Case study daily care of a term infant

The purpose of this case study is to discuss an episode of Normal Midwifery, which in this instance, will relate to the “ Daily Care of a Term Infant”.

The case study will highlight the episode of care in detail, evaluate the management of the baby’s Physical care and the woman’s Educational, Psychosocial needs with relevant evidence based support.

The anonymity of mother and baby will be maintained in accordance with NMC (2008) and ESC 1 (NMC, 2007) and will be referred to as “ the woman” and “ the baby” through out the Case Study. Consent was also requested from the woman for herself and baby to be included in the Case Study in line with ESC 1 (NMC, 2007).

BACKGROUND

The woman was a 28 year old who was parity 1+0, had a spontaneous vaginal delivery of a baby girl with only Entonox as pain relief and was now 2nd day postnatal. The baby girl weighed 3288 grams with no complications after delivery and had APGAR scores of 8 at 1 minutes and 9 at 5 minutes. The woman had 40 minutes uninterrupted skin-to-skin with the baby after birth and decided to artificially feed rather than breast feed, although benefits of breast feeding were explained to the woman.

The Student Midwife first met the woman during her Labour the previous day and was present at the birth.

As the Student Midwife was working a day shift with her Mentor, it was requested that the Student Midwife carry out the Daily Examination of the baby in line with KCND (NHSQIS, 2009), while the Mentor observed.

The initial examination and assessment of the baby was done at birth by the Mentor as suggested by Demott, Bick, Norman (2006) and included assessing the newborn's physiological adaptation to extra-uterine life, colour, tone, breathing and heart rate according to Resuscitation Council (2006). The purpose of the Daily Examination there after is to monitor the progress of the baby and for early detection of deviation from the normal established at Initial Examination. These findings were documented in SWMR Baby Post Natal notes in line with NMC (2008) and KCND (NHSQIS, 2009).

The Student Midwife before entering the woman's room to commence examination familiarised herself with the woman's Medical case / SWMR notes and baby's SWMR notes, to review the medical history including: family history, maternal, antenatal and perinatal history, fetal and neonatal history so as to be prepared to assist with any concerns the woman may have regarding Physical, Educational or Social needs as recommended by KCND (NHSQIS, 2009).

PHYSICAL

The Student Midwife greeted the woman on entering the room and enquired how the woman was feeling. It was established that the woman was pain free and feeling fairly rested after labour the previous day. The Student Midwife then asked how the woman had found the baby overnight, regarding specifically feeding, sleeping pattern, passing urine & meconium. The

woman confirmed that the baby had been feeding approximately every 3 – 4 hours taking 30 mls each time, between feeds the baby was reported to have been settled and sleeping. It was also reported that the baby had been having wet nappies and one episode of a large amount of meconium being passed. It was important to establish that meconium had been passed within the first 24 hours as failure to do so may have indicated a gastrointestinal problem including Hirshsprung's disease. The woman was reassured that the passing of urine and meconium was important as this ensures that the renal and gastrointestinal systems are functioning normally. The information given was recorded in the baby's SWMR notes following NMC (2008).

It was then explained to the woman that the Student Midwife was going to examine the baby from head to toe, this would involve the baby being completely undressed at some point during the examination and that it would be carried out in front of her. Any findings would be discussed with her at the time and any concerns that she may have would be answered. Consent was then sought from the woman in line with NMC (2008) for the examination to be carried out, as the baby could not give consent, which was duly given.

As it is important that the baby does not become cold due to the inefficiency of regulating temperature due to immaturity of the hypothalamus as suggested by Farrell and Sittlington in Fraser and Cooper (2009), the Student Midwife ensured that all windows and doors were closed to exclude any draught before commencing the Daily Examination of the baby. Also the Student Midwife washed her hands and applied latex free gloves to protect

herself from any of the baby's bodily fluids and to protect the baby who is at risk of infection as suggested by Johnson and Taylor (2006).

Whilst undressing the baby the Student Midwife was mindful to show respect to the baby by gentle handling and lack of excessive noise as suggested by Carbjal and Coudered (2003). Safety of the baby was also considered and the Student Midwife ensured that the cot was stable and in view of the mother prior to commencing the examination. The baby's identity was confirmed by checking details on both identity bands on the baby with the mother and the mother's identity was also confirmed by checking her identity band in line with the Newborn and Infant Physical Examination (NIPE) Standards and Competencies (NHS, 2008).

A methodical examination was commenced by the Student Midwife which follows. All findings were discussed with the woman and documented in the baby's SWMR notes as recommended by NMC (2007) who state that midwives must adhere to the guidelines for records and record keeping as a legal requirement.

DAILY EXAMINATION

Temperature

Before removing the baby's clothes, the Student Midwife took the baby's temperature from the axilla site using an electronic thermometer whilst the baby lay in the cot. The reading was 36. 8ËšC which was within the normal range for an axilla reading (36. 5 – 37. 3ËšC) as described by Bain in Fraser and Cooper (2009).

Reassurance was given to the mother when she asked if the baby was warm enough that the reading was normal. The Student Midwife also offered the information of how the woman could check to see if the baby was too warm or cold by feeling under the baby's clothes just below the neck and at the top of the baby's back. Also a good indication was if the woman had two layers on, then generally the baby would require the same amount of layers. It was also advised that the baby would not require to wear a hat indoors if the room is at a comfortable temperature of between 18 – 21ËšC but would require it outdoors due to cool air.

General Appearance

The Student Midwife removed the baby's clothes, leaving only the nappy on which would be removed later in the examination, to observe the general appearance of the baby.

The baby's skin was noted to be pink all over showing no signs of central cyanosis, although hands and feet still showed slight signs of peripheral cyanosis which is normal during the first 24 – 48 hours according to Farrell and Sittlington in Fraser and Cooper (2009). This was explained to the mother so no undue worry was caused due to the blue tinge of the hands and feet.

Also there was no sign of jaundice which is common after 48 hours from birth as all newborns have a transient rise in serum bilirubin which usually settles after 10 – 12 days post natal. The woman was advised to watch for any colour change of the baby's skin from pink to yellow tinge or for the white of the eye (sclera) to be tinged with yellow. It was explained that this is a

normal occurrence as suggested by Johnston, Flood, Spinks (2003) and as long as the baby had a good urine output, was awake regularly and fed well then there would be no cause for concern. However if the baby develops jaundice which last longer than expected, has excessive sleeping patterns, continually passes pale stools and dark urine, then the woman should get immediate attention for the baby as this is abnormal for a formula fed baby.

The baby’s breathing was observed whilst lying in the cot and was noted to be within the normal range of 40 – 60 breaths/minute with the chest and abdomen rising and falling, showing no signs of distress. Being awake, alert and active the baby was seen to be moving all limbs as expected with good tone.

Head

The baby’s head was gently examined by the Student Midwife. This was done by gently running the finger tips across the baby’s head to feel along the suture lines and fontanelles. The Student Midwife when doing this was determining if any moulding, caput succedaneum or cephal haematoma had occurred during passage down the birth canal or from pressure from the cervical os. Slight moulding was detected and this was explained to the woman that this was normal and was caused by the bones in the skull overlapping during delivery and will resolve itself within a couple of days. The anterior fontanelle was then gently felt and found to be level. This indicated that there was no intracranial pressure which would cause it to rise or dehydration which would cause it to be depressed. It was explained that it is common to notice pulsating at the anterior fontanelle which is no cause of

concern and that this soft spot closes over by the time the baby was 18 months old as confirmed by Wylie (2005).

Eyes

Both eyes were checked and found to be clear of any discharge.

The Student Midwife suggested to the woman that if the eyes were to become sticky, which is common due to blocked tear ducts and can be seen as a crust on the eyelid, the eyes should be cleaned. To do this the woman should use cooled boiled water and cotton wool balls. Each eye should be cleaned from the inner eye outwards only using the cotton wool ball once then discarding. Each eye should be cleaned separately to avoid cross infection.

Mouth

Mouth was inspected by opening the mouth by gently pressing a

finger against the angle of the jaw at the chin. This enabled the Student Midwife to look inside to assess the tongue, gums and palate. The Student Midwife did not insert small finger into mouth to check for a cleft palate or suck reflex as this had been established at Initial Examination of the newborn and no abnormalities had been detected. The mouth was seen to be moist and clear of any white plaques which may have suggested oral thrush as stated by Bain in Fraser and Cooper (2009).

Skin

Closer inspection was then done by the Student Midwife of the baby's skin, looking in particular for any rashes, spots, bruising or infection. The baby's nappy was removed and buttocks examined to ensure skin was intact. All appeared normal with no excoriation identified.

The Student Midwife advised the woman that information on minor disorders would be given to her at the end of the examination as the Student Midwife was conscious of the baby's temperature being maintained.

Umbilicus Cord

The umbilicus cord and clamp were inspected for signs of infection and separation. Nothing unusual was detected. The baby was redressed as quickly as possible to maintain body temperature and given to the woman to settle.

Information was given to the woman on daily cord care which included that the umbilicus should be cleaned with warm tap water and patted dry which has been shown to aid separation as stated by Trotter (2003). This should be done daily and at a nappy change if required. It was explained to the woman that hand washing is essential before and after cord care as suggested by Farrell and Sittlington in Fraser and Cooper (2009) as the cord is a potential site for infection and Straphylococcus aureus is commonly found here as confirmed by Newell, Miller, Mogan et al (1997). When the woman asked when the clamp would be removed, it was confirmed that this may be done on the third or fourth day when the cord has dried out as suggested by World Health Organisation (WHO) (1999).

The Student Midwife confirmed that the Daily Examination of the baby was complete and that she would now give the woman further information on minor disorders, safe baby care practice in particular Sudden Infant Death Syndrome and address any other concerns that the woman may have.

EDUCATIONAL NEEDS

Through out the examination the Student Midwife gave the woman information on day-to-day care and signs of illness.

As previously mentioned further discussion took place with the woman regarding Minor disorders and safety issues, which is in line with NHS QIS (2004) who suggest that ay assessment or examination at birth or later should be seen as an opportunity for parental education or health promotion. This included the following ailments and explanation given to the woman:

Skin Rashes

Erythema toxicum. A red blotchy rash with white pinhead papules which is common during the first 7 days post natal and will disappear on its own.

Miliaria. A sweat rash which occurs in babies who become too warm. It appears as clear papules on face, scalp, chest and areas where clothes rub due to unopened sweat glands. The baby should have excess clothing removed and placed in a cooler environment. The papules will disappear on their own.

Milia. White or yellow papules commonly seen on cheeks, nose and forehead. Will disappear on their own.

Sore buttocks/Nappy rash. The skin beneath the nappy area becomes red and excoriated due to either infrequent nappy changing, frequent loose stools or hot weather. By exposing the cleaned skin to a warm dry atmosphere aids the excoriated skin to heal. Care in using commercial barrier creams must be noted as they can prevent the one-way design of disposable nappies, blocking the perforations in the linings resulting in the urine and stools being next to the baby's skin longer.

Breast Engorgement of the Baby

This can occur in both female and male babies around the 3rd day post natal. The breasts appear to have a lump under the nipple which is caused by the drop in oestrogen levels in the baby after birth which stimulates the breast to produce milk. No treatment is required and will rectify itself. It is important that mothers do not squeeze the breast as this may result in infection.

Pseudo-menstruation

It is common to notice a clear discharge or blood-stained vaginal discharge from baby girls during the withdrawal of the mother's hormone oestrogen after the birth. The mother was reassured that this is a normal physiological process which does not require treatment, although can be alarming if not aware of it.

Safe Baby Care Practices

The importance of reducing the risk of Sudden Infant Death Syndrome (SIDS) is done by ensuring the baby sleeps in a cot in the parent's room for the first

6 months. The baby should always be put on their back to sleep, with their feet to the foot of the cot. They should be lightly covered with the room at a normal temperature, not too hot. Bed sharing is not recommended especially after consuming alcohol, drugs or after smoking. The baby should be in a smoke-free atmosphere. These recommendations are formed by the Department of Health (1996).

Following the birth of the baby the role of the Midwife is to observe and monitor the health of the mother and he newborn, offering information and support in breastfeeding, which is not applicable in this instance, parenting skills and signs of morbidity according to Merchant (2006). This involved effective communication with the woman through out the examination to ensure that the woman conveyed her concerns, maintained control over her decision making with regards to the baby, assisted her in making informed choices and reduced her anxiety levels and emotional distress as suggested by Raynor (2006). In order that the woman's physical and emotional status was commensurate with effective communication, the Student Midwife had to assess the woman's emotional state when receiving information, which was done by asking how the woman was feeling before commencing the baby's Daily Examination. The woman's state could have been effected by pain, tiredness, hormonal changes or if the baby was crying/distressed due to being hungry or requiring changing. Therefore the timing of conducting the Examination was essential to ensure that the woman retained the majority of the information given to her without being distracted due to other factors. In this instance the woman was receptive to the information given, which would assist her in the daily care of her baby, as according to McCourt

in Page and McCandlish (2006) the transition to parenthood is a time when adults are responsive to information and will look for it actively.

As the Midwife becomes familiar with the appearance and behaviour of a normal term newborn, the recognition of signs and signals caused by morbidity are easily communicated to the mother to assist her in recognising when there are any deviations from the normal with her baby. The importance of this is in preparing the mother for discharge home as the length of time spent in hospital is decreasing according to Bain in Fraser and Cooper (2009).

As well as educating the woman with clinical skills (e. g. daily care of the baby, recognising signs of illness) the Midwife's role also encapsulates being able to provide relevant information / advice on general health promotion, social support and mental health.

PSYCHOSOCIAL NEEDS

As the woman was a first time mother it was important to establish that the woman had adequate support in caring for herself and the baby. This was established by the Student Midwife by familiarising herself with the woman and baby's SWMR and Case notes which would highlight any social issues that may have needed addressing as the social circumstances in which a woman lives and a newborn brought into play a major part in their health and well being according to Raynor (2006). In this instance the woman was in a stable relationship with no reported Domestic Abuse, was not in temporary housing, had no social work involvement, no mental health issues

and had good family support as routinely asked during Booking appointment and recorded in SWMR notes.

It was important for the Student Midwife to spend time with the woman and baby in quiet surroundings, free from interruption which offered privacy and allowed the communication of sensitive and confidential information to be shared between the woman and the Student Midwife following NIPE Standards and Competencies (NHS, 2008). This gave the Student Midwife the opportunity to assess the woman's psychosocial well-being by asking how she was coping (defined as coming to terms with a situation according to Lazarus (1966)) so far with the baby / becoming a mother and also to ascertain the woman's expectations of becoming a mother. It is known that in adjusting to motherhood, the woman can feel insecure and loses confidence in her own abilities in the early postnatal period, especially on the lead up to and after discharge as confirmed by Ward and Mitchell (2004). Factors which can influence this are the woman's personality, previous learning, quality/quantity of support available and past experiences of coping. The woman, in this instance stated that although she knew it would take some time to adjust to lack of sleep and was slightly anxious about going home, she had good support from her partner, mother and friends; she had no immediate concerns about caring for the baby.

CONCLUSION

In conclusion it is the Student Midwife's opinion that the Daily Examination of the Term Infant was carried out following KCND (NHS, 2009) guidelines and that the NIPE Standards and Competencies (NHS, 2008) were adhered to.

The baby was examined in a safe and comfortable environment, was shown respect and care from the Student Midwife whilst performing Daily Examination and full explanation was given to the woman as to what was being checked and looked for. The Student Midwife ensured that the woman had the opportunity to ask questions or offer sensitive information through out this encounter by providing privacy and confidentiality in line with NMC (2008) and ESC (NHS, 2009).

All findings and discussion were documented in mother and baby SWMR notes accordingly in line with NMC (2007)

The role of the Midwife in Educational and Psychosocial needs is to give the woman, relevant health advice for the baby and themselves, reassurance and permission to say how they feel. This follows a health orientated and woman centred model of care, which recommends that the role of the Midwife is to encourage the woman’s self confidence, ability to take control and self esteem as suggested by Bates in Stewart (2004).

In a recent study it was concluded that healthy, low risk women wanted attentive, proactive, professional support from the Midwife during the transition to motherhood according to Seefat-van Teeffelen, Nieuwenhuijze, Korstjens (2009) which the Student Midwife believes was given during this Daily Examination of a Term Infant.