Parenting and Newborn Case Study

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R.M. was born on January 15, 1987 and is 24 years of age. She is Caucasian and currently resides in a suburban area home with her fiancé, whom she has been with for almost one year, her four year old daughter, and two year old son. She works as a home health care aid and has done so for five years, providing her with health insurance. She was adopted as a baby into an orthopedic doctor's home with two other siblings; all of who are very active in her and her children's lives. Her fiancé works in contracting and currently holds a full time position, as well. Her two children at home are not the biological children of her present fiancé; however, she states that he has plans to adopt them. Due to the full time occupations of both household contributors, her children attend a pre-school and day care center at a country club near by.

R.M. has had a history of iron deficiency anemia, increased white blood cells, seasonal allergies, migraines, and kidney/ bladder infections. Her doctor ordered 325mg of Percocet daily for her development of sciatica after the first trimester of the recent pregnancy. She also developed a kidney infection 14 days prior to her delivery, which she stated was treated with antibiotics. There is family history of mental retardation on the father of baby's (FOB) side with his cousin having Mental Retardation and Developmental Disabilities (MRDD) and the FOB's brother deceased at birth with an unknown cause. R.M. has had two previous C-Sections, or cesarean section, which is a surgery to deliver the baby through an incision in the mother's lower abdomen (Venes, 2009). Due to numerous C-Sections, she is at an increased risk for uterine rupture where the scar on the uterus breaks open during labor (Davidson, London, & Ladewig, 2008).). R.M. is anemic and this could cause preterm labor (Davidson, London, & Ladewig, 2008). She is also at an increase risk for urinary tract infection with a history of kidney stones and infection, which could lead to preterm labor, as well (Davidson, London, & Ladewig, 2008).

R.M. also claimed that she has been a smoker for about seven years with an estimate of five cigarettes per day, but she quit for every pregnancy. She only occasionally has a social alcoholic beverage and states that she doesn't at all during a pregnancy. In this pregnancy the patient received late prenatal care and her first doctor visit was at 15 weeks. If R.M. was unaware of her pregnancy until this time, she may have unknowingly exposed her baby to teratogens, or anything that adversely affects normal cellular development in the embryo or fetus, such as certain chemicals, radiation, therapeutic and elicit drugs, and intrauterine viral infections (Venes, 2009). Her pre-pregnant weight was 124 lbs and she is 5ft 8in tall, making her body mass index, or BMI, 18.85 (Ball, Bindler, & Cowen, 2010). Before delivery, she weighed 150 lbs, making her total weight gain in pregnancy to be 26 lbs.

This is the fourth gravida, or pregnancy, R.M. has had (Davidson, London, & Ladewig, 2008). Her three living children, including her newborn, were all delivered after 37 weeks of pregnancy so they are considered to be para, or full term (Davidson, London, & Ladewig, 2008). In February of 2010, she had an electric abortion procedure, or voluntary termination of pregnancy for other than medical reasons (Venes, 2009), in her fourth week of that pregnancy. The father of the baby is not aware of this.

R.M. was admitted to the hospital on March 29, 2011 at 1145 for pelvic pressure, contractions, and a lot of pain. Her documented last menstrual cycle was June 29, 2010 making her estimated due date April 5, 2011. She gave birth to her third child, M.M., at 1302 on the same day. M.M. is a 6lb 2oz baby girl, born term at 39 weeks gestation, or weeks of pregnancy. The delivery was a repeat cesarean section sedated with spinal anesthesia: form of regional anesthesia involving injection of local anesthetic into subarachnoid space of the spinal cord (Venes, 2009). Her incision was a low, transverse, uterine incision: the surgical removal of the

fetus, placenta, and membranes through a transverse incision into the lower uterine segment. The use of this incision is associated with a decreased incidence of maternal and fetal mortality and morbidity in future pregnancies (Venes, 2009).

M.M. was born with vernix caseosa which is a white, cheesy-like covering that coats the baby's skin in the womb (Davidson, London, & Ladewig, 2008). The umbilical cord included the normal two arteries and one vein. She had a regular heart rate but presented with meconium staining, which may have been a sign of infant distress leading to the possibility of fetal pneumonia due to aspiration of the amniotic fluid contaminated with meconium stool, or the first feces of an infant that typically appears within the first 24 hours and persists for about three days after birth. (Davidson, London, & Ladewig, 2008). She was pink in color, with a strong, vigorous cry and clear lungs after bulb suctioning (Davidson, London, & Ladewig, 2008). Her apgar score was eight after one minute and nine after five minutes. This scoring system is used to evaluate the physical condition after birth and the immediate need for resuscitation. It is based on the heart rate, the respiratory effort, the muscle tone, skin color, and reflex irritability (Davidson, London, & Ladewig, 2008). Each of the criteria can receive two points at most and a score of seven to ten indicates a good fetal condition (Davidson, London, & Ladewig, 2008).

R.M. was chosen for the case study because it was interesting to look at the physical and emotional aspects related to smoking during and after pregnancy. The patient was open to talk about many topics and had an interesting and complex health history for her age. The goal of this case study is to view what possible risk factors she may have had during her pregnancy and which risk factors have moved to the post-partum phase, or phase after delivery.

ASSESSMENT DATA: NURSES NOTE E.S. KSU-SN

0800: Pt. R.M. 24 year old female; A&OX3. Blood type- A (pos); BP-118/68, P-90, RR-15, T-36.8° C. PERRLA; lung sounds- L expiratory & inspiratory wheezes (clears with cough). Pt. ordered respiratory status assessments qh to monitor RR and lung sounds. Bowel sounds- present X4 quadrants. Pt. has moist productive cough. R breast soft non-tender/L breast soft tender- Pt. is breastfeeding; Fundus, or top of the uterus (Davidson, London, & Ladewig, 2008).- firm, midline, -2 below umbilicus; Surgical incision- clean, dry, & intact; Moderate lochia: vaginal discharge of blood, mucus, and tissue from the uterus (Venes, 2009), rubra: discharge of first 2-4 days after pregnancy, bright red in color (Venes, 2009), Ø clots; Perineal area intact. Pedal pulses +2/bil; +1 pedal edema, no redness. Pt denies tenderness, numbness, or tingling; SCD devices in use, abdominal binder in place; skin turgor-WNL; cap refill-WNL. IV HL in L forearm, dressing clean, dry, & intact. Foley catheter discontinued at 0830 with 200mL clear amber urine, pt tolerated well. Pt continues to watch baby sleep and states she's very tired and didn't sleep much. Pt c/o 7/10 burning pain at surgical incision & c/o of sharp stabbing 8/10 pain in lower abdominal incision with cough. Pt questions when she is able to receive pain medication.

Infant M.M. 19 hours old; infant sleeping at mother's bedside. Blood type- A (pos); T- 37° C, R-50, HR-146. Skin pink, warm, and dry; Mucous membrane moist and pink. Pulses normal. Lung sounds-clear. Bowel sounds present. Fontanels, or unossified membranes or soft spots lying between the cranial bones of the skull of a fetus or infant (Venes, 2009). Anterior (top of head) fontanel=smooth/ even; posterior (back of head) fontanel =smooth/even. Eyes aligned with ears. Small amount of caput succedaneum, edema of the fetal scalp that crosses the suture lines which usually is reabsorbed within one to three

days after delivery (Davidson, London, & Ladewig, 2008). Tone- good, extremities relaxed. Reflexes normal: Moro (+), grasp (+), rooting (+), sucking (+), babinski (+). On lower back small amount of lanugo, or fine-downy hair that covers the fetus in utero and shortly after birth to help regulate temperature (Davidson, London, & Ladewig, 2008).Ø dimples; Cord on and drying; Genital/ diaper area clear. Hugs safety sensor-intact; last feeding @ 0700, duration- 20 mins L breast. Infant response- sleeping.

0830: Medicated with 325mg Feosol PO for Hgb 9.6. Pt tolerated well.

0900: R.M –RR-16 lung sounds: L expiratory & inspiratory wheezes, R expiratory wheeze (clears with cough).

1000: Pt R.M. RR-13 lung sounds: L expiratory & inspiratory wheezes, R clear (clears with cough). Pt encouraged cough, deep breathing, and incentive spirometer. Pt is talking with fiancé about how badly she "wants a cigarette". Pt educated on nicotine passing through breast milk during breast feeding. Pt verbalized understanding by stating "I guess I better wait 'til after she's done breastfeeding then." Pt had 75% of breakfast left on tray and stated "I'm full".

1100: Pt. R.M. RR-12 lung sounds: L expiratory & inspiratory wheezes, R clear (clears with cough). Pt breastfeeding. Infant response-irritable.

1200: RR-14 lung sounds: L & R expiratory & inspiratory wheezes. Pt ate 30% of lunch. Pt in bed nursing. Infant not responding well/ crying. Pt R.M. crying and states "I am so bad at this. She seems hungry but when I try it doesn't seem like she gets anything". Pt readjusted feeding position and educated about colostrum, breast fluid that may be secreted from the second trimester and onward but it most evident in first two to

three days after birth and before the onset of true production of milk (Venes, 2009). Pt states “Oh, I didn’t know that. It would’ve been nice to know with my first two kids”. Pt response showed signs of being calmer. Medicated with 2g Mefoxin IVPB then flushed with 3mL NaCl. Pt tolerated well.

1230: Pt R.M. in room. Fiancé present. Pt up to void with assist X 1. Pt c/o continuous burning 8/10 pain at incision site. Pt continues to question when she is able to receive pain medication. When pt told she is ordered to receive Percocet and Toradol, she states “that’s not strong enough”. Pt encouraged to hold pillow to abdomen with each cough. Pt received 5000 units of Heparin SC. Tolerated well

Infant M.M. fussy in crib at mother’s bedside. Pt had wet/dirty diaper with small amount of brown pasty stool. Diaper area cleaned and changed. Cord care done; on and drying. Last feedings @ 0900 20 mins R breast & 1200 8 mins R breast.

1300: Pt R.M. RR- 14. Lung sounds- R lung clear. L lung expiratory wheeze only. Pt breast feeding showing less anxiety. Infant response- content. Pt received 2 tabs Percocet (5/325) PO & 15mg Toradol IVP flushed with 3mL NaCl. Tolerated well.

1400: Pt R.M. RR- 13. Lungs R & L clear. Pox 94% RA. Intervention follow up for pain medication- pt states pain reduced to 5/10 pain and “took the edge off to sleep but didn’t do much otherwise”.

Infant M.M. in nursery. Hepatitis B vaccine given in R VL. Infant crying, but relaxed after a few minutes. No redness noted at injection site.

1530: Pt. R.M. sitting in bed. T-36.6° C, P-76, BP-116/76, R-15, Pox-94% RA. PERRLA. Lung sounds- R clear, L expiratory wheeze only (clears with cough). Breast-soft/non-tender bilat. Fundus- firm, midline, -2; Bladder non-distended. Pt voiding adequately; surgical incision- C, D, & I; Lochia-moderate, rubra, Ø clots; perineal area intact. Pedal pulses +2/bil; +1 pedal edema, no redness. Pt denies tenderness, numbness, or tingling; SCD devices in use, abdominal binder in place; skin turgor-WNL; cap refill-WNL. Pt c/o burning pain 7/10 and states "I can't wait until my dad gets here so he can make the doctors give me more medicine". Pt continues to show signs of sadness but shows signs of effective bonding with baby.

Infant M.M. sleeping in crib at mother's bedside; Hugs safety sensor- intact; T- 37.2° C, R-50, HR-150. Skin warm and dry; Mucous membrane- pink and moist; Pulses normal. Lung sounds-clear; Abdomen-soft, symmetrical, non-distended; Bowel sounds present; Cord- on & drying Anterior fontanels=smooth/ even, posterior fontanels=smooth/even; Tone- normal, extremities relaxed; Eyes aligned with ears. Last feeding @ 1300 25 mins L breast.

PRENATAL MEDICATIONS

Medications	Dose, Route	Mechanism of Action	Indications for use	Possible side effects	Nursing Responsibilities
Percocet 5/325 (oxycodone 5mg+acetaminophen 325 mg)	PO q 6 hours	Binds to opiate receptors in CNS. Alter the perception of and response to painful stimuli, while producing generalized CNS depression.	Moderate to severe pain: Patient taking due to history of very painful sciatica during pregnancy. Patient was taking Percocet for about 5 months during pregnancy.	Confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, **respiratory depression,** constipation, ortho hypotension, **physical/psychological dependence, tolerance,** urinary retention	Assess type, location, and intensity of pain prior to and 1 hr after administration. Patients taking controlled-release tabs should require additional short-acting opioid doses for breakthrough pain. Assess BP, pulse, respirations before and periodically during admin. If RR<10/min, assess level of sedation. Assess bowel function routinely
Flexeril/Cyclobenzaprine	PO 10 mg q 8 hours PRN for spasm	Reduced tonic somatic muscle activity at the level of the brainstem. Structurally similar to tricyclic antidepressants	Management of acute painful musculoskeletal conditions associated with muscle spasm. **Taking	Dizziness, drowsiness, confusion, fatigue, headache, nervousness, dry mouth, blurred vision, arrhythmias, constipation, dyspepsia, urinary retention	May be administered with meals to minimize gastric irritation. Swallow whole; do not open, crush or chew. Assess patient

			R/T history of Sciatica**		for pain, muscle stiffness, and range of motion before and periodically throughout therapy.
PreNatalVitamin (PNV)	1 tab PO daily	Similar to other multivitamins, but do contain different amounts of specific nutrients to better suit the needs of an expecting mother. Vitamins such as folic acid, calcium and iron are in higher concentrations while nutrients such as Vitamin A are reduced	**Prenatal vitamin to keep healthy before, during, and after pregnancy	Upset stomach, headache, unusual or unpleasant taste in your mouth	N/A
Pepcid	PO 20 mg daily	Inhibits the action of histamine at the H2-receptor site located primarily in gastric parietal cells, resulting in inhibition of gastric acid secretion.	Treatment of heartburn, acid indigestion, and sour stomach **Heartburn from pregnancy	Confusion, dizziness, drowsiness, hallucinations, arrhythmias, agranulocytosis, aplastic anemia, anemia, thrombocytopenia, neutropenia	Assess for epigastric or abdominal pain and frank or occult blood in the stool, emesis, or gastric aspirate. Monitor CBC with differential periodically during therapy **Inform patient that smoking interferes**

					with the action of histamine antagonists. Encourage patient to quit smoking or at least not to smoke after last dose of the day.

POSTPARTUM MEDICATIONS

Medications	**Dose, Route**	**Mechanism of Action**	**Indications for use**	**Possible Side Effects**	**Nursing Responsibilities**
Feosol/Ferrous Sulfate	325 mg 1 tab PO qd	Enters the bloodstream and is transported to the organs of the reticuloendothelial system (liver, spleen, bone marrow) where it becomes part of iron stones.	Treatment & prevention iron deficiency anemia **Taking due to history of iron deficiency anemia. -Repeat C-section blood loss Hgb-11.9 (before C/S) Hbg- 9.6 (after C/S)	Nausea, constipation, dark stools, epigastric pain, GI bleeding, vomiting, dizziness, headache, syncope	Assess nutritional status & dietary history to determine possible cause of anemia& need for patient teaching. Assess bowel function for constipation or diarrhea. Monitor Hgb, Hct, & reticulocyte values Prior to and every 3 wk during the 1st 2 mo of therapy and periodically thereafter. Serum ferritin and iron levels may also be monitored to assess effectiveness of therapy.
Heparin	5000	Potentiates the	Prophylaxis	bleeding, anemia, thrombocytopenia	-administer SQ deep. tissue

	Units=1mL SQ q 12 hours	inhibitory effect of antithrombin on factor Xa and thrombin.	and treatment of various thromboembolic disorders **Prevent clots. Order: Bed Rest, SCDs	, pain at injection site, Osteoporosis (long-term use) fever, hypersensitivity	-alternate injection sites -Assess for signs of bleeding/hemorrhage -Monitor for hypersensitivity signs -Observe injection sites for hematomas/inflammation -Monitor platelet count every 2-3 days throughout therapy Protamine sulfate=antidote Assess for evidence of additional or increased thrombosis
Toradol	15mg=0.5 mL IVP q 8 hours	Inhibits prostaglandin synthesis, producing peripherally mediated analgesia, also has antipyretic and anti-inflammatory properties	Short-term management of pain *Treatment: patient complains of Pain 8/10. Incision pain, abdominal pain, cramping	Abnormal thinking, GI bleeding, euphoria, asthma, dyspnea, edema, vasodilation, urinary frequency, exfoliative dermatitis, stevens-johnson syndrome, toxic epidermal necrolysis, anaphylaxis, prolonged bleeding time	Assess pain prior to and 1-2 hr following administration Patients who have asthma, aspirin-induced allergy, and nasal polyps are at increased risk for developing hypersensitivity reactions.
NaCl	3mL Soln IV q 12 hours	Sodium is a major cation in extracellular fluid and helps maintain water	Maintenance of fluid and electrolyte. Used for flushing and	CHF, pulmonary edema, hypernatremia, hypervolemia,	Assess I&O WEIGHT, EDEMA, LUNG SOUNDS throughout

		distribution, fluid and electrolyte balance, acid-base equilibrium and osmotic pressure	maintaining patency.	hypokalemia, irritation at IV site	therapy
Depo-Provera Contraceptive	150 mg=1 mL IM (X1 before discharge)	Provide a fixed dosage of estrogen/progesterone over a 21-day cycle. Ovulation is inhibited by suppression of follicle-stimulating hormone (FSH) and luteinizing hormone (LH).May alter cervical mucus and the endometrial environment, preventing penetration by sperm and implantation of the egg.	Prevention of pregnancy Contraception	uterine bleeding irregularities, increased weight, decreased sex drive, acne, headache, bleeding between periods, increased weight, amenorrhea, injection-site reactions	Assess BP before and periodically during therapy Monitor hepatic function periodically during therapy
Percocet 5/325	5mg/325 mg 1 tab PO q 4 hours PRN	Binds to opiate receptors in CNS. Alter the perception of and response to painful stimuli, while producing generalized CNS depression.	Moderate to severe pain **Patient complains of Pain 8/10 (C-Section abdominal pain, incision pain, cramping)	Confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, **respiratory depression,** constipation, ortho hypotension, **physical/psychological dependence, tolerance,**	Assess type, location, and intensity of pain prior to and 1 hr after administration. Patients taking controlled-release tabs should require additional short-acting opioid doses for breakthrough pain.

				urinary retention	Assess BP, pulse, respirations before and periodically during admin. If RR<10/min, assess level of sedation. Assess bowel function routinely
Mefoxin IVPB	2 g in 50mL IVPB q 6 hours @ 100mL/hr	Binds to bacterial cell wall membrane, causing cell death	Treatment of infections. prevention of possible: -C-section incision -UTI (Foley catheter) -Hx of kidney infection -Hx of ↑***WBC*** -"Diagnosis: *Risk for Infection"& possible pneumonia* WBC: **18.07↑ [3/29]**	Seizures, pseudomembranous colitis, diarrhea, rashes, pain at IM site, phlebitis at IV site, allergic reactions including anaphylaxis, superinfection, anemia, bleeding, eosin	Assess for infection at beginning and throughout therapy. Observe patient for signs and symptoms of anaphylaxis. Monitor bowel function

*All medications 3/29/11from patient's chart

*All medication information from Skyscape Davis' Drug Guide (Deglin & Vallerand, 2010)

INFANT MEDICATION

Medication	**Dose, Route**	**Mechanism of Action**	**Indications for use**	**Possible Side Effects**	**Nursing Responsibilities**
Hepatitis B Vaccine	5mcg/ 0.5ml IM	An immune gamma-globulin fraction containing high titers of antibodies to the hepatitis B	Prevention of hepatitis B infection in newborn	Allergic reactions including anaphylactic shock and angioedema. Dizziness, faintness,	Assess patient for signs of anaphylaxis (hypotension, flushing, chest tightness, wheezing, and diaphoresis)

		surface antigen. Confers passive immunity to hepatitis		malaise, weakness, urticaria	after administration.

*All medications 3/29/11from patient's chart

*All medication information from Skyscape Davis' Drug Guide (Deglin & Vallerand, 2010)

DIAGNOSTIC TESTS (ultrasounds...etc)

Test	**Date**	**Norms**	**Patient Findings**
Ultrasound	10/14/2010 @ 15wk2d	Normal	Everything is normal-WNL
Ultrasound	3/29/2011	Normal	Everything is normal-WNL

LABORATORY DATA

Prenatal Tests	**Norms**	**Patient Results**	**Analysis**
Type & Rah	---	A +	
Hemoglobin & Hematocrit	12-16 g/dL	Hgb: 11.9 before C-section 9.6↓ after C-section	Blood loss due to repeat C-section, delivery of placenta (650mL blood)
VDRL/RPR	NR	NR	N/A
Rubella	Immune	Immune [1/5/11]	N/A
Chlamydia/Gonorrhea	Negative	Negative [10/08/10]	N/A
PAP test	Normal	Normal [02/2010]	N/A
1 hour Glucose Screen	<180	122 [1/5/11]	N/A
Group B Strep culture	negative	negative	N/A
Hepatitis B screen	Immune	Immune	N/A
WBC	5,000-10,000	18.07↑	Possible infection, possible start of pneumonia, possible due to history of ↑WBC, previous (14 days) kidney infection
RBC		3.70↓	Due to Blood loss during C-section
Neutrophil Absolute		12.72↑	Due to Blood loss during C-section

*All laboratories. Done 3/29/11

*All laboratory data/interpretation from Skyscraper Nurse's Lab Tests (Cavanaugh, 2009)

NEWBORN LABORATORY DATA

Prenatal Tests	Normals	Patient results	Analysis
pCO2 [3/29]	35-45 mm Hg	53.3↑	Possibly due to meconium stain

All other labs within normal ranges

*All laboratories. Done 3/29/11

*All laboratory data/interpretation from Skyscraper Nurse's Lab Tests (Cavanaugh, 2009)

OB HISTORY

2/8/07	38 week	6 lb 7 oz	Female	Primary C-Section (P C/S): first C-section for a patient (Venes, 2009).	Spinal Anesthesia:	WBC were ↑
8/7/08	38 week	8 lb	Male	Repeat C-Section (R C/S) - second or repeated incision at the prior c-section site (Venes, 2009).	Spinal Anesthesia	N/A
2/10	4 week	--	--	Electric abortion	**Father of baby does not know**	

*All information taken from patient's chart

DIAGNOSIS #1

Nursing Diagnosis 1: Physiological	Risk for infection related to current health status (Carpenito- Moyet, 2010). Supporting data: Foley catheter, C-section, history of increased WBC, history of kidney infection/stones, WBC 18.07 H, history of anemia, left lung expiratory and inspiratory wheezes, Mefoxin 2g IVPB
Short-term goal:	The patient will have a decrease in audible wheezes by the end of clinical shift.
Long-term goal:	The patient will not have further signs of infection as evidence by no additional increase of WBCs, a decrease in wheezes, maintenance of temperature, and clean/intact incision no longer than one week postpartum.
Interventions:	**I:** Encourage fluids at every assessment. **R:** Urinary catheters provide a site for microorganism entry. Increased fluid intake can help to flush the urinary tract (Carpenito- Moyet, 2010). **I:** Prompt patient to cough, deep breath, and encourage incentive spirometer every hour. **R:** Individuals with pain and post-anesthesia, compromised ability to move, and those with ineffective cough are at risk for infection due to pulling of respiratory secretions (Carpenito- Moyet, 2010).

	I: Wash hands before and after all contact with client **R:** Hand washing is one of the most important means to prevent the spread of infection (Carpenito- Moyet, 2010). **I:** Educate patient on proper post-discharge surveillance of vaginal discharge and incision for signs or symptoms of infection and when notify health care provider. R: Many post-partum infections are evident after discharge due to brief period of hospitalization for this type of surgery (Cardoso Del Monte & Pinto-Neto, 2010).
Evaluation- Short-term goal	The patient's audible wheezes decreased from left inspiratory and expiratory wheezes, to only expiratory wheezes that cleared with cough by end of clinical shift.
Evaluation- Long-term goal	The patient does not have further signs of infection as evidence by no additional increase of WBCs, no increase in wheezes, maintenance of temperature, and a clean/intact incision, but is unable to be effectively evaluated at the time. Will continue to monitor.

DIAGNOSIS #2

Nursing Diagnosis 2:	Anxiety related to altered emotional status AEB. . . (Carpenito- Moyet, 2010). Supporting data: Pt questions when she is able to receive pain medication. Patient states

Psychological	pain medication "is not enough"; Patient cries often; Patient cries while attempting to breastfeed; consistent pain of 8/10 throughout clinical shift; patient experiencing post partum hormonal changes
Short-term goal:	The patient will have decreased anxiety by less crying and more signs of psychological comfort within eight hours.
Long-term goal:	The patient's anxiety will not progress or last longer than two weeks.
Interventions:	**I:** Provide reassurance and comfort to the patient when needed. **R**: Reassurance and comfort can help reduce anxiety in a post partum patient (Davidson, London, & Ladewig, 2008). **I:** Give concise directions at all times. **R**: Some fears are based on inaccurate information which accurate data can relieve (Carpenito- Moyet, 2010) **I**: Encourage expression of feelings. **R**: Asking the client to express feelings and emotions may help to relieve the patient's anxiety by letting them know they have someone to talk to instead of keeping it to themselves (Davidson, London, & Ladewig, 2008). I: Encourage patient to bond with baby as much as possible R: More mother-infant bonding can help to reduce the mother's anxiety

	and depression (Figueiredo & Costa, 2009)
Evaluation- Short-term goal	Patient showed a decrease in anxiety by reduced episodes of crying and improved psychological comfort within eight hours.
Evaluation- Long-term goal	The patient shows signs that anxiety will continue to diminish by reduced episodes of crying and improved psychological comfort, but is unable to be evaluated at the time. Will continue to monitor.

DIAGNOSIS #3

Nursing Diagnosis 3: Education	Ineffective breastfeeding related to lack of knowledge … (Carpenito-Moyet, 2010) Supporting data: Pt crying and states "I am so bad at this. She seems hungry but when I try it doesn't seem like she gets anything". when pt educated about colostrum pt states "Oh, I didn't know that. It would've been nice to know with my first two kids", Pt states she's very tired and didn't sleep much, Pt has small appetite- only ate 25% of breakfast, pt states she "wants a cigarette"
Short-term goal:	The patient will exhibit confidence in establishing satisfying, effective, breastfeeding by the end of clinical shift.
Long-term goal:	The patient will demonstrate effective breastfeeding independently within three days post partum.
Interventions:	**I:** Explain the process of breastfeeding to patient

	R: Constant positive feed back is essential for breastfeeding mother. The decision to breast feed is very personal and should not be made without adequate information (Carpenito- Moyet, 2010). **I:** Offer the use of available support systems through peer counselor programs or visual education programs as needed. **R:** Peer and visual programs are more effective in encouraging and educating a struggling breast feeding mother (Hannula & Tarkka, 2008) **I**: Ensure the infant grasps a good portion of the areola, not just the nipple. **R**: Successful breastfeeding is dependent on the ability of the infant to latch on (Carpenito- Moyet, 2010). **I:** Ask patient to list anticipated difficulties. **R**: listening to mother and partner's concerns can help prioritize apprehensions (Carpenito- Moyet, 2010).
Evaluation- Short-term goal	The patient exhibited more confidence in breast feeding by understanding education of colostrum and effective breastfeeding with a content infant in afternoon assessment.
Evaluation- Long-term goal	The patient shows signs of ability to demonstrate effective breastfeeding independently but was unable to be evaluated at this time. Will continue to monitor.

Nursing Diagnosis 4: Nutrition	Ineffective health maintenance related to effects of daily habits…(Carpenito- Moyet, 2010) Supporting Data: Late prenatal care, Pt states she's very tired and didn't sleep much, Pt has small appetite- only ate 25% of breakfast and 30% of lunch, pt states she "wants a cigarette", pt has L exp and insp wheezes, pt has moist productive cough, pt has BMI of 18.85 (lower end of normal), pt has signs and symptoms of stress and anxiety. Smoker for 7 years with 5 cigarettes/day, socially drinks alcohol.
Short-term goal:	The patient will verbalize intent to improve daily habits related to health maintenance by end of clinical shift.
Long-term goal:	The patient will have an improvement in daily habits pertaining to health maintenance within the next month.
Interventions:	**I**: Offer patient the opportunity to explore strategies to quit smoking. **R**: The best quit-smoking programs are those that combine multiple strategies (Carpenito- Moyet, 2010). **I:** Educate patient on proper nutrition and sufficient caloric intake while breastfeeding **R:** Caloric intake should increase 200kcal/day for a breastfeeding mother because more calories are burned through the breastfeeding process (Davidson, London, & Ladewig, 2008).

	I: Advise the patient to use distraction, relaxation, and imagery to reduce stress. **R:** Reduction of stress can help to improve the quality of health (Davidson, London, & Ladewig, 2008). **I**: Discuss and encourage patient and fiancé to pursue smoking cessation together at next assessment. **R**: Eliminating a smoking environment can help to reduce the psychological need for smoking. If both household members decide to quit there is no trigger to remind the other (Ashford, Hahn, Hall, Rayens, & Noland, 2009).
Evaluation- Short-term goal	The patient verbalized intent to improve smoking habits related to health maintenance by stating "I guess I better wait 'til after she's done breastfeeding then."
Evaluation- Long-term goal	The patient verbalized intent to improve daily habits pertaining to health maintenance, but requires strict, further monitoring to be evaluated effectively.

CONCLUSION:

Certain aspects that remain unclear pertaining to the patient may not have been considered. The patient complained of a very persistent pain throughout the morning and perhaps, further therapeutic interventions such as a heating pad could have been

requested for her. Her high level of pain may have reduced the quality of bonding time with her newborn. The patient may have more stressors at home that were not discussed, such as having to take time off from her job with two other children under five years of age and a fiancé who works full-time.

R.M. has evident signs of dysphoria. She may have more reasons, other than previously stated, causing her feelings of anxiety. Within one year of having a voluntary abortion, R.M. discovered she was pregnant again. The first doctor visit for this pregnancy was at 15 weeks, which limited the option to voluntarily abort a possible unwanted pregnancy. R.M. did not state that the pregnancy was unwanted; however, certain discussions were not in depth due to visitors.

In conclusion to this case study, R.M. shows signs that all of the established short-term goals were met. However, due to the patient's past habits, some of the long-term goals may not be so easily met. The patient has smoked for seven years, but claims to have quit for each pregnancy and began smoking again afterward. The long-term goal for R.M. to have an improvement in daily habits pertaining to health maintenance within the next month may, or may not, be met depending on if, or when, she decides to start smoking again. Appropriate nursing interventions to encourage the patient to pursue smoking cessation were done. Ultimately, the willingness of R.M. to commit to improving her quality of health is up to her.

Resources

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