

**HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,
BEREKUM**

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM GYANSAH ELIZABETH

BY

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LICENSE TO PRACTICE AS A REGISTERED MIDWIFE**

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TABLE OF CONTENTS

PREFACE	i
ACKNOWLEDGEMENT	ii
INTRODUCTION	iii
LITERATURE REVIEW	v
WHY I CHOSE MY CLIENT	xv
CHAPTER ONE	1
ASSESSMENT OF CLIENT / FAMILY	1
1.0 INTRODUCTION	1
1.1 PERSONAL AND SOCIAL HISTORY	1
1.2 FAMILY HISTORY	1
1.3 MENSTRUAL HISTORY	2
1.4 SURGICAL HISTORY	2
1.6 LIFESTYLE AND HOBBIES	2
1.7 PAST OBSTETRIC HISTORY	3
1.8 PRESENT OBSTETRIC HISTORY	4
CHAPTER TWO	6
ANTENATAL CARE	6
2.0 INTRODUCTION	6
2.1 FIRST CONTACT WITH CLIENT	6
2.2 FIRST ANTENATAL HOME VISIT	11
2.3 SECOND ANTENATAL HOME VISIT	12
2.4 SUBSEQUENT VISIT TO THE CLINIC	13
2.5 CARE PLANS DURING ANTENATAL PERIOD	15
CHAPTER THREE	21
INTRAPATAL CARE	21
3.0 INTRODUCTION	21

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR.....	21
3.2 MANAGEMENT OF THE FIRST STAGE OF LABOUR.....	23
3.3 MANAGEMENT OF SECOND STAGE OF LABOUR.....	28
3.4 IMMEDIATE CARE OF THE BABY	29
3.5 MANAGEMENT OF THIRD STAGE OF LABOUR.....	30
3.6 EXAMINATION OF PLACENTA AND MEMBRANES	31
3.7 PREVENTION OF DISEASES.....	32
3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR.....	32
3.9 NURSING CARE PLAN ON LABOUR.....	36
CHAPTER FOUR.....	43
POSTNATAL CARE	43
4.0 INTRODUCTION	43
4.1 DAY OF DELIVERY	43
4.2 SUBSEQUENT CARE OF THE BABY	44
FIRST BATH OF THE BABY	45
DAY OF DISCHARGE	47
POSTNATAL HOME VISITS	49
4.3 SECONDDAY POST DELIVERY(FIRST POSTNATAL HOME VISIT.).....	54
4.4 THIRD DAY POST DELIVERY (2 ND POSTNATAL HOME VISIT)	50
4.5 FOURTH DAY POST DELIVERY (3 RD POSTNATAL HOME VISIT).....	52
4.6 FIFTH DAY POST DELIVERY (4 TH POSTNATAL HOME VISIT).....	54
4.7 SIXTH DAY POST DELIVERY (FIFTH POSTNATAL HOME VISIT).....	55
4.8 SEVENTH DAY DELIVERY (SIXTH DAY POSTNATAL HOME VISIT).....	56
4.9 EIGHT DAY POSTNATAL (SEVENTH POSTNATAL HOME VISIT).....	57
4.10 FIRST DAY POST NATAL VISIT TO THE CLINIC (8 th DAY POST DELIVERY).....	58
TERMINATION OF CARE.....	60
CIRCUMCISION OF THE BABY	60
4.11 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POST DEELLIVERY).....	61

SUMMARY AND CONCLUSION	69
BIBLIOGRAPHY.....	73
APPENDIX I	71
APPENDIX II	73
APPENDIX III	75
APPENDIX IV	77
SIGNATORIES	80

PREFACE

Client and family centered maternity care is a systematic approach of carrying out holistic and individualized care to both the expectant mother and her family during the period of pregnancy, labour and puerperium. The study is carried out by a student midwife based on a thoughtful understanding of the client as a unique individual with specific problem and needs and to assist her solve them. The client and family are assured of confidentiality.

The aim of the family centered maternity care study is to obtain the best possible healthy outcome for the client and her family members. The study also offers the student midwife the maximum opportunity to use the knowledge acquired in the classroom to assess herself.

The care study is an academic project which gives the student midwife the chance to choose a client and manage her from period of pregnancy to ten days early puerperium.

The student midwife uses the nursing process which involves assessment, diagnose, planning, intervention and evaluation to adequately care for the client.

The care study forms part of the academic exercise and also in partial fulfillment of course requirement by the nursing and midwifery council to enable the student midwife obtains a certificate in midwifery.

ACKNOWLEDGEMENT

I wish to express my sincere gratitude to God Almighty for granting me the knowledge, wisdom, understanding and strength to reach this far.

My sincere gratitude goes to my client Madam Elizabeth Gyansah and her family for their cooperation and information which helped me a lot in the writing of this care study.

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Again, I wish to acknowledge the authors and publishers whose various books were used as references.

Lastly, my heartfelt gratitude goes to my family for their support both spiritually and financially.

INTRODUCTION

The client and family centered maternity care study refers to all the midwifery care rendered to the expectant mother and her family throughout pregnancy, labour and puerperium. It entails every aspect of the woman's social, physical, spiritual and psychological well-being.

The care is considered within the framework of the family and the community with the aim of preparing the pregnant woman to face labour, puerperium and to initiate lactation and subsequent care of the baby.

This particular care study is about Madam Elizabeth on 14th August, 2023 at Nchiraa Health Center (Bono East region), after familiarity was built between myself and Madam Elizabeth at the antenatal clinic. It was her 13th antenatal visit and her gestational age was also 36 weeks. After a comprehensive introduction of me to her, she was informed about my idea of using her for my family centered maternity care study which she agreed. She was thanked for her cooperation and accepting my request.

Madam Elizabeth was cared for, during the antenatal periods. Visitation to her home was made to know her family, her surroundings and the community in which she lives. The client and her entire family were included in the care. The condition from the beginning till the end of the interaction was good and satisfactory. Madam Elizabeth had a successful pregnancy, delivered spontaneously on 03rd September, 2023 to an alive baby boy. She had a successful puerperium and was in good health.

This care study is in four chapters;

The Chapter One reveals client's particulars such as social, family, obstetric, medical and surgical histories.

Chapter Two talks about the antenatal care rendered to Madam Elizabeth throughout her pregnancy.

Chapter Three is concerned about management of Madam Elizabeth during labour.

Chapter Four is also concerned about management of Madam Elizabeth during puerperium. The chapter two, three and four has care plan attached to each. The source of information obtained is from the client herself, her family, antenatal record book and other relevant text books.

LITERATUREREVIEW

PREGNANCY

Myles (2014) describes pregnancy as a unique experience for every woman and each pregnancy the woman experiences will be new and uniquely different, nausea and vomiting, constipation, heartburns, headache, leg cramp are minor disorders of pregnancy. A change in the urinary system during pregnancy occurs as a result of enlarging uterus affecting all the parts 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 urethras, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection.

According to Davis (2021), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant.

Fetal weight accounts for about 7 1/2 pounds by the end of pregnancy. The placenta, which nourishes the baby, weighs about 1 1/2 pounds. The uterus weighs 2 pounds. A woman gains about 4 pounds due to increased blood volume and an additional 4 pounds due to increased fluid in the body. A woman's breasts gain 2 pounds during pregnancy. Amniotic fluid that surrounds the baby weighs 2 pounds. A woman gains about 7 pounds due to excess storage of protein, fat, and other nutrients. The combined weight from all these sources is about 30 pounds (Davis, 2021).

The World Health Organization (WHO) envisions a world where “every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal

period” (Tunçalp, et al., 2019).Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization, 2016) . According to the World Health Organization (2016), the components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.

ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care (World Health Organization, 2016). In addition, as indirect causes of maternal morbidity and mortality, such as HIV and malaria infections, contribute to approximately 25% of maternal deaths and near-misses (9), ANC also provides an important opportunity to prevent and manage concurrent diseases through integrated service delivery (World Health Organization, 2016). Through this form of preventive health care, women can learn from skilled health personnel about healthy behaviors’ during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives. Through antenatal care, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus (United Nations Children's Funnd (UNICEF), 2022)

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum period. Prenatal period is divided into trimesters, the first trimester is 1 to 12 weeks

because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Second trimester is 13 to 28 weeks, third trimester extends from weeks 28 to 40. The term 'post- date' is typically used to describe a pregnancy beyond forty weeks (40).

Verrals (1992) pregnancy is a state of conception to the delivery of the fetus. The normal duration is 280 days (40 weeks or 9 month and 7 days) counted from the last normal menstrual period to delivery, or 265days from conception to delivery. The weeks are grouped into three trimesters namely first trimester (week 1- week 12). During the first trimester the body undergoes many changes. Hormonal changes affect almost every organ system in the body. These changes can trigger symptoms like stopping of menstrual period, and other signs include; heartburns, mood swings headache, frequent micturation, morning sickness, tender, swollen breast and etc. Second trimester (week 13- week28) as the body changes to make room the growing fetus, the pregnant woman may have backache, stretch marks darkening of the areola, numbness and tingling sensation and etc. Third trimester (week 29-week 40) in the third trimester, some of the discomfort in the second trimester may continue and the cervix undergoes a slight growth and becomes softer as pregnancy advances.

LABOUR

Labor consists of a series of rhythmic, involuntary or medically induced contractions of the uterus that result in effacement (thinning and shortening) and dilation of the uterine cervix (Artal-Mittelmark, 2022). The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex position between 37

and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition" (WHO, 2020).

The stimulus for labor is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland (Artal-Mittelmark, 2022). Normal labor usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labor usually lasts 12 to 18 hours on average; subsequent labors are often shorter, averaging 6 to 8 hours (Artal-Mittelmark, 2022).

As discussed by Artal-Mittelmark (2022) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labor. Labor begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As labor progresses, contractions increase in duration, intensity, and frequency. As specified by Marshall and Raynor (2014), the onset of labour is a process, not an event; therefore it is very difficult to identify exactly when the painless (sometimes painful) contractions of prelabour develop into the progressive rhythmic contractions of established labour.

Traditionally, three stages of labour are described: the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effects observed in women during this time (Marshall & Raynor, 2014).

1. **The 1st stage**—from onset of labor to full dilation of the cervix (about 10 cm). Begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in *primi Gravida* and six to twelve hours in *multigravida* (Artal-Mittelmark, 2022).
 - a. The **latent phase of labour** is prior to the active phase stage of labour and may last 6–8 hours in *primigravidae* when the cervix dilates from 0 cm to 4 cm dilated. The latent phase of labour is so subjective and poorly understood that a normal range is difficult to measure. According to Marshall and Raynor (2014), the cervical canal shortens from 3 cm long to <0.5 cm in length during this time. A woman may believe herself to be laboring, whereas sound midwifery judgement and understanding of the physiology of the first stage of labour may lead the midwife to the diagnosis of the latent phase of labour. Both the woman and midwife being aware of the latent phase of labour, and allowing this time to pass with no intervention, can prevent the medical diagnosis of poor progress or failure to progress later in labour. In a hospital setting, it is good practice not to commence the partogram until active labour has commenced. Assessing the active phase of labour has been highlighted as essential in reducing interventions in normal labour (Marshall & Raynor, 2014).
 - b. The **active phase** within the first stage of labour is the time when the cervix usually undergoes more rapid dilatation. This begins when the cervix is at least 4 cm dilated and, in the presence of rhythmic contractions, progressively

dilates to 10 cm or full dilatation. When in labour, contractions will often be accompanied or preceded by a bloodstained mucoid show: that is, the release of the operculum from the cervical canal as effacement and dilatation progresses. Occasionally, the membranes will rupture, at which stage the midwife may seek assurance that there are no significant changes in the fetal heart rate due to the rare complication of cord prolapse and that meconium is not present in the liquor, indicating fetal compromise (Marshall & Raynor, 2014).

- c. The **transitional phase** of the first stage of labour is from when the cervix is around 8 cm dilated until it is fully dilated or until expulsive contractions associated with the second stage of labour are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time. Many women may feel the urge to push during transition. In addition to physiological responses, women can experience a range of experiences and emotions. The woman may verbalize her distress, direct it at her birth partner(s), alternatively she may be quiet and contemplative (Marshall & Raynor, 2014).
2. The second stage of labour has traditionally been regarded as the phase between full dilatation of the cervical os, and the birth of the baby (Marshall & Raynor, 2014). On average, it lasts 2 hours in nulliparas (median 50 minutes) and 1 hour in multiparas (median 20 minutes). It may last another hour or more if conduction (epidural) analgesia or intense opioid sedation is used. For spontaneous delivery, women must supplement uterine contractions by expulsively bearing down. In the 2nd stage, women should be attended constantly, and fetal heart sounds should be

checked continuously or after every contraction. Contractions may be monitored by palpation or electronically (Artal-Mittelmark, 2022). During the 2nd stage of labor, perineal massage with lubricants and warm compresses may soften and stretch the perineum and thus reduce the rate of 3rd- and 4th-degree perineal tears (Aasheim, et al., 2017).

3. The **third stage** can be defined as the period from the birth of the baby to complete expulsion of the placenta and membranes. It involves the development of the relationship between mother, baby and father, the separation, descent and expulsion of the placenta and membranes, the control of haemorrhage from the placenta site, and sometimes, the initiation of breast-feeding. Although traditionally labour is divided into three distinct component parts to aid comprehension, it should be viewed as one continuous process. With this in mind, it is important to understand that the physiology of the third stage depends, in part, on what has happened during pregnancy as well as during the first and second stage of labour, and on the woman's basic level of health and wellbeing. The midwife's knowledge and evidence-based skills play a crucial role in ensuring that the care received by the woman works with, not against, physiological processes. The placenta may shear off during the final expulsive contractions accompanying the birth of the baby or remain adherent for some time. The third stage usually lasts between 5 and 15 minutes, but any period up to 1 hour may be considered normal (Marshall & Raynor, 2014).

PUERPERIUM

The words “postpartum” and “postnatal” are sometimes used interchangeably. In this report we use the word “postpartum”, except in sections exclusively dealing with the infant. In those sections the word “postnatal” is used. The postpartum period (also called the puerperium) according to Western textbook definitions starts shortly after the birth of the placenta (American College of Obstetricians and Gynecologist, 2018).

Following the birth of a baby, placenta and membranes, the newly birthed mother enters a period of physical and emotional/psychological recuperation. Skin-to-skin contact is advocated immediately following birth and during the postnatal period as there is clear evidence of benefit to the mother and father. The puerperium starts immediately after birth of the placenta and membranes and continues for 6 weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. A general expectation is that by 6 weeks after birth a woman’s body will have recovered sufficiently from the effects of pregnancy and the process of parturition. However, there has now been a recognition that the return to a non-pregnant state of health and wellbeing can take much longer (Marshall & Raynor, 2014).

According to Marshall and Raynor (2014), after the birth of a baby and expulsion of the placenta, the mother enters a period of physical and psychological preparation and this period, called the puerperium starts immediately after delivery of the placenta and membranes and continues for a period of 6 to 8 weeks. Puerperium is a period after childbirth where the uterus and other organs and structures which were affected by pregnancy returns to their non-gravid state. This period is also divided into three;

1. Immediate puerperium: this is the first 24 hours after delivery.

2. Early puerperium: is between the second and the seventh day after delivery.
3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

During this time a number of physiological and psychological changes take place which are;

The reproductive organs return to the non-pregnant state.

1. Lactation is established
2. Bonding between infant and parents is also established

The mother recovers from the stresses of pregnancy and delivery, and assumes responsibility for the care and nurture of her infant. The main aim of management during puerperium is to;

1. Manage minor disorders in both mother and baby.
2. Counsel and teach on nutritional needs of the puerperal mother.
3. Counsel, teach and encourage the mother to breastfeed exclusively for six months and how to properly fix baby to breast.
4. Counsel and teach mother on importance of rest and sleep, ambulation and exercise as well as family planning.

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in

mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014)

WHY I CHOSE MY CLIENT

Madam ElizabethG2 P1 reported to the antenatal clinic on 14th August 2023, which happened to be her 13th visits to the antenatal clinic at Nchiraa Health Centre.

During examination, client's facial expression was not cheerful. Client was asked and she complained of frequency of micturation which has been disturbing her sleep and she was educated on the physiology of micturation. It was explained to her that due to the growing uterus exerting pressure on the bladder, she was encouraged to put chamber pot within her reach at night so that it does not disturb her sleep. Opportunity was taken for introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on community midwifery practical. Permission was sought from her if she could be used for the study. She agreed and was told to share her problems. The midwife in-charge was informed and permission was granted. After going through the normal antenatal process, she gave the direction to her house, her phone number was taken and she was promised of a visit. Appreciation was expressed

CHAPTER ONE

ASSESSMENT OF CLIENT / FAMILY

1.0 INTRODUCTION

This chapter gives the preview on various information about the client social, family, medical, surgical, menstrual, past and present obstetrical histories as well as client's lifestyle, hobbies and her community as a whole.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Elizabeth gravida2 para1 alive is a 28year old lady who comes from the Bono East Region and stays at Nchiraa. Madam Elizabeth stays near the town health centre. She is fair in complexion, weighs 66kilograms and 149 centimeters in height at booking. Madam Elizabeth is a trader. She is a Christian and fellowships at the church of Pentecost at Nchiraa. Madam Elizabeth is a junior high school graduate. Client speaks and understands Twi and English. Client next of kin is her daughter Amanfo Christabel.

1.2 FAMILY HISTORY

Madam Elizabeth is the last born to Mr.and Mrs Gyansah. Her father is a farmer and her mother is unemployed. Among the three children, there are two females and one male. No known histories of any chronic or hereditary diseases such as cancer, diabetes mellitus, epilepsy, hypertension, sickle cell disease, mental illness in the family. She has no congenital abnormality such as extra digits, cleft palate, cleft lip, spinal bifida in the family.

1.3 MENSTRUAL HISTORY

Madam Elizabeth had her menarche at the age of sixteen years which lasts for five days with normal flow. Madam Elizabeth does not take any medication during her period normally changes her pad two times in a day during her menses to promote personal hygiene. She has never experienced dysmenorrhea in her life. Her last menstrual period was 2nd December, 2022 and her expected date was 7th September, 2023.

1.4 SURGICAL HISTORY

Madam Elizabeth has never undergone any surgical procedure and has never been involved in accident which could affect her pelvis. She also added that she has neither donated nor received blood transfusion.

1.5 MEDICAL HISTORY

According to Madam Elizabeth she has no known medical history of disease such as anemia, heart disease, respiratory disorders, epilepsy, and hypertension

1.6 LIFESTYLE AND HOBBIES

Madam Elizabeth normally wakes up around 6:00am, she brushes her teeth with toothbrush and toothpaste after which she sweeps her room and compound. She then goes to throw her rubbish in a Zoom Lion container outside the house. By 7: 00am she has done her house chores and prepares their breakfast after that she takes her bath. Client takes her porridge with bread in t he morning, rice with ground nut soup in the afternoon and fufu with light soup in the evening. Client said during her leisure time, she rests on

her bed or watch television. Client urinates frequently when she takes in enough fluid and empties her bowel at least twice a day.

1.7 PAST OBSTETRIC HISTORY

Pregnancy; Madam Elizabeth gravida2 para1 alive and healthy went through her pregnancy successfully without any complications. She had her first pregnancy in the year 2019. She said she took two doses of Tetanus` diphtheria injection as well as 5 doses of Sulphadoxine Pyrimethamine (SP) in her first pregnancy. The interval between her pregnancies is 3years. She delivered her child at term. She said during her pregnancy, she only experienced some minor disorders such as backache, waist-pains, nausea and vomiting of which she reported to the clinic and they were explained to her as a normal physiological change in pregnancy which would resolve as pregnancy progressed. She has never suffered any pregnancy induced conditions such as pregnancy induces hypertension, preeclampsia and gestational diabetes. She visited the antenatal clinic for at least 11 times during her pregnancy.

Labour; Client said her labour started spontaneously in the evening before she was sent to the clinic. According to Madam Elizabeth, her baby was delivered at the health center spontaneously when labour was due with no complications such as retained placenta and post partum hemorrhage. Client said she did not labour for a longer time because it did not exceed 17hours. When asked she said that it does not also take long for the placenta to be delivered and the child was in good health, breastfeeding was initiated at birth and abnormalities such as cleft lip, cleft palate, extra digits were not detected at birth. The amount of blood lost 250mls.

Puerperium; Madam Elizabeth went through puerperium successfully without any complications such as puerperal psychosis and sepsis. She started breastfeeding her child after delivery. Her child looked healthy and normal. Her child was fully immunized against the childhood preventable diseases. She practice exclusive breastfeeding for six months and weaned after 2 years. She said her child was fully immunized against vaccine preventable disease according to schedules. She uses the artificial family planning method thus combined oral contraceptive pills. Client also stated that her family supported her in taking care of the baby and some of the household chores.

1.8 PRESENT OBSTETRIC HISTORY

Madam Elizabeth G2P1alive first visited the clinic on the 8thJanuary 2023 when her gestational age was 4weeks and symphysio-fundal height was not present. Client last menstrual period was on the 2nd December, 2022 and her expected date delivery was calculated as 7th September, 2023. Her vital signs and laboratory investigations on that day were as follows;

Temperature	36.0degree celsius
Pulse	85 bpm
Respiration	20cpm
Blood pressure	120\80mmHg
Weight	62kg
Height	149cm
Lab Investigations	
Haemoglobin	13.6g\dl

Sickling	Negative
Blood Group	B
Rhesus factor	Negative
Urine for pregnancy test	Positive
Hepatitis B	Negative
VDRL	Non-Reactive
Protein in urine	Negative
Glucose in urine	Negative
G6PD	Negative
Urine albumin	Negative
Antibody screening for HIV	Non-Reactive
Stool test	Negative

On head to toe examination, there was no abnormality detected. Education on danger signs was given. She was educated on the need to attend Antenatal Clinic regularly. She was put on the following drugs.

Tab Ferrous sulphate	200mg-1dly×30 days
Tab Folic acid	5mg 1dly×30 days
Tab Multivitamin	200mg 1dly×30 days

After client's first visit at the antenatal clinic, she visited the facility as scheduled until she was met at her gestational age of 36weeks

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This involves the care rendered to Madam Elizabeth during pregnancy. This includes first contact with client, antenatal home visits, physical environment, psychosocial assessment, subsequent home visit, subsequent visit to the clinic and nursing care plans drawn to solve problems identified during this care.

2.1 FIRST CONTACT WITH CLIENT

Client was met for the first time on the 14th August 2023, when she was thirty-six (36) week gestation and was attending her 13th antenatal visit at Nchiraa health center. Madam Elizabeth complained of frequency of micturation and the physiology of frequency of micturation was explained to her that during pregnancy the descending fetus compresses on the bladder reducing its capacity which makes her feel the urge to urinate. She was advised that after she finished urinating she should clean her vulva with tissue. Self-introduction was made to Madam Elizabeth as a student midwife from Holy Family Nursing and Midwifery Training College Berekum who has been stationed there for 6 weeks clinical to write care study and would use her as client. Her antenatal booklet was taken and her previous antenatal records. Client was encouraged to ask questions when necessary and also thanked for her cooperation. Client vital signs were checked below;

Temperature	36.5 degree celsius
Pulse	85bpm
Respiration	25cpm
Blood pressure	108\80mmHg
Weight	60kilogram
Height	149centimeters
Haemoglobin level	12.5g\dl

Urine Testing

Client was directed to the washroom to give sample of her urine specimen bottle for urine testing of proteins and glucose by the use of a urine reagent strips. The quantity, colour, odour, smell and sediment were noted. Urine strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip tapped against side of urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with colour on the container. There was no change in colour of the strip indicating negative result for both protein and glucose. This procedure was aimed at detecting and ruling out any abnormalities and to provide sharp intervention where necessary.

GENERAL PHYSICAL EXAMINATION

A tray was set containing the following items;

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

A screen was provided for privacy, she was assisted to change her dressing and wear examination gown after having emptied her bladder. Permission was sought for head to toe examination to be carried out and she granted. Madam Elizabeth was assisted unto the bed in lateral position. Hands were washed with soap under running water and dried with clean dry towel. She positioned herself dorsally for physical examination under the supervision of the clinical coordinator.

On examination of the head and neck, the hair was nicely and neatly braided without dandruff. The face was not puffy, pink conjunctiva with no discharge from both eyes and was in aligned with ears. Tooth was cleaned without any calculus, dental carries and peri dental diseases and no offensive odour of the mouth. No cracked lips and the lips were also dried. The neck was also palpated for lymph nodes, and distended neck vein but nothing was found.

On breast examination, the breast were exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of her skin. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was reminded of self-examination. There were no lymph nodes and no discharge

from the nipple when squeezed. The same was done to other breast and no abnormality was found.

The upper extremities both left and right upper limbs showed equal size and length. No oedema of the hands and the finger nails were well trimmed short and neat with no extra digit.

Lower extremities no varicose vein on legs was found, legs was examined for size, and equality and palpated for oedema, tenderness in the calf muscle.

The back was examined and palpated for spinal or vertebra abnormalities and there was none, sacra region were inspected for signs of oedema or rash on her buttocks.

The abdomen was inspected and it was medium in size and ovoid in shape. Linear nigra was present and scars and striae gravidarum were absent.

The zero end of the tape measure was placed on the fundus of the uterus and was extended to the upper border of the symphysis pubis and the symphysio fundal height was obtained as 33 centimeters.

Palms were rubbed together to prevent induced contractions, standing at the right-hand side of the woman and facing the head, fundus was palpated with both hands and fingers curved around the fundus and the buttocks of the foetus were felt occupying the upper pole of the uterus. The fundus was at the xiphisternum.

On lateral palpation; one hand was used to stabilize one side of the uterus and the other hand was moved gently in a circular manner at the right side of the abdomen and the fetal

limbs were palpated which felt rough. This was repeated at the left side of the abdomen and the fetal back was felt. Fetal position was left occipitoanterior

On pelvic palpation; upon facing the lower limbs of the client at her right-hand side, both hands were placed on either sides of the lower abdomen pointing downwards and inwards below the umbilicus, the presentation was cephalic and the lie was longitudinal.

The anterior shoulder was located using two fingers. The upper border of the symphysis pubis was also located. Five fingers were admitted between the anterior shoulder and the upper border of the symphysis pubis indicating descent of 5/5th above the pelvic brim.

Fetal stethoscope was warmed by rubbing it in the palm and placed on the right side of the abdomen where the back was located. Fetal heart rate was listened and counted for one full minute while comparing it to the maternal pulse which was 144 beats per minute.

Permission was sought from client and she agreed. There was no rash, giving critical attention to the groins there was no offensive discharge, old scars, vulva warts and varicosity. She was asked to stretch her legs and lie to relax, while gloves were removed and placed them into the kidney dish. She was thanked for her cooperation and hand washing was done, she was asked to sit up before getting off the couch. She was assisted to dress up. Details of the examination were made known to her and findings were also communicated to her. Findings were recorded in her Maternal Record Book; she was given the platform to ask question and if she has any complains. Client did not ask question but complained of constipation and waist pain, . She was educated to take more

fruits, vegetables, whole grain and to put pillow on her back when sleeping. Education was given on birth preparedness and complication readiness as well as the need for family planning after delivery. Her medications given were as follows;

Tablet multivitamin	200mg 30days,
Tablet Folic Acid	5mg daily for 30 days,
Tablet Ferrous Sulphate	200mg daily for 30days

. After conversation, she was asked if she had any complain and she responded no. Again the direction to her house was taken and client was reminded of her next visit to the clinic scheduled on the 21st August 2023 and she was bid goodbye

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Elizabeth home was on 18th August 2023 around 5:00pm. The goal of the visit was to observe the environment where she lives and make assessment of her home situations to avoid health threatening conditions and to provide continuous care after delivery. It was really a warm welcome to the house by the family, after exchanging greetings; an introduction was made to her in law. She was asked of the general condition of the family and she responded, “they are doing well”. She was asked if she has complains and she complained of constipation, and back pain and physiology of back was explained to her. She was asked whether she is taking her routine drugs as prescribed and responded yes and she was encouraged to continue the medication and if she is having any problem about her health she should report to the clinic.

PHYSICAL ENVIRONMENT

The house was built with cement bricks and roofed with aluminium sheets. Client occupies the big room with her child. The room has two windows were well arranged for proper ventilation and she was congratulated and asked to keep it up gain she was asked whether she sleeps under insecticide treated net and she said yes She was again educated on the importance of sleeping under an insecticide net. The kitchen was well kept, her bathroom was kept clean, and her toilet was also well kept. The source of water was good, the source of light is electricity. The house was neatly kept with good drainage system. She was thanked and permission to leave was sought. She was informed about the next visit to the clinic.

PSYCHOSOCIAL

Madam Elizabeth and her family have cordial relationship with each other. Madam Elizabeth has a warm and friendly relationship with her in law and neighbors. Her friends most at times visit her and she also visits them at her leisure time. Madam Elizabeth introduced me to her neighbors. She has respect for humans and likes to make new friends. Madam Elizabeth attends to social gathering like funerals and wedding ceremony at all times.

2.3 SECOND ANTENATAL HOME VISIT

The second visit to Madam Elizabeth house was on the 25thAugust, 2023 which was Friday at 4:00pm. She was met when she was almost done with preparation of her food. She was greeted, warm welcome was given and seat was offered. The aim was to inquire about her general condition and client complained of lower abdominal pain. The

physiology of lower abdominal pain was explained to her that stretching of round ligament due to fetal movement. Client was asked to bring her layet she will send to hospital for inspection if everything is well packed. Some of the items included delivery pads, ten cot sheets, four old sheet, three toilet rolls, two carbonic soap, two antiseptic solutions, rubber makintosh for delivery, baby socks, cap, and baby dress. Client was then educated on danger signs and on complication readiness. Madam Elizabeth vital sign was checked and recorded as

Temperature	36.5 degree celsius
Pulse	85bpm
Respiration	21cpm
Blood pressure	122\70mmHg
Smphysio fundal height	35cm
Fetal heart rate	140bpm

Client and relatives were thanked for nice reception for their time and permission was sought for departure.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Madam Elizabeth visited the clinic on 28th August 2023 at 9:00am. Client complains of backache and the physiology of backache was explained to her that it was caused by increased release of relaxin which causes ligament laxity. She was asked of her previous complain during home visit and she said she could now cope with the lower abdominal

pain, waist pain, constipation, and frequent micturition. Routine examination was conducted and recorded as;

Temperature	36.9 degree celsius
Pulse	80bpm
Respiration	20cm
Blood pressure	122\80mmHg
Weight	65kg
Symphio fundal height	35cm
Fetal heart rate	143bpm

All procedures to be carried out on were explained to her and consent sought. She was asked to empty her bladder. Provision of privacy was done by screening the bed and then helped her to undress and assisted her onto the bed. Thorough hand washing was done and cleaned with clean hand towel and shead to toe examination under the supervision of midwife in-charge. Her general appearance was good and no abnormality was detected.

Abdominal examination was carried out. On inspection, the abdomen was globular, striae gravidarum and linear nigra were present with no scar. On palpation, the symphio-fundal height was 37 with gestational age of 38weeks. On lateral palpation, fetal back was at right side and lie was longitudinal, presentation was cephalic with head descent 5\5th.

2.5 CARE PLANS DURING ANTENATAL PERIOD

Problems Identified During Antenatal

Madam Elizabeth complained of the following;

1. On 28th August, 2023 frequency of micturition
2. On 28th August, 2023 Constipation
- 3 On 28th August 2023 Waist pain
4. On 28th August, 2023 Back pain
5. On 28th August, 2023 Lower abdominal pain

Short Term Objectives

1. Client will be able to cope with frequency of micturition 24 hours after delivery.
2. Client will pass stool once within 48 hours.
3. Client's waist pain will be reduced and cope with throughout pregnancy within 24 hours.
4. Client's lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours.
5. Client backache will be reduced and cope with throughout pregnancy.

Long Term Objectives.

Madam Elizabeth will go through pregnancy, labour and puerperium successfully without any complication to herself and the foetus.

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSUNG OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
28/08/23 09:00am	Frequency of micturition related to growing uterus exerting pressure on the bladder.	Client will be able to cope with frequent micturition 24 hours after delivery as evidence by by client verbalizing that frequent micturition as reduced. 2. Midwife observing that client micturition has subside.	1. Reassure client that frequent micturition will subside because is normal physiology . 2. Educate client on the physiology of micturition. 3. Encourage client on the use of panty liners. 4. Encourage client on kegel exercise to thighten the muscle. 5. Encourage client to keep chamber pot reach of her bed.	1.Client was reassured on her condition. 2. Client was told it was due growing fetus exerting preesure on the bladder . 3. Client used panty liners. 4. Client understood on how to do kegel exercise thighten her muscle. 5. Chamber pot was placed in reach of client	28/08/22 09:00pm	Goal fully met as client verbalized that she been relieved of frequency of micturition. Midwife observing that client micturition has reduced.	B.F

DATE/TIME	NURSING DIAGNOSIS	OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	INTERVENTION	DATE/TIME	EVALUATION	SIGN
28/08/23 9:00am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large intestine during pregnancy.	Client will pass stool more than one within 48 hours as evidenced by Client verbalizing that she was able to pass stool more than one in 48 hours.	<ol style="list-style-type: none"> 1.Reassure client that constipation will be relieved. 2. Explain the physiology behind constipation to client due to relaxation of smooth muscle of large intestine. 3. Educate her to take in foods rich in fiber. 4. Encourage her to take in more water . 5. Encourage client to eat more fruits everyday. 6. Educate the client to do exercise. 	<ol style="list-style-type: none"> 1 Client was reassured that her. 2.Explanation of physiology of constipation was given to client. 3.Client took food rich in fiber like fruits and vegetables. 4.Client drinks more water everyday. 5.Client eats more fruits everyday. 6.Client understood the health benefits of exercises and engaged herself in exercises.(walking) 	29/08/22 4:00pm	Goal fully met as Client verbalizing that she passed stool once within 48 hours and is relieved from discomfort of constipation.	B.F

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
28/08/23 9:00am	Waist pain related to relaxation of pelvic ligament.	Client's waist pain will be reduced within 48 hours as evidenced by: 1.Client verbalized that her waist pains has resolved. 2.Midwife observing client perform daily activities without complains of waist pains.	1. Reassure client that waist pain will be subside. 2. Encourage client to have enough rest. 3. Educate client to seat in between activities. 4. Educate client to manage work activities and moderate exercises. 5. Educate client on the physiology of waist pain	1. Client was reassured. 2. Client had enough rest during the day. 3. Client understood and sat down in between activities 4. Client was educated to manage works and moderate exercises 5. Client was educated on the physiology of waist pain due to descent of fetal head putting pressure on sacral nerves.	29/11/23 7:30pm	Goal fully met as evidenced by client verbalized that waist pain has reduced . Midwife observing that client waist has no waist pain.	B.F

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
28/08/23 7:00am	Lower abdominal pains related to descent of the fetal head in late pregnancy.	1.Client’s lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours as verbalizing by client the pain has subsided 2. Midwife observing that client can cope with lower abdominal	1. Reassure client that abdominal pain will subside. 2. Explain the physiology of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client husband to help her with household chores.	1. Client was reassured that pain will be relieved with time after delivery. 2. The cause of lower abdominal pains was explained to client that pain was due to stretching of ligament during fetal movement. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client’s husband helped client with household chores like sweeping and washing.	28/08/23 7:00pm	Goal fully met as evidenced by client verbalizing that her lower abdominal pains has reduced after intervention was given. Midwife observing that client pain has subside with cheerful facial expression,	B.F

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
28/08/23 7:00am	Backache related to physiological adjustment of growing uterus causing change in posture	Client backache will be reduced and cope with throughout pregnancy as within 4 hours evidence by 1. client verbalizing that backache has reduced 2. Midwife observing that backache has subsided.	1. Reassure client to allay anxiety 2. Explain the physiology of backache in late pregnancy to client 3. Encourage client to sit down in between activities 4. Encourage client to rest her back on a pillow when sitting 5. Encourage client family to help her with house hold chores 6. Encourage client to sleep on a firm mattress.	1. Client was reassured that backache will be relieved. 2. Explanation of physiology of backache in late pregnancy was given to client. 3. Client sat down in between activities. 4. Client rested her backache on a pillow when sitting. 5. Client family helped with her house chores. 6. Client slept on firm mattress	29/08/22 12:00pm	Goal fully met as evidenced by client verbalizing that she has been relieved of backache . Midwife observing that client backache is subside	B.F

CHAPTER THREE

INTRAPATAL CARE

3.0 INTRODUCTION

This chapter describes the management of labour, immediate care of the newborn, examination of the newborn and 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 Sunday, 3rd September, 2023 Madam Elizabeth reported to the facility Nhiraa Health Center, at around 5:40am with her mother complaining of lower abdominal pains and she was assured that it is due to⁴ the pressure of descent of the fetal head pressing on the sacral nerves and it will resolve soon after delivery. They were welcome and offered a seat while glancing through her ANC book and with the help of midwife in-charge and her expected date of delivery was on the 12th September, 2023. Her hemoglobin was 12.0g\dl and she was 38weeks and 6days. Madam Elizabeth complained of waist pains and noticed blood stained mucus at around 3:50am. Even her facial expression during interaction shows that she was in pains inquiries about her last meal was made and she said ate rice with tomato stew at 5:20pm. Madam Elizabeth was reassured that everything was going to be alright. She was sent to the examination room and assisted to change her clothing. Procedures going to be done were explained to her and permission was sought to carry on. She was asked to empty her bladder which was tested for sugar, albumin and acetone amount 150mls but was all negative. She was assisted to lie on the bed and a

quick examination from head to toe was conducted and no abnormality was detected but during the examination, her face looked anxious. Abdominal examination was then conducted. On inspection, abdomen looked globular in shape with no scar and fetal movement was noticed. Linear nigra and striae gravidarum were also present.

On palpation at 5:50am, the symphysio-fundal height measured 37cm. Fundal palpation revealed the buttock in upper pole, lateral palpation revealed back of the fetus at the right side of abdomen and limbs at left side. The lie was longitudinal, presentation was cephalic and the position left occipito anterior. Descent was 4⁵th above the pelvic brim. On auscultation, fetal heart rate was 138bpm with regular and rhythmic volume. Uterine contractions were checked and recorded as 2 in 10 minutes lasting for 31 seconds.

The procedure was explained to her that she was going to be examined vaginally. She put in lithotomy position with knees flexed and thigh separated. A tray was set up for vaginal examination. Hands were washed with soap under running water and dry with clean towel and sterlie gloves were worn on both hands. The vulva swabbed with 5 sterlie cotton wool swabs soaked in salvon, swabbing the majora first, then minora and vestibule.

Inspection of the vulva for oedema, warts, scar varicosities was done and no abnormalities were detected. The vulva was shaved neatly. The vagina examined and it was warm and moist with no offensive discharge, cervix was soft and thin and there was evidenced of show. Cervical dilatation was 4cm, cervix had effaced and was soft and thin with membrane intact and there was no moulding. The sacral promontory was not

reached and ischial spines were blunt. Sub-pubic angle accommodated two fingers in the arch.

She was cleaned and applied clean perinea pad at the vulva. Gloves were remove and disposed off and hands were with soap under running water and dry with clean towel. Client bed was shown to her, findings was communicated to her and progress of labour and how far cervix had dilated to her and documented findings on the partograph sheet. She was encouraged to urinate frequently to helps in descent of fetal head. Madam Elizabeth was advised not to bearing down prematurely to prevent cervical tear and oedematous cervix. Her vital signs checked and recorded as follows,

Temperature	36.8 degree celsius
Pulse	85bpm
Respiration	25cpm
Blood pressure	120\70mmHg
Hemoglobin	12.5g\dl

3.2 MANAGEMENT OF THE FIRST STAGE OF LABOUR

Uterine contraction, maternal pulse and fetal heart rate were checked half hourly and urinalysis, temperature was checked every two hourly and vaginal examination, blood pressure were done four hourly and recorded o the partograph.

At 6:20am, fetal heart rate was 130bpm with good volume and rhythm. Uterine contraction was 2 in 10 minutes lasting for 32 seconds, maternal pulse was 80bpm.

At 6:50am fetal heart rate 134bpm and uterine contraction was 2 in 10 minute lasting for 33 seconds and maternal pulse 84bpm. Client looked anxious because of severe pains and worried about unknown outcome of labour and so client was reassured to allay anxiety.

At 7:20am fetal heart rate was 132bpm and uterine contraction was 3 in 10 minutes lasting for 35seconds and maternal pulse 82bpm.

At 7:50am fetal heart rate was 140bpm and uterine contraction was 3 in 10 minutes lasting for 36seconds and maternal pulse 78bpm.

At 8:20am fetal rate was 136bpm and uterine contraction was 3 in 10 minutes lasting for 38 seconds and maternal pulse was 80bpm.

At 8:50am fetal heart rate was 138bpm and uterine contraction was 4 in 10 minutes lasting for 38 seconds, maternal pulse 82bpm.

At 9:20am fetal heart rate was 138bpm with good volume and uterine contraction was 4 in 10 minutes lasting for 39 seconds and maternal pulse was 86bpm

At 9:50am maternal temperature 36.2degree celsius, pulse 86bpm, blood pressure 110\60mmHg, urine passed measured 120m\l and protein and acetone were tested and negative for both. Fetal heart rate was 140bpm with good volume and regular rhythm. Uterine contraction was 4 in 10 lasting for 41 seconds, examination was done , cervical dilation was 8cm, head descent was done abdominally and read 2\5th above pelvic brim. Membranes were intact and there was no moulding.

At 10:20am maternal pulse was 76bpm , uterine contraction 4 in 10 minutes lasting 42 seconds. Fetal heart rate was 134bpm .

At 10:50am fetal heart rate was 135bpm with good rhythm and contraction was 4 in 10 lasting for 44 seconds and maternal pulse 82bpm. Madam Elizabeth was sweating profusely so her face towel was soaked in water and used it in cleaning her body. The window opened and switched on the fans to ventilate the room adequately.

At 11:20am, fetal heart rate was 140bpm and uterine contraction was 4 in 10 minutes lasting for 46 seconds and maternal pulse was 88bpm. She complained of fatigue and was encourage to calm down to prevent maternal exhaustion during contractions and diversional therapy employed by engaging her in conversation.

At 11:50am uterine contractions became stronger and expulsive in nature counting 4 in 10 lasting for 48 seconds. Fetal heart rate was 130bpm with good volume and rhythm, maternal pulse was 90bpm. Membranes ruptured spontaneously and was clear, vaginal examination was done to rule out cord prolapsed, confirm full dilatation of the cervix and it was 10cm dilated. Head was 0\5th on pelvic examination, there was moulding (++) and there was no caput formation. The progress of labour was communicated to to midwife in charge and she confirmed findings with another vaginal examination. Perineum was bulging and anus was gaping.

PREPARATION FOR BIRTH

A helper was indentified both skilled (ward in charge) and the non- skilled (mother) to assist in the delivery when needed. Emergency plan was also reviewed which includes, calling of referral center and calling of taxi driver to help in transportation of client to referral center, an obstetrician and pediatrician when need arise. Client was reminded that she will be assisted to wash her hands and chest when second stage is eminent to prepare

for skin to skin care to prevent infections to baby. The room was well lighted and portable lamp was also in place when lights out. Preparation of the area for ventilation and checking of equipment was also done by prepare a dry, flat and safe space for receiving the baby for ventilation when needed and equipment to help in resuscitation were checked for their functioning . The items include the suction device, ventilation bag and mask, stethoscope, scissors, timer, head covering, cloths and gloves. Delivery set and emergency drugs were readily available when checked. Her vital signs and other observation were checked and recorded as,

Temperature	36.7 degreecelsuis
Pulse	82bpm
Respiration	22cpm
Blood pressure	110\70mmHg
Fetal heart rate	138bpm
Descent	3\5 th
Contraction	2 in 10 minutes seconds

SETTING OF TROLLEY

The trolley was clean and a sterile delivery with other clean items were made available on both top and bottom shelf as below; upper shelf containing the following packed in the delivery set;

Top shelf

- Delivery pack containing; four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots with cotton swabs and gauze respectively
- One cord scissors
- Receiver
- Episiotomy scissors

Lower shelf

- Bed pan
- A receiver for placenta
- Container with syringes and needles
- Fetoscope
- A syringe containing oxytocin drug in a covered container
- Antiseptic lotion. Example Savlon
- Extra perineal pad
- Sterile gloves
- Small cap containing water and bulb syringe
- Cord clamp
- Two cot sheets
- Lidocaine

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

She was positioned in a lithotomy position as client opted for this position. A gown, mackintosh apron, mask and boots were worn. After that, hands were washed with soap under running water and dried. Sterile gloves were worn. Fetal heart rate and maternal pulse was checked and recorded after each contraction. Vaginal examination was done to confirm full dilation of the cervix, perineum, pubis and inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent fecal matter from contaminating the delivery field. Client complained of inadequate food intake and was served with malt. Her perineum was shiny and over stretched, so she was instructed to place buttocks down to prevent tears. Flexion was maintained by placing fingers of the right hand on the advancing head in order to allow the smallest diameter to distend the perineum. Descent of the fetal head continued till crowned. As soon as the baby's head crowned, she was asked to breathe through her mouth and give only small pushes with contraction to prevent rapid expulsion of the fetal head which could result in perineal tears and intra cranial injury. The sinciput, face and chin swept the perineum and the head was delivered by extension. The mouth and nose were gently cleaned with sterile gauze. The eyes were wiped with sterile cotton wool swab from the inside out as well as the face. The neck was quickly felt for cord around neck. The mother was reminded that the baby will be delivered on to her abdomen while waiting for restitution and external rotation of the fetal head. This was accompanied by internal rotation of the shoulders. The anterior shoulder was delivered by pressing the head down gently and the posterior shoulder swept the perineum to be delivered. The rest of the body was delivered by lateral flexion

onto the mother's abdomen at 12: 00noon, baby cried immediately after birth, baby was dried with the sterile cot sheet on the mother's abdomen for one hour and covered with a sterile cot sheet to prevent heat loss, provide warmth and to promote bonding.

3.4 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from within outwards the neck was felt for cord around was absent. Baby was delivered unto mother abdomen. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The umbilical cord was clamped about 2 centimeters away from the baby's abdomen and again, clamped 3centimeters away from the first clamp with an artery forceps. The cord was cut in between the two clamps by covering the scissors with gauze to prevent splashing of blood. The baby was shown to the mother to confirm the sex of the baby and she said is a male. This was done 3 minutes after delivery of the baby. The baby was dried and head covered with cap and place on the mother's abdomen to initiate skin to skin and covered baby and mother with a warm cot sheet to maintain warmth. The baby's APGAR score assessed at the first and fifth minutes were 8/10 and 9/10 respectively. An identification band with mothers name, sex of the baby, date and time of delivery was put around baby's wrist. The baby was breathing quietly and easily.

APGAR SCORE

TIME	COLOUR	BREATH	HEART	TONE	REFLEX	TOTAL
1 MINUTE	2	2	2	1	1	8/10
5 MINUTES	2	2	2	2	1	9/10

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

Madam Elizabeth was informed and procedure was explained to her. Client still in the lithotomy position, the cord clamped and cut end of the cord was placed in a receiver in between the thighs near the perineum to receive the placenta, membranes and blood loss. A gentle palpation of the uterus was done, and the in charge was asked to confirm, to rule out undiagnosed twin. There was no other fetus, so 10unit of oxytocin were given intramuscularly on the thigh of the mother by the midwife in-charge to aid in contraction of the uterus and expulsion of the placenta. Cord was re-clamped closer to the perineum and the cord with artery forceps were held with the dominant hand. The non-dominant hand was placed on the fundus to check for contraction. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and forceps were also held firmly at the same time with downward traction, the process was repeated until the placenta became visible at the vulva. The placenta was cupped by both hands and twisted to remove pressure on the

fragile membranes. The placenta and membranes were delivered completely at 12:03pm. Quick examination of the placenta was done to make sure there are no retained products. The placenta was placed in a receiver for thorough examination to be done. The perineum was cleaned and gauze was used to wrap two fingers of each hand to inspect the vagina and cervix but no tear or laceration was detected. The uterus was massaged to expel clot. Client was taught how to massage the uterus and was asked to feel for immediately. She was educated to massage the uterus by herself and report any change immediately. Client was clean off the liquor and blood with a clean pad after examination. A new perineal pad was applied at the vulva and she was made comfortable in bed. She was asked to cross her legs to keep the perineal pad in position.

3.6 EXAMINATION OF PLACENTA AND MEMBRANES

The placenta was sent to the sluice room and it was immersed in 0.5% chlorine solution for examination. The cord was situated at middle of the placenta with two arteries and a big vein in the cord with no knot. The cord with membranes hanging and membranes were examined for completeness and it was intact. The placenta was then laid on the flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and fully viewed, the lobes fitted together without any gap, this indicated that there were no missing lobes and edges also forming uniform circle at maternal surface, there was no infarcts on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of placenta. The fetal surface was intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss 200ml. After the examination the instruments were immersed in 0.5% chlorine solution for 10

minutes. The instruments were removed, washed, rinse, dried and made ready for sterilization. She was asked to urinate when she had the urge for the uterus to contract and was told that if she should feel any change, she should not hesitate to report.

3.7 PREVENTION OF DISEASES

Cord was dressed with Methylated Spirit and client was to observe the cord for redness and discharge from the cord. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorder. Chloramphenicol eye drop on the eye to prevent infections. Hands were washed under running water with soap and cleaned with a clean towel. Mother was educated to wash hands before and after breastfeeding baby. She was further explained to breastfeed on demand.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During this period mother and baby was observed. Client was asked of the complains during labour and she said all the complains has resolved.

Examination of the New Born

Procedure was explained to my client, gloves were worn. The head was examined first, for bulging and fontanel, size, shape, laceration and caput succedaneum but none was present. Head circumference was measured and it was 32cm using the tape measure from occipital protuberance to supra orbital ridges and its length was 49cm. Mouth was inspected for any false teeth, tongue tie, cleft palate etc. Nostrils were checked for any deviations and the neck for congenital goiter and lymph nodes. Chest was inspected for size, shape and chest wall movement with respiration and respiration rate was 42 cycles

per minutes and the apex heart beat was 140 beat per minute. Breast were palpated for masses and nipple for extra nipple but was normal. Examination of both upper and lower extremities was done and normal. Examination of both upper and lower extremities was examine for oedema, fracture for hand and legs and no abnormality was detected. Abdomen was inspected for shape and size. Baby's back was examined for swelling, spinal bifida or missing vertebrae but none was noticed. Skin was pink and no abnormality found. Anus and rectum were inspected for potency and the scrotum was also examined if testes is well descended and no abnormality was found. Baby's weight was recorded as 3.0kg. And vital signs were recorded as,

Temperature 36.5degree celsius

Apex heart rate 136bpm

Respiration 42cpm

Hand washing was done and findings was communicated to mother. Baby was wrapped in a warm cot sheet and was placed beside her for breastfeeding.

Management of Mother

Madam Elizabeth and her baby were transferred into the lying –in room, made comfortable and also congratulated for her corporation. Uterus was felt for contractions symphysio fundal height 15 centimeter. The total blood loss after fourth stage 250mls. Lochia was red in colour (rubra), moderate in quantity and had no smell, urine passed was 90 mls and her vital signs together with bleeding were monitored every 15minutes for 2 hours, 30 minutes for 1hour till the end of the 6 hours. The baby condition was

checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. Client was educated on frequency of 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. Client was seen fatigued due to stress of labour. Client in law was allowed to see her and she was served with beverage and bread. The first post-delivery vital signs were checked and recorded as follows; and the rest were recorded on partograph.

Temperature 36.8 degree celsius

Pulse 78bpm

Respiration 22cpm

Blood pressure 110\80mmHg

SUMMARY OF LABOUR

Client was admitted to the ward with her mother complaints of waist pain and lower abdominal pain and when assessed labour started and was monitor. Labour progressed normally and spontaneous vaginal delivery of live male child at 12:00noon. Active management of Third stage of labour was done. Perineum was intact and blood loss was small (250mls). Condition of the baby was very good as well as mother. The placenta and its membranes were intact. Duration of labour lasted for six (6) hours.

CONDITION OF THE MOTHER

Fundal height	17cm
Uterus	Contracted
Lochia	Red (rubra)
Urine output	100mls

Condition of Baby At Birth

General examination of the baby was done and no abnormalities detected . The baby had pink skin colour, umbilical cord was not bleeding. The baby was classified as normal and routine care given. Baby passed urine and meconium within some few minutes after birth.

The baby's vital signs were as follows,

Temperature	36.5 degree celsius
Apex heart rate	136bpm
Respiration	41cpm
APGAR in first minute	8\10
APGAR in fifth minute	9\10
Sex	male
Head circumference	33cm
Full length	50cm
Abnormality	None
Condition of baby	Very good

APGAR SCORE

Apgar score at first minute 8/10, Apgar score at fifth minute 9/10 and Baby condition was satisfactory.

Duration of Labour

1 st Stage	5 hours 35 minutes,
2 nd Stage	45minute
3 rd Stage	10 minutes.
The total duration of labour	6hours 30 minutes

Record of Mother

Date of Delivery	27 th August, 2023
Time of delivery	12:00pm
Mode of delivery	Spontaneous vaginal delivery
Perineum	Intact

3.9 NURSING CARE PLAN ON LABOUR

Problems Identified

1. Lower abdominal pains
2. Waist pain
3. Anxiety
4. Fatigue
5. Inadequate food intake

Short Term Objectives

1. Client will be relieved of abdominal pains within 24 hours
2. Client will be relieved of waist pain within 3 hours.
3. Client will be relieved of anxiety by the end of labour
4. Client will be relieved of fatigue within 1hours.
5. Client will eat half of her meal served.

Long Term Objectives

Client will deliver a healthy and an alive baby without complications to mother and the baby during labour and puerperium.

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA -TION	SIGN
03/09/23 4:00am	Lower abdominal pains related to cervical dilatation	Client will be relieved of lower abdominal pains within 1 hour as evidence by 1. Client practicing comfort measures. 2. Midwife visualizing that client is coping with lower abdominal pain. Client.	1. Reassure client that she will be relieved of lower abdominal pains . 2. Educate client on the process of labour. 3. Massage sacral region during contraction to relief pain. 4. Encourage client to rest in between contraction. 5. Communicate progress of labour to client.	1.Client was reassured that she will be relieved of fatigue. 2. Client understood the progress of labour. 3. Sacral region of client was massage during each contraction to relief her of pain. 4. Client was encourage to rest in between contraction. 5.The progress of labour was communicated to client.	04/09/23 6:40am	Goal met as client informed midwife she was relived of her tiredness. Midwife observing that client is less tired.	B.F

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/09/23 5:40am	Waist related to descent of fetal head.	Client will be relieved of waist pains within 3 hours. 2. Midwife observing that client waist pains is subside.	1. Reassure Client that waist pain is normal. 2. Explain the physiology of waist pains. 3. Give client sacral massage. 4. Engage client in conversation. 5. Encourage client to do deep breathing exercise.	1. Client was reassured that waist pain she will be relieved of waist pains. 2. The physiology of waist pain was explained to her that it is due descent of fetal head. 3. Client was given sacral massage. 4. Midwife interact with client. 5. Client was encouraged to do deep breathing exercise.	04/09/23 8:40am	Goal fully met as client said her waist is subside. Midwife observing that client is no more in pains..	B.F

CARE PLAN FOR LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/09/23 6:50am	Anxiety related to the unknown outcome of labour	Client will be allay anxiety within 1 hour as evidenced by client verbalizing that she can eat meal served 2. Midwife observing that client is relieved of anxiety .	1. Reassure Client that anxiety is temporary. 2. Orient client to delivery room to allay fear and anxiety. 3. Encourage client to ask questions and briefly and simply. 4. Explain every procedure to client. 5.Be with client throughout labour.	1. Client reassured was that everything will be fine. 2. Client was oriented toward environment. 3. Client was allowed to ask questions. 4. All procedures was explained to the client. 5. Midwives were with client throughout labour.	04/09/23 7:50am	Goal met as client told midwife that she is no more anxious. Midwife observing that her anxiety is relieved.	B.F

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA- TION	SIGN
03/09/23 11:20am	Fatigue related to stresses in labour	Client will be relieved of fatigue within 1hour as evidenced by client verbalizing she is relieved of fatigue. 1. As midwife observing that client fatigue has subsided	1. Reassure Client she will be relieved of fatigue. 2.Encourage client remain calm to prevent maternal exhaustion. 3.Encourage deep breathing exercise. 4.Encourage client to rest in between contraction 5.Serve client with cool drink.	1. Client was reassured that she will be relieved of fatigue. 2.Client was encourage to remain calm to prevent further maternal exhaustion. 3. Client was encourage to continue deep breathing exercise. 4. Client was encourage to rest in between contraction. 5.Client was served with cool drink	04/09/23 12:20pm	Goal met as client said her fatigue is subsided. Midwife observing client fatigue is relieve.	B.F

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/09/23 11:20am	Inadequate food intake related to stress of labour	Client will eat half of her meal served within 2hours as evidenced by client verbalizing she can eat meal served.	1. Reassure client was reassured that everything will be fine 2. Plan meal with client 3.Explain the process of labour to client. 4.Serve client with beverage. 5.Involve client in planning meal.	1. Client was reassured. 2.Meal was plan client. 3.Process of labour was explained to client. 4 Client was served with beverage. 5. Client was involved in meal planning.	04/09/23 1:20pm		B.F

CHAPTER FOUR

POSTNATAL CARE

4.0 INTRODUCTION

This chapter talks about the management of puerperium thus the care rendered to both mother and baby after delivery. It also throws more on the subsequent care of baby, preparation towards discharge, subsequent post-delivery assessment, home visits, postnatal review and

4.1 DAY OF DELIVERY

Madam Elizabeth and Baby were made comfortable in bed. Vital signs of client were checked and recorded as follows;

Temperature	36.8degree celsius
Pulse	80bpm
Respiration	20cpm
Blood pressure	110\80mmHg

On examination, breast were firm and the nipples were prominent. Palpation of the uterus 15cm above the symphysis pubis, lochia was heavy in amount, red in colour and with no clots. She was advised to change her perineal pads frequently when soiled and to report any abnormal vaginal bleeding. Client was encouraged to empty the bladder frequently since full bladder interferes with contractions of the uterus with subsequent bleeding. Client relatives were also allowed to visit mother and baby. Client relatives

were asked to bring her any food of her choice. She was educated on fixing baby for breastfeeding. Baby was examined from head to toes for any sign of injury. Vital signs were checked and recorded as follows,

Temperature	36.5 degree celsius
Apex heart rate	140bpm
Respiration	40cpm
Weight	2.9kg

4.2 SUBSEQUENT CARE OF THE BABY

Baby was monitored continuously and condition of baby was good throughout. Baby was bathed six (6) hours after delivery. Immediately after baby bath, cord was checked for bleeding dressed. Baby was dressed and wrapped in warm cot sheet to keep baby warm to prevent hypothermia. Baby temperature was maintained by wrapped baby well and also the temperature was assessed. Client was advised not put anything such as cow dung, herbs, or ointment on the cord. The breathing rate was also checked and was in normal range.

Mother was educated on frequent breastfeeding as many as possible a day and also exclusive breastfeeding, proper hand washing and also on the essential care of the new born such as cord care. Then mother was encouraged to report any danger sign such as irregular breathing rate, jaundice, fever, report immediately to the nearest health facility.

FIRST BATH OF THE BABY

At 7 am the next day baby was given the first bath, Madam Elizabeth was informed about the need for the baby to be bathed, and she agreed gladly.

Requirements;

1. Top Shelf
2. Methylated spirit in sterile gallipot
3. Baby's diapers
4. Sterile cotton wool swabs and gauze in galipot
5. Sterile gloves
6. Sterile water in gallipot
7. Baby's oil
8. Baby sponge and soap in soap-dish
9. Baby's towel
10. Bottom shelf
11. Mackintosh apron
12. Receptacle for used water
13. A bowl for mixing water
14. Kidney dish for used gauze and swab
15. A bowl containing hot and cold water respectively
16. Disposable gloves

All needed items and baby bath trolley were made ready. Water was mixed and temperature was tested with the elbow. Hands were washed and sterile gloves worn. Baby was placed on a protected flat surface, and covered with a single sheet. Sterile cotton was dipped in sterile water and used to clean the baby's eyes from the inner canthus outward and disposed into a receiver. Face was cleaned with a wet towel. Nape of neck was supported by the palm and the ears were plugged with the thumb and middle finger. Baby's head was washed in a circular motion with soapy sponge after which it was rinsed out and dried with a towel. Body was bathed, paying particular attention to the skin folds, rinsed and dried with a towel. Vaseline was applied all over the body of the baby to provide warmth. Gloves were removed, hands washed and dried.

Cord Dressing;

Baby's cord was inspected for bleeding and there was no bleeding. Six sterile cottons were used to dress the cord using methylated spirit. One was used to hold the clamp and two were used to swab the base of the cord. The whole cord was swabbed anteriorly and posteriorly with a separate swab each from the bottom upwards, the tip of the cord was then cleaned with the remaining cotton and left opened to heal by dry gangrene. Baby was wrapped nicely to maintain warmth. Mother was asked to fix the baby to breast by ensuring that she sit in a good position to attached baby well to breast feed. Mother was educated that baby should be breastfeed on demand.

DAY OF DISCHARGE

In the morning on the 4th September, 2023 Madam Elizabeth and her in law around 7:00am came to find out how they were doing. After exchanging pleasantries, permission was sought to examine her and the baby . Hands were washed with soap under running water .Vital signs of client and baby were checked and recorded at 7:30am as follows,

Temperature	36.2 ⁰ C
Pulse	79bpm,
Respiration	22cpm
Blood pressure	120/80mmHg.

Client was examined from head to toe and no abnormally found. Client was discharged on 4th September, 2023. On examination breast were firm and nipples prominent. There was colostrum in the breast. Uterus was firm and well contracted. Symphysio-fundal height was 15cm above the symphysis pubis. Client complained of after pains and was encouraged to breast feed on demand as it helps involution of uterus and advised to continue the postnatal exercises to strengthen the pelvic floor muscles about ten to twenty minutes everyday. She also complained of backache and was encouraged to sleep on firm mattress and apply a gentle massage over when positioning and attachment. Her vulva was inspected, lochia was reddish brown in colour (Rubra), and flow was small and not offensive. She was also advised to always keep the perineum clean and change pads to prevent infection. Baby was re-examined, and observations were recorded at 10am as;

MORNING

Temperature 36.6 degree Celsius

Apex heart rate 142bpm

Respiration 42cpm

Weight 2.5kg

Drugs	Dosage	Route of administration
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BCG	0.05mls	left upper arm
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OPV O	2drops	orally
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Baby was immunized to protect him against tuberculosis and poliomyelitis respectively.

Client was advised not to apply anything at the injection site but to count time the immunization at the child welfare clinic when the child is six weeks old in order to protect her against the childhood diseases like yellow fever, pertussis among others.

Client was later informed of discharge. She was helped to pack her belongings and the following drugs were prescribed for the mother.

Tablet Folic Acid 5mg dly × 14days,

Tablet Ferrous Sulphate 200mg bd × 14days,

Tablet Vitamin B Complex 200mg tds × 14days

and Tablet Paracetamol 1000mg bd × 5days

Drugs and dosages were explained to her and the need to take the drugs was stressed. Her NHIS card used to settle her bills. Client was educated to avoid applying hot water on the baby's fontanelles and sutures. She was recommended to continue using treated mosquito net and maintained good personal hygiene, she was encouraged to have rest and sleep and was reminded of a visit to her house to continue the care for seven days. The family were bidden farewell.

POSTNATAL HOME VISITS

4.3 SECOND DAY OF DELIVERY (FIRST HOME VIST)

In the evening first visit was made to Madam Elizabeth on the 5th September, 2023 at her house at 4:30pm to find out how they are doing. Both mother and baby looked healthy on arrival. Family was much pleased with the visit. In trying to find out her previous complain, client said her after pain and backache has subsided. Explanation was given to her and permission was sought to examined mother and the baby. Hands were washed with soap under water both were assessed from head to toe to detect any abnormality for early treatment, she was asked to empty her bladder. The fundus was measured and it was 14cm, lochia was red (rubra) and not offensive. Client complained of breast milk is not coming and was encouraged to massage the breast excess breast milk and relatives were asked to involve her in breastfeeding. Observations were recorded at 4:30pm as follows,

EVENING

Temperature	36.6 degree celsius
Pulse	89bpm
Respiration	22cpm

Blood pressure	110/80mmHg
Symphysio fundal height	14cm
Uterus	well contracted
Breast	lactating

Permission was sought to top and tail the baby in front of mother for her to observe and it was granted. Baby was examined thoroughly from head to toe, cord was dry and not offensive. The cord was also dressed with cotton wool soaked in methylated spirit, it was cleaned and kept dry and there was no bad odour. According to client, baby passed meconium about three times and passed urine as well. Observation was recorded at 4:30pm as follows,

EVENING

Temperature	36.7 degree celsius
Apex heart rate	140 beat per minute
Respiration	42 cycle per minute

Permission was sought to leave and she was reminded that she would be visited the next day.

4.4 THIRD DAY POST DELIVERY (2ND POSTNATAL HOME VISIT)

On 6th September,2023, the second visit was made to Madam Elizabeth house around 8:00am in the morning, she was asked if she has complaints and she complained of

breast engorgement and loss of appetite and was encouraged apply hot compress on the breast. Permission was sought to examine both mother and baby. The head to toe examination was done on her and no abnormality was found. Her perineum was clean, the lochia was found to flow minimal, the colour was red (rubra) and without bad odour. The symphysis fundal height was 13centimeters. She complained of inadequate sleep and was encouraged to have warm bath before going to bed and also limit number of visitors with the baby. Her vital signs were checked and recorded as follows,

MORNING

Temperature	36.3 degree celsius
Pulse	79 beat per minute
Respiration	20 cpm
Blood pressure	110\60mmHg
Uterus	Contracted
Breast	lactating and heavy

EVENING 5pm,

Temperature	36.5 degree celsius
Pulse	79 bpm
Respiration	21cpm
Blood pressure	100\60mmHg
SFH	13cm
Breast	Lactating

offensive smell. Her breasts were lactating well. Symphysis fundal height was 11centimeters. Her vital signs were checked and recorded as follows;

Morning;

Temperature 36.0⁰C,

Pulse 78bpm,

Respiration 18cpm

BP 100\70mmHg

At 4pm

Temperature 36.2

pulse 70bpm

Respiration 16cpm

Blood pressure 109|68mmHg

Symphysis fundal height 11centimeters.

Breast lactating

Uterus well contracting

General examination was carried out and no abnormality was present. The baby also passed stool and urine. The cord was neatly dressed and it was detaching. Observations were recorded as follows; Morning

Temperature	37.0 ⁰ c,
Apex heart beat	134bpm
Weight	2.7kg
Respiration	51cpm

At 4:00pm

Temperature	36.8 degreecelsuis
Apex heart rate	135bpm
Weight	2.7kg.
Respiration	46cpm

4.6 FIFTH DAY POST DELIVERY (4TH POSTNATAL HOME VISIT)

The fourth home visit was made to Madam Elizabeth's house at 4:00pm on 8thSeptember, 2023. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was 10centimeters; her vital signs were checked and recorded as follows;

Temperature	36.5 ⁰ c
Pulse	74bpm,
Respiration	19cpm,
BP	100/60mmHg.

During the examination, it was realized that the cord had fallen off and baby was bathed. Madam Elizabeth confirmed that it fell off during the night. The stump was then dressed

and the area was cleaned and dried. The baby passed urine and stool which was yellow in colour. Observations were recorded as follows;

Temperature	36.8 ⁰ c,
Apex heart rate	120bpm,
Respiration	51cpm
Weight	2.7kg.

Client was asked if she has any complained client said she find it difficult to sleep at night and education was given to her on personal hygiene and the need for her to rest during day time.

4.7 SIXTH DAY POST DELIVERY (FIFTH POSTNATAL HOME VISIT)

The fifth postnatal home visit was on 9th September, 2023 at 4:00pm. 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. After the head to toe examination, no abnormality was found. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. Symphysis fundal height was 9 centimeters. Client's vital signs were checked and recorded as follows:

Temperature	36.5 ⁰ c,
Pulse	72bpm
Respiration	19cpm
BP	100/60mmHg.

Baby was bathed, head to toe examination was done and no abnormalities were found on the baby. Stump of cord was then dressed and the area was cleaned and dried. Findings were taken and recorded as follows;

Temperature	36.5 ⁰ c
Apex heart beat	125bpm,
Respiration	40cpm,
Weight	2.8kg .

Madam Elizabeth was educated to breastfeed the baby on demand . Permission was sought to leave.

4.8 SEVENTH DAY DELIVERY (SIXTH DAY POSTNATAL HOME VISIT)

The sixth day postnatal home visit was done on 10th September, 2023 at 5:00pm.

Greetings were exchanged with client and her family and mother said the baby crying has minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink(serosa) normal flow without any bad odour. Madam Elizabeth said the baby had pass stool that evening before arrival. Symphysis fundal height 8 centimetres.

Client vital signs were checked and recorded as follows:

Temperature	36.5
Pulse	79bpm
Respiration	20cpm
Blood pressure	110 70mmHg
Breast	Lactating

Baby was already bathed, head to examination was done and no abnormality was found on the baby. The stump was then dressed and the area was clean and dry. Baby vital signs and weight were taken and recorded as follows:

Temperature	36.7degree celsuis
Apex heart beat	142bpm
Respiration	44cpm
Weight	2.9kg

Education was given to her on importance of ensuring good personal hygiene and need to feed the baby frequently on demand. Client said she appreciated a lot and she was thanked for her cooperation. Permission was sought to leave.

4.9 EIGHT DAY POSTNATAL (SEVENTH POSTNATAL HOME VISIT)

The seventh day postnatal home visit was done on 11th September, 2023 at 7:20pm.

Greetings were exchanged with client and family and a seat was offered in client room.

Mother and baby were both in a healthy condition. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Symphysio fundal height was 7centimeters Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Elizabeth said baby pass stool in the afternoon before arrival.

Client vital signs were checked and recorded as follow:

Temperature	36.6 degree celsius
Pulse	80bpm
Respiration	21cpm
Blood pressure	120 70mmHg

Baby was already bathed, head to examination was done and no abnormality was found on baby. The stump was then dressed and the area was clean dry.

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

Temperature	36.6degree celsius
Apex heart beat	135bpm
Respiration	40cpm
Weight	3.0kg

Client was educated on the danger signs in baby like and the need to seek early care. She said she appreciated that a lot, and she was thanked for her cooperation, she was reminded that tomorrow will be her first visit to the clinic and last visit to her house. Permission was sought to leave.

4.10 FIRST DAY POST NATAL VISIT TO THE CLINIC (8th DAY POST DELIVERY)

On 12th September, 2023 at 7:30am, Madam Elizabeth and her baby came to the facility. A seat was offered to her. Client and baby were healthy. Procedure to be carried out was explained to her and she consented. Madam Elizabeth was asked to empty her bladder before the head to toe examination. Midstream urine was taken and checked for protein and sugar and all tested negative. Head to toe examination was done and everything was within the normal range. Lochia was checked and the flow was scanty, the colour was brownish (serosa) with no odour. Privacy was provided and she was assisted to lie on the

couch for the head to toe examination. Hands were washed with soap under running water and dried with a clean towel. Head to toe examination was done on her. On the head, hair was neat and the conjunctiva was pink, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth. Breast was lactating well, no engorgement, sore or cracked nipples were absent. The abdomen was palpated and there was no tenderness, the uterus 5cm. Observations were checked and recorded as follows;

Temperature	36.2degree celsius
Pulse	74bpm
Respiration	19cpm
Blood pressure	100\50mmHg
Weight	74kg
Haemoglobin	11.6g\dl

She was thanked for the cooperation and helped to dress up.

Head to toe examination was done on baby and no abnormality was found. Umbilical stump was dressed, cleaned and dried and baby's weight was 3.1kg. She was also educated on the importance of the child welfare clinic. Mother was reminded that she will be handed over to the midwife in-charge for continuity of care and was educated to consult them in case of any problem. Baby's vital signs was checked and recorded as follows;

Temperature	36.6 degree celsius
Apex heart rate	122bpm
Respiration	44cpm

TERMINATION OF CARE

On 13th September, 2023 at 11:00am, explanation was made to her that the program was ending that day, but client was reassured of midwife in charge competency. She was educated on the family planning, immunization of the baby till five years old. Client and mother were thanked for their corporation, information was provided to her, that the midwife would be taking care of her from now onwards. Client was also encouraged to register her child at the birth and death registry and she was educated exclusive breastfeeding for six months .Client was again encouraged to report the facility first any time herself or the baby isn't feeling well and also have rest to regain her strength. Client was accompanied to her house and a seat was offered. Client and her family was thanked for their cooperation Permission was sought to leave.

CIRCUMCISION OF THE BABY

After examination of the baby, Madam Elizabeth was informed that the circumcision is about to be done and asked if she wanted to observe but replied in the negative . The baby was prepared and circumcised by the midwife in charge. Gel was applied to the area circumcised area wrapped with gauze after which baby was clothed and given to the mother to breastfeed.

Education was then given to wash hands with soap under running water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

Client was reminded of her second postnatal visit to the clinic. Baby was registered at Birth and Death Registry. Madam Elizabeth and her family were thanked for their cooperation and for helping me to achieve my aim.

4.11 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POST DEELLIVERY)

Madam Elizabeth visited the clinic with the baby on 25th October, 2023 she was welcomed to the clinic by the midwife in charge. Both mother and baby were in healthy condition and had no complaints. Physical examination was done and no abnormality was found, breast was lactating well, uterus was also well involuted and menstruation had not commenced and vital signs was checked and recorded as follows,

Temperature	36.1 degree celsius
Pulse	67 bpm
Respiration	18cpm
Blood pressure	110\70 mmHg
Weight	81 kilogram

Baby's general condition was good, head to toe examination was done and baby's posterior fontanel was closed and vital signs were checked and recorded as follows,

Temperature	36.3 degree celsuis
Apex heart rate	134 beat per minute
Respiration	44 cycles per minute
Weight	3.9 kilogram

Baby was given immunization against polio, diphtheria, pertussis, tetanus, haemophilus influenza type B, hepatitis B given to children at six weeks. The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhoea respectively was also reminded to be given,

Vaccine	Dosage	
Polio1	2 drops	Oral
Rotavirus	1.0milimeters	Oral
Penta	0.5milimeters	
Route of administration	intramuscularly on right thigh	

They were handed over to the child welfare clinic, family planning unit to ensure continuity of care and were educated to consult them in case of any problem. Client was congratulated, according to the midwife in charge.

On 13th September, 2023 client was handed over to the child welfare clinic for continuity of care, she was encouraged to always send the baby for the monthly CWC schedule for the baby to be fully immunized against the six-childhood killer disease. Client was congratulated and permis

sion was sought to leave according to midwife in charge.

Problem Identified

1. After pains
2. Backache
3. Breast engorgement.

4. Inadequate sleep
5. Loss of appetite

Short Term Objectives

1. Client will be relieved of after pains within 24 hours
2. Client will be relieved of backache within 48 hours.
3. Client will be relieved of breast engorgement within 24 hours.
4. Client will be able to sleep for 4hours within 72hours
5. Client will be able to eat half of her meal served.

Long Term Objective

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

4.12 CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/09/23 4:00pm	After pains related to involution of the uterus.	Client will be relieved of after pains within 24 hours as evidenced by client verbalizing that she is no more in pains. 2. As midwife observing that client after pain as reduced	1. Reassure client that after pain is normal. 2. Encourage client to void frequently. 3. Encourage client to breastfeed frequently and on demand. 4. Explain the physiology of the pain to client. 5. Give client paracetamol 1g to reduce pain .	1. Client was reassured. 2. Client was encouraged to void frequently. 3. Client was encouraged to breastfeed frequently and on demand. 4. The physiology of after pain was explained to client that during breastfeeding her uterus shrinks back to its normal shape and size 5. Client was given paracetamol 1g daily before breastfeeding.	14/09/23 4:00pm	Goal fully met as client said that she was relieved of pain.	B.A

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA- TION	SIGN
13/09/23 4:00pm	Backache related to position and attachment of baby to breast.	Client will be relieved of backache within 48hours as evidence by; client verbalizing that she has been relieved of back pain. 2. As midwife observed that client is relieved from backache	<ol style="list-style-type: none"> 1. Reassure client 2. Explain the physiology of pains. 3. Encourage client to apply warm pack at the back. 4. Apply gentle massage over the back. 5. Encourage client to sleep on to sleep on firm mattress 6. Encourage client to position and attached baby to breast 	<ol style="list-style-type: none"> 1. Client was reassured 2.The physiology of backache was explained to client that due to changes of musculoskeletal system that persist after delivery due pregnancy hormone loosen . 3.Client was encouraged to apply warm water bottle pack at the back. 4.Client was encouraged to gently massage her back. 5.Client was encouraged to sleep on a firm mattress. 6. Client was encouraged to position and attachment baby to breast 	15/09/23 4:00pm	Goal met as client reported that she has been relieved of backache. Midwife observing that client backache is subside.	B.A

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA- TION	SIGN
13/09/23 9:00am	Breast engorgement related to inadequate emptying of the breast	Client will be relieved of breast engorgement within 24 hours as evidenced by client verbalizing that the pain has reduced. 2. Midwife verbalization that client breast is subside.	1. Reassure client that breast engorgement will be relieved. 2. Explain the physiology of breast engorgement to client. 3. Teach client to express excess breast milk. 4. Ask client to apply warm and compress alternatively. 5. Encourage client to continue breastfeeding on demand.	1. Client was reassured. 2. Physiology of breast engorgement was explained to client that excess accumulation of breast milk if the baby is not able to suck well. 3. Client was taught to express breast milk 4. Client applied warm and cold compress on her breast alternatively. 5. Client was encouraged to continue breastfeeding baby on demand.	14/09/23 9:00am	Goal fully met as client informed the midwife that her pain was no more and breast engorgement has subsided. Midwife that client breastfeed her with no pain.	B.A

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
19/1/23 4:00pm	Inadequate sleep related to night breast feeding.	Client will be able to sleep for within 72hours evidenced by client verbalizing that she is able to sleep.	<p>1.Encourage client to have periodic rest during the day when baby is asleep.</p> <p>2.Educate client to breast feed baby to his satisfaction.</p> <p>3.Encourage her relative to help her with the household chores.</p> <p>4.Encourage client to have a warm bath in the evening before bed.</p> <p>5.Encourage client to limit the number of visitors.</p>	<p>1. Client was encouraged to have a periodic rest when baby was asleep.</p> <p>2. Client was educated to breast feed baby to his satisfaction.</p> <p>3. Client's relatives were encouraged to help her with the household chores.</p> <p>4. She was encouraged to have a warm bath before bed.</p> <p>5.Client was encouraged to limit the number of visitors</p>	22/1/23 4:00pm	Goal fully met as client verbalized that she had adequate sleep.	B.A

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/09/23 9:00am	Loss of appetite related to stresses after labour.	Client will be able to eat her meal served in a frequent interval.	1.Reassure client that she resumed her eating pattern. 2.Educate client on the need to take adequate diet 3.Involve client in planning of meal. 4.Serve client with food in an attractive manner. 5.Administer vitamin supplement to prevent anaemia .	1. Client was reassured. 2.Client was educated on the need to take adequate diet. 3.Client was involved in the planning of meal. 4.Client food was served attractively. 5.Vitamin supplement was administered.	15/09/23 9:00am	Goal fully met as client said that she ate half meal served.	B.A

SUMMARY AND CONCLUSION

This client and family centered care study was carried out on Madam Elizabeth a 28year old gravida 2 para 1 all alive, who comes from Nchira (Bono East region). The care given during antenatal, labour and puerperium was successful without any complication.

She attended her first antenatal Clinic on 8th May, 2023 the first meeting was on 14th August 2023, when she was 36weeks plus 4 days, gestation at Nchiraa Health Center. Friendship was established, effective was rendered to client throughout pregnancy, labour and puerperium. She attended the clinic till delivery as expected. Education on good nutrition, personal hygiene, and exclusive breastfeeding was given to her She had spontaneous vaginal delivery to a live male child on 3rd September 2023. She encountered some minor problems during pregnancy, labour and puerperium, with laboratory investigations, examinations and nursing care plan, her identified problems during pregnancy, labour and puerperium were solved without any complication to herself and the family.

She had an intensive puerperal care and was handed over to a Public Health nurse for continuity of care. There were proper documentations of all the activities and procedures carried out on her for proper reference.

This study has helped me gain more experience in situation where classroom acquired knowledge has demonstrated on client and the family. It has expanded the knowledge, skills and potentials to render better and quality care to any pregnant woman.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
24/01/23	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.2g/dl	12.9g/dl	Normal
		Sickling	Negative	Negative	Normal
		Grouping	A, B, AB, O	O	Normal
		Rhesus factor	Positive/negative	Positive	Normal
		HIV/AIDS	Negative	Negative	Normal
		Hepatitis	Negative	Negative	Normal
		VDRL	Negative	Non-reactive	Normal
		G6PD	Normal	Normal	Normal
28/02/23	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.2g/dl	12.6g/dl	Normal
05/06/23	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.9g/dl	12.2g/dl	Normal

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
31/07/23	Sugar protein Haemoglobin level	Negative Negative 12.5g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
28/08/23	Sugar protein Haemoglobin level	Negative Negative 12.3g/dl	Negative Negative 12.3g/dl	Normal Normal Normal

APPENDIX II
PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	5mg daily	Oral	Helps in the formation of normal blood cells	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	200mg twice daily	Oral	Increases appetite and helps in the formation of red blood cell	Increased appetite	Gastrointestinal irritation	None
Tablet ferrous sulphate	Iron preparation	200mg daily for 30days	Oral	Helps in the formation of red blood cells	Formation of red blood cells	Abdominal discomfort, diarrhea dark stool	None
Tablet Sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets start from 16 weeks (quickenning) and subsequent doses at 4 weeks interval till birth.	Oral	Prevention of malaria	Prevent malaria in pregnancy	Itching, vomiting, nausea	None

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION & USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tetanus toxoid injection	Anti-tetanus	0.5miligram	Subcutaneous	Helps in the prevention of tetanus	Prevention of tetanus	Slight fever and chills	None
Oxytocin	Oxytocic drug	10units	Intramuscular	Increase uterine contraction and control of bleeding.	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	200000unit once daily	Oral	Growth and development proper sight	Growth development, prevent infection and blindness	Vomiting	None
Tablet paracetamol	Analgesic	500mg	Oral	Helps to reduce increased body temperature and pain	Relieve pain	Liver damage with prolong use	None

**APPENDIX III
PHARMACOLOGICAL DRUGS FOR BABY**

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins	1milliliter	Intramuscular	Production of prothrombin that aids in clotting	No bleeding	Hypersensitive reaction	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent eye infection	Infection of the eye was prevented	None	None
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Gives immunity against poliomyelitis	Baby is under observation	Diarrhea, fever	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.05 ml	Intradermal	Production and prevention of tuberculosis	Baby is under observation	Blister formation and slight fever	Blister was formed

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION/USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX IV
ANTENATAL CHART

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTATIONAL AGE	FUNDAL HEIGHT (CM)	PRESENT - ATION	DESC ENT	FOETAL HEART RATE	COMPLAINS	TREATMENT	NAME AND SIGNATURE
08/05/23	62	118/75	Negative	12weeks	12	Variable		-	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	B.A
05/06/23	62	123/68	Negative	16weeks	15	Cephalic	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	B.A
03/07/23	62	129/70	Negative	22weeks Plus 4	21cm	Cephalic	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	B.A

ANTENATAL CHART CONT'

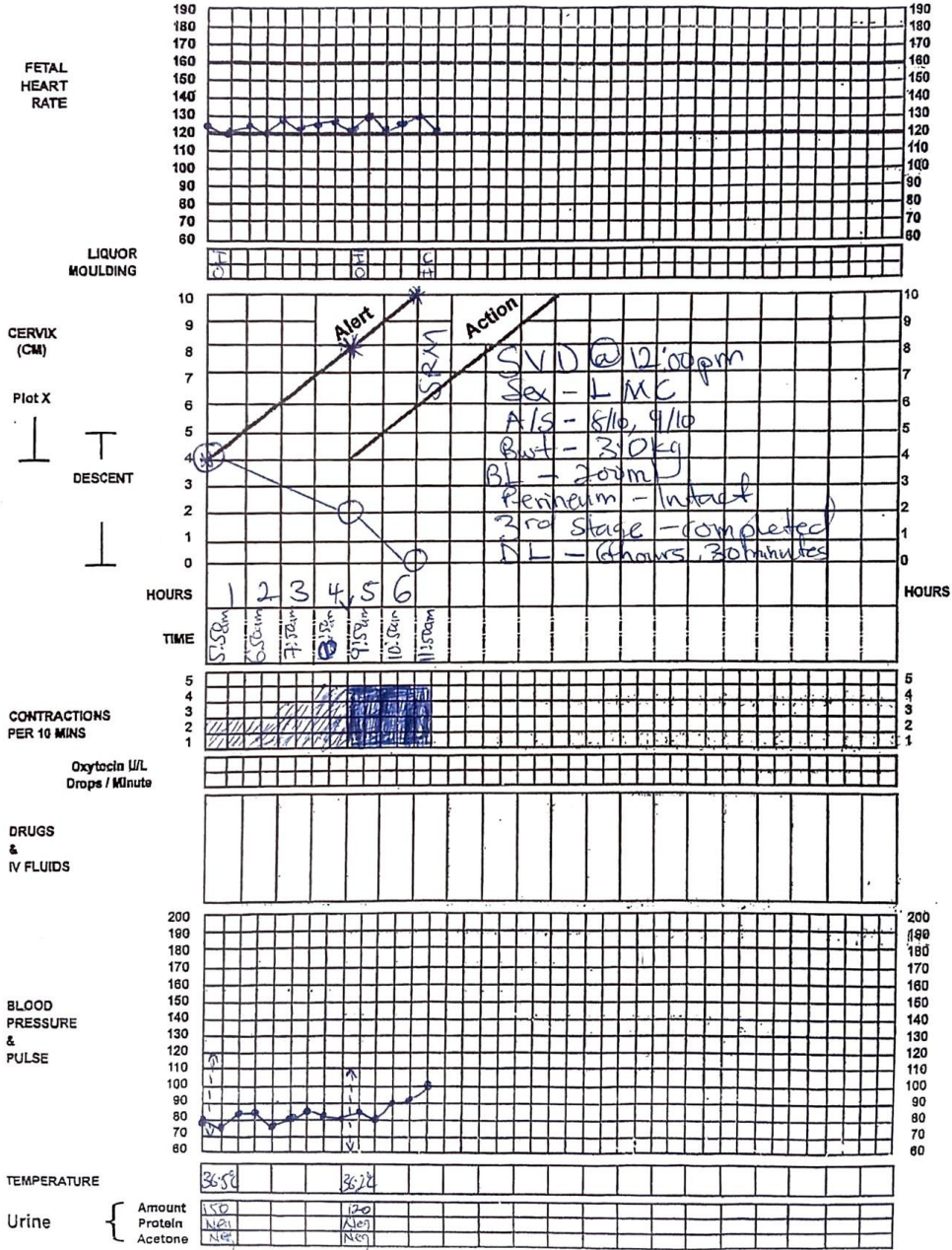
Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gestational age	Fundal height (cm)	Present ation	Descent	Foetal heart rate	Complains	Treatment	Name and signature
31/07/23	62	113/70	Negative	26weeks	25cm	Cephalic	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	B.A
28/08/23	61	94/63	Negative	30weeks+ 2days	30	Cephalic	-	128beat per minute	Sleep disturbance	Tablet (Multivite, folic acid, ferrous sulphate, Paracetamol, Sulphadoxine Pyrimethamine)	B.A
31/07/23	62	109/64	Negative	34+4days	32	Cephalic	-	133 beat per minute	Frequent micturition	Tablet (Multivite, folic acid, ferrous sulphate) Sulphadoxine Pyrimethamine	B.A

ANTENATAL CHART CONT'

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTA-TIONAL AGE	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT	FOETAL HEART RATE	COMPLAINS	TREAT-MENT	NAME AND SIGNA-TURE
07/08/23	62	109/67	Negative	36weeks+ 4day	33	Cephalic	5/5 th	144 beat per minute	Constipation	Tablet (Multivite, folic acid ferrous sulphate.	B.F
14/08/23	60	107/58	Negative	37weeks+ 4days	35	Cephalic	5/5 th	143 beat per minute	Waist pain Complain	Tablet (Multivite, folic acid and ferrous sulphate.	B.F
28/08/23	57	119/70	Negative	38weeks+ 4days	37	Cephalic	5/5 th	142 beat per minute	Lower abdominal pains	Tablet (Multivite, folic acid and ferrous sulphate.	B.F

WHO Modified Partograph

Registration No. 18/23 Name (Last, First) Gyansah Elizabeth Age 28
 Date 03/04/23 Parity/Gravida 1 LMP _____ EDD _____ Gestation (wks) 38 wks
 ROM (Time, Date) 11/58am Labour Durable (Hrs) 6.20 Facility/Clinic Name Nchirad health Centre



LABOR NOTES

Client delivered a male infant of weight 3.0kg at exactly 12:00pm on 03 September 2023. Apgar score of 8/10, 9/10. Placenta/axes delivered at 12:05pm and estimated blood loss was 250ml. Estimated blood loss 250ml. Both mother and baby are doing well and have been moved to the Lys in ward for continuity of care.

Please circle or write responses.

DELIVERY

DATE: 03/09/23 TIME: 12:00pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other
 PERINEUM: Intact / Episiotomy / Laceration
 ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time: 12:08pm Type/Dose: Oxytocin / 10units
 PLACENTA: TIME: 12:05pm Complete / Incomplete
 BLOOD LOSS AMOUNT: Small (Less than 250 cc)
 Moderate (250-499 cc)
 Large (more than 500 cc)
 Significant for mother

BABY

Weight: 3.0kg
 Sex: Male / Female
 Baby Position: Vertex / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	2	1	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	12:15pm	110/70	67	15cm		100mls
	12:30pm	120/60	68			
	12:45pm	115/60	75			
	1:00pm	120/80	72			
	1:15pm	120/70	75			
	1:30pm	120/75	81			
	1:45pm	110/60	84			
Every 30 minutes For 1 hour	2:00pm	110/80	79			
	2:30pm	120/70	72			
	3:00pm	120/80	71			150mls

Birth Attendant: ONURAA SAKIRA SENIOR (STUDENT) Date: 03/09/2023

SUPERVISED BY BEKOE FLORENCE (MIDWIFE)

LSS 4th Edition external review draft © ACNM (to be published 2008)

MATERNITY CHART

NAME: Gilansah Elizabeth
 AGE: 28 yrs WARD: Lying-in
 IP NO.: 18/23 BED NO.: 2

Date	03/09/23	04/09/23	05/09/23	06/09/23	07/09/23	08/09/23	09/09/23	10/09/23	11/09/23
Days in Hospital	0	1	2	3	4	5	6	7	8
Day, P, O.									
Hour	AM PM	8:00	8:00	8:00					7:30
	1:00	4:30	5:00	4:00	4:00	8:00	5:00	5:00	
Temperature									
Pulse	78 bpm	79 bpm	80 bpm	81 bpm	82 bpm	83 bpm	84 bpm	85 bpm	86 bpm
Resp.	22 bpm	23 bpm	24 bpm	25 bpm	26 bpm	27 bpm	28 bpm	29 bpm	30 bpm
E.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.	110/50	110/60	110/70	110/60	110/60	110/70	120/70	110/60	100/50

TEMPERATURE CHART

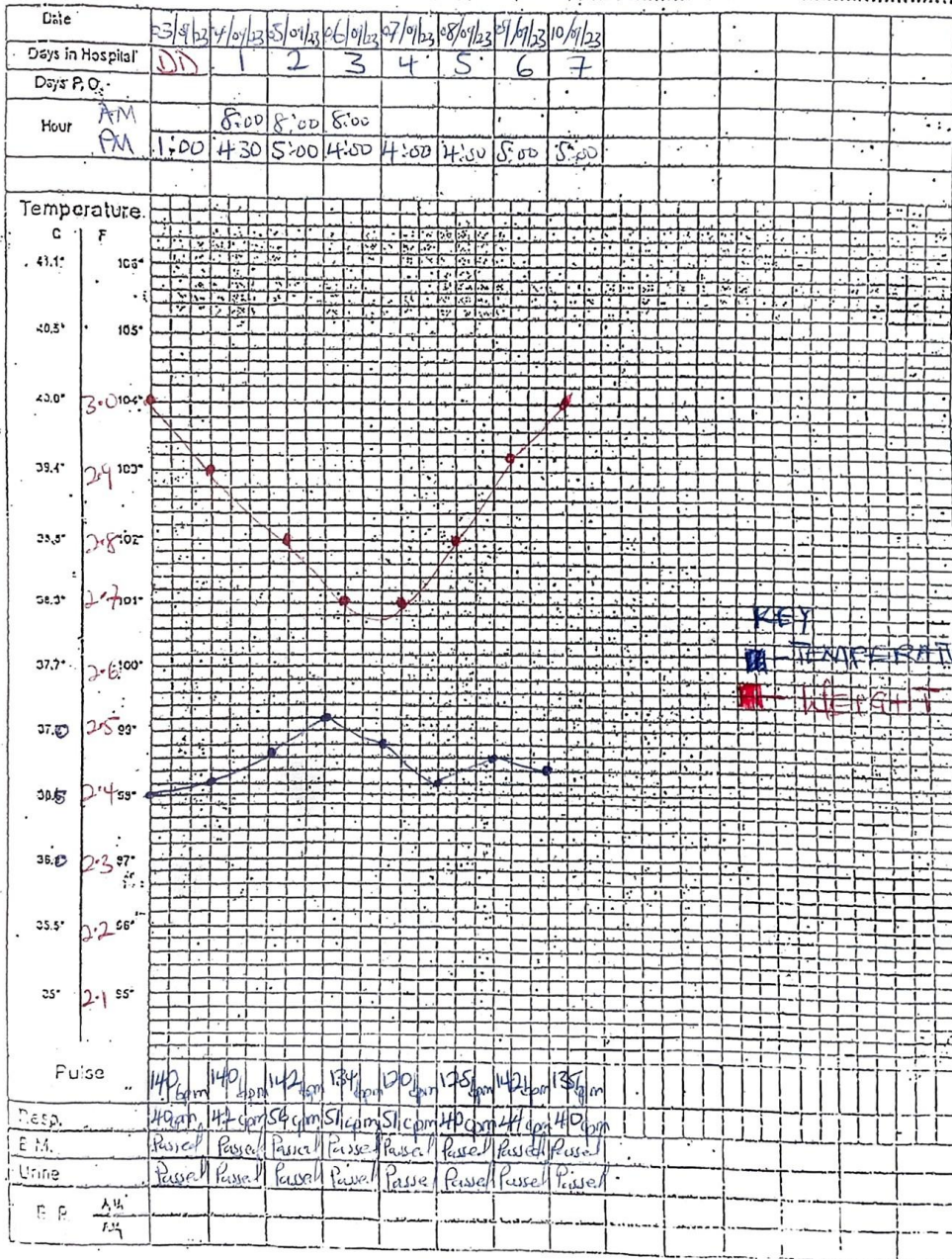
NAME: Baby Gyansuh Elizabeth

AGE: New born

WARD: Lying - in

IP NO.: 18/23

BED NO.: 2



NEW BORN CHART

Name: Baby Gyansah Elizabeth No: 18/23 Birth Weight: 3.0kg
 Sex: Male Mother's No: 18/23 Length: 47cm
 Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term baby
 Date of Birth: 03/09/2023 Time: 12:00 pm Date of Discharge: 04/09/2023

Date	D1		D2		D3		D4		D5		D6		D7		D8	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
No. of Days																
Weight	3.0kg	2.9kg	2.8kg	2.8kg	2.9kg	3.0kg			3.2kg	3.3kg						
Temperature																
Stools	Passed	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	Passed		
Remarks	Head Neck Trunk Limbs Genitals No abnormalities detected															

NEW BORN EXAMINATION FORM

Name: Baby Kwansah Elizabeth Date of Assessment: 03/09/2023 Time: 1:00pm
 Date of Birth: 02/04/2023 Time of Birth: 12:00pm Sex: M F Age at time of Assessment (days/hrs) 1 hour
 Astational Age 3 weeks Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 8 5min 10 Birth Weight: 3.0 kg Length: 47 cm Head Circumference: 33 cm
 Temperature at time of Assessment: 36.5 °C Urine passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): Owusuag Sandra Senior (student)

<p>1. Respiration Rate <u>40 bpm</u> <input type="checkbox"/> Rate < 30 b/m * <input type="checkbox"/> Rate < 60 b/m * <input type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor *</p> <p>2. Activity/Movement <input checked="" type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb * <input type="checkbox"/> No Movement</p> <p>3. Tone <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased *</p> <p>4. Colour <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced *</p> <p>5. Cord <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red, draining pus <input type="checkbox"/> Bleeding</p> <p>6. Cry <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Shriill * <input type="checkbox"/> Absent *</p>	<p>7. Suck <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent</p> <p>8. Head swelling <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal hemorrhage <input checked="" type="checkbox"/> No swelling</p> <p>9. Sutures <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated *</p> <p>10. Fontanel <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm) *</p> <p>11. Eyes <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other _____</p> <p>12. Ears <input checked="" type="checkbox"/> Normal (size / shape/position). <input type="checkbox"/> Abnormal: _____</p> <p>13. Mouth <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____</p>	<p>15. Neck <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____</p> <p>16. Clavicle <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture</p> <p>17. Chest <input type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____</p> <p>18. Heart rate Rate: <u>140 bpm</u> <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160 *</p> <p>19. Femoral pulse <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable *</p> <p>20. Abdomen <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maases: _____ <input type="checkbox"/> Other _____</p> <p>21. Back (spine) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairly patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature</p>	<p>22. Limbs <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____</p> <p>23. Genitalia Male Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____</p> <p>Female Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Fistula (meconium/urine through abnormal opening in vagina) * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____</p> <p>24. Anus <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate *</p> <p>25. Resuscitation provided <input checked="" type="checkbox"/> None <input type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP</p> <p>26. Services provided <input checked="" type="checkbox"/> Vitamin K1 given <input checked="" type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input type="checkbox"/> Breastfeeding established <input type="checkbox"/> Immunization (BCG/Polio) <input type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization <input type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids</p>
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*May indicate severe disease that requires urgent referral
 Diagnoses (if known) Normal baby
 Classification: (Overall assessment) Normal Baby with a Problem Danger Sign/ <1500g/ severe Jaundice
 Plan: Routine Care Problem. Continue supportive in-patient care Urgent Referral / Advanced Care Discharge

NEW BORN EXAMINATION FORM

Name: Baby Gwansah Elizabeth Date of Assessment: 04/09/2023 Time: 1:00pm
 Date of Birth: 03/04/2023 Time of Birth: 12:00pm Sex: M F Age at time of Assessment (days/hrs) 1 day
 Astational Age 2 weeks Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 8 5min 10 Birth Weight: 3.0 kg Length 47 cm Head Circumference: 33 cm
 Temperature at time of Assessment: 36.5 °C Uring passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): Owusuqa Sandra Senior (Student)

<p>1. Respiration Rate <u>42 bpm</u> <input type="checkbox"/> Rate <30 b/m * <input type="checkbox"/> Rate <60 b/m * <input type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor *</p> <p>2. Activity/Movement <input checked="" type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb * <input type="checkbox"/> No Movement</p> <p>3. Tone <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased *</p> <p>4. Colour <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced *</p> <p>5. Cord <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red, draining pus <input type="checkbox"/> Bleeding</p> <p>6. Cry <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Shrill * <input type="checkbox"/> Absent *</p>	<p>7. Suck <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent</p> <p>8. Head swelling <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal haemorrhage <input checked="" type="checkbox"/> No swelling</p> <p>9. Sutures <input type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated *</p> <p>10. Fontanel <input type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm) *</p> <p>11. Eyes <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other _____</p> <p>12. Ears <input checked="" type="checkbox"/> Normal (size / shape/position). <input type="checkbox"/> Abnormal: _____</p> <p>13. Mouth <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____</p>	<p>15. Neck <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____</p> <p>16. Clavicle <input type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture</p> <p>17. Chest <input checked="" type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____</p> <p>18. Heart rate Rate: <u>142 bpm</u> <input type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160 *</p> <p>19. Femoral pulse <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable *</p> <p>20. Abdomen <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Masses: _____ <input type="checkbox"/> Other _____</p> <p>21. Back (spine) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairly patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature</p>	<p>22. Limbs <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____</p> <p>23. Genitalia Male Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Undescended testis <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____</p> <p>Female Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Fistula(meconium/urine through abnormal opening in vagina)* <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____</p> <p>24. Anus <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate *</p> <p>25. Resuscitation provided <input checked="" type="checkbox"/> One <input type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP.</p> <p>26. Services provided <input type="checkbox"/> Vitamin K1 given <input type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input type="checkbox"/> Breastfeeding initiated <input checked="" type="checkbox"/> Breastfeeding established <input checked="" type="checkbox"/> Immunization (BCG/Polio) <input checked="" type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization <input type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids</p>
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*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal baby

Classification: (Overall assessment) Normal Baby with a Problem Danger Sign/ <1500g/ severe Jaundice
 Plan: Routine Care Problem. Continue supportive in-patient care Urgent Referral / Advanced Care Discharge 1 day

SIGNATORIES

NAME OF STUDENT MID WIFE

NAME: OWUSUAA SANDRA SENIOR

SIGNATURE.....

DATE...07/06/2024

THE MIDWIFE- IN -CHARGE (NCHIRAA HEALTH CENTRE)

NAME: AFIA BERNICE

SIGNATURE..... (Fv)

DATE...07/06/2024

THE SUPERVISOR

NAME: MS ERNESTINA MENSAH

SIGNATURE.....

DATE:..07-06-2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE.....

DATE:..10/06/2024

**PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM**