HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

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A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

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PREFACE

The practice of midwifery in the past focused mainly on the client in an effort to meet the client‟s needs. However, all the needs of client could not be met because they lacked family support. Again, Midwifery has undergone a lot of changes globally and nationally. These changes have brought the introduction of client and family centered maternity care concept. The concept of family centered maternity care is a systematic way by which a comprehensive maternity and nursing care is given to a pregnant woman and her family throughout pregnancy, labour and puerperium by the use of the nursing care process. The confidentiality of the client is ensured, client feels at ease to provide vivid history and discussions on confidential matters. This system gives the student midwife the opportunity to use all the knowledge and skills acquired during his/her training to give quality maternity care to the pregnant women and her family throughout the period of pregnancy, labour and puerperium.

The study also enables the student midwife to identify and help client solve their health problems. To achieve this, the student identifies the health problems, assess the client, set objectives, provide the necessary interventions, and evaluate the care to know if goals have been fully met at the end of the care.

The care study forms part of the academic exercise from the Nursing and Midwifery Council of Ghana which serves as a partial fulfillment towards the award of a professional midwifery certificate

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

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INTRODU CTION

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 wellbeing. 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 Rita, a 36-year-old woman gravida 3 para 2 alive during her period of pregnancy, labour and puerperium. The care study started 9th of May 2022 at Antie Aggies maternity Home in the Berekum East district within the Bono Region of Ghana. The interaction started when Madam Rita was seen eating with long painted finger and toe nails at the antenatal clinic. She was then approached and educated on the reasons why she should keep her finger nails short and avoid painting since it can hinder health care givers from detecting anaemia and the long nails can habour dirt which can cause illness. She was told to always keep her nails short and without painting them and also educated on the need to practice good personal hygiene. It was her third antenatal visit and her gestational age was also 37weeks. After a comprehensive introduction to her, she was informed about the desire to choose her for the client/family centered maternity care study which she happily agreed. She was thanked for her cooperation and accepting the request.

Madam Rita was cared for during the antenatal period, 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. She had a successful pregnancy, delivered spontaneously on 24th May, 2022 to an alive baby girl. She had a successful puerperium and was in good health. She was then handed over to the midwife in-charge at Antie Aggies maternity home for continuity of care on the 8th of May,2022

This care study is in four chapters; chapter one talks about client‟s particulars such as social, family, psychosocial, obstetric, medical and surgical histories followed by chapter two which talks about the antenatal care rendered to Madam Rita throughout her pregnancy and chapter three is concerned with management of Madam Rita during labour and finally chapter four is also about her management during puerperium. The chapter two, three and four have care plan attached to each. In addition is a summary and conclusion, bibliography as well as appendixes.

LITERATURE REVIEW

PREGNANCY

Myles (2009) pregnancy is confirmed when many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of certain hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends solely on the mother for survival when in utero. There are varieties of care that are rendered to the expectant mothers and their entire families include history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, ferrous sulphate and multivitamins), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet and rest and sleep, exercise, personal hygiene and environment hygiene, birth preparedness and complication readiness. Pregnancy has been divided into three. First trimester, second trimester and third trimester. First trimester is from conception to 13 weeks of gestation. Second trimester starts from 14 weeks to 26weeks of gestation during which the woman‟s body begin to adjust to the pregnancy. Third trimester is from 27 weeks to 40 weeks of gestation where the woman assumes a lumber curve position associated with back and waist pains. The anatomical and physiological change in the uterus plays an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic fluid. At the time of labour it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractility and elasticity.

Tiran (2008) Pregnancy is a period from conception to the delivery of the fetus. The normal duration of pregnancy is 280 days (40 weeks) counted from the first day of the last normal menstrual periods to delivery. During this period, physiological and psychological changes such as relaxation of the cardiac sphincter, relaxation of the smooth muscles of the intestines, varicose veins, constipation and lower abdominal pain occur due to the effect of estrogen and progesterone. The mother experiences frequency of micturition due to the effect of progesterone on the detrusor muscles. Pregnancy has been divided into three. First trimester, second trimester and third trimester. First trimester is from conception to 13 weeks of gestation. Second trimester starts from 14 weeks to 26weeks of gestation during which the woman‟s body begin to adjust to the pregnancy. Third trimester is from 27 weeks to 40 weeks of gestation where the woman assumes a lumber curve position associated with back and waist pains.

Fraser and Cooper (2014), pregnancy is a time of enormous physical, psychological changes and adaptations as the woman and her family prepare or expect a new member in the family. For most women, is an exciting and happy period but may be over shadowed by fear and expectation. The average duration of pregnancy is 280 days or approximately 40 weeks of gestation and this is counted from the first day of the last menstruation period. Pregnancy is in three trimesters. First trimester is from conception to 13 weeks of gestation. Second trimester starts from 14 weeks to 26weeks of gestation during which the woman‟s body begin to adjust to the pregnancy. Third trimester is from 27 weeks to 40 weeks In the third trimester of pregnancy, the woman exhibit symptoms like backache, waist pains, frequent micturition, lower abdominal pain and insomnia.

Weller B.F (2009) Pregnancy is a state of being with a fetus from the time of conception to the expulsion of the fetus. The normal period is 280 days or 40 weeks counted from the first day of

the last menstruation period. It is divided into three trimesters. The first trimester is from the day of conception to the 12th week. The second trimester starts from the 12th week to the 28th week and the third trimester is from the 29th week to delivery. During this period many physiological changes occur in all the system of the woman‟s body due to hormonal changes and these changes may lead to minor disorders like constipation, backache, heartburn and if not managed may deteriorate the woman‟s health and the fetus. In the third trimester of pregnancy, the woman exhibits symptoms like backache, waist pains, frequent micturition, lower abdominal pain and insomnia. These disorders can be very distressing and life threatening if not managed appropriately. These changes and many other problems (example, personal and environmental) are identified during antenatal care and the expectant mother is assisted and managed as to how to cope and adjust to the situation. This is normally done through health education, counseling and interaction with the client and family.

King (2014) pregnancy starts from the time conception is confirmed until the beginning of labour. The woman is given focus antenatal care where the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choice throughout pregnancy. pregnancy is a time of profound anatomic and physiologic change in a woman‟s body. In addition to the reproduction organs all maternal physiologic system makes adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis Pregnancy last approximately 280 days or 40 weeks counted from the first day of the last menstruation period. The antenatal period is into trimesters, first trimester is considered to be 1 to 12 weeks because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time, the second trimester is from 13 to 28 weeks. The third trimester extends from 29 to 40 weeks. In the third trimester of

pregnancy, the woman shows symptoms like backache, waist pains, frequent micturition, lower abdominal pain and insomnia.

Marshall & Raynor (2014) pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choices throughout pregnancy The aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife are, providing a holistic approach to the woman‟ care that meets her individual needs, recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations, facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan, offering parenthood education through focus antenatal care service.

Ojo and Briggs (2009) pregnancy occurs when menstruation ceases and returns some weeks or months after delivery. Most women experience some minor disorders such as frequency of micturition, heartburns among others. The hormones estrogen and progesterone are produced in large quantities. These hormones exert some action on the various systems of the woman. These conditions may not be life threatening but can be harmful. The woman therefore needs to be educated on these conditions so that they can understand and cope well with their occurrence. Pregnancy is in three trimester, first trimester, second trimester and third trimester. The first trimester is from onset to 12weeks of gestation, second trimester is from 13weeks to 26weeks and third trimester is from 27weeks to 40weeks. In late pregnancy, at 36weeks to 38weeks of gestation fundus reaches the xiphoid sternum, at this level until the fetal head engage at the

pelvic brim. This is accompanied with lower abdominal pain, waist pain and frequency of micturition

Konar (2013) pregnancy is the progressive anatomical, physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing fetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological there is enormous growth of the fetus during pregnancy. In late pregnancy, (third trimester) frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness. The gums become congested and spongy and may bleed to touch. Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of acid gastric content into esophagus may produce chemical esophagitis and heartburn. There is diminished gastric secretion and delay emptying time of stomach. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

LABOUR

Myles (2014) labour purely in physical sense may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and active phase, latent phase may last 6 to 8 hours in primigravida. where there is a dilation of 1 to 3cm. This active phase begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. The partograph is an essential element for monitoring labour. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last for six hours after delivery of the placenta.

Fraser and Cooper (2008) Labour is described as the process by which the products of conception are expelled through the birth canal. Labour was classified under four stages: First, second, third and fourth stage. The first stage of labour begins with the dilatation of the cervix up to ten centimeters (10cm) dilation or full dilation of the cervix. This is a result of the regular rhythmic and painful uterine contractions. The second stage of labour also starts when the cervix is fully dilated and it continuous till the expulsion of the fetus. The third stage of labour is the complete expulsion of the placenta and its membranes and the control of bleeding. The fourth stage also is the six hourly close observations of the mother and the baby after the third stage. It involves the checking of the vital signs of both the mother and the baby. It also deals with the

establishment of lactation and detection of abnormalities and any complications in both mother and baby. During this stage, the mother is also given health education on personal hygiene, care of the cord, frequent change of perineal pad, frequent ambulation to prevent postpartum hemorrhage, and exclusive breastfeeding.

Ojo and Briggs (2006) labour is the process by which the uterus empties its content after the 38th weeks of pregnancy. It entails contraction and retraction of the uterine muscle fiber, the dilatation of the cervical os and complete expulsion of the baby, liquor amnii, placenta and membrane. The causes of onset of labour are unknown but many theories have offered few of these and are stated as, overstretching and over distention of the uterus at term, placental efficiency is diminished toward term, resulting in reduction in the level of estrogen and progesterone. The uterus becomes sensitive to the effect of oxytocin produced by the posterior pituitary gland there is an increase contractibility of the uterus towards term. Braxton Hicks" contractions increase in amplitude and may bring about the onset of labour. First stage of labour starts from the onset of regular uterine contractions to full dilation of the cervical os. It lasts 6-12 hours in multigravida. The first stage of labour comprises; painful uterine contractions, waist pain, lower abdominal pain, progressive dilatation of the cervix, formation of the fore waters and rupture of membranes. During the first stage, the progress of labour, the fetal and maternal conditions are monitored closely with the partograph to detect any deviation from normal. The monitoring begins when the woman in labour is in the active phase that is when the cervical os is 4cm dilated. Second stage of labour; starts from full dilatation of the cervical os to the complete expulsion of the baby. It usually last for 5-30 minutes in multigravida. Third stage of labour entails complete expulsion of the placenta and membranes, usually within 5-15 minutes after birth of the infant. The fourth stage is a period of six hours following the delivery the placenta.

During this period, the mother and baby are closely observed to detect any complications that may rise.

Tiran (2008) Labour is defined as the process by which product of conception are expelled from the uterus through the birth canal. labour normally occurs spontaneously at term that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until foetus, membranes and placenta are expelled by the maternal effort through the vagina. The partograph is a graphical recording of labour progress obtained by assessment of visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and foetal wellbeing. Labour comprises four stages. . The first stage of labour begins with the dilatation of the cervix up to ten centimeters (10cm) dilation or full dilation of the cervix. This is a result of the regular rhythmic and painful uterine contractions. The second stage of labour also starts when the cervix is fully dilated and it continuous till the expulsion of the fetus. The third stage of labour is the complete expulsion of the placenta and its membranes and the control of bleeding. The fourth stage also is the six hourly close observations of the mother and the baby

Marshall & Raynor (2014) Labour, purely in the physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and baby and can influence the likelihood and or experience of future pregnancies. Pregnancy is considered to last approximately 40 weeks; Complex physiological and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth. Four stages of labour are described. The first stage of labour begins with the dilatation of the cervix up to ten centimeters (10cm) dilation or full dilation of the cervix. This is a result of the regular

rhythmic and painful uterine contractions. The second stage of labour also starts when the cervix is fully dilated and it continuous till the expulsion of the fetus. The third stage of labour is the complete expulsion of the placenta and its membranes and the control of bleeding. The fourth stage also is the six hourly close observations of the mother and the baby labour is a continuous process not only encompass specific physical changes but should also account for the emotional effect observe in women during this time. Recently, the partograph has been accepted as the tool for recording the progress of labour. It is a chart on which salient features of labour are entered in a graphic form and therefore provide opportunity for early deviation from normal

Konar (2013) defined labour as series of events that takes place in the genital organs in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. The onset of labour is determined by a complex interaction of maternal and foetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors. Levels of maternal estrogen rise sharply during the last weeks of pregnancy, resulting in changes that overcome the inhibiting effects of progesterone. High levels of estrogen cause uterine muscle fibres to display oxytocic receptors and form gap junctions with each other. Estrogen also stimulates the placenta to release prostaglandins that induce a production of enzymes that will digest collagen in the cervix, helping it to soften. There are four stages of labour

Marie Elizabeth (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; spontaneous in onset, with vertex presentation, without undue prolongation, natural termination with minimal aids, without having any complication affecting the health of the mother and or the baby. The features of true labour signs are: painful uterine contraction at regular intervals, „Show‟, Progressive

effacement and dilatation of the cervix, formation of the „bag of waters". The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is six hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravida. Fourth stage is the stage of observation after expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P"s.

PUERPERIUM

Fraser and Cooper, (2008) Puerperium starts immediately after the delivery of the placenta and its membranes and continuous for six weeks. It is within this period that all systems of the woman‟s body recover from the effects of pregnancy and return to their non-pregnant state. Lactation is well established and baby accepted into the family. During this period also, there is the drainage of lochia (the discharges from the uterus). It is normally red in colour during the first 3-4 days described as lochia rubra, from 5-9 days, it is pink in colour and is called lochia serosa; and from next 2-3 weeks it is paler, creamy-brown in colour and this is called lochia alba. Further that it has been traditional to associate after pains with multiparity and breastfeeding. However, women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pains is by an appropriate analgesic.

Myles (16th edition) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. The general expectation is that by six weeks after the birth, a woman‟s body will have recovered sufficiently from the effects of pregnancy and the process of parturition. The difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person‟s level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman‟s long-term health. The abdominal muscles are flaccid and within a period of six weeks postpartum called puerperium, where bruises are healed, the genital organs and any other organ which underwent changes during pregnancy return to their pregravid state. The process of

readjustment is called involution. Lactation is established during this period. Lochia is the term used to describe the discharge

- Lochia rubra: red, 1-4 days
- Lochia serosa: 5-9 days the colour is pink or pale brownish
- Lochia alba: 10-15 days, pale white

Henderson (2009) puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pregravid condition, a period estimated to be around 6 weeks. Puerperium is a time of major physiological change and a time of major emotional and personal upheaval. It also says that an early postnatal check includes: maternal hemoglobin and assessment of the baby and the mother looking particularly for tiredness and depression. The falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve.

Konar (2013), puerperium is the period following child birth in which the bodies tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state; Involution of the uterus and other soft parts of the genital tract, commencement of lactation. Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given. Further said that involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal. Further states that, puerperium begins as soon as the placenta is expelled

and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into; immediate – within 24 hours; early – up to 7 days and remote – up to 6 weeks. Lochia is the vaginal discharge during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge, it is named as;

1. Lochia rubra: red, 1-4 days
2. Lochia serosa: 5-9 days the colour is yellowish or pink or pale brownish
3. Lochia alba: 10-15 days, pale white

Ojo and Briggs (2006) at the end of labour the uterus is still very large and mobile; the genital tract is greatly bruised, distended and perhaps lacerated. The abdominal muscles are flaccid. Within the period of six weeks postpartum are called puerperium, and where the bruises heal and genital organs and any other which underwent changes during pregnancy return to their pregravid states. This process of readjustment is called involution and lactation is established during this period. Involution is brought about by a shriveling up of the muscle fibers and the absorption of their substance, partly into the bloodstream and partly into the lochia. The lochia is made up of blood from the site where the placenta was attached and the crumbling of the uterus which had developed so greatly in pregnancy. In the first five days after childbirth, the lochia mostly consists of blood and is consequently red in colour and is called lochia rubra. For the next 5 to 10 days, it is reddish brown as the blood loss lessens and more of the uterine lining in expelled and is called lochia serosa. By the 12 day, it has become pale either yellowish or white and the discharge may persist varying in amount for up to six weeks. This book also talks about minor disorders that may occur after delivery as the body begins to change to it non-pregnant state. After pains; after delivery, the uterus does not stop contracting. The contraction continues

painlessly for the most part, but in some woman, particularly multigravida, painful contractions persist in the few days of the puerperium and may require analgesics. Backache; It mostly affect one woman in five in the weeks for occasionally month after childbirth. Backache appears to be more common if the woman has had an epidural anesthetic or a long second stage of labour. There is no specific treatment and backache gets better by itself. Urination; In the first 24 hours after delivery, the mother sometimes finds it difficult to pass urine because of the stretching during delivery of the vaginal tissues and the tissues around the bladder and with early ambulation help.

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into;

1. Immediate –within 24 hours
2. Early- up to 7 days
3. Remote –up to 6 weeks

Immediately following delivery, the uterus becomes firmer and retracted with alternating. Hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscle fibers is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a

long time (4 to 8 days) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

1. Lochia rubra (red) 1 -4 days.
2. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
3. Lochia Alba (pale white) 10 -15 days.

The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Marshall & Raynor (2014) puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world, 40 days for recuperation is a time-honored practice. The general expectation is that by six weeks after birth all the systems in a woman‟s body will have recovered sufficiently from the effects of the pregnancy and recovered to their non-pregnancy state. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8 days) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

1. Lochia rubra (red) 1 -4 days.
2. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
3. Lochia Alba (pale white) 10 -15 days.

the general expectation is that by 6 weeks after the birth, a woman‟s body will have recovered sufficiently from the effects of pregnancy and the process of parturition.

WHY CLIENT WAS CHOSEN

On the 9th of May 2022, Rita Asumah was chosen as the client for the family centered maternity care study because she was met with long painted finger nails, so she was picked to gain the opportunity to educate her on the negative effects of long nails and importance of not painting nails when pregnant. She was encountered at 9:55am at Aggies Maternity home in the Berekum East district in the Bono region.

Familiarity was built with Madam Rita at the antenatal clinic, she was advised that painting her nails hinders care givers from detecting when she is anemic and her long nails can harbor dirt which can cause her to fall sick when she eats with it. It was her third antenatal visit and her gestational age was 37weeks.

After a comprehensive introduction she was informed about the desire to use her for the client/family centered maternity care study which she happily agreed. She was finally thanked for her cooperation and introduced to the midwife in-charge.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter deals with the assessment of the client and her family, which involves a systematic collection of data from the client and her family. Information was acquired through observation, interview, medical records and antenatal records. This information helps the student midwife to provide holistic care for the client and her family taking into consideration the physical, psychological and spiritual needs.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Rita, gravida 3 para 2 all alive is a 36year old lady who stays at Adom new town, house number AD573 near the Christ Apostolic Church. She is a trader who sells bowls. She is a Christian and a Bono by tribe. She is married to Mr. Kumi who is a Christian and a farmer. Madam Rita mentioned that her next of kin is husband. She completed Senior High school and speaks Bono and English fluently. She has two female children with Mr. Kumi. The eldest is four years old whiles the second born is two years old. Madam Rita is dark in complexion, weigh"s 79kg, 152cm tall and neither smokes nor takes in alcohol.

1.2 FAMILY HISTORY

Madam Rita is the second child to Mr. Kwarteng and Madam Janet, her father and mother are farmers and stay at Adom She has three siblings, all males. There is no known history of hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy, mental illness and congenital abnormalities in her family, no history of multiple pregnancy. She said her self and family seek for medical treatment and pray whenever they are not feeling well. She said all her family members who passed away died naturally.

1.3 MEDICAL HISTORY

According to Madam Rita, she has never had any chronic illness, like hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, respiratory disorder, epilepsy, and anemia. She only said she sometimes suffers minor headache which she visits the clinic immediately to seek for medical treatment after which she gets well. She has no known allergy to food or any drug. She went on to say that she has not received any blood transfusion or donated blood before.

1.4 SURGICAL HISTORY

She said she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous laparotomy such as caesarean section or appendectomy.

1.5 MENSTRUAL HISTORY

Madam Rita said she had her menarche at the age of 12 years and her menses lasts for 5 days during every month. She said she has a cycle of 28 days. She also said she changes her pads twice daily indicating she has normal menstrual flow. She has never experienced dysmenorrhea in her life.

1.6 HOBBIES AND LIFESTYLE

Madam Rita is a person who usually sleeps at 8:30pm and wakes up at 4:00am to perform her household chores. After brushing her teeth, sweeps her compound, empties her bin, fetches water into her barrel and takes her bath. She cooks breakfast. She also added that she goes to the market on Thursdays since that‟s a market day. She also goes to church with her husband and children. She mentioned that, she likes singing and dancing very well. She said she prefers Fufu with any kind of soup to other foods. She goes to the market every day to sell her bowls but stopped because of the pregnancy. She does her laundry on any day she has time after she is done with her general cleaning. She added that she likes watching television. She said she eats three times daily, but ever since she became pregnant she only eats on demand. Her husband now picks the kid from school since she is pregnant. She said they all sit together and take their

supper around 6:00pm and she supervises the kids to do their homework, bath them and herself as well and go to bed. She also mentioned that she empties her bowel every morning or evening and micturate whenever she has the urge to.

1.7 PAST OBSTERTRIC HISTORY

Madam Rita gravida 3 para 2 all alive and healthy went through her pregnancy successfully without any complication. She had her first pregnancy in the year 2017, second pregnancy in 2020. She said during her pregnancy, she only experienced some minor disorders such as waist pain, lower abdominal pain, constipation, frequency of micturition, nausea and vomiting of which she reported to the clinic and they were explained to her as normal physiological changes in pregnancy which would resolve as pregnancy progresses and after delivery. She also said she has never had any spontaneous or induce abortions and still births in her life. Her previous pregnancies got to term. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induced hypertension (pre-eclampsia). She also visited antenatal for four (4) times during her pregnancy and received 1 dose of sulphadoxine pyrimethamine as well as 1 dose of tetanus toxoid injection.

Madam Rita delivered her first female child spontaneously at the clinic who was active and healthy at birth but the second child was born at home before she reached he hospital. She further stated that the duration for her delivery did not exceed 12hours. She also said she never had any perineal tear or been given episiotomy during her previous deliveries. She also added that she never experienced post-partum hemorrhage. Her placenta was delivered completely with no retained product of conception. She said her estimated blood losses were small. Her child never had any birth injuries, asphyxia or jaundice. Her children were active at birth and healthy with birth weights of 2.5kg.

She also said she started breastfeeding within the first hour after birth. She practiced exclusive breastfeeding for 6months and then added complementary feed after the 6months for two year for the first child and one year for the second child. She had a safe breastfeeding with no complication. She added that her children did not have any abnormalities like cleft lip, extra digits or webbed digits. Her children were fully immunized against the childhood preventable diseases, such as diphtheria, measles, polio, tetanus, tuberculosis, and whooping cough. Her

children never suffered any ill health. She herself did not experience any ill health such as puerperal psychosis, Anaemia and malaria. She also did not experience problems like postpartum hemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. In relation to family planning, she never used any method since she was finding it difficult to get pregnant after marriage. She also stated that her family supported in taking care of the children, herself and some of the household chores.

1.8 PRESENT OBSTETRIC HISTORY

Madam Rita first visited the clinic on 31st January, 2022. Her gestational age was 24 weeks. According to her LMP, her expected date of delivery was calculated as 30th May, 2022. Her vital signs and laboratory investigations on that day were as follows;

Vital signs

Temperature - 36.6˚c

Pulse - 72bpm

Respiration - 18bpm

Blood pressure - 110/70mmHg

Weight - 78kg

Height - 152cm

Lab investigations

Hb - 12.8g/dl

Sickling - Negative (-)

Blood group - O

Rhesus factor - Positive (+)

HIV	-	Negative (-)
HEP B	-	Negative (–)
VDRL	-	Non-reactive
G6PD	-	No Defect
Urine for pregnancy test	-	Positive (+)
Protein in urine	-	Negative (–)
Glucose in urine	-	Negative (-)
Stool for ova	-	No abnormality

On examination (head to toe), no abnormality was detected, fundal height was 22cm, presentation was cephalic according to scan, foetal heart rate was 138bpm and education on danger signs in pregnancy was given. She had no complains so was educated on the need to attend antenatal clinic regularly as scheduled. She was given her third dose of tetanus diphtheria (TD) injection. She was put on the following drugs;

1. Tab folic acid one daily x 30
2. Tab multivitamins 200mg daily x 30
3. Tab ferrous sulfate 200mg once daily x30

She made her routine visits regularly, no abnormalities were detected, laboratory investigation ultrasound scan requested were carried out with no abnormalities detected till she was met on the 9th of May 2022.

CHAPTER TWO

ANTENATAL CARE

2. 0 INTRODUCTION

Basically, this chapter deals with the first encounter with the client during the antenatal period, client‟s subsequent visits to the antenatal clinic, subsequent antenatal home visits as well as the nursing care plan for client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Rita was met for the first time on 9th May, 2022, when she was 37weeks pregnant which was her fifth visit to the antenatal clinic at Aggies maternity Home around 9:40am. Introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed at Berekum for eight weeks clinical and to write a care study on a chosen client. The desire to take her as a client was expressed to her and she agreed. All the procedures to be carried out on her were explained to her understanding and she agreed for them to be done. She was encouraged to ask questions when necessary and was also thanked for her co-operation. Her vital signs together with some lab investigations done on her were recorded below.

Temperature	-	36.0 degree Celsius
Pulse	-	86 beats per minute
Respiration	-	23 cycles per minute
Blood pressure	-	110/710millimeter of mercury
Weight	-	79 kilograms
Hemoglobin level	-	11.5 g/dl

Specimen bottle was given to her to collect midstream urine to be checked for the presence of protein and glucose by the use of a urine reagent strip and the test read negative. Permission was sought from her for head to toe examination to be performed and she consented. All the necessary requirements needed for the examination were gathered and sent to the examination

room.

A tray comprising of the following items was set; sterile gallipot with sterile cotton wool swabs with a lid, receiver for used cotton wool swabs, tape measure, fetal stethoscope, a watch with a second hand, a pen and client‟s folder.

Privacy was provided using a screen and also drawing down the curtains to make her feel comfortable after explaining the procedures. Having emptied her bladder, permission was sought for head to toe examination to be carried out and she granted. She was assisted to undress and wrapped herself with a cloth. She was helped to lie on the examination couch. Hands were thoroughly washed with soap under running water and dried with clean towel. She was asked to assume a dorsal position. Physical examination from head to toe was carried out under the supervision of the midwife in- change and the aim was to help detect any abnormality or deviation from normal for prompt management.

On examination of the head, her hair was nicely braided. Her hair was inspected for dandruff, cleanliness, alopecia (loss of hair) and lice, among others. The face for signs of oedema and chloasma but none was present and her eyes were also inspected for pallor of the conjunctiva, jaundice of the sclera, sunken eyes and discharges but the conjunctiva was pink in colour, sclera was clear and no sunken eyes or discharges. The nose and ears were inspected for growth, discharges or bleeding but there were none. The mouth was inspected and the lips were moist without cracks, dryness and inflammations. She was engaged in a conversation just for her to open her mouth for quick assessment of the mouth. The gums and tongue where pink without sores, lesions or bleeding. Her teeth were strong, whitish in colour with no odour from the mouth. Neck was also inspected and palpated for enlarged thyroid glands, enlarged lymph nodes and distended neck vein but there was none.

After explaining procedure, inspection proceeded with initial inspection of breasts. After exposing both breasts, the right breast was a little bigger than the left breast and breasts were normally situated with prominent nipples which were centrally placed. The breast looks hemispherical in shape. Primary and secondary areola was present with Montgomery‟s tubercle fairly distributed. Breast was inspected for rashes on the skin and nipple whether everted or inverted. Both breasts were palpated for lumps, enlarged axillary lymph nodes, but none was present. The nipple and areola were gently pressed, and colostrum was expressed and it was swabbed with a sterile cotton wool swab and smelt for bad odour, but it was not offensive and

was shown to her. She was educated that the colostrum would serve as the first line of immunity and prevents allergies to the child and she was educated to feed the baby with it when delivered. Client was congratulated and educated to support the breast with a firm brassier with broad stripes. She was educated on the need for self- breast examination and encouraged to regularly examine her breast at least once in a month after her menses and if any abnormality is detected, she should report to the midwife or any other staff on duty. She was told she can examine her breast when bathing, lying down or standing in front of a mirror.

Her upper limbs were of equal size and length. Client was asked if she had tingling and tightness of the fingers on making a fist and she said no. The palms were inspected for pallor, the nails including the capillary refill of the nail beds were checked and they appeared to be pink in colour. Madam Rita"s finger nails were overgrown and painted, with no extra digit.

On examination of the lower extremities, legs were palpated for oedema, tenderness of the calf muscle and none was present and also inspected for varicose vein which were absent and they were of equal size and length. Her toe nails were neatly but painted and kept long. she was encouraged to keep her nails trimmed and short without painting to help identify pallor and avoid dirt.

She was assisted to lie on the lateral side for examination of her spine but no abnormality such as oedema of the sacral region, scoliosis, kyphosis was detected and her vertebral column was normal without pain at the costovertebral angle.

ABDOMINAL EXAMINATION

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal standing on her right side. Items used for the examination were shown to her to allay fear.

ON INSPECTION, shape was ovoid, and the size corresponded with the gestational age, no striae gravidarum present but linea nigra was seen from the symphysis pubis to the umbilicus and fetal movements were visible. No scars were seen on the abdomen.

SYMPHYSIO-FUNDAL MEASUREMENT commenced by first rubbing the palms together to generate warm in order to prevent stimulation of contractions. The zero end of the measuring tape was placed on the fundus of the uterus and the tape was extended to the upper border of the symphysis pubis and the symphysio-fundal height was 36 centimeters and her gestational age was 37week.

ON FUNDAL PALPATION palms were placed on either side of the fundus with fingers curved around the fundus to detect what was occupying the fundus. A soft mass was felt indicating the buttocks.

ON LATERAL PALPATION hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus was palpated in a rotational manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. The position was therefore right occipito anterior.

ON PELVIC PALPATION Madam Rita"s feet were faced and she was asked to flex her knees (legs) slightly and to breathe out slowly to relax the abdominal muscles. Palms were placed on either side of the uterus, with one palm just below the level of the umbilicus and fingers directed towards the symphysis pubis with thumbs almost meeting. A hard mass was felt which indicated the head and that the presentation was cephalic.

DESCENT of the head was assessed by locating the anterior shoulder and two fingers (left) were kept over the anterior shoulder and upper border of symphysis pubis was located. Placing the right ulna border just above the symphysis pubis and anterior shoulder, all the five fingers accommodated the area indicating descent was $5/5^{th}$ above the pelvic brim.

AUSCULTATION was done with fetal stethoscope; it 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 to without touching the fetal stethoscope. By the use of a breast watch, fetal heart beat was counted for one full minute while comparing it to the maternal pulse it was 146 beats per minute taking note of the volume and rhythm.

Permission was sought from client to conduct **vulva examination** and she agreed. She was asked to flex her knees and separate her leg. On inspection, it was realized that she had maintained a good personal hygiene and she was therefore commended. The vulva was clean and well shaved with no varicose veins, warts, oedema and no discharges or blood. She was assisted to lie on her side, sit up and got down from the couch and also assisted to dress up. She was made comfortable by offering a seat and she was thanked for her co-operation. Hand washing was done with soap under running water and dried with a clean towel.

Afterwards, all findings were communicated to her understanding and she was encouraged to ask questions which she said she had none. However, when asked of her complaints, she complained of and constipation. She was reassured and educated to take in more fruits and also eat enough fiber diet such as cereals, whole grains, vegetables and fruits. She was also educated that the pain was due to stress after ruling out other signs of malaria. Madam Rita was encouraged to rest in between work, have enough rest and to take her drugs as prescribed. Education was given on birth preparedness and complication readiness she was advised that when she goes home, she should gather all the necessary items she would need during labour in one bag as very soon she may be due for delivery.

She was also encouraged to report any abnormality to the hospital very early so that early treatment could be given to prevent further complications even when it was not yet time for her to come to antenatal clinic. She was also reminded about her next visit to the clinic as 23rd May, 2022. It was made known to her that a visit would be paid to her house to discuss some important issues pertaining to her pregnancy which would be beneficial to her health and that of the fetus which she willingly agreed and gave her number and directions to her house.

Her medications given were as

- Tablet Ferrous Sulphate 200mg daily for 30 days
- Tablet Folic Acid 5mg for 30 days.
- Tab paracetamol 1g tid for 3 days.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Rita"s house was on 13th May 2022 at 2;00pm. The aim of the visit was to observe the environment where she lives, her source of water and light, how well ventilated her room is and the number of people she shares her room with, where she attends to natures call, how she disposes her refuse and also how she relates with her family members and her co-tenants in the house. The journey was made with a tricycle and it is about fifteen minutes" drive from the facility.

On arrival, it was realized that she lives in a compound house with her co-tenants. A warm welcome and a seat were offered in her room. She was asked how herself and the family were faring which she responded that they were all fine. She was asked whether she was doing something but she said she just finished with her chores. During the interaction, it was identified that she lives in a single room with her children and husband.

The room was divided by curtains and part was used as a hall and they slept behind the curtains. The area before the curtains was well kept and the furniture was arranged nicely, it had adequate lightening and ventilation she was congratulated and asked to keep it up. She added that in the night she lays a mat on the floor for the children to sleep and she and her husband share the bed. She was asked whether the children sleep under an insecticide treated bed net but she said no since they sleep on the floor. She was educated on the importance of sleeping under a treated insecticide net and advised to find a carpenter to put some nails on the wall and also get a conical shaped insecticide treated bed net from the health facility so that during the evening she could hang it for the children to sleep under and early the next morning she could remove it which she agreed. The area behind the curtains was neat but clothes were hanged loosely on the wall and cross bar. Their clean clothes were well packed into their various bags.

They had a wooden bed with an insecticide treated net hanging loosely over it. She was advised to fold and pack the clean clothes nicely into their various bags and also not to hang any clothes whether dirty or neat on the cross bar since mosquitoes can hide in them and bite them at night. She was also advised to put her laundry in a basket or get a box and keep the dirty clothes in.

A walk was taken around the house. It is a four bed room house built with cement blocks and

roofed with aluminum sheets. It has a separate corridor and a wash room. Client together with other tenants cook on the corridor. There were no dirty dishes found around. The toilet and bathroom were also well kept because it was scrubbed on daily basis by occupants. A pit has been dug in a nearby bush where they discard refuse and burn them. They fetch water from a nearby tap in their vicinity.

Madam Rita was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. She was encouraged to eat more fruits and vegetables and drink more water. Her layette was inspected and it was complete, however they were in separate polyethene bags. She was encouraged to pack the items in a single bag and identify a birth companion. She was thanked and permission was sought to leave. She was informed about the next visit on 20th of May 2022.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Rita‟s house was on the 20th of May 2022 at 1:00pm. She was met cooking with her husband lying on the floor playing with their younger child. They were greeted and a warm welcome was given and a seat offered. The wellbeing of the family was inquired and she said they were all doing well by God's grace and that the elder child has not yet close from school. The aim of the visit was to inquire about her health whether some changes have been made on what were discussed the other time about the fixing of insecticide treated net for the children and also keeping, arranging their bedroom well and neat and if constipation has subsided. On inspection all these things were corrected as taught, her sister was her birth companion and she had packed her delivery items with a purse of money and her insurance card as well as antenatal book. She was then congratulated and asked to keep it up. She said she was able to pass stool once within 48 hours and sometimes twice within 48 hours after an enquiry was made on her previous complain of constipation. Education on rest and sleep as well as true labour signs such as painful rhythmic uterine contractions, appearance of “show” was given to her and told to report to the clinic anytime she saw any of those signs. She was allowed to ask questions and appropriate answers were given. She complained of heart burns and sleep disturbance. She was educated to empty her bladder completely before going to bed and keep a chamber pot close to her to avoid walking long distance in the night to empty her bladder. Permission was sought to leave, she was thanked and reminded of her next visit to the clinic.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 23rd of May 2022, Madam Rita visited the clinic around 8am. She was warmly welcomed and a seat was offered to her. She was asked how she was faring and she said she was fine. Enquire was made on her previous complains of heart burns and sleep disturbance and she confirmed they have subsided Her weight checked was 80kg. Her vital signs were checked and recorded as follows;

- Temperature 36.4degree Celsius
- Pulse 69 beats per minutes
- Respiration 17 cycle per minute
- Blood Pressure 110/70 millimeter of mercury

Sample of her urine was taken and checked for protein and glucose and they were all negative. All procedures to be carried out on her were explained to her and privacy was provided. Hand washing was done with soap under running water and dried with a clean towel. She was assisted onto the examination bed; physical examination was done from head to toe and everything was normal.

On abdominal examination, the abdomen was seen to be ovoid and medium in size. Palpation was done and the fetal buttocks was located in the upper pole of the uterus whiles the back of the fetus was felt at the right side of the maternal uterus and the fetal limbs felt on the left side of the mother. The lie was longitudinal. The head occupied the lower pole and the descent checked was 4/5th. The symphysio-fundal height was 36cm with a fetal heartbeat of 138 beats per minute and gestational age 39weeks.

All findings were communicated to her after the procedure and she was thanked for her co-operation. She was asked whether she had any complaint that day and she complained of backache. She was reassured and told that the pain was as a result of the effect of the hormones progesterone and relaxin which relaxes the pelvic ligaments and muscles. She was advised to maintain a straight back when even lifting light objects and also to get a hard board under her mattress for a firm back support. She asked for permission to leave and she was asked to come to the clinic for next visit on 23rd May 2022.

2.5ANTENATAL NURSING CARE PLAN

PROBLEMS IDENTIFIED

1. Overgrown fingernails
2. Constipation
3. Heart burns
4. Sleep disturbance

SHORT TERM OBJECTIVES

1. Client will maintain short finger nails throughout pregnancy and beyond.
2. Client will be able to move her bowel at least once within 48 hours.
3. Client heartburns will reduce and cope with throughout pregnancy.
4. Client will have at least two (2) hours of sleep within 24 hours.

LONG TERM OBJCETIVES

Madam Rita will go through pregnancy, labour and puerperium safely without any complications

ANTENATAL CARE PLAN

Date /Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
09/05/22 10:00am	Overgrown finger nails related to ignorance	Client will maintain short finger nails throughout pregnancy and beyond.	1. Reassure client 2 Educate client on the importance of keeping shorter finger nails 3. Educate client to wash her hands frequently. 4. Educate client to use soft brush to wash the tip of her finger nails after trimming.	1. Client was reassured 2. Client was educated importance of good personal hygiene to her and her baby 3. Client was educated to wash her hands frequently. 4Client was educated to use soft brush to wash the tip of her finger nails after trimming.	26/5/2022 10:00am	Goal fully met as Madam Rita was seen with shortly trimmed nails.	

ANTENATAL CARE PLAN CONT'D

Date /Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
13/5/22 2:00pm	Constipation related to increase progesterone which causes relaxation of the smooth muscles	Client will be able to move her bowel at least once within 48 hours. as evidence by Madam Rita verbalizing.	1. Reassure client 2 Explain the physiology of constipation to her. 3. Educate client to eat foods containing roughage like vegetables and fruits. 4. Encourage the intake of at least 2000 mls of water within 24 hours	1. Client was reassured 2. She was told it was due to the effect of progesterone on her GIT. 3. Client was advised to eat foods containing fruits and vegetables. 4. Client was encouraged to take at least 2000mls of fluids within 24 hours	15/05/22 2:00pm	Goal fully met as client said she moved her bowel once.	

ANTENATAL CARE PLAN CONT'D

Date /Time	Nursing Diagnosis	Nursing Objectives/ outcome criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
20/05/2022@ 1:00pm	Heart burns related to increased progesterone level causing the relaxation of the cardiac sphincter	Client heartburns will reduce and cope with throughout pregnancy. as evidence by: Client verbalizing it.	1. Reassure client. 2.Educate client on the causes of heart burns. 3.Encourage client to go to bed at least 30 min after meals. 4. Educate client to elevate the head end of the bed when sleeping 5. Educate client to decrease the intake of spicy foods	1. Client was reassured 2. Client was educated that it was due to regurgitation of gastric content due to relaxation of the cardiac sphincter. 3. Client was encouraged to go to bed at least 30 minutes after meals. 4. Client was educated to use more pillows when sleeping to elevate the head end of the bed. 5Client was educated to decrease the intake of spicy foods	23/5/22 9:00am	Goal fully met as the intensity of heartburns reduced.	

Date /Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
20/05/22 1:00pm	Sleep disturbance related to frequency of micturition	Client will have at least two (2) hours sleep within 24 hours as evidence by client verbalizing that she slept for at least two (2) hours.	1. Reassure client 2. Educate client on the physiology of frequent micturition. 3Educate client to take a warm bath before going to bed 4. Tell client to urinate before going to bed. 5. Educate client to limit the intake of fluid at night 6.Encourage client to eat before 6pm	1. Client was reassured 2. She was educated that it was due to descent of the presenting part. 3Client was educated to take warm bath before going to sleep 4. Client was told to urinate before going to bed. 5. She was also educated to limit the intake of fluids such as tea, caffeine at night. 6.Client was encouraged to eat before 6pm.	21/5/2022 1:00pm	Goal met as client reported that she slept for 3 hours.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, the immediate care of the newborn, examination of the newborn and the care plans drawn for the management of the problems encountered during labour. The goal of care during labour and delivery is to ensure the most positive outcome mainly a healthy mother and baby.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

ADMISSION

On 24st May, 2022, Madam Rita reported to the labour ward at Auntie Aggies Maternity Home around 12:40am with her husband with the complaints of lower abdominal pain. Rapport was established and they were offered seats. Client was taken to the nurses‟ station for necessary information to be taken while glancing through her antenatal card. She was asked if she had experienced any danger signs like, bleeding from the vagina, leakage of liquor and persistent vomiting. Madam Rita replied that she had not seen any of the signs. She appeared anxious she was asked the reason for her anxiety and she said she does not know how the labour will end. and she was told that she was in competent hands and that she would have a safe delivery. History of her last meal, last bowel action and if she has taken any medication were taken.

Madam Rita said lower abdominal and waist pains started at 6:00am and also noticed the appearance of „show‟. Madam Rita‟s husband was reassured that everything was going to be alright. Client was sent to the examination room and assisted to change her clothing. Permission was sought to examine her and all procedures were explained to her.

She was then asked to pass urine and her urine measured 100mls, midstream sample was tested for albumin, sugar and acetone but the results were negative. She was assisted to lie on the couch and a quick examination from head to toe revealed no abnormality.

Her vital signs checked and recorded were as follows:

Temperature	-	36.6^{o}C
Pulse	-	88 beat per minute
Respiration	-	22 cycle per minute
Blood pressure	-	109/81 mmHg

Abdominal examination was then carried out after privacy was provided. On inspection the shape of the abdomen was ovoid, linea nigra and fetal movement were noticed. Fundal, lateral and pelvic palpations were performed. The symphysio-fundal height was 36 cm, the lie was longitudinal, and presentation was cephalic. The descent of the head was 2/5th above the pelvic brim and uterine contraction was 3 in 10 minutes lasting 30 seconds. On auscultation fetal heart rate was 140 bpm with good volume and regular rhythm.

A sterile tray for vaginal examination was brought to the bed side and the procedure was explained to her. Hands were washed and dried and sterile gloves worn. The vulva was inspected for rashes, varicose veins, warts, scars and oedema but none was present. The vulva was swabbed with savlon solution, using sterile swabs, the labia majora were swabbed with two sterile cotton wool soaked in savlon solution, the labia minora was also swabbed the same way and a single cotton wool soaked in savlon solution was used to swab the vestibule after which vaginal examination was carried out.

The vagina felt moist, warm and distensible. The cervix was thin, soft, effaced and the presenting part well applied to it. The cervical dilatation was 4cm with membranes intact. No moulding was felt. The sacral promontory was not reached, the sacrum was well curved and the ischial spines were blunt. She was asked to lie on her side and a fist was placed in between the tuberosities and it admitted the fist. Client was cleaned after the examination and a clean perineal pad was applied to the vulva.

Madam Rita was tidied up and encouraged to lie on her left side. All findings were explained to her and reassured that labour was progressing well. All procedures were done under the supervision of the midwife-in-charge and recorded on a partograph.

PREPARATION FOR BIRTH

A skilled helper was identified, the midwife in charge was also supervising the delivery. She was made aware that her assistance may be needed if the need arose. The non-skilled helper was the client husband and he was also made aware that he would be called to help when needed. The phone number of the referring hospital was made available in case of any emergency and also a driver was informed that in case of emergency he would be called.

The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, light was switch on, and touch light was also made ready in an event of light off. Hands were washed with soap and water and dried with clean towel. The client was also assisted to wash her hands, chest and abdomen with clean water and soap and dried with clean towel to prepare for skin to skin contact. Delivery set was available waiting to be set at appropriate time. Oxytocin and other emergency drugs like magnesium sulphate were also made available.

Resuscitation area was made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for their function ability.

MANAGEMENT OF FIRST STAGE

The fetal heart rate, maternal pulse and uterine contractions were checked every 30 minutes, temperature, blood pressure, descent as well as vaginal examination was done 4 hourly and the results plotted on the partograph. She complained of tiredness and was reassured and encouraged to avoid screaming and perform deep breathing exercise when there are contractions. Again, milo and bread were served. She was stayed with; sacral massage was given and was also supported to breathe through her mouth. Madam Rita was reassured that labour was progressing well and was encouraged to pass urine frequently to prevent her bladder from being full, since this could impede descent of the fetus.

Madam Rita was asked to lie on her left lateral to prevent supine hypotensive syndrome or ambulate to enhance descent. She complained of tiredness. She was then encouraged desist from shouting when in pain and to take sips of water to quench her thirst and to keep her mouth and throat wet.

At 4:40 am, she was due for her next V/E. The procedure was explained to her and was asked to empty her bladder before doing the next examination. At this time the fetal heart rate recorded was 140beats per minute with good volume and rhythm. Descent of the fetal head was 1\5th and uterine contractions were 4 in 10-minute lasting 38 seconds. On vaginal examination cervical dilatation was 8 cm with intact membranes and moulding was not felt.

Her vital signs were checked and recorded as follows.

Temperature	-	37.0 ^{o}C
Pulse	-	84 beats per minute
Respiration	-	20 cycles per minute
Blood pressure	-	120\78 mmHg

All the findings were communicated to her and recorded on the partograph. She was reassured, encouraged to continue with the relaxation techniques and do deep breathing exercise. She was also given sips of water. She was cleaned with a wet towel since she was sweating profusely.

The delivery trolley was set containing the following;

TOP SHELF

- Sterile scissors
- sterile gloves
- Two sterile artery forceps
- sterile drape
- sterile membrane pierce
- cord clamp
- Sterile episiotomy park containing scissors and suturing forceps
- sterile gallipots

- injection tray containing 10 units of oxytocin, vitamin k, syringe and needle

BOTTOM SHELF

- Drum containing gauze and cotton wool
- chittle forceps
- jug for measuring the amount of blood loss
- urethral catheter and drainage bag
- examination gloves
- Identification band

Other items included sutures, lidocaine face mask, goggle, boots, plastic apron, baby‟s cot with cot sheets and baby‟s dress, bed pan, light source were brought closer.

At 6:40am Madam Rita complained of severe bearing down sensations with the uterine contractions becoming more expulsive and frequent. The anus was gapping with the perineum bulging. Vaginal examination was repeated, cervix was fully dilated bulging membrane which was artificially ruptured. Liquor was clear and moulding was ++ since the bones were overlapped each other but easily be separated. Foetal heart rate was 140bpm, contractions were 4:10 for 45 seconds, descent was 0/5th. The midwife in-charge confirmed the findings.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Rita was transferred to the second stage room and positioned on the delivery bed at 6:40am. What is expected of her during the delivery was explained to her. She was asked to empty her bladder and then was assisted to lie in the dorsal position with knees flexed apart. She was reassured and every procedure to be done was explained to her. Protective clothing such as mackintosh apron, rubber boots and goggles were worn. Hands were washed with soap under running water and dried with sterile towel and sterile gloves were worn on both hands. The vulva and the upper thigh were swabbed with savlon solution and client draped with sterile towels. She was reminded that her baby will be delivered unto her abdomen to provide warmth and improve bonding. A clean perineal pad was applied to the anus to keep the delivery area clean. Madam Rita was encouraged to push with each contraction and rest in between contractions. The midwife in –charge checked the maternal pulse and fetal heart rate to ascertain the condition of both mother and fetus. This was done following uterine contractions to assess the recovery rate of the fetal heart rate after contractions and was recorded.

As labour progressed, the head advanced gradually and flexion was aided by gently pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, Madam Rita was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum and the head was slowly delivered by extension to prevent tear and injury to the baby. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The face was cleaned with gauze swabs. The cord was quickly felt for around the baby‟s neck but there was none.

The head was supported and restitution was allowed to take place and internal rotation of the shoulders as indicated by external rotation of the head through 45 degrees took place. This brought the shoulders into anterior-posterior diameter of the pelvic outlet. Client was asked to push with the next contractions. Both palms were placed on either side of the baby‟s ear and gently pressed the head downwards to deliver the anterior shoulder which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered. The rest of the body was delivered by lateral flexion unto the mother‟s abdomen at 6:55 am. An alive healthy female baby was delivered who cried soon after delivery. The baby was quickly cleaned from head to toe with a clean cot sheet and wrapped her with another clean cot sheet while on her mother‟s abdomen after client confirmed the gender as a female. Client was congratulated for her efforts. The baby was moved to the mother‟s chest for skin-to-skin contact and covered them with a new sheet. Mother was informed that the baby was going to be there for an hour to improve bonding and initiate breastfeeding.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head of the baby was born. Different sterile gauze was used to clean the baby‟s eyes from inner canthus outwards. The face was wiped with gauze. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The cord was clamped and cut in between two clamps. The baby was shown to mother to confirm the sex of the baby. Identification band was prepared with the mother‟s name, baby‟s sex, weight and date of birth and was tied around the baby‟s wrist. Baby was then cleaned and wrapped in a warm sheet with the head covered with a cap to prevent hypothermia.

The baby was put to breast to ensure the natural release of oxytocin to help with the contraction of the uterus, initiate lactation and promotion of bonding between mother and baby. The baby was then nursed with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

3.4 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

After the cord separation, a sterile receiver was placed near the vulva in between the thighs to receive the end of the cord. Client"s abdomen was palpated to rule out any second foetus in utero before 10 units of oxytocin was given intramuscularly by the midwife-in-charge to prevent any bleeding. The client was asked to empty her bladder which she said she had no urge. The left hand was placed on the fundus to feel for contractions. As soon as contractions were felt, the clamp was held with the right hand while the left hand was placed on the lower abdomen in the suprapubic area to push the uterus. The right hand which held the clamped cord, was used to apply gentle downward traction in a downward and backward direction. Counter-pressure was maintained with the left hand on the suprapubic area while traction was applied to the cord until the placenta was visible at the vulva. Both hands were used to receive the placenta at the introitus and placed in a bowl at 7:00 am.

The uterus was massaged to maintain the contraction. Client was thought to massage her uterus and she was asked to feel the hardness of the uterus which indicated that the uterus was well contracted. This procedure was done every 15minutes for two hours making sure the uterus was firm, while blood loss was checked.

The placenta and membranes were examined quickly, and all the lobes were complete and healthy. The uterus was massaged and blood clots were expelled. Perineum, vaginal walls and cervix were examined under a light source and there were no tears.

The blood loss was approximately 100mls. Client was cleaned and a new perineal pad was placed at the perineum to make her comfortable in bed. Client was encouraged to change her pad and urinate frequently to prevent postpartum hemorrhage, and infections. She was also educated on how it would help in the contractions of the uterus.

Madam Rita was congratulated for her cooperation. The delivery bed was cleaned and the equipment‟s used were decontaminated in 1:9 chlorine for 10 minutes and then washed in warm soapy water, rinsed under running water. The equipment was put into the autoclave machine for sterilization and stored.

3.5 EXAMINATION OF PLACENTA AND MEMBRANES

After client was made comfortable in bed, the placenta was examined thoroughly in the sluice room. The maternal surface was examined in a cupped hand with no missing lobe, and membranes were intact. The cord was situated at the center of the placenta and there was one vein, two arteries in the cord and no abnormality was detected. The placenta was held by the cord allowing membranes to hang down. The membranes were spread out to aid in inspection. On examination; the chorion and amnion were intact. The fetal surface was smooth with shiny and bluish-grey in colour. The maternal surface of the placenta was red with complete lobes separated by grooves (sulci).

The placenta was discarded after decontaminating it. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed and put in the autoclave after which the instruments were stored. Hands were dipped in 0.5% chlorine solution before discarding the gloves. Amount of blood loss was 150ml. Client was congratulated for the effort made.

3.6 MANAGEGEMENT OF FOUTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are under continuous observation in order to detect early complications, Madam Rita and her baby were monitored for one hour in the delivery room before transferring them into the lying-in-ward for continuous monitoring.

BABY

PREVENTION OF DISEASES

The following procedures were performed to prevent serious infection to the eye, cord and also prevent hemorrhagic disease of the newborn.

Two (2) drops of chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton and methylated spirit and vitamin K 1.0mg intramuscularly was given to the baby after head to toe examination was done. Baby skin was smeared with baby oil to provide warmth. Hands were washed with soap under running water and cleaned with dry towel.

EXAMINATION OF THE NEW BORN

The procedure was explained vividly to Madam Rita, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a covered flat surface and only the part to be examined was exposed. The head was examined for bulging and sunken of fontanels, size, shape, laceration and caput succedaneum but no abnormality was detected. Head circumference was measured by encircling the head with tape measure from occipital protuberance to the supra orbital ridges and it measured 34cm and the baby"s length was 54cm. The ear was examined for position, size, and patency. Eyes (conjunctiva) were also examined for pallor, sub conjunctiva hemorrhage and abnormal discharges but no abnormality was detected. The nose was also inspected for size, shape and nostrils checked to rule out deviated septum but everything was normal. The mouth was inspected for cleft palate, tongue tie, false teeth and suckling, rooting and swallowing reflexes were checked but everything was normal. The neck was examined for congenital goiter and swollen lymph nodes but there was none. The chest was inspected for shape, size and chest wall movement with respiration and respiration rate was 44 cycles per minute and the apex heart beat was also 130 beats per minute. Breasts were palpated for masses and nipple was checked for position and extra nipple and everything was normal. Examination of the upper extremities was done and hands were inspected for clubbing, extra or missing digits and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer crease. Shape and colour of nail beds were inspected and reflexes (grasping, Moro) checked but were normal. The abdomen was examined the size and shape were normal. The cord was inspected but no bleeding was noted. The liver and spleen were palpated for enlargement and no abnormalities were detected. With the lower limbs, no webbing, extra toes and club foot were found. The baby was turned prone with the head on one side and the spine was checked for swelling, spinal bifida and for missing vertebrae, but no abnormalities were noticed. On examination of the skin, the skin was pink and no abnormality found. The anus and the rectum were inspected for patency and no

abnormality was detected since the baby had passed meconium and urine. The baby was weighed and it recorded 3.6kg. The temperature was checked and it was recorded as 36.5 degrees Celsius.

Gloves were removed and disposed of. Hand washing was done and dried with clean towel. All finding was then communicated to the mother and documented. The baby was then classified as a normal baby and routine care initiated. The baby was wrapped in a warm dry sheet and was placed beside her mother to breastfeed.

MOTHER

Client"s vital signs as well as her uterus and lochia were checked 15 minutes for two hours, 30 minutes for an hour and hourly for three hours. Her vital signs were checked and recorded as follows:

Temperature - 36.5oC

Pulse - 84 beat per minute

Respiration - 20 cycle per minute

Blood pressure - 115/65 mmHg.

Madam Rita was asked to empty her bladder frequently in order to help contractions of the uterus. She was served with warm beverage and also encouraged to establish bonding and to initiate and maintain lactation. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also as a form of family planning.

Madam Rita was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was well contracted and symphysio-fundal height was 18cm, there was no active bleeding from the vagina. She was encouraged to report if she saw any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. The findings of all assessments carried out were within the normal range. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of skin was pink.

3.7 SUMMARY OF LABOUR AND DELIVERY

Date of delivery - 24th May 2022

Time of delivery - 6:55am

Type of delivery - Spontaneous Vaginal Delivery

Time of placental delivery - 7: 00am

Duration of labour

1st stage - 8 hours ,30mins

2nd stage - 15 minutes

3rd stage - 10 minutes

Total - 8 hours 55 minutes

Condition of baby

Apgar score at first minute - 8/10

Apgar score at fifth minute - 10/10

Sex of baby - female

Weight - 3.6 kg

Head circumference - 33 cm

Full length - 50 cm

Meconium - Passed

Urine - Passed

Condition - satisfactory

Condition of mother

Temperature	-	36.0 °C
Pulse	-	78 beat per minute
Respiration	-	19 cycles per minute
Blood pressure	-	115/65 mmHg
Fundus	-	19 cm
Lochia	-	Red (rubra)
Odour of Lochia	-	Non – offensive
Perineum	-	Intact
Condition	-	Satisfactory

Condition of placenta and membrane

Lobes and membranes	-	Complete and healthy
Maternal surface	-	Normal
Foetal surface	-	Normal

NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

1. Lower abdominal pains
2. Anxiety.
3. Fatigue
4. Profuse sweating.

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pain throughout labour.
2. Client‟s anxiety will resolve at the end of labour.
3. Client will regain her strength within 2 hours after labour.
4. Client‟s profuse sweating will reduce for her to cope with throughout labour

LONG TERM OBJECTIVES

Client will go through labour, delivery and puerperium successfully without complications to client and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
24/05/22 3:00am	Lower abdominal pains related to physiology of labour.	Client will cope with lower abdominal and waist pains throughout labour. as evidenced by client verbalizing	1. Explain the physiology of labour pains to her. 2. Reassure client that labour will soon end. 4. Encourage client to perform breathing and relaxation exercises 5. Provide diversional therapy 6. Perform sacral massage for client.	1. The physiology of labour pains was explained to her 2. Client was reassured that labour would soon end 4. Client was encouraged to perform breathing and relaxation exercises 5. Client was stayed with and engaged in a conversation 6. Client"s sacral region was massaged by her support person.	24/5/2022 7:00am	Goal fully met as client said she was coping.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
24/5/22 3:00am .	Anxiety related to unknown outcome of labour.	Client‟s anxiety will resolve at the end of labour. as evidence by client verbalizing that she is no longer anxious.	1. Reassure client. 2. Explain every procedure to be carried to client. 3. Allow her to ask questions and answer her tactfully. 4. Update client with progress of labour. 5. Allow support person to be with her	1. Client was reassured that labour will end safely. 2. Procedures like checking of vital signs, vaginal examination were explained to client. 3. Client was allowed to ask questions and answers were given tactfully. 4. Client was updated about progress of labour using the dilatation board after V/E. 5. Client‟s husband was allowed to be with her and massage her sacral region during contractions.	24/5/20 7am.	Goal fully met as client said she was no longer anxious.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/5/2022 3:30 am	Fatigue related to advance state of labour.	Client will regain her strength within 2 hours after labour. as evidence by the client verbalizing	1. Reassure client. 2. Encourage client not to scream during contractions. 3. Encourage client to continue with the relaxation technique. 4. Support client to perform deep breathing exercise during 5. Serve client with light diet	1. Client was reassured that she will regain her strength. 2. Client was encouraged not to scream during contractions. 3. Client was encouraged to continue with the relaxation technique. 4. Client was supported to perform deep breathing exercise during contraction. 5. Client was served with milo and biscuit/	24/05/22 8;00 am	Goal fully met as client verbalized, she had been relieved of tiredness.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/5/2022 6:00am	Profuse sweating due to the process of labour	Client"s profuse sweating will reduce for her to cope with throughout labour as evidenced by client verbalizing,	1. Reassure client. 2. Explain the process of labour to client. 3. Support client to perform deep breathing exercise. 4. Wipe client body with wet towel 5. Serve client with sips of water	1. Client was reassured. 2. Process of labour was explained to client. 3. Client was supported to perform deep breathing exercise during contraction. 4.Client was wiped with wet towel 5. Client was given sips of water and ice to suck	24/5/2022 7;30am	Goal fully met as evidenced by client sweating subsiding	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about the management of puerperium thus the care rendered to both mother and baby after delivery. It begins immediately after the expulsion of placenta and membranes and control of hemorrhage and ends at the 40th day or six (6) weeks after delivery.

4.1 DAY OF DELIVERY

Before transferring Madam Rita and her baby to the lying-in ward they were both assessed carefully. She was made comfortable in an already prepared bed. Madam Rita vital signs were checked and recorded as; Temperature-36.2$_0$C, Pulse-74 beat per minute, Respiration-20 cycle per minute, Blood pressure-120/80mmHg..On palpation the uterus was well contracted and the symphysio-fundal height was 18 cm above the symphysis pubis, lochia was small in amount and red in colour with no clots. She was advised to change her perineal pads frequently when soiled and to report any abnormal vaginal bleeding to the midwives on duty. Client was encouraged to urinate frequently since full bladder interferes with the contraction of the uterus with subsequent bleeding.

Madam Rita was encouraged to take in adequate fluid and eat a well-balanced diet to help repair worn out tissues and promote growth. She was served with a cup of beverage. She was also educated on how to position and attach the baby to breast and observed as she breastfed the baby. The baby was examined from head to toe and no sign of injury was observed. The baby‟s weight was 3.6 kg, respiration was 42cpm, and apex beat was 142 bpm.

4.2 SUBSEQUENT CARE OF THE BABY

At 1 pm, six hours after birth, Madam Rita was informed about the need for the baby to be bathed and she responded positively. The baby was then picked to be bathed in the presence of the mother so that education could be given during the procedure.

REQUIREMENT FOR BABY BATH

TOP SHELF

- Methylated spirit in sterile galipot
- Sterile cotton wool swabs and gauze in a galipot
- Surgical gloves
- Sterile water in a galipot
- Baby‟s diapers
- Baby‟s dress
- Baby‟s towel and cot sheet to wrap the baby
- Baby‟s oil or Vaseline
- Baby‟s sponge
- Baby soap in a soap dish

BOTTOM SHELF

- Disposable gloves
- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water
- Mackintosh apron

After picking all needed items, the cold and hot water were mixed and the temperature was tested with the elbow. The plastic apron was then worn; hands were washed with soap under running water and dried with clean towel. Gloves were then worn and the baby was placed on a protected flat surface, undressed and covered with the towel living the face. The eyes were cleaned with a sterile cotton, dipped in sterile water from the inner canthus outwards and disposed into a receiver. The face was cleaned with a wet face towel. The nape of the neck was supported by the left palm and the ears were plugged with the thumb and index finger to prevent water from entering the ear. Mother‟s attention was drawn to this. The baby‟s head was washed in a circular motion with a soapy sponge after which it was rinsed out and dried with a towel. The baby was placed on a flat surface and the rest of the body was bathed (arms, chest and back),

paying particular attention to the skin folds. The whole body was gently immersed in the bath of water with the head supported above the water level. Baby‟s body was dried with towel paying attention to the skin folds. Vaseline was applied all over the body of the baby to provide warmth. Gloves were removed, hands washed and dried. Sterile gloves were then put on. Cord was inspected for bleeding and there was no bleeding. Sterile cotton wool swabs and methylated spirit was used to dress the cord. One was used to hold the clamp and the cord was dressed aseptically with a cotton wool swab soaked in methylated spirit from the base upwards to the cord clamp and left it opened to heal by dry gangrene. The baby was wrapped nicely to maintain the temperature. The baby‟s head was covered with a cap and dressed warmly to prevent heat loss and the baby was given to the mother to breastfeed in an effort to support breastfeeding. Mother was asked to fix the baby to breast by ensuring that she sat in a comfortable position, which meant the baby was attached well to breast and is sucking well. The baby‟s vital signs checked were recorded as: Temperature-36.0ºC, Respiration-38cpm, Heart rate-138bpm

The mother was educated that the baby should be fed at least 8 to 12 times a day and exclusively for six months. Mother was educated on breast feeding problems such as cracked or sore nipples, breast engorgement and mastitis. She was asked to report to the clinic especially if the problem was not resolved and also signs of engorgement were noticed. Mother‟s vital signs checked were recorded as: Temperature- 36.3ºC, Pulse-82, Respiration- 20 cpm Blood Pressure - 100/60mmHg.All findings were communicated to Madam Rita and all documentations were done.

4.3 FIRST DAY POSTNATAL (DAY OF DISCHARGE)

The first day after delivery was 25th May, 2022. Madam Rita and baby slept soundly during the night and their condition remained satisfactory. Madam Rita woke up looking cheerful and healthy. She was served with warm water to bath. Her vital signs were checked and recorded as follows; Temperature-36.2^{0}C, Pulse-74beat per minute, Respiration-20 cycle per minute, Blood pressure-120/80 mmHg.

Client was examined from head to toe and no abnormality was detected She complained of after pain. The breasts were heavy and colostrum was expressed. The uterus was firm and well contracted. Client complained backache and severe lower abdominal pains when the baby

suckles. Symphysio-fundal height was 16 cm above the symphysis pubis. Her vulva was inspected, the lochia was dark red in colour, flow was small and it was not offensive.

She was taught and supervised to do postnatal exercises. She was encouraged to keep the perineum clean and to use clean perineal pads to prevent infection. She was also reminded to wash her hands before and after changing her perineal pad.

The importance of good personal hygiene was explained to her, in order to prevent puerperal sepsis and neonatal infections to the mother and her baby respectively. Exclusive breastfeeding was also encouraged and Madam Rita was advised to top and tail the baby until the cord was off. Hands were washed and dried with dry towel and baby examined from head to toe and no abnormalities were found. The baby was topped and tailed in the presence of the mother and the cord inspected for bleeding or any infection but there was none. Hands were washed and dried, sterile gloves worn and cord dressed with methylated spirit and left it open to dry. Mother was advised not to apply any hot compress or concoction on the cord to prevent infection of the cord. Baby"s vital signs were checked and recorded as follows; Temperature-36.5oC, Apex beat-132 beat per minute, Respiration-43 cycle per minute, Weight-3.5 kg. Baby was immunized with Bacilli Calmette Guerin (BCG) 0.05 mls and oral polio „O" vaccine, 2 drops in the mouth to protect her against tuberculosis and poliomyelitis respectively. After this, client was advised not to apply anything at the injection site but to continue the immunizations at the child welfare clinic when the child was six weeks old in order to protect her against the childhood diseases like measles, yellow fever, pertussis among others. Mother and baby were declared fit by the midwife in-charge after all the examination. Client was informed about the discharge. She was helped to pack her belongings and the following drugs were prescribed for the mother;

Tablet folic acid - 5mg dly x 14 days

Tablet fersolate - 200 bd x 14 days

Tablet paracetamol - 1g tds x 5 days

The drugs and dosages were explained to her and the need to take the drugs was stressed. Her NHIS card was used to settle her bills.

Madam Rita was advised on the importance of keeping the baby"s cord clean and dry and to avoid the application of concoctions or unprescribed medications on it. She was educated on the importance of reporting to the clinic anytime they noticed danger signs like bleeding from the cord, offensive Odour from the cord or high temperature of the baby.

Client was also educated to avoid applying hot water on the baby"s fontanels and sutures. In order to prevent nappy rashes, she was advised to change the baby"s napkins whenever soiled and also apply baby"s oil on the buttocks.

Madam Rita was encouraged to sleep in mosquito net together with the baby to prevent malaria and advised to breastfeed the baby on demand. Her husband was also encouraged to help his wife to take care of the baby. Client was encouraged to have adequate rest and sleep. She was reminded of visits to her house to continue the care for seven days. The family was seen off.

4.4 FIRST POSTNATAL HOME VISIT (FIRST DAY POST NATAL)

Madam Rita was visited on 25th May, 2022 at 5:00pm with the aim to assess their general conditions and to detect early conditions that could be harmful to their health so as to give immediate treatment or refer to the hospital for further management. Permission was sought to examine the baby. The baby was placed in her cot and head-to-toe examination was done without any problem. The baby was topped and tailed, hands were washed and new sterile gloves were worn, cord was inspected and dressed. The cord was not offensive and was quite dry. According to Madam Rita, her baby passed meconium and urinated. Baby"s vital signs checked. Findings were recorded as follows; Temperature-36.6^{0}C, Apex beat-132 beat per minute Respiration-32 cycles per minute Suckling - Good, Cord - Clean and dry, Colour - Pink, Stool
- Meconium

Madam Rita was also examined from head to toe for any abnormality but none were present The breasts were heavy and full with colostrum expressed. The uterus was well contracted and the symphysio-fundal height was 16cm during abdominal palpation. She said she wanted to know more about family planning which she was educated on the various family planning methods. The lochia was red (rubra), small in quantity and not offensive. After the examination, all the findings were communicated to her. She complained of back ache of which she was ensure that it was due to the altered posture during late pregnancy and was assisted in positioning the baby

during breastfeeding to avoid worsening it. Vital signs were also checked. Findings were recorded as follows: Temperature-36.6^{0} C, Pulse-80 beat per minute, Blood pressure-110/60 mmHg, Pulse- 80 beat per minute, Respiration-22 cycle per minute , Breast - Lactating Uterus - Contracted. . Madam Rita was supervised to perform the postnatal exercises. She successfully attached the baby to breast and baby was able to suckle well. She was encouraged to make sure the baby empties one breast before giving the other breast to prevent engorgement and to make sure the baby takes adequate breast milk. Permission was then sought to leave and promised to visit them the next day.

4.5 SECOND POSTNATAL HOME VISIT (SECOND DAY POSTNATAL)

On the 26th of May 2022, Madam Rita and family were visited in the morning and evening to access their condition of health. She was reassured and encouraged to perform the postnatal exercise; for about ten to twenty minutes and also to continue the postnatal exercises to strengthen the pelvic floor muscles and also advised to breast feed the baby on demand as it helps in contraction thus involution of the uterus. She was enquired about the afterpain and backache and responded they had subsided a little.

Client permission was sought to perform physical examination and vital signs. The symphysio-fundal height was 14cm on abdominal palpation. On inspection of the vulva it was healthy and the flow of lochia was small and the colour was rubra .vital signs checked were recorded morning and evening respectively as ; Temperature- 36.6 ^{0}C , 36.8^{o}C, Pulse-80 , 83 beat per minute, Respiration-20 , 21 cycle per minute, Respiration-20 , 21 cycle per minute, Blood pressure-109/70, 110/60 mmHg ,Breast- Lactating , Lactating ,Uterus - Contracted , Contracted SFH - 14cm , 14cm

Permission was sought to examine the baby. The baby was top and tailed and cord examined, it was clean and dry and dressing was done. Baby"s vital signs were checked and recorded as follows; Temperature -36.8 ^{0}C, 36.3^{o}C Respiration -30, 36 cycle per minute Apex beat -132, 130 beat per minute Weight - 3.5, Suckling - Good, Good, Cord-Clean and dry, Dry and clean Colour - Pink. Pink, Stool - Meconium. Meconium

All the findings were communicated to the client and her family. Family planning education was reinforced and they promised to use a method after six weeks. They were congratulated for their cooperation and promised to visit the next day.

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

On the 27thMay, 2022, client was visited again during the morning and evening to continue the care of the baby, the mother and the family. Baby was topped and tailed, cord dressed and the cord was dry and shrinking. Baby was well and suckled well on the breast on observation. She said her baby passed stools and urine. Babies vital signs were checked and recorded in the morning and evening respectively as Temperature36.4^{0} C ,36.3^{0} C Apex beat-130, 133beat per minute, Respiration-29, 30cycle per minute, Weight- 3.4kg,3.4kg Suckling – Good, Good, Cord - Clean and dry , Dry and clean, Colour - Pink , Pink, Stool - yellowish, yellowish . Mother was also well, breast was lactating, uterus was well contracted and symphysio-fundal height was measured. Her assessment results were communicated to her and recorded morning and evening respectively as; Temperature-36.5^{0} C,36.5 ^{0}C, Pulse,80,84 beat per minute,- Respiration-20,22 cycles per minute, Blood pressure-120/80,110/70 mmHg, ,Breast- Lactating , Lactating, Uterus - Contracted, SFH - 12cm,Lochia - Rubra.

Madam Rita complained of sleeping disturbances as a result of night feeding. She was reassured and educated on the various positions she can assume during breastfeeding and also told to feed the baby on demand and to support the breast with a supportive brassier. They were promised to be visited again and thanked before leaving the house.

4.7 FOURTH POST NATAL HOME VISIT (FOURTH DAY POST NATAL)

On the 28th May, 2022, client was visited in the morning to continue the care of client and family. Mother and baby were in good condition when inquired. She added that the backache was resolving. Baby was topped and tailed, cord dressed and the cord was almost off. Baby was well and suckled well on the breast on observation. She said her baby passed stools and urine. Findings after assessment were recorded as Temperature-36.8^{0} C, Apex beat-132 beat per minute, Respiration-29 cycle per minute, Weight- 3.3kg, Suckling-Good, Cord Almost off, Colour - Pink, Stool- yellowish

Madam Rita was also assessed after explaining procedure to her and she emptying her bladder. Her symphysio-fundal height was 10cm. Lochia was inspected and it was pink in colour(serosa), odourless and small in flow. Vitals checked were recorded as Temperature -36.4^{0c}, Pulse-70 beat per minute, Respiration-20 cycles per minute, Blood pressure-120/80mmHg, Breast-Lactating, Uterus - Contracted. She was encouraged to do postnatal exercises, eat a well-balanced diet with more fruits and fluids, sleep under insecticide treated mosquito net with the baby to help promote and maintain adequate general health and prevent malaria. They were promised to be visited again and thanked before leaving the house.

4.8 FIFTH POST NATAL HOME VISIT (FIFTH DAY POST NATAL)

On the 29thMay, 2022, client and family were visited, hands were washed and dried after explanation of procedure. The baby was bathed since the cord fell the previous night. She was examined from head to toe but nothing abnormal was detected. The stump of the umbilical cord was cleaned with methylated spirit and left opened. No sign of infection such as redness was noted vital signs were checked and recorded as Temperature-37.0^{0} C, Apex beat-130 beat per minute, Respiration-32cpm, Weight -3.2kg, Suckling-Good, Colour-Pink Stool -Yellowish. Madam Rita complained of breast pains and breast engorgement during physical examination. She was reassured and encouraged to put on a firm brassier and continue to breast feed the baby on demand. She was also encouraged to allow one breast to be emptied before the baby is attached to the other breast. No abnormality was detected on the mother and baby during the general examination except for the mother‟s breast engorgement. Client‟s symphysiofundal height was 8cm and lochia was serosa. Vital signs checked and recorded as Temperature-36.7^{0} C Pulse-80 bpm, Respiration-20 cpm, Blood pressure-110/70 mmHg Blood pressure, Breast - Engorged, Uterus -Contracted, SFH -8cm, Lochia – Serosa. They were congratulated for their cooperation and permission was sought to leave.

4.9 SIXTH POST NATAL HOME VISIT (SIXTH DAY POST NATAL)

On the 30th May, 2022 client and family were visited, hands were washed and dried. Procedure was explained to client after which she went and emptied her bladder. The baby was bathed and examined from head to toe but nothing abnormal was detected in the presence of client and sister. The stump of the umbilical cord was cleaned with methylated spirit and left opened. The stump was healing nicely. Madam Rita said the breast felt a bit lighter. Baby"s vital signs were checked and recorded as wt.- 3.9kg, Temperature- 36.8^{0} C Apex beat 132 beat per minute, Respiration- 30 cpm, Suckling- Good, Colour - Pink, Stool - Yellowish. No abnormality was detected on the mother and baby during the general examination. Client"s symphysiofundal height was 6cm. On inspection, the lochia was creamy brown with scanty flow and not offensive. Client was advised to have adequate rest and sleep during the day while her sister cared for the baby. The sister was encouraged to assist her sister. All the findings were communicated to the client and her family. Family planning education was reinforced and they promised to use a method after six weeks.

Mother vital signs were checked and recorded as follows; Temperatue-36.5^{0} C, Pulse-80bpm, Respiration-20cpm, BP-120/80mmHg, Breast-Lactating, Uterus-Contracted, Lochia-Alba Permission was sought to leave and client was told the next day was going to be the last visit.

4.10 SEVENTH POST NATAL HOME VISIT (SEVENTH DAY POST NATAL)

On the 31st May 2022, Madam Rita and family were visited in the morning to access their condition of health. Client permission was sought to perform physical examination and vital signs. The symphysio-fundal height was 4cm on abdominal palpation. On inspection of the vulva it was healthy and the lochia was creamy brown with scanty flow and not offensive. Temperature-36.6^{0}C, Pulse-80bpm, Respiration,20cpm, Blood pressure,109/70 mmHg, Breast - Lactating, Uterus-Contracted, SFH - 4cm, Lochia-Alba. Permission was sought again to examine the baby. The baby was bathed by the mother under supervision and stump examined, it was clean and dry and dressing was done. Findings were recorded as follows; Temperature36.8 ^{0}C, Respiration-30 cycle per minute, Apex beat-132 bpm, Weight-3.2kg, Suckling-Good, Colour-Pink, Stool - Yellowish.

All the findings were communicated to the client and her family. They were congratulated for their cooperation and told it was the last home visit. Madam Rita was reminded of her first postnatal visit to the clinic which fell on the 1st June, 2022 the need for registration of the child at the Births and Deaths Registry was emphasized. Client was encouraged not to hesitate to visit the clinic anytime she has any health problem before the date of appointment. She was advised to continue with exclusive breastfeeding of the baby for six months

Client"s husband and sister were encouraged to assist her in the household duties and caring of the baby to ensure adequate rest and sleep. The need for personal and environmental hygiene was stressed on and Madam Rita and family were thanked for their co-operation and support. Permission was sought to leave.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Rita and her baby arrived at the clinic for postnatal care on the 1st of June, 2022 accompanied by her mother. Client was neatly dressed and looked cheerful. They were welcome and given a comfortable seat. Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and she said they were doing well. Madam Sharifa said her baby was able to feed well and slept well. Madam Rita also confirmed that baby passed urine and stools regularly.

Permission was sought to examine the baby generally. The baby was taken and undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. Baby"s weight was 3.3kg. There were no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby"s abdomen was not distended and the umbilical stump was completely healed. The baby"s vital signs were checked and recorded as follows; Temperature-36.6^0 C, Apex beat-130 beat per minute, Respiration-30 cycle per minute

The baby was neatly wrapped before she was given back to the clients" sister. The findings were communicated to the mother and thanked for the care. Madam Rita was advised to dress the baby with light clothes so as to prevent the rashes on the baby"s skin.

Madam Rita was examined and her vital signs were recorded as; Temperature-36.6 ^{0}C Pulse-82 beat per minute Respiration -20 cycle per minute, Blood pressure -110/70 mmHg.

Permission was sought from to examine client from head to toe. The procedure was explained and she was asked to empty her bladder and midstream sample tested negative for protein and glucose. Privacy was provided after which hands were washed and dried and examination was commenced.

On inspection, it was observed that the conjunctiva was not pale, the nose was not discharging. The breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the uterus was palpable. There was no drainage of Lochia on inspection. After that findings were communicated to her. Madam Rita was advised to ensure that the baby completes the immunization schedule. She was reminded of her second postnatal visit to the clinic. Baby was registered at the Births and Deaths Registry and client was handed over to the midwife in-charge for continuity of care. Madam Rita and her entire family were thanked for their co-operation and for helping me to achieve my aim.

4.12 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 8th July, 2022 client came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows: Temperature-36.4, pulse-78bpm, resp-20cpm, Bp-110/70mmHg**.**Madam Rita was given a urine sample container to provide midstream urine to be sent to the laboratory for urine analysis to be performed. A sample of blood was also taken to the laboratory for hemoglobin level estimation. The samples were then sent to the laboratory. The results from the Laboratory were as follows; Hb 12.2g/dL, Urine protein-Negative, Glucose - Negative

The results were explained to her and recorded in her card. Head to toe examination was done on her with no abnormalities detected. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy.

Her baby was also examined from head and abnormalities were detected. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. Vital signs were checked and recorded as follows: Temperature 36.2ºC, Respiration 34cpm, Apex heartbeat, 134bpm and Rita and her baby were handed over to the child welfare clinic and family planning unit for the six weeks immunization against diphtheria, pertussis, tetanus, Hemophilus influenza and hepatitis B. Weight 4.5kg. Madam

She was encouraged to ask questions but she had none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health-related problem. She was thanked for her co-operation and understanding.

4.10 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. Sleeping disturbances.
2. After pains
3. Engorgement of breast.
4. Back ache

SHORT TERM OBJECTIVES

1. Client"s after pain will reduce within 72 hours.
2. Client will have at least 2 hours sleep within 24 hours.
3. Client"s breast engorgement will reduce within 72hours.
4. Backache will be subsided within 72 hours.

LONG TERM OBJECTIVES

Mother and baby will get through a safe puerperium without any complication.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
25/5/2022\ 5:00pm	Backache related to physical body alteration during late pregnancy	Client"s backache will subside within 72 hours as evidenced by client verbalizing	1. Reassure client 2. Explain the physiology of the backache 3. Assist client to position during breastfeeding 4.serve analgesics 5Ensure enough rest	1. Client was reassured 2. The cause of back ache was explained to her. 3.Client was assisted to position and fix baby well to breast. 4. Client was served with analgesic. 5.Client was encouraged to have enough rest	28/5/2022 5:00pm	Back ache relieved as woman verbalized	

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
26/5/2022 8:00 am	Sleep disturbance related to breastfeeding of baby at night	Client will have at least2 hours sleep within 24 hours as evidenced by client verbalizing	1. Reassure client. 2. Encourage client to sleep when baby sleeps 3.Give kangaroo mother care. 5. Encourage family support.	1. Client was reassured 2. Client was advised to sleep when baby sleeps 3. Kangaroo mother care was ensured 4. Husband and sister were encouraged to support client.	27/5/2022 @ 8:00 am	Goal was fully met as client said she had adequate sleep.	

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/5/22 7:30 am	After pains related to uterine contraction	Client"s after pain will reduce within 72 hours as evidenced by client verbalizing	1. Reassure client. 2. Explain the physiology of afterpain to client 3. Encourage client to urinate regularly. 4. Encourage client to feed baby on demand. 5. Serve analgesics as prescribed.	1. Client was reassured that pain is temporary 2. She was told it was due to uterine contraction. 3. Client was encouraged to urinate at least every two hours. 4. Client was encouraged to feed baby at least every 2 to 3 hours or frequently as demanded by baby. 5. Client was served with paracetamol as prescribed.	28/5/2022 7:30 am	Goal was fully met as client verbalized a reduction in pain.	

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/5/2022\ 9:00 am	Engorgement of breast related to increased production of breastmilk by prolactin	Client"s breast engorgement will reduce within 72 hours as evidenced by client verbalizing	1. Reassure client 2. Explain the physiology of the engorgement of breast to client. 3. Assist client to position and fix baby well to breast. 4. Encourage client to breastfeed baby on demand 5Express excess breast milk	1. Client was reassured 2. The cause of breast engorgement was explained to her. 3. Client was assisted to position and fix baby well to breast. 4. Client was encouraged to breastfeed baby on demand 5.Excess breastmilk was expressed	30/5/2022 9:00 am	Goal was fully met as client verbalized a reduction of breast engorgement.	

SUMMARY AND CONCLUSION

This script is a family centered maternity care given to Madam Rita; a 36-year-old gravid 3 Para 2 all alive. Client is a native of Berekum and lives at Adom. She was first met at the Antenatal clinic on the 9th May, 2022 at Aggies Maternity Home, when she was 37weeks pregnant. Various observations and examination including laboratory investigations were carried out to aid in the progress of normal pregnancy.

She experienced some minor disorders which were managed successfully. Madam Rita‟s labour and delivery were carefully managed without any complications and she delivered an alive 3.6 kg female infant on the 24th of May, 2022, Aggies Maternity Home.

She went through puerperium successfully where both mother and baby were finally handed over to the Public Health Nurse at Aggies Maternity Home on the 8th of July, 2022, for continuity of care.

This family centered maternity care given to Madam Rita has enabled me gain much experience about the importance of proper client management during pregnancy, labour and puerperium. It has also helped me to improve my skills as a student midwife in planning, interviewing, implementing, setting objectives and evaluating them to solve client‟s problem identified. As a result, I will be able to give quality care to every woman who comes under my care.

BIBLIOGRAPHY

Dawn, F. & Sian, E.M.P. (2005). *Blackwell's nursing dictionary* (2nd ed.). London: Blackwell publishing limited.

Fraser, D.M. & Cooper, M.A. (2009). *Myles* textbook *for midwives* (15th ed.). London: Churchill Livingstone

Korah, S.B. (2002). *B.I Churchill's Handbook of Midwifery*, Reprinted Ed. B.I Churchill Livingstone Pvt Ltd, New Delhi.

Oduro – Kwarteng, V. (2012*). Obstetric nursing (2nd ed.),* Kumasi: Robee printing press.

Ojo, O.A., & Briggs, E.B. (1982). *A Text book for Midwives in the Trophies* (2nd ed.), London: Edward Arnold

Tiran, D. (2008). *Baillie's Midwives Dictionary* (11th ed.), London: Bailliere"s Tindal

APPENDIX 1

PHARMACOLOGY OF DRUGS

DRUG	**CLASSIFICA -TION**	**DOSAGE OF DRUG**	**ROUTE**	**ACTION AND USES**	**SIDE EFFECTS OF DRUGS**	**REMARKS**
Tablet Fersolate	Vitamin preparation	200 mg daily X 30 days	Oral	1. Helps in the formation of red blood cells. 2. Supplement the iron of the body. 3. Used in the treatment of iron deficiency anemia.	1. Gastro intestinal upset and black tarry stool. 2.Nausea	1. Hemoglobin level increased. 2. Black tarry stool noticed.
Tablet Folic Acid.	Vitamin preparation	500 mg daily x 30 days	Oral	1. Helps in the formation of red blood cells. 2. Prevents neural tube defect. 3. Treatment for iron deficiency anemia.	1. Gastro intestinal upset. 2. Nausea.	1. Hemoglobin level increased. 2. No reactions observed.
Tablet Multivite	Vitamin preparation	5 mg 2 daily x 14 days	Oral	1. Improvement of appetite. 2. Helps in red blood cell and bone tissue formation.	Nausea and vomiting.	No reaction observed
Tablet Vitamin B Complex	Vitamin preparation	200 mg 3 x daily x 7 days	Oral	Helps in metabolism of carbohydrate, protein and fat.	Abdominal discomfort.	No reaction.

DRUG	CLASSIFICA-TION	DOSAGE OF DRUG	ROUTE	ACTION AND USES	SIDE EFFECTS OF DRUGS	REMARKS
Tablet paracetamol	Antipyretic and analgesic.	1000 mg x 3 daily x 5 days.	Oral	1. Alleviates pain. 2. Reduce body temperature.	Prolong usage may damage the liver.	No reactions observed.
Injection Oxytocin	Oxytocic drug	5 – 10 units	Intramuscular on the thigh.	Stimulates uterine contractions, controls bleeding, used for induction and augmentation of labour.	Uterine rupture if overdose is given. Nausea and vomiting.	None observed.
Polio 0	Vaccine	2 drops	Oral	Stimulate production antibodies against poliomyelitis.	Nausea	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Vaccine	0.05 mls	Intramuscular on the right upper arm.	Stimulate production of antibodies against tuberculosis	Small pustule which persist for some weeks and rise in temperature.	Blister observed.
Vitamin K	Antihemorrhagic vitamin.	0.5 – 1 mg	Intramuscular	1. Help in clotting of blood. 2.Helps to prevent hemorrhagic disease of newborn	Flashes of the face.	No side effect was observed.

PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin k	Group K vitamin	1ml	Intramuscular	Production of prothrombin	Prevented bleeding	Bleeding prevented	None observed
Chloramphenicol eye drop	Antibiotics	2-3drops	Instillation	To prevent eye infection	Eye was not infected	Increase risk of aplastic anemia	No side effect observed
Injection Bacillus Calmette Guerin	Antigen	0.05 ml	Intradermal	Production of antibodies to prevent tuberculosis	Under observation	Blister formation, slight fever and pain	Blister formation
Polio vaccine	Antigen	2 drops	Oral	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhea	None observed

PHARMACOLOGY OF DRUGS FOR THE BABY CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumoccocal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, Hemophilus influenza B	Under observation	Low grade fever	None observed
Rotavirus 1	Antigen	1.5 mls	Oral	Prevention of gastroenteritis	Under observation	None	None

APPENDIX II

LABORATORY INVESTIGATION TABLE F

DATE	SPECIMEN	INVESTIGATION TYPE	FINDINGS	REMARK
28/03/2022	Blood	Groupings	O	Normal
		Rhesus factor	(D) positive	Normal
		hemoglobin level (Hb)	10.9 g/dl	Low
		Hepatitis B (HBsAg)	Negative	Normal
		Sickling	Negative	Normal
		VDRL	Non-reactive	Normal
		Glucose 6 phosphate dehydrogenase (G6PD)	No defect	Normal
		HIV Status	Negative	Normal

	Urine	Protein	Negative	Normal
		Glucose	Negative	Normal
	Stool	Worm infestation	Negative	Normal
28/03/2022	Urine	Protein/glucose	Negative/negative	Normal
05/04/2022	Urine	Protein/glucose	Negative/negative	Normal
Date	**Specimen**	**Investigation type**	**Findings**	**Remark**
9/05/2022	Urine	Protein/glucose	Negative/negative	Normal
09/052022	Blood	Haemoglobin level (HB)	11 g/dl	Normal
		Hepatitis B (HBsAg)	None reactive	Normal
		PMTCT	None reactive	Normal

23/052022	Urine	Protein/glucose	Negative/Negative	Normal

APPENDIX III

TABLE G ANTENATAL PROGRESS

Date	**Temperature (oc)**	**WT (Kg)**	**BP. (mmHg)**	**Urine** Protein / Glucose	**Gestational Age in Weeks**	**Fundal height (CM)**	**Presentation**	**Descent**	**Fetal Heart Rate (Bpm)**	**Routine medication**	**Complain, Treatment and Advise**	**Name & signature**
29/05/2020	36.3	49	107/71	Negative / Negative	6	NP	_	_	+	Routine drugs x30 days	Nausea and vomiting.	AM
21/8/19	36.5	51	110/70	Negative / Negative	19+0	18	_	_	+	Routine drugs x30 days	No complains.	E.A
20/9/19	36.0	53	116/60	Negative / Negative	23+2D	21	Cephalic	_	+	Routine drugs x30 days	Feels well	E.A

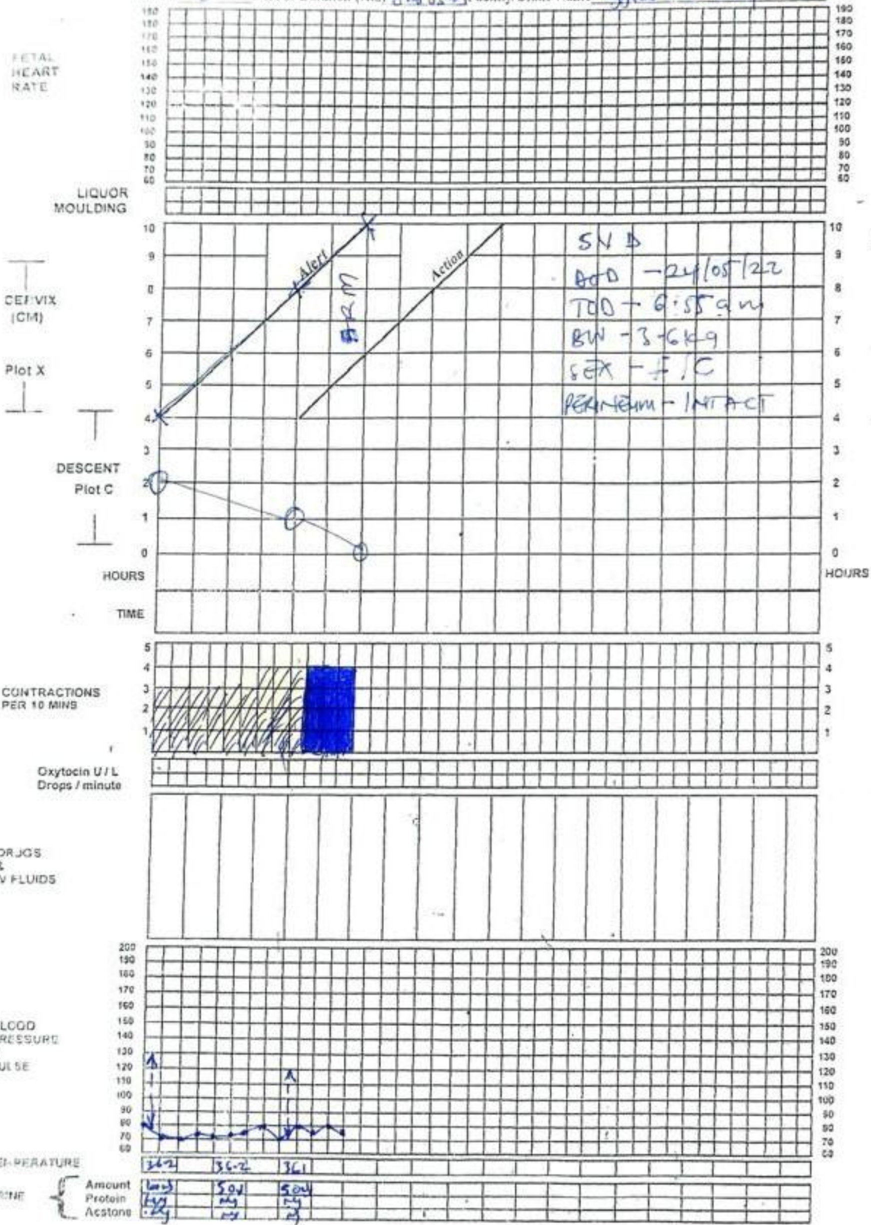
01/11/19	36.6	53	111/80	Negative Negative	27+0	28	Cephalic	_	130	Routine drugs x30 days	Waist pain.	S.J
03/12/19	37.0	55	100/70	Negative Negative	31+6	30	Cephalic	5/5th	132	Routine drugs x30 days	Feels well	A.C
06/1/2020	36.6	57	110/70	Negative Negative	36+3	35	Cephalic	5/5th	137	Routine drugs x14 days	Waist pain & heart burns	A.D
Date	**Temperature (oc)**	**WT (Kg)**	**BP. (mmHg)**	**Urine**	**Gestational Age in Weeks**	**Fundal height (CM)**	**Presentation**	**Descent**	**Fetal Heart Rate (Bpm)**	**Routine medication**	**Complain, Treatment and Advise**	**Name & signature**
13/1/2020	36.1	58	98/70	Negative Negative	37+3	37	Cephalic	5/5th	136	Routine drugs x7 days	Headache Tab. Paracetamol 1g x	S.Z

											3days.	
20/1/2020	36.0	60	110/80	Negative / Negative	38+3	36	Cephalic	5/5th	137	Routine drugs x7 days	Backache	S.Z

INSECTICIDE TREATED NET (ITN)	DATE SUPPLIED 31/01/202		

TETANUS IMMUNISATION	PREVIOUS TT		CURRENT TT 3	
	☐ Yes	☐ NO	......	DATE…31/01/2022……………………………………

WHO Modified Partograph by Lwl



Registration No: 720/22 Name(Last, First): ABUMAH RITA Age: 36yrs
Date: 24/5/22 Parity/Gravida: G3 P2 LMP: unknown EDD: 30/5/22 Gestation(wks): 39wks
ROM: 0 Labour Duration (Hrs): 8hrs 55mins Facility/Clinic Name: Aggies Maternity Home

FETAL HEART RATE: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

LIQUOR
MOULDING

CERVIX (CM): 10, 9, 8, 7, 6, 5, 4

Plot X

Alert

Action

ARM

SVD
DOD – 24/05/22
TOD – 6:55am
BW – 3.6kg
SEX – F/C
PERINEUM – INTACT

DESCENT Plot C: 3, 2, 1, 0

HOURS

TIME

CONTRACTIONS PER 10 MINS: 5, 4, 3, 2, 1

Oxytocin U/L
Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE & PULSE: 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

TEMPERATURE: 36.2 | 36.2 | 36.1

URINE: Amount / Protein / Acetone

LABOR NOTES

Client reported to the facility with history of waist and lower abdominal pains. Client was examined and findings plotted on [illegible] partograph. Client delivered a female at 6:15 am with APGAR score of 8/10 [illegible] 3rd stage actively managed, BW 3.6kg, HC [illegible]cm, BL 47cm

Please circle or write responses.

DELIVERY

DATE: 24/5/22 TIME: 6:15am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No

Medication: Time 6:16am Type/Dose: oxytocin 10 iu

PLACENTA: TIME: (Complete) / Incomplete

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

BABY

Weight: 3.6kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8
5min	2	2	2	2	2	10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	7:15am	115/65	84	18cm	Small	120mls
	7:30	120/80	76	Contracted	"	—
	7:45am	120/80	74	Contracted	"	—
	8:00am	110/70	74	contracted	small	—
	8:15am	110/80	72	contracted	"	—
	8:30am	120/70	74	contracted	"	—
	8:45am	110/70	72	contracted	small	—
	9:00am	110/80	72	contracted	"	—
Every 30 minutes For 1 hour	9:30am	100/70	74	contracted	"	—
	10:00am	120/80	72	contracted	small	50mls

Birth Attendant: Abigail Annan and Agnes Mensah Date: 24/05/22

MATERNITY CHART

KEY
- FUNDAL HEIGHT
- WEIGHT

NAME: RITA ASUMAH

AGE: 36 YRS WARD: MATERNITY

IP NO.: BED NO.:

Date	24/5/22	25/5/22	26/5/22	27/5/22	28/5/22	29/5/22	30/5/22	31/5/22
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour	7:30 am	9:00 am	10:00 am	10:00 am	10:00 am	10:00 am	10:00 am	10:00 am
Temperature								
Pulse	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Resp.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
F.M.								
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.	115/65	120/80	119/50	120/80	120/80	110/70	120/70	110/70

TEMPERATURE CHART

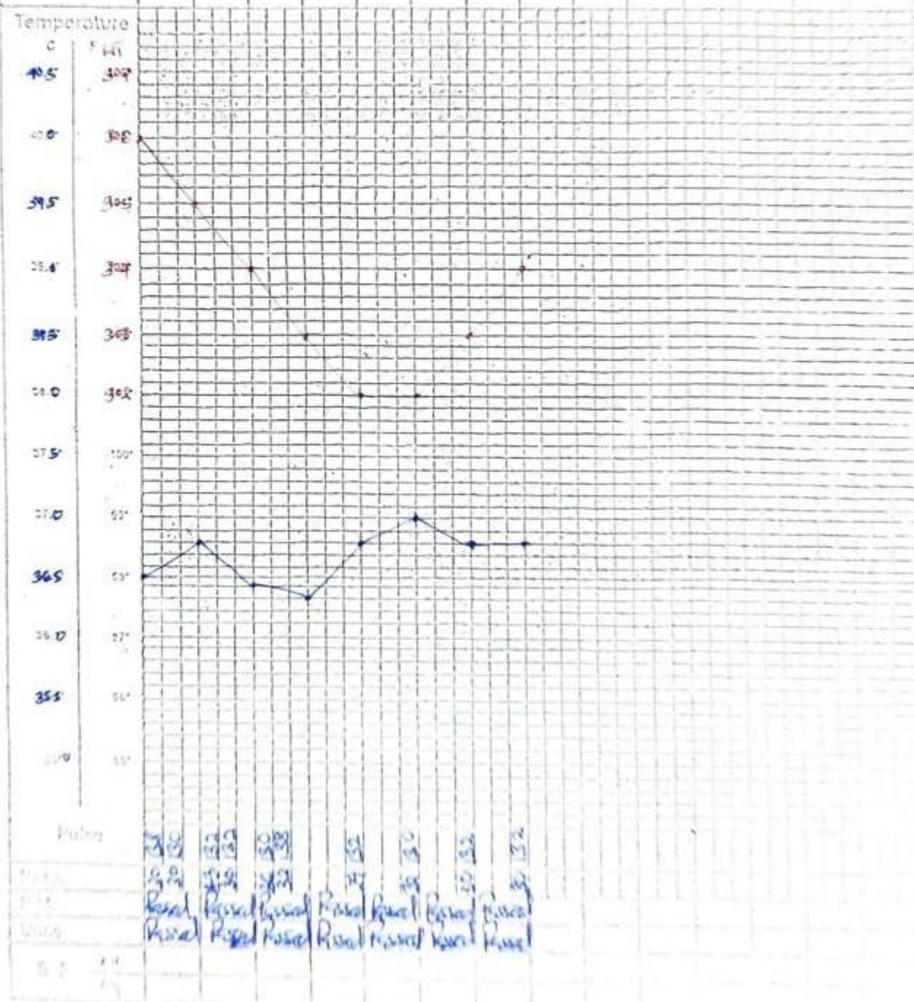
KEY
- PART [illegible] (red)
- TEMPERATURE [illegible] (blue)

NAME: BABY [illegible] [illegible]

AGE: NEWBORN WARD: MATERNITY

IP NO.: BED NO.:

Date	24/5/[illegible]	25/5/[illegible]	26/5/[illegible]	[illegible]	28/5/[illegible]	29/5/[illegible]	30/5/[illegible]	31/5/[illegible]						
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7						
Days P.O.														
Hour	11:30 am	9:00 am	10:30 am	10:30 am	10:15 am	10:30 am	10:00 am	11:00 am						



NEW BORN EXAMINATION FORM

Name: Baby Rita Asumah Date of Assessment: 25/05/22 Time: 7:55am
Date of Birth: Time of Birth: Sex: [ ] M [ ] F Age at time of Assessment (days/hrs) 24 hours
Astational Age 39 weeks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section
APGAR: 1min 9 5min 10 Birth Weight: [ ] 3.4kg [ ] Length: 47 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.3 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Abigail Annan

1. Respiration
Rate 42
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Heart rate
Rate: 140
- [ ] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

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

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

22. Limbs
- [x] Normal
- [ ] Abnormal

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

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

24. Anus
- [x] Patent
- [ ] Imperforate*

25. Resuscitation provided
- [x] None
- [ ] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

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

***May indicate severe disease that requires urgent referral**

Diagnoses (if known)

Classification: (Overall assessment) [x] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice

Plan: [x] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

NEW BORN EXAMINATION FORM

Name: Baby Rita Asumah Date of Assessment: 24/5/22 Time: 7:55am
Date of Birth: 24/5/22 Time of Birth: 6:55am Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 1 hour
Astational Age [ ] [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section
APGAR: 1min [8] 5min [10] Birth Weight: [3.6] 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): Abigail Annan

1. Respiration
Rate 44
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

15. Neck
- [x] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ____

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

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

18. Heart rate
Rate: 142bpm
- [ ] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

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

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

22. Limbs
- [x] Normal
- [ ] Abnormal ____

23. Genitalia
Male Genitalia
- [x] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ____

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

24. Anus
- [x] Patent
- [ ] Imperforate*

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

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

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

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

NEW BORN CHART

Name: BABY RITA ASUMAH No: .... Birth Weight: 3.6kg

Sex: FEMALE Mother's No: 720/22 Length: 50cm

Nature of Delivery: SVD Diagnosis: 25/05/22

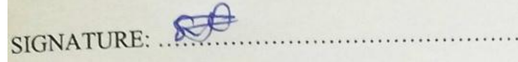
Date of Birth: 24/05/22 Time: 6:55am Date of Discharge: ....

Date	24/05/22		25/05/22		26/05/22		27/05/22		28/05/22		29/05/22		30/05/22		31/05/22							
No. of Days	M		D1		D2		D3		D4		D5		D6		D7							
Weight	3-6		3-5		3.4		3.3		3.2		3.2		3.3		3.4							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.5		36.8	36.4	36.4	36.3	36.8		36.8		37.0		36.8		36.8							
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed							
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed							
Remarks	Head, Neck, Genitalia, Limbs → No abnormalities detected.																					

SIGNATORIES

CANDIDATE NAME

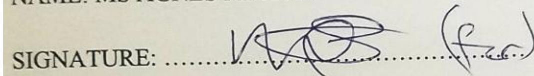
NAME: MISS ABIGAIL ANNAN

SIGNATURE: 

DATE: 11-10-2022

THE MIDWIFE IN-CHARGE

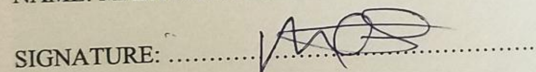
NAME: MS AGNES MMOAH

SIGNATURE: 

DATE: 11-10-2022

SUPERVISOR

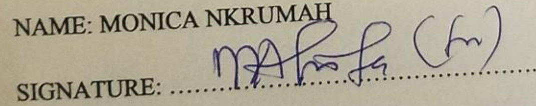
NAME: MARTHA KYEREMAA

SIGNATURE: 

DATE: 12-10-2022

PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: 

DATE: 12-10-2022

STAMP: