### Name of Procedure/Guidelines/Protocol:

Procedure for measuring respiratory rate in a neonate.

### Purpose of Procedure/Guidelines/Protocol:

To provide guidance on measurement of respiratory rate for a neonate.

### Replaces:

New

### Applicable to which staff:

Neonatal and SCBU nursing staff

### Name & title of author:

Una Toland Lead Nurse Neonatal Services and ANNP team SH&SCT

### Equality Screened by:

N/A

### Proposals for dissemination:

Una Toland via team managers to nursing staff

### Proposals for implementation:

With immediate effect

### Training Implications:

To be included in induction training of all new nursing staff

### Date Procedure/Guideline/Protocol submitted to Procedures Committee:

31-03-13

### Outcome:

Approved

### Date of CYP SMT approval Comments:

### Date of approval by Trust SMT (if required):

### Date approved by HSCB (Social Work only):

### Date for further review (3 year default):

### Date added to repository:

### Date added to Intranet:

State where to be placed on Intranet: SOUTHERN HEALTH & SOCIAL CARE TRUST
PROCEDURE FOR MEASUREMENT OF RESPIRATORY RATE

Statement: The infant requires measurement of respiratory rate. (Note: one respiration consists of one breath in and out and the pause in between). The normal respiratory rate for an infant is approximately 30-60 breaths per minute (NICE 2006). Often at rest we can see an infant with a respiratory rate of 20 and higher when crying.

Equipment:
Watch with a second hand

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>Decontaminate hands as per local policy adhering to 7 step technique and 5 moments.</td>
<td>To reduce transmission of infection</td>
</tr>
<tr>
<td>Avoid taking a reading if the infant is crying. Alleviate discomfort if the infant is restless.</td>
<td>To obtain an accurate reading</td>
</tr>
<tr>
<td>Count the number of breaths using a watch with a second hand for one whole minute. You can do this via observation or touch. You should remove access clothing to allow for observation of chest movement.</td>
<td>To obtain an accurate respiratory count</td>
</tr>
<tr>
<td>By observing we are looking for a baby whose colour is normal for their ethnicity, alert with good muscle tone and normal symmetrical chest movements with no signs of respiratory distress. Note if any noises are transmitted by the infant during respiration. If respirations are difficult to observe visually, place your warm hand lightly across the baby’s chest and count each rising movement. <strong>Recession</strong>: a term used to describe in-drawing of the chest wall below (subcostal) and between (intercostal) the ribs. <strong>Grunting</strong>: this is a moaning noise heard at the end of each expiration. It represents air being exhaled against a partially closed epiglottis in an effort to increase the pressure in the terminal airways so that they can be kept open. <strong>Nasal Flaring</strong>: Babies are obligatory nose breathers and mild flaring of the nostrils may be</td>
<td>To establish if there any breathing difficulties for the infant so that prompt and appropriate action can be taken</td>
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</table>
them clearing foetal lung fluid. However, if seen other than initially after birth, it may be a sign of respiratory distress. **Tachypnoea**: respiratory rate above 60 breaths per minute.

| Leave the infant comfortable and decontaminate your hands after the procedure | To reduce transmission of infection |
| Record the readings on the infant’s chart and inform the nurse in charge if findings deviate from the normal range for this infant |

March 2013

References:


Examination of the New-born. A Practical Guide. Helen Baston and Heather Durward
