked for most accurate weight.

Introduction to Newborn Physical Assessment

Weight should be recorded in grams or kg depending on your facility.

Can be converted to lbs. for parents by multiplying by 2.2.

Some weight loss in the first 2 weeks of life is normal and expected as infants adjust to life outside the womb and no longer have a constant supply of nutrients and fluids from the placenta.

Can lose up to 10% of their birth weight (this is part of why an accurate birth weight is so important!)

Should be back up to birth weight by 2 weeks.

Slide 6:

Average birth weight is around 7.5 lbs., however there is a wide range for normal.

Infant weight should be graphed on a growth chart, “normal” is between 5th-90th percentile

Growth charts compare the infant to themselves, should stay around the same percentile range, a nice “curve” as they grow without steep drops or sharp inclines

Not all growth charts are created equally!

CDC Growth charts are created with average numbers of hundreds of infants in the USA during the 60s and 70s when most infants were formula fed.

WHO growth charts are based on world values, where a larger majority of infants are breastfed.

The two DO grow at different rates during the first year of life and the distinction is important to accurately assess growth.

Infants born before 38 weeks may be graphed at their “corrected age” (how many weeks would they be had they been born at term) or on a preemie growth chart.

Slide 7:

Large for Gestational Age infants weigh more than expected for their gestational age. These are infants at >90th percentile for weight.

Causes include maternal obesity, gestational diabetes, genetic syndromes

Small for Gestational Age infants weigh less than expected for their gestational age. These infants are <5th percentile for weight.

Causes of SGA include maternal factors such as autoimmune disease and smoking, problems with the uterus or placenta, and genetic abnormalities in the infant.

Slide 8:

- Procedure for weighing an infant includes zeroing the scale
- Set to grams/kg depending on facility
- Remove blankets and diaper from the infant
- Do not just subtract the weight of a dry diaper, you want these early weights to be ACCURATE
- Place the baby on the scale and record the weight.

Slide 9:

- Measure babies lying down until age 2
- Length measured in inches
- Average newborn is between 18-21 inches
- This can also be graphed on a growth chart

Slide 10:

- Place the infant flat on their back
- Head facing forward with top against the top of stadiometer
- Extend one leg and place the heel flat on the tape measure
- Record the length in inches

Slide 11:

- Average head circumference at birth is about 34.5cm
- The head grows rapidly in the first 4 months
- Accurate baseline is extremely important
- Macrocephaly: Larger than average head circumference or rapidly growing head. Can be normal with family hx of large heads. Can also indicate hydrocephalus (if normal and rapidly expanding, along with other symptoms) or genetic abnormalities
- Microcephaly: Smaller than average head or failure to grow appropriately on the curve. Typically caused by genetic abnormalities

Slide 12:

- Apply a round tape measure to the head
- Position at the most prominent area of the forehead
- And the widest area of the back of the head

Introduction to Newborn Physical Assessment

- Record the measurement in centimeters

Slide 13:

An infant skull is made of 6 separate bones

- Frontal
- 2 parietal
- 2 temporal
- Occipital

The bones move and slide over each other like tectonic plates to facilitate birth and rapid growth in the first few months of life.

The head needs to fit through the birth canal and bones may override.

Also needs to expand as the brain grows, most rapidly during the first 4 months.

Slide 14:

- The bones meet and are loosely held together at suture lines
- Coronal, sagittal, and lambdoid sutures
- May override during birth, usually returns to normal within a few hours/days
- Larger spaces where the sutures and bones meet are called fontanelles
- Anterior and posterior
- Allow for expansion/growth of the head in infancy
- When sutures or fontanelles fuse too soon this creates abnormal head shape or restricted brain growth and requires treatment, sometimes surgery

Slide 15:

Image of fontanelles and sutures

Slide 16:

- Anterior fontanelle
- Largest, about 2-3 cm
- Closes between 9-18 months
- Posterior
- Smaller, only about 1cm
- Closes between 1-2 months
- Fontanelles should be flat, may be pulsatile
- Should not be sunken (dehydrated) or bulging (increased ICP)

Slide 17:

- Cephalhematoma

- Blood pools in the space between the periosteum and bones of the skull
- (Periosteum in the membrane covering bone)
- Due to trauma during birth
- Often forceps or vacuum but can also occur with rapid births
- Does not cross suture lines (because it is contained within the periosteum)
- Can take 4-6 weeks to reabsorb, may cause increase in bilirubin/jaundice while resolving
- This is due to the breakdown of blood

Slide 18:

- Caput Succedaneum
- Edema/fluid accumulation under the scalp
- Pressure of the head on the uterus or vaginal wall during birth
- Crosses suture lines
- Usually resolves within a few days
- Not problematic unless persisting for weeks

Slide 19:

- The umbilical cord connects fetus to placenta and supplies the fetus with oxygen and nutrients during pregnancy
- 2 umbilical arteries and 1 umbilical vein
- Rapidly shrinks down after birth and falls off usually within 2 weeks
- Can fall off within a few days or hang on for 3 weeks. As long as the site is healthy, the timing doesn't really matter!

Slide 20:

- It is dying flesh! May smell faintly foul, leak/ooze clear/cloudy/yellow/brown fluid
- This does not indicate infection, this is normal!
- Often very concerning to parents
- Takes 1-3 days after cord falls off to dry out completely
- The health of the skin AROUND the cord is what should be assessed
- Should be pink, same temp as surrounding skin, smooth/intact
- Warning signs include redness, heat, break in the skin

Slide 21:

- Current recommendation is to keep the area clean and dry

Introduction to Newborn Physical Assessment

- Diaper should be folded underneath the cord
- Can wipe away drainage or clean skin with a warm washcloth
 - Sponge baths only until umbilicus is dry
- Nothing else!!
 - Used to recommend alcohol or triple dye
 - Grandmothers will often still recommend this outdated info!

Slide 22:

- Granuloma
 - When cord has fallen off and area underneath does not dry out after 1-3 days
 - Wet, pink, oozing clear fluid
 - Needs to be treated – cauterized with silver nitrate
- Umbilical hernia
 - Weakness in the abdominal wall that allows intestines to protrude the skin
 - Soft, bulging mass under the skin
 - Can be pushed back in
 - Often resolves on its own, if still present at age 3, requires surgical repair

Lesson One – Introduction to Newborn Physical Assessment

REVIEW: Practice and Assessment of Assessing the Newborn

30 minutes

Purpose:

Participants will practice assessing newborns on Trainers, models, or trainers and then complete a quiz to assess mastery.

Materials:

- *Introduction to Newborn Physical Assessment Check-Off Instructor Resource*
- *Introduction to Newborn Physical Assessment Check-Off*
- Infant Vital Signs Trainer
- Stethoscope
- Tape measure
- Newborn scale and stadiometer
- *Introduction to Newborn Physical Assessment Quiz*
- *Introduction to Newborn Physical Assessment Quiz – Answer Key*

Facilitation Steps:

1. Give students the following handout: *Introduction to Newborn Physical Assessment Check-Off* page.
2. Access the *Introduction to Newborn Physical Assessment Check-Off Instructor Resource* page. Following the steps on the check-off page, demonstrate conducting a newborn physical assessment on the Infant Vital Signs Trainer. Refer to the Quick Start Guide for more information on use.
3. Students should properly document this on their *Introduction to Newborn Physical Assessment Check-Off*.
4. Hand out the *Introduction to Newborn Physical Assessment Test* to participants. Give them a couple of minutes to complete it.
5. Have participants self-check or peer check the answers as you share them from the *Introduction to Newborn Physical Assessment Test – Answer Key*.

Introduction to Newborn Physical Assessment Check-Off Instructor Resource

PART ONE: Demonstrate how to use the training tool to assess a newborn using the following steps:

1.	Gather appropriate equipment	
1.	Knock, enter room and provide for privacy	
2.	Identify yourself with name and title (student nurse, medical assistant, nurse aide, etc.)	
3.	Wash your hands with sanitizer or soap/water	
4.	Identify patient by asking name and date of birth; state that you would verify this information with a medical record	
5.	Explain the procedure to the caregivers and ask if they have any questions	
6.	Calculate an APGAR score by assigning a 0-2 score to the following steps: *APGARs are only calculated on newborns in the first few minutes of life	
a.	Observe the infant's skin color as either pale/blue, pink with blue extremities, or pink	
b.	Place your stethoscope over the apical impulse and count a HR for 1 minute	
c.	Stimulate the infant with a heel flick or by rubbing the back and observe for an absent response, some mild grimace, or full response of pulling away/sneezing/coughing/crying	
d.	Observe the infant for muscle tone and note it as flaccid, some movement of arms and legs, or active general movement	
e.	Observe the infants respiratory rate and pattern and note it to be either absent/apneic, slow and irregular or grunting, or a vigorous cry	
7.	Gather a weight by first setting the scale to grams and zero it	
8.	Remove any blankets or diapers from the infant	
9.	Place the infant on the scale and remove your hand from the infant	
10.	Record the weight in grams	
11.	Place the infant supine on the stadiometer and make sure the top of the head is level with the top of the stadiometer	
12.	Place one hand on the infant's abdomen to hold them still and extend one of the infant's legs with the other hand, resting the heel flat on the measuring tape	
13.	Record the length in inches	
14.	Measure a head circumference by placing a looped tape measure around the infant's head	
15.	Position so the tape measure so it covers the widest possible circumference, from the most prominent part of the forehead to the widest part at the back	

Introduction to Newborn Physical Assessment

16.	Record the measurement in centimeters	
17.	Observe the infant's fontanelles by looking at the head from the top	
18.	Note where the sutures and fontanelle should be, you can lightly palpate if needed	
19.	Note any overriding or any edema/fluid and if it crosses suture lines	
20.	Observe the infant's umbilical cord	
21.	Make note of any granuloma, drainage, abnormal odor, or redness or swelling to the abdomen around the cord	
22.	Ask the caregivers if they have any questions	
23.	Wash your hand with sanitizer or soap/water	
24.	Document the assessment findings below: Date: Time: APGAR if needed: Weight: Length: Head circumference: Fontanelle: Umbilicus:	
	Score:	

Optional:

PART TWO: Have participants practice on the Trainer until they are comfortable with the procedure. You may give the patient a name and birth history and current presentation.

PART THREE: Ask the participants to explain recommended cord care to you as if you are a new parent. You may ask for guidance on typical care or ask specific questions such as "My baby's cord is oozing, smells bad, is falling off, etc."

Name: _____ Class: _____

Introduction to Newborn Physical Assessment Check-Off

1.	Gather appropriate equipment	
2.	Knock, enter room and provide for privacy	
3.	Identify yourself with name and title (student nurse, medical assistant, nurse aide, etc.)	
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Introduction to Newborn Physical Assessment

18.	Observe the infant's fontanelles by looking at the head from the top	
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23.	Ask the caregivers if they have any questions	
24.	Wash your hand with sanitizer or soap/water	
25.	Document the assessment findings below: Date: Time: APGAR if needed: Weight: Length: Head circumference: Fontanelle: Umbilicus:	
	Score:	

Introduction to Newborn Physical Assessment

Use the Trainer to perform a newborn assessment. Your instructor will give you patient information.

Patient Initials: _____

Date: _____

Time: _____

APGAR: _____

Weight: _____

Length: _____

Head circumference: _____

Fontanelle: _____

Umbilicus: _____

Patient Initials: _____

Date: _____

Time: _____

APGAR: _____

Weight: _____

Length: _____

Head circumference: _____

Fontanelle: _____

Umbilicus: _____

Patient Initials: _____

Date: _____

Time: _____

APGAR: _____

Weight: _____

Length: _____

Head circumference: _____

Fontanelle: _____

Umbilicus: _____

Name: _____ Class: _____

Introduction to Newborn Physical Assessment Quiz

Select the best answer to the following multiple-choice questions:

1. You are observing the head of a 1-day old infant when you notice a lump the size of a golf ball on the right side of the baby's head. It is soft and boggy to the touch. It is located over the parietal lobe and does not cross suture lines. Based on this assessment, you suspect what?
 - a. Cephalhematoma
 - b. Caput Succedaneum
 - c. Anterior fontanelle
 - d. Sagittal suture
2. The parents of a 5-day old infant call the pediatrician's office with concerns that their baby's umbilical cord is starting to separate and is leaking small amounts of clear/brownish drainage with a faintly foul odor. Based on this parent report, you know that this is likely what?
 - a. Infection
 - b. Granuloma
 - c. A normal finding
 - d. Umbilical hernia
3. For the most accurate weight on a newborn, how should you proceed after zeroing the scale?
 - a. Weigh a clean diaper so you can subtract this number from the weight of the baby
 - b. Remove the infant's diaper and weigh them naked
 - c. Weight the infant and then remove their diaper and weigh it, subtracting that weight
 - d. Weigh the mother holding the infant and then without the infant, subtracting the second weight
4. You are assessing a newborn who is 5 minutes old. The infant is pink except for her hands and feet, crying vigorously, with a heart rate of 164. You flick her feet, and she pulls away and coughs. She is moving actively on her mother's chest. What APGAR score would you give this infant?
 - a. 7
 - b. 8
 - c. 9
 - d. 10
5. Which unit of measurement do you use when recording head circumference?
 - a. Inches
 - b. Millimeters
 - c. Centimeters
 - d. Grams

Introduction to Physical Assessment Quiz – Answer Key

Select the best answer to the following multiple-choice questions:

1. You are observing the head of a 1-day old infant when you notice a lump the size of a golf ball on the right side of the baby's head. It is soft and boggy to the touch. It is located over the parietal lobe and does not cross suture lines. Based on this assessment, you suspect what?
a. Cephalhematoma
b. Caput Succedaneum
c. Anterior fontanelle
d. Sagittal suture
2. The parents of a 5-day old infant call the pediatrician's office with concerns that their baby's umbilical cord is starting to separate and is leaking small amounts of clear/brownish drainage with a faintly foul odor. Based on this parent report, you know that this is likely what?
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Sources

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