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Family Paper: An Invitation into the World

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I was invited. I was invited to assist in the delivery of a human mind, body, and soul: an invitation into the world. Within this obstetrics and gynecology clinical, I was able to assist in the care of mothers and infants during antepartum, intrapartum, and postpartum, with each patient bringing a different story with different expectations and different outcomes. This experience has been truly beautiful and reassuring as to where my place in this world may belong. During this class, I was also given an assignment to follow a mother and her family throughout delivery, in addition to providing teaching at a home visit. Within the first few weeks of the semester, I met a young couple who invited me to participate in the birth of their first child, Brynn Taylor. Through many conversations in the hospital during antepartum, intrapartum, and postpartum, reading through charts, and visiting their home, I was able to put together this complete mother, newborn, and family assessment.

FAMILY ASSESSMENT:

After I was assigned Jane Taylor as my patient, I made sure to read her chart and all other information available to me. As I was reading through the demographic section of her file, I noticed that her husband Phil was from my hometown of Saginaw, Michigan. I also noticed that Jane was a registered nurse, which would give us much to talk about. After reading that, I was thrilled to meet the couple because I knew we would instantly have commonalities to share that could lead to more personal conversation. I entered the room and introduced myself to Jane and Phil and took a seat next to them both. I explained that I was a nursing student who would be assisting the nurse for the remainder of the day. My instructor also came in and met both Jane

and Phil and asked if it would be alright for me to stay and assist with the delivery. They both said that would be fine and I officially considered myself to be invited.

Since Jane was only partially dilated, I was able to sit and talk with her and her husband for a while. She was quite anxious about the pregnancy and delivery, so talking seemed to calm her down a bit. I mentioned that I was really interested in women's health and that I was a third year in the nursing school. Jane then noted that she was a nurse at the University Hospital and a former graduate from the nursing school at Wayne University. In fact, Jane is a current student in the nurse practitioner program here at the University of Michigan. We spoke of classes and on site experience and eventually teachers. As it turned out, we both had the same instructor for a class. It was nice to sit and just chit chat with Jane because it not only seemed to make her less anxious, but it also made us more comfortable with each other. I felt as though I was not just assisting in her care, but also genuinely forming a connection with her as a person.

Soon after, I mentioned that I was from Saginaw, which leads to an even more coincidental finding. Phil, Jane, and I spoke of Saginaw, the segregation, high school rivalries, and sports. Eventually, I came to mention that I was a swimmer in high school. All of a sudden, I saw a huge grin on Phil's face; it turns out he and Jane were both collegiate swimmers at Wayne. After talking about gruesome swim races and strenuous practices, he asked me if I knew a man named Geoff who coached swimming in Saginaw for a club team. To no surprise, Geoff was my former coach. Throughout our thirty minute long conversation, we all laughed and talked about memories and coincidences that our paths crossed. After leaving the room, I felt very comfortable and confident working with Jane and Phil. It was the first time I would be assisting with a birth and I was a bit nervous to meet the couple, but after that was overcome, the excitement took over.

From the charts and information provided via Careweb, in addition to the home visitation, I was able to learn much about the Doe family. This was their first child (G1, T0, P0, A0, L0), so the primary family consists of Jane who is 28 years old and Phil who is 24 years old. As mentioned earlier, the couple met while attending Wayne University where Jane attended nursing school and Phil studied to become a robotic programmer. Jane is now a nurse at the on the 7th floor of Mott's Children's Hospital, but will be on maternity leave until January 2005. Phil works with automobile part and their programming in a town close to Canton, where they currently live.

The couple appears to be really close and seems to work together to provide care for each other and their child. They seem to function following the Family Systems Theory which focuses on member interaction, cooperation, and modification (Wong & Hockenberry, 2003). They notice problems in the functionality of the family unit without posing individual blame and use growth and change to promote homeostasis. For example, it is hard to take care of the baby especially since Jane is getting her masters degree and working, while Phil is also working. Therefore, they have found ways to cooperate and adjust. Jane takes care of the baby during the days that she does not have class. During the three days a week that Jane does have class, Phil or Jane's mother takes care of the baby. They seem to share responsibilities within the home such as cooking, cleaning, and taking care of the baby in the middle of the night. Since Jane chose to bottle feed, she stated that it was easier to attend to the baby at night because either she or Phil could get up to feed her. They seem to have an open, honest, and comfortable relationship, and have adjusted their new roles as mother and father quite well. Brynn is a lot of hard work, but is a new and exciting bundle of joy in their lives.

The couple seems to be hard working, knowledgeable, and in love. Although their lives are busy, they make time to go out together alone, as well as with the baby. In fact, the night I came over to their home to talk with them, they were getting ready to go out to dinner. When I asked about daycare or babysitting, they mentioned that they have several friends and family that are close by who are always volunteering to watch Brynn. In fact, Jane mentioned that since this was the first baby in the family, every one was excited to be able to look after Brynn.

As for Jane and Phil's general health status, they responded that they feel great. They were both athletes and still continue to exercise, usually two to three times per week. In addition, Jane and Phil are both non-smokers. Jane also reveals to consuming one or less alcoholic beverages per week. Although Phil has no evident history of any health problems, Jane does have asthma, as well as family grandparental history of diabetes, heart disease, and asthma. Jane had one seizure at age 18 from unknown cause and has been admitted to the Emergency Room once within the past year for an asthma exacerbation. She therefore receives allergy shots and takes Zertec 10 mg per mouth once per day to fight her allergies, in addition to Advair 250/50 one puff twice per day and Albuterol when needed. In general, though Jane rates her asthma as mild and they both consider themselves to be healthy adults.

All the information found in Jane's chart and found through talking with her and her husband seemed to correlate with my observations. While visiting them at their home, I noticed many of the items mentioned in conversation; for example, I noticed Jane's nursing books on the kitchen table. I also noticed the "high-tech" baby seat that Phil had mentioned in passing conversation. Overall, everything seemed to fit right into place.

As for the environment, the Does live in two-story home in a welcoming sub-division of Canton, Michigan. The house has definitely undergone some renovations since Brynn came

home. A once vacant bedroom has been turned into Brynn's bedroom where there is a crib and a place to change diapers. The bedroom is right next to Phil and Jane's room, so it is only one cry away. They also make sure to use baby monitors that seem to be so sensitive that they claim that they can hear Brynn breathing if they listen to the monitor in the middle of the night. Everything in the room, including the crib, appears to be safe and non-threatening to the baby.

As for the rest of the house, Brynn's needs have pretty much taken over. Her car seat and various stuffed animals sit in the kitchen and on random couches in the living room. She has another crib in the living room, so that she can be looked over while Phil and Jane are downstairs. There are boppy pillows and diapers in the living room as well. I feel like the couple is still getting used to having a baby in the house. After all, I went to visit them less than two weeks after the baby had been brought home. It is a major adjustment to home-life. In general, the Does seemed to have things taken care of in the house to accommodate to Brynn and there own comfort.

As for the neighborhood, the Does reside in a well-lit sub-division that is two or three streets away from a highly traveled high-speed road in Canton. It seems to be safe, quiet, close to public schools and transportation, and populated by many families. These are important factors to recognize because as the baby grows into a toddler and adolescent, they are mobile. If a ball is accidentally thrown into the street or if one rides out of site on his/her tricycle, the streets should be of minimal threat. Their neighborhood seems to be far enough from high speeds, private, safe, friendly, and well-lit; all which are important to consider when thinking of a child's safety. It appeared to be a great place to raise a family.

CHILDBEARING CYCLE:

ANTEPARTUM: FIRST TRIMESTER (1-13 weeks):

Jane and Phil were considering getting pregnant in winter of 2003 and therefore, scheduled an appointment for a routine health maintenance check up on December, 11, 2003. Dr. Jennifer Nastelin performed a full body assessment and physical, as well as teaching for a healthy pregnancy. She advised Jane to come off her birth control Ortho Tri-cyclen lo at least two months before trying to conceive, to get a rubella titer, and to start taking pre-natal vitamins in order to ensure the essential 4mg of folic acid per day (Lowdermilk & Perry, 2003). Jane took her last birth control pill on December 20th and conceived within the next three weeks.

Jane was also weighed for her pre-pregnancy baseline data. She was 5 feet and 3 inches tall, 130 pounds, with a body mass index of 22.97, which places her at a normal weight for her frame. This is important because being overweight can place a woman at a higher risk for operative birth, gestational diabetes, postpartum hemorrhaging, pre-eclampsia, as well as many other conditions (Lowdermilk & Perry, 2003). While visiting Dr. Nastelin, they should have reviewed proper diet together in order to meet the demands for Jane and her growing fetus. This includes going over the food guide pyramid to ensure a healthy diet which includes: 6-11 servings of carbohydrates, 3-5 servings of vegetables, 2-4 servings of fruit, 3 servings of high protein foods, 3-4 servings of dairy, and a sparse amount of fats, oils, and sweets. Jane should be consuming around 2200 kcal within the first trimester, with an addition 300 kcal during the second and third trimester. She should also be taking 4 mg of folic acid (to prevent neural tube defects), 8 glasses of water, 30 mg of iron (to increase placental perfusion and increase blood volume), and 1200 mg of calcium per day. Jane should be cautioned to avoid alcohol, smoke, undercooked meat, raw eggs, sweeteners, and should be limited 1-2 cups caffeine. Luckily, Jane

already exercises at least twice a week, is a non-smoker, and reports consuming one or less alcoholic drinks per week.

Besides being informed on dietary intake, Jane should also be advised on her physical activity and estimated desirable weight gain. During the first trimester, it is normal to gain 2-4 pounds with an additional weight gain of 1 pound per week during the second and third trimesters. For Jane's normal BMI of 22.97, it is estimated that she should gain a total of 25-35 pounds. A healthy weight gain pattern includes an average weight gain of 2-4 pounds in the first trimester, with an average gain of one pound per week throughout the second and third trimesters (Lowdermilk & Perry, 2003). Monitoring weight gain and an adequate diet is very important to ensure that the fetus is getting adequate nutrients and also to avoid excessive weight gain which a places a woman at a higher risk for operative birth, gestational diabetes, postpartum hemorrhaging, pre-eclampsia, as well as many other conditions (Lowdermilk & Perry, 2003).

As stated earlier, Jane does exercise regularly. Yet, there are some encouraged guidelines to follow during pregnancy for exercise and physical activity. Exercising is a great way to maintain cardiac and respiratory fitness, as well as to strengthen muscles, yet Jane should make sure not to overwork herself. It is important to stay hydrated before, during, and after exercising. She should also never work herself to the point of exhaustion: any feelings of pain, cramping, dizziness, or increased swelling in the lower extremities should be reported to her health care provider (Lowdermilk & Perry, 2003). Exercises can be done to strengthen the lower back, since much pressure will reside there later in the pregnancy, but Jane should be informed to avoid putting arching her back or putting too much strain on that area.

During the first trimester, Jane should have been seeing her midwife (Kathy Bedikian and her nurses) every 4 weeks to monitor the pregnancy, as well as obtain a basic blood count, pap-

smear, cultures, multiple screens, and urinalysis. She should also have a glucose test and an ultrasound done to screen for early signs of gestational diabetes and structural abnormalities of the developing fetus, respectively. Teaching will also be provided at these visits to ensure proper diet, exercise, and weight gain as discussed earlier, in addition to reviewing expected changes in Jane's body such as possible morning sickness, mood swings, breast changes, and various skin changes. She should also be told which medications are safe to take for colds and flu, and necessary times to call a health care provider, such as when green or yellow sputum is found or when any vaginal bleeding occurs.

During Jane's first trimester appointments, she had a complete blood count which yielded results such as hemoglobin level of 13.1 mg % (normal for 1st trimester is greater than 10.5 mg %), hematocrit level of 37.1 % (normal for 1st trimester is greater than 32%), and a white blood cell count of 7,500/cc (normal is than 15,000/cc). These are all within normal ranges (Lowdermilk & Perry, 2003). She also underwent a blood test and Rh factor test to find her blood type to be O with absence of the Rh factor. Her ABS (antibody screen test) was also negative, which means that Jane had not made antibodies to Rh antigens, which would be present on the red blood cells of an Rh positive fetus. Jane's Rh negative blood and her negative ABS titer is an indication for the need of Rhogam at 28 weeks gestation, and again after birth if the baby is Rh positive. Rhogam is given prophylactically to avoid the mother from recognizing the Rh antigen on the fetal red blood cells as being foreign.

On one of her initial visits, Jane also underwent a pap smear with cervical cultures, in addition to various screens. This lab analysis showed no signs of atypical cells or dysplasia. Cervical cultures were performed to screen for Chlamydia and Gonorrhea, which both came back

negative. Her HIV, Hepatitis B, and VDRL screen all came back negative. She had a rubella titer performed as well, which came back as positively immune.

During all visits throughout the pregnancy, it is important to do a urinalysis as well. Glucose, protein, nitrate, and leukocyte levels are monitored in the urine to check for early signs of gestational diabetes, pre-eclampsia, bacteria, or infection. These findings are all normal and acceptable at levels of the following: glucose should be less than or equal to +1, protein should be less than or equal to a trace, nitrates should not be present since they indicate the presence of bacteria, and leukocytes should not be present because they may indicate an infection. Jane's urine analyses all fell within normal ranges (Lowdermilk & Perry, 2003). As an example, on March 3rd (gestational age 11 weeks 6 days), Jane came in for a routine first trimester visit and was noted to have negative glucose, a trace of protein, negative nitrates, and negative leukocytes. At this same visit, they noted her blood pressure to be in a normal range at 95/65. She weighed in at 136 pounds which is a total weight gain of 6 pounds. Although Jane should is encouraged to gain only 2-4 pounds within the first trimester, 6 pounds is not something to be extremely worried about. Her weight gain should be noted and assessed at the next visit to make sure it does not get excessive. Fetal heart tones were also shown to be present. At this visit, Jane also mentioned that she had some nausea and vomiting. She had been using her Albuterol inhaler as needed, but stated that she had had no problems for the last three weeks. She revealed that she had been following a regular diet and had been exercising using an elliptical and weights. Thus far, Jane seems to be enduring quite a healthy pregnancy.

ANTEPARTUM: SECOND TRIMESTER (14-26 weeks):

Throughout the first and second trimester, much screening and teaching is performed. Jane seemed to be quiet knowledgeable about her body changes, pregnancy, and the health of the

fetus (perhaps because she is a pediatric nurse). All of her screens, tests, and visits from the first trimester revealed a normal, healthy pregnancy. Chorionic Villus Sampling (CVS) can also be done in the first trimester between weeks 10-12 to detect genetic abnormalities, while amniocentesis can be performed at around 15 weeks. These tests are usually recommended in high risk pregnancies or when results from a quad test or ultrasound are abnormal (Lowdermilk & Perry, 2003). Since Jane's pregnancy seems to be healthy thus far, neither of these tests was needed.

During the second trimester visits every 4 weeks, it is important to go over common physical and emotional changes that occur during early pregnancy. On each visitation, Jane should have a urinalysis in addition to an assessment where values can be compared to her baseline data and previous visits' data. Within the second trimester, Jane should also have another ABS, complete blood count, and glucose test performed. A quad screen should also be performed between 15 to 20 weeks gestation, which screens for birth defects such as neural tube defects, abdominal defects, and Down syndrome (Lowdermilk & Perry, 2003). Jane had this test performed at 15 weeks and 5 days gestation, with promising results for a healthy baby.

Although I do not have information on Jane's second trimester visits except for specific lab values, I will review normal findings for tests performed in the second trimester. Since Jane is absent of the Rh factor, she was screened again at 26 weeks and 5 days to makes sure her body was not making antibodies against her baby's possible Rh positive blood. She also received an injection of Rhogam at this visit. Her one hour glucose test revealed a normal glucose level of 93 mg/dl. Her complete blood count showed normal as well: hemoglobin of 11.5 mg %, hematocrit of 32.8 %, and white blood cell count of 9,600/cc. Urinalysis revealed normal values of glucose negative, protein negative, nitrates negative, yet there was an abnormal amount of

leukocytes found in the urine (25/ul). Although this is normal in the third trimester, it may otherwise indicate a urinary tract infection, so a urine culture was performed just to make sure this was not the case. This came back negative. An ultrasound should have also been performed to compare to the previous one. This not only checks for structural abnormalities, but also the size of the fetus, dating accuracy, amount of amniotic fluid, and lung and cardiac maturity, and fetal movement (Lowdermilk & Perry, 2003). Fundal height should be recorded and will normally be equal in height (in cm) to the number of weeks gestation within the second and third trimesters considering that her bladder is empty during measurement (Lowdermilk & Perry, 2003). Fetal heart tones should have also been assessed at each visit and will normally fall between the range of 110-160 beats per minute (Lowdermilk & Perry, 2003).

As stated earlier, Midwife Bedikian should also have reviewed expected changes that Jane may have encountered such as first fetal movements (quickening), backaches, varicose veins, hemorrhoids, heart burn, mood swings, and/or pains on either side of the abdomen, buttocks, or legs due to the enlarging uterus. It is also important to discuss interest and safely in sexual activity. Often times, women fear sex during pregnancy, yet it is safe to continue and enjoy sex during this time. As long as membranes are not ruptured and the partner is not infected with any sexually transmitted diseases, there is no risk for infection (Lowdermilk & Perry, 2003). During their visits, it is a good idea to also share information on Lamaze classes, breast feeding, infant care, etc. just to get the couple thinking about delivery and changes that will affect their lives after the baby comes home. Mothers should be taught signs of labor such as contractions, bloody show, and rupture of membranes and what to do in these scenarios. At this point in her pregnancy, Jane was also working 32 hours per week in 8 hour shifts. She was

beginning to feel contractions and was therefore instructed to follow modified bed rest in hopes of delaying pre-term labor.

ANTEPARTUM: THIRD TRIMESTER (27-40 weeks):

During the third trimester, Jane was coming in to see Midwife Bedikian every 2 weeks for weeks 28-36, and every week after that. Within this trimester, it is important to educate and prepare Jane for birth and child development. She should be given information on how to choose a pediatrician, breast/bottle feeding, childcare options, circumcision for males, and birth certificate information. Each visit should again include vital signs, fundal height check, weight gain check, and urinalysis. The following table provides information regarding Jane's last 5 visits before the onset of labor:

Date	FHR (beats/min)	Blood Pressure (mm Hg)	Weight (pounds)	Weight Gain (pounds)	Glucose in Urine	Protein in Urine
08.23.04	130	101/63	154	24	negative	negative
09.07.04	140s	101/66	156	26	negative	negative
09.13.04	138	100/60	157	27	negative	negative
09.20.04	130	110/62	158	28	negative	trace
09.27.04	130s	116/63	160	30	negative	negative

All of these findings are within normal ranges for the gestational age, and Jane was feeling great. During her September 7th visit, she was tested positive for Group B strep, which informed Midwife Bedikian that Jane would need to receive antibiotics during labor to protect the newborn from acquiring this bacterial infection. An ultrasound was also done, although I did not retrieve exact results on this test. Various other tests are available during the third trimester to assess fetal movements in high-risk patients: non-stress tests, biophysical profiles, stress test, and amniotic fluid indexes; yet, since Jane's pregnancy was running smoothly, these were not needed or performed.

During Jane's visits, she mentioned that she had not had any asthma exacerbations, that she should feel fetal movement, and that she continued to have contractions with activity. Everything was looking great and the due date was quickly approaching: October 10th.

INTRAPARTUM: LABOR AND DELIVERY:

Jane felt signs of labor before coming in to the hospital. In fact, she came in for her 39 week check up on September 27th and had reported that her water had broken. The nurse and Midwife Bedikian performed the routine visit checks as stated above, educated Jane on the risk for infection with PROM and explained ways to avoid this, and sent her home. That night, Jane said that the baby was moving all over the place, and that she could not sleep. She also said the contractions were coming on stronger and more frequently, so they came into the hospital that night. When I arrived in the morning to meet Jane and her husband at 0730 on September 28th, she was already in the latent stage of labor, was catheterized, and had already received her epidural. In fact, 2 gm of Ampicillin was given via IV at 2000, 1 oz. of Morphine was given at 2215 via IVP, and Pitocin was started at 2100 all on the night they arrived (September 27th) and were continued throughout the delivery by the nurse.

Labor is divided into four stages and is considered normal when the woman is near term, has no known complications, presents with a single fetus in a vertex position, and labor is completed within 18 hours (Lowdermilk & Perry, 2003). According to these standards, Jane's labor falls right under the "normal" category. Within the first stage of labor are three individual phases: latent phase (0-3cm dilation), active phase (4-7 cm dilation with descent), and transition (8-10cm dilation with descent). By the time I arrived, Jane was just entering the active phase of labor. She was a bit anxious, so we laughed, talked, and shared stories. All the while, the nurse and I were keeping close monitoring on Jane's condition and the fetal heart tones. After I took a

short break for lunch, I came back to find Jane near the end of the transition phase. She was getting uncomfortable, feeling pressure, and feeling the need to have a bowel movement. Within the next 15 minutes, Jane was completely dilated. The first stage of labor lasted from 2300 on the night before until 1248 on September 28th; this is completely normal keeping in mind that in some first-time pregnancies, complete dilation can last up to 20 hours (Lowdermilk & Perry, 2003).

Stage two of labor begins with complete dilation and ends with the birth of the infant. This stage takes an average of 50 minutes to 2 hours for a nulliparous woman, and even up to 3 hours for a nulliparous woman is has received epidural analgesia (Lowdermilk & Perry, 2003). Jane was a fast, strong, and efficient pusher. She placed both knees up to her chest, while Phil held one foot up and I held the other one up. Every time Jane went to push, she took a deep breath, held it in, brought her knees up closer to her chest, pushed her feet against our hands, and pushed long and hard through tight lips. With each push, blood and amniotic fluid leaked out of her vagina. After a few minutes, we could see Brynn's head (the baby presented in the vertex position). Although Jane did not want to see or feel the head, all of us in the room encouraged Jane and told her that Brynn was almost out. The baby's head slowly stretched the labia and soon the entire crown of Brynn's head was exposed. After one more hard push, the baby's head was completely out. There was a nuchal chord and so the Midwife Bedikian pulled the chord out and managed to pull it over the baby's head. While the head was out, the baby was suctioned for to avoid aspiration of amniotic fluid. One push later, after forty-eight minutes of tiresome pushes and nine months of living in a womb, Brynn Parker Doe was born: a beautiful, healthy, baby girl.

The baby was immediately wrapped in a warm blanket and placed on Jane's chest while Midwife Bedikian clamped the chord and handed Phil the scissors to cut it. While Jane and Phil

cried together and embraced the delivery of their first child, Midwife Bedikian delivered the placenta.

Stage three of labor begins at this point with the birth of the fetus and lasts until the placenta was delivered. “The placenta normally separates with the third or fourth strong uterine contraction after the infant has been born (Lowdermilk & Perry, 2003, p.481).” It is normally delivered within a few minutes to an hour after the fetus is delivered. In Jane’s case, the placenta was spontaneously delivered only 8 minutes after the birth of Brynn and was fully complete. Her estimated blood loss was 250 ml which is within normal limits of 300-600 ml. Immediately after the delivery of the placenta, the Pitocin running was increased in order to contract the uterus and prevent hemorrhaging.

Stage four of labor begins with the delivery of the placenta and ends after four hours of close postpartum monitoring. During these four stages of labor, the nurse plays a vital role in the well being of the mother and the fetus. During admission and labor, the nurse must assess vital signs, FHT’s, contractions, ROM, comfort of the mother, dilation, effacement, presentation, position, membrane status, station, and labor expectations. They must also be aware of the medications given, hydration status, bladder status, energy, emotions, and support. During transition, the mother will need strength, support, confidence, and a voice of patience and reason. The nurse must not only provide this for the mother, but also monitor the fetal heart tones and fulfill requests for medication. During stage two of labor, the nurse should be by her side to assist with a calm voice, pushing, and counting. The nurse should be prepared for the delivery by having the warmer on with the baby’s suction and blankets ready. After assisting the physician or midwife with the delivery, the nurse must be sure to accurately record all pertinent data on all the appropriate forms. Other nurses are usually in the room to help as well. After the

placenta is delivered, the Pitocin is increased, and the chord is clamped, the nurse will assess the mother and baby through the postpartum period. The nurse plays a vital role in not only the physical well being of the mother and baby, but also emotional, mental, and social aspects of childbirth. It is quite rewarding to be such an influence on a woman and the invitation of her child into this world.

POSTPARTUM ASSESSMENT:

After Jane and Phil spent a few minutes with Brynn, the nurses and I took the baby to the warmer, assessed the baby's vitals, and took Apgar scores, while Midwife Bedikian cleaned Jane and got her comfortable again. Jane's mother, father, and sister came in as well to get acquainted with the new addition to the family. Although frequency of monitoring the mother varies depending on the agency, it is a good idea to physically assess the mother's vitals every 15 minutes for the first hour, and every 30 minutes for the second hour. Once the mother has stabilized, she can then be monitored every 4 hours (Lowdermilk & Perry, 2003).

By following the BUBBLE-HE (breast, uterus, bladder, bowels, lochia, episiotomy, Homan's, emotional) assessment tool, a nurse can provide and efficient and thorough postpartum check on the mother. Although I did not have access to this information regarding Jane, I will state what should be assessed in the postpartum check. During the first two hours, the mother is usually just assessed, while after some rest, teachings begin. In the case of a healthy delivery like Jane's, the mother is discharged within 24 hours, so there is much to be assessed and taught before the family returns home with multiple new responsibilities.

Starting with breasts, the mother should be asked whether she will be breast or bottle feeding. If breast feeding, the mother should be instructed on how to breast feed during the first session. The nipples must be assessed for shape, soreness, and latch. The mother may need a

breast pump or a visit from the lactation consultants. If the mother is HIV positive, Hepatitis C positive, or is on medication that could be harmful to the baby, then the mother should be advised to bottle feed. If not breast feeding, a breast binder must be ordered and used consistently and correctly in order to reduce nipple stimulation. Type of formula and nipple must also be talked about, as well as frequency and length of feedings. Engorgement must be addressed, as well as mastitis, and interventions for both. Regular breast exams must also be encouraged and taught, if the mother does not already do them. Jane made up her mind before the delivery that she would be bottle feeding Brynn. Therefore, we were able to bring her formula and perform the teaching on bottle feeding before the delivery occurred. At her 6 week postpartum evaluation, she reported that the baby is bottle feeding well and that her lactation has been suppressed successfully.

The uterus should be assessed immediately after delivery to ensure firmness. If the fundus is boggy at all, it should be massaged instantly and Pitocin should be increased in order to prevent hemorrhaging. If the uterus is deviated to one side, the bladder may be full, obstructing the uterus to one side. Once the bladder is empty, the uterus should be checked to make sure it is midline and firm. During each assessment, the fundal height should be checked by laying the woman down on her back, and measuring how many fingerbreadths (approximates cm) are between the top of the fundus and the umbilicus. In general, the fundal height should be at the umbilicus after 12 hours postpartum and should descend one cm each day after pregnancy until it can no longer be palpated (Lowdermilk & Perry, 2003). Although I do not have specific information on the fundal assessments of Jane, I assume that her fundal height decreased according to these guidelines because she was discharged within 24 hours.

The bladder should also be assessed to make sure the mother has voided since birth. Once she had urinated after delivery, the foley catheter may be removed. The nurse should also assess the mother's walking to see if she is able to walk to the bathroom on her own or if she needs assistance. The mother should be asked if she feels urgency, stinging, burning, or any other discomforts. As for Jane, she was able to void after delivery and her catheter was removed within hours of delivery.

Her bowel movements should also be monitored and bowel sounds should be assessed. Many mothers may find it difficult to have a bowel movement after delivery, especially due to the pain medication. Therefore, they are usually placed on a laxative and anti-flatulent. For example, Jane was administered Docusate Sodium 100 mg, PO, BID and Magnesium Hydroxide 10 ml, PO, every six hours as PRN laxatives. She was also given Semethicone 80 mg, PO, every six hours as a PRN anti-flatulent.

Lochia amount and type should be assessed to make sure the mother is not suffering from hemorrhaging. The first three days, it is normal to see rubra (dark red) for the first three days, serosa (pinkish-brown) for days 3-10, and alba (white or yellow) for days 11-21 after delivery (Lowdermilk & Perry, 2003). The amount should never exceed more than one saturated maxi pad per hour. The health care provider should be contacted immediately if this occurs. In Jane's 6 week postpartum visit, she mentioned that her lochia lasted for two weeks and that she has resumed sexual intercourse without any problems and has reported that her last menstrual period was on October 18th, 2004.

Episiotomy represents assessing the condition of the woman's perineum and/or incision. The mother should be assessed for any trauma or lacerations that could have occurred during delivery. She should be instructed to turn on her side and lift up her buttock in order to be

assessed for redness, edema, ecchymosis, discharge, and approximation (REEDA). If the mother is sore underwent trauma, she should be instructed to take a sitz bath, take proper medication, and use ice to soothe the area. In Jane's case, she suffered no lacerations and recovered quite quickly. She was given Motrin and IB profen to reduce pain, swelling, and soreness.

The mother should also be assessed for any clot formation, especially if she had a cesarean section, pregnancy induced hypertension, history of deep vein thrombosis, or extensive bed rest. Leg exercises should be promoted while lying in bed to prevent the forming of thrombo-embolism. If a thrombus is suspected by a positive Homan's sign, warmth, redness, or tenderness, the health care provider should be contacted. To my knowledge, Jane showed no signs of clotting problems.

Lastly in the BUBBLE-HE assessment is emotional status. The mother should be assessed for any history of or signs of postpartum depression such as feeling overwhelmed, crying, or hallucinations (Lowdermilk & Perry, 2003). She should also be offered support groups just in case that is something that appeals to her. In her 6 week postpartum evaluation, Jane reported feeling no signs of postpartum depression. It is also important to make sure the mother receives adequate teaching in subjects such as contraception plans, resuming exercise, breast/bottle feedings, expected lochia amount and type, expected norms for the baby, and/or any questions that the mother or family may have.

NEWBORN ASSESSMENT:

Baby Brynn was born at 1336 on October 28th at 39 weeks gestation. After the baby was born and the chord was clamped and cut, Brynn was put under the warmer to be assessed and bundled up. Although I do not have the vital signs collected after birth, I will mention the

normal ranges that they should fall under. I assume that Brynn feel under these ranges since she was discharged after 48 hours.

A normal heart rate for a newborn is 100 beats/minute during sleep and up to 180 beats/minute during cries. The heart should beat in a sinus rhythm, there should be equal and strong femoral pulses, and there should be murmurs heart on auscultation. A normal respiration range is 30-60 breaths per minute with patent nares and audible breath sounds on auscultation. The normal temperature range for a newborn is 36.5 -37 degrees Celsius. Normal ranges for blood pressure include systolic readings of 60-80 mm Hg and diastolic readings of 40-50 mm Hg. The baby should be able to resist having extremities pulled away from their body and should stop crying once curled back up in the fetal position. It is normal for the newborn to have pink skin or slightly cyanotic skin is acceptable for the first few hours of life. The skin may also be dry or cracking and may present with mottling or erythema, petechiae, or ecchymoses. A full term baby may present with vernix, especially in creases of the skin. The newborn may also have lanugo, particularly in places such as the shoulders and the pinnas of the ears. The head may show signs of molding or slight irregularity in symmetry due to the delivery process, as well as possible overlap of sutures. The eyes should each be as wide as the space between the two and should look symmetric in size and shape. The ears should be well-formed and semi-firm, while the nose should be patent, midline, and somewhat flat. The mouth should appear to be symmetric with pink gums and the tongue inside the mouth. The soft and hard palates should be intact and the uvula should be midline. The newborn should have a distinct chin and a moist mouth, as well as rooting, sucking, and extrusion reflexes. The abdomen should be slightly round and prominent and bowel sounds should be heard within the first two hours of life, while meconium should be passed within the first 24-48 hours of life. The chord should appear to be

whitish gray with two visible arteries and one vein and should be delineated and dry around the base. The back should have vertebrae in alignment with a patent anus. The newborn should have spontaneous movement of the extremities with 5 fingers on each hand and 5 toes on each foot. Reflexes should be present such as grasp, such, Moro, tonic neck, rooting, gag, and Babinski. The female genitalia should appear to be edematous with a possibility of pseudomenstruation and/or vernix between the labia. The newborn should urinate within the first 24 hours of life as well.

As for information found on Brynn, she weighed 7 pounds and 11 oz (3490 grams) at birth and had a head circumference of 36 cm with a length of 50.2 cm. These findings are all within normal ranges. The baby will be expected to lose 5-10% of their initial birth weight within the first two weeks of life. After the baby was weighed, I helped to clean the vernix off the baby and watched the nurses administer 1.0 mg of Vitamin K into the left thigh, as well as place Erythromycin ointment in Brynn's eyes to prevent the spread of any present bacteria during vaginal delivery. Brynn's Apgar score after one minute was 8, with the 2 points lacking in the color category, but after five minutes the score raised to 9, with only 1 point lacking in the color category. It is normal to be somewhat cyanotic in the fingers and toes during the first few hours after birth, but this should go away shortly. After the baby's first bath, the length and head circumference measurements were made and a Hepatitis B virus vaccination was given in the baby's right thigh. After the bath and the vaccination, I assume Brynn was bundled back up and handed back over and Jane and Phil. Overall, Brynn appeared to be a beautiful, healthy, full-term baby born to two loving, caring parents.

IN-DEPTH FOCUS:

For the in-depth focus portion of this assignment, it was tough to think of teaching project that Jane was not already educated on. Since she is a registered nurse on a pediatric floor and is currently in a nurse practitioner program, she is constantly learning about obstetrics, gynecology, and pediatrics. Therefore, I thought it would be a great idea to educate her and Phil on developmental milestones that Brynn will cross within her first year. Although I am sure that Jane has learned expected times that a baby will have reflexive grasps or will smile spontaneously, but it is hard to remember them all. To track their child's progress and developmental achievements, I made them a notebook with charts of different milestones separated by month (attached is an example for month one). These were found and altered from our pediatric notes, Block's Theoretical Framework, scholarly journals, and internet resources.

Phil and Jane were excited to have these guidelines to follow the growth of Brynn. The nursing diagnosis was therefore, readiness for enhanced knowledge of infant developmental milestones related to expressing an interest in learning and explaining knowledge of the topic (Ackley & Ladwig, 2004). According to Ackley and Ladwig (2004, p. 612), this diagnosis can be defined as, "the presence of acquisition of cognitive information related to a specific topic is sufficient for meeting health-related goals and can be strengthened." This diagnosis was chosen because Jane's previous knowledge on the topic is recognized, but can definitely be strengthened in order to provide adequate attention and care to the development of her child.

The information was presented using the notebook that I gave them as a gift (picture attached). This notebook had a decorative cover with their baby's name across it in colorful letters. Inside the notebook was the infant developmental check off sheet, extra sheets of paper, photograph covers to insert photographs, and a little stuffed animal. It acted as not only an educational piece, but also a scrapbook type of memory.

As stated earlier, the information came from various sources and was all compiled together to form this packet. For example, in between birth to three months, the newborn's face should be able to express emotions such as excitement, pleasure, worry, and distress. They should also begin to have more regular sleep patterns (Sears, 2002). The notebook went through many phases such as the ones above, and was divided by month. Each phase had a box provided to take note of the date that this task was achieved and a box to add descriptive comments and/or memories. This gave Phil and Jane even more incentive to recognize, respond, and learn from the baby's cues.

Following these cues have often been described as the origin of attachment: "cue sensitivity in which mothers learn to recognize their baby's characteristics such as temperament or sleep-wake cycle, to communicate with their baby, and develop love for it (Goulet, Bell, Tribble, Paul, & Lang, 1998, p. 1073). The baby will communicate by smiling or cooing, and the parents will react and respond in an either positive or negative manner. By making an effort to learn the infant's language, reflexes, sleep cycles, etc, the parents can eventually enhance some behaviors within the infant (Goulet et al., 1999). Therefore, "parents who are sensitive and responsive to their infant's cues will promote his/her growth and development (Goulet et al, 1998, p. 1076). This notebook will encourage Phil and Jane to watch for particular cues, boost growth and development, and create a closer attachment bond between Brynn and her parents.

While explaining some of the various phases or cues that Brynn may go through, I also mentioned to Phil and Jane that the dates noted are not exact, but rather generalized. Babies tend to build skills based on environment, stimulation, and interaction (Sears, 2002). Therefore, each infant may spend different amounts of time at each stage; thus, creating a wide range of "normal" findings. Yet, it is important to talk to a pediatrician if multiple skills are not being

accomplished. Pediatricians can refer parents to an infant development specialist, who are special education teachers who make home visits to incorporate play skills and motor skills with receptive and expressive language (Dingman, 2002). As Jane already knew, I mentioned that if she felt that Brynn was not developing in a timely manner, she could call her pediatrician to have an assessment performed such as the Denver Developmental Test of the Bayley Scales of Infant Development (Dingman, 2002).

Overall, the visit went fairly well. On my drive to Canton, I happened to take the wrong highway and go way out of the way…twice. Therefore, I was on the phone with Jane laughing, apologizing, and asking for directions to get out of mess I created for myself. After I found the house, Phil and Jane showed me around and eventually ended up in the living room. We sat and talked about her recovery and how the baby was doing. We also talked about home responsibilities and how they managed to take care of Brynn during the day. After chit-chatting for a bit, I showed them the notebook and explained to them the reasons to keep track of cues, how to use it, and showed a few examples. Jane seemed fairly familiar with much of the information, yet mentioned that she had forgotten most of the appropriate months that these cues occurred. We took pictures together and talked about all the lifestyle changes that had occurred since Brynn entered the picture. After about 45 minutes, I thanked them graciously for the invitation to Brynn's arrival and left my name and phone number in case they ever needed a babysitter, and left. Both Phil and Jane were such a pleasure to work with. They were understanding of my role as a nursing student, they were open and honest with their personal lives, and they allowed me to take part of the most beautiful experience of life: life itself.

BLOCKS THEORETICAL FRAMEWORK

1 MONTH

Date achieved:

Moro reflex present (stretch-like motion)		
Vigorous sucking reflex present (begins sucking in response to stimulation)		
Lying on tummy on table; lifts head briefly		
Lying on tummy; makes crawling movements w/ legs		
Held in sitting position: back is rounded, head held up momentarily		
Hands tightly fisted		
Reflex grasp of object w/ palm		
Startled by sound; quieted by voice		
Ringing bell produces decrease of activity		
May follow object w/ eyes to midline		

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