A Mother and Her Newborn, A Journey Through Pregnancy

Clay Kremer and Katie Zollinger

NURS 30010 Parent Newborn Nursing

# Professor Lazaroff

August 3, 2010

 A Mother and Her Newborn, A Journey ThroughPregnancy

 During the limited hours with T.S., a therapeutic, trusting relationship was developed between the student nurses and the patient. This new, eighteen year-old, first day postpartum mother was both a para of one and a gravida of also one. Gravida refers to “a pregnant woman” while para is defined as “a woman who has had children who have reached the age of viability” (Davidson, London, & Ladewig, 2008, p. 1215, 1220).

Therefore, she had been pregnant once and had also had one child, her current newborn, who has reached the age of viability. This patient was chosen to be analyzed in a case study evaluation due to the multiple areas her student nurses believed she could modify to help improve both her own health and the health of her newborn, L.S. The purpose of the following paper is to analyze her in her unique situation and the individualized care needed to help L.S. and her baby reach this goal that she voiced was so vital to her but acknowledged she may need help.

 **Demographics**

 L.S. grew up as an only child where she was home-schooled in downtown Canton, Ohio. She recently graduated and received her high school diploma. Her mother believed that this would help to “keep her out of trouble” while T.S. begged to differ. She was unemployed and her face sheet in her chart stated that she had an occupation of a “child.” T.S. had never been employed and planned to live off her boyfriend’s support during the child’s first years of life. She was using Buckeye Insurance to help fund her stay. Her boyfriend, C.A., was a carpenter and made approximately forty-thousand dollars a year and lived also in downtown Canton, Ohio. She informed us also that in the future she believes that she wants to become a cake decorator due to the immense joy she experiences when partaking in both baking and decorating of cakes.

  **OB/Antenatal history/Relevant pathophysiology**

T.S. begun her menses when she was eleven years old. Menarche is defined as “the beginning of both the menstrual and reproductive function in the female” (Davidson, et al., 2008, p. 1218). She stated that she became sexually active when she was fourteen years old and estimated that she has had approximately twenty-five sexual partners. T.S. claimed that she never has contracted a sexually transmitted infection and her records have no evidence of one. T.S. also admitted that she had never used a contraceptive before and was interested in using one in the future now.

She realized that she may be pregnant when she was sexually active with her current boyfriend and was late for her period by three weeks. Her last menstrual period was September fifth of two-thousand and nine. This is defined as the “last normal menstrual period experienced by the woman before pregnancy and it used to sometimes calculate the infant’s gestational age” (Davidson, et al., 2008, p. 1217). From there, her estimated date of birth (EDB) or “due date” for delivery of the baby was calculated to be July eleventh of two-thousand and ten (Davidson, et al., 2008, p. 1217).

 **Assessment**

 The assessment of the mother was done first since the baby had just fallen asleep. Her vital signs were an oral temperature of ninety-eight degrees Fahrenheit which translates to 36.2 degrees Celsius. T.S.’s pulse was regular, strong and measured at seventy-two beats per minute at the apical site. Her pulses of extremities were plus two, bounding and strong. T.S.’s respirations were unlabored, deep, and measured at sixteen respirations per minute. T.S. appeared to be relaxed and calm resting in bed. She denied any shortness of breath or discomfort. Her pulse oximetry read at one-hundred percent on room air.

 She has no significant medical or surgical history besides seasonal allergies. T.S. did also have allergies to penicillin and codeine and when they are taken she suffers from hives. She noted that her maternal grandmother did have diabetes and hypertension, but T.S. had no other outstanding family history.

 Her breasts were smooth with even pigmentation. She explained that they were larger than before she was pregnant. Her nipples were also noticed to be supple and intact but sore and reddened with a few small cracks. She complained of nipple pain and stated, “I don’t think I can keep breastfeeding if it is going to be this painful.”

 T.S.’s lungs sounds were clear in all lobes bilaterally. She admitted to smoking half of a pack a day for four years including the time that she was pregnant. She also stated that she plans on continuing to smoke when she is breastfeeding. T.S. informed the student nurses that she has never drank alcohol before. Her abdomen was soft with rectus muscles intact and voiced no pain or tenderness on palpation. Her fundus was firm and midline at the umbilicus. According to Davidson, et al. (2008), the fundus is defined as the “upper portion of the uterus between the fallopian tubes” (p. 1214).

 She had a scant amount of lochia rubra formed on her pad measuring less than an inch in one hour. It smelled earthy and not foul. Lochia is the “maternal discharge of blood, mucus, and tissue from the uterus that may last several weeks after birth” while lochia rubra is “red, blood-tinged vaginal discharge that follows birth and lasts two to four days” (Davidson, et al. 2008, p. 1218).

 Her perineum showed slight edema and bruising with no evidence of hemorrhoids. She did complain of being sore “down-there” and was wondering if there was anything she could do to alleviate the pain. T.S. also denied any costovertebral angle tenderness. She ambulated throughout the room without any pain and had her legs were absent of erythema and edema.

 T.S.’s elimination status was within normal limits considering it was only her first day posptpartum. She was passing flatulence but stated, “I am afraid to have a bowel movement because I already hurt so bad on my bottom.” T.S.’s last bowel movement was the day prior. Her bladder was not palpable and she was voiding clear, straw colored urine every four hours without difficulty.

 The mother was content and eager to learn what was being taught to her. She enjoyed holding her baby, rocking, and cooing to her newborn. She made eye contact with baby often and talked to it quietly. T.S. told us how happy she was with her beautiful baby and that she was healthy but she admitted she often felt sad and cried often. She stated, “I feel like I can’t control my emotions at all. This should be one of the happiest times of my life but I feel sad and cry a lot.” Her floor nurse was notified of this comment.

 According to Erik Erikson, T.S. is in the appropriate developmental stage of identity versus role confusion. During this stage she must develop a sense of self in the adult world where she has roles that she personally feels as important and beneficial for her individual life (Ball, Bindler, & Cowen, 2010, p. 134). As of right now she describes her role as a mother and wants to decorate cakes when she gets older.

 T.S.’s current postpartum weight was one-hundred and forty-seven pounds while her pre-pregnant weight was one-hundred and seven pounds. With a height of five feet and four inches, her current body mass index, BMI, an “index for estimating obesity,” was 25.2 indicating that she was slightly overweight. (Davis’ Drug Guide, 2008). T.S. appeared slightly overweight with a distended stomach but ensured the student nurses she planned to lose all forty pounds she gained in pregnancy. At the time she did not use stool softeners or laxatives and had no diet restrictions.

 T.S. plans to do all the cooking and shopping for the household, and they were not planning to be on food stamps or WIC. T.S. did not suffer from any diseases related to nutrition. She has never participated in an exercise program and stated that she “plans to breastfeed to lose the weight.” T.S. also stated that she wished she knew how to eat better because she know what she eats is what the “baby eats.”

 Her twenty-four recall is as follows. For breakfast, she consumed three pancakes with one tablespoon of butter with regular maple syrup and about one-hundred and twenty milliliters of orange juice. For a mid-morning snack, she had one stick of beef jerky. T.S. informed the student nurses she usually has a midmorning snack and an afternoon snack. For lunch, she had a cheeseburger from a fast food restaurant, a small fry, and one-hundred and twenty milliliters of soda pop. A snack for this day was a medium apple. Dinner consisted of one-cup of cooked noodles with one-quarter cup of spaghetti dressing and a piece of garlic bread. T.S. drank one-hundred and twenty milliters of two percent milk with this dinner. She stated she usually drinks about five of her one-hundred and twenty milliliter bottles daily making her total daily fluid intake approximately nine-hundred and sixty milliliters daily.

 To deliver her baby, T.S. was a bit nervous. She did go to most of the doctor visits, but she admitted she did not attend any prenatal classes. She was induced on the seventh of July two-thousand and ten. She was given a Pitocin induction of twenty units in one-thousand milliliters of lactated ringer’s intravenously and then one milliunit every fifteen minutes. T.S. was in labor for approximately ten hours.

The physician progress notes stated that she was in the latent phase of the first stage for approximately four and a half hours, the active phase of the first stage for about two hours, and the transition stage of the first stage for about three hours. The baby was not in a breech position when born but a vertex position. She did lack some prenatal care additional to the classes that will be described later.

The latent phase of the first stage is marked by the onset of regular, mild contractions with a duration of twenty to forty seconds every three to thirty minutes and the cervix dilation of zero to three centimeters (Davidson, et al. 2008, p. 588). Duration is defined as the “time length of each contraction which is measured by the beginning of the increment to the completion of the decrement (Davidson, et al. 2008, p. 1212). Cervix dilation is the “process in which the cervical os and the cervical canal widen less than one centimeter to approximately one centimeter, allowing birth of the fetus” (Davidson, et al. 2008, p. 1210).

 The active phase of the first stage is defined as cervical dilation of four to seven centimeters and moderate to strong contractions with a frequency of two to five minutes and duration of forty to sixty seconds (Davidson, et al. 2008, p. 588). Frequency is the “time between the beginning of one contraction and the beginning of the next contraction” (Davidson, et al. 2008, p. 1215). The active phase is where the mother received her epidural for pain management. An epidural is defined as a “regional anesthesia effective through the first and second stages of labor” (Davidson, et al. 2008, p. 1213). The epidural was inserted in the third and fourth lumbar interspace. The site was prepped with betadine and Ropivicaine 0.2% at two micrograms a milliliter ran at ten milliliters an hour to treat the patient’s pain. She stated that it helped immensely.

Following the active phase was the transition phase were the cervical dilation is reach eight to ten centimeters and strong contractions occur every ninety seconds to two minutes with a duration of sixty to ninety seconds (Davidson, et al. 2008, p. 588). She then was in the second and third stage for a combined time of thirty minutes. The second stage is begins with “complete cervical dilation and ends with the birth of the infant” (Davidson, et al. 2008, p. 590).

During the second stage of labor, T.S.’s infant displays signs of fetal bradycardia believed to be from hyperstimulation. This is defined as a fetal heart rate of less than one-hundred and twenty beats per minute during a ten-minute period of monitoring (Davidson, et al. 2008, p. 629). First the mother was repositioned and ten liters per minute oxygen nasal cannula was applied. When this was ineffective, the fetal bradycardia was treated by terbutaline 0.25 milligrams subcutaneously as a one-time dose. This was effective and the fetal heart beat returned to a baseline rate of one-hundred and thirty beats per minute. The baseline rate is “the average fetal heart rate during a ten minute period, rounded to five beats per minute (Davidson, et al. 2008, p. 627). The third stage begins with childbirth and ends with the placenta delivery and the final fourth stage of labor is the time following delivery where the woman’s “body readjusts physiologically” (Davidson, et al. 2008, p. 592-593). It was predicted she lost approximately one hundred milliliters of blood during childbirth.

 The newborn of the teenager was L.S., a thirty-two hour old female baby who weighed six pounds and ounces 11.7 ounces (3054 grams) with a height of 45.7 centimeters. The mother kept a watchful eye on her child as it was assessed and the student nurses explained what they were doing to ease her. The baby was breastfeeding well except for L.S. was latching on to the nipple with difficulty when feeding. Smoking is a risk factor for L.S. Her mother smoking one half of a pack of cigarettes a day is a risk factor for this newborn. The baby’s gestational age at birth was thirty-nine weeks and two days and received both Apgar scores of eight and ten, one and five minutes after birth. The “physical condition and the need to resuscitate the newborn” are both evaluated by the Apgar scale (Davidson, et al. 2008, p. 670).

L.S.’s blood pressure at birth was 60/42. Her axillary temperature at time of assessment was thirty-seven degrees Celsius while a strong, regular apical pulse rate was measured at one-hundred and forty beats per minute and respirations were primarily diagrammatic with the rising and falling of the stomach measuring at forty-four respirations a minute. Respirations appeared to be unlabored and easy for the newborn.

The cry of L.S. was strong and lusty. Her body was in a flexed position with her hands tightly clenched and her chin resting on her chest. The infant’s skin color was pink with capillary refill less than two seconds and skin turgor elastic and returning to shape after pinching. The head circumference was 32.3 centimeters which was two centimeters larger than the chest circumference of 30.3 centimeters. Breath sounds were auscultated and determined to be clear in bilateral lobes. The distance between the nipples was five centimeters. The head of the newborn composed of one fourth of the body size. No molding was present on the baby’s head. The anterior fontanelle was approximately three centimeters long and two centimeters wide shaped as a diamond. The posterior fontanelle was measured at approximately one centimeter. Both fontanelles were not bulging or overlapping. A slight pulsation could be palpated at each fontanelle and the areas were also soft to palpation. A fontanelle is defined as an “unossified space, or soft spot, consisting of a strong band of connective tissue lying between the cranial bones of the skull” (Davidson, et al. 2008, p. 1215).

L.S.’s hair on her head was smooth and fine and covered her scalp high over her eyebrows. She had symmetrical movement of all her facial features. Her eyes and ears were at the same level and lips were equal on both sides of the midline. The eyes of the newborn were bright and clear. She tended to focus on faces and brightly colored geometric shapes while awake.

Her nose was midline and she had patent nares. She had a strong suck reflex that what demonstrated while she was breastfeeding. Her proportional tongue was pink in color, smooth in texture, and not coated. It was free moving in all directions and midline.

L.S. passed her hearing test and responding to sounds in the room. Her ears were without cysts, lesions, or nodules. During the assessment of her neck, it was noted that her clavicles were straight and intact. Her neck was short and straight with skin fold creases.

The abdomen was soft and slightly distended. Bowel sounds were present in all four quadrants. The baby had one wet diaper and three diapers with dark green-black, tarry stool in them for the day by 1800. The clamp for the umbilical cord was still attached and secure. The umbilical cord was white and gelatinous.

Next, the genitalia of L.S. were assessed. Her labia majora covered the covered minora. The urinary meatus and vaginal orifice were both visible on inspection. The buttocks was symmetrical and anus was patent. The infant passed her first meconium stool when she was twelve hours old. The leg creases were also symmetrical. The baby’s extremities were noted all as equal with normal range of motion present. There were no signs of hip instability and the spine was c-shaped with no signs of a spinal deformity such as dimpling.

The baby also reacted appropriately to having her reflexes tested. When L.S.’s cheek was stroked she turned in the direction of the stroking and opened her mouth. Then she began sucking strongly and rhythmically on the finger. This is defined as a rooting and sucking reflex. The rooting reflex is an “infant’s tendency to turn the head and open its lips to suck when one side of the mouth or cheek is touched followed by the finger then been placed in the mouth and the baby beginning to rhythmically and forcefully suck it” (Davidson, et al. 2008, p. 1223-1224).

 The palmar grasp is defined as the infant taking hold of an adult finger when the palm of the infant is stimulated (Davidson, et al. 2008, p. 858). When a finger was placed in L.S.’s palm and stimulated the palm, she grasped the finger. The foot of the baby was stroked from the heel up to the ball of the foot and over across the foot, and L.S. responded by fanning and extending all her toes. This is known as the Babinski reflex. The Babinski reflex is defined as a “reflex found normally in infants under six months of age in which the great toe dorsiflexes when the sole of the foot is stimulated” (Davidson, et al. 2008, p. 1209).

 The Moro reflex was also tested when there was an accidental loud noise in the room. The Moro reflex is “flexion of the newborn’s thighs and knees accompanied by fingers that fan, then clench, as the arms are simataneously thrown out and then brought together, as though embracing something” (Davidson, et al. 2008, p. 1219). Upon assessment, when that baby was startled by the loud noise, the baby had one symmetric extension and abduction of the arms and legs with the fingers extended. During this, her fingers made the shape of a C. Then her body went back to her normal, relaxed state. The test of L.S.’s reflexes, along with her other assessments, concluded that she had no neurological deficits at this time.

**Laboratory Data**

Prenatal Data

| **Prenatal Tests** | **Norms** | **Patient Results** | **Analysis** |
| --- | --- | --- | --- |
| Type & Rh | A, B, AB, O+ or - | O+ |  |
| Hemoglobin & Hematocrit  | 12-16 g/dL; 38-47% | 11.2 g/dL; 35.6% | Physiologic anemia related to pregnancy |
| VDRL/RPR | Negative  | Negative  |  |
| Rubella | Immune | Immune |  |
| Urine C & S | Negative | Negative |  |
| Sickle Cell | Negative  | Negative |  |
| Chlamydia/Gonorrhea | Negative | Negative |  |
| PAP test | Normal (no cell changes noted) | Abnormal | Presence of candida vaginitis |
| Triple Screen | Negative | n/a |  |
| 1 hr Glucose Tolerance | Less 140 mg/dL | 82 mg/dL |   |
| 3 Three hour Glucose Fasting: 1 h 1 hour 2 hour 3 hour |  | n/an/an/a |  |

 Nurse’s Lab Tests PDA

At T.S.’s thirty-six gestation week check-up, she tested positive for GBS. Group B streptococcus, GBS, is a benign bacterial infection for the mother to contract, but this bacteria can be deadly to her newborn causing risks for the neonate such as prematurity, sepsis, respiratory distress syndrome, and even death (Davidson, et al. 2008, p. 533). Due to this, all pregnant women should be tested between thirty-six to thirty-eight weeks gestation (Davidson, et al. 2008, p. 670). T.S. had an allergy to pencillin, so this was treated my Kefzol two grams intramuscularly administered while she was in labor and another gram administered three hours before birth.

Diagnostic Tests

T.S. was asked in a nonjudgmental way why she did not have any diagnostic tests done while she was pregnant. T.S. responded: “I refused to have an ultrasound or amniocentesis done while I was pregnant. I did not think I needed to have one done at my young age since nothing appeared to be wrong with my pregnancy and I figured it was a waste of time. My mother never did any of that stuff with me.”

Postpartum Lab Data

|  |  |  |  |
| --- | --- | --- | --- |
| **TESTS** | **NORMS** | **PATIENT RESULTS** | **ANALYSIS** |
| Hemoglobin & hematocrit | 12-16 g/dL; 38-47% | 10.3 g/dL; 30.6% | Due to blood loss and physiological anemia, supplemental oral iron held. |

 Nurse’s Lab Tests PDA

Newborn Laboratory Data

|  |  |  |  |
| --- | --- | --- | --- |
| **TESTS** | **NORMS** | **PATIENT RESULTS** | **ANALYSIS** |
| Type & Rh | A, B, AB, O+ or - | O+ |  |
| PKU | Negative | Negative  |  |

 Nurse’s Lab Tests PDA

**Medications, Mechanisms, and Nursing Interventions**

Prenatal Medications

| Medications | Dose, route | Indications for use | Possible side effects | Nursing responsibilities |
| --- | --- | --- | --- | --- |
| One Multivitamin, prenatal by mouth daily | Take one vitamin by mouth daily. | Nutrient supplement during pregnancy and lactation. | Allergic reactions to preservatives, constipation. | Assess patient for nutrient deficiency throughout therapy. |
| Terazol-7 insert one vaginal suppository (80 mg) qhs for 3 days. | One vaginal suppository (80 mg) qhs for 3 days. | Vaginal candidiasis. | Abdominal pain, dysmenorrhea, itching, vulvovaginal burning, fever. | Inspect involved areas of skin and mucous membranes before and frequently during therapy. |
| Flexeril 10 mg PO TID. | 10 mg TID (range 20-40 mg/day divided in 2-4 divided doses; not to exceed 60 mg/day). | Management of acute musculoskeletal conditions associated with muscle spasm. | Dizziness, drowsiness, dry mouth, blurred vision, urinary retention. | Assess patient for pain, muscle stiffness, and range of motion before and periodically throughout therapy. |

 Davis’ Drug Guide Postpartum Medications

| **Medications** | **Dose, route** | **Indications for use** | **Possible side effects** | **Nursing responsibil-ities** |
| --- | --- | --- | --- | --- |
| One Multivitamin, prenatal by mouth daily | Take one vitamin by mouth daily. | Nutrient supplement during pregnancy and lactation. | Allergic reactions to preservatives, constipation. | Assess patient for nutrient deficiency throughout therapy. |
| Motrin 600 mg q6h PRN. | 400-800 mg 3-4 times daily (not to exceed 3600 mg/day) | Mild to moderate pain. Lowering of fever. | Headache, GI bleeding, hepatitis, constipation, dyspepsia, n/v, allergic reactions, stevens-johnson syndrome, exfoliative dermatitis.  | Patients who have asthma, aspirin-induced allergy, and nasal polyps are at increased risk for developing hypersensitivity reactions. Assess for rhinitis, asthma, and urticaria. |
| Darvocet-N 100 two tablets q4h PRN. | 100 mg q4h PRN (not to exceed 600 mg/day as naspylate). 100 mg propoxyphene naspylate=65 mg propoxyphene hydrocodone.  | Mild to moderate pain with or without fever. | Dizziness, weakness, n/v, abdominal pain, disorientation. | Assess BP, P, and R before and periodically during administration. If respiratory rate is less or equal to ten respirations a minute, assess level of sedation. |

Davis’ Drug Guide

 Newborn Medications

| **Medications** | **Dose, route** | **Indications for use** | **Possible side effects** | **Nursing responsibilities** |
| --- | --- | --- | --- | --- |
| Hepatitis C vaccine 10 mcg IM within two months of birth. | 10 mcg IM | Prophylactic treatment against all subtypes of Hepatitis B virus. | Soreness at injection site, erythema, edema, warmth at site. Low grade fever.  | Do not dilute. Shake well. Monitor for adverse reactions. Have epinephrine available to treat possible allergic reactions. |
| 0.5% erythromycin (Ilotycin Opthalmic) 0.5 cm ophthalmic in bilat eyes within one hour of birth. | Narrow ribbon or strand 0.5-1 cm long along conjunctival surface of each eye, starting at inner canthus. | Preventive treatment of gonorrhea in newborns required by law. | Sensitivity reaction, may interfere with ability to focus and may cause edema and inflammation. | Meticulous hand hygiene. Do not irrigate after instillation. May wipe away excess after 1 min.  |
| Vitamin K, Phytonadione 0.5 mg IM within one hour of birth. | 0.5-1 mg IM within one hour of birth. | Prophylaxis and treatment of vitamin K deficiency. | Pain and edema at injection site. Allergic reactions may also occur. | Protect drug from light. Observe for signs of local inflammation. Observe for bleeding (usually occurs on second and third day). |

Davis’ Drug Guide

 The patient refused to have her newborn daughter to be vaccinated with the Hepatitis-B vaccine. She finally admitted that she was scared that her daughter will develop autism from the vaccine. T.S. was reassured that there is no scientific proof or this and given a pamphlet on the vaccine.

Postpartum Treatment and Procedures

|  |  |  |
| --- | --- | --- |
| **PROCEDURE/TREATMENT** | **NORMS** | **PATIENT FINDINGS** |
| Apply one application of lanolin after each feeding after nipples have been cleaned and dried. | Relief of nipple soreness. | Relieved nipple soreness. |
| Keep nipples clean and dry at all times. | Promote healthy healing of nipples. | Stated: “I can tell they feel a little better when they are clean and dry.” |
| Assess uterus tone and location. | Uterus is midline and firm. | Uterus was midline and firm. |
| The patient was educated and informed of the use of stool softeners nightly to prevent constipation. | Patients state relief of constipation and fears. | Patient stated this “eased her fears” and was planning on using a stool softener that night. |
| The patient was educated about pseudomenstruation. | Verbalize understanding that small amount of bloody drainage in a female’s baby diaper is normal and due to mother’s hormones. | Verbalize understanding that small amount of bloody drainage in a female’s baby diaper is normal and due to mother’s hormones. |
| The patient was educated about smegma. | Able to verbalize what smegma is and not to remove it for this may cause trauma. | Verbalized what smegma is and not to remove it for this may cause trauma. |
| The patient was educated on postpartum blues and when to contact health care professional if condition persists. | State symptoms and cause of postpartum blues and to contact health care provider if symptoms last longer than two weeks. | Stated the cause of why she was feeling sad and often cried. Stated that she should let her primary care physician know if her symptoms persist for longer than two weeks. |
| The patient was educated on the dangers of smoking while breast feeding and given cessation information.  | Patient stop smoking due to the risks they learn about concerning breast feeding using cessation program. | Patient voiced concern over dangers of smoking while breastfeeding and her interest in a cessation program. |
| Patient was given sitz bath. | Relief of perineal pain. | Decrease in perineal pain. |
| Patient was educated on the importance of vaccinating newborn and lack of proof vaccines cause autism. | Vaccination of baby. | Stated, “I will consider vaccinating her.” |
| Patient was taught how to bundle baby to promote temperature regulation. | Mother demonstrates proper bundling technique. | Mother demonstrated proper bundling technique. |
| Patient was instructed on the importance of proper nutrition and exercise and how to do so.  | Improvement of diet and regular exercise participation.  | Voiced desire to improve diet and participate in regular exercise.  |
| The importance of drinking water in the postpartum period was stressed. | Increase in fluid intake. | Increase in fluid intake. |

**Nursing Care Plan-Maternal Postpartum**

|  |  |
| --- | --- |
| **Nursing Diagnosis:** | Acute pain related sore, reddened nipples with few cracks as evidenced by client statement of “I don’t think I can keep breastfeeding if it is going to be this painful.” |
| **Goal:** | The patient will state relief of pain by rating pain on a scale of 0-10 as a 0 by time of discharge. The client will properly recall ways to decrease and prevent nipple soreness and irritation by the end of my shift. |
| **Interventions:** | 1. **Intervention:** Keep nipples clean and dry at all times.

**Rationale:** Keeping nipples clean and dry is the recommended treatment to prevent cracked nipples or worsened cracked nipples (Page\_Tamara 128)1. **Intervention:** Apply one application of lanolin after each feeding after nipples have been cleaned and dried.

**Rationale:** Lanolin helps prevent further has been effective in treating nipple soreness (Page\_Tamara 129).1. **Intervention:** Assess and teach mother for proper positioning techniques of her baby for breastfeeding by the next feeding.

**Rationale:** It is known that nipple irritation can be caused by improper positioning of the baby during breastfeeding (Page\_Tamara 129).1. **Intervention:** Assess and teach proper nipple attachment techniques of her baby to the breast for breastfeeding by the next feeding.

**Rationale:** It is known that nipple irritation can be caused by incorrect attachment of the baby to the mother’s breast (Page\_Tamara 129). |
| **Evaluation of Goal:** | At the end of my shift, the patient was able to state ways to decrease and prevent nipple irritation. The client demonstrated the modified cradle position, cradle position, football hold position, and side-lying position for proper positioning of the baby during breastfeeding. She stated that she preferred the side-lying position and found this position less painful than the positions she was using before. The mother demonstrated how to obtain a deep latch by initiating the infant’s rooting reflex and then drawing the infant towards her while holding her nipple with the “C-hold” (thumb is placed on top of the breast near the 12 o’clock position and the other four fingers are placed on the underside of the breast near the 6 o’clock position). After each feeding the mother ensured that her breasts were both clean and dry. She then applied lanolin cream to her nipples. The patient met the short-term goal of properly recall ways to decrease and prevent nipple soreness and irritation by the end of my shift. By the time of discharge, the patient should be able to state relief of pain by rating pain on a scale of 0-10 as a 0 by time of discharge. If this goal is not met, the care plan needs to be re-evaluated.  |

|  |  |
| --- | --- |
| **Nursing Diagnosis:** | Readiness for enhanced nutrition related to concern about poor nutrition as evidenced by stating that she wished she knew how to eat better because she know what she eats is what the “baby eats.” |
| **Goal:** | The patient will report how to improve her current meals to meet daily requirements by the end of my shift. The patient will demonstrate balanced eating choices by selecting meals from sample menus appropriately by the time of discharge.  |
| **Interventions:** | 1. **Intervention:** Teach the patient the importance of maintaining proper diet while breast feeding and how to lose weight by eating healthy and being active by end of shift.

**Rationale:** Studies have shown that lack of a healthy diet while breast feeding can affect growth, motor activity, and anxiety of the newborn (maternal diet restriction, 43).1. **Intervention:** Client will be able to list important food groups, the foods in each food group, and how many servings are necessary of each by the end of my shift.

**Rationale:** By being able to explain important food groups, the foods in each food group, and how many servings are necessary the patient will be to make healthy eating choices.1. **Intervention:** The client will be able to choose nutrient dense appropriate meals from a sample menu by the time of discharge.

**Rationale:** This allows the client to be able to apply and evaluate their knowledge of nutrition.1. **Intervention:** Client will have dietary consult by dietitian by the time of discharge.

**Rationale:** The patient will benefit from having a nutrition specialist consult her and evaluate her knowledge during this time when nutrition is critical to the newborn and mother. |
| **Evaluation of Goal:** | The patient reported how to improve her current meals to meet daily requirements by the end of my shift. She said that now she looks forward to planning healthy meals at home for her and her boyfriend. The patient will demonstrate balanced eating choices by selecting meals from sample menus appropriately by the time of discharge to meet the next goal. If this goal is not met, the care plan needs to be re-evaluated.  |

|  |  |
| --- | --- |
| **Nursing Diagnosis:** | Knowledge deficit related to effects of smoking on breast milk as evidenced by planning on continuing smoking during breastfeeding. |
| **Goal:** | The patient will state the effects that smoking has on breast milk by the end of my shift. The patient will begin a smoking cessation program by the time of discharge. |
| **Interventions:** | 1. **Intervention:** Inform patient that smoking decreases milk production by 7/8/10 1400.

**Rationale:** Smoking has an inhibiting effect on prolactin, a hormone that promotes milk production, causing decreased milk production (smoking and lactation, 1371).1. **Intervention:** Inform smoking cigarettes has been known to cause irritability of infant by 7/8/10 1400.

**Rationale:** Nicotine in breast milk has been proven to cause increased irritability and excessive crying to the infant who consumes the breast milk (smoking and lactation, 1372).1. **Intervention:** Inform the patient of smoking cessation options available to them and have them list personal advantages and disadvantages of each by 7/8/10 1600.

**Rationale:** Individualized patient treatments should be explored with the patient to help them decide which option may work for them best.1. **Intervention:** The patient will start a smoking cessation program by the time of discharge.

**Rationale:** Clients involved in cessation programs have the highest rate of success in stopping smoking. |
| **Evaluation of Goal:** | The patient was able state the effects that smoking has on breast milk including increased irritability with excessive crying and decreased milk production by the end of my shift. T.S. seemed to be concerned about how her smoking could affect her breast milk and ultimately her baby. Treatment options were also explored and the patient listed some advantages and disadvantages for them in their life of each option. At the time of discharge the patient should begin a smoking cessation program or the care plan needs to be re-evaluated. |

|  |  |
| --- | --- |
| **Nursing Diagnosis:** | Powerlessness related to feelings of sadness and frequent crying as evidenced by client states, “I feel like I can’t control my emotions at all. This should be one of the happiest times of my life but I feel sad and cry a lot.” |
| **Goal:** | The patient will verbalize understanding of feelings of sadness and frequent crying spells by end of shift. The patient will inform the staff when to contact health care provider if problem persists by time of discharge.  |
| **Intervention:** | 1. **Intervention:** Inform patient that the feelings are due from a shift in hormones due to childbirth and if the feelings persist, treatment is available.

**Rationale:** 13% of new mothers report postpartum depression but it is believed that the numbers are actually higher since it often goes undiagnosed (Kuosmanen, pg. 55).1. **Intervention:**  Inform the patient to inform health care provider if symptoms last more than two weeks.

**Rationale:** Postpartum blues lasting longer than two weeks is considered postpartum depression and needs to be medically treated.1. **Intervention:** Anticipate questions and interest in more information at all times concerning postpartum blues and depression.

**Rationale:** The client will feel empowered when knowledgeable about their condition.1. **Intervention:** Perform screening to identify if patient is at risk for postpartum depression by time of discharge.

**Rationale:** Clients who are higher risk can be evaluated on further dates and receive more information from a nurse concerning postpartum depression (kuosmanen, p. 556) |
| **Evaluation of Goal:** | The patient verbalized understanding of feelings of sadness and frequent crying spells by end of shift. She stated this made her feel like these feelings weren’t here fault and gave her a “feeling of empowerment.” She informed the student nurse that she will inform health care providers if the problem persists. The patient will inform the staff when to contact health care provider if problem persists by time of discharge. If this goal is not met, the care plan needs to be re-evaluated. |

**Conclusion**

 While providing nonjudgmental care for T.S., a few aspects were missed during our short time with her. She will still need counseling on contraceptives to determine which contraceptive would fit her lifestyle most appropriately. Also, T.S. may profit from taking cake decorating classes so she can still socialize with adults and enjoy a hobby. T.S. would also benefit from ongoing care for her mental statue, nutrition, and smoking cessation. Hopefully with the care provided, the patient was able to make educated decisions and lifestyle modifications to better the life for not only herself but also her newborn child.

References

Ball, J.W., Bindler, R.C., & Cowen, K.J. (2010). *Child health nursing: Partnering with children*

 *and families.* Upper Saddle River, NJ: Pearson Education.

Cavanaugh, B.M. (2010). *Nurse’s lab tests.* Philadelphia: F.A. Davis.

Deglin, J.H., & Vallerand, A.H. (2008). *Davis’ drug guide for nurses.* Philadelphia: F.A. Davis.

Giglia, R, Binns, C.W., & Alfonso, H. (2006). Maternal cigarette smoking and breastfeeding

 Duration. *Acta Peaediatricia,* *95,* 1370-13074.

Kumon, M., Yamamoto, K., Takahashi, A., Wada, K., & Wada, E. (2010). Maternal dietary

restriction during lactation and influences postnatal growth and behavior in the offspring of mice. *Neurochemistry International,* *57,* 43-50.

Kuosmanen, L., Kumpuniemi, S., Vuorilehto, M., & Melartin, T. (2010). Post-natal depression

 screening and treatment in maternity and child health clinics. *Journal of Psychiatric and*

 *Mental Nursing, 17,* 554-557.

Page, T., Lockwood, C., & Guest, K. (2003). Management of nipple pain and/or trauma

 associated with breast-feeding. *Joanna Briggs Institute, 1,* 127-147.