A FAMILY CENTERED MATERNITY CARE STUDY

WRITTEN ON LAWYA FATI AT

KINTAMPO MUNICIPAL HOSPITAL

BY

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PREFACE

Family centered maternity care study is a systematic approach to maternity care of an expectant mother, client's family as well as her community members during pregnancy, labor and puerperium. The family centered maternity care is an academic work that gives the student midwife the opportunity to practice the knowledge and skills acquired during her training. She does this by providing total and quality nursing care to the woman and her family.

Family centered maternity care study is also the nursing care of an expectant mother and family, based on understanding of the client as a unique individual with specific problems, needs and nursing care as stated by Nurses' and Midwives' Council (1997).

The study comprises of all the information about the client and her family, which enables the student to recognize the client as a unique individual with specific problems and needs to render good nursing care to promote the health of the client physically, psychologically and socially.

The family centered maternity care is to support and enable pregnant women to go through pregnancy without any complications and have an alive baby at term. It also boosts the student midwife's confidence since she is able to put into practice what she has been taught theoretically. It is also a requirement for the award of a certificate of the Nursing and Midwivery Council of Ghana in the final examination of the student midwife in the award of a professional midwifery certificate.

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My heartfelt gratitude goes to my parents; Mr. and Mrs. Bediako and my siblings; Doris Konamah Bediako, Anthony Kwaku Duah and Richard Atta Bediako for their love, support, prayers and encouragement throughout my training and in making this work a success.

My profound gratitude also goes to the authors of the various books used and to all examiners who are going to mark this script and to all who in diverse ways contributed directly or indirectly for making this study a success. God bless you all.

INTRODUCTION

The family centered maternity care is an academic work which provide the student midwife with the opportunity to nurse a client throughout her pregnancy, labor and puerperium using the skill and knowledge acquired during the 3-year training programme. This family centered maternity care study is about Madam Lawya Fati, a 23-year-old, gravida 2 para 1, alive. She comes from Walawale in the Northern Region but lives in Marigold in Kintampo in the Bono East Region. My interaction with her started on the 27th October,2021 and ended on the 21st November, 2021 when she was handed over to a public health nurse for continuous care at Kintampo Municipal Hospital. The term pregnancy is the period from conception to the delivery of the fetus. The normal duration is about 280 days or 40 weeks or 9 months and 7 days counted from the first day of the last menstrual period. Pregnancy is characterized by many physiological changes such as changes in physical appearance and emotional state of the woman. This is due to estrogen and progesterone (pregnancy hormones) which may result in some discomfort in the woman and thus referred to as minor disorders of pregnancy. Some of these minor disorders are morning sickness, ptyalism, frequent micturition, constipation and heart burns which may be life threatening if neglected, example, morning sickness causing hyperemesis gravidarum.

Antenatal care is the health care provided by midwives and obstetricians during pregnancy to ensure that fetal and maternal health are well satisfied. Therefore, antenatal care is very important during pregnancy in order to promote a healthy pregnancy and baby and also prepare client and family for labor through education and counseling. It is therefore the midwife’s responsibility to help the woman understand the changes and counsel her. It is also advisable for every woman to attend antenatal clinic so that they can be assessed to avoid or treat any complication that may arise as early as possible.

Labor is the commencement of painful regular rhythmic uterine contractions accompanied by cervical effacement and dilatation to complete expulsion of the product of conception. Normal labor often lasts 18 to 24hours resulting in the birth of a healthy, normal and live baby.

Labor has four stages. The first stage begins with the onset of painful rhythmic uterine contractions and ends when there is full dilatation (10cm) of the cervix. The second stage begins when the uterine cervix is fully dilated and ends with the birth of the baby. The third stage begins with the birth of the baby and ends with the delivery of the placenta and its attached membranes and control of bleeding. The fourth stage is the immediate and subsequent care given to the mother and baby within the first six hours after delivery. The midwife's responsibility is to ensure safe delivery by monitoring and assessing the mother, the baby and progress of labor and plotting the results on a partograph so as to identify any abnormalities during labor.

Puerperium is the period of 6-8 weeks after delivery where the maternal uterus or reproductive organs return to their non-pregnant stage. There are also emotional and psychological changes during this period. It is the responsibility of the midwife to support and counsel the woman to prevent postpartum "blues", depression or psychosis and to cope with the changes that occurs during puerperium.

The script is structured into four (4) main chapters.

Chapter One (1) talks about the client's particulars and histories involving the client's personal, social, family, medical, surgical, past and present obstetrical histories as well as habits of daily living. Chapter

Two (2) is about antenatal care rendered to the client at the clinic and antenatal home visit till the onset of labor.

Chapter Three (3) talks about the care given throughout the stages of labor and delivery of the baby. Chapter Four (4) consists of the management and care rendered during puerperium.

At the end of each chapter is a care plan drawn to solve identified problems.

Finally, there is summary, conclusion and bibliography on the study and other appendices attached to the script. The client will be called Madam Fati throughout the project.

LITERATURE REVIEW

It is essential to review literature on pregnancy, labor and puerperium in order to have a fair idea about the physiological changes that occur during these periods so that the necessary support and care can be rendered to the mother and her family. This considers the critical points of current knowledge including substantive findings as well as theoretical findings in pregnancy, labor and puerperium.

PREGNANCY

Pregnancy as defined by Denise Tiran (11th edition) is, from conception to delivery of the fetus. The normal duration is 280 days (40 weeks or 9 months and 7 days), counted from the first day of the last menstrual period to delivery or 265 days from conception to delivery. My client was pregnant for 38 weeks and 5 days at the time of delivery but could not calculate the number of days due to client's inability to recall the last menstrual period. She experienced minor disorders like constipation, frequency of micturition, among others and they were managed accordingly.

According to the Oxford Concise Medical Dictionary (6th) edition, "pregnancy is a period during which a woman carries a developing fetus, normally in the uterus from conception until the baby is born. It lasts for approximately 280 days from the first day of the last normal menstrual period."

From the above definitions, I conclude by defining normal pregnancy as a state in which a living fertilized ovum embeds in the endometrium of the uterus and develops into a fetus until it is born. During this stage, many changes take place in the women to enable them carry the growing embryo to term (37-40 weeks). Women therefore need to be given quality care throughout

pregnancy as the changes that come with it can be life threatening to the mother and the fetus when neglected.

According to Korah and Philip (1996), there should be approximately 12 kg weight gain during pregnancy; 2 kg in the first 20 weeks and 0.5 kg per week till term. A pregnant woman therefore needs adequate antenatal care to promote and maintain her health throughout pregnancy.

Antenatal care is a care provided by midwives and obstetricians during pregnancy to ensure that the fetal and maternal health is satisfactory, to enable early detection and treatment of any deviations from normal as stated by Denise Tiran (11th edition)

A woman should start antenatal care as soon as she realizes she is pregnant or as soon as pregnancy is diagnosed and continue until she delivers safely. Recently, Focused Antenatal Care is stressed and this is an approach to antenatal care that emphasizes on individualized care, client centered, fewer but comprehensive visits, disease detection and not risk categorization care given by a skilled attendant as stated by Kinze and Gormez (2004).

The expectant mother is taken care of by one midwife whom she sees during each antenatal visit for continuity of care until she gets to term. Mother then comes back to see the same midwife during antenatal visits. The aim of Focused Antenatal Care can be explained as; to help maintain a healthy pregnancy, also look forward for a healthy outcome for the mother physically, psychologically, socio-economically and spiritually.

LABOUR

Labor is the process by which the fetus, placenta and membranes are expelled through the birth canal between 37 and 40 weeks of gestation by Fraser and Cooper (2009). It entails the contraction and retraction of the uterine muscle fibers, the dilatation of the cervical os and complete expulsion of the fetus, liquor amnii, placenta and membranes.

The Word Health Organization (WHO 1997) defines labor as 'low risk throughout, spontaneous in onset with the fetus presenting by vertex, culminating in the mother and infant in good condition following birth'.

At the end of pregnancy, the mother's body goes through a process called labor which result in the birth of the baby. In a primigravid woman, the head of the fetus sinks into the pelvic cavity and gets engaged at 36 weeks, engagement of the fetal head does occur in the multiparous woman mostly during labor but it is not felt due to poor abdominal muscle tone as compared to a primigravid woman according to Korah and Philip (1996).

We have false (spurious) labor and True (actual) labor according to Korah and Philip (1996). In false labor, the uterine contractions are irregular and erratic which may not be present always and is not painful or associated with discomfort or backache. Show, cervical effacement and dilatation are absent. While in true labor, the uterine contractions are regular, rhythmic, painful, occurring at the same interval associated with backache and discomfort. Show is present, cervical effacement and dilatation take place.

According to Korah and Philip (1996), labor is divided into three stages; First stage starts with painful rhythmic uterine contractions and completes with full cervical dilatation (10cm. In primigravid

woman, it takes 12-24 hours and in a multigravida woman, it takes 6-12 hours but my client's first stage of labor lasted 11 hours.

The second stage begins with the full dilatation of the cervix and ends with expulsion of the fetus. In the primigravid woman, it takes 1-1 hour 30 minutes and in a multigravida woman, it takes 5-30 minutes but my client's second stage of labor lasted 30 minutes.

The third stage of labor is from the end of expulsion of the fetus till the expulsion of the placenta, membranes, liquor amnii and control of bleeding. In a primigravid woman, it takes about 10-30 minutes and in a multigravida woman, it takes 5-10minutes but my client's third stage lasted 5 minutes.

The 15th edition of Myles (2009) classified labor into four stages: The first stage begins with regular painful rhythmic contractions and is completed when the cervix is fully dilated, that is 0-10 centimeters. This lasts between 12-15 hours in primigravida and 6-12 hours in the multigravida. The second stage is the expulsion of the fetus. It begins when the cervix is fully dilated and completes when the baby is born. It last 30-60minutes in a primigravida and 5-30minutes a multigravida.

The third stage of labor starts from the birth of the baby to the expulsion of the placenta and membranes. It last 5-15minutes both in primigravida and multigravida.

The fourth stage of labor is also known as the immediate postpartum. It begins soon after the delivery of the placenta and goes from one to six hours. This is the period of critical observation and subsequent care is given to the mother and baby because of the risk of postpartum hemorrhage. Close observation such as vital signs, examination on both mother and baby are carried out under the fourth stage of labor.

From the above definitions and explanations, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal which normally occurs at term between 37 complete weeks and 42weeks of gestation. My clients labor started spontaneously with an onset of painful regular rhythmic uterine contractions, there was a mucoid discharge seen (show) which prompted her to report to the hospital. My client went into labor at the 38th week of gestation. She went through the first stage successfully lasting 11hours.The second and third stages also lasted 30minutes and 5minutes respectively. The fourth stage was also managed successfully without any major abnormalities such as postpartum bleeding and sub involution of the uterus. My client's labor therefore lasted 11 hours, 35 minutes.

PUERPERIUM

According to Fraser and Cooper (2003), 'puerperium is a period after child birth where the uterus and other structures which were affected by pregnancy return to their non-gravid state'.

According to Kwame and Aryee (1997), 'puerperium refers to the period after delivery of the placenta up to the end of 6 weeks'.

Puerperium therefore is the period immediately following the delivery of the baby, placenta and membranes or it is the period of 6-8 weeks after delivery where the reproductive organs are returning to their non-pregnant state and this is also known as Post-Partum Period.

During puerperium, there are number of health related concerns for the woman along with social and psychological issues, thus during this period, the woman is encouraged and advised to visit

the midwife regularly so that careful observation and monitoring can be done on both mother and baby to avoid any deviation from normal.

In my own perspective, puerperium is the period immediately after childbirth where the uterus and other organs and structures which were displaced during pregnancy returns to their non-pregnant state in a period of six to eight weeks after delivery.

My client was managed from the day of delivery 13th November,2021 till the seventh day after delivery (20th November,2021). Her puerperium started immediately after the delivery of the placenta and was monitored closely within the first 24hours after delivery alongside her baby. She was discharged 12hours postpartum with her baby girl in a good condition with normal drainage of Lochia. Home visits were done continuously for the first seven days to monitor the wellbeing of my client and her baby. During these puerperal days, she did not face any abnormalities or complications such as sub-involution, puerperal pyrexia, offensive lochia etc. She only had complaints on pains during lactation and frequency of micturition which was managed successfully. On the tenth day postpartum, my client visited the clinic for post-delivery care in good health as well as her baby. Unfortunately, I couldn’t stay with my client throughout the whole period of puerperium (6 to 8weeks) but she and her baby girl were handed over to a public health nurse for continuity of care throughout puerperium on the tenth day after delivery (22nd November,2021).

During puerperium, mothers experience vaginal discharge known as Lochia. This is as a result of bleeding from the placental site. The lochia has a heavy odor, which is not offensive. Mothers are normally asked to monitor this discharge for signs of strong odor or unusual color, mucus, which can indicate that the woman is experiencing infection. The lochia changes from rubra (red lochia),

serosa (pink or serous lochia) and alba (white lochia) gradually which lasts for 10-14 days. The period is divided into three: Immediate Postpartum- This is the first 24 hours after delivery. Early puerperium- It falls between the second and seventh day after delivery. Late puerperium- This is the period from the second week to the sixth week after childbirth, according to Kwakuwe and Enveyam (2002)

According to Korah and Philip (1996), the lochia rubra (red lochia) is seen for the first 3 days, lochia serosa (pink or serous lochia) is also seen from the 4th-9th day and the lochia alba (white lochia) is seen from the 10th-14^{th}day of puerperium. My client had lochia rubra for the first three days (1st-3^{rd}day), lochia serosa from the 4th-7th day. It was verified on inspection of the perineal pad during my home visits.

Basically, the care of the mother and baby during puerperium is towards promoting physical well-being, encouraging mother on exclusive breastfeeding and immunization. This promotes the development of bonding between mother and baby. (Ojo and Briggs)

WHY CLIENT WAS CHOSEN

Madam Fati was met on the 27th October, 2021 at the Kintampo Municipal Hospital on her 10th visit to the antenatal clinic. As she walked into the palpation room, she looked angry, client was approached and was asked if she had any complaint and she complained of keeping long. After engaging her in a conversation for some time, she began to smile.

During the palpation, she was also co-operative and in the course of the conversation she complained of difficulty in moving her bowel and from her records, her gestational age was 36^{+2} weeks. Introduction was made as a student from Holy Family Nursing and Midwifery Training College, Berekum and was at the hospital for practical experience.

She was reassured and constipation explained to be a normal change that occurs in pregnancy and needs to be managed, education on minor disorders of pregnancy was done.

Madam Fati was informed of my intention to take her for my case study and then asked of her consent which she was very glad to hear and pledged to co-operate with me.

Contacts were exchange and she showed me the location to her house and promised to pay her a visit which she was very glad to hear. The midwife in charge was informed about my intentions to use Madam Fati as my client for the care study.

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter entails information about client which was asked during history taking which includes her personal, medical, surgical, menstrual, past and present obstetric histories as well as hobbies and lifestyle.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Fati G2P1 is a 23year old woman who hails from Walewale in the Northern region of Ghana. She stays at Marigold, in Kintampo with her husband and daughter. Madam Fati is a housewife. She is a Muslim. She is fair in complexion, 160cm tall and weighs 65kg. Client speaks Twi and Gonja, with education up to junior high level. Client is married to Mr. Abu Seidu who is a driver and hails from Walewale. She has a 5year old daughter called Mariam Seidu. Client's next of kin is her husband, Mr. Abu Seidu. Client lives in a compound house with other tenants which contains ten rooms and an open space in the house serves as a site for domestic purposes. Pipe borne is her main source of water which is located inside the house. The bathroom and toilet is situated inside the house. A bigger refuse bin is right in front of their house which is being emptied every 2 weeks.

1.2. HABITS OF DAILY LIVING / HOBBIES

According to the client, she wakes up around 5:30am to do her household chores. And prepares her daughter for school around 7:00am. She often empties her bowel at least once a day and any time she feels the urge and also urinates often. She eats three times a day that is; breakfast, lunch

and super. Her favorite meal is “fufu” with groundnut soup. She usually takes mashed “kenkey” with either pie or bread as snack. She baths at least twice a day. She usually watches television, chat with her neighbors and rest sometimes during her leisure time. Finally, she goes to bed between 8:00pm to 9:00pm.

1.3. FAMILY HISTORY

Madam Fati is the daughter of Mr. and Mrs Mohammed who resides at Wale wale in the Northern region. Madam Fati is the third born of the six children of her parents. She said her family has no known medical history like hypertension, sickle cell disease, heart disease, epilepsy, mental illness etc. in the family, she also said multiple pregnancies run in the family. Death occurs naturally in their family.

1.4. MEDICAL HISTORY

Madam Fati has never been admitted at the hospital but has received outpatient department treatment for ailments such as headache, stomach upsets and malaria.

She said there is no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, epilepsy, respiratory disease and mental illness. And she has no allergy to any food or drug. Client said she had never drank alcohol nor smoke before.

1.5. SURGICAL HISTORY

Madam Fati said she has never undergone any surgical procedure ever since she was born and has also never sustained any injury either through road traffic accident or domestic accident that affected her pelvis, limbs or spine. Upon examination, she had no scar indicating surgical procedure. And have never been transfused before.

1.6. MENSTRUAL HISTORY

Client's had her menarche at the age of 13 and the menstrual cycle is 28 days lasting usually for 5 to 7 days. She bleeds moderately without any dysmenorrhea.

1.7. PAST OBSTETRIC HISTORY

Pregnancy

Madam Fati, gravida 2 para 1 alive. Her firstborn is a female called Mariam Seidu who is 5 years old. Pregnancy was at term that is 38 weeks of gestation before labor set in. Client said she had had no abortion either induced or spontaneous. During previous pregnancy, client experienced some minor disorders such as waist and back pains, nausea and loss of appetite. She received her first and second tetanus diphtheria injections and full dose of sulfadoxine pyrimethamine in her past pregnancy.

LABOUR

Madam Fati had a spontaneous vaginal delivery to a live female baby at the Kintampo Municipal Hospital, who cried immediately after delivery and had no complication. Her birth weight was 2.9kg. She also added that she labored for 16hours and had no episiotomy or perineal tear. After delivery, placenta and membranes were completely expelled shortly after an injection and blood loss was minimal.

PUERPERIUM

Client said puerperium was without any complications such as puerperal sepsis, post-partum hemorrhage or mastitis. She practiced exclusive breastfeeding for 6months and continued with complementary feeds such, wean mix, cereals and other foods taken by the family and weaned her

baby by the age of one and half years. Client said her baby received care and immunizations during postnatal visits to the postnatal clinic and child welfare clinic. Client received support from the husband and sister in-law during puerperium. Client practiced natural method of family planning by using the calendar method thus tracking her cycle.

1.8. PRESENT OBSTERTERICAL HISTORY

Madam Fati G2P1 first reported to Kintampo Municipal Hospital on 12th April,2021 with 8weeks gestation according to scan and complained of lower abdominal pains and general body weakness. Client could not remember her last menstrual period. The expected date of delivery was calculated to be 22nd November,2021 was calculated using scan.

Vital signs checked and recorded as follows.

- Temperature - 36.2^0c
- Pulse - 84 bpm
- Respiration - 22 cpm
- Blood pressure - 115/74 mmHg
- Height - 160 cm
- Weight - 65 kg

Urine test for protein, acetone and sugar tested negative. Other laboratory investigations were done and recorded as follows;

- Hemoglobin level - 12.8g/dl
- Blood group - O
- Rhesus factor - Positive

- HIV status - Negative
- Hepatitis B - Negative
- G6PD - No defect
- Sickling - Negative

Head to toe examination was conducted on client and no abnormalities detected. She was also given the following routine drugs.

- Tablet Folic Acid - 5 milligrams daily for 30days
- Tablet ferrous sulphate - 200 milligrams daily for 30days

Client said that she was given a mosquito net and also education was given to her on

prevention of malaria, rest and sleep, nutrition, and personal hygiene. And was told to report to the hospital anytime she feels unwell even if is not yet her time to come. She received tetanus diphtheria 1st immunization which was confirmed in her antenatal book and her first dose of Sulphadoxine Pyrimethamine (SP) was taken on 7th June,2021.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter provides information about client's visit to the antenatal, care rendered to client and subsequent visits made by the student midwife to client's home. Client's problems were stated and care plan was drawn to provide holistic care.

2.1 FIRST CONTACT WITH CLIENT

The first contact with Madam Fati was on 27th October,2021 at Kintampo Municipal Hospital. Which was on Wednesday around 9:00am. Client was in her 36^{+2} weeks of gestation. Her antenatal book was taken and she had had nine appointment records already.

As she was warmly welcomed to the hospital, self-introduction was made and rapport was established. Client was informed about my intention to use her for the care study. It was followed by checking of her vital signs. The records of which were as follows:

- Temperature - 36.2^0c
- Pulse - 98 bpm
- Respiration - 20 cpm
- Blood pressure - 117/69 mmHg
- Weight - 74 kg

Her blood sample and mid stream urine were taken to the lab for further investigations

- Haemoglobin level - 10.5 gram per decilitre
- Urine for protein and sugar - Negative.

The procedure for head to toe examination was explained to her and she was asked to

empty her bladder. Permission was sought from client to carry out the procedure. As the equipment for the examination was already set in the

palpation room. Privacy was provided and client was assisted to undress herself for

the head to toe examination. She was instructed to sit on the bed, lie on her left side and assume a supine position. Hand washing was done with soap under running water

and dried with a clean towel.

GENERAL PHYSICAL EXAMINATION

A tray comprising of the following items;

1. A sterile gallipot with sterile cotton wool swabs with a lid
2. A receiver for used cotton wool swabs.
3. A tape measure
4. A fetal stethoscope
5. A watch with a second hand
6. A pen and client's folder

Head examination

Head; was examined for cleanliness, lice, dandruff, ringworm, alopecia, scalp infection and no abnormality was detected. Client was congratulated for keeping the hair clean and encouraged to keep it up.

The face; was inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected. The ears were also inspected for discharges and nothing abnormal was

detected. The mouth was inspected for dryness, cracks and infections of the lips. The gums and tongue for pallor, sores, and lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and nothing abnormal was detected.

Breast examination

Both breasts were exposed to check for size, shape and condition of the skin. One breast was covered and was asked to put the hand of the examined breast under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self- examination of the breast, nipples were squeezed gently for fluid (colostrum) for odor or blood and cleaned with cotton wool swab and it was clear. On examination, both breasts were almost equal in size with areolar and no lymph nodes and lumps detected. Client was encouraged on the need to perform self-breast examination regularly after delivery, as it helps in early detection of any abnormality. Client was encouraged to wear well- fitting braziers to support the breast and enhance comfort.

Chest; was observed for breathing pattern.

Limbs;

The upper and lower extremities were checked for tingling sensations, stiffness, edema, and varicosities. Palms and soles were checked for pallor. Nails were examined for cleanliness, capillary refill and cyanosis. And no abnormality was detected no extra digits.

Abdominal examination

Before abdominal palpation bladder must be emptied, because full bladder will make the examination uncomfortable and can also make the measurement of the fundal height less accurate. Client was asked to empty her bladder if she has the urge, then abdominal examination was started by robbing hands together in order to help prevent premature induction of contraction.

On Inspection, the shape of the abdomen was ovoid with no scars or rashes. Linea nigrae and straie gravidarum were present. Fetal movement was obviously noticed.

To Measure the symphysio-fundal height, the fundus and upper boarder of the symphysis pubis were located. The zero mark of the measuring tape was placed on the fundus and extended along the uterus and then extended to the symphysis pubis. The symphysio-fundal height was 36 centimeters and gestational age was 36^{+2} weeks.

On Fundal palpation: Facing the head end of client, palms were rubbed for warmth and fundal palpation was done with both palms curved inwards at the fundus of the uterus. Through the process, it was detected that the buttocks of the foetus were occupying the fundus.

Lateral palpation; on lateral palpation still facing the woman, the palms were place on either side, with one hand stabilizing one side of the maternal abdomen, the other hand in a rotary movement to locate the fetal back. This was repeated at the other side and the fetal limbs were felt at the left side. The position of the fetus therefore was right occipito anterior

Pelvic palpation; on pelvic palpation, the lower pole of the abdomen is just palpated. Client was asked to bend her knees slightly in other to relax her abdominal muscles and take a deep breath through her mouth. The sides of the uterus just below the umbilical level are grasped without causing any discomfort between the palms. The fingers are held together downwards and inwards, a hard mass with a round outline was felt which indicates the fetal head.

Descent; the anterior shoulder was located during palpation, upon locating the symphysis pubis with the ulna boarder just above the symphysis and anterior shoulder. Five fingers occupied the space indicating descent of $5/5^{th}$.

Auscultation; the fetoscope was warmed by rubbing it on the palms. The fetoscope was placed at the area where the back was located to listen to the fetal heart rate which was been compared with the maternal pulse to prevent wrong readings. Fetal heart was 140 beats per minutes.

Permission was sought to inspect her vulva. Client's vulva was inspected, before the examination the light was turned on and directed towards the genital area for clear view. Hands were washed and dried then gloves were worn. The labia, clitoris and the perineum were checked, they had no abnormalities such as edema, rashes, warts or blisters and there was no female genital mutilation and no abnormal discharges were seen. The gloves were removed after the examination. Client was asked to lie on her left side and stand up and was given a seat to sit on.

Education was given on birth preparedness and complication readiness, diet, prevention of malaria and personal hygiene. She was encouraged to report to the clinic when she detects any abnormality. Findings were communicated to client and recorded. She was informed of her next visit to the clinic. The intention of visiting her house was made known to her and direction to her house was shown as phone numbers were exchanged and appointment was also booked to visit her in her house. A date which was scheduled for the home visit was on 2nd November,2021.

Her routine medications were given to her as follows;

Tab folic acid 5mg daily for 7 days

Tab ferrous sulphate 200mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days

She was encouraged to take the drugs as prescribed and reminded again of the next visit to the hospital which was on 4th November,2021. She was thanked for the cooperation and escorted. Madam Fati was asked about the preparations towards delivery and layette was inspected, everything on the delivery list was intact and was neatly arranged in a traveling bag. She said she had a donor and a number of an okada rider in case emergency arises. Education on the signs of true labor which were, painful regular and rhythmic uterine contraction, a blood stained mucoid discharge thus show from the vagina, rupture of membranes was given. Client was encouraged to visit the clinic immediately any of these signs are experienced and take her drugs as prescribed. Client was further asked if there is any problem and she complained of experiencing pains in her lower abdomen, fatigue and heart burns. Client was educated on her complains and was told to take enough rest. Interpersonal relationship was made with her neighbors.

Vital signs were checked and recorded as follows;

Temperature - 36.70c

Blood pressure - 110/70 mmHg

Pulse - 88 bpm

Respiration - 22 cpm

Weight - 75 kg

Physical examination from head to toe was done and nothing abnormal was detected. Abdominal examination was done, and the abdomen looked globular. Fetal movements were noticed.

On palpation, the fundal height was 36cm with 36^{+5} weeks' gestation. The lie was longitudinal, presentation was cephalic and a descent of 5/5th above the pelvic brim.

On auscultation, the fetal heart rate was 136bpm with regular rhythm and good volume. Client was thanked and was told to get up, dress and sit down.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Fati's house was on 2nd November,2021, which was on Tuesday at 10:00 am as scheduled. The main aim of the visit was to observe the environment, source of water, light, ventilation, number of people she shares her room with, where she disposed her refuse and her interpersonal relationship with her family members and neighbors. And also how she was doing.

2.3 PHYSICAL ENVIRONMENT.

Client's house is about 15minutes drive from the hospital. Madam Fati came to meet me at the roadside and took me to her house. She welcomed me and offered me a seat. The house is located close to and is near the road side. Client lives with husband, daughter and other tenants in the house. The house was built with blocks and plastered with cement, roofed with aluminum sheet and painted yellow. It has ten rooms and a store room with bathroom and toilet located inside the house and a compound for domestic activities. Their source of water is the pipe borne water located in the house. Client cooks in her kitchen. According to Madam Fati, the bin is emptied every two weeks. Permission was asked to go to her room and was granted. The room was well kept with chairs and table arranged neatly in the room, client was congratulated and asked to keep it up. The room had two big windows for proper ventilation. In the room, they had a wooden bed with an insecticide treated net hanging loosely over it, Madam Fati was encouraged to sleep under it with the family every day. Their clothes were nicely folded in her wardrobe and their source of light was a florescent light. The backyard was well cleared and tidy. Client was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of infections and also to wash the hands with soap under running water after visiting the toilet and touching objects.

A day was scheduled for the next visit, and that was on 8th November, 2021. She was thanked and bid good bye.

2.4 PSYCHOSOCIAL

Client lives in a house with ten rooms with her husband, children and other tenants at marigold, a town in kintampo. It is a permanent house built with block. Madam cooks in the kitchen inside her house. Their toilet and bathroom are inside the house. She fetches water from a pipe in the house for domestic activities and stores it in a clean large blue barrel with a lid. Madam Fati's room is a well ventilated and her windows are louvered. Electric power was her source of light. Client introduced the student midwife to other neighbors as her personal midwife who will be taking care of her throughout pregnancy, labour and puerperium and it was realized that she was in good relationship with them.

2.5 SUBSEQUENT VISIT TO ANTENATAL CLINIC

On 4th November,2021, Madam Fati came to the clinic as scheduled around 9am. She was welcomed and offered a seat. Vital signs were checked and recorded as follows;

Temperature - 36.8^{0}c

Blood pressure - 110/70 mmHg

Pulse - 84 bpm

Respiration - 22 cpm

Weight - 75 kg

Client's midstream urine and blood sample was taken to the lab for further investigations. Results are as follows;

Blood for hemoglobin level - 11.2g/dl

Urine for sugar and protein - Negative.

Physical examination from head to toe was done and nothing abnormal was detected. Abdominal examination was done, and the abdomen looked globular. Fetal movements were noticed.

On palpation, the fundal height was 37cm with 37^{+3}weeks gestation. The lie was longitudinal, presentation was cephalic and a descent of $4/5^{th}$ above the pelvic brim.

On auscultation, the fetal heart rate was 138bpm with regular rhythm and good volume. Client was thanked and helped off the examination bed and then assisted to dress up and a seat was given to her. All findings were communicated and documented in her maternal health record book. Client complained of constipation and was encouraged to take in enough fluid, foods rich in fiber and fruits to aid in bowel movement. Client's routine drugs were given. These were as follows;

Tablet folic acid 5mg daily for 7 days

Tablet ferrous sulphate 200mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days

Next appointment day was communicated to her as 11th November, 2021. Madam Fati was reassured and escorted.

2.6 SECOND ANTENATAL HOME VISIT

On 8th November,2021, the second home visit was made. The main aim of the visit was to know how client and family are doing and to remind client on birth preparedness and complication readiness. On arrival, the client gave a smiling welcome and a seat was offered. Client was asked how she was faring and a quick introduction was made to the family since they were all around. Inspection was made on the required items for delivery and everything was intact. Education was given to them on the importance of family bonding especially between children and the unborn baby to prevent sibling rivalry, the need to practice exclusive breast feeding after birth was also made. Client complained of increased frequency of micturition and explanation was given as a normal physiology during the latter part of pregnancy. It was further explained that the fetal head

exerts pressure on the bladder which causes increased urination. Vital signs were checked and recorded as:

Temperature	-	36.80c
Blood pressure	-	110/70 mmHg
Pulse	-	84 bpm
Respiration	-	22 cpm
Weight	-	75 kg

Physical examination from head to toe was done and nothing abnormal was detected. Abdominal examination was done, and the abdomen looked globular. Fetal movements were noticed.

On palpation, the fundal height was 37cm with 37^{+6} weeks' gestation. The lie was longitudinal, presentation was cephalic and a descent of $4/5^{th}$ above the pelvic brim.

On auscultation, the fetal heart rate was 140bpm with regular rhythm and good volume. Client was thanked and seat was given to her to sit on.

Client said her husband and sister in law would be the helpers to the clinic if labor commences. Client was reminded on the signs of true labor and was encouraged to report as soon as those signs are being notice. Madam Fati and her husband were thanked. Permission was sought to leave and client was told to call anytime she sees any signs of labor or if any problem occurs.

2.7 NURSING CARE PLAN DURING ANTENATAL CARE

On 2ND November,2021, Client complained of;

1. Lower abdominal pains
2. Fatigue
3. Heartburns

On 4TH November,2021, Client complained of;

4. Constipation

On 8th November,2021, Client complained of;

5. Increased frequency in micturition

SHORT TERM OBJECTIVES

- Client will be able to cope with lower abdominal pains throughout her period of pregnancy.
- Client will restore energy within 24 hours.
- Client will be relieved of heartburns within 48 hours.
- Client will restore her normal bowel movement within 48 hours.
- Client will be able to cope with increased frequency of micturition within 24 hours

LONG TERM OBJECTIVES

Client will stay healthy throughout her pregnancy period without any complication.

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
2/11/2021 9:30am	Lower abdominal pains related to pressure exerted by the presenting part.	Client will be able to cope with lower abdominal pains throughout pregnancy as evidenced by; Client verbalizing, she is able to cope with pains.	1. Explain to client the cause of lower abdominal pain. 2. Educate client to avoid prolong standing when performing activities. 3. Encourage client to have adequate rest. 4. Encourage client to adopt a good posture.	1.Client was being told that the pain was as a result of pressure exerted by the presenting part. 2. Client was educated to sit down when performing domestic activities. 3. Client was encouraged to have enough rest during the day and night. 4. Client was encouraged to adopt a comfortable position when sitting or lying down.	10/11/2021 7:30pm	Goal was fully met as evidenced by client verbalizing that the pain has reduced.	RAB

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
2/11/21 10am	Fatigue related to advanced stage of pregnancy.	Client will be able to restore energy within 24 hours as evidenced by 1.Client verbalizing her endurance to routine activities.	1. Educate client to avoid strenuous activities. 2. Educate client to involve others in household chores. 3. Encourage client to have enough rest. 4. Encourage client to plan her activities. 5. Encourage intake of good nutrition.	1. Client was educated to avoid activities that involves a lot of energy, like running. 2. Client was encouraged to assign roles to other family members to reduce work load. 3. Client was encouraged to rest and sleep in between activities to conserve energy. 4. Client was encouraged to plan her daily activities and prioritized them individually to reduce workload. 5. Client was encouraged to take in foods rich in protein, iron, minerals and carbohydrate to boost energy level.	10/11/21 7:30pm	Goal was fully met as evidenced by client verbalizing her endurance to routine activities.	RAB

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
2/11/2021 9:30am	Gastrointestinal reflux related to physiological process of pregnancy.	Client will be relieved of heartburns within 48 hours as evidenced by; 1. Client verbalizing that she has been relieved of heartburns. 2. Midwife observing that; client is adhering to management measures.	1. Educate client to avoid bending over immediately after eating. 2. Educate client to adopt a good posture. 3. Educate client on appropriate nutrition. 4. Encourage client to eat small amount of meal. 5. Educate client to eat early.	1.Client was educated to sit for a while after eating. 2. Client was educated to sit when doing household chores. 3. Client was educated to avoid spicy and oily foods. 4. Client was encouraged to eat small amount of meals at frequent interval and avoid over eating. 5. Client was educated to avoid going to bed immediately after eating.	10/11/2021 2pm	Goal was fully met as evidenced by client verbalizing that the heartburns have been reduced.	RAB

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
4/11/2021 9am	Altered bowel movement (constipation) related to deficient peristaltic movement in the gastro intestinal tract secondary to hormonal influence (progesterone)	Client's normal bowel movement will be restored within 48 hours as evidenced by; 1. client verbalizing that she is able to pass stools once daily. 2. Midwife observing that client is relieved.	1. Encourage client to take in enough fluid. 2. Educate client on proper nutrition. 3. Encourage client to engage in minimal exercise 4. Encourage client to empty her bowel frequently. 5. Educate client to take in lukewarm water.	1. Client was encouraged to take at least 3 litres of water daily. 2. Client was educated to take in diet rich in fibre and roughages. 3. Client was encouraged to do exercise such as walking or sweeping. 4. Client was encouraged to empty her bowel any time she feels the urge to. 5. Client was educated to take in lukewarm water in the morning before meals.	10/11/2021 7pm	Goal fully met as client was able to pass stool once daily	RAB

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
8/11/2021 10:30am	Frequency of micturition related to descent of the presenting parts.	Within 24 hours, client will understand the physiology behind frequency of micturition and cope with it throughout pregnancy. As evidenced by 1. client verbalizing her ability to cope. 2. Midwife observing client's ability to cope with frequent micturition.	1. Reassure client 2. Explain the physiology to her. 3. Encourage client on the need to practice personal hygiene. 4. Encourage client to void every 1 – 2 hours. 5. Encourage her to have a pail close to her bedside when sleeping.	1. Client was being told that, it is as a result of the baby moving to the pelvis. 2. It was explained to client that is as a result of descent of the presenting part. 3. Client was encouraged on the need to keep vulva clean and wear cotton under wears. 4. Client was encouraged to void whenever she feels the urge to. 5. Client was encouraged to use a pail at night rather than walking a distance to urinate	11/11/2021 10:30pm	Goal fully met as client verbalized that she has now understood why she is urinating frequently and will try to cope with it.	RAB

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about the care rendered to the client during labor which includes; management of first and second stage, immediate care of baby at birth, active management of third stage, delivery and examination of placenta and membranes, examination of baby, management of fourth stage and summary of labor.

3.1. ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Saturday,13th November, 2021 around 2:10am, Madam Fati came to the clinic with husband and sister in law. They were welcomed and offered a seat. Client complained of having lower abdominal pains and hardening of the abdomen which was uterine contractions which started around 8:00pm in the night. She said the pains were becoming very strong and that she couldn't bear them anymore.

On assessment, client was seen to be in pain but was coping with it as seen in her facial expression and was anxious. She was then taken to the first stage room and offered a bed, she was asked if she had eaten anything and the answer was no since it was too early. Client's antenatal book was taken and glanced through for previous history and gestational age which was 38 weeks +5days. A bed was prepared for the client and was assisted to change her clothes. She was given a bedpan and was asked to urinate in it whenever she had the urge to. Baby's layette was checked again (because it was first checked during home visit) and everything was intact. She was asked to empty her bladder for which she did to help in the decent of the fetal head. Urine was straw in color and measured 150mls. Midstream urine sample was taken to test for protein

and sugar it all recorded negative. Prior to the procedure of examination, client was given an explanation on the procedures to be performed and her consent was sought. Her vital signs were checked and recorded as;

Temperature - 36.7^0c

Pulse - 80 bpm

Respiration - 24cpm

Blood Pressure - 120/79mmHg

She was then assisted into a supine position and provided with privacy as well. After hand washing, head to toe examination was done under the supervision of the in-charge and no abnormalities were detected. Her face was a bit tensed because of the painful contractions.

On abdominal inspection, the abdomen was ovoid with the presence of stria gravidarum and linea nigra gestational age of 38weeks+5days and symphysio fundal height of 37cm.

On fundal palpation, a soft mass palpated at the fundus showed the fetal buttocks, laterally the right side of the abdomen was smooth and curved which indicated the back of the fetus whilst the left side of the abdomen felt rough indicating the limbs of the fetus. The lie was longitudinal, pelvic examination revealed a hard mass which indicated that the presentation was cephalic.

At 2:40am, descent was $3/5^{th}$, on auscultation the fetal heart beat was 148 beats per minute and uterine contractions of 3 in 10 minutes lasting for 35seconds.

Consent was sought from Madam Fati to perform vaginal examination to determine the dilatation of the cervix. Procedure was explained to client to allay anxiety and she agreed. A tray was set containing a sterile glove, a gallipot with sterile cotton wool swabs and another gallipot containing savlon, a sanitary pad and a receiver. Client was helped to assume a lithotomy position and was

draped. Hands were washed thoroughly with soap under running water, hands were dried and sterile gloves were worn. The vulva was inspected and nothing abnormal was detected. The vulva was then swabbed with five sterile cotton wool swabs soaked in savlon solution.

The vulva was swabbed from labia majora to minora, and then the vestibule using a different swab each time. She was then sensitized (touched) on the inner thigh to notify her that vaginal examination was about to be performed. On vaginal examination, the vagina was warm and moist. The cervix was soft, thin and the presenting part well applied to it. The cervical dilatation was 4 cm. The membranes were intact. The sacral promontory was not reached and the ischial spines were blunt. She was cleaned and a pad was applied to the perineum. Hands were thoroughly washed and dried. The findings were communicated and explained to client by showing her the dilatation board and findings recorded on the partograph.

At 3:10am; Uterine contractions was 3 in 10minutes lasting for 30 seconds, fetal heart rate was 140bpm and maternal pulse was 82bpm.

At 3:40am; Uterine contractions was 3 in 10minutes lasting 30 seconds, fetal heart rate was 138bpm, and maternal pulse was 88bpm.

At 4:10am; Uterine contractions was 3 in 10minutes lasting 38 seconds, fetal heart rate was 140bpm and maternal pulse was 90bpm.

At 4:40am; Uterine contractions was 3 in 10minutes lasting 30 seconds, fetal heart rate was 142bpm and maternal pulse was 88bpm whiles temperature was recorded as 36.7^{o}c. Later client was seen touching her perineum with uncleaned hands. She was then advised to avoid such practice as she is introducing infections into her body.

At 5:10am; Uterine contractions was 4 in 10minutes lasting 35seconds, fetal heart rate was 146bpm and maternal pulse was 82bpm.

At 5:40am; Uterine contractions was 4 in 10minutes lasting 40 seconds, fetal heart rate was 148bpm and maternal pulse was 90bpm.

At 6:10am; Uterine contractions was 4 in 10minutes lasting 40seconds, fetal heart rate was 145bpm and maternal pulse was 86bpm.

At 6:40am, Uterine contractions was 4 in 10minutes lasting 45seconds with fetal heart rate 150bpm. It was time for the next vaginal examination, which indicated that the cervical os had dilated for 8cm. Spontaneous rupturing of membranes. Descent was $1/5^{th,}$ fetal moulding was +, blood pressure was 120/70mmHg, temperature was 36.1°C, pulse was 90bpm. She was assisted to lie on her left and breathe through her mouth since she was complaining of severe lower abdominal pains. She also complained of hunger. Her sister in law bought her some porridge and she ate all.

PREPARATION FOR BIRTH

In preparing for birth a skilled and an unskilled helper were identified. Client's sister in law served as an unskilled helper, she was told she would be called in case she was needed, the midwife in – charge served as the skilled helper to help assist in caring for both mother and baby. The emergency plan which included transportation in case of any referral was made ready. Telephone numbers of the receiving facility was on the wall of the labor ward. The area for delivery was prepared by closing the windows to provide privacy. The mother's hands and chest were cleaned to prepare for skin to skin care when labor was imminent. The lamp was tested to check if it was working, an emergency lamp was also ready, and the environment for delivery was also cleaned. The ventilation bag and mask were tested and they were in good shape for use. Client was informed

that her time of delivery was getting near and she should be ready. Client was then told to lie on her left side to enhance placental blood flow to the fetus, she was also told to urinate whenever she had the urge to empty her bladder since it would help in the decent of the fetal head. Client was encouraged to do deep breathing exercise when pain commenced and she was asked not to bear down prematurely. She was reassured and was told that the discomfort was due to the engagement of the fetal head. Client was given sacral massage to restore her comfort. Client was sweating and vomiting so she was encouraged to take in enough fluid to prevent dehydration. Fetal heart, contraction, and pulse were checked and recorded every 30 minutes. Vaginal examination, decent of fetal head and blood pressure were monitored 4hourly. Temperature was also recorded two hourly.

At 7:10am; Uterine contractions was 4 in 10minutes lasting 48seconds, fetal heart rate was 148bpm and maternal pulse was 94bpm.

At 7:40am, contractions were 4 in 10 minutes lasting 45 seconds, fetal rate was 148bpm and maternal pulse was 92bpm.

At 8:10am, contractions were 4 in 10minutes lasting 48seconds. Fetal heart was confirmed by the midwife on duty heart rate was 142bpm, maternal pulse was 96bpm.

At 8:40am, descent was $0/5^{th}$, contractions were 4 in 10minutes lasting 46seconds. Fetal heart rate was 150bpm and maternal pulse was 90bpm. She complained of bearing down. Client was encouraged to breathe through her mouth. It was explained to Madam Fati that the cervix was fully dilated and was confirmed by vaginal examination of 10cm and moulding of ++ and her baby would soon be delivered.

Delivery trolley already set was push to client’s bedside to conduct delivery.

The top shelves contained the following items

Sterile delivery packs containing;

Two artery forceps

Four clean towels

Two gallipot with cotton wool swab and gauze respectively

One cord scissors

Episiotomy set

Oxytocin

Cord clamp

Sterile gloves

Lower shelf containing

Perineal pads

Receiver for placenta

Measuring jug

Syringe and needle

Receiver for used swabs

Identification band

Urethral catheters of different sizes

Urine bag

Fethoscope

Antiseptic lotion

Bed pan

Mackintosh

Three clean cot sheet

A drug tray containing injection Lidocaine, water for injection, injection vitamin K, and Chloramphenicol eye drop.

3.2. MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labor starts from full dilatation of the cervix (10 centimeters), to the delivery of the fetus.

Madam Fati was assisted to assume the lithotomy position which she chose with her legs well supported on the bed. Protective clothes were worn and hands were washed with soap and water then dried with a clean towel. Sterile gloves were put on and delivery pack was opened. The perineum, pubis and upper thighs were cleaned with savlon solution. Clean towel was used to drape the abdomen and another was placed under the buttocks. Fetal heart rate was also checked to assess the wellbeing of the fetus and recorded as 140beats per minutes. Vaginal examination was done again to confirm full dilation and then client was asked to bear down with contractions and rest in between. A clean perineal pad was applied to the perineum to support it. As soon as the head advanced, fingers were placed on the occiput to maintain flexion to allow the smallest

diameter to distend to prevent damage to the pelvic floor tissues and the vagina as well as to prevent rapid expulsion of the head. After crowning, she was told to stop bearing down as the head was delivered slowly by extension as the sinciput, face and chin swept through the perineum. The baby's eyes were cleaned with moist sterile gauze from the inner canthus out, to prevent infection to the eyes. The neck was felt for cord around neck to prevent neonatal asphyxia and there was none. Then waited for restitution of the head to occur to indicate the shoulders are in anterior posterior diameter with the pelvic outlet followed by external rotation of the head. The anterior shoulder was delivered by downward traction and posterior shoulder by upward traction. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 9:00am and she was congratulated. The abdomen was then palpated to exclude undiagnosed twins but there was none. 10 units of oxytocin injection was given intramuscularly on the lateral side of the woman's thigh.

IMMEDIATE CARE OF THE BABY

The baby was cleaned thoroughly immediately after birth and was then placed skin to skin on the abdomen to promote bonding. The baby and mother were covered with clean cloth to prevent hypothermia and promote warmth. The baby's cord was clamped with artery forceps at 3cm away from umbilicus and cut 2cm in between the two forceps after pulsations had ceased 3 minutes after the birth of the baby, the cord was covered with a piece of gauze to prevent splashing of blood. Baby was shown to the mother to identify the sex which was a female child. An identification band was placed on the baby's wrist with the sex, mother's name and time of delivery and she was placed on the mother's abdomen and covered with a warm cot sheet. Baby's Apgar score assessed at first one minute of birth was 8/10 and then five minutes after birth was 9/10.

3.3. MANAGEMENT OF THE THIRD STAGE OF LABOUR

After delivery of the fetus, the uterus was palpated to rule out any undiagnosed second twin after which 10 units of oxytocin was given intramuscularly on the thigh. The bladder was emptied by passing a straight urethral catheter and urine was estimated to be 100mls.

A sterile receiver was placed at her perineal region to receive the placenta and membranes. The non-dominant hand was placed on the fundus to feel for contraction of the uterus. The cord was re-clamped nearer to the perineum with one artery forceps. The cord and artery forceps was held with the dominant hand. As soon as the uterus contracted, the non-dominant hand was removed and placed just above the symphysis pubis with the palm facing the abdomen of the mother to provide counter traction to prevent uterine inversion during removal of the placenta. At the same time, the dominant hand that held the clamped cord was pulled gently in a downwards traction. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva. The placenta was held with the two cupped hands, and was gently turned until the membranes were twisted and delivered slowly. The time of delivery was noticed as 9:05am. The placenta was examined briefly for completeness and abnormality. The uterus was rubbed to expel clots to initiate contractions. The cervix, vaginal walls and perineum was cleared and inspected for lacerations and tears but none was found. She was taught how to massage her uterus and monitor blood loss. She was tidied up and a clean perineal pad was placed at the vulva and she was accompanied to the 4th stage room and made comfortable in bed. She was once again congratulated.

EXAMINATION OF THE PLACENTA

A thorough inspection of the placenta and membranes was done in order to ensure no part of it have been retained during its delivery. The placenta was held by the cord allowing the membranes to hang loosely downwards after removing it from chlorine solution. The cord was of normal size

and shiny and was centrally inserted with one big vein and two arteries surrounded by Wharton's jelly. The fetal surface was shinny and smooth with its color being bluish grey. The branches of the cord vessels were seen radiating on its' surface. The placenta was placed in the palm with the maternal surface facing upward. During inspection, the color was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface and neither was it edematous. It was then disposed off appropriately.

The working surface was wiped with 0.5% chlorine solution and decontaminated the delivery instruments in 0.5% chlorine solution for 10 minutes, washed with soap, rinsed, allowed to air dry and packed into the autoclave for sterilization. Findings were recorded on the labor ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also completed.

3.4. MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Fourth stage of labor is a period of first six hours following delivery of the placenta and membranes. It also includes the care and close monitoring of the mother and baby. Uterus was felt for contractions and her vital signs together with bleeding were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour, 1 hourly till the end of the 6 hours. The baby's condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. Madam Fati's first post-delivery vital signs were checked at 9:15am and was recorded as;

Temperature - 36.6^0c

Pulse - 82 bpm

Respiration	-	23 cpm
Blood pressure	-	120/80 mmHg
Lochia	-	rubra
Symphysio - fundal height	-	16cm

She was encouraged to empty the bladder frequently to prevent postpartum complications like postpartum hemorrhage. Uterus was massaged and blood loss was monitored. She was educated on personal hygiene and exclusive breastfeeding. Vital signs were checked and recorded on the partograph.

EXAMINATION OF THE NEWBORN

Mother and baby were made comfortable in a bed after the third stage. Hands were washed with soap under running water to prevent infection. The eye of the baby was cleaned and chloramphenicol eye drop was administered to protect the eye against infection such as ophthalmia neonatorium. The cord was also dressed using 6 cotton wool swabs soaked with methylated spirit. Mother was educated to wash hands before and after breast feeding baby. Head to toe examination of the newborn was done in the presence of the mother. The procedure was explained to the mother and consent was sought. Hands were washed and gloves were worn. The baby was placed on a clean warm flat surface and the part being examined was exposed at a time. The head was examined for shape and size, fontanels, overriding of bones at sutures, any edematous swelling and lacerations and everything was normal. The circumference was then measured by encircling the head with a tape measure from the occipital protuberance to the supra orbital ridges. The eyes were clear with no redness. The ear was examined and the cartilage of the two ears was well developed. The nose was inspected for size, shape, presence of polyps and the septum to detect if

there was any deviation, with which they were none. The mouth was checked for cleft lip and palate by using the little finger to feel the palate, the gums for presence of false teeth and the tongue for tongue tie and it was normal. Suckling and rooting reflexes were also checked. The neck was examined for congenital goiter and rigidity, swelling or any growth but no abnormality was detected. With the examination of the chest, inspection was done to check shape, movement of the chest wall, grunting respiration and sternal retraction and all was well. The breast was palpated for masses, the position of the nipple and extra nipple were checked but everything was normal. The apex heart beat was also checked and recorded as 125bpm. The upper extremities were inspected for extra digits, webbing, missing digits, hands and arms for symmetry, movement, paralysis, number of palmer creases, shape and color of nail beds and also grasping and moro reflexes were checked. The abdomen was inspected for shape, size, and distension and palpated for enlarged spleen and liver, the cord for bleeding and number of vessels. The bowel was auscultated for bowel sounds, palpated for tone and distention. The bladder was palpated for masses and tenderness which was normal. The external genitalia were examined for presence of labia majora, minora and pseudo menses. The anus was also checked for patency as baby passed meconium and urine. The lower limbs were also examined. The baby was turned on her back with the head turned to one side and the spine was checked for presence of any swelling, dimples, hairy patches, spinal bifida and meningocele and no abnormality was detected. The skin was examined for color, rashes, birthmark and peeling. In all there was no abnormality found. The length, head circumference, weight and temperature of the baby were taken and recorded. Finally, injection vitamin K 1.0mg was given on the right thigh of the baby to prevent hemorrhagic disease of the new born. Vital signs were also checked and the findings were communicated to the mother and documented as follows:

Head circumference - 34 cm

Length - 53 cm

Weight - 3.3 kg

Temperature - 36.5^0c

Respiration - 43 cpm

Pulse - 125 bpm

SUMMARY OF LABOUR

Date and time for delivery - 13th November,2021 and 9:00am

Time of expulsion of placenta and its membranes - 9:05am

Blood loss - 150mls

Mode of delivery - Spontaneous vaginal delivery

Drugs (Oxytocin) - 10units

DURATION OF LABOUR

1st Stage - 6 hours

2nd Stage - 20 minutes

3rd Stage - 5 minutes

Total time - 6hours, 25minutes.

Condition of Mother After Delivery

Temperature	-	36.6°c
Pulse	-	82bpm
Respiration	-	23cpm
Blood pressure	-	120/80mmHg
Uterus	-	Well contracted
Symphysio fundal height	-	16cm
Perineum	-	Intact
Lochia	-	Rubra

SUMMARY OF BABY AFTER BIRTH

Sex	-	Female
Birth weight	-	3.3 kg
Pulse	-	125 bpm
Respiration	-	43 cpm
Temperature	-	36.5^0c
Length of the baby	-	53 cm
Head circumference	-	34 cm
Meconium	-	passed
Urine	-	Passed

Baby's condition was satisfactory.

Apgar Score

	First minute	**Fifth minute**
Appearance	2	2
Pulse	2	2
Grimace	1	1
Activity	1	2
Respiration	2	2
Total	8/10	9/10

3.5. NURSING CARE PLAN FOR LABOUR

This includes problems identified during labor, nursing diagnosis, short term objectives, long term objectives and care plan for labor.

PROBLEMS IDENTIFIED ON CLIENT ON THE 13TH NOVEMBER,2021 INCLUDES;

- Client complained of lower abdominal pains.
- Client was anxious.
- Client was sweating excessively.
- Client was seen touching her perineum with bear hands.

SHORT TERM OBJECTIVES

- Client will cope with lower abdominal pains till she delivers.
- Client will be less anxious throughout labor.
- Client will be comfortable within 2 hours.
- Client will be free from infection throughout labor.

LONG TERM OBJECTIVES

Client will go through labor and deliver safely without any complications to her and the baby.

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
13/11/21 6:50am	Lower abdominal pains related to painful uterine contractions in labor.	Client will cope with lower abdominal pain throughout labor as evidenced by; 1. Client verbalizing that she is coping with the pain. 2. Midwife observing client adopting good coping mechanisms. Like; walking.	1. Explain the cause of the pain to client. 2. Encourage deep breathing exercise. 3. Encourage client to cope with pain. 4. Allow client to assume a comfortable position.	1.Client was being told that her pain is as a result of the contraction and will go after the child is out. 2. She was encouraged and taught how to perform deep breathing exercise. 3.Client was encouraged to cope with the pain she was experiencing such as, avoid pushing prematurely. 4. Client was assisted into a comfortable position and encouraged to walk around if she wanted to, for relief.	13/11/21 9:30am	Goal was partially met as client verbalized that she is coping and midwife observed client adopted coping mechanism. Like; walking.	RAB

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
13/11/21 2:20am	Anxiety related to unknown outcome of labor	Client's confidence will increase and anxiety level will be reduced throughout labor, as evidenced by; 1. Client being able to relax and cooperate during procedures. 2.Midwife observing client with relaxed expression.	1. Explain procedures to client. 2.Encourage client to ask questions. 3. Involve client's relatives in the process of care. 4. Encourage her to voice out all her needs and fears. 5.Tell client about progress of labor.	1. All procedures to be performed on client were explained to her to allay anxiety. 2.Client was engaged in conversation to bring out her questions and was answered appropriately. 3. Client's relatives were involved to give emotional support to the woman. 4. Client was encouraged to voice out all her needs and fears. And all her questions were answered appropriately 5. Client was informed on progress of labor after each procedure and was congratulated.	13/11/21 9:30am	Goal fully met as client was no more anxious and cooperated throughout labor.	RAB

NURSING CARE PLAN DURING LABOR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDER	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
13/11/21 2:50am	Excessive sweating related to painful uterine contractions	Client will be comfortable within 2 hours' time as evidenced by; the midwife observing that the excessive sweating has reduced.	1. Open nearby windows. 2. Give client cold water. 3. Mop her face and body. 4. Change bed linen to make her comfortable. 5. Switch on nearby fans to improve ventilation.	1. Nearby windows were opened for air to circulate. 2. Client was given cold water to sip. 3. Client's face and body was mopped with a clean damp towel. 4. Client's bed linen was changed when wet to make her feel comfortable. 5. Nearby fans were switched on.	13/11/21 9:30am	Goal fully met as midwife observed the excessive sweating has reduced.	RAB

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/11/21 4:40am	Potential for infection related to client's poor hygiene practices.	Client will be free from infection throughout labor as evidenced by; 1. Client showing no signs and symptoms of infection. 2. Midwife observing client has no signs of infection such as fever.	1. Educate client to practice good personal hygiene. 2. Educate client on how to dispose off used pads. 3. Place sanitary pads at easy reach for client. 4. Encourage client to change pads always. 5. Encourage client to wash the hands before and after changing soiled pads	1. Client was educated on the importance of adopting good personal hygiene. 2. Client was educated on the appropriate disposal of used pads. 3. Sanitary pads were placed beside client's bedside. 4. Client was encouraged to change soiled pads frequently. 5. Client was taught on proper hand washing technique and to practice it before and after handling used pad.	13/11/21 4:00pm	Goal fully met as evidenced by client not showing signs of infections	RAB

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter comprises of the day of delivery, postnatal home visits, first and second subsequent visit to the clinic by client and her baby.

4.1 MANAGEMENT DURING PUERPERIUM

Madam Fati and her baby were sent to the lying in ward after the third stage. They were made comfortable in bed. Their conditions were monitored closely and she was encouraged to have good sleep. At 10:00am, mother was assessed for bleeding and blood loss was 50mls, her lochia was rubra and the flow was normal. The uterus was firm and well contracted with symphysio-fundal height being 16cm. Her vital signs were checked and recorded as follows;

Temperature - 36.8^0c

Pulse - 86 bpm

Respiration - 22 cpm

Blood pressure - 114/75 mmHg

Lochia - rubra

Vital signs were checked every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for the last 3 hours. On examination, no abnormality was detected. She was encouraged to empty her bladder frequently to prevent postpartum hemorrhage and also change her perineal pad when soaked to prevent infection. She was asked to massage the uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest hemorrhage. At 10:15am, client complained

of lower abdominal pain and she was served with 1g of tablet paracetamol to help relieve pain. She was educated to breastfeed exclusively on demand and wash hands before breastfeeding baby. She breastfed her baby after which her husband and sister in law came to congratulate her. Client was left to rest.

SUBSEQUENT CARE OF THE BABY

The baby was allowed to be with the mother for some hours. After that period the mother was informed about the need for thorough head to toe examination to exclude any abnormality and birth injuries to the baby. A set up tray containing the following; sterile gallipots with cotton wool, swabs, cord ligature, cord scissors, receiver, warm towel, tape measure and gloves, weighing scale, plastic apron, good light source and normal saline, were sent to the examination table for the procedure. This was done in the presence of the mother. The nearby windows were closed to make the room warm to prevent the baby from hypothermia. Hands were washed and dried before. The baby was placed on a covered flat surface, and exposed only the part of the body to be examined. The moro, suckling and rooting reflexes were present. Her general appearance and cry were normal, color was pink, no skin rashes, lesion, peeling or birthmarks were noticed. There was vernix caseosa and lanugo present on the baby. The head was examined, and the size and shape were normal, no caput succedaneum or lacerations were noticed. The sutures were not wide and fontanelles were not bulging or sinking and pulsation was also good. The eyes were examined and they were normally situated. There was no redness, discharge, hemorrhage or jaundice. The ears were normally situated with the pinna well formed with no discharge. The nose was also situated in the center of the face and septum well formed. The nostrils were inspected and there was no discharge. There was no cleft palate or harelip notice on the mouth, no false teeth and tongue tie were seen in the mouth. The neck was examined and found to be flexible. No congenital goiter,

swelling and growth were detected. The chest was examined for shape and no abnormality was detected. Breast was palpated for consistency engorgement and masses but none was noticed. The nipples were at their normal position and no extra nipple and fluid were seen. The upper extremities were examined and hands were of the same length. There was no extra or missing digits, clubbing or webbed fingers. The nail bed and the grasping reflex were present. The abdomen was inspected and there was no distention. No liver and spleen was palpable. The cord was not bleeding and it has three vessels in it. The external genitalia were examined and there was no abnormality detected the lower extremities were examined, legs and feet were of the same length. There were no missing digits webbed or clubbed feet and forefoot abduction. The back was also checked for any swelling, dimples or hairy patches and missing vertebra but no abnormality was detected. The hip was checked, barlows test for developmental hip dislocation was done and nothing abnormal was detected. The findings of the examinations were communicated to the mother and no abnormalities were detected. Vital signs were checked and recorded as;

Temperature - 36.5^0c

Respiration - 44 cpm

Weight - 3.3 kg

Length - 53 cm

Head circumference - 34 cm

BABY'S FIRST BATH

Baby was given her first bath after six hours of delivery. Procedure was explained to client. Trolley was set and pushed to client's bedside containing

Top Shelf contained

- Methylated spirit in sterile galipot
- Sterile cotton wool swabs and gauze in a galipot
- Sterile water in a galipot

Bottom shelf

- Baby's towel and baby's diapers
- Baby's dress
- Surgical gloves
- Cot sheet to wrap the baby
- Baby's sponge
- Soap in a soap dish
- Disposable gloves
- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water
- Mackintosh apron

The procedure was explained to the mother on how to bath the baby and all items to be used were assembled. Plastic apron was worn. Hands were washed with soap and dried and gloves worn. Cold and hot water were mixed and temperature tested with elbow. Baby was placed on a protected flat surface and undressed after which she was wrapped with a cot sheet. Baby was not over exposed to prevent hypothermia. Client was asked to be present and observed so that when they go home she will repeat the same process till cord falls off. Baby was placed on a clean cot sheet and started with the cleaning of the eyes, this was done with two cotton wool swabs, the inner cantus was cleaned to the outer cantus and the face was cleaned with clean dumped towel. The head was also bathed, supported with one hand and thumb and index finger of the same hands were also used to plug the ears to prevent water from entering. The head was washed with soapy sponge, rinsed and dried. Baby was then exposed; the arms and front trunk were washed. Baby was turned with hand supporting one arm and chest and the baby resting in the elbow and the back of the body was bathed. Baby was immersed in the bath of warm water with the head above the water and rinsed. Baby was dried with a clean towel paying attention to the skin folds. Hands were washed and gloved with surgical gloves using an aseptic technique. The ligature was observed for looseness and relegated. The stem of the cord was held with one swab soaked in methylated spirit. The skin was swabbed 5cm away from the base of the cord. The base of the cord was cleaned with a fresh cotton wool swab. The stem of the cord was swabbed from the base upwardly in strokes to the tip. The cord was exposed and baby sent to mother. Findings were communicated to the mother. Shea butter was smeared on the baby's skin, hair combed and diaper was put on. Baby was well dressed and wrapped in a clean cot sheet again and handed over to the mother to breast feed. Client was advised not to cover the cord with diapers and also to change wet diapers frequently to prevent infection. She was advised to top and tail the baby till the cord falls off before proper bathing.

4.2. FIRST DAY POSTNATAL AND DISCHARGE

On the 14th of November 2021, which marked the first day of post-delivery, client and her baby looked healthy with no abnormality detected after head to toe examination was done. At 9:00am, vital signs were checked and recorded as;

MOTHER

Temperature	-	36.4^0c
Pulse	-	84 bpm
Respiration	-	23 cpm
Blood Pressure	-	120/80 mmHg
Fundal Height	-	15cm
Breast	-	Lactating
Lochia	-	Rubra

BABY

Temperature	-	36.4^oc
Apex heart beat	-	125 bpm
Respiration	-	42 cpm
Weight	-	3.2 kg

Permission was sought from client to perform a quick assessment on her and was granted. On palpation, the uterus was well contracted. The perineal pad was inspected with lochia being red

(rubra) and in small amount and not offensive. She was encouraged to change her pad frequently to prevent ascending infections to the uterus. She was encouraged to breastfeed baby exclusively and on demand. Permission was sought to examine the baby. Hands were washed with soap and dried with clean dry towel. On general examination there was no abnormality detected. The cord was checked for bleeding and discharge but there was none. The baby passed meconium and urine which was normal. The baby was dressed and put to breast. Client was educated on the effect of hot compress application on baby's head in other to close fontanels and was discouraged from doing so. She was educated on provision of warmth and prevention of infection. The mother and the baby were reassessed with no abnormality detected. She was encouraged to wrap baby well to maintain her temperature, and to breastfeed baby exclusively for six months on demand especially in the night, mother was encouraged to feed baby every 2 to 4 hours or 8 to 12 times per day, and also on how to recognize and manage some common breast problem such as cracked nipple, breast engorgement, and mastitis. She was also encouraged not to apply anything on the cord aside the methylated spirit that will be given to her. Client was encouraged to have enough rest and perform post-natal exercise. Madam Fati and family were informed about her discharge. Some routine drugs were given to her and the dosage and time for taking the drug were explained to her. Client was informed of continuity of care for seven days where she would be visited at home. She was assisted in packing her things and was encouraged to register the baby at the birth and death registry. Client was told to report to the facility on Monday,15th November for baby's immunization. Client was discharged home at 4:00pm with the following drugs;

Tablet folic acid - 5mg once daily for 7days.

Tablet Paracetamol - 1g twice daily for 3 days.

Capsule Amoxicillin - 500mg tds x 7days.

Tablet ferrous sulphate - 200 mg once daily for7 days.

4.4. FIRST DAY POSTNATAL HOME VISIT (14/11/21)

This was on the day of discharge Madam Fati and family were visited at 4:30pm. The purpose of the visit was made known as to support her and the baby during postnatal period to prevent complications to them. She had already taken her bath and was well dressed. Head to toe examination was done on her after the procedure had been explained to her and no abnormality was detected. The lochia was rubra (red) and was moderate with no offensive smell. Her vital signs were checked and recorded as;

Temperature - 36.5^0c

Pulse - 80bpm

Respiration - 20cpm

Blood pressure - 113/80 mmHg

Lochia - Rubra

Uterus - contracted

Breast - lactating

Permission was sought from the mother to top and tail the baby with warm water. Afterwards, the cord was dressed with methylated spirit and cotton wool swabs and left it opened while mother was sitting close watching the procedure. The procedure was explained to her and the baby was physically examined from head to toe but no abnormalities were detected. There were no swellings

or bruises on her head or body. Her skin color was pink all over. The breathing pattern was normal. After the procedure, mother told me that the baby passed meconium stool and urine. She was then encouraged to change diapers frequently. The baby's vital signs were checked as;

Temperature - 36.6^0c

Apex heart rate - 130 bpm

Respiration - 45 cpm

Weight - 3.2 kg

Cord - clean and not bleeding

Color - pink

Suckling - good

She complained of lower abdominal pain during breastfeeding, she was encouraged to continue breastfeeding and was reassured that the pain will subside as it is normal after delivery. She was reminded on her visit to the hospital the following day. Permission was sought to leave.

4.5. SECOND DAY POSTNATAL HOME VISIT (15/11/21)

At 8:00am a visit was paid to Madam Fati and the family, they were all in good health. Madam Fati was examined from head to toe. The breast was lactating well. She was educated to continue breastfeeding and also to feed the baby on demand. Client's vital signs were checked and recorded as;

Temperature - 36.6^0c

Pulse - 75 bpm

Respiration - 20 cpm

Blood pressure - 120/90 mm

Lochia - rubra

Uterus - contracted

Fundal height - 14cm

Breast condition - lactating

Client's sister in-law was assisted to top and tail the baby and after she was thought how to use methylated spirit in dressing the cord. The sister in-law wrapped the baby loosely in a sheet and made comfortable in bed. Baby's vital signs and other observations were recorded as follows;

Temperature - 36.5^0c

Apex heart rate - 132 bpm

Respiration - 33 cpm

Cord - shrinking

Suckling - good

Stool color - dark green

Color - pink

Weight - 3.1 kg

Client was escorted to the hospital for immunization.

At 10:00am, madam Fati, the baby and I together with her sister in law had reached the facility for the immunization. Baby was then weighed and measured as 3.1 kg. Two drops of polio '0'was given by mouth and injection BCG 0.05ml was administered intradermal to prevent polio and

tuberculosis. Client was educated not to apply anything on the injection site. Client was escorted and thanked.

At 4:00pm in the evening, client was visited again. Greetings were exchanged and a seat was offered. Reason for the visit was made known as to assess their general wellbeing. Permission was sought from client to perform general examination on her and the baby and it was granted. Head to toe examination was made on both mother and baby and there was no abnormality detected. Client complained of backache and she was educated on how to assume a comfortable sitting position when she is breastfeeding her child. Vital signs were checked and recorded as;

Mother's vital signs

Temperature - 36.5^{o}c

Pulse - 80 bpm

Respiration - 20 cpm

Blood pressure - 118/86 mmHg

Lochia - rubra

Uterus - contracted

Breast condition - lactating

Fundal Height - 14cm

Baby's vital signs

Temperature - 36.5^{0}c

Apex heart rate - 138 bpm

Respiration - 44 cpm

Cord - shrinking

Suckling - good

Stool color - dark green

Color - pink

Client was thanked and permission was sought to leave and it was granted.

4.6. THIRD POSTNATAL HOME VISIT (16/11/2021)

At 8:00am a visit was paid to Madam Fati and the family, they were all in good health. Madam Fati was examined from head to toe. The breast was lactating well. Client said the baby can now hold the breast. She was educated to continue breastfeeding and also to feed the baby on demand. Client's vital signs were checked and recorded as;

Temperature - 36.6^{0}c

Pulse - 80 bpm

Respiration - 20 cpm

Blood pressure - 110/80 mmHg

Fundal height - 13 cm

Lochia - rubra

Uterus - contracted

Breast condition - lactating

Client's sister in-law was assisted to top and tail the baby and after she was thought how to use methylated spirit in dressing the cord. The sister in-law wrapped the baby loosely in a sheet and made comfortable in bed. Baby's vital signs and other observations were recorded as follows;

Temperature - 36.8^{0}c

Apex heart rate - 132 bpm

Respiration - 33 cpm

Cord - shrinking

Suckling - good

Stool color - dark green

Color - pink

Weight - 3.0 kg

Client was reminded about evening visit. Permission was then sought to leave and it was granted. At 3:00 in the evening, client was visited once again. Greetings were exchanged and purpose of the visit was made known. Assessment was made on both the mother and the baby with her permission. No abnormality was detected and their vital signs were checked and recorded as;

Mother's vital signs

Temperature - 36.8^{0} c

Pulse - 80 bpm

Respiration - 20 cpm

Blood pressure - 120/69 mmHg

Lochia - rubra

Uterus - contracted

Breast condition - lactating

Baby's vital signs

Temperature - 36.7^{0}c

Apex heart rate - 132 bpm

Respiration - 33 cpm

Cord - shrinking

Suckling - good

Stool color - dark green

Color - pink

Madam Fati was given education on exclusive breast feeding and was encourage to wear loose dresses and braziers. Client was told that the remaining visit will be done once in a day. Permission was sought to leave and it was granted.

4.7. FOURTH POSTNATAL HOME VISIT (17/11/2021)

Client and family were visited at 8:30am. The aim of the visit was to know how they were doing. The main motive of the visit was made clear to them. Permission was asked to conduct a head to toe examination and it was granted. Head to toe examination was done and there was no abnormality detected on the client, perineal pad was inspected for lochia and the flow was moderate, pink in color (serosa) and not offensive. Findings recorded as follows;

Temperature - 36.5^{o} c

Pulse - 80 bpm

Respiration - 22 cpm

Blood pressure - 119/80 mmHg

Lochia - serosa

Uterus - contracted

Fundal height - 12 cm

Breast condition - lactating

Baby was topped and tailed by client's sister in-law under supervision. Baby's cord was dressed with methylated spirit and it looked dried and about to slough off, and baby was dressed nicely

and wrapped in white cloth and made comfortable in bed. Baby was assessed and the observations were recorded as follows;

Temperature - 36.8°c

Apex heart rate - 132 bpm

Respiration - 32 cpm

Cord - shrinking

Suckling - good

Stool color - yellowish green

Color - pink

Weight - 3.0 kg

Client complained of not able to have adequate sleep due to interruption with breastfeeding, Client was also advised to sleep in the afternoon when the baby too is asleep. Client was encouraged on good and enough breastfeeding during the day and to ensure the atmosphere is calm at night this will enable the baby to sleep at night and can also rest. Permission was asked to leave.

4.8. FIFTH POST NATAL HOME VISIT (18/11/2021)

At 8:30 am, client was visited once again. On arrival, Madam Fati was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God's grace. Her sister in law had already started with the baby bath so she was supervised in the process and the stump of the cord was dressed with methylated spirit and the baby was kept in the cot sheet.

Permission was asked to perform head to toe examination and was granted. No abnormality was detected. Her perineal pad was inspected and lochia was serosa with moderate flow and odorless. The perineum and vulva were clean and the symphysio fundal height was taken.

Vital signs checked were also recorded as follows:

Mother

Temperature - 36.4^0 c

Pulse - 85 bpm

Respiration - 23 cpm

Blood pressure - 120/80 mmHg

Lochia - serosa

Uterus - contracted

Fundal height - 11 cm

Breast condition - lactating

Baby

Temperature - 36.6^0c

Apex heart rate - 120 bpm

Respiration - 34 cpm

Cord - off and clean

Suckling - good

Stool color - yellowish brown

Color - pink

Weight - 3.1 kg

Findings were communicated to her, she was then asked if she had any complains or concern but there was none. She breastfed baby till she slept. She was educated on proper and regular hand washing before changing of pad when soiled to prevent infection. She was encouraged to wash underwear and dry them in the sun and not in the room. She was advised to change baby's diapers regularly when wet and was educated on vulva toileting. Client was informed that the care will be terminated in two days and permission was sought to leave.

4.9. SIXTH POSTNATAL HOME VISIT (19/11/2021)

Client was visited at 8:00am. On arrival, client and husband were eating, so seat was offered. Afterwards the aim of my visit was made clear. Her husband was excused and we entered her room. Permission was asked to perform head to toe examination and no abnormality was detected. Fundus was measured and perineal pad was checked and the flow was slight and no offensive smell. Client said that she had normal bowel and bladder function. She was encouraged to continue with the postnatal exercise to hasten the involution of the reproductive organs. She was also encouraged her to continue to sleep under a treated mosquito net with the baby to prevent malaria. According to her, she was helped with house chores by the family and as a result she never was tired during the day and therefore had enough time to rest. Her husband was encouraged to help in taking care of the baby and support her. Her husband was being told that, though exclusive breast feeding was a natural method of family planning, it would only last for a short period and so they had to visit a family planning unit at six weeks to start with a modern and preferred method. Baby was soundly sleeping, a quick head to toe examination was made and no abnormality was detected. Client was reminded on my termination of care.

Client's assessment and vital signs done were recorded as follows;

Temperature - 36.4^0 c

Pulse - 84 bpm

Respiration - 20 cpm

Blood pressure - 120/72 mmHg

Lochia - serosa

Uterus - contracted

Fundal height - 10 cm

Breast condition - lactating

Baby's assessment done and was recorded as follows;

Temperature - 36.6^0c

Apex heart rate - 136 bpm

Respiration - 32 cpm

Cord - off with clean stump

Suckling - good

Stool color - Yellowish brown

Color - pink

Weight - 3.2 kg

4.10. SEVENTHDAY POSTNATAL HOME VISIT

On 20th November,2021 at 9:30am was the last visit to Madam Fati's house. Client was doing well with baby and the entire family. All procedures to be carried out were explained. Hands were

washed and examination from head to toe was done but no abnormality was detected. Her symphysio fundal height was measured as 9cm. Lochia was inspected and it was pink in color (serosa) with no odour. The breast was soft and was lactating very well. Vital signs were checked and recorded as;

Temperature	-	36.3^0c
Pulse	-	80 bpm
Respiration	-	20 cpm
Blood pressure	-	110/70 mmHg
Breast	-	Well Lactating

The baby was examined and client supervised to bath and dress the stump of the cord which was done perfectly.

The baby's vital signs were checked and recorded as;

Temperature	-	36.7^0c
Apex heart beat	-	138 bpm
Respiration	-	42 cpm
Stool	-	yellow
Weight	-	3.3kg

The baby was dressed and handed over to the mother for breastfeeding. Emphasis was made on her perineal care and the intake of nutritious diets as well as avoiding the use of hot application on the fontanels. Client was encouraged to continue exclusive breastfeeding for 6 months. It was further explained that, exclusive breastfeeding could serve as a family planning method. Mother was reminded of the postnatal visit to the clinic and its importance. Client was told to report to the hospital when there was any problem as soon as possible, Madam Fati together with the entire

family was thanked for their cooperation. Client and her family also expressed their heartfelt gratitude after which goodbye was said.

4.11. FIRST POSTNATAL VISIT TO THE CLINIC

On the eighth day, 22nd November, 2021 at 8:25am Madam Fati and baby accompanied by sister in law arrived at the clinic for postnatal care. Client was neatly dressed and looked cheerful. They were welcomed and given a seat.

Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and she said they were doing well.

Client said her baby was able to feed well and passes urine and stools regularly.

Permission was sought from client to examine the baby generally. She granted me the permission and the procedure was explained to her.

The baby was taken, undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. Baby's weight was 3.6kg. There were skin rashes detected on the baby however there were no discharges from the eyes, nose and ears, and was told to apply powder on it. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was almost healed. The baby's vital signs were checked and recorded as follows;

Temperature - 36.4^0 C

Apex beat - 140 bpm

Respiration - 34 cpm

Weight - 3.4 kg

Head circumference - 34 cm

Fetal length - 53 cm

The baby was neatly wrapped before she was given back to the client sister in law. The findings were communicated to the mother.

Madam Fati was advised not to over dress the baby so as to prevent the rashes on the baby's skin from becoming worse.

Client was examined and her vital signs were recorded as follows;

Temperature - 36.6 ^{0}C

Pulse - 82 bpm

Respiration - 20 cpm

Blood pressure - 110/70 mmHg

Blood sample was taken to test for hemoglobin level and the result was 11.9g/dl. Permission was sought from client to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of midstream urine was taken and tested for glucose and protein and all tested negative. Hands were washed and dried and examination was commenced.

On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharging. Client's breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the symphysio-fundal height measured 8cm and she was encouraged to

do postnatal exercise. The flow of lochia was less and was serosa. After, findings were communicated to her and advised not to absent herself from postnatal clinic. Client was encouraged to report to the facility in case any emergency arises of any health issues.

TERMINATION OF CARE

Madam Fati was informed that the study at the facility has ended and for that matter she was handed over to the midwife in charge and also to the public health nurses to continue her postnatal care and she will be called if the need arises for any information, and she gladly said she will be available anytime needed. Both mother and baby were healthy without any complications. She and her entire family were thanked for making time for the study, kindness and cooperation and wished them the best of luck.

4.12. NURSING CARE PLAN DURING THE PUERPERIUM

This includes problems identified during puerperium, short term objectives, long term objectives and care plan for puerperium.

PROBLEMS IDENTIFIED

Client complained of lower abdominal pains.

Client complained of backache.

Client complained of sleepless night.

Skin rashes observed on the baby during physical examination.

SHORT TERM OBJECTIVES

- Client will be relieved of abdominal pain within 72 hours.
- Client will be relieved of backache within 24 hours.
- Client will be relieved of sleeplessness within 24 hours.
- Client’s baby will have normal skin integrity within 5 days.

LONG TERM OBJECTIVE

Client and baby will go through puerperium without any complications.

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
13/11/21 1:30am	After pain related to involution of the uterus.	Client will be relieved of pain within 72 hours as evidenced by; 1. client verbalizing that the pain has reduced. 2. midwife observing client in a relaxed mood of expression.	1. Explain to client the physiology of after pain during the puerperium. 2. Client was educated and encouraged on the need to urinate frequently. 3. Teach client on good body posture while breastfeeding. 4. Tell client to apply warm compress to the abdomen. 5. Serve prescribed analgesics (Tablet paracetamol, 1g.) 6. Encourage client to continue breastfeeding.	1.Client was informed that the lower abdominal pain is as a result of involution of the uterus. 2. Client was encouraged to urinate frequently to enable the uterus to contract. 3. Client was taught how to position and fix baby to breastfeed despite the pains. 4. Client was told to apply warm compress to the abdomen to relieve pain. 5. Prescribed analgesic was served to relieve pain. (Tablet paracetamol, 1g). 6.Client was encouraged on the need to continue breastfeeding to avoid breast engorgement.	16/11/21 2pm	Goal was fully met as client verbalized that she was relieved of after pain.	RAB

NURSING CARE PLAN DURING PUEPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSNG INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/11/21 6:00am	Backache related to poor posture during breastfeeding	Client will be relieved of backache within 24 hours as evidenced by; 1. client verbalizing that backache has been relieved. 2. midwife observing client adopting good posture during breastfeeding.	1. Explain to client the physiology behind the pains. 2. Educate client to adopt good posture when breastfeeding. 3. Demonstrate to client the correct position for breastfeeding. 4. Educate client to have enough rest and sleep. 5. Serve prescribe analgesics (tablet paracetamol 1g).	1. Client was told that her backache is as a result of poor posture during breastfeeding 2. Client was educated to sit on a chair with a back rest and raise her legs on a small table whiles breastfeeding. 3. Client was taught the correct position and attachment of baby to breast. 4. Client was educated to sleep for at least 2 hours and 8 hours during day and night time respectively. 5. Prescribed analgesic was served to relieve pain(tablet paracetamol 1g).	16/11/21 2:30pm	Goal was fully met as client verbalized that backache had been relieved.	RAB

NURSING CARE PLAN DYRING PUERPERIUM

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
17/11/2021 9:00am	Insomnia related to feeding baby at night.	Client will be relieved of sleeplessness within 24hours as evidenced by Client verbalizing she can sleep well.	1.Encourage her to feed the baby on demand. 2. Encourage her to sleep when baby is asleep. 3. Explain the importance of night breast feeding to her. 4. Encourage her support person to help her in the household chores. 5. Encourage client to rest enough during the day.	1. Client was encouraged on the essence of feeding on demand. 2. She was encouraged to sleep immediately baby is asleep. 3. Importance of night breast feeding was explained to her. 4. Client relatives were encouraged to help her in her household chores like washing to enable her to sleep during the day. 5. Client was encouraged to have enough rest and sleep for about 2 hours during daytime.	18/11/21 9:00am	Goal was fully met as client slept for 5 hours during the night and 2 hours during the day.	RAB

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/11/2021 10:00am	Skin rashes related to excessive sweating of baby at night.	Baby will have normal skin integrity within 5 days as evidenced by; 1. mother verbalizing that skin rashes have subsided. 2. Midwife observing diminished skin rashes on examination.	1. Educate client not to overdress the baby. 2. Educate client not to scratch the rashes. 3. Educate client to change baby's diapers regularly 4. Educate client to apply cream (e.g. Vaseline and shea butter to the area 5. Educate client to bath baby with mild soap and water.	1. Client was educated not to overdress the baby at night. 2. Client was educated not to scratch the rashes to prevent infection. 3. Client was educated to change baby's diapers regularly. 4. Client was educated to apply barrier cream (e.g. Vaseline and shea butter) to the area. 5. Client was educated to bath baby with mild soap and water always	26/11/21 9:00pm	Goal was fully met as skin rashes subsided, baby had normal skin integrity.	RAB

SUMMARY AND CONCLUSION

This client and family centered maternity care study was carried on Madam Fati, a 23-year-old gravida 2 Para 1 alive and her entire family through pregnancy, labor and puerperium safely without any complications.

Madam Fati was met as a regular attendant to the health center who was in her 36th week +2 days at the time she was met. Arrangements were made for her to be used as client and she accepted willingly. Various histories were taken and she was visited to render midwifery care to her and her entire family in her house. Client was assisted throughout her late pregnancy, labor and puerperium safely without any complication. During the care, she encountered some minor disorders and was managed appropriately through the use of the nursing process. She was also educated on importance of exclusive breastfeeding, personal hygiene; danger signs in pregnancy, nutrition, postnatal exercise among others were all discussed until she delivered.

Client had a spontaneous vaginal delivery to a live female infant on 13th November,2021with weight of 3.3kg at 9:00am. Placenta and membranes were delivered by the active management of the third stage. Client went through normal puerperium without any complications as of the time she was discharged home on the same day. Postnatal care was well rendered to her and the baby and all problems during the period were addressed promptly. Visits were made to her house to give daily routine care. She was visited till the 7th day after delivery and she later reported to the hospital for the first week and was handed over to the child welfare clinic for continuity of care.

In conclusion, client family centered maternity care study equipped me with the skills to deal with challenges of pregnant, laboring and puerperal women. It also established between the midwife and client as well as her family good interpersonal relationship.

Again, care study encourages learning by doing, the development of analytical and decision-making skills as well as reporting skills. Being base on the nursing process, the students become familiar with the use of nursing process as a basic for practice thereby encouraging evidence based nursing care, as it provides a systematic way of collecting data, analyzing information and reporting the results of nursing care.

The study also broadened student knowledge on issues concerning pregnancy, labor and puerperium. With this experience gained, standard care will be rendered to all clients that will come irrespective of their social status and the environment in other to reduce maternal and infant morbidity and mortality.

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APPENDIX I

ANTENATAL CHART

DATE	WEIGHT	BLOOD PRESSURE	URINE TEST	GESTATIONAL AGE	SYMPHYSIO FUDAL HEIGHT	PRESENTATION	DESCENT	FETAL HEART RATE	TREATMENT	COMPLAINS	NAME/SIGN.
12/4/21	65kg	115/74mmHg	negative/ negative	8weeks	-	-	-	-	Routine Drugs	No complains	AE
10/05/21	69kg	115/73mmHg	negative/ negative	12weeks	-	-	-	-	Routine Drugs	No complains	AE
7/06/21	69kg	107/71mmHg	negative / negative	16weeks	16cm	-	-	-	Routine Drugs	Feels well	GA
5/07/21	71kg	109/71mmHg	negative / negative	20weeks	21cm	Cephalic	-	154bpm	Routine Drugs	Feels well	GA

DATE	WEIGHT	BLOOD PRESSURE	URINE TEST	GESTATIONAL AGE	SYMPHYSIO FUDAL HEIGHT	PRESENTATION	DESCENT	FETAL HEART RATE	TREATMENT	COMPLAINS	NAME/SIGN.
2/8/21	73kg	100/60mmHg	negative/ negative	24weeks	25cm	Cephalic	5/5th	148bpm	Routine drugs	Abdominal pains	AE
30/8/21	75kg	110/70mmHg	negative/ negative	28weeks	27cm	Cephalic	5/5th	140bpm	Routine drugs	Feels well	GA
13/9/21	73kg	120/63mmHg	negative / negative	30weeks	29cm	Cephalic	5/5th	143bpm	Routine drugs	Well	FM
29/9/21	73kg	103/65mmHg	negative / negative	32weeks +2days	31cm	Cephalic	5/5th	124bpm	Routine drugs	Well	FM
13/10/21	75kg	118/74mmHg	negative / negative	34weeks +2days	33cm	Cephalic	5/5th	144bpm	Routine drugs	No complains	MA
27/1021	74kg	117/62mmHg	negative/ negative	36weeks +2days	34cm	Cephalic	5/5th	140bpm	Routine drugs	No complains	MA
4/11/21	75kg	128/77mmHg	Trace/negative	37weeks +3days	36cm	Cephalic	5/5th	138bpm	Routine drugs	No complains	MA
11/11/21	75kg	127/74mmHg	negative/ negative	38weeks +3days	37cm	Cephalic	5/5th	132bpm	Routine drugs	No complains	MA

ITN Given – 2/06/2020

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
12/04/21	1. Blood	Hemoglobin level Sickling status Grouping and Rhesus factor HIV status VDRL Hepatitis status G6PD status	11.4g/dl-16g/dl Negative A, B, AB, and O Positive and negative None reactive None reactive Negative None reactive	12.8g/dl Negative O Positive Negative Non-defect Negative Non-defect	Normal Normal Normal Normal Normal Normal Normal Normal
	2. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
2/08/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
30/08/21	1.Urine Blood	Sugar Protein Hemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 10.6g/dl	Normal Normal Normal
13/9/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	 Normal Normal
29/9/21	1.Urine 2. Blood	Sugar Protein Hemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 11.6g/dl	Normal Normal Normal

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
13/10/21	1.Urine 2. Blood	Sugar Protein Hemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 11.8g/dl	Normal Normal Normal
27/10/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
4/11/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
11/11/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRA-TION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Hematinic	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell and also prevents neural tube defect.	Hemoglobin level increase	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the metabolic process in the body.	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of hemoglobin and red blood	Hemoglobin level increased	Gastrointestinal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

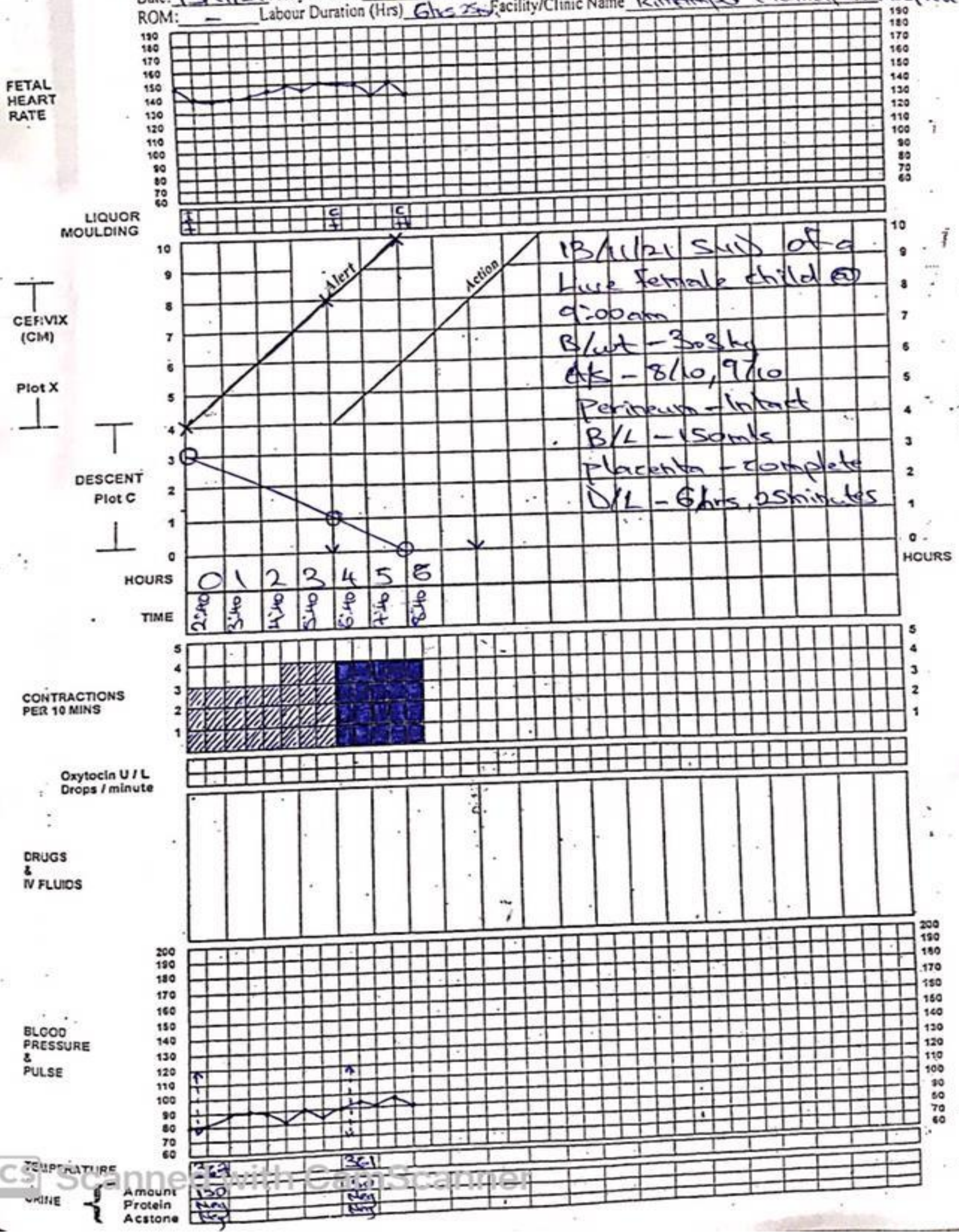
NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet sulphadoxin epyrimetha mine	Anti-malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None
Tetanus diphtheria	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Client had good uterine contractions and bleeding was controlled	Nausea and vomiting	None
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development, immaturity and proper sight	Normal vision and healthy skin	Vomiting	None
Tab paracetamol	Analgesia and antipyretic	100 milligram 3 times daily for 3 days	Orally	Helps to reduce high body temperature and reduce pain	Pain was reduced	Liver damage	None
Capsule amoxicillin	Antibiotic	500 milligram 3 times daily start	Orally	Action against susceptible bacteria during the stage of active multiplication.	Client was free from infection	Diarrhea	None

PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby was under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby was under observation	Blister formation	None



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LABOR NOTES

Client G2P1 with gestation of 38+5d wks had an SVD @ 9:00am on 13th November, 2021. 10 units of oxytocin was given to client after second twin was not diagnosed on palpation, client sustained no tear. Active third stage of labour was completed successful @ 9:05am through C.C.T. Skin to skin contact was ensured. Essential care was done for the baby. Baby and mother were cleaned and were in good condition. Baby and mother were made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 13/11/2021 TIME: 9:00am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 9:01am Type/Dose 10 unit & Oxytocin

PLACENTA: TIME: 9:05am (Complete) / Incomplete

BLOOD LOSS AMOUNT: 150mls (Small) (Less than 250 cc) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.3kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8
5min	2	2	2	2	1	9

COMPLICATIONS OF MOTHER / BABY: (None) / Other:

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	9:15am	120/80	82	16	Small	150mls
		9:30am	117/74	86	16	Small	–
		9:45am	114/75	86	Contracted	✓	–
		10:00am	120/80	84	✓	✓	–
		10:15am	115/76	80	✓	✓	Emptied
		10:30am	110/70	78	✓	✓	–
		10:45am	112/74	86	✓	✓	–
		11:00am	120/80	84	✓	✓	–
	Every 30 minutes For 1 hour	11:30am	120/80	84	✓	✓	100mls
		12:00pm	111/74	82	✓	✓	Emptied

Birth Attendant Bediako Rita Attaa and Grace (staff) Date 13/11/2021

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MATERNITY CHART

NAME: Madam Fati Lawya

AGE: 23years WARD: Lying-in

IP NO.: 134841 BED NO.: 3

Date		13/11/21	14/11/21	15/11/21	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21
Days in Hospital		(1)	1	2	3	4	5	6	7
Days P. O.		–	–	–	–	–	–	–	–
Hour	AM	9:15	9:00	8:00	8:00	8:30	8:30	8:00	9:30
	PM	–	–	–	–	–	–	–	–

Temperature.

C	F
41.0	105
40.5	104
40.0	103
39.5	102
39.0	101
38.5	100
38.0	99
37.5	98
37.0	97
36.5	96
36.0	95
35.5	94

Key
- Temperature
- Fundal height

Scale
1unit to 0.2cm/0.1c

		13/11/21	14/11/21	15/11/21	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21
Pulse		82	84	75	80	80	85	84	80
Resp.		23	23	20	20	22	23	20	20
B.M.		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.	AM	120/80	120/80	120/70	110/80	[illegible]	[illegible]	[illegible]	110/70
	PM	–	115/70	118/76	120/69	–	–	–	–

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NEW BORN EXAMINATION FORM

Name: Baby Ama Lowusa
Date of Birth: 13/11/2021 Time of Birth: 9:00am Date of Assessment: 13/11/2021 Time: 9:10am
Gestational Age [ ] 38+5 [ ] Mode of Delivery: [ ] (Vaginal) Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 1 hour
APGAR: 1min 8/10 5min 9/10 Birth Weight: [ ] 3.3kg [ ] Assisted Vaginal C-Section
Temperature at time of Assessment: 36.5 °C Length: 53 cm Head Circumference: 34 cm
Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Bediako Rita Attaa (student midwife)

Respiration
Rate 43cpm
[ ] Rate < 30 b/m *
[ ] Rate < 60 b/m *
[ ] 30-60 b/m
[ ] Retractions *
[ ] Grunting *
[ ] Stridor *

Activity/Movemnet
[ ] Spontaneous symmetric movements
[ ] Reduced/Absent Movement in ≥1 limb *
[ ] No Movement

Tone
[ ] Normal
[ ] Floppy *
[ ] Increased *

Colour
Pink all over
Pink body but blue hands/feet
Blue all over *
Pale *
Jaundiced *

Cord
Normal
Red. draining pus
Bleeding

Cry
Normal
Shrill *
Absent *

7. Suck
[x] Good
[ ] Weak
[ ] Absent

8. Head swelling
[ ] Caput succedaneum
[ ] Cephalhaematoma
[ ] Subgaleal hemorrhage
[x] No swelling

9. Sutures
[x] Normal
[ ] Overlapping
[ ] Fused
[ ] Widely Separated *

10. Fontanel
[x] Normal
[ ] Sunken *
[ ] Raised *
[ ] Wide (>5cm)*

11. Eyes
[x] Normal
[ ] Subconjunctival bleed
[ ] White pupil or cornea
[ ] Eye discharge
[ ] Other

12. Ears
[x] Normal (size / shape/position)
[ ] Abnormal: ________

13. Mouth
[x] Normal
[ ] Cleft palate
[ ] Cleft Lip
[ ] Other: ________

15. Neck
[x] Normal
[ ] Swelling
[ ] Webbed
[ ] Other: ________

16. Clavicle
[x] Normal
[ ] Swelling/Fracture

17. Chest
[x] Normal (Shape/movement)
[ ] Abnormal ________

18. Heart rate
Rate: 122bpm
[x] Normal (100-160)
[ ] <100 *
[ ] >160*

19. Femoral pulse
[x] Present
[ ] Not palpable*

20. Abdomen
[x] Normal
[ ] Distended*
[ ] Scarphoid*
[ ] Abdominal defect*
[ ] Maases: ________
[ ] Other ________

21. Back (spine)
[x] Normal
[ ] Abnormal Swelling *
[ ] Hairly patch over spine
[ ] Abnormal dimple
[ ] Abnormal curvature

22. Limbs
[x] Normal
[ ] Abnormal ________

23. Genitalia
Male Genitalia
[ ] Normal
[ ] Undescended testes
[ ] Abnormal meatus
[ ] Hernia
[ ] Other: ________

Female Genitalia
[x] Normal
[ ] Fistula(meconium/urine through abnormal opening in vagina) *
[ ] Large clitoria *
[ ] Other: ________

24. Anus
[x] Patent
[ ] Imperforate*

25. Resuscitation provided
[x] One
[ ] Suction/stimulation
[ ] Bag and mask
[ ] Endotracheal Tube
[ ] Ventilator/CPAP

26. Services provided
[x] Vitamin K1 given
[x] Eye care provided
[x] Cord care provided
[x] Breastfeeding initiated
[x] Breastfeeding established
[ ] Immunization (BCG/Polio)
[ ] BCG [ ] Polio Immunization
[x] Antibiotics in mother
[ ] Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known) ________

Classification: (Overall assessment) [x] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [x] Routine Care [ ] Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge

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NEW BORN EXAMINATION FORM

Name: Baby Atta Lawyo Date of Assessment: 13/11/2021. Time: 2:00pm
Date of Birth: 13/11/2021 Time of Birth: 9:00am Sex: [ ] M [x] F . Age at time of Assessment (days/hrs) 5 hrs
Astational Age [ ] 38+5 [ ] Mode of Delivery: [ ] (Vaginal) Assisted Vaginal C-Section
APGAR: 1min 9/10 5min 7/10 Birth Weight: [ ] kg [ ] Lenghth 53 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.5 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Bodiako Rita Attaa (student midwife)

1. Respiration
Rate ________
[ ] Rate < 30 b/m *
[ ] Rate < 60 b/m *
[x] 30-60 b/m
[ ] Retractions *
[ ] Grunting *
[ ] Stridor *

2. Activity/Movemnet
[x] Spontaneous symmetric movements
[ ] Reduced/Absent Movement in ≥1 limb *
[ ] No Movement

3. Tone
[x] Normal
[ ] Floppy *
[ ] Increased *

4. Colour
[x] Pink all over
[ ] Pink body but blue hands/feet
[ ] Blue all over *
[ ] Pale *
[ ] Jaundiced *

5. Cord
[x] Normal
[ ] Red. draining pus
[ ] Bleeding

6. Cry
[x] Normal
[ ] Shrill *
[ ] Absent *

7. Suck
[x] Good
[ ] Weak
[ ] Absent

8. Head swelling
[ ] Caput succedaneum
[ ] Cephalhaematoma
[ ] Subgaleal hemorrhage
[x] No swelling

9. Sutures
[x] Normal
[ ] Overlapping
[ ] Fused
[ ] Widely Separated *

10. Fontanel
[x] Normal
[ ] Sunken *
[ ] Raised *
[ ] Wide (>5cm)*

11. Eyes
[x] Normal
[ ] Subconjunctival bleed
[ ] White pupil or cornea
[ ] Eye discharge
[ ] Other

12. Ears
[x] Normal (size / shape/position).
[ ] Abnormal: ________

13. Mouth
[x] Normal
[ ] Cleft palate
[ ] Cleft Lip
[ ] Other: ________

15. Neck
[x] Normal
[ ] Swelling
[ ] Webbed
[ ] Other: ________

16. Clavicle
[x] Normal
[ ] Swelling/Fracture

17. Chest
[x] Normal (Shape/movement)
[ ] Abnormal ________

18. Heart rate
Rate: ________
[x] Normal (100-160)
[ ] <100 *
[ ] >160*

19. Femoral pulse
[x] Present
[ ] Not palpable*

20. Abdomen
[x] Normal
[ ] Distended*.
[ ] Scarphoid*
[ ] Abdominal defect*
[ ] Maases: ________
[ ] Other ________

21. Back (spine)
[x] Normal
[ ] Abnormal Swelling *
[ ] Hairly patch over spine
[ ] Abnormal dimple
[ ] Abnormal curvature

22. Limbs
[x] Normal
[ ] Abnormal ________

23. Genitalia
Male Genitalia
[ ] Normal
[ ] Undescended testes
[ ] Abnormal meatus
[ ] Hernia
[ ] Other: ________

Female Genitalia
[x] Normal
[ ] Fistula(meconium/urine through abnormal opening in vagina) *
[ ] Large clitoria *
[ ] Other: ________

24. Anus
[x] Patent
[ ] Imperforate*

25. Resuscitation provided
[x] One
[ ] Suction/stimulation
[ ] Bag and mask
[ ] Endotracheal Tube
[ ] Ventilator/CPAP

26. Services provided
[x] Vitamin K1 given
[x] Eye care provided
[x] Cord care provided
[x] Breastfeeding initiated
[x] Breastfeeding established
[ ] Immunization (BCG/Polio)
[ ] BCG [ ] Polio Immunizati
[x] Antibiotics in mother
[ ] Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
Diagnoses (if known)________

Classification: (Overall assessment) [x] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [x] Routine Care [ ]Problem Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Dischar

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TEMPERATURE CHART

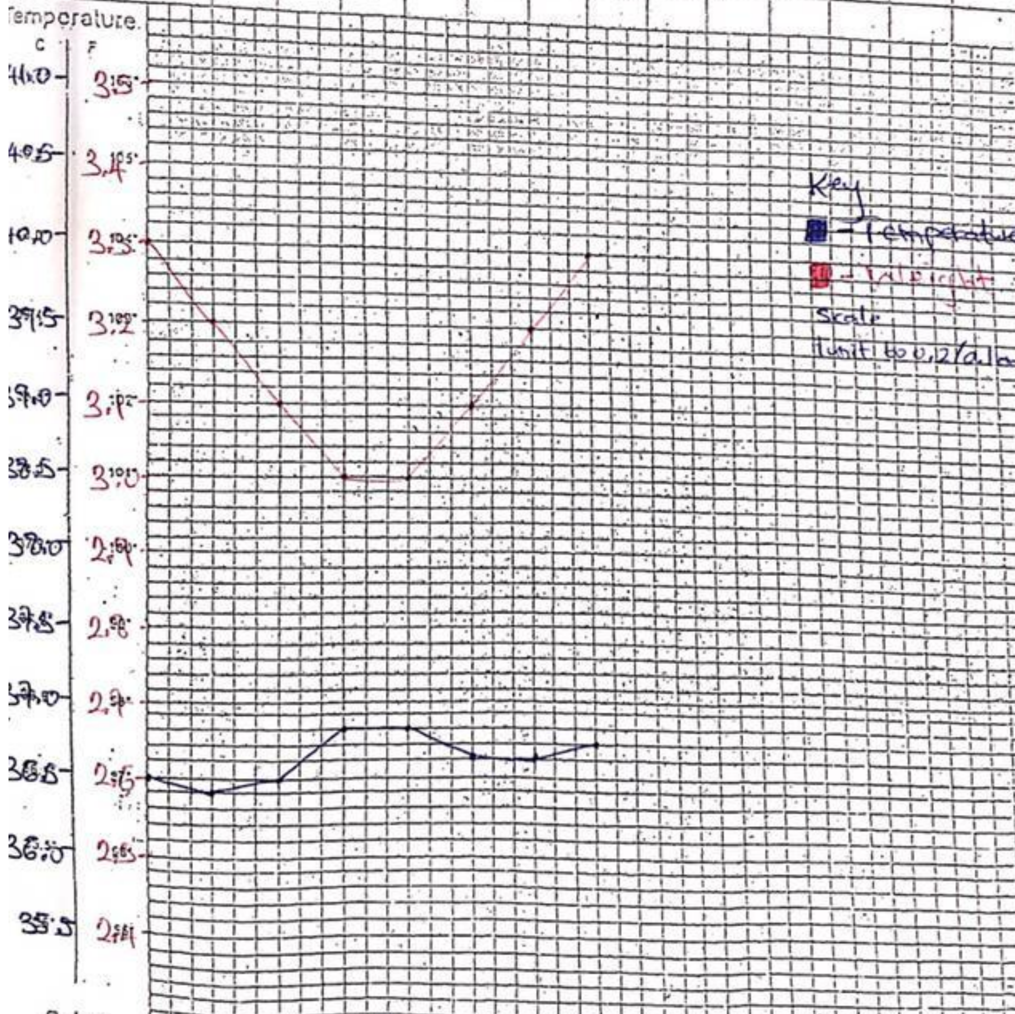
NAME: Baby Ama Lawya

AGE: Newborn

NO.: — WARD: Lyingin

BED NO.: 3

Date	13/11/21	14/11/21	15/11/21	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21
Days in Hospital	DD	1	2	3	4	5	6	7
Days P. O.	—	—	—	—	—	—	—	—
Hour AM	9:20	9:00	8:00	8:00	8:30	8:30	8:00	9:30
Hour PM	—	—	—	—	—	—	—	—



Pulse	125	125	132	132	132	120	136	138
Resp.	43	42	33	33	32	34	32	42
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.	—	—	—	—	—	—	—	—

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NEW BORN CHART

Name: Baby Ama Lawya No: - Birth Weight: 3.3kg

Sex: Female Mother's No: 134841 Length: 53cm

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term baby

Date of Birth: 13th November, 2021 Time: 9:00am Date of Discharge: 14th November, 2021

Date	13/11/2021		14/11/2021		15/11/2021		18/11/2021		17/11/2021		18/11/2021		19/11/2021		20/11/2021							
No. of Days	0D		1		2		3		4		5		6		7							
Weight	3.3		3.2		3.1		3.0		3.0		3.1		3.2		3.3							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.5	-	36.4	36.8	36.5	36.5	36.8	36.7	36.8	-	36.6	-	36.6	-	36.7	-						
Stools	Passed	'	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Remarks	Head, Neck, Trunk, Limbs, Genitalia — NAD																					

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SIGNATORIES

THE STUDENT MIDWIFE

NAME: BEDIAKO RITA ATTAA

SIGNATURE:..

DATE: 10/10/2022...........................

THE INCHARGE

NAME: MS SHEILA OPPONG

SIGNATURE...(for)

DATE: 11/10/2022...........................

THE SUPERVISOR

NAME: MISS UBAIDA ABDUL-KARIM

SIGNATURE:..

DATE: 10/10/2022...........................

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:..(f)

DATE: 11/10/2022...........................

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM

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