PHYSIOLOGIC MONITORING/HYGIENE/COMFORT - NEWBORN/PEDIATRIC

PURPOSE: To outline the management of newborns (less than 1 month) and children (17 years or less) in relation to physiologic monitoring/hygiene/comfort. (Except ICUs).

ASSESSMENT:

1. Assess all body systems including pain score (Newborn assessment also includes umbilical cord site and maternal-infant bonding):
   - Upon admission
   - Within one hour of assuming care/record findings within 2 hours
   - Reassess every 4hours (Pediatric Services) and more often as patient condition/ care plan indicates
   - See table for Newborns

2. Monitor and record vital signs (VS) a minimum of every 4 hours Newborns-see table.

Newborn Vital Sign Assessment and Reassessment		
	Normal Newborn	***At Risk Newborn**
Assessment	Baseline at 1 hour of age	Baseline at 1 hour of age
Reassessment	every 8 hours	every 4 hours
Vital Signs	Immediately after birth, then every 30 minutes for first 2 hours of birth Then every 8 hours	Immediately after birth, then every 30 minutes for first 2 hours of birth Then-every 4 hours
*Newborn of diabetic mother, small for gestational age (SGA), large for gestational age (LGA), phototherapy, drug withdrawal		

3. Weigh every 24 hours.
4. Assess skin condition a minimum of every 8 hours for normal newborn; every 4 hours for at risk newborn and pediatric.
5. Assess diaper wetness a minimum of every 4 hours (newborn nursery), every 2 hours (Pediatric acute care unit), and prn.
6. Assess urine output (UOP) as follows (Pediatric Services):
   - Weigh all diapers
   - Measure UOP every void
   - Measure UOP via indwelling bladder catheter every 1 hour
7. Assess amount, color, and consistency of stool.
8. Monitor lab values as drawn.

HYGIENE:

9. Bathe patient a minimum of every 24 hours.
   Bathe newborn with gentle soap such as castile soap within the first 24 hours of life after the transition period only after body temperature has been greater than 36.7 ° Celsius (C) /98° Fahrenheit (F) for more than 30 minutes
10. Assess umbilical cord a minimum of every 8 hours.
11. Provide oral care a minimum of every 8 hours if patient if unable to perform own oral care.
12. Provide foreskin/perineal/indwelling bladder catheter care a minimum of every 12 hours.

SAFETY:

13. Do not take rectal temperature (Newborn Services).
14. Verify newborn identification band in Newborn Services with delivery record and

mother's identification band for the following on admission and upon separation or return to mother:
- Mother's last and first name
- MRNs of mother and newborn
- Date and time of delivery
- Tag number and sex of newborn

15. Check all equipment settings/parameters/alarms within 1 hour of assuming care and as adjust as indicated.
    - Alarms must be audible at all times and are never to be set on continuous mute or turned off
16. Monitors with non-functioning alarms must be taken out of service immediately and patient must be immediately placed on a monitor with functioning alarms.
    - All monitors with non-functioning alarms must be reported immediately to Biomedical/Clinical Engineering
17. Keep side rails up and call light within patient's reach at all times as appropriate based on age and developmental parameters.
18. Evaluate the need for medical immobilization for patients whose mental status/ developmental level precludes compliance.
19. Instruct nursing attendant to report abnormal vital signs to RN per electronic health record indication.
20. Leave crib side rails up at all times unless an adult is at the bedside.
    - Regular (low top) crib: Maintain crib rails up.
      These cribs are used if the child does not walk or pull self up to a standing position. They are usually used for infants, however also used for toddlers if they are intubated, sedated or not very large.
    - High top crib: Maintain crib rails up and top down.
      Use high top crib if the child is pulling self up to a standing position or would be in danger of falling out of a regular crib due to size. They are usually used for toddlers up to 4 years of age depending on size and condition.

REPORTABLE CONDITIONS:

21. Report significant changes to provider:
    - Absence of urine or stool within 24 hours of birth
    - Abnormal assessment findings
      Abnormal VS from baseline or age specific parameters per provider's order.

PATIENT/FAMILY TEACHING:

22. Instruct on the following as indicated:
    - Bathing
    - Skin/cord care
    - Diapering/dressing
    - Positioning/use of bulb suction
    - Use of vehicle restraints (car seat/seat belt)
    - The purpose of pink badge (worn by postpartum and pediatric staff) which allows these staff members to remove newborn/infant from the parent/caregiver
    - Feeding/meal times
    - Equipment and procedures
    - Safety measures (e.g. fall precautions, choking risk, infant positioning)
    - Discharge instructions

ADDITIONAL STANDARDS:

23. Refer to following as indicated:
    - Breast Feeding/Bottle Feeding Management
    - Pressure Ulcer Prevention and Management

DOCUMENTATION:

24. Document in accordance with documentation standards.

Initial date approved: 12/00	Reviewed and approved by:	Revision Date: 08/03, 03/05, 3/15, 6/2020