HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEAGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM COMFORT

BY

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(DIPLOMA).

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PREFACE

Client/Family centered maternity care study is a systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labour and puerperium. The Client/ Family Centered Maternity care study also helps the student midwife to use new trends in midwifery like the pictograph, which was tested and recommended by the World Health Organization (WHO) for the management of first stage of labour. Also, the active management of third stage of labour was introduced to limit the occurrences of postpartum hemorrhage

The Client/Family centered maternity care study helps the student midwife to put into practice the Safe Motherhood initiative that has been adopted in order to help reduce maternal mortality among pregnant women and to improve the quality of health care through antenatal, labour and postnatal periods.

The Client/Family centered care study is a required study that every final year student of Registered Midwifery programmed is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of professional certificate in Registered Midwifery practice.

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INTRODUCTION

The Client/ Family centered maternity care study was carried out on Madam Comfort, 21 years old, Gravida 2 Para 1^{A}, who was nursed during the community midwifery practical experience at Tanoso Health Center, Tanoso during pregnancy, labour and puerperium. Madam Comfort was first met on 1 st November 2021 when she came for antenatal follow up. She was in good health when met

Introduction was made to client and permission was sought if she could be used for the study, which she accepted without reluctance. She was visited at home to assess her environment and community in which she lives. For the purpose of this study, Madam Comfort will be used throughout the study.

Madam Comfort's problems identified during pregnancy, labour and puerperium were managed by the use of the nursing process. She delivered a healthy baby boy safely and was managed properly during puerperium without any complication.

There are **four (4) chapters** outlined in this script to help guide the reader.

Chapter One talks about client's particulars and her histories.

Chapter Two; outlines the care given to the client during antenatal period and home visits made to her residence.

Chapter Three; is a vivid narrative of the care given to the client during labour and delivery

Chapter Four; entails the care given to client during puerperium.

A care plan was drawn for the management of problem identify in chapters 2, 3, and 4 followed by summary and conclusion, bibliography, signatories as well as various appendices like antenatal records, laboratory records and pharmacology of drugs for both mother and baby.

LITERATURE REVIEW

PREGNANCY

According to Tindall (2008), pregnancy is the period from conception to delivery of the fetus. Normal duration is 280 days, 40 weeks, or 9 months and 7 days counted from the first day of the last normal menstrual period to delivery.

According Mayes (2009), confirmation of pregnancy is established by a detailed history and a clinical examination based on the signs and symptoms of pregnancy, resulting from the physiological alteration in the body's system and organs. These include amenorrhea, breast changes and tenderness, nausea and vomiting and then increased frequency of micturition. These signs and symptoms become obvious to the woman as her pregnancy advances.

Copper and Fraser (2009) also states that all changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nature the fetus, prepare her body for labour, develop her breast, and lay down stores of fats to provide calories for production of breast milk during puerperium. They further stated that, the woman's psychological state is also affected by hormonal changes. It further states that, the gestational period is divided into three Trimesters.

The first trimester is from the time of conception to the 12^{th} week; the second trimester is from the 12^{th} week to the 24^{th} week and the third trimester is from the 24^{th} week to the 36^{th}week or 40^{th} week

During pregnancy, antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby.

Perry (2006), states `that maternal physiologic adaptations are attributed to the

Hormones of pregnancy and to mechanical pressures arising from the enlarging uterus. These

adaptation protect the woman's normal physiologic functioning, meet the metabolic demands that pregnancy imposes on her body, and provide a nurturing environment for fetal development and growth. Perry further stated that, the gestational age is divided into three trimesters.

The first trimester is from the time of conception to the 13^{th} week, the second trimester is from the 14^{th} week to the 26^{th} week and the third trimester is from the 27^{th} week to the 40^{th} week.

According to Konar (2013), during pregnancy, the body undergoes many changes and some of the changes include the following organs;

- **Breast changes:** the breast changes are evident between 6-8 weeks. There is enlargement with vascular engorgement evidenced by the delicate veins visible under the skin. The nipple and the areola (Primary) become more pigmented specifically in dark women. Montgomery's tubercles are prominent. Thick yellowish secretion (colostrum) can be expressed as early as 12 weeks.
- **Abdomen:** the uterus remains a pelvic organ until 12 weeks; it may be just felt per abdomen as a suprapubic bulge.
- **Pelvic changes:** the pelvic changes are diverse and appear at different periods collectively. These may be informative in arriving at a diagnosis of Pregnancy. Some of the pelvic changes includes;

1. Jacquemier or Chadwick's sign: it is the dusky hue of the vestibule and anterior vaginal wall visible at about 8 weeks of pregnancy. The discolorations is due to local vascular congestion.
2. Vaginal sign: apart from the bluish discolorations of the anterior vaginal wall, the walls become softened and there is copious non-irritating mucoid discharge appears at 6^{th} week. There is increased pulsation felt through the lateral fornices at 8^{th} week called osiander's sign.
3. Cervical signs: the cervix becomes soft under the influence of progesterone as early as 6^{th} week (Goodells sign), A little earlier in multiparous. The pregnant cervix feels like the lips of the mouth while that of the non-pregnant state like the tip of the nose. On speculum examination, the bluish discolorations of the cervix is visible and this is due to the increased in vascularity.
4. Uterine signs: size, shape and consistency of the uterus undergo changes. The uterus is enlarged to the size of hen's egg at the 6^{th} week, size of a cricket ball at 8^{th} week and size of a fetal head by 12 week. The pyriform shape of the non-pregnant uterus becomes globular by 12 week.

- Myles (2014) postulates that changes in the respiratory system is asssociated with marked changes in respiratory physiology mediated by biochemical and mechanical factors. These accomodate the progressive increase in oxygen consumption and the physical impact of enlarging uterus. Normal oxygen consumption is 250ml/min at rest and increases by 20% in pregnany in order to meet the 15% increase in the maternal metabolic rate. The changes result in hyperventilation.

- Myles (2009),added that changes in the urinary system during pregnancy occurs as a result of enlarging uerus affects all the part of the urinary tract at various times with the hormones of pregnancy having an even greater influence than mechanical effects. Progesterone relaxes the walls of the ureters, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection.

According to King (2014), the signs of pregnancy has been categorised into three and they include:

Presumptive signs of pregnancy (report from the woman)

- Cessation of menstruation in a woman who previously experienced regular cycles.
- Nausea and vomiting
- Increased urination

Probable signs of pregnancy (detected by physical examination)

- Breast changes e.g. expression of colostrum's, enlargement of breast and nipples.
- Skin changes e.g. chloasma, linear nigra
- Enlargement of abdomen
- Palpate fetal movement

Positive signs of pregnancy

- Sonographic evidence of pregnancy
- Audible fetal heart rate

According to (Llewellyn-Jones, 2007), pregnant woman encounters certain problems or discomfort due to the changes in the system. Some of which includes

1. Constipation: during pregnancy the hormone progesterone lowers the muscle tone of the gut throughout pregnancy, which leads to constipation
2. Frequency of urination: irritability of the bladder is quite common in early pregnancy and occurs again in the last week when the baby's head passes into the pelvis. If the urination is associated with pain and scalding, the expectant mother should consult her doctor.
3. Heartburn: this is annoying and fairly common complaint which is more frequent in late pregnancy. It is due to the passage of small amounts of stomach contents into the lower part of the esophagus. In pregnancy the valve guarding the entrance to the stomach relaxes due to the activity of progesterone and because the enlarging uterus pushes against the stomach, it is often worse at night when the burning sensation in the upper abdomen can be quite depressing.
4. Leg cramps: some expectant mothers develop leg cramps in leg pregnancy. These occur mostly at night and also as a result of low calcium level in the body. It can be managed by standing on the toes of the affected leg and press firmly toward the floor.
5. Ptyalism (excessive salivation): is rare in pregnancy and it usually begins early in pregnancy and ceases with the birth of the baby. It may be associated with gastro-esophageal reflux or due stimulation of the salivary glands by ingestion of starch during pregnancy according to (Myles ,2009).

Antenatal care according to Ghana Health Service (2008), states that is the care and education given during pregnancy. Antenatal services are an important part of preventive and promotes health care.

The objectives of ANC includes

- To ensure safe delivery and postpartum health

- To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
- To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical or obstetrics.

According to Ghana Health Service (2008),the number of visists the clients makes to the facility means the number of times the client needs to be seen during pregnncy. The number of times clients visit the antenatal clinic may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule:

- First visit from onset of pregnancy up to 16 weeks gestation
- Second visit Between the 24^{th} to 28^{th} week of pregnancy
- Third visit At 32^{nd} week of pregnancy
- Fourth visit At 36^{th} week

Despite the schedule for visit, women should be counseled to report to the clinic at any time she feels unwell or has any problem.

Myles (2009), talks about antenatal care as the care that is given to a pregnant woman from the time conception is confirmed until the beginning of labour. The midwife will provide a woman-centered approach to the care of the woman and her family by sharing information with the woman to facilitate her to make informed decisions about her care.

Some of the aims of antenatal care according to Myles (2009) include;

- Being an advocate for the woman and her family during her pregnancy, supporting her right to choose care that is appropriate for her own needs and those of her family.

- Recognizing complication of pregnancy and appropriately referring the woman within the multidisciplinary team.
- Facilitating the woman to make informed choice, methods of infant feeding and giving appropriate and sensitive advice to support her decision.
- Exchanging information with the woman and her family, enabling them to make informed choices about pregnancy and birth.

According to Ablordeppey (2005), Antenatal care can be grouped into two and it includes the traditional and focused antenatal care.

Traditional approach to antenatal care based on the European models developed in the early 1900s, assumes that more frequent ANC is better and thus quantity of care is emphasized rather than the essential elements of care. It focuses on risk assessment and not detection and management of pregnancy related complications.

Focused antenatal care is an individualized, client-centered, comprehensive antenatal care and emphases on quality of care rather than quantity of care. The major goals of focused ANC are to help the Women maintain normal pregnancies through:

- Identification of pre-existing health conditions
- Early detection of complications arising during the pregnancy
- Health promotion and disease prevention
- Birth preparedness and complication readiness planning.

Focused antenatal care

- Emphasizes quality of visits over quantity of visits and recognizes that frequent visits do not necessarily improve pregnancy outcomes
- Realizes that the previous concept of dividing pregnancies into high risk and low risk does not hold because every pregnant woman is at risk of complications and should therefore receive the same basic care including monitoring of complications.
- According to the various points of views given above, it can therefore be concluded that pregnancy affects the physical and psychological wellbeing of the woman.

LABOUR

According to Mayer's (2014), the aims of midwifery care in labour are to achieve a safe labour and birth for the mother and baby, and a pleasant fulfilling experience of childbirth for the mother and her partner.

King (2014) also added labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration, and intensity to cause demonstrable effacement and dilatation of cervix.

According to Perry (2009), normal labour occurs between 37 completed weeks and 42 weeks gestation and stated that, the transition from pregnancy to labour is a sequence of event that often begins gradually.

It outlines three stages of labour as:

First stage - this starts when the cervix dilates from 0cm, in the presence of strong rhythmic contractions and it's completed when the cervix is fully dilated (10cm). The latent phase is prior

to active first stage of labour and may last 6-8hrs in first time mothers when the cervix dilates from 0cm to 3-4 cm dilated (stable 1996). The active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4 cm dilated and in the presence of rhythmic contractions, is completed when the cervix is fully dilated (10 cm). The transitional phase is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated (or until the expulsion, the woman feels contractions during second stage). There is often a brief check in the intensity of uterine activity at this time (Sherborn Matterson 2001, woods 2006)

Second stage - it begins when the cervix is fully dilated in physiological labour, and the woman usually feels the urge to expel the fetus. It is complete when the baby is born.

Third stage - the third stage is about the separation and expulsion of the placenta, its membranes and the control of bleeding. It lasts from the birth of the baby until the placenta and membranes have being expelled.

According to Copper and Freser (2009), it must go through some uterine actions. These are; fundal dominance, polarity, contraction and retraction, formation of upper and lower uterine segments, the retraction ring, cervical effacement, cervical dilatation. In addition, there are some mechanisms involved formation of fore waters, general fluid pressure, rupture of the membranes and fetal axis pressure

Perry (2006) states that labour and birth represent the end of pregnancy, the beginning of

Extra uterine life for the newborn and a change in the lives of the family. Perry divided labour

Into three stages. The first stage begins with the onset of regular uterine contraction and ends with full cervical effacement and dilatation.

1. The second stage begins with the full cervical dilatation (10cm) and complete effacement (100%) and ends with the birth of the baby.
2. The third stage of labour last from the birth of the baby until the placenta is expelled.

PUERPERIUM

Tindall (2008), defined puerperium as 6 - 8 week period following childbirth during which the uterus and other structure return to their non - pregnant state.

According to Mayer's (2011), puerperium is defined as the time between the end of labour until the reproductive organ have returned as nearly as possible to their pre gravid condition, a period estimated to be around six - eight weeks.

Copper and Freser (2009),said that the provision of midwifery care to women following the birth of their babies aim to encompass aspect of observing and monitoring the health of the new mother and her baby as well as offspring support and guidance in breastfeeding and parenting skill. A number of physiological changes takes place during the period. The reproductive organ returns to their non-pregnant state, physiologic changes that occur in other organs and systems are also reversed. The mother adjusts to the arrival of a new member of the family and recovers from stresses of pregnancy and childbirth and lactation is established.

Changes in endocrine activities; Oxytocin is secreted by the posterior pituitary gland and acts upon the uterine muscles and breast tissues. It maintains contractions of the uterine muscles and thus prevents hemorrhage. Suckling of the baby stimulates further secretion of oxytocin which aids involution of the uterus and lactation of breast milk. After the placenta is expelled the level of human chorionic gonadotrophic hormone, human placental lactogen, estrogen and progesterone

falls rapidly. This fall causes the anterior pituitary gland to secrete prolactin which acts upon the acini cells in the alveoli of the breast to produce milk. In lactating mothers the level of prolactin remains high and the resumption of release of the follicle stimulating hormone is suppressed therefore ovulation and menstruation stops.

Involution of the uterus; this is the return of the uterus to its non-pregnant state during the puerperium.

Perry (2006), defines puerperium as the interval between the birth of the newborn and the return of maternal reproductive organs to their normal non pregnant state.

According to Perry, this period has traditionally been considered as lasting six weeks, but

can vary among women.

According to Konar (2013), involution is the process whereby the genital organs revert approximately to the state as they were before pregnancy. The woman is termed as puerperal.

Konar (2013), further states that, puerperium begins as soon as the placenta is expelled and last approximately 6 weeks when the uterus becomes regressed almost to the non- pregnant size. The period is arbitrarily divided into; immediate –within 24 hours; early –up to 7 days and remote – up to 6 weeks.

Copper and Freser (2009), states that changes in the urinary tract include a marked diuresis after delivery which lasts for 2-3 days. This is due to the reduction in blood volume occurring in the immediate postnatal period. The dilatation of the urinary tract, which occurs in pregnancy due to increased vascular volume, resolves and the renal organs gradually return to their pregravid state.

Henderson (2009), further states that the falling progesterone level affect the alimentary tract. The smooth muscles tone gradually improves throughout the body, and the symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

WHY CLIENT WAS CHOSEN

On the 1st November, 2021, 21 years old Gravida 2 Para 1^{A} was met at Tanoso Health centre. She had come for the ninth antenatal clinic visits as booked by the midwife. Her gestational age was 36 weeks. On arrival at the clinic, client seemed friendly with the staffs and it was realized that she may be someone who would be ready to share information. Madam Comfort happened to be the first woman met who fell within the eligibility criteria for writing the client/ family centered maternity care study and after thorough glance through client's antenatal book , she was chosen.The midwife in charge was notified and she also gave her approval for client to be chosen. Self-introduction was made as a student midwife from Holy Family Nursing and Midwifery Nursing Training, Berekum on a clinical placement for community midwifery. Intension to use her was expresses her and, she consented, direction to her house, and phone number was taken and a promised was made to visit client.

CHAPTER ONE

1.0 INTRODUCTION

This chapter is about assessment of the client and her family, which involves gathering of data. Information was acquired through observation, interview, medical records and antenatal records. This information helped the student midwife to provide holistic care for the client and her family taking into consideration the social and personal, family, social, surgical, hobbies and lifestyle, past obstetric and present obstetric history.

CLIENT'S PARTICULARS

1.1 PERSONAL AND SOCIAL HISTORY

Madam Comfort a Gravida 2 Para 1^{A} is a 21year old woman who stays at Tanoso in Ahafo near the Methodist Church. She weighed 70 kilograms and she is 170centimeters (cm) tall, dark in complexion and She schooled to J.H.S level because her parents were financially incapacitated. Madam Comfort is unemployed. She is married to a noble man by name Mr. Debra who is a Mason and a Christian.

1.2 PSYCHOSOCIAL HISTORY

She lives in a compound house with her husband and some other relatives. There are five (5) rooms in the building in which they reside with their relatives who helps client when less busy. Madam Comfort speaks Twi and according to her, her next of kin is her mother Madam Mary Fosuaa. She does not indulge in any harmful social habits like smoking and drinking alcohol.

1.2 FAMILY HISTORY

Madam Comfort was born to Mr. Ebo Affaul and Mrs. Fosuaa Mary. Both her father and mother lives Tonoso in the Ahafo Region. Client says her siblings reside in different places because of

marriage and job opportunities and are healthy. According to Madam Comfort, there are no known histories of hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy, mental illness and congenital abnormalities in her family. She added that, there are no known congenital abnormalities such as missing digits, extra digits, cleft palate, cleft lip, imperforate anus and spinal bifida among others in the family. When asked in addition, her family seek for medical treatment and prays whenever they are not feeling well. There is no history of multiple pregnancies. As well, she said all her family members who passed away died naturally.

1.4 SURGICAL HISTORY

She said she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury or road traffic accident or accident of any form that called for any abdominal or spine surgery to affect her pelvis. On examination, there was no scar indicating previous laparotomy, caesarean section, appendectomy among others.

1.5 MEDICAL HISTORY

Client said, she has never been admitted to the hospital but receives medical treatment as an outpatient when she suffers minor illness or buys drugs from a licensed chemical seller when she falls sick. In addition client has never donated blood neither has she been transfused. Madam Janet has no medical condition such as hypertension, sickle cell, diabetes, asthma, glucose-6 phosphate dehydrogenase (G6PD) defect, mental and heart diseases. She has never had any allergic reaction to any food or drug given.

1.6 MENSTRUAL HISTORY

As said by Madam Comfort she has 26 days cycle and added that, her menstrual flow is moderate, lasting foe 3 days and experiences dysmenorrhea for the first day. She uses sanitary

pad, changes when soiled and bath twice daily. Client had her first menstruation at age 15. Client does not remember her last menstrual period and per her ultra-scan, the estimated date is 22nd November, 2021.

1.7 HOBBIES AND LIFESTYLE

Madam Comfort is a woman who goes to bed at 8:00pm and wakes up at 5:00am. She said that when she wakes up in the morning, she does her morning devotion with the husband. After that, she brushes her teeth, sweeps her room and compound but not always, because she does it with one neighbor in turns then disposes her rubbish away at the community dumpsite, which is a three minutes' walk away from her house. She washes her dishes and prepare her daughter for school. Client expressed that she normally prepares breakfast for the family before the child goes to school. She said her breakfast is usually milo with skimmed milk and two fried eggs and a toasted bread. Her brother send child to school and brings her back when they close since she is pregnant. After preparing breakfast, she takes her bath, goes to her elder sister's salon near the house, and sometimes rest. She mentioned that, she has a great interest in ludu and prefers banku with okro soup and meat to other foods.

Madam Comfort said that ever since she became pregnant she eats on demand. She also said that she prepares supper at 3:30pm and it is ready for the family to enjoy around 5:00pm. Again, she normally baths her child and does it after supper. At 7:30pm, she put the child to bed. Client mentioned that she empties her bowel twice (2) and empties her bladder when she feels the urge to and frequently takes in enough fluid in the day.

1.8 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Comfort Gravida 2 Para1^{A} went through her first pregnancy in the year 2018 successfully without any complication. She carried pregnancy to term. According to client, giving birth with a three (3) year interval is something being planned by them as couples. She said during her pregnancy, she experienced some minor disorders such as nausea and vomiting, frequency of micturition, lower abdominal pain, backache, which she reported to the clinic and was explain to her as being normal physiological changes in pregnancy and that, they would resolve as pregnancy progresses or some after delivery. She never suffered any pregnancy-induced condition as gestational diabetes and pregnancy induce hypertension (pre-eclampsia). She also visited antenatal clinic for eight (8) times during her pregnancy and received all doses of sulphadoxime Pyrimethamine as well as two (2) doses of tetanus diphtheria injection in all her last pregnancy.

LABOUR

Madam Comfort said labour set in spontaneously and through the vagina at Tanoso Health Center. She further stated that the duration of her labour lasted for about fourteen (14) hours after which she delivered an alive female baby. She was healthy weighed 3.0 as recorded. She also said she did not had any perineal tear neither was she given episiotomy during her previous delivery. She added that she did not experience any post-partum hemorrhage, retained placenta and membranes. She said her estimated blood loss for her delivery was small.

PUERPERIUM

Madam Comfort said she was healthy after delivery and baby also carried immediately after birth. She added that she started breastfeeding the baby within the first hour after birth and practiced exclusive breastfeeding for 6months and then added complementary feeds during the 6th month.

However, she weaned her at age two. She had a safe breastfeeding with no complication. According to client her child was fully immunized against the vaccine preventable diseases according to

Schedules and never suffered any illness as she grows. She is alive and healthy. Client

Said she did not experience any illness such as puerperal psychosis, anemia, malaria, post-partum hemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. In relation to family planning, she uses the natural family planning method thus the lactational amenorrhea and calendar method. Madam Comfort also stated that her family and husband supported her in care of her baby and some of the household chores.

1.9 PRESENT OBSTETRIC HISTORY

Madam Comfort, Gravida 2 Para 1^{A} felt slight changes as morning sickness, leading to nausea and vomiting prior to confirmation of the pregnancy. Her first visit to the clinic was on 19th Apirl, 2021 with gestational age of 7 weeks, client did not remember her last menstrual period.so an ultra sound scan was requested which gave her expected date of delivery as 22nd November, 2021. Her vital signs and other assessment on that day were recorded as follows;

Temperature	36.8 degree Celsius
Pulse	84 beat per minutes
Respiration	22 cycle per minutes
Blood pressure	110/70 millimeter of mercury
Weight	70 kilograms

Height	170centimeters
Symphysiofundal height	7centimeters

LAB INVESTIGATIONS

Hemoglobin level	11.6grams per deciliter
Sickling	Negative (-)
Blood group	A
Rhesus factor	Positive (+)
Urine for pregnancy test	Positive (+)
PMTCT	Negative (-)
HEP-B	Negative (–)
VDRL	Non-reactive
Glucose in urine	Negative (-)
G6PD	No Defect
Protein in urine	Negative (–)

Stool for routine examination indicated no abnormality.

On head to toe examination, no abnormality was detected. Madam Comfort had no complaints so she was educated on the need to attend antenatal clinic regularly. She was put on the following drugs and was scheduled for the next visit.

1. Tab iron III daily x 30 days

2. Tab multivitamins 200mg daily x 30 days

3. Tab folic acid 5mg daily x 30 days

Since then, client has been coming for antenatal care as schedule, as of the day she was met and all finding have been within normal ranges.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the antenatal care given to client and the family at large throughout the period of pregnancy. This includes first contact with the client, antenatal home visits, subsequent visit to the clinic and care plans drawn to manage the problems encountered by the client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Comfort G2P1A was met on Monday 1st November, 2021 at Tanoso Health Center at 11:30am when she came for her usual antenatal visit. She was 36weeks of gestation and it was her fifth (5) time of attending antenatal clinic. On her arrival at the clinic, client seemed to be friendly with the staff and someone who would be ready to share information. Madam Comfort happen to be the tenth woman met who fell within the eligibility criteria for writing the client/ family centered maternity care study after thorough glance through client's antenatal book hence she was chosen. Rapport and introduction was established as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on clinical placement for Community Midwifery.

Permission was asked to use her as client for the care study since she met the criteria after glancing through her antenatal card. The study in details was explained to her and she wholeheartedly agreed. She asked if she will pay any amount since she will be taken care at home but it was explained to her that no, but her cooperation is what is needed. She was thanked for her understanding. The midwife in-charge was informed about the selection of Madam Comfort for

the study which she agreed. Client had a normal gait with no deformity observed. Her vital signs were checked and recorded and investigations carried out were;

Temperature	36.5degree Celsius
Pulse	81beats per minute
Respiration	22cycle per minute
Blood pressure	100/60 millimeter of mercury
Weight	77.0 kilograms
Hemoglobin level	10.6 grams per deciliter

Urine testing

Client was given a specimen bottle and was asked to provide midstream urine which tested negative for protein and sugar with a urine reagent strip. Urine was smelled for odour and it was normal, the colour was observed and was normal. All findings were recorded and communicated to her to allay anxiety. Hands were washed with soap under running water and dried. Results were recorded in the antenatal book.

PHYSICAL EXAMINATION (HEAD TO TOE EXAMINATION)

Physical examination (head to toe) procedure was explained to client and consent was sought. Client was assisted onto a bed for the examination. Privacy was provided, by closing the windows around and the door was also closed, hands were washed with soap under running water and dried. Procedure was explained to the client and permission was sought to examine Madam Comfort

under the supervision of senior midwife in-charge and she agreed. Hands were rubbed together to keep them warm to prevent premature contraction.

All necessary equipment needed for the examination were gathered on a trolley comprising of the following items;

- Gallipot with sterile cotton wool swabs
- A fetal stethoscope
- Examination gloves
- A pen and client's folder
- A receiver for used swabs
- A tape measure
- A watch with a second hand

She was helped to lie on the examination bed and assisted to assume a left lateral position while hands were washed with soap under running water and dried with a clean towel. Palms were warmed. The general health status of the client was assessed, and then standing on the right hand of the client and maintaining eye contact, examination was done starting from head to toe.

On Head and neck inspection, her hair was neatly done with no dandruff, lice, scalp infection present. Client was congratulated to keep it up. There was no edema, chloasma and rashes on the

face or the eyelids. On examining of the eyes, the conjunctiva was pink and sclera white, without discharges. The nose was also without congestion. The ears were inspected for discharges and alignment with were all normal. Client has a healthy teeth with pink tongue and no halitosis as she was engaged in conversation but with slight dry lips, hence encouraged to apply Vaseline or lip gloss on her lips. Client's neck had no enlarged thyroid gland or distended neck vein. Each step was explained to client as examination went on.

On Breast examination, both breasts were exposed to check for size, shape, nipple's position and condition of the skin but nothing abnormal was noticed. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated thoroughly in a circular manner using the inner aspect of the fingers and there were no masses or lumps. The areolar was squeezed gently with cotton wool for any abnormal discharge and observed, but there was none. Same procedure was performed on the other breast and no abnormality was detected. Client was educated and taught how to perform self-breast examination periodically.

On the upper extremities, hands and fingers were inspected for equality symmetry, edema, pallor of palms and capillary refill at the nail bed but nothing abnormal was detected. The lower extremities were of the same size and were of equal symmetry. It was also palpated for edema, tenderness in the calf muscles, varicose veins, but nothing abnormal was detected.

The back was examined and there was no deformity of the spine, edema of the sacral region and costovertebral angle tenderness too was absent.

On Abdominal inspection, Client had no scars, but foetal movements, linear nigra and striae gravidarum were present. The shape and size of the abdomen were globular and medium respectively. Hands were warmed by rubbing them together to avoid inducing contractions. The abdomen was palpated for masses, tenderness as well as enlarged spleen and liver but no abnormalities were detected.

Symphysio-fundal height, Palms were rubbed together to generate warmth in other to prevent stimulation of contraction. 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 contour of the abdomen along the midline to the upper boarder of the symphysis pubis and it measured 35cm and her gestational age was 36.

On Fundal palpation, the palms were placed on either side of the fundus for fundal palpation. Still facing the head of the client, fingers were curved around the fundus to determine what lies in the upper pole. A soft mass was palpated indicating the buttocks. The fundus has grown to the level of the xiphisternum.

On lateral palpation, the palms were placed on each side of the abdomen, with one hand stabilizing one side of the maternal uterus the other hand was moved gently in a circular manner and the fetal limbs were palpated at the right side. Same was done at the other side of the abdomen, fetal back was felt a smooth surface at the left side indicating the back.

On pelvic palpation position was changed to face the feet of the client as pelvic palpation was done. Madam Comfort was asked to bend her knees slightly and also to breathe in and out slowly and the palms were placed just below the level of the umbilicus with the fingers directed towards

the symphysis pubis and the thumb almost meeting. A hard mass was felt indicating the head of the fetus, the presentation was cephalic, and the lie was longitudinal.

In assessing the descent of the presenting part, the anterior shoulder was located during palpation and upon locating the symphysis pubis, the ulna border of the hand was placed just above the symphysis pubis. Five fingers occupied the space between the anterior shoulder and the upper border of the symphysis pubis indicating a descent of 5/5th.

On auscultation, the fetal stethoscope 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 heartbeat. With one hand at the maternal radial pulse to ensure that the maternal pulse was not misinterpreted for the fetal heartbeat. The fetal heart rate was counted for 1(one) full minute noting the volume and the rhythm and was it recorded as 146 beats per minute.

On Vulva examination, Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel also examination gloves were worn. The vulva was inspected for edema, scar, genital warts, rashes, abnormal vulva discharges and varicose veins but none was present. The Mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. The clitoris had no scarring or laceration from previous deliveries. She was educated on cleaning the vulva in the anterior-posterior direction anytime she passes faeces. Also, client was advised to wash her panties regularly and dry them in the sun, avoid inserting herbs into her vagina or douching. Hand washing was done after the procedure and dried. She was thanked for her cooperation and findings were communicated to her. Client was asked to assume lateral position and sit up before getting out of bed, she was the assisted to redressed and asked whether she had any complaint but there was none. All was done under the supervision of

the midwife in charge. All items used were decontaminated appropriately. Hand washing was done and dried with clean dry towel. All findings were communicated to her. Client was inform that, her next visit is on the 8th November, 2021. Health education was given on the importance of preventing malaria in pregnancy and encouraged to report any abnormality like headache, excessive vomiting etc. to the clinic. Client was then reminded on her next visit to the clinic which is 8th November, 2021. Then home visit was discuss with her. The intention of visiting her in the house was made known to her and she showed the direction to her house and phone numbers were exchanged. A date was scheduled for the home visit which was 3rd November, 2021. Hands were washed and dried and medication served as follows:

Tablet ferrous sulphate - 200mg daily for 7days

Tablet folic acid – 5mg for 7days

Client was encouraged to take drugs as prescribed, thanked her for cooperation and bid goodbye.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Comfort's house was on Wednesday 3rd November 2021 at 9:30 am. The aim of the visit was to observe the environment where she lives, her source of water and light, the number of people she shares her room with, where she attends natures call (toilet), how she disposes off her refuse and also how she relates with her family members and her neighbors.

On arrival, she warmly welcomed and offered a seat in her room and also water to drink and she was thanked for that. She was asked how, she and the family were faring to which she responded that they were doing well. She was asked whether she was busy but the response was no, so we started with our conversation.

We had our conversation on the varander. The place was well kept with a stool orderly arranged. She was educated on the importance of sleeping under an insecticide treated net and advised to find a carpenter to put some nails on the wall and also get a conical shaped insecticide treated bed net from the health facility and hang it so that during the evening she could sleep under it which she agreed. Permission was then asked to enter the inner room where she sleeps. She led me to the room, on entering; the room was neat and there was a cross bar, with dirty clothes hanging on it. In addition, their clothes were well packed into their various bags thou clothes were packed but client was ask to remove the item on the cross bar to prevent mosquito from hiding inside to bite them. Madam Comfort had neatly arranged her utensils in her cupboard on her varander. There were no dirty dishes found in the kitchen. The common bathroom she uses together with her neighbors, was well kept because she told me they scrub every day. A dustbin with a well-fitting lid and a black rubber was placed inside the bin was seen outside the house which she told me they empty it every morning into the public refuse container which is some few meters away from their house. They fetch water from the next house.

Madam Comfort was educated on the importance of leaving the cross bar empty to prevent mosquito form hide inside and encouraged to continue with her medication. Then birth preparedness and complication readiness was discussed, during which client was requested to bring her layette for inspection which include items like Dettol, antenatal card and health insurance were missing. Client was encouraged to add those items and other items needed for delivery, identity a companion to accompany her when she gets into labour, keep some money on her for some miscellaneous at the clinic, get a driver who is always available and a blood donor to donate blood in case of any emergency. It was realized she has good relationship with her co tenants. Finally, she was asked if she had any complaint that day and she complained of heartburns which

was explained to her that it is due to the relaxation of the cardiac sphincter of the stomach causing reflux of acidic contents of the stomach into the lower esophagus and was educated to minimize the intake of oily and spicy food and eat in bit. She was made aware that it was a normal physiology which will resolve after delivery. She was reminded about the next visit on 8th of November 2021.She was thanked and permission to leave was sought which was granted.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Comfort's house was on Saturday 6th November, 2021 at 10:00am. She was met outside the house charting with a friend. They were greeted and a warm welcome as well as seat was offered. The wellbeing of the family was inquired and she said they were all doing well by God's grace.

The aim of the visit was to inquire about her health whether some changes have been made on what we discussed the other time about the fixing of insecticide treated net, also if she has maintained the arrangement in their bedroom. Client was asked about her previous complains and she said it was better now. She complained of leg cramps, and it was explained to client is due to the poor blood supply to a part of the body. She was advice to raise her legs on pillows, when sleeping or siting on inspection, all these things were corrected as taught, her husband and neighbor were her birth companion and she had pack her delivery items with a purse of money and her insurance card as well as antenatal book. Also a blood donor and taxi driver have been identified. Education on rest and sleep and true labour signs that is the appearance of blood stained mucus discharge (show), regular rhythmic uterine contractions were given. Then she was told to report any time she experiences any of these to a heath facility. She was allowed to ask questions for appropriate answers to be given. Nevertheless, she had no complain. Permission was sought to

leave which was granted, she was thanked and reminded of her next visit to the clinic on the 8th of November, 2021.

2.4 SUBSEQUENT VISIT TO THE CLINIC BY CLIENT

Madam Comfort visited the clinic on Monday 8th November, 2021 at 9:00am. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she said they are all doing well. Madam Comfort was asked about the previous complain and she answered that because she is complying with the orders given, and that it is better now.

Afterwards it was inquired if she has any other problem and she complained of backache and interrupted sleep. It was explained to Client that the backache was due to decent of the fetal head pressuring on pelvic joint cause by estrogen and progesterone. She was encouraged to maintain a good sitting posture, minimize her workload and apply warm compresses to the lower back. And also insomnia, she was reassured and educated on measures to adopt to cope with the complaints such as drinking less water before bed, urinating before bed, taking warm baths before bed and resting during the day Also Client was examined from head to toe and no abnormality was detected. Vital signs and other observation were checked and recorded are as follows;

Temperature	36.6 degree Celsius
Pulse	82 beats per minute
Respiration	24 cycle per minute
Blood pressure	110/60 millimeters of mercury

Weight	77.8 kilograms
Symphysiofundal height	35centimeters
Descent	5/5th
Fetal heart rate	138 beats per minute
Hemoglobin	11.8 grams per deciliter

Urine was tested for protein and glucose, which was negative.

Client was advised to take in food rich in vitamins, minerals and proteins, take in enough fruits that contains roughages, to take in more fluid, and was encouraged to take in her routine drugs. The need to deliver at the health facility was stressed on to prevent any complications like retain placenta, postpartum hemorrhage and importance of deep breathing exercise during labour was Stressed. she was told not to delay at home when labour sets in but in the absence of any of the mention signs of true labour and danger signs she will continue for her usual weekly visit . She was accompanied to the roadside and was bid farewell.

2.5 NURSING CARE PLAN

PROBLEMS IDENTIFIED

On 03/11/21 client complained of:

1. Heart burns

2. Was at risk for malaria

On 06/11/21 client complained of:

3. Leg cramps

On 08/11/21 client complained of

4. Backache
5. Insomnia

SHORT TERM OBJECTIVE

1. Madam Comfort will be relieved for heartburns within 48 hours.
2. Client will not have malaria infection with 14 days and throughout pregnancy
3. Madam Comfort will be relieved of backache within 72 hours
4. Client will be relieved of pain and tingling felt in the lower extremities (leg cramps) within 12hours
5. Madam Comfort will be able to sleep for at least 6hours within 24 hours at night

LONG TERM OBJECTIVES

Madam Comfort will carry the pregnancy, labor and puerperium without any complications to both mother and baby.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM AKOTO JANET CONTINUES

Date/Time	Nursing Diagnosis	Nursing Objectives/outcome criteria	Nursing Order	Nursing intervention	Date /Time	Evaluation	Sign
03/11/21 10:00am	Heart burns related to the relaxation of the cardiac sphincter and acid reflux into the lower esophagus.	Client's heart burns will be relieved after 24 hours as evidence by; 1. Client verbalizing that intensity of heart burns has reduced. 2. Midwife visualizing that client know longer complaints of heartburns.	1. Reassure client that the intensity of the condition will reduce. 2. Educate client on the physiology of heart burns 3. Educate client to elevate head of bed when sleeping. 4. Encourage Madam Comfort to reduce the intake of oily and spicy foods. 5. Encourage client to stay a little while after meal before going to bed.	1. Client was reassured that the intensity of the condition will reduce 2. Client was informed that it is due to pregnancy hormones 3. Client was propped herself in bed when sleeping 4. Madam Comfort reduced the intake of oily and spicy foods 5. Client stayed a little while after meal before going to bed.	04/11/21 10:00am	Goal fully met as client reported a reduction in the intensity of heartburns and midwife visualizing that client is known longer complaints of heartburns	

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TABLE 2: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM AKOTO JANET CONTINUES

Date/time	Nursing Diagnosis	Nursing Objective	Nursing order	Nursing Intervention	Date/Time	Evaluation	Sign
06/11/21 10:20am	Backache related to structural changes that occurs as pregnancy advances.	Madam Comfort backaches will be reduced within 24 hours as evidenced by; Client verbalizing that the pain has be subsided and midwife visualizing that client has a cheerful expression and normal gait for pregnancy	1. Reassure client that the back pain will be relived after delivery. 2. Encourage client to sit in an upright position. 3. Educate client to reduce strenuous exercise and perform manageable ones. 4. Encourage client to have enough rest. 5. Educate client on the structural changes that occurs during pregnancy.	1. Client was assured that the back pains will subside. 2. Client was sitting in an upright position with supported back 3. Client performed manageable exercises. 4. Client took enough rest in between activities. 5. Client knew it was due to structural changes that occurs during pregnancy.	07/11/21 10:20am	Goal was met as client verbalized that back pains have subside.	

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
08/11/21 9:00am	Altered body comfort (leg cramps) related to insufficient blood supply to the lower limbs.	Madam Comfort will be relieved of leg cramps within 48 hours as evidenced by; 1.Client verbalizing there is a reduction in the pain 2 .Midwife observing that client is relieved of the pain by her facial expression.	1. Reassure client that her pain will be relived. 2. Explain the physiology of leg cramps to client. 3. Advise client to perform some exercise 4. Encourage client to apply warm compress. 5.Encourage client to apply a gentle massage over the painful area	1.Client was reassured to allay her fear and anxiety 2. Client was educated that her condition was due to limited blood supply to the lower limbs. 3.Client performed dorsiflexion of the legs 4. Client applied warm compress to the calf muscle. 5. Client applied gentle massages over the painful area.	10/11/21 9:00am	Goal fully met as client verbalized reduced pain and midwife observing that client is relieved of the pain.	

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/TIME	EVALUATION	**SIGN**
11/11/21 11:00am	Interrupted sleep related to frequent micturition at night.	Client will be able to sleep for at least an hour during the day and 6 hours a night within 24hours as evidenced by 1. Client verbalizing that she is able to take a nap in the day and sleep for 6 hours in the night. 2. Midwife visualizing that she looks refreshed.	1. Reassure client of sleeping during the night. 2. Explain the physiology of frequent micturition to the client. 3. Encourage client to lean forward when voiding. 4. Educate client to take warm baths to promote relaxation. 5. Encourage client to reduce fluids containing natural diuresis in the evening	1. Client was reassured that she will be able to sleep during the night. 2. Client is enlightened on the Physiology of frequency of micturition as a reduction in bladder capacity by descending fetal head 3. Client was leaning forward when voiding to empty the bladder completely. 4 she took a warm bath to promote relaxation. 5. Client was not taking tea coffee in the evening.	12/11/21 9:00	Goal was met as client reported that she is able to take a nap in the day and sleep for 6 hours in the night and midwife visualizes that she looks refreshed.	

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/TIME	EVALUATION	**SIGN**
12/11/21 9:00am	Risk for malaria related to exposure to mosquito bite. (Not sleeping under treated mosquito net.)	Client will be free from mosquito bite, as evidenced by Client sleeping under treated insecticide bed net.	1. Educate client on the possible effect of not using the mosquito net. 2. Demonstrate to client how to fix the mosquito net. 3.Encourage client to take her S.P. medication as prescribed 4. Educate the client environmental hygiene to destroy the breeding of mosquitoes.	1. Client was informed of having bites, which will lead to malaria infection, and it effects. 2. Client fixed the mosquito net correctly. 3. Client was taking her S.P whenever she was due. 4. Client was taught to weed around cover her water and to dirty oil on the ditches and stagnant water around.	**15/11/21** **10:20 am**	Goal fully met as evidence by Client delivered her baby without malaria infection.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, the immediate care of the newborn, examination of the newborn and the care plan drawn for the management of the problems encountered during labour and delivery.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Monday, 21 November 2021, Madam Comfort reported to the labour ward at Tanoso Health Center at 8:00pm with her next door neighbor. Rapport was established and they were offered seats. Client was then taken to the nurses' station for necessary information to be taken while reading her antenatal card Madam Comfort's layettes were inspected and it was intact. Client gave complaints of severe waist pains and uterine contractions since morning she was reassured and was educated to reduce duration of sitting and ambulate to aid descent of the fetal head, she appeared anxious. They were reassured of competent health team and safe delivery to allay anxiety.

She was encouraged to pass urine and it measured 50mls, sample was tested for albumin, sugar and acetone, which were negative.

Her vital signs checked and recorded as follows:

Temperature - 36.2 degree Celsius

Pulse - 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure -110/70 millimeters of mercury

Madam Comfort was taken to the examination room and assisted to change into gown. Permission was sought to examine her and all procedures were explained to her. Client was assisted to lie on the bed in a supine position and a quick thorough head to toe examination was conducted and revealed no abnormality.

Abdominal examination was precede by inspection; there was no scar except for some few trace marks of striae gravidarum and linea nigra. The shape and size of the abdomen was globular and medium respectively. She felt the fetal movement according to her. The fundus was locate and the zero mark of the tape measure was placed there. The tape was extended along the contour of the abdomen along the midline to the upper boarder of the symphysis pubis, Symphysio-fundal height measured 36 centimeters, and gestation was 38weeks plus 2 days.

On palpation, upon facing the head of the woman, each palm was placed on either side of the fundus. The fingers were curved around the top of the fundus to determine what occupied the upper pole of the fundus. A soft mass was felt which indicated the buttock of the fetus.

During lateral palpation, each palm was placed on each side of the uterus, midway between symphysis pubis, fundus.one hand was used to stabilize the uterus, and the palm of the other was used to examine. Fetal back (smooth part) was located at the right-hand side of the woman's abdomen and the fetal limb (rough part) on the left side.

On pelvic palpation, upon facing the woman's feet, she was asked to bend her knees slightly and to breathe out slowly to help relaxation of the abdominal muscles. Each palm was placed on either side of the uterus, just below the umbilicus, fingers directed towards the symphysis pubis as the thumb were almost meeting, and a hard mass was felt indicating the head of the Fetus. Location

of the anterior shoulders was done using two fingers. The symphysis pubis was located and with the ulna border of the hand just above the symphysis pubis and the anterior shoulder, three finger occupies the space between the symphysis pubis and the anterior shoulder indicating descent of $3/5^{th}$ .therefore from the above examination, it was deduced that the lie was longitudinal, presentation was cephalic, decent was $3/5^{th}$ and the position was right occipito anterior.

On Auscultation; the fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read 141 beats within the minute with regular rhythm and good volume.

Vaginal examination: before vaginal examination, Permission was sought from Madam Comfort to seek her consent and she agreed. A tray already set with two sterile gallipots, one containing sterile cotton and a container with savlon lotion, sterile gloves, a receiver for the used swabs and a sanitary pad. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves were put on and client was asked to assume a dorsal position with the knee flexed for examination. The vulva was inspected for edema, wart, scars and varicose veins but there was none present. The dominant hand was used to pick the cotton wool and dipped into the lotion; swab was dropped from dominant hand into the non-dominant hand and swab per stroke. Labia majora was wiped from anterior to posterior and the used swab was disposed off into a receiver. Labia minora was wiped from anterior to posterior and the used swab was disposed. The vestibule was parted using the non-dominant hand and the dominant hand was used to swab the vestibule from anterior to posterior. The used swab was disposed into the receiver. Client's permission was sought and the right middle and index fingers were inserted into the vagina by

firmly pressing downwards the posterior wall. This caused relaxation of the vaginal wall. The condition of the vagina was warm and moist, cervix was soft, thin and effaced with cervical dilation of five (5) and well applied to the presenting part, membranes were intact and there was no moulding. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached at 11cm.Sacrum was well curved and intertubulus diameter admitted all four knuckles A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. After doing the vaginal examination, gloves hands were checked before being disposed of, all findings and the progress of labour was explained to client and her support person, also the midwife in charge was also informed about the progress. The dilatation board was used to explain the cervical dilatation and progress of labour to client. Client was thanked for cooperating and all information gathered was recorded. Client was made comfortable in bed and encouraged to ambulate, as much as she can.

3.2 PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan

Her neibour brought Madam Comfort to the facility. The staff midwife on duty was identified as the skilled helper, and she also supervised the delivery. The unskilled helper was client's neibour and she was made aware that she would be called to help when needed. The phone number of a hospital (ST. JOHN'S HOSPITAL, DUAYAWNKWANTA) called and informed of the labour in case to prepare them for any emergency. Also a nearby driver was informed that in case of emergency he would be called.

PREPARATION OF AREA OF DELIVERY

The delivery room was made clean and warm by drawing down the curtains, light was switched on, and torchlight was also made ready in an event of light out. Client was told that her hands, chest and abdomen will be cleaned with water and soap prior to delivery and dried with clean towel to prepare for skin-to-skin contact.

PREPARATION OF RESUSCITATION AREA AND CHECKING OF THE FUNCTION OF EQUIPMENT'S

Resuscitation area was made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, suction tube and machine, stethoscope needed to help baby breath were assembled and tested for their function. Delivery set was available waiting to be set at appropriate time. Oxytocin and other emergency drugs like magnesium sulphate were also made available.

3.3 MANAGEMENT OF FIRST STAGE

The fetal heart rate, maternal pulse and uterine contractions were checked every30 minutes, temperature, blood pressure, respiration as well as vaginal examination was done 4 hourly and the results was plotted on the partograph. She complained of being fatigue and maturating frequently. She was reassured she is in the hands of competent midwives.

Madam Comfort was reassured that labour was progressing well and was encouraged to pass urine whenever she feel the urge to prevent full bladder, since this could impede descent of the fetal head and contraction of the uterus.

Madam Comfort was encouraged to ambulate or if she wants to rest, then she should lie on her left lateral side to maintain placental perfusion and prevent supine hypotension syndrome. Client took one third of the porridge served. Sacral massage was performed for client.

At exactly 12:00am on 22nd November 2021, client was due for her second vaginal examination when she ruptured membranes spontaneously with clear liquor, vaginal examination was performed to exclude cord prolapse but there was none. Client was 8cm dilated with moulding (+) and station of +3. Client was observed mishandling her perineal pad and was educated on its effect on her health. The fetal heart rate recorded was 144 beats per minute with good volume and rhythm. Uterine contractions were 4 in 10 minute lasting 47 seconds.

Her vital signs were checked and recorded as follows.

Temperature	-	36.1 degree Celsius
Pulse	-	80 beats per minute
Respiration	-	21cycle per minute
Blood pressure	-	110/60 millimeters of mercury

All the findings were communicated to her and recorded on the partograph. She was advised not to touch her pad when in place. She was then given water to wash her hands, then cleaned with a clean damp towel and was given sips of water since she was sweating profusely.

Delivery trolley containing the following was set;

Top shelf containing sterile items are as follows:

Two artery forceps

4 drapes

Cord scissors

2 gallipots and with cotton swabs and gauze

Receiver for placenta

Episiotomy set (scissors, dissecting forceps and suturing and forceps)

Bottom shelf

Drum containing gauze and cotton wool

Cheatle forceps in its container

Jug for measuring the amount of blood loss

Identification band

Perineal pads

Mackintosh

Cord clamp in his pack

An injection tray containing 10 units of oxytocin drug, water for injection, vitamin K, chloramphenicol eye drop

Examination gloves

Antiseptic lotion

Fetal fetoscope

Syringes and needles

Sterile gloves in its pack

Two clean cot sheets

Lidocaine

Bulb syringe in a receiver containing water

Other instruments include sutures, facemask, goggle, boots, plastic apron baby's dress, bedpan, light source was directed to the bed immediately

At 12:50pm, temperature was checked and recorded as 36.1^{o}C and blood pressure was 110/60mmHg. Fetal heart rate was 138bpm and maternal pulse was 84bpm. Client's perineum was observed bulging and she kept on complaining of the urge to bear down so another vaginal examination was conducted, liquor was still clear, moulding was two (++) cervical OS was 10cm dilated, head station was +1 and contractions 4in 10 lasting for 60seconds. Madam Comfort complained of severe bearing down sensations with uterine contractions becoming more expulsive. The anus was gapping and perineum bulging. The midwife in charge was called to confirm full dilation of the cervix. The already prepared delivery trolley was sent to the bedside of the client and protective clothes were worn. All findings were explained to her and recorded on the partograph sheet.

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

At 12:55am, Madam Comfort was transferred to the second stage room and was positioned on the delivery bed at 1:00am. She was told to be cooperative during delivery; Client was assisted into the supine position with knees flexed and legs apart, which was her choice. She was reassured and every procedure to be done was explained to her. Hands were washed with soap under running water, dried with sterile towel and sterile gloves were worn on both hands.

She was reminded that her baby would be delivered onto her abdomen to provide warmth and initiate bonding. At this point, a clean perineal pad was applied to the anus to prevent foetal eye from being contaminated with faecal matter. Madam Comfort was then encouraged to push with each contraction and rest in between contractions.

As labour progressed, the head advanced gradually and flexion was aided by gently pressing the advancing head downwards in other to allow the smallest diameter of the fetal head to distend the vulva and the perineum. The foetal head was recede with contractions and flexion was maintained until crowning of the head occurred, Madam Comfort was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head, which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum with the next contractions and the head was slowly delivered by extension by holding the two parietal bones. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The mouth and nose were cleaned with gauze swabs. Baby's neck was checked for cord around neck but there was none felt restitution took place, followed by external rotation of the head, this brought the shoulders into anterior-posterior diameter of the pelvic outlet. Madam Comfort was asked to push with the next contractions and was reminded also that the baby will be delivered onto her abdomen. Both palms

were placed on either side of the baby's ear and gently downwards pressure to deliver the anterior shoulder, which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered as it was flexed towards mother's abdomen. The rest of the body was delivered by lateral flexion onto the mother's abdomen, an alive male baby was delivered and it cried loudly after delivery at 1:00am as the midwife in charge noted.

The baby was quickly dry from head to toe with a clean cot sheet paying attention to the hair then skin folds he was covered with another dry clean cot sheet while on her mother's abdomen. Madam Comfort was congratulated for the hard work done.

3. 5 **IMMEDIATE CARE OF THE BABY**

The immediate care of the baby started as soon as the head of the baby was born. Different sterile gauze was used to clean the baby's eyes from inner canthus to the outer canthus to prevent infection and its face dried with another sterile gauze. Baby was delivered unto mother's abdomen and cried loudly. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The wet sheet was removed and had 7/10 as its first minute Apgar score. The cord was clamped two fingerbreadths away from the baby's abdomen and the second three fingerbreadths from the first clamp. The cord was then cut between the two clamps with gauze over the site to avoid splashing, the fifth minute APGAR Score was done and baby had 9/10.The baby was shown to mother to confirm the sex of the baby. Identification band was prepared with the mother's name, baby's sex and date of birth and was tied around the baby's wrist. Baby was then placed on the mother's abdomen to initiate skin to skin. The mother and baby were covered with a warm sheet and the head covered to prevent hypothermia.

The baby was put to breast to ensure the natural release of oxytocin to help with the contraction of the uterus, initiate lactation and promote bonding between mother and baby. The baby was then nursed on the mother's chest to continue skin to skin for an hour with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

The Apgar score assessment was as follows:

INDICATOR	FIRST MINUTE	FIFTH MINUTE
Appearance	1	2
Pulse	2	2
Grimace	1	2
Activity	1	1
Respiration	2	2
Total	7/10	9/10

3.6 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

The third stage of labour was managed using active management of third stage of labour. It is applied regardless of the assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth of the baby and delivery of the placenta by the use of controlled cord traction. After the cord separation, a sterile receiver was placed near the vulva in between the thighs to receive the end of the cord as well as blood loss. Client's abdomen was palpated to rule out any unidentified twin in utero before 10 units of oxytocin was given intramuscularly by the midwife-in-charge to aid in contraction of the uterus

and to prevent any bleeding. The client was asked to empty her bladder, which she said she had no urge. The non-dominant hand was placed on the fundus to feel for contractions. As soon as contractions were felt, the clamp was held with the dominant hand while the non-dominant hand was placed on the lower abdomen in the suprapubic area to give counter traction of the uterus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and the forceps were also held firmly at the same time and with downward traction, the process was maintained until the placenta became visible at the vulva. The placenta was cupped by both hands and twisted gently to remove pressure on the fragile membranes. The placenta and membranes were delivered completely at 1:05am.The uterus was massaged to maintain the contraction and expel clots. Client was taught to massage her uterus and she was asked to feel the hardness of the uterus, which indicated that the uterus was well contracted. This procedure was done every 15 minutes for two hours making sure the uterus was firm.

The placenta and membranes were quickly examined, and all the lobes were intact and healthy. The placenta and membranes was placed in a receiver, which was placed in between her thighs for thorough examination later. The uterus was massaged and blood clots were expelled. Perineum, vaginal walls and cervix were examined under a light source and there were no tears. Client was encouraged to call when the uterus feels soft to touch.

The estimated blood loss was 130mls. Client was cleaned and a new perineal pad was placed at the perineum to make her comfortable in bed. Client was encouraged to change her pad and urinate frequently to prevent postpartum hemorrhage and infections. She was also educated on how breastfeeding will help in the contractions of the uterus. Madam Comfort was congratulated for her cooperation.

3.7 EXAMINATION OF PLACENTA AND MEMBRANES

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 cord was held, allowing the membranes to hang loosely downwards. The cord was of normal length and the edge of the umbilical cord had two arteries and one vein. The cord insertion was central. The foetal surface was shinny and smooth with its colour being bluish grey. The branches of the cord vessels were seen radiating on its' surface to just the edge of the placenta. The placenta was placed on a flat surface with maternal surface facing upward. Through inspection, the colour was dark red and the cotyledons were intact. There were no extra lobes (succenturate lobe) it was then disposed of appropriately.

The working surface was wiped with 0.5%chlorine solution and decontaminated the delivery instrument in 0.5%chlorine solution for 10minutes, washed with soap and water, rinsed allowed to air dry and send for sterilization. Finding were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also completed.

3.8 MANAGEMENT OF FOURTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are monitored continuously to detect early deviations from normal. Madam Comfort and her baby were monitored for six hours before transferring them to the lying-in-ward.

Client's vital signs were checked and recorded as follows:

Temperature - 36.5 degree Celsius

Pulse	-	87 beat per minute
Respiration	-	20 cycle per minute
Blood pressure	-	120/70 millimeter of mercury.

Madam Comfort was asked to empty her bladder whenever she feels the urge in order to help contractions of the uterus. Madam Comfort was served with warm beverage. She was educated on how breastfeeding enhances the release of oxytocin, which would improve uterine contractions, drainage of lochia, control of hemorrhage and as a form of family planning.

Madam Comfort was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was well contracted and Symphysio-fundal height was 16cm, there was no active bleeding from the vagina. She was encouraged to report if she sees any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. Madam Comfort vital signs and uterus were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for three hours and findings recorded on the pictograph. The findings were within the normal ranges. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of its skin remains pink.

3.9 CARE OF THE BABY

prevention of diseases

The following procedures were performed to prevent infection to the eye and cord and prevent hemorrhagic disease of the newborn. Prevention of disease is done within the first 90 minutes. Two (2) drops of Chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton and methylated spirit and vitamin K 1.0mg intramuscularly was given to the baby to

prevent bleeding. Hands were washed with soap under running water and cleaned with dry clean towel. Baby was then wrapped to keep him warm.

3.10 EXAMINATION OF THE NEWBORN

After an hour, baby was taken from the mother and it was put on a cleaned covered flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. Baby's colour was pink on observation.

The head was examined for shape and size, widened sutures, bulging and depressed fontanelles, any edematous swelling, caput succedaneum, anencephaly, microcephaly, among others but none detected. The ears were examined for size, shape, patency, softness of the cartilage and alignment with the eye. The eyes were examined for its presence, colour, redness of the conjunctiva, jaundice of the sclera and deformities and its alignment with the ears and no abnormalities were seen. The nose was examined for shape, size, patency, deviated septum and discharges but no abnormalities were detected. The buccal cavity was inspected for false teeth, tongue-tie, cleft lip and palate by using the little finger to feel palate, sub mucous cleft but no abnormality was detected. In addition, rooting and suckling reflexes were present on assessment. The neck was also palpated for rigidity and congenital goiter.

The chest was inspected for shape, size and chest wall movement with respiration rate of 42 cycles per minute and the apex heartbeat was 130 beats per minute. Breasts were palpated for masses, there was none, and nipple was checked for position, which was normal.

The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or missing digits. No abnormalities was detected. Baby's ability to perform Moro and grasp reflexes was also checked. Hands and arms were inspected for symmetry, movement and paralysis.

Colour of nail beds were inspected. The lower extremities were inspected for equality, clubbed feet, talipes, extra or loss digits but none was present. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' was not heard.

The abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastrochisis were absent. The spleen and liver were palpated for enlargement and no abnormalities were found.

The back was also examined with baby lying prone with chest supported. Two fingers were run through the back to check for swelling, missing vertebra spinal bifida, meningocele, among others but none was detected.

The genitalia was developed with two(2) well descended testes each in a scrotal sac and normal sized scrotum and penis, urethra meatus was located centrally on the glans penis and anal orifices were patent as it passed urine and meconium respectively.

Head circumference 35 centimeters, Length of the baby was 50 centimeters. Baby's weight was 3.2 kilograms. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her. Baby's vital signs and weight were checked and recorded as follows;

Temperature	36.2 degree Celsius
Apex heart beat	130 beats per minute
Respiration	42 cycles per minute
Weight	3.2 kilograms

3.11MANAGEMENT OF THE MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for 3 hours and recorded as follows;

Temperature	36.2 degree Celsius
Pulse	84beat per minute
Respiration	21cycle per minute
Blood pressure	110/70millimeter of mercury

The fundus was rubbed for contraction. Blood clots were expelled, and the Symphysiofundal height was 16 centimeters. Client was transferred to the lying-in-ward and baby put to breast. The total blood loss after the fourth stage was 130 milliliters. At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia was red in colour (rubra), small in quantity and had no foul smell. Vitamins 'A' capsule 200,000 I.U was given to mother. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's neighbor was allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labour notes were recorded on the pictograph sheet.

3.12 **CONDITION OF MOTHER AFTER BIRTH**

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were rechecked and the following examinations were done and recorded as follows;

Blood pressure	110/80 millimeter of mercury
Temperature	36.3 degree Celsius
Pulse	79 beats per minute
Respiration	21cycles per minute
Fundus	14centimeters
Blood loss	130mls
Bladder	100mls

Condition of mother after delivery was good.

3.13 **CONDITION OF BABY AFTER BIRTH**

The baby's vital signs and observations are as follows;

Temperature	36.5 degree Celsius
Apex heart beat	130 beats per minute
Respiration	42 cycles per minute
APGAR score for first minute	7/10
APGAR score for fifth minute	9/10
Sex	Male
Weight	3.2 kilograms
Abnormalities	None
Condition of baby	Very good.

3.14 **LABOUR CARE PLAN**

PROBLEMS IDENTIFIED DURING LABOUR;

On 21st November 2021 client is noted to be anxious

On 21st November, 2021client complained of;

1. Fatigue

2. Mishandling of perineal pad

3. Profuse sweating

LONG TERM OBJECTIVES

Madam Comfort will go through labour successfully and deliver a healthy baby without any abnormality or complications

SHORT TERM OBJECTIVES

1. 1 .Client will be relieved of anxiety within 30minutes
2. Client's fatigue will resolve within 12 hours.
3. Client will show no signs of infection within 72hours.
4. Client will remain well hydrated and comfortable within 2hours.

Date/Time	Nursing Diagnosis	Nursing Objective Outcome criteria	Nursing Order	Nursing Intervention	Date/time	Evaluation	Sign
21/11/21 8:40 pm	Anxiety related to unknown outcome of labour	Client's anxiety will be allayed within 30 minutes as evidence by; 1.client verbalizing that she is no more anxious 2. Midwife observing that client is relaxed in bed.	1. Reassure client that it shall be well 2. Explain to client all interventions to be done to her. 3. Educate her on possible outcome of labour. 4. Encourage client to express her concerns and fears and address them. 5. Allow client on communicate with relatives.	1. Client was reassured that she is in the competent hand. 2. All intervention done on client were explained to her. 3. Client was educated that she can have caesarian section and vacuum extraction done but we are hoping for vaginal delivery. 4.clients expressed her fear and concerns and they were addressed 5. client communicated with relative all the time.	21/11/21 9:10am	Goal fully met as client said she was no more anxious and midwife visualized that client is relaxed in bed.	

Date/Time	Nursing Diagnosis	Nursing Objective	Nursing Order	Nursing Intervention	Date/time	Evaluation	Sign
21/11/21 8:40pm	Fatigue related to effect of labour pains	Client will be relieved of fatigue within 2 hours as evidence by; the client visualizing that she feels energetic and midwife that client looks refreshing and not showing signs of fatigue	1. Reassure client that fatigue will reduce. 2. Encourage client to rest when contractions wear off. 3. Encourage client to perform deep breathing exercise. 4.Improve ventilation in the room 5. Serve client with soft drinks.	1. Client was reassured that fatigue will reduce. 2. Client took enough rest when contractions wear off. 3. Client was performing deep breathing exercise 4. Fans were switched on and widows were opened throughout labour. 5. Client sipped soft drinks, such as malt at regular intervals.	21/11/21 10:40am	Goal fully met as evidenced by client verbalizing that she has been able to cope with fatigue till the end of labour	

Date/Time	Nursing Diagnosis	Nursing Objectives	Nursing Order	Nursing Intervention	Date/Time	Evaluation	sign
21/11/21 8:40pm	Potential risk for infection related to mishandling of perineal pad.	Client will be free from infection within 72 hour as evidenced by midwife observing that client shows no signs of infection as vital signs especially Temperature.	1. Reassure client that she will be free from infections. 2. Encourage client to wash her hands before and after touching perineal pad. 3. Educate client on the need to change perineal pad whenever soaked to prevent infections. 4. Advice client to discard pad if fallen. 5. Teach client how to fix pad properly.	1. Client was reassured that she will be free from infections. 2. She washed her hands before and after touching perineal pad. 3.Client was changing her perineal pad when soaked to prevent infection 4. Client discarded and applied fresh perineal pad when it filled. 5. client was taught how to fixed pad properly	24/11/21 9:00am	Goal fully met as; midwife visualizing that client show no signs of infection.	

Date/Time	Nursing Diagnosis	Nursing Objectives	Nursing Order	Nursing Intervention	Date/Time	Evaluation	sign
21/11/21 8:40pm	Profuse sweating related to stress of labour.	Madam Comfort will remain hydrated within 20 minutes and to the end of labour as evidence by; 1. Midwife observing that client's skin tegour and vital signs are normal.	1. Reassure client of promote care. 2. Encourage client to drink fluids frequently. 3. Educate client on the need to perform deep breathing exercise. 4. Advice client was asked to bath warm water. 5. Teach client to open windows and fans.	1. Client was reassured of competent care to promote comfort. 2. client drunk at regular interval 3. Client continued deep breathing exercise. 4. Client's face and body were cleaned with wet towel. 5. Windows were opened and fans switched on.	21/11/21 10:20am	Goal fully met as evidenced by Midwife observed that client was not sweating and was comfortable.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter entails the management of both mother and baby from the delivery day to six weeks post-partum. Then care plans drawn for the management of problems encountered during puerperium. In addition, health education, counseling, assessment, support for infant feeding and immunization service are inclusive.

4.1 **Day of delivery**

On Monday, 22nd November 2021, Madam Comfort and her baby were transferred to the lying in room at 08:30am. They were closely observed for six hours postpartum. She was made comfortable in bed and baby was then put to breast. Client was educated on the need to ensure that baby was kept warm to prevent hypothermia and ensure proper personal hygiene and empty her bladder frequently so that the uterus could contract and prevent bleeding. The need to change Perineal pad when soiled and applying of new pad to make client comfortable and also to prevent long term genital tract infection was also emphasized. Client was educated to breastfeed baby on demand, practice exclusive breastfeeding and also fixing of the baby well to breast. Client was helped to fix baby to breast and problems associated with breastfeeding such as mastitis, engorgement, cracked nipples and their management were explained to client. Emphasis was also laid on hand washing after visiting the toilet, removing baby's soiled napkins, before handling and breastfeeding the baby to help prevent infection. Client vital signs were checked every 15mins for 2 hours, 30 minutes for 1 hour and hourly for the last 3 hours.

Her vital signs and other assessment were recorded as follows:

Temperature	36.2 degree Celsius
Pulse	84 beats per minute
Respiration	21 cycles per minute
Blood pressure	120/70 millimeter of mercury
Lochia	small and rubra
Fundal height	16 centimeters
Condition of uterus	contracted
Breast	lactating

Vital Signs for baby and weight was checked and recorded as follows:

Temperature	36.5 degree Celsius
Respiration	42 cycles per minute
Apex heart beat	138 beats per minute
Weight	3.2 kilograms

Client complained of after pains, she was reassured and education was given on the physiology of after pains. Client was encourage to continue breastfeeding baby and she was given paracetamol tablet 1g start. She was told that the pain was because of contraction of the uterus so that it returns

to normal. Madam Comfort ate banku and okro stew, which was brought, by her husband and her sister who is nearby. She breastfed her baby afterwards, took her bath and went to bed.

4.2 SUBSEQUENT CARE OF THE BABY

Continuous monitoring was given to baby and the condition of baby was healthy. Baby was bathed six (6) hours after delivery. Immediately after the baby's bath, cord was checked for bleeding and also was dressed. Baby breathing rate was checked and was within the normal range. Baby was also dressed and wrapped in a warm cot sheet to keep it warm to prevent hypothermia. Client was educated on the newborn care such as cord care and also for any danger sign such as irregular breathing, jaundice, fever and report immediately to the nearest health facility.

BABY BATHING AND CORD DRESSING

REQUIREMENTS

Top shelf

Sterile gloves

Sterile cotton wool swab

Sterile water in a gallipot

Sterile gallipot

A clean baby dress, cap and socks (if available)

Gallipot containing cotton wool swab

Sterile tray for cord dressing

Down shelf

Diapers

Dress

Baby's oil or Vaseline

Baby's powder

Basin

Bath thermometer

Mackintosh

Disposable gloves

2 Jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver receptacle for used swab

Methylated spirit

Bathing of the baby was done after six hours following delivery. Madam Comfort's consent was sort to bath the baby, which she accepted. She was asked to watch closely in order to enable her learn how to bath baby at home. Requirements needed for the procedure were gathered. Then, Plastic apron was worn, cold and hot water were mixed and temperature tested with elbow. Hands were washed with soap and water, dried and examination gloves worn. Baby was placed on a protected flat surface and undress after which he was wrapped with a cot sheet. Baby was not over

exposed to prevent hypothermia. A thorough examination was done and there was no abnormality seen. Eyes were cleaned with cotton wool swabs soaked in sterile water from inner cantus of the eyes out and face was also cleaned with damp towel. The nape of baby's neck was supported with one hand protecting the ears with the middle finger and the thumb. Baby's air was washed with soapy sponge. Then supporting the nape and the body resting on the elbow, after that baby was lifted to the edge of the basin. Soap was rinsed off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to skin folds. Baby's back was turned with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds. Baby was firmly supported, lifted into a basin of water with head above the water and rinsed thoroughly in a quick manner from the trunk to the limbs. Baby was placed on flat surface and covered with a clean big towel. He was dried with a small towel, paying attention to skin folds. Baby was smeared with pomade and dressed with socks and cap. She was then wrapped in a cot sheet exposing the cord for dressing.

CORD DRESSING

After baby was bathed, the cord was dressed with cotton wool swabs soaked in methylated spirit, baby was wrapped in a towel to keep him warm and procedure was explained to the mother the mother was asked to protect him on a table as preparation was being made. A tray containing a galipot with cotton wool swabs soaked in methylated spirit, and a receiver was set. A protective apron was worn, nearby windows were closed and baby was kept on an examination table, still wrapped up and protected by mother. Hands were washed thoroughly with soap and water and dried with a clean towel. Gloves were worn and the exposed cord was inspected for bleeding but it wasn't bleeding. A cotton wool swab was used to hold the tip of the cord, the base of the cord

was cleaned with one of the cotton wool swabs soaked in methylated spirit. The whole cord was cleaned from the base upwards using a swab each. The tip of the cord was also cleaned. Cord was then left exposed to dry. A diaper was then put on the baby folded below the umbilicus and baby was dressed and wrapped with clean cot sheet and handed to mother to breastfeed then both gloved hands were immersed in 0.5%chlorine solution and it was removed. Hand washing was done with soap and water and dried with a clean towel

4.3 FIRST DAY POST DELIVERY (FIRST POSTNATAL HOME VISIT)

Tuesday 23rd November 2021 was the first day after delivery and baby looked healthy with no abnormality detected after head to toe examination. Client was asked about the after pains which she said is better. Mother and baby were examined from head to toe and no abnormality was detected. Vital signs were checked and recorded as follows;

Observation	Morning
Temperature	36.5 degree Celsius
Blood pressure	110/60 millimeter of mercury
Respiration	24 cycles per minute
Pulse	70 beats per minute

The breasts were lactating small, small, uterus was well contracted, Symphysio- fundal height 15cm. The lochia was red (rubra) and the amount was moderate and not offensive. Madam Comfort was encouraged not to apply hot compress on the baby's head with the aim of aiding fast closure of the fontanelles, the effect of such practices were given to her. She was informed of her discharge and encouraged to register the baby at birth and death registry.

Baby vital signs are as follows:

Observation	Morning
Temperature	36.3 degree Celsius
Apex beat	136 beats per minute
Respiration	43cycles per minute
Weight	3.1 kilograms

Examination on the baby revealed that, baby can suckle, has normal respirations, and no abdominal distension and it has also pass stool and urine. The baby was then wrapped in a clean and warm cot sheet and handed over to the mother for breastfeeding and findings were communicated to her. The position and attachment to the breast was done well under supervision and client demonstrated it. Client was reminded on the intake of nutritious diet and taking of fruits. Client was also educated on postnatal exercises such as Kegel and early ambulation. She was also educated on changing of diapers when soilefd, and keeping baby warm always. The baby was given oral polio vaccine and Bacillus Chalmette Guerin (BCG) vaccine intradermal at the right upper arm as a protection against Tuberculosis. Madam Comfort was educated not to massage or apply anything to the injection site. Client was encouraged to visit the Baby Clinic for growth monitoring and to continue with baby's immunization. She was made aware that there will be a tissue reaction over the area and a scar formation indicating that the baby has effectively been immunized. She was also asked to register the baby at the birth and death registry. Mother and baby was reassessed before leaving the facility and no abnormalities were noticed. Madam Comfort was informed of the first postnatal visit to the clinic to be 29th November, 2021. The Midwife in-charge confirmed these findings and

they were discharged after their bills have been settled using her National Health Insurance card. She was given the following drugs;

Tablet folic acid	5mg daily for 15 days
Tablet ferrous Sulphate	200mg bid for 15 days
Tablet multivitamins	200mg daily for 15 days
Tablet paracetamol	1g tids for 5 days
Tab Metronidazole	400mg tids for 14days

At 9:10am, client was helped to pack her things and was reminded of the intended postnatal visits for a period of one week, which was explained to her that she would be visited at home for seven days, morning and evening for the first three days then once daily from the fourth day, which she agreed. They were then seen off and promised to be visited during the evening.

FIRST POST NATAL HOME VISIT

At 4:00 pm. same day, client was visited at home. Greetings were exchange and seat was offered. She was asked about her health and that of the family and a positive respond was given. Client was informed of the procedure that will be carried out and a permission was sought out. After washing of hands with soap under running water, Madam Comfort was examination head to toe. Her breasts were lactating well. Uterus well contracted on palpation, Permission was sought to inspect client's perineal pad and lochia was rubra, moderate in flow without any offensive smell, with no abnormality found on the whole. Madam Comfort was encouraged to breastfeed baby on demand. Vital signs were checked and recorded as follows for mother;

Evening's Observation

Temperature 37.1 degree Celsius

Pulse 79 beats per minute

Respiration 24 cycles per minute

Blood pressure 110/60 millimeter per mercury

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

Evening's Observation

Temperature 36.8 degrees Celsius

Pulse 136 beats per minute

Respiration 45 cycles per minute

Baby was examine from head to toe for abnormality but none was found. Baby's cord was dressed under client's observation. Madam Comfort was informed about the next postnatal home visit. Permission was then sought to leave and it was allowed

4.4 SECOND DAY POST DELIVERY (SECOND DAY POSTNATAL HOME VISIT)

On 24th November 2021, at 8:00am and 5:30pm Madam Comfort was visited in her house. Both mother and baby looked healthy on arrival. The family was much pleased to be visited. Client was asked about her previous complain which she said was better. Explanation was given to Madam Comfort that, she and the baby would be examined from head to toe to see if there are deviation for early treatment, she was asked to empty her bladder. Client's conjunctiva was examined and it was not pale, the uterus was well contracted and breast was lactating, Symphysiofundal height measured 14 centimeters. The perineum was clean when inspected, Lochia was red with moderate flow and there was no bad odour. Madam Comfort was taught to express breast milk to reduce congestion of breast milk and breastfeed baby on demand. The condition of both mother and baby was good, but she complained of headache and so much interrupted sleep. She was educated to sleep when baby sleeps and on the importance of rest when less busy. She was asked to demonstrate how she breastfed her baby which was performed well. Her vital signs were taken and recorded as;

Observation	Morning	Evening
Temperature	36.3 degree Celsius	36.5 degree Celsius
Pulse	79 beats per minute	82 beats per minute
Respiration	22 cycle per minute	24 cycle per minute
Blood pressure	120/70 millimeter of mercury	110/80 millimeter of mercury

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

Observation	Morning	Evening

Temperature	37.0 degree Celsius	36.6 degree Celsius
Pulse	132 beats per minute	136 beats per minute
Respiration	45cycles per minute	42 cycles per minute
Weight	3.0 kilograms	

Baby was examined thoroughly from head to toe to examine for abnormality but none was found. Madam Comfort was encouraged to complete emptying of one breast before she breastfeeds baby with the other breast. The baby had passed meconium and urine when the diaper was removed. The cord was also dressed with cotton wool soaked in methylated spirit; it was cleaned and kept dry. Permission was sought to leave and she was reminded that she will be visited the next day.

4.5 THIRD DAY POST NATAL (THIRD DAY POST NATAL HOME VISIT)

On 25th November 2021, the second visit was made to Madam Comfort's house around 8: 00am in the morning and 5:00pm in the evening. Permission was sought to examine both mother and baby. The head to toe examination was also done on her and no abnormalities were detected. She was not pale and breast was lactating well now. Abdomen was soft with no palpable masses, the uterus was well contracted and Symphysiofundal height was 13centimeters.Her perineum was clean when perinea pad was taken for observation, the lochia was found to flow moderately the colour was red (rubra) and without bad odour. Her vital signs were checked and recorded as follows;

Observation	Morning	Evening
Temperature	36.7oC	36.3oC

Pulse	79bpm	82bpm
Respiration	21cpm	23cpm
Blood pressure	120/60mmHg	110/70mmHg

Baby's vital signs and weight were taken and recorded as follows;

Observation	Morning	Evening
Temperature	37.2oC	36.9oC
Apex heart beat	127bpm	127 bpm
Respiration	42cpm	44cpm
Weight	3.0 kg	

General examination was carried out and no abnormality was present. The cord was clean and dry and shrinking on examination. It was then dressed neatly. The baby has passed stools and the colour was yellow and urine according to Madam Comfort. Client was asked about the interrupted sleep, and client said she was able to sleep better than the other days.

Permission was sought to leave and Client said she was very grateful and appreciated the care that was given to them.

4.6 FOURTH DAY POSTPARTUM (FOURT HDAY POSTNATAL HOME VISIT)

On 26th November, 2021 the fourth home visit was made to Madam Comfort's house at 8:30am in the morning and she was greeted. Mother and baby were doing well. Procedures to be carried out on both mother and baby were explained and consent sought, her breasts were examined and they were lactating well. Abdomen was soft with no palpable masses Symphysiofundal height was 12cm and on client's perineal pad, lochia was rubra, moderate in flow without any offensive smell. Her vital signs were checked and recorded as follows;

Observation	Morning
Temperature	37.2oC
Pulse	64bpm
Respiration	21cpm
Blood pressure	120/70 mmHg

General examination was carried out on the baby as well and no abnormality was present. The baby also passed stool and urine. The cord has fallen and so baby was bathed and stump was neatly dressed. Baby's vital signs and weight were taken and recorded as follows;

Observation	Morning
Temperature	37.1oC
Apex heart beat	124bpm

Respiration 46cpm

Weight 3.1kg

4.7 FIFTH DAY POST PARTUM (FIFTH DAY POSTNATAL HOME VISIT)

On the fifth day postpartum, Madam Comfort was visited at 8:30am on 27th November, 2021. The health status of the family was inquired; both mother and baby were doing well. Head to toe examination was done and everything was normal as breast were still lactating well and symphysiofundal height was 11 centimeters, lochia was rubra with scanty flow without odour on inspection. Her vital signs were checked and recorded as follows;

Temperature 36.4oC

Pulse 73bpm

Respiration 20cpm

Blood pressure 110/70mmHg

Baby's vital signs and weight were taken and recorded as follows;

Temperature 37.2oC

Apex heart beat 134bpm

Respiration 46cpm

Weight 3.2kg

General examination was done, no abnormality was found. The cord was then dressed and it was dried and shrinked. The baby passed stools, which was yellow in colour and urine. Client

complained that,her elder child has been angry and has refused to eat since they were discharge home. It was explained to her that, the elder child feel neglected and she was advised to care for her and allow her to play with the baby under supervision to avoid sibling rivalry. Permission was sought to leave and Client said she was very grateful and appreciates the care that was given to them.

4.8 SIXTH DAY POSTPARTUM SIXTH DAY POSTNATAL HOME VISIT)

The sixth postnatal home visit was on 28th November 2021 at 8:00am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition when it was inquired. Madam Comfort said the baby cries a lot, she was reassured that the crying of the baby will reduce when she feeds the baby on demand and changes her diaper frequently because babies have lusty cry to evoke attention. After that, a head to toe examination was conducted and no abnormality was detected. Client was not pale, breast were lactating and inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. She was educated on the need to take adequate diet. Symphysiofundal height of Madam Comfort was 10 centimeters. Both mother and baby were handed over to the midwife in charge for continuity of care and were educate to consult them in case of any problem. Client's vital signs were checked and recorded as follows:

Temperature	36.1oC
Pulse	78bpm
Respiration	22cpm

Blood pressure 110/70mmHg

Baby's vital signs and weight were taken and recorded as follows:

Temperature 37.0oC

Apex heart beat 136bpm

Respiration 45cpm

Weight 3.3kg

Cord was off and mother confirmed it fell off the night before that morning. Head to toe examination was done and no abnormalities were seen. Baby was bathed. Stump was then dressed and the area was cleaned and dried. Madam Comfort was reminded of the next visit to the clinic and she said she was very grateful. Permission was sought to leave.

4.9 FIRST DAY POSTNATAL VISIT TO THE CLINIC

On 29th November 2021 at 9:00am, Madam Comfort and her baby came to the facility. A seat was offered to client, she looked healthy. Procedure to be carried out was explained to her after some minutes rest and she consented. Midstream urine was taken and checked for protein and sugar and all tested negative. Hemoglobin level was 12.5g/dl. Her vital signs were checked and recorded as;

Temperature - 36.2oC

Pulse - 79bpm

Respiration - 22cpm

Blood pressure - 110/70mmHg

Madam Comfort was asked to empty her bladder before the head to toe examination if she has the urge. Procedure to be carried out on Madam Comfort was explained to her. Privacy was provided and she was assisted to undress, given a gown to wear and lie on the couch for the head to toe examination. Hands were washed with soap and water and dried with a clean towel.

Head to toe examination was done on her. On the head, hair was neat and tied with a ribbon, the conjunctiva was not pale, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, no engorgement, sore or cracked nipples were detected. The abdomen was palpated and there was no tenderness, no scars, enlarged liver or spleen on examination, the uterus was well contracted and measured 9cm. There was no edema, varicosities and tenderness in calf. The perineum was clean, there was no offensive vaginal discharge, and the lochia was not offensive with slight flow. Client was thanked for the cooperation and encouraged to assess a family planning method in addition to lactational amenorrhea method. Madam Comfort was then helped to dress up.

Head to toe examination was done on baby and no abnormalities were found. Umbilical stumped had healed. Baby's weight was 3.6kg. She was also educated on the importance of the child welfare clinic. Mother was told to send the baby to the circumcision area for the baby to be circumcised. Baby's circumcision was done by the midwife in-charge. All findings were recorded and communicated to mother. She was educated to avoid applying concoctions and homemade preparations on the circumcised penis. Also, client was told to check for any bleeding from the circumcised penis .She was informed about the six weeks post-natal visit

Client was thanked for her support; explanation was given to Madam Comfort on the need to be handed over to the midwife in-charge for continuity of care and was informed of frequent calling for checkup on them.

Baby's vital signs was checked and recorded;

Temperature - 36.8oC

Apex heart beat - 129bpm

Respiration - 46cpm

Weight - 3.4kg

4.11 CARE PLAN DURING POST PARTUM PERIOD

PROBLEM IDENTIFIED

On 22nd November, 2021 client complained of;

1. After pains

On 24th November 2021 client complained of;

2. Headache
3. Interrupted sleep

On 27th November, 2021 client complained of;

4. Sibling rivalry

SHORT TERM OBJECTIVES

1. Client's afterbirth pains would subdue within 12 hours.
2. Client's headache would reduce within 24 hours.
3. Client will sleep at least 8 hours within 24 hours
4. Client will regain harmony in her family within 24hours

LONG TERM OBJECTIVE

Client will go through puerperium successfully without any complication to both mother and bab

Date/Time	Nursing Diagnosis	Nursing Objective	Nursing Order	Nursing intervention	Date/Time	Evaluation	Sign
22/11/21 9:30pm	Acute pain (after pains related to involution of the uterus.	After pains will be reduced within 24 hours as evidenced by 1.client verbalizing that she is relieved of the after pain 2. Midwife visualizing that client breastfeeds with relaxed facial expression.	1. Reassure client that the pain will reduce. 2. Encourage client to empty her bladder frequently 3.Encouraged client to continue breastfeeding the baby on demand 4. Encourage client to lie prone with pillow at the abdomen. 5.Give analgesics to reduced pain	1. Client was reassured that she would be relieved of after pain 2. Client was emptying her bladder whenever she get the urge. 3. Client was breastfeeding baby on demand. 4.client was lying prone with pillow at the lower abdomen 5. Paracetamol 1g was given to reduced pain.	23/11/21 9:30am	Goal fully met as client said she is relieved of the pain and midwife observed client breastfeed with relaxed facial expression.	

Date/Time	Nursing diagnosis	Nursing Objective	Nursing Order	Nursing Intervention	Date/time	Evaluation	Sign

24/11/21 8:00am	Headache related to stress from puerperium.	Client will be relieved of headache within 24 hours evidenced by; 1. Client verbalizing she relived of the pain. 2. Midwife observing client had a cheerful facial expression	1. Reassure client that condition can be managed 2. Encourage client to take some rest in the day 3. Encourage client to take in 8-10 glasses of water daily 4. Encourage support person to do most of the chores for client to rest 5. Serve prescribed medication	1. Client was reassured of competent nursing care. 2. Client was taking at least 2 hours rest in the day and sleep 6 hours at night. 3. Client took at least 8 glasses of water daily 4. support person was helping allowing client to rest 5. client was served with paracetamol 1gtds×5	26/11/21 8:00am	Goal achieved as client informed the midwife that her headache has reduced	

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE TIME	EVALUATION	SIGN

24/11/21 8:00	Sleep pattern Disturbance (Interrupted sleep) related to frequent waking to breastfeed at night.	Client will be able to sleep for at least 8 hours: 2 hours during the day and 6hours during the night within 24 hours as evidenced by client verbalizing that she is sleeping well.	1. Reassure client that her sleeping pattern will return to normal. 2. Encourage client to ensure baby full before putting it to sleep 3. Educate client to sleep whenever baby is asleep. 4. Encourage family members to assist in the care of the baby 5.Educate client to limit number of visitors	1. Client was reassured that her sleeping pattern would return to normal. 2. Client breastfed the baby fully before putting it to sleep 3. Client slept whenever baby was asleep. 4. Family members assisted her in the care of the baby. 5. Client limited number of visitors.	26/11/21	G oal met as client said she slept for 6 hours during the night.	
DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/	NURSING ORDER	NURSING INTERVENTION	DATE/TIME	EVALUATTION	SIGN

		OUTCOME CRITERIA					
27/11/21 8:30am	Sibling rivalry related to elder child feeling neglected	Client's children will live in harmony as evidence by; 1. Client reporting that the elder child plays with the baby. 2.midwife observing that elderly child is playing and singing lullaby for the baby	1. Explain to client the reason for elderly child's behavior. 2. Advice client to care for elderly child. 3. Advice client to allow elderly child to play with baby under supervision. 4. Advice client to introduce baby to the elderly child.	1. It was explained to client that elderly child behavior was as a result of neglect 2. Client was advised to give attention to elderly child. 3. Client was advised to supervise elderly child to play with the baby. 4. Client was advised to introduce baby to elderly child as her brother.		Goal fully met as evidenced by; 1. Client reporting that elderly child is happy and has accepted the baby as a brother.	

SUMMARY AND CONCLUSION

Client G2P1^{A} was met at Tanoso Health Center, Tanoso when she reported for review on the 1st November, 2021. She was managed from the 36 weeks of pregnancy through labour and puerperium.

During pregnancy, she experienced some minor disorders like lower abdominal pains, waist pains, sleeplessness, loss of appetite and others as stated of which the necessary management and education were given to her. She was also educated on environmental hygiene, birth preparedness and complication readiness. She adhered to all educations given to her and went through pregnancy successfully.

During labour, she encountered challenges like painful uterine contractions and anxiety of which her pain and anxiety were allayed by encouraging her as well as some nursing interventions as stated. Client had positive labour outcome to a healthy live male child on 22/11/21 without any complications to mother and baby.

After delivery, client experienced fatigue, headache and sleeplessness among others as some disorders associated with puerperium. Client was managed accordingly and they resolved within the shortest possible time. Her entire family was not left out, they were also involved in rendering care to the client and her baby.

All postnatal visits to the house and subsequent visit to the clinic by the client were done and all examinations were conducted on both mother and baby. Client, her baby and the entire family were handed over to the public health nurse in her community for continuity of care.

In conclusion, this care study was of great benefit because it helped in acquiring new knowledge and put into practice what has been thought in the classroom. It has also given me much knowledge on how to render care to a woman during pregnancy, labour and puerperium in the society and the nation as a whole.

To the country, this will help reduce maternal and neonatal mortality as well as morbidity rate among expectant mothers and babies. To the clinic it will help increase the number of attendance to the clinic during antenatal care, labour and puerperium. Client and her baby were healthy at the end of the whole interaction

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
03/05/21	Blood	Haemoglobin	11.4-16g/dl	11.6g/dl	Normal
		Blood group	A, B, AB, O	A	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		G6PD	No defect	No defect	Normal
		Hepatitis B	Negative	Negative	Normal
		Syphilis	Negative	Negative	Normal
		HIV Status	Negative	Negative	Normal

03/05/21	Urine 	Protein Glucose	Negative Negative	Trace Negative	Abnormal Normal
29/06/21	Urine Blood	Glucose Prote in Haemoglobin	Negative Negative 11.4 – 16g/dl	Negative Negative 12.2g/dl	Normal Normal Normal
14/07/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
05/08/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
DATE	**SPECIMEN**	**INVESTIGATION**	**NORMAL VALUES**	**FINDINGS**	**REMARKS**

02/09/21	Urine	Protein Glucose	Negative Negative	Negative Negative	normal Normal
30/09/21	Urine Blood	Protein Glucose Haemoglobin	Negative Negative 11.4 – 16g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
13/10/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
25/10/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
16/11/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

ITN Given – 1/06/2021

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD 3 NO TD 4		TD 5 NO	
	CURRENT TT 3rd dose		Date		Date	
			27/07/20		16/11/20	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 28/06/2021	Gestation age In weeks 17weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 26/07/2021	Gestation age In weeks 21weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)23/08/21	Gestational age in weeks 25weeks
	4th dose 3 tabs (Direct observed therapy)20/09/21	Gestation age in weeks 29weeks	5th dose 3 tabs (Direct Observed Therapy) 18/10/21	Gestation age in weeks 33 weeks	6th dose 3 tabs (Direct observed therapy)15/11/21	Gestation age in weeks 37weeks

*NB:- Sulfadoxine _Pyrimethamine – (SP) should be given to pregnant women after 16 weeks or when mother feels baby's movement(after quickening) till delivery and should be given at least 1month after last dose

APPENDIX II

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamins preparation	5 milligrams once daily	Orally	Helps in proper formation of blood cell.	Increases haemoglobin level	Malaise, pruritus	None observed
Tablet multivitamin	Minerals and vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Dark stools, Constipation	None observed
Tablet ferrous sulphate	Haematinics	200 milligrams 2 twice	Orally	Aids in formation red blood cells, Increase appetite	Increase appetite	Black stool, Diarrhoea	None observed

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 sulphadoxime Pyrimethamine	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
Injection tetanus	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

(MOTHER)
PHARMACOLOGY OF DRUGS USED CONTINUED

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,vomiting,Uterine spasm, slow heart rate	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

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Paracetamol tablet	Antipyretic/Analgesic	1g tids x 3 days	Orally	Reduces mild to moderate pains	Client's pain was relieved	Liver damage due to prolong use	None observed
Metronidazole tablet	Anti-infective	400mg tids x 30	Orally	Prevention of infection	Infection was prevented	Diarrhea,Headache,Nausea	None observed

(BABY)

PHARMACOLOGY OF DRUGS USED

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Haemostatics	1.0mg	Intramuscular	Production of Prothrombin which aids in clotting	No bleeding	Risk of haemolysis in people with G6PD,rashes and brain damage	None observed
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None observed

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTINE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUG	SIDE EFFECT EXPERIENCED
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhoea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None
Hepatitis B vaccine	Antigen	0.5 millilitres	Subcutaneous	Immunity against Hepatitis B virus	Under observation	Fever	None
Diphtheria pertussis tetanus	Antigen	0.5 millilitres	Intramuscular	Immunity against diphtheria pertussis tetanus	Under observation	Fever	None

ANTENATAL CHART RECORD

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar)	Haemo-globin level (g/dl)	Gestational age (w. eeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remarks
19/04/21	54	110/70	Negative Negative	11.6	10	-	-	-	-	Headache	Tablet folic acid, multivitamin, ferrous sulphate, tablet paracetamol 1000mg,1st dose of tetanus injection	Well
17/06/21	56	100/60	Negative	12.0	14	palpable	-	-	-	Waist pain	Tablet folic acid, multivitamin, ferrous sulphate, tablet fluids,2nd dose of tetanus injection	Well

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar	Haemo-globin level (g/dl	Gestational age (weeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remarks
14/6/21	65	120/80	Negative	12.5	17	14	-	-	FM+	Feels well	Folic Acid, Multivitamin, Ferrous sulphate,1st dose of SP.	Healthy
12/07/21	66	115/60	Negative	-	22	18	-	-	138	Feels well	Folic Acid, Multivitamins, Ferrous sulphate.	Well
09/08/21	68	100/60	Negative	-	25	25	-	-	140	No Complain	Folic Acid, Multivitamins, Ferrous sulphate	Healthy
06/09/21	70	100/60	Negative	-	39	29	Ceph	-	142	No Complain	Folic Acid, Multivitamins, Ferrous sulphate	Healthy

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar	Haemo-globin level (g/dl	Gestational age (weeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remark
04/10/21	70.34	100/60	Negative	-	34	33	Ceph	-	129	Feels well	Folic Acid, Multivitamins, Ferrous sulphate,	Well
18/10/20	70.55	102/61	Negative	-	36	35	Ceph	-	135	No Complain	Folic Acid, Multivitamins, Ferrous	Well
15/11/21	70.67	110/70	Negative	-	37	36	Ceph	5/5th	138	Feels well	Folic Acid, Multivitamins, Ferrous	Well

SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS BELINDA BOATENG

SIGNATURE: ……

DATE: ……

THE MIDWIFE-IN-CHARGE OF ABOFOUR HEALTH CENTER

NAME: MRS. ABENA BOAHEMAA

SIGNATURE: ……

DATE: ……...

THE SUPERVISOR

NAME: MISS. ERNESTINA MENSAH

SIGNATURE: ……...

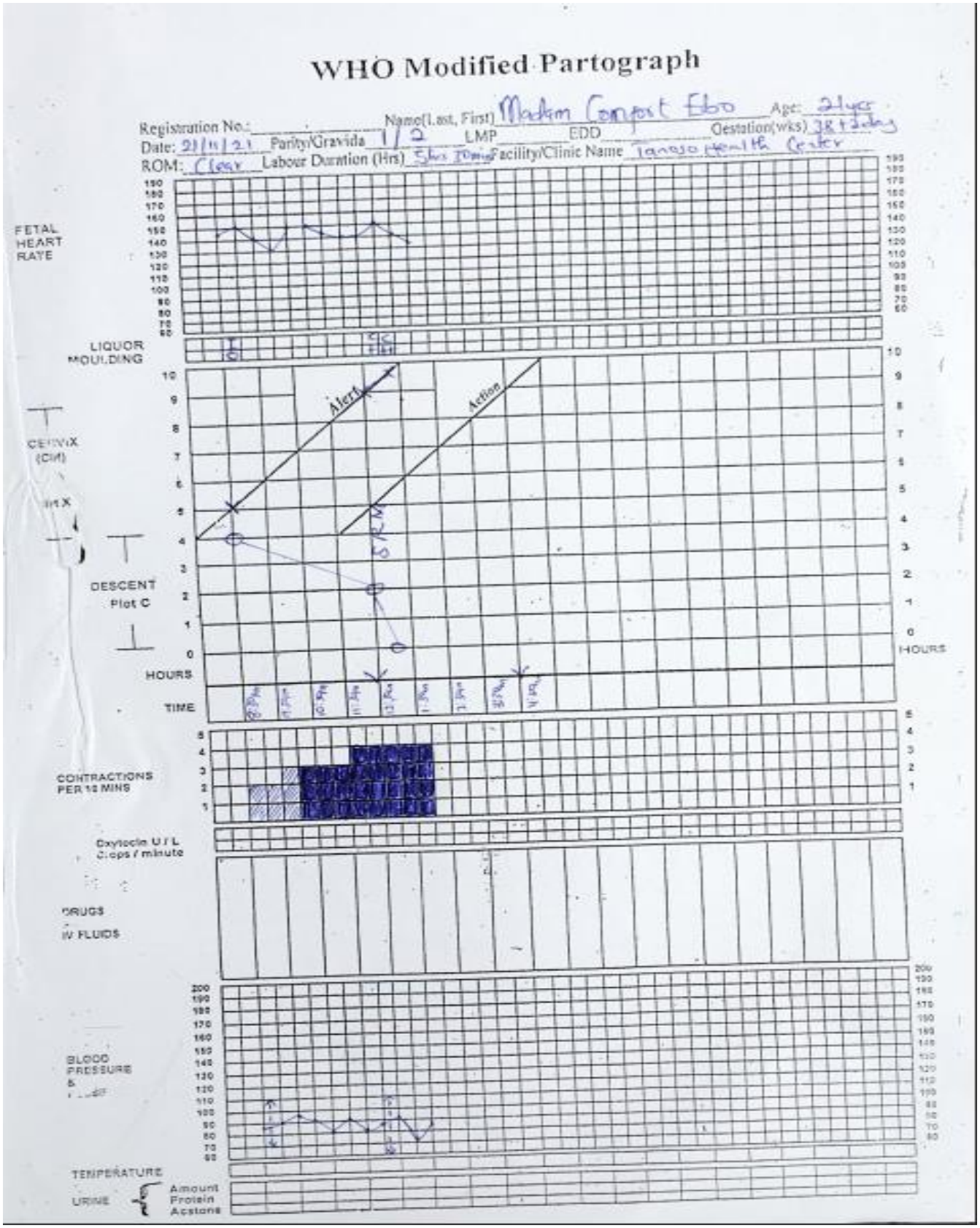
DATE: …….

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: ……

DATE: ……


WHO Modified Partograph
Registration No:
Name(Last, First) Madam Comfort Ebo
Age: 24yrs
Date: 21/11/21
Parity/Gravida 1/2
LMP
EDD
Gestation(wks) 38+2days
ROM: Clear
Labour Duration (Hrs) 5hrs 10mins
Facility/Clinic Name Tanoso Health Center
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
DESCENT Plot C
HOURS
TIME
Alert
Action
CONTRACTIONS PER 10 MINS
Oxytocin U / L
Drops / minute
DRUGS
IV FLUIDS
BLOOD PRESSURE
TEMPERATURE
URINE
Amount
Protein
Acetone

LABOR NOTES

Client had SVD at LMC with APGAR Score 7/10 for the first minute and 9/10 for the fifth minute. Birth weight 3.2kg. Head Circumference 0-35. full length - 50cm. Perineum - intact Blood loss 130mls Uterus well Massaged and well contracted. Skin-to-Skin was initiated. breastfeeding initiated. Vit k given. General examination, eye care and Cord care was done.

Please circle or write responses.

DELIVERY

DATE: 22/11/21 TIME: 1:00am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 1:00 am Type/Dose 10 units

PLACENTA: TIME: (Complete) / Incomplete

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

BABY

Weight: 3.2kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

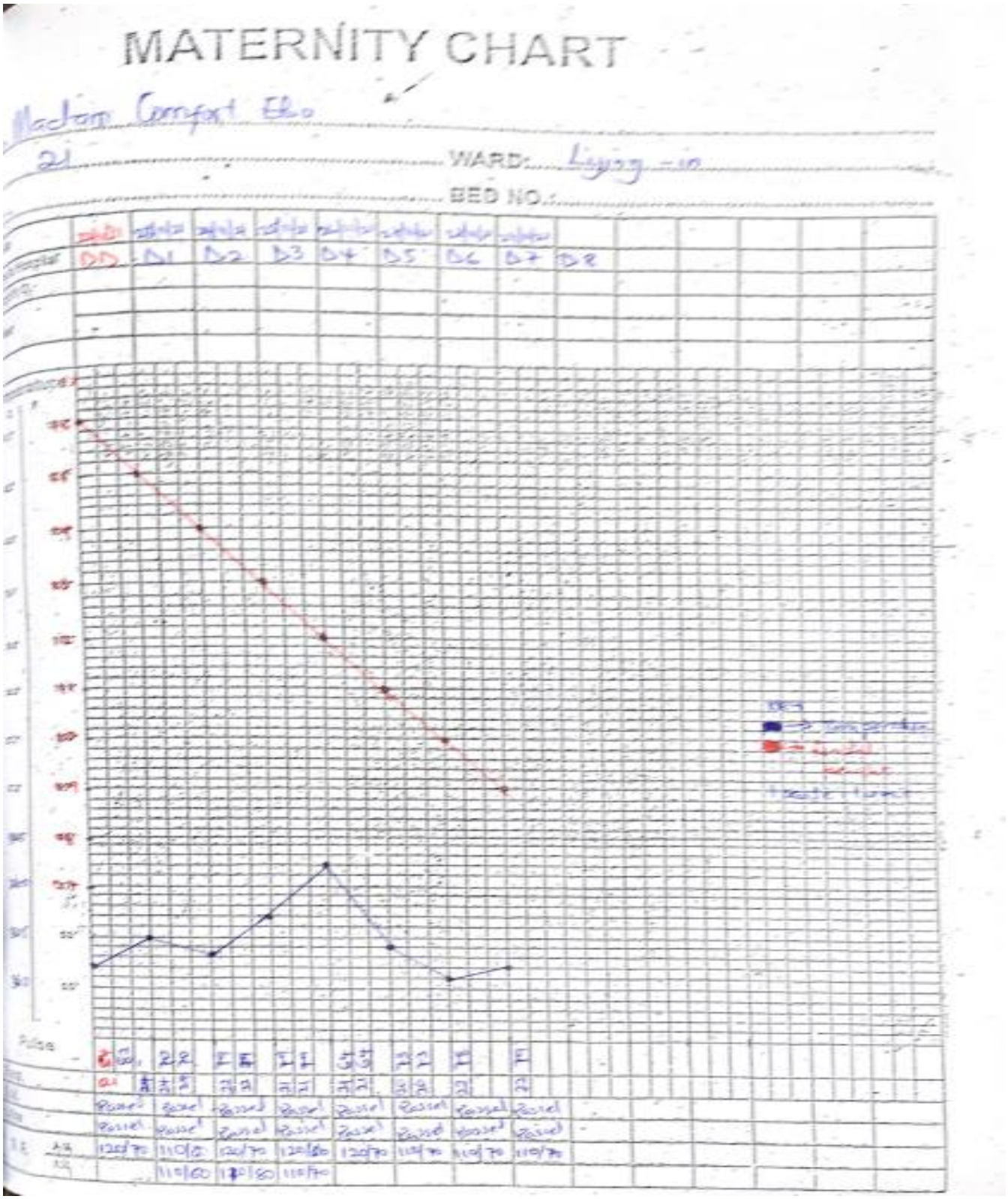
Time	Cola	Breath	Heart	Tone	Reflex	TOTAL
1min	1	2	2	1	1	7/10
5min	2	2	2	1	2	9/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	1:10am	110/60	82	1bcm	Small	
	1:25am	110/70	80	Contracted	small	100mls
	1:40am	110/70	82	well contracted	Small	
	1:55am	110/60	82	well contracted	small	
	2:10am	110/60	81	well contracted	Small	
	2:25am	110/60	84	well contracted	Small	
	2:40am	110/60	85	well contracted	Small	
	3:10am	100/60	86	well contracted	small	
Every 30 minutes For 1 hour	3:40am	100/60	82	well contracted	small	
	4:10am	100/60	82	well contracted	Small	50mls

Birth Attendant Belinda Boateng Date 22/11/21


MATERNITY CHART
Madam Comfort Ebo
21
WARD: Ligog - 10
BED NO.:
DD
D1
D2
D3
D4
D5
D6
D7
D8
Pulse
Received
Received
Received
Received
Received
Received
Received
Received
120/70
110/60
120/70
120/80
120/70
110/70
110/70
110/70
110/60
120/80
110/70

NEWBORN EXAMINATION FORM

Name: Baby Compet EGo Date of Assessment: 22/11/21 Time: 2.05pm
Date of Birth: 22/11/21 Time of Birth: 1:00 Sex: ☑M ☐F Age at time of Assessment(days/hrs): 1 hour
Gestational Age: 38+2dy Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section
APGAR: 1 min 7/10 ☐ 5min 9/10 ☐ Birth Weight: ☐ 3.2 Kg ☐ Length 50 Cm Head Circumference 35
Temperature at time of Assessment: °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Belinda Boateng

1. Respiration

Rate 44
☐ Rate < 30 b/m*
☐ Rate > 60 b/m*
☑ 30-60 b/m
☐ Retractions*
☐ Grunt ng*
☐ Stridor*

2. Activity Movement

☑ Spontaneous symmetric movement
☐ Reduce d/Absent movement in > 1 limb
☐ No movement*

3. Tone

☑ Normal
☐ Floppy*
☐ Increased*

4. Colour

☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over*
☐ Pale*
☐ Jaundice*

5. Cord

☑ Normal
☐ Red draining pus
☐ Bleeding

6. Cry

☑ Normal
☐ Stirill*
☐ Absent*

7. Suck

☑ Good
☐ Weak
☐ Absent*

8. Head swelling

☐ Caput succedaneum
☐ Cephalhaematoma
☐ Subgalcal hemorrhage
☑ No swelling

9. Sutures

☑ Normal
☐ Overlapping
☐ Fused
☐ Widely separated*

10. Fontanelle

☑ Normal
☐ Sunken*
☐ Raised*
☐ Wide(>5cm)*

11. Eyes

☑ Normal
☐ Subconjunctival bleed
☐ White pupil or cornea
☐ Eye discharge
☐ Other

12. Ears

☑ Normal (size/shape/position)
☐ Abnormal:

13. Mouth

☑ Normal
☐ Cleft palate
☐ Cleft lip
☐ Other:

14. Neck

☑ Normal
☐ Sweling
☐ Webbed
☐ Other:

15. Clavicle

☑ Normal
☐ Swelling/Fracture

16. Chest

☑ Normal (shape/movement)
☐ Abnormal

17. Heart rate

Rate: 136
☑ Normal (100-160)
☐ <100*
☐ >160*

18. Fermoral pulse

☑ Present
☐ Not palpable*

19. Abdomen

☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses:
☐ Other:

20. Back (spine)

☑ Normal
☐ Abnormal Swelling*
☐ Hairy patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

21. Limbs

☑ Normal
☐ Abnormal

22. Genitalia Male Genitalia

☑ Normal
☐ Undescended tests
☐ Abnormal meatus
☐ Hernia
☐ Other:

23. Female Genitalia

☐ Normal
☐ Pistula (meconium/urine through abnormal opening i vagina)*
☐ Large clitoris
☐ Other:

24. Anus

☑ Patent
☐ Imperforate*

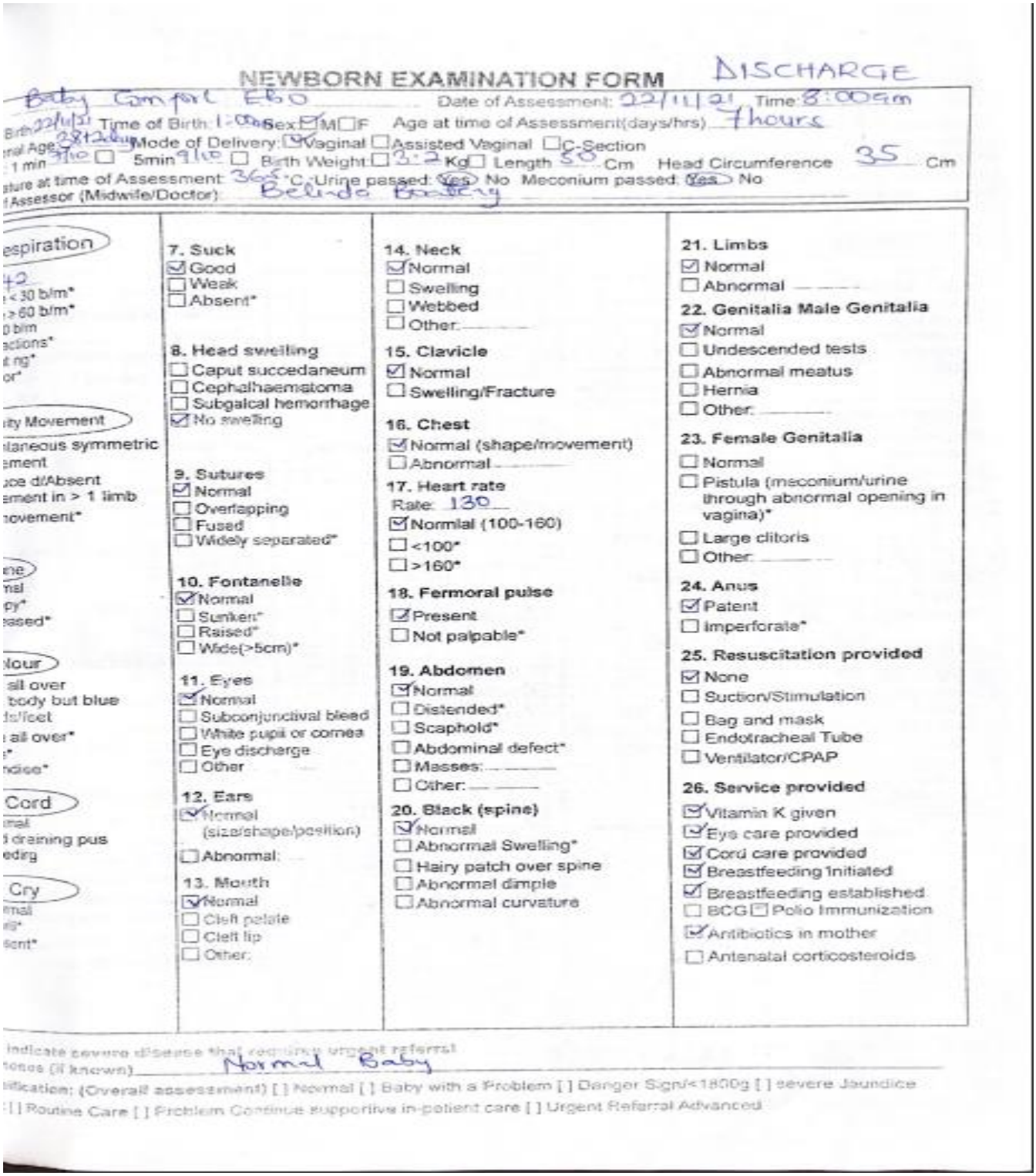
25. Reasuscitation provided

☑ None
☐ Suction/Stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

26. Service provided

☑ Vitamin K given
☑ Eye care provided
☑ Cord care provided
☑ Breastfeeding initiated
☑ Breastfeeding established
☑ BCG ☑ Polio Immunization
☐ Antibiotics in mother
☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
Diagnoses (If known): Normal Baby
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice
Plan: [ ] Routine Care [ ] Problem Continue supportive in-patient care [ ] Urgent Referral Advanced



NEWBORN EXAMINATION FORM

DISCHARGE

Baby Comfort EBO

Date of Assessment: 22/11/21 Time: 8:00am

Time of Birth: 1:00am Sex: ☑M ☐F Age at time of Assessment(days/hrs): 7hours

Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section

1 min 9/10 ☐ 5min 9/10 ☐ Birth Weight: ☐ 3.2 Kg ☐ Length 50 Cm Head Circumference 35 Cm

Temperature at time of Assessment: 36.5°C Urine passed: (Yes) No Meconium passed: (Yes) No

Assessor (Midwife/Doctor): Belinda Bosery

Respiration

42

☐ < 30 b/m*

☐ > 60 b/m*

☐ 0 b/m

☐ ractions*

☐ ng*

☐ or*

Activity Movement

☐ laneous symmetric

☐ ement

☐ oce d/Absent

☐ ement in > 1 limb

☐ ovement*

Colour

☐ all over

☐ body but blue

☐ ds/feet

☐ all over*

☐ *

☐ ndice*

Cord

☐ mal

☐ draining pus

☐ eding

Cry

☐ mal

☐ g*

☐ sent*

7. Suck
☑ Good
☐ Weak
☐ Absent*

8. Head swelling
☐ Caput succedaneum
☐ Cephalhaematoma
☐ Subgalcal hemorrhage
☑ No swelling

9. Sutures
☑ Normal
☐ Overlapping
☐ Fused
☐ Widely separated*

10. Fontanelle
☑ Normal
☐ Sunken*
☐ Raised*
☐ Wide(>5cm)*

11. Eyes
☑ Normal
☐ Subconjunctival bleed
☐ White pupil or cornea
☐ Eye discharge
☐ Other

12. Ears
☑ Normal (size/shape/position)
☐ Abnormal:

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft lip
☐ Other:

14. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other:

15. Clavicle
☑ Normal
☐ Swelling/Fracture

16. Chest
☑ Normal (shape/movement)
☐ Abnormal

17. Heart rate
Rate: 130
☑ Normal (100-160)
☐ <100*
☐ >160*

18. Fermoral pulse
☑ Present
☐ Not palpable*

19. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses:
☐ Other:

20. Black (spine)
☑ Normal
☐ Abnormal Swelling*
☐ Hairy patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

21. Limbs
☑ Normal
☐ Abnormal

22. Genitalia Male Genitalia
☑ Normal
☐ Undescended tests
☐ Abnormal meatus
☐ Hernia
☐ Other:

23. Female Genitalia
☐ Normal
☐ Pistula (meconium/urine through abnormal opening in vagina)*
☐ Large clitoris
☐ Other:

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☑ None
☐ Suction/Stimulation
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26. Service provided
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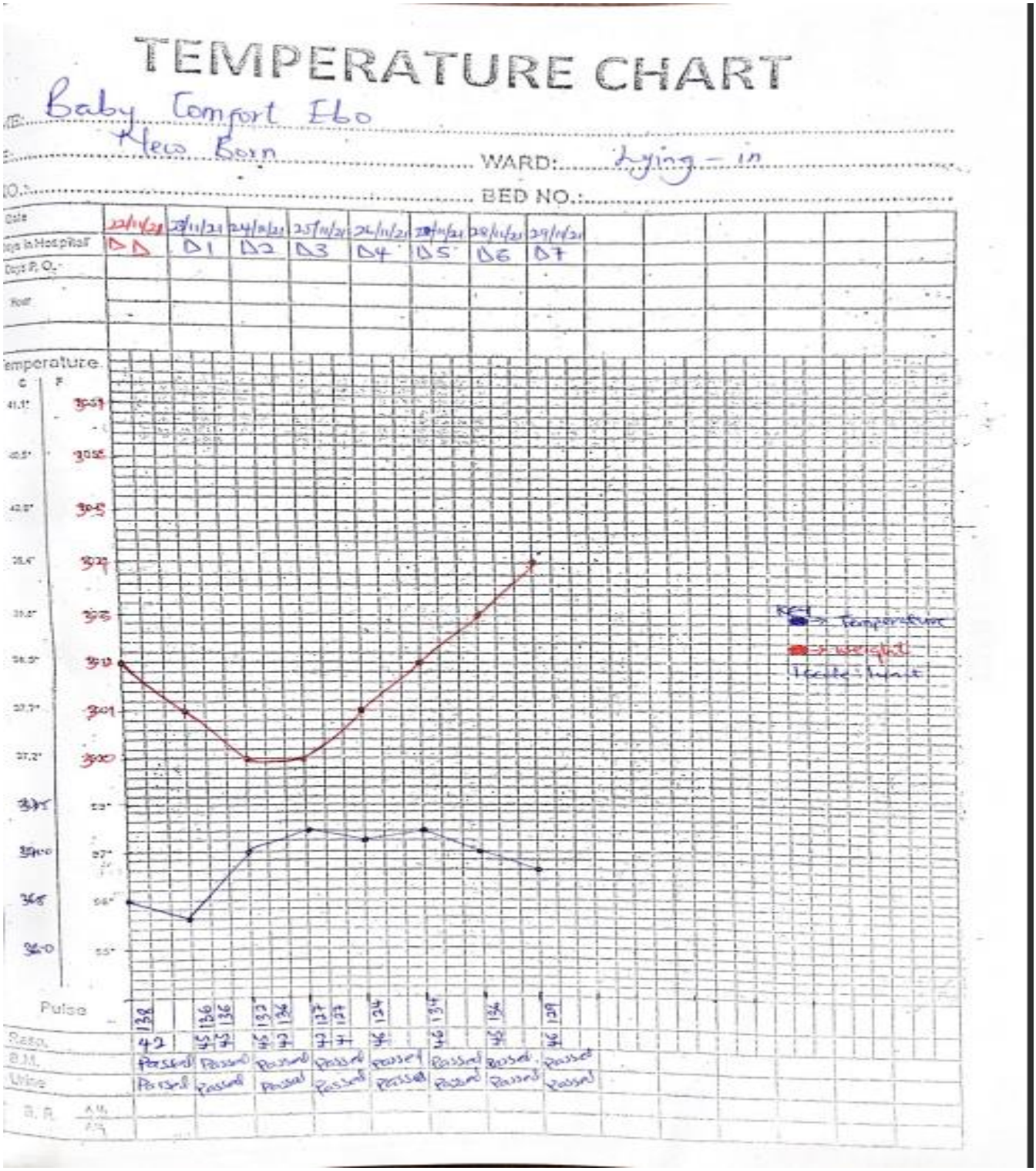
☐ BCG ☐ Polio Immunization
☑ Antibiotics in mother
☐ Antenatal corticosteroids

Indicate severe disease that requires urgent referral

Notes (if known): Normal Baby

Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice

[ ] Routine Care [ ] Problem Continue supportive in-patient care [ ] Urgent Referral Advanced


TEMPERATURE CHART
Baby Comfort Ebo
New Born
WARD: Lying - in
BED NO.:
Date
Days in Hospital
Days P. O.
Temperature
Pulse
Resp.
B.M.
Urine
B. P.
22/11/21 23/11/21 24/11/21 25/11/21 26/11/21 27/11/21 28/11/21 29/11/21
D0 D1 D2 D3 D4 D5 D6 D7
Key
= temperature
= weight
Feeds: Infant
Passed

NEW BORN CHART

Name: Baby Comfort Ebor ..... No: ..... Birth Weight: 3.2kg .....

Sex: Male ..... Mother's No: ..... Length: 50 cm .....

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: 22nd November 2021 Term Bab

Date of Birth: 22nd November 2021 ..... Time: 1:00am ..... Date of Discharge: 22nd November 2021

Date	22/11/21		23/11/21		24/11/21		25/11/21		26/11/21		27/11/21		28/11/21		29/11/21							
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight	3.2kg		3.1kg		3.0kg		3.0kg		3.1kg		3.2kg		3.3kg		3.4kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	36.5°c	36.1°c	36.3°c	36.8°c	37.0°c	36.6°c	37.2°c	36.9°c	37.1°c	37.0°c	37.2°c		37.0°c		36.8°c							
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Remarks	Head Neck Abdomen → NAD																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS BELINDA BOATENG

SIGNATURE: .....

DATE: 05/10/2022

THE MIDWIFE-IN-CHARGE OF ABOFOUR HEALTH CENTER

NAME: MRS. ABENA BOAHEMAA

SIGNATURE: ..... (for)

DATE: 07/10/2022

THE SUPERVISOR

NAME: MISS. ERNESTINA MENSAH

SIGNATURE: .....

DATE: 06/10/2022

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: ..... (for)

DATE: 10/10/2022

ASSISTANT CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUSO