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Maternal Newborn Case Study

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## Introduction

M.B., age 37, gravida one para one, meaning one pregnancy and one birth after 20 weeks, with four adopted boys arrived at Aultman Hospital for an induction or the initiation of labor (Davidson, Ladewig, & London, 2008). Her estimated due date was January 30, 2010. She delivered a healthy baby girl on February 2, 2010 at 1848 via an elective cesarean section or the birth of the fetus via a surgical incision through the maternal abdomen and uterus (Davidson, Ladewig, & London, 2008). The newborn weighed six pounds, 11.6 ounces and was breast feeding followed with formula.

We chose M.B. to use for our case study because of her history and complications during labor and delivery. She was diagnosed with infertility, also known as a diminished ability to conceive, in 1994, and her prenatal testing showed an increased risk for fetal anomalies or abnormalities due to advanced maternal age. Advanced maternal age is any pregnant woman over the age of 35 years, which can increase the likelihood of a cesarean delivery and developing chromosomal abnormalities such as Down syndrome (Davidson, Ladewig, & London, 2008).

The purpose of this case study is to demonstrate our knowledge and critical thinking skills in the labor and delivery setting. The following will contain information regarding patient history, and prenatal-, labor and delivery-, postpartum-, and newborn data; as well as, a nursing care plan.

## Demographics

M.B. attended two trade schools and is now licensed as a manicurist and real estate agent. She denies the presence of any factors that may affect the recovery process. M.B. has a history of infertility, increased levels of thyroid stimulating hormone increasing her risks of fetal congenital anomalies, and her husband was born with a cleft palate (Davidson, Ladewig, & London, 2008).

Currently, she is a non-smoker, which she has been for ten years, is a social drinker and has no history of substance abuse or sexually transmitted diseases. She is a Christian with no diet limitations.

#### OB/Antenatal History/Relevant Pathophysiology

M.B. attended a six week birthing class to prepare herself for the delivery, and is now a gravid one para one with four adopted boys. When she arrived for induction, she anticipated on having a vaginal delivery, but with complications such as; unfavorable cervix or failure of the cervix to thin and dilate, fetal head unengaged or floating above the inlet of the pelvis, and advanced maternal age, her and her husband elected to have a Cesarean section during which she received spinal anesthesia or local anesthetic injected into the spinal fluid. The fetal head must be engaged in order to have a vaginal delivery. Failure of the fetal head to engage may be due to disproportion of the pelvis and fetal head (Davidson, Ladewig, & London, 2008). Her last menstrual period was approximated to be sometime in April, and her estimated due date was January 30, 2010. She delivered at 1848 on February 2, 2010 at 40 weeks and three days gestation. During delivery, the umbilical cord was around the newborn's neck in a true knot due to delivery of the newborn through a loop in the umbilical cord (Davidson, Ladewig, & London, 2008).

#### Prenatal Data

##### *Laboratory Data*

| <b>Prenatal Tests</b> | <b>Norms</b>                     | <b>Patient Results</b> | <b>Analysis</b>   |
|-----------------------|----------------------------------|------------------------|---|
| Type & Rh             | A, B, AB, and O either<br>+ or - | O +                    | She has anti-A and anti-B antibodies in her sera and has the Rh factor. |

| <b>Prenatal Tests</b>                                | <b>Norms</b>                               | <b>Patient Results</b>                      | <b>Analysis</b>  |
|--|--|---|--|
| Hemoglobin & Hematocrit                              | Hgb= 12-16 g/dl<br>Hct= 38-47%             | Hgb=12.8 g/dl<br><b>Hct= 37.6%</b>          | Hgb= WNL<br>Hct is low which may indicate physiological anemia.          |
| VDRL/RPR   | NR or negative                             | NR (non-reactive)                           | She is negative for syphilis.  |
| Rubella  | Immune                                     | Immune                                      | She was vaccinated.  |
| Urine Culture and Sensitivity                        | Negative                                   | Negative                                    | She is negative for pathological organisms.                              |
| Chlamydia/Gonorrhea                                  | Negative/ Negative                         | Negative/Negative                           | She is negative for growth of pathogens.                                 |
| PAP test   | Normal or no atypical cells on the cervix  | Normal                                      | She has no atypical or cancerous cells on her cervix.                    |
| Quad Screen  | Normal AFP levels, UE, hCG, and inhibin-A. | Fetus has increased risk for Down Syndrome. | She has an abnormal quad screen.   |
| 1 hr Glucose Tolerance                               | Anything less than 140mg/dL.               | 91  | She had a negative screening result and therefore she does not have GDM. |
| 3 hr. Glucose Fasting:<br>1 hour<br>2 hour<br>3 hour |  |   |  |

Source: RNLabs4 (Cavanaugh, 2007)

*Diagnostic Tests (ultrasounds, amniocentesis)*

| <b>Test</b> | <b>Date</b> | <b>Norms</b>          | <b>Patient Findings</b>                     |
|-------------|-------------|-----------------------|---|
| Ultrasound  | 9/10/09     | No anomalies present. | Reassured against possible fetal anomalies. |

Source: (Davidson, Ladewig, & London, 2008)

*Prenatal Medications*

| <b>Medications</b> | <b>Dose, route</b> | <b>Indications for use</b>           | <b>Possible side effects</b>                  | <b>Nursing responsibilities</b>                  |
|--------------------|--------------------|--------------------------------------|---|--|
| Prenatal Vitamin   | 1 tab daily po     | Treat or prevent vitamin deficiency. | - Allergic reactions<br>- Urine discoloration | - Discuss importance of taking prenatal vitamins |

Source: (Deglin & Vallerand, 2009)

## Labor and Delivery Data

*Description*

M.B. originally came to the hospital for an induction and had planned on having a vaginal delivery. After learning that she had an unfavorable cervix, the fetus' head was not engaged, and knowing that age 37 was considered advanced maternal age, her and her husband decided that a cesarean section was the safest option. Vacuum extraction, which is a procedure used to assist birth of a fetus via suction applied to the head, was used during the cesarean section, and M.B. received spinal anesthesia, which produces local insensitivity to pain (Davidson, Ladewig, & London, 2008). The delivery of the newborn took three minutes. M.B.'s baby girl was born at 40 weeks and three days, weighing six pounds 11.6 ounces or 3050 grams. Upon delivery, the umbilical cord was wrapped around the newborn's neck one time and was in a true knot. The newborn had an apgar score of eight in the first minute after birth and nine five minutes later. The apgar score is used to evaluate the condition of the newborn physically and the need for resuscitation (Davidson, Ladewig, & London, 2008). I later assessed the newborn when she was 13 hours old and found no signs of distress. M.B. bonding well with her newborn baby girl and is breastfeeding her and following with formula.

*Laboratory Data*

| <b>Labor Labs-<br/>2/2/10@ 1014</b> | <b>Norms</b>                      | <b>Patient Results</b>             | <b>Analysis</b>                                     |
|-------------------------------------|-----------------------------------|------------------------------------|---|
| WBC                                 | 5,000-10,000/mm <sup>3</sup>      | 8,820 /mm <sup>3</sup>             | WNL   |
| RBC                                 | 4.2 – 5.4 million/mm <sup>3</sup> | <b>4.18 million/mm<sup>3</sup></b> | RBCs are slightly abnormal                          |
| Hemoglobin                          | Hgb= 12-16 g/dl                   | Hgb=12.8 g/dl                      | WNL   |
| Hematocrit                          | Hct= 38-47%                       | <b>Hct= 37.6%</b>                  | Hct is low which may indicate physiological anemia. |
| Platelet                            | 150,000-450,000 mm <sup>3</sup>   | 261,000/mm <sup>3</sup>            | WNL   |

Source: RN Labs4 (Cavanaugh, 2007)

## Postpartum Data

*Assessment*

Our first postpartum assessment of the mother was at 0930. Her vital signs were as follows: pain was 0/10, temperature was 36.7°C, pulse was 80 beats per minute, respirations were 18 per minute, and blood pressure was 102/58 – all of which were within normal limits. M.B.'s lung sounds were clear on both sides, and she denied any shortness of breath. Breasts have begun filling with milk, were non-tender, and the nipples were normal. Newborn was experiencing difficulty latching onto the nipple; therefore, breastfeeding was being followed with formula. The abdominal incision site had no drainage, and the dressing was dry and intact. The fundus was firm, midline, and one fingerbreadth below the midline indicating normal uterus contraction. Bowel sounds were active in all four quadrants, and M.B. was voiding adequately. I assisted M.B. to the bathroom on two different occasions, both of which she expressed no signs of dizziness. M.B. had a moderate amount of lochia rubra or red vaginal discharge of uterine contents. M.B. was emotionally stable and was bonding well

with the newborn, which was evident by M.B's cuddling, talking, and holding of the newborn. Edema was noted in both legs, and M.B. denied any numbness, tingling, or headaches.

Our next assessment was at 1500, and the vital signs were as follows: pain was 0/10 temperature was 37.0°C, pulse was 84 beats per minutes, respirations were 16 per minute, and blood pressure was 110/60. The rest of the assessment findings were unchanged from 0930. To see full assessment details, refer to the last four pages of this case study.

#### *Laboratory Data*

| <b>Postpartum Labs-<br/>2/3/10</b> | <b>Norms</b>                      | <b>Patient Results</b>             | <b>Analysis</b>   |
|------------------------------------|-----------------------------------|------------------------------------|---|
| WBC                                | 5,000-10,000/mm <sup>3</sup>      | <b>14,670/mm<sup>3</sup></b>       | WBCs are high due to Cesarean birth.                                    |
| RBC                                | 4.2 – 5.4 million/mm <sup>3</sup> | <b>3.58 million/mm<sup>3</sup></b> | RBCs are low due to the average blood loss of 500 ml during a Cesarean. |
| Hemoglobin                         | Hgb= 12-16 g/dl                   | <b>Hgb=11.5 g/dl</b>               | Hgb is low due to the blood loss during the Cesarean.                   |
| Hematocrit                         | Hct= 38-47%                       | <b>Hct= 32.7%</b>                  | Hct is low due to the blood loss during the Cesarean.                   |
| Platelet                           | 150,000-450,000 mm <sup>3</sup>   | 229,000 mm <sup>3</sup>            | WNL   |

Source: RNLabs4 (Cavanaugh, 2007)

#### *Postpartum Medications*

| <b>Postpartum Medications</b> | <b>Dose, route</b> | <b>Indications for use</b> | <b>Possible side effects</b> | <b>Nursing responsibilities</b> |
|-------------------------------|--------------------|----------------------------|------------------------------|---------------------------------|
|                               |                    |                            |                              |                                 |

| Postpartum Medications | Dose, route          | Indications for use           | Possible side effects  | Nursing responsibilities  |
|------------------------|----------------------|-------------------------------|--|---|
| Senokot S              | 1 tab qhs<br>po      | Treatment of constipation     | - dehydration<br>- abdominal cramps<br>- n&v<br>- diarrhea<br>-allergic reaction             | - Hold if having diarrhea<br>- Administer with a full glass of water<br>- Don't administer within 2h of other laxatives.  |
| Torodol                | 15mg/1ml q8h<br>IV   | Short-term management of pain | -drowsiness<br>-dizziness<br>-HA<br>-edema<br>-GI bleeding<br>-allergic reaction             | - Do not give with ibuprofen<br>-Assess pain prior to and 1-2h after administration<br>- Flush with 3ml NS before and after administration  |
| Sodium chloride 0.9%   | 3 ml q 12h<br>IV     | To keep the Heplock patent    | - Irritation at IV site<br>- Allergic reaction   | - check for no resistance   |
| PRNs                   |                      |                               |  |   |
| Roxicet                | 1 tab q 4h prn<br>po | Moderate to severe pain       | - confusion<br>-sedation<br>- constipation<br>-respiratory depression<br>- allergic reaction | - Dose should not exceed 4g per 24h<br>- Asses type, location, and intensity of pain prior to and 1h after administration<br>-Assess BP, pulse, and respirations before and periodically during administration<br>-Asses bowel function routinely |



| Postpartum Medications | Dose, route                     | Indications for use     | Possible side effects  | Nursing responsibilities  |
|------------------------|---------------------------------|-------------------------|--|---|
| Roxicet                | 2 tabs q4h prn<br>po            | Moderate to severe pain | <ul style="list-style-type: none"> <li>- confusion</li> <li>-sedation</li> <li>- constipation</li> <li>-respiratory depression</li> <li>- allergic reaction</li> </ul> | <ul style="list-style-type: none"> <li>- Dose should not exceed 4g per 24h</li> <li>- Asses type, location, and intensity of pain prior to and 1h after administration</li> <li>-Assess BP, pulse, and respirations before and periodically during administration</li> <li>-Asses bowel function routinely</li> </ul> |
| Tylenol                | 650mg / 2 tabs<br>q6h prn<br>po | Mild pain and fever     | <ul style="list-style-type: none"> <li>- Hepatic failure</li> <li>- Renal failure</li> <li>- Allergic reaction</li> </ul>  | <ul style="list-style-type: none"> <li>- Take with a full glass of water</li> <li>- Asses type, location, and intensity of pain prior to and 1h after administration</li> <li>- Assess fever as well</li> </ul>   |
| Ibuprofen              | 600mg/1tab q6h<br>prn<br>po     | Mild to moderate pain   | <ul style="list-style-type: none"> <li>- HA</li> <li>- constipation</li> <li>- n&amp;v</li> <li>- Allergic reaction</li> <li>- dizziness</li> </ul>                    | <ul style="list-style-type: none"> <li>- Start after Toradol completed</li> <li>- give with food</li> <li>- Asses type, location, and intensity of pain prior to and 1h after administration</li> </ul>   |

| Postpartum Medications    | Dose, route                          | Indications for use   | Possible side effects   | Nursing responsibilities   |
|---------------------------|--------------------------------------|---|---|--|
| Simethicone<br>- chewable | 80mg/ 1 tab<br>TID prn<br>po         | Relief of painful symptoms of excess gas in the GI tract that may occur postoperatively or as a consequence of:<br><br>-Air swallowing<br>- Dyspepsia<br>- Peptic ulcer<br>- Diverticulitis | - none significant  | - Assess for abdominal pain, distention, and bowel sounds prior to and periodically during therapy<br><br>- Assess frequency of belching and passage of flatus   |
| Bisacodyl                 | 10 mg/1 supp<br>qday prn<br>rectally | For constipation  | - abdominal cramps<br>- nausea<br>- allergic reactions                          | - Take on an empty stomach for more rapid results<br><br>- Assess pt. for abdominal distention, presence of bowel sounds, and usual pattern of bowel function.<br><br>- Assess color, consistency, and amount of stool produced.       |
| Zolpidem                  | 5mg/1 tab qhs<br>prn<br>po           | Insomnia  | - dizziness<br>- behavior changes<br>-N/V<br>- diarrhea<br>- allergic reactions | - May repeat X1<br><br>- Assess mental status, sleep patterns, and potential for abuse prior to administration<br><br>- Assess alertness at time of peak effect<br><br>- Assess for pain.<br>Untreated pain decreases sedative effects |

| Postpartum Medications | Dose, route                       | Indications for use  | Possible side effects   | Nursing responsibilities   |
|------------------------|-----------------------------------|--|---|--|
| Naloxone               | 0.1mg/0.25ml<br>prn<br>IV push    | - antidote for suspected opioid overdoses<br>- reversal of CNS depression and respiratory depression | - hyper- or hypotension<br>- n&v<br>- allergic reaction   | - May repeat q2 min. for total of 0.6mg until resp. 10 breaths/min. or greater<br>- Rate: (opioid overdoses) 30 sec.<br>- Rate: (induced respiratory depression) administer dilute solution of 0.4 mg/10ml at a rate of 0.5ml direct IV q 2min.  |
| Nalbuphine             | 2.5mg/0.13ml<br>q2hprn<br>IV push | For itching  | - dizziness<br>- HA<br>- sedation<br>- dry mouth<br>-N/V<br>- clammy feeling<br>- sweating<br>- allergic reaction | - Second nurse must clarify original order, dose calculations, and infusion pump settings<br>- Rate: administer slowly each 10 mg over 3-5 min.<br>- Can be given undiluted<br>- Assess BP, pulse, and respirations before and periodically during administration. If respiratory rate is less than 10/min, assess level of sedation |

Source: (Deglin & Vallerand, 2009)

### *Postpartum Procedures and Treatments*

| PROCEDURE/TREATMENT  | NORMS   | PATIENT FINDINGS   |
|----------------------|---|--|
| 2/3/10 0850 Heplock  | Pt. tolerates well, and heplock is patent           | M.B. tolerated well, and heplock was patent.             |
| 2/3/10 0900 Foley DC | Pt. tolerates well, and catheter met no resistance. | No resistance noted on removal, and M.B. tolerated well. |

|                             |  |  |
|-----------------------------|--|--|
| 2/3/10 1055 Dressing change | Well approximated with minimal amount of drainage, and pt. tolerates well. | Well approximated, no drainage noted. M.B. tolerated well. |
|-----------------------------|--|--|

### *Postpartum Nutritional Assessment*

M.B.'s pre-pregnant weight was 193 pounds, and her end weight was 220 pounds; therefore, M.B.'s total weight gain during pregnancy was 27 pounds. Her BMI is 37. She is the main caretaker, housekeeper, and does most of the shopping and cooking, but on occasion her husband helps out. M.B. also gets help financially with the WIC program. She states she has a good appetite, usually is a stress snacker, and drinks three to four cups of fluids a day. M.B. denies she has any concerns about her nutritional habits, and/or her use of laxatives or stool softeners. She did state that she is an exercise instructor at a YMCA, and works out for 45 minutes three days a week.

### *Newborn Data*

#### *Newborn History*

Throughout M.B.'s pregnancy, a variety of prenatal labs were done prior to birth (Davidson, Ladewig, & London, 2008). Her blood type was O positive, and she tested negative for both hepatitis B and syphilis. She was immune for rubella, the culture done for group B streptococci was negative, and her one hour glucose screen was 91. After delivery, M.B. is now a gravid one para one with four adopted children.

#### *Newborn Assessment*

Our first newborn assessment was at 0925. She was weighed one time, which was at birth. Her weight was previously stated. Her vital signs were as follows: temperature was 36.9°C, pulse was 130 beats per minute, and respirations were 42 per minute – all of which were within normal limits. Her lungs are clear on both the right and left. Bowel sounds are present in all four

quadrants, abdomen is soft, and her cord is drying. The fontanelles, or soft spots, are soft, her tone is good, and her cry is vigorous. All extremities are symmetrical with full range of motion. Her reflexes are all present; the moro, or startle, the babinski, the root, and the suck reflexes. The babinski reflex is the fanning and extension of the toes when the foot is stroked from the heel upward, and the rooting reflex is when one strokes the side of the newborns cheek and she turns her head to that side (Davidson, Ladewig, & London, 2008). Although the suck reflex was present, the lactation consultant was notified on February 3, 2010 due to the newborns ability to suck and latch on.

Our next assessment was at 1500, and the vital signs were as follows: temperature was 37.3°C, pulse was 121 beats per minutes, and respirations were 43 per minute. The rest of the assessment findings were unchanged from 0925. To see full assessment details, refer to the last four pages of this case study.

#### *Newborn Laboratory Data*

| <b>Newborn Tests</b>         | <b>Norms</b>  | <b>Patient Results</b> | <b>Analysis</b>  |
|------------------------------|---------------|------------------------|--|
| Blood Sugar                  | 30-60 mg/dL   | 60 mg/dL               | WNL  |
| Blood Gases- 2/2/2010 @ 1903 |               |                        |  |
| pH                           | 7.35 – 7.45   | <b>7.293 (L)</b>       | pH is acidic because of the retention of the pCO <sub>2</sub> which in turn is retained due to the cord around the neck. |
| pCO <sub>2</sub>             | 35 – 45 mmHg  | <b>53.2 mmHg (H)</b>   | pCO <sub>2</sub> is high because the infant can't get rid of the CO <sub>2</sub> due to the cord around the neck.        |
| pO <sub>2</sub>              | 75 – 100 mmHg | <b>19.9 mmHg</b>       | pO <sub>2</sub> is low because there was a cord around the neck X1 in a true knot.                                       |
| HCO <sub>3</sub>             | 22 – 26 mEq/L | 25.2 mEq/L             | WNL  |

| Newborn Tests      | Norms     | Patient Results | Analysis   |
|--------------------|-----------|-----------------|--|
| Base excess        | +1 to -2  | - 2.0 mmHg      | WNL  |
| O <sub>2</sub> sat | 96 – 100% | <b>26.6%</b>    | O <sub>2</sub> sat is low because the pO <sub>2</sub> is low. This means the cells of the newborn are not getting adequate oxygen. |

Source: RN Labs4 (Cavanaugh, 2007)

### Newborn Medications

| Newborn Medications           | Dose, route                                 | Indications for use   | Possible side effects  | Nursing responsibilities  |
|-------------------------------|---|---|--|---|
| Hepatitis B Vaccine<br>2/3/10 | 0.5 ml IM<br>(Right anterior thigh)         | Prevent hepatitis B infection by providing passive immunity | - dizziness<br>- rashes<br>- pain at injection site<br>- allergic reaction | - Administer in the anterolateral thigh<br>- Assess for signs of anaphylaxis after administration |
| A&D ointment                  | 1 app as directed to diaper area<br>topical | Prevent and treat diaper rash                               | - Allergic reaction  | - Clean the diaper area and apply with each diaper change.  |

Source: (Deglin & Vallerand, 2009)

### Evidence of Care Planning

|                           |  |
|---------------------------|--|
| <b>Nursing Diagnosis:</b> | Risk for postpartum hemorrhage related to labor and delivery.<br>(Physiological)   |
| <b>Goal:</b>              | The patient will remain free of hemorrhage during my 8-4 shift.<br>Long Term Goal: The patient will remain free from hemorrhage during hospitalization.  |
| <b>Interventions:</b>     | <p><b>1. Intervention:</b> Assess the uterine fundus for height and consistency with each assessment and as needed.</p> <p><b>Rationale:</b> The height should be at the level of the umbilicus or one fingerbreadth below the umbilicus. The consistency should feel firm. If the height of the uterine fundus is above the umbilicus it could indicate excessive bleeding and prevent the uterus from contracting back to its pre-pregnant size. Also, a boggy or relaxed uterus will not control bleeding by compression of the uterine muscle fibers</p> |

|                            |  |
|----------------------------|--|
|                            | <p>(Carpenito-Moyet, 2008).</p> <p><b>2. Intervention:</b> If the uterus is relaxed or boggy, massage it with firm, but gentle circular strokes until it contracts.<br/><b>Rationale:</b> Massaging stimulates the uterine muscle to contract (Carpenito-Moyet, 2008).</p> <p><b>3. Intervention:</b> Encourage the patient to empty or attempt to empty her bladder every two hours or as needed.<br/><b>Rationale:</b> A full bladder or distended bladder will displace the uterus, increase uterine atony, and therefore, prevent effective contractions (Hutchon &amp; Martin, 2002)</p> <p><b>4. Intervention:</b> Encourage the patient to report immediately to the nurse if there is an excess of bleeding, or a pad being saturated within 15 minutes, or any clot larger than the size of a fist while hospitalized.<br/><b>Rationale:</b> An excess of bleeding means the uterus is not contracting effectively (Davidson, Ladewig, &amp; London, 2008).</p> |
| <b>Evaluation of Goal:</b> | By the end of my 8-4 shift the patient remained free from hemorrhage. Long term goal: The patient remained free from hemorrhage during hospitalization.  |

|                            |   |
|----------------------------|---|
| <b>Nursing Diagnosis:</b>  | Risk for infection related to a site for organism invasion secondary to surgery. (Physiological)  |
| <b>Goal:</b>               | The patient will report risk factors associated with infection and understand precautions needed to avoid infection by end of shift.  |
| <b>Interventions:</b>      | <p><b>1. Intervention:</b> Educate the patient on the importance of hand hygiene daily.<br/><b>Rationale:</b> Hand hygiene is the most important way of reducing the spread of disease causing organisms (Hall, S., 2007).</p> <p><b>2. Intervention:</b> Educate the patient on the signs and symptoms of infection and the need to promptly report them as needed.<br/><b>Rationale:</b> Early recognition and reporting of signs and symptoms of infection allow for earlier and better treatment (Carpenito-Moyet, L. J., 2008).</p> <p><b>3. Intervention:</b> Assess the patient's nutritional status daily and educate the patient about the importance of adequate nutrition.<br/><b>Rationale:</b> Maintaining adequate caloric and protein intake in the diet reduces the patient's susceptibility to infection (Carpenito-Moyet, L. J., 2008).</p> <p><b>4. Intervention:</b> Assess the patient's abdominal incision for redness, warmth, or purulent drainage every shift.<br/><b>Rationale:</b> The abdominal incision increases the patient's risk for infection, and should be assessed often (Carpenito-Moyet, L. J., 2008).</p> |
| <b>Evaluation of Goal:</b> | By the end of my shift the patient has remained free from infection with no signs of redness, warmth, or purulent drainage at abdominal incision site.  |

|  |   |
|--|---|
|  | Patient reports understanding of the risk factors associated with infection and the precautions needed to avoid an infection. |
|--|---|

|                           |  |
|---------------------------|--|
| <b>Nursing Diagnosis:</b> | Risk for Altered Nutrition: Less than body requirements related to the newborn's ability to suck and latch on.<br>(Nutritional)  |
| <b>Goal:</b>              | The patient will have a better understanding of the steps to be taken to better ensure an adequate suck and latch, and the newborn will demonstrate adequate ability to suck and latch on and will ingest adequate daily nutritional requirements by time of discharge.  |
| <b>Interventions:</b>     | <ol style="list-style-type: none"> <li>1. <b>Intervention:</b> Encourage mother to be patient and wait until baby's mouth is yawn-wide.<br/><b>Rationale:</b> An open mouth will increase the odds of getting a good latch (Cox, S., 2007).</li> <li>2. <b>Intervention:</b> Encourage mother to learn and establish her newborn's sucking behavior within the first few weeks after delivery.<br/><b>Rationale:</b> Parents are better able to determine when their newborn is hungry, has had enough, and how often their newborn should nurse once a feeding style is established (Fujimaki, K., 2004).</li> <li>3. <b>Intervention:</b> Teach the mother how to facilitate a good latch by ensuring the newborn's lips are rolled out, and a thin lip line is visible around the areola.<br/><b>Rationale:</b> By ensuring that the lips are rolled out, the mother can facilitate painless and effective sucking (Dann, M., 2005).</li> <li>4. <b>Intervention:</b> Continue to monitor newborn's daily intake. If not adequate, initiate alternative supplemental formula feeding.<br/><b>Rationale:</b> Supplemental formula feeding will help to ensure the newborn is receiving adequate daily nutritional requirements (Thanattherakul, W., 2001).</li> <li>5. <b>Intervention:</b> Educate mother about the need to avoid artificial nipples, including pacifiers.<br/><b>Rationale:</b> The use of artificial nipples can cause nipple confusion resulting in aversive feeding behaviors, such as newborn fussiness, frantic crying, an inability or refusal to latch on to the breast, and ineffective or weak sucking (Thanattherakul, W., 2001).</li> </ol> |
| <b>valuation of Goal:</b> | By the end of my shift the patient has reported a better understanding of the proper breastfeeding techniques and has continued using supplemental formula feeding when necessary.   |

|                           |  |
|---------------------------|--|
| <b>Nursing Diagnosis:</b> | Risk for disturbed sleep pattern related to frequent interruption of rest for newborn care.<br>(Psychological) |
| <b>Goal:</b>              | The patient will report an optimal balance of rest and activity during my 8-4 shift.                           |



|                            |   |
|----------------------------|---|
| <b>Interventions:</b>      | <p><b>1. Intervention:</b> Organize and bundle activities or work tasks as needed to avoid frequent interruption for the patient.<br/><b>Rationale:</b> Organizing what is to be done and when it is done will allow the nurses to not walk in and out of the room so much, allowing the mother to get adequate rest (Hunter, Rychnovsky, &amp; Yount, 2009).</p> <p><b>2. Intervention:</b> Offer or encourage the patient to allow you to arrange rest times by having the newborn remain in the nursery for a period of time or until the next feeding.<br/><b>Rationale:</b> This will allow the mother to get more rest while she does not have to care for the newborn for that short period of time (Davidson, Ladewig, &amp; London, 2008).</p> <p><b>3. Intervention:</b> Encourage the patient to rest or sleep when the baby is sleeping in her room.<br/><b>Rationale:</b> Sleeping at the same time the baby sleeps will promote more rest time for the mother because when the baby sleeps, there is no newborn care needing to be done (Carpenito-Moyet, 2008).</p> <p><b>4. Intervention:</b> Administer pain medication as prescribed and as needed.<br/><b>Rationale:</b> This will decrease the pain from the incision site or any common discomfort to be controlled and allow for better rest (Hunter, Rychnovsky, &amp; Yount, 2009).</p> |
| <b>Evaluation of Goal:</b> | By the end of my shift the patient reported she felt well rested.<br>Continue to encourage holding the baby in the nursery while she sleeps and sleeping while the newborn is sleeping.   |

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| <b>Nursing Diagnosis:</b> | Readiness for enhanced knowledge related to breastfeeding as evidenced by expressing newborns problem with her sucking and latching on ability to the lactation consultant.<br><br>(Educational)  |
| <b>Goal:</b>              | The patient will demonstrate a basic understanding of how to promote a more effective latch, and therefore a better suck.   |
| <b>Interventions:</b>     | <p><b>1. Intervention:</b> Provide the patient with written materials to read over and to use in the future and encourage her to talk about any concerns she may have.<br/><b>Rationale:</b> Women are discharged usually within 72 to 96 hours after delivery and must learn so much information prior to discharge, she may forget important points and this way she can refer back to it (Offman, 2004).</p> <p><b>2. Intervention:</b> Demonstrate different holding positions as needed.<br/><b>Rationale:</b> Exploring the different holding positions allows the mother to see which she feel more comfortable with, as well as giving the newborn the opportunity to see which position is easier for her to latch on (Carpenito-Moyet, 2008).</p> |

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|                            | <p><b>3. Intervention:</b> Demonstrate and explain the rooting reflex. Show the mother how to hold the breast with fingers under breast and thumbs on top, to point the nipple directly at the baby's mouth.</p> <p><b>Rationale:</b> All of these promote a more effective latch, as evidenced by the baby's lips rolled back, chin touching the breast and the majority of the areola, not just the nipple, drawn into the newborn's mouth (Offman, 2004).</p> <p><b>4. Intervention:</b> Assist the patient while she breastfeeds and attempts to have the newborn latch on. At the same time provide a verbal explanation of the steps to be taken.</p> <p><b>Rationale:</b> Verbal guidance at the same time as one is actively participating helps one understand the process (Offman, 2004).</p> <p><b>5. Intervention:</b> Continue to follow breast feedings with formula until proper latch and sucking is perfected.</p> <p><b>Rationale:</b> Without a proper latch and suck, the newborn is not getting the proper nutrition needed. Therefore, the formula will give the newborn this proper nutrition until breastfeeding can be effective (Carpenito-Moyet, 2008).</p> |
| <b>Evaluation of Goal:</b> | By the end of my shift the patient had found the holding position that was more effective for the newborn and demonstrated a better understanding of how to promote a better latch of the newborn by explaining and effectively demonstrating.   |

### Conclusion

Reflecting back as we read through our case study, we feel we did not address a couple aspects regarding the patient as we would have liked. We should have considered assessing her spiritual well-being to see if we would have needed to develop a patient care plan regarding that. The last aspect we should have addressed for patient care would have been the importance of sleep. During our shift, there were no visitors, and yet the patient did not get rest. We should have been more aware to this and offered to take the newborn girl to the nursery until the next feeding, so the mother could sleep.

However, we are thankful for the opportunity we had to care for such a wonderful mother and her newborn girl. This case study has helped give us valuable knowledge regarding the care given to the postpartum mother and newborn, as well as giving us the opportunity to explore and utilize the charting system used by Aultman Hospital's Labor and Delivery Floor nurses. It also

gave us an opportunity to not only practice our communication skills, but to improve them by communicating with the patient, staff, instructor, and fellow students. Overall, it was a great experience that we will only continue to build upon to be the nurses we want to become.

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