HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE
BEREKUM

A CLIENT AND FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM OFORIWAA DEBORA

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A CLIENT/FAMILY CENTERED MARTERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL MIDWIFE

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PREFACE

A family centered maternity care is a tool that allows the midwife to put into practice the skills and knowledge which has been acquired during her training to provide quality services to mother and baby. Improving this care, the individual is totally cared for, taking into consideration, her social, economic, physical, emotional, as well as spiritual aspect of life. The midwife identifies and manages the problems of the client by the use of nursing process through-out pregnancy, labour and puerperium. The care ensures that maximum and individualized care is given to expectant women and also help the client to have a live and healthy baby after the delivery process.

The client/family centered maternity case study is a requirement by the Nursing and

Midwifery Council of Ghana as a partial fulfilment of the award of a Professional Registered Midwifery Certificate.

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Uttermost thanks goes to God Almighty for the knowledge, strength and protection which was bestowed on me throughout the compilation of this care study.

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My next gratitude goes to the Midwife In-charge of the staff of Jinijini Health Center {Antenatal and Maternity Unit} for the support and encouragement.

Again, Special thanks goes to my client, Madam Oforiwaa Debora and her family for their cooperation, participation and maximum effort throughout the time this study was carried out. I am deeply grateful to my family for their support psychologically, physically, socially and emotionally throughout this study. To all my well-wishers, God richly bless you all.

Finally, I say a special thanks to the authors and publishers of the various reading materials that were used in my work.

INTRODUCTION

In our now contemporary era, efforts are being made to achieve the Sustainable Development Goal 3 that involves good health and wellbeing. A client and family centered maternity case study is a systematic approach rendering comprehensive obstetric care to an expectant mother and her family during pregnancy, labour, and puerperium without any complications to both mother and baby.

In achieving this objective, the client is given a comprehensive care considering her as a unique individual with special problems. This may include physical, emotional, financial, psychological or spiritual problems. By careful assessment of these problems and needs, the midwife is able to plan an appropriate care for the client and her family that could enable her to achieve her goal.

This client/family centered maternity care was rendered on Madam Oforiwaa Debora, a 28 year old pregnant woman Gravida 4 para 3 all alive who was met at the Jinijini Health Center on 14th November, 2022, at a gestation of 38weeks+1days.

Madam Debora commenced antenatal clinic on the 16 of May 2022 during her 6th antenatal visit. She had no history of any medical conditions such as hypertension, asthma, sickle cell and the like. She had been screened on Hepatitis B, malaria parasite and HIV/AIDS and all revealed negative. Her hemoglobin level was good and she was feeling well. Various health education on the danger signs of pregnancy which includes, bleeding, excess vomiting, severe headache and oedema were given to her.

The script is organized into four chapters, appendices, pharmacology of drugs administered, various records during puerperium, bibliography and signatories;

Chapter one; this gives details about how the midwife obtained information, collected data and every history about the client, family and community. This is a thorough assessment done on the client and her family to detect any deviation from normal and offer help if possible.

Chapter two; this entails first contact with the client, subsequent antenatal visits to the clinic, home visits, problems identified and short- and long-term goals and the nursing care plan.

Chapter three; this talks about the four stages of labour and its management as well as chapter four which gives details on the complete expulsion of the placenta and its membranes until the sixth week of puerperium during which mother and baby will be monitored. A nursing care plan will be drawn at the end of chapters two, three, and four in order to identify the client's problems and manage them accordingly.

LITERATURE REVIEW

PREGNANCY

Weller (2014) defines pregnancy as being with a child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and fetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and fetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

King (2014) 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 support the developing fetus and at the same time, maintain maternal homeostasis Pregnancy last approximately two hundred and sixty, six days (266 days) or thirty-eight weeks (38 weeks) from ovulation. 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. Historically, the second trimester was considered to be 13 to 28 weeks was limit of viability. The third trimester extends from 29 to 40 weeks. The term ‘post-date’ or ‘post term’ is typically used to describe a pregnancy beyond forty (40) weeks.

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 choice 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.

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, 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 heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer disease is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters (29 to 40 weeks). General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

Oduro-Kwarteng (2012) defines pregnancy as having a developing embryo of fetus in the uterus as a result of the union of an ovum and spermatozoa. The normal duration of pregnancy is 280days (40wks or 9months and 7 days) counted from the first day of the last menstrual period.

LABOUR

According to Oduro-Kwarteng (2015), normal labour occurs when the;

Foetus is born at term and alive

Presented by vertex

Process complete spontaneously by natural unaided effort of mother

Time does not exceed 12 hours when the woman enters active phase of labour

Baby is born without complications.

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 may last 6 to 8 hours in primigravida. LATENT This 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. 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.

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, with labour usually occurring between 17 and 42 weeks' gestation. 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, second, third stage and fourth but this is a rather pedantic view, as labour is obviously a continuous process.

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.

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 water'. 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 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.

PUERPURIUM

Oduro-Kwarteng (2012) defines puerperium as a period that starts immediately after delivery of the placenta up to 6-8 weeks. This period is characterized by a lot of physiological changes some of which may include the following

A) Lactation is well established

B) The reproductive organs return to their non- pregnant state

C) Other physiological changes which occur during pregnancy are reversed.

D) The foundations of the relationship between the infant and its parents are laid.

E) The mother recovers from physical and emotional stresses of pregnancy and delivery and assumes responsibilities for the care and nature of the infant.

According to Marie (2013) puerperium is 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; Immediate –within 24 hours. Early- up to 7 days, 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 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 color of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia Alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

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. 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. 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

Marie Elizabeth (2013) 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

4. 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 fibres 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.
4. 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. 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.

Madam Debora was chosen as the client for maternity care study on 14th Novemeber,2022 at Jinijini Health Center which happened to be her 6th visit. After a short education, it was noticed that the client lacked knowledge on family planning and she had a lot of misconceptions about family planning. Her pregnancy was without complications, with good past obstetric history and she met the criteria for selection after enquires was made.

An introduction was made as a midwife from Holy Family Nursing and Midwifery Training College, Berekum on community midwifery practical. She was asked for permission to be used as a client for care study of which she agreed. The midwife in-charge was informed and permission was granted.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Oforiwaa Debora as the client used for the study. Her family community which constitutes the social, surgical, medical, past obstetrical, lifestyle, menstrual, present obstetrical histories and the environment in which she lives.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Debora a 28year old lady who was born on the 17th October, 1993 and hails from Ayimom in the Bono Region and is currently staying with her husband in Ayimom a suburb of Jinijini in the Bono region. She is dark in complexion, 165cm in height and weighs 55 in kilograms at booking. Madam Debora and husband are both devoted Christians and attend the Church of Baptist located in Ayimom. According to Madam Debora, she had her education up to junior high school level in Berekum at the Bono Region but could not continue due to financial difficulties. Client is married to Mr. Effah Kofi, who is also a farmer, 30years of age, 168cm tall, dark in complexion and was also born at Ayimom in the Bono Region also resides in Ayimom a suburb in Jinijini. He is proficient in English and Twi while his wife speaks only Twi also, Madam Debora has a 10year old son named Prosper whom she said is her next of kin and is receiving education in Ayimom. Client was into farming prior to her pregnancy but no more into it. Client verbalized that her husband is supportive and they live happily together.

1.2 FAMILY HISTORY

Opanin Ofosu Kwame and Madam Afia Agyei are the parents of Madam Debora. Both parents are alive and residing at Jamdede. Her mother is also into trading and her father remains a farmer by occupation. The client is the last amongst 4 siblings made up of 2 females and 2 males. According to her, there are no hereditary medical conditions such as diabetes, sickle cell disease, mental disorder, epilepsy, hypertension, human immune virus and Asthma in her family. She further stated that there has been a history of multiple pregnancies in her family and that of her husband's family of which death has been relatively natural to the family.

1.3 MEDICAL HISTORY

According to the client, she has never been admitted to a hospital before and also affirmed that she sometimes experienced minor illnesses of which required medical so upon few occasions has ended up at the outpatient's department of the Jinijini Health Center. She also made claims that usually she experiences malaria per diagnosis. She has no known allergies to food and drugs and also, has no medication for chronic illness.

1.4 SURGICAL HISTORY

Madam Debora claimed she has never had a road-traffic accident that has affected her pelvis and any part of her body before. She has neither undergone any surgical operation that has affected her pelvis, spine nor reproductive organs. Also, she has never received blood transfusion or donated blood before.

1.5 MENSTRUAL HISTORY

According to Madam Debora, she had her menarche at the age of 14 years while in the Junior High School. She has a 28-day menstrual cycle bleeding during menstruations and occur 5 days each month with no sign of dysmenorrhea. She makes use of two sanitary pads daily to guide her flow and changes after when necessary. She recalled her last menstrual period to be March, 2022 but does not remember the exact day.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Debora goes to bed usually around 9pm and gets out of bed at 5am the next day. She visits the bathhouse to urinate anytime her bladder is full and empty her bowels at least once a day. After which she washes her face and brushes her teeth with tooth brush and toothpaste. The next thing she does is to sweep her compound and empties her refuse dump when is full, after which she prepares breakfast and she takes it together with her husband and children. She prepares her children for school and continues with her house chores, that is washing their dirty clothes and the utensils been used. After all these, she takes her bath, put on her farm clothes and joins her husband at the farm just some minutes away from their house. Around 12pm she comes back home and take something for her lunch and send some to her husband. After some minutes later she comes back home and takes her rest until 4pm she starts preparing her evening meal for her husband. By 5:30pm supper will be ready by then her husband and children will be back from home and school of which she serves them and make sure the children have taken their bath and she also take her bath, after which she eats her supper .She eats three times a day .She neither smokes cigarettes nor takes any alcoholic drink .On Saturdays, Madam Debora cleans the house, goes to the farm to get some foodstuffs for the week .Her dirty clothes as well as that of her husband and children are washed and dried in the sun. Madam Debora's favorite food is Fufu with groundnut soup and

always enjoys conversing with her sister and children and sleeps during her leisure time. On Sundays, she goes to church with her husband and children and closes around 12pm, comes back home and prepares lunch for the family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy: Madam Debora, gravida 4 Para 3, alive, went through her pregnancy without any ill-health and had term pregnancy. There were no complications like Ante Partum Hemorrhage, Pregnancy Induced Hypertension, Hyperemesis Gravidarum and Abortion. Throughout her pregnancies she had five doses of Sulphadoxine-pyrimethamine as prophylaxis against malaria. She was a regular attendant to antenatal care till she delivered. She had her fourth doses of tetanol toxoid injection on the 17th October,2022

Labour:

She labored for 10 hours and had spontaneous vaginal delivery to her first son Adom Prosper on 9th May, 2009.Ofori Victor her second son was born 3rd March, 2014. Her only daughter Vincentia Agyei was born on 12th January,2019 all at Jinijini Health Center.

The first child weighed 3.5kg at birth, the second child weighed 2.6kg at birth her third child weighed 3.0 at birth.

Babies were able to initiate breast feeding within the first 30 minute and their conditions were stable. According to Madam Debora, her placenta was delivered completely and her amount of blood loss was 150ml.

She said she experienced lower abdominal pains after delivery which subsided the next day.

Puerperium: Madam Debora's puerperal period, according to her was also normal. She had no puerperal psychosis. Her children suckled her breast soon after she delivered hence lactation was established. Client visited the postnatal clinic frequently. She and her children were healthy throughout. She practiced exclusive breastfeeding for six months for her baby and combined complementary feed like corn dough porridge, well mashed food and cerelac while she continued the breastfeed. According to Madam Debora, all her children received the immunization against childhood preventable diseases. She also said she received support from her husband and sister during previous deliveries. She weaned off the breast at one and half years. She was healthy till two years when she started to experience symptoms like fever and diarrhea but treated at O.P.D. Madam Debora said used natural family planning to space her birth.

1.8 PRESENT OBSTETRIC HISTORY

Madam Debora visited the antenatal clinic when she was 11 weeks pregnant on 16th May, 2022at Jinijini Health Center. According to Madam Debora's antenatal card, her last menstrual period could not be remembered. Madam Debora first ultrasound scan estimated of delivery was November 11th ,2022 and second ultrasound scan was December 5th ,2022.

On Madam Debora's first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and physical assessment was done and recorded. Results of investigations which were carried out were as follows;

Hemoglobin Level	-	14.1g / dl
Sickling Test	-	Negative
Blood group	-	O

Rhesus factor	-	Positive
G6PD	-	No Defect
Syphilis (VDRL)	-	Negative
HIV status	-	Negative
Urine R/E	-	Negative
Stool R/E	-	No abnormalities detected

The following observations were made and recorded;

Temperature	-	$36.3^{O}{}_{C}$
Pulse	-	82bpm
Respiration	-	24cpm
Blood Pressure	-	91/64mmHg
Hepatitis B Status	-	Negative

Other measurements were taken as follows:

Weight	-	55kg
Height	-	165cm

Records on Madam Debora's antenatal card indicated that she was examined from head to toe and no abnormalities were detected. She was educated on danger signs in pregnancy and was also given treated insecticide net to sleep under to prevent malaria in pregnancy. She said she has no

complains, therefore she was served with the following routine drugs;

Tablet Folic acid 5mg (1 daily) for 30 days

Tablet Fersolate 200mg (1daily) for 30 days.

Tablet Multivite 200mg (1 daily) for 30 days

She was scheduled for the next visit, which she followed correctly and carried out all the laboratory investigations requested until she was met on the 21st November,2022 when she was 39weeks +1 day pregnant.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives a brief insight of the care given to Madam Debora during pregnancy specifically from the 38 weeks +1 day. It lays more emphasis on the first contact with client, various home visits and subsequent visits and also the nursing care plans drawn to solve her problems during pregnancy.

2.1FIRST CONTACT WITH THE CLIENT

Madam Debora was met on 14th November, 2022 at Jinijini Health Center during the antenatal day when she was 38weeks+1day pregnant. It was her 6th visit to the hospital. This woman was approachable, and ready to share any information when given the mandate. Introduction was made as Antwi Boasiakoh Georgina, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, sent to Jinijini Health Centre on seven weeks clinicals to have a practical experience in midwifery. Her antenatal book was collected and found out that she fell within the criteria. It was noticed that during education on family planning she was listening very attentively. She asked a lot of questions on issues she did not understand. A decision was made to select Madam Debora as a client because it was realized she had a lot of misconceptions about family planning. She has also been attending antenatal clinic regularly and has no abnormal condition which can be a threat to her pregnancy. She has been complaining of waist pains and constipation. A decision to use her for the client /family centered maternity care study in order to educate her on how family planning. A brief information was given to her about the care study and why she was chosen and she readily accepted it and guaranteed her full support and cooperation.

She was then taken through the general examination when it got to her turn with procedure explained. She was encouraged to ask questions. Her vital signs were checked and recorded as follows;

Temperature	-	$36.6^{O}C$
Pulse	-	82bpm
Respiratory rate	-	24cpm
Blood pressure	-	113/77mmHg

Other observations made were recorded as follows;

Weight	-	63kg

Urine tested for protein and glucose were negative.

After the above procedures, education was offered to her on the following; warning signs in pregnancy like bleeding per vaginum, oedema and losing of liquor, budgeting and layette, signs of impending labour, taking of medication as prescribed and avoidance of drug abuse, sleeping under an insecticide net to prevent malaria and good nutrition.

Physical Examination

Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. She was asked to empty her bladder, privacy was ensured and was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge; no abnormality was detected.

Head and Neck.

Client's hair was examined and it was neatly combed with no dandruff or lice. The sclera and conjunctiva were normal with no yellowish discoloration. There was no discharge from the nose and ears. The mouth, tongue and teeth were clean. On neck palpation, no lymph nodes were found.

The breast has no lumps, dimples or discharge during palpation. Client was taught how to do self-breast examination and she was educated to examine her breast regularly for early detection and reporting of any abnormalities.

The hands and fingers were inspected and the nails were short and neat.

Extremities.

The upper and lower extremities were examined and no abnormalities like swelling was seen.

Back.

The back was also inspected for oedema at the sacral region and the condition of the skin. There was no oedema at the areas inspected and the condition of the skin was good.

Abdominal Examination

Before abdominal examination, palms were rubbed together to provide warmth to prevent induced contractions.

Inspection; the abdomen was inspected for scars, linea nigra and striae gravidarum and none of these were detected. The size and shape were globular and medium respectively with some foetal movements.

Measuring Of Symphysio-Fundal Height; To measure the symphysio fundal height the hands were warmed by rubbing palms together before the upper border of the symphysis pubis and the uterine fundus were located. The zero end of the measuring tape was placed on the upper border of the symphysis pubis and the tape extended to the fundus of the uterus and the symphysio-fundal height measured 34 centimetres and gestational age of 38weeks +1 day.

Fundal Palpation; upon facing the head of the woman on her right-hand side, the fundus was palpated with both palms and a smooth surface was felt indicating the foetal buttocks.

Lateral Palpation; with one hand stabilizing the right side of the maternal uterus, the other hand was moved gently on the left side where rough parts were felt indicating the foetal limbs as palpated. This was repeated at the right side and a smooth round part was observe indicating the foetal back and this will also help to locate the position of the foetus to help listen to the foetal heart sounds using the fethoscope.

Pelvic Examination; facing the woman's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards a hard mass was felt and the fetal head was palpated. The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent; the anterior shoulder was located and five fingers were admitted between the shoulder and the symphysis pubis indicating $5/5^{th}$ above the pelvic brim.

Auscultation; A fethoscope was warmed by rubbing in between the palms and placed at the back of the foetus to listen to the foetal heart sounds for one minute noting the volume and rhythm whiles comparing it with the maternal pulse to ensure that it was not maternal radial pulse being

listened to; foetal heart beat was 138 beats per minutes. Fetal movements were noticed after auscultation and woman was asked if she feels any foetal movements and any change.

Vulva Examination; Permission was sought to examine the vulva and it was granted of which she was helped to assume a lithotomy position. Hands were washed under running water with soap and dried with a clean towel and examination gloves were put on. The mons pubis was well shaved; there were no scars, oedema, varicose veins and genital warts, the labia, clitoris and perineum were also inspected for cleanliness, size, shape ,redness ,tenderness ,rashes ,signs of trauma ,sores ,bleeding and abnormal discharges of which no abnormalities were detected . Also, there was evidence of good vulva hygiene so she was applauded for the good work done and was asked to continue with it. She was however encouraged against the wearing of nylon panties but instead use cotton panties. She was also educated about douching. The client was asked to lie laterally and sit up before getting out of the couch. She was congratulated for allowing the procedure to be done on her. Hands were washed and dried and all findings were explained to her and recorded in her antenatal book.

She complained of pains in the lower abdomen which she thought would affect the baby during delivery and puerperium. She was reassured and educated that it was due to the pregnancy since the fetus is engaging into the pelvis thereby exerting pressure on other organs and nerves in the sacral region. She was thanked for her cooperation. The stages and true signs of labour were explained to her. That was; first, second, third and fourth stages also show, painful rhythmic uterine contractions respectively. Madam Debora was educated to report to the clinic if she sees any.

She was served with routine drugs as below;

- Tab Fersolate 200mg daily for 7 days

- Tab Multivitamin 200mg daily for 7 days
- Tab Folic acid 5mg daily for 7 days

She gave direction to her house and phone numbers were exchanged. Client having agreed to be used for the study, arrangement was made to visit her house on 16th November, 2022. She was thanked and was escorted to the entrance of the hospital.

2.2 FIRST ANTENATAL HOME VISITS

First home visit to Madam Debora was on the 16th November, 2022 at 4:30 pm as it was booked. The main aim was to know where she lived and meet other members of her family and also talk about birth preparedness and complication readiness plan. The journey was made by a tricycle to the client's house by using the directions given. The house was a little far from the clinic. It was located near Ayimom palace. She was very glad for the visit. A quick assessment of the environment was done after which a seat and a cup of water were offered after, which interaction with her started. Client lived in their own house with her family. Introduction was made to the family. The house is built with bricks and roofed with aluminum sheets. There are three rooms in the house and one small separate room used as kitchen. The house is not painted but inside of her room is a combination of white and blue. Madam Debora and her husband use the same room whilst her three children use the room. She sleeps in a well treated mosquito net. Their surroundings were neat and not bushy. There was a bathroom and a toilet outside the house. The floors of the rooms were cemented and windows made with wood. She uses basket with a lid of plywood to collect her refuse and empties her bin when it is full into a container which is provided and emptied at the public refuse dump whenever it was full. They used water from the bathroom drains through a pipe into a container and is poured out.

They fetch water from a nearby bore-hole which is stored in a barrel with a plastic lid. They have electricity as a source of light. Water used for other purposes such as cooking, bathing, washing is stored in a black coloured barrel covered with a lid. Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance and take money along.

Madam Debora was reminded on the true signs of labour, and the process of labour. She was also educated on the intake of a well-balanced diet, the importance of having enough rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again educated on her environmental hygiene. Her sister arrived just as the discussion was about to be concluded. She was encouraged to give a helping hand to reduce tiredness and promote adequate rest and sleep. She was reminded about the next visit to the clinic which was on the 21st November, 2022. Permission was sought to leave. She was very grateful. She was thanked for her cooperation and willingness to hear the advice out.

2.3 PHYSICAL ENVIRONMENT

Madam Debora lives with husband and sister in a nice house built with bricks and roofed with aluminum sheets. The bathroom and toilet are behind the house. The bathroom is made of aluminum sheets whilst the toilet is built with blocks with windows and doors to provide ventilation. They use electricity as the source of light. Madam Debora’s personal hygiene was good because she bathed twice daily and kept her surroundings clean and emptied their refuse at the pubic refuse damp in their area. They fetch water from a nearby bore-hole and is stored in a barrel with lid for future use. Permission was asked and to inspect the barrel and upon inspection they appeared neat and clean.

2.4 PSYCHOLOGICAL ENVIRONMET.

Madam Debora, her husband and family have a good relationship with each other. She has a warm and also friendly relationship with her neighbors and other relatives and people who stay around her area. Madam Debora said she doesn't have a lot of friends but usually visits few friends when convenient and they also visit her sometimes. Madam Debora's sister added she is very friendly and easy to approach and does not find it difficult making new friends. Madam Debora also added she believes respect is something you should give to people being it young, old, or even age mates.

2.5 SECONDANTENATAL HOME VISITS

On the 28th November, 2022 Madam Debora was paid a visit as she was promised. A cheerful welcome was given by client. Madam Debora and her sister were met, they were all happy. After exchange of pleasantries, she complained of constipation, vaginal discharges and frequency of micturition but was reassured and the physiological change in pregnancy was explained to her and was told it was going to disappear after delivery.

Client was reminded on the true signs of labour and education was given to her to have enough rest and sleep, intake of fluid and nutritious foods. Madam Debora said her husband was being helpful in performing the household chores. Client stated that the pain she was experiencing at her waist and lower abdomen during the first visit has subside. Permission was sought to leave. She was thanked for her co-operation.

2.6 SUBSEQUENT VISIT TO THE CLINIC

Madam Debora reported to the hospital on 21st November, 2022 at 8:00am as scheduled. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature - 36.5°C

Pulse - 81bpm

Respiration - 21cpm

Blood pressure - 102/70mmHg

Other observations were recorded as follows

Hemoglobin - 11.6g/dl

Weight - 65kg

Client was asked to empty her bladder; midstream urine sample was tested for protein and glucose which were negative.

Madam Debora was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination symphysio –fundal height was 36cm and her gestational age 39weeks +1day, lie was longitudinal, presentation was cephalic with a descent of 5/5th above the pelvic brim. On lateral palpation, the position was right occipito-anterior. On auscultation; the fetal heart rate was 133bpm. It was regular rhythmic and good volume.

All findings were communicated to her and recorded in her antenatal card. She was asked to continue her routine drugs and report to the health center if she sees any signs of labour because she was almost due.

Madam Debora was asked about the constipation she was experiencing during the second home visit. She explained that she was now able to pass more stools than before because she has been drinking a lot of water.

PROBLEMS IDENTIFIED ANTENATAL PERIOD

On 14th November, 2022, client complained of

1. Lower abdominal pain.
2. Waist pain.

On 21st November2022, client complained of

3. Constipation
4. Vaginal discharge (leucorrhoea)
5. Frequency of micturition

SHORT TERM OBJECTIVES

1. Client ‘s lower abdominal pain will reduce within 24 hours and throughout pregnancy.
2. Client’s waist pain will reduce within 24 hours.
3. Client will have her bowel movement once within 48 hours throughout pregnancy.
4. Client’s vaginal discharge will subside within 48 hours till the end of pregnancy.
5. Client will understand the cause for the frequency of micturition within 24 hours after delivery.

LONG TERM OBJECTIVE

Madam Debora will pass through pregnancy, labour and puerperium successfully without any complications to both mother and baby.

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
14/11/22 at 8:00am	Lower abdominal pains related to descent of the fetal head.	1.Client 's lower abdominal pain will reduce within 24 hours and throughout pregnancy as evidenced by Midwife observing smiling facial expressions. 2.Client verbalizing that lower abdominal pain has reduced.	1. Reassure client. 2. Explain the cause of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client husband to help client with household chores.	1. Client was reassured that her pain would be subsided. 2. The cause of lower abdominal pains was explained to client. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client's husband helped client with household chores like sweeping and washing.	15/11/22 at 8:00am.	Goal fully met as evidenced by client verbalizing that her lower abdominal pains has reduced after intervention was given.	

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
14/11/22 at 8:00am	Waist pain related to relaxation of the pelvic joints.	Madam Debora's waist pain will reduce within 24 hours and throughout pregnancy as evidenced by: Client verbalizing that her waist pain has reduced. 2. Midwife visualizing client expressing low pain after performing activities.	1. Reassure client. 2. Educate client to engage in tolerable work activities and moderate exercises. 3. Teach husband on how to do sacral massage on Madam Debora. 4. Encourage her to take enough rest in between activities. 5. Administer prescribed analgesic (paracetamol 1g).	1. Client was reassured that she will be relieved of waist pain. 2. Madam Debora was educated to engage herself in tolerable works and moderate exercises. 3. Husband did sacral massage for client. 4. She took enough rest in between activities. 5. Prescribed analgesic thus was paracetamol administered.	15/11/22 at 8:00am	Goal fully met as evidenced by client verbalized that waist pain has reduced and she is coping.	

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
21/11/22 at 8:00am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large bowel during pregnancy.	Client will have her bowel movement once within 48 hours throughout pregnancy as evidenced by Client verbalizing that she was able to empty her bowel freely Stating that she is relief of discomfort of - constipation.	1. Reassure Madam Debora. 2. Explain the physiology of constipation to the client. 3. Educate client to take foods rich in fiber. 4. Educate client on the intake of fluids. 5. Educate client to engage in tolerable exercises such as -walking.	1. Client was reassured that she will have free bowel. 2. The physiology of constipation was explained to the client. 3. Client took food rich in fiber like vegetables and fruits. 4. Client took a lot of fluids. 5. Client understood the health benefits of exercises and engaged herself in tolerable - exercises. (walking)	23/11/22 at 8:00am	Goal fully met as evidence by client verbalizing that she passed stool twice daily and relieved from discomfort of constipation.	

NURSING CARE PLAN DURING ANTENATAL CARE CONTINUES

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
21/11/22 at 8:00am	Vaginal discharge related to increased vascularity and mucus production of the genital during pregnancy.	Client's vaginal discharge will subside within 24 hours and throughout pregnancy as evidenced by client: Verbalizing that her amount of vaginal discharge has reduced. 2. Midwife observing client free of vaginal - infection.	1. Reassure client. 2. Explain the physiology of vaginal discharge to client. 3. Encourage client to wear cotton panties. 4. Encourage client to practice good personal hygiene. 5. Encourage client to dry panties in the sun if possible or iron them.	1. Client was reassured that the discharge will reduce. 2. Physiology of vaginal discharges was explained to client. 3. Client wore cotton panties. 4. Client practiced good personal hygiene like washing her panties regularly. 5. Client dried panties in the sun or ironed them to reduce the rate of infections when it was possible.	22/11/22 at 8:00am	Goal fully met as evidence by client verbalizing that her amount of vaginal discharge has reduce.	

NURSING CARE PLAN FOR ANTENATAL CARE CONTINUES

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
21/11/22 at 10:00am	Frequency of micturition related to the growing uterus exerting pressure on the bladder.	Client will understand the cause for the frequency of micturition within 24 hours after delivery as evidence by client verbalizing: She is able to cope with the frequency of micturition. Midwife observing that client complains less of the - frequent voiding.	1. Reassure client. 2. Encourage her to lean forward when voiding to help empty her bladder. 3. Encourage her to urinate immediately when she has the urge. 4. Educate her on the use of panty liners. 5. Educate client on how to tighten the muscles.	1. Client was reassured and reminded of the frequency of micturition. 2. She leaned forward when voiding. 3. Client urinated immediately when she has the urge. 4. Client used panty liners. 5. Client understood what was taught on how to tighten the muscles around the vagina and anus.	22/11/22 at 10:00am	Goal fully met as evidence by client verbalizing that she has been relieved of frequency of micturition.	

CHAPTER THREE

3.0 INTRODUCTION

This chapter describes the management of first to fourth stages of labour, the immediate and subsequent care of the newborn and the care plans drawn for the management of the problems encountered during labour.

3.1 LABOUR

ADMISSION AND MANAGEMENT OF LABOUR

Admission of Client

Madam Debora reported to the health center with her husband on 8th December,2022 at 3:00pm which was Thursday with complain of excessive sweating. They were warmly welcomed and offered seats and further assured that she is in safe hands and readiness to support her. Client's antenatal card was collected and quickly glanced through with the midwife in- charge to refresh the memory on her past and present histories. Labour history was taken and according to her, she experienced severe pain and has seen show 2:45pm. It was explained to her that it was engagement of the fetal head which was putting pressure on the sacral nerves. She really looked anxious, so she was therefore reassured to allay anxiety and was seen mishandling her perineal pad by touching it anyhow even when it was not soiled. Her items for delivery were nicely and neatly packed in a bag and it contained all the needed items of which it was collected and labelled. She was asked about the last meal, bowel action and any drug taken. She was made comfortable in bed and all procedures to be carried out were explained to her and her consent was sought. She was encouraged also to ask questions. Her vital signs were checked and recorded as follows;

Temperature	-	36.9°C
Pulse	-	76bpm
Respiration	-	24cpm
Blood Pressure	-	114/80mmHg

Other observation recorded as

Hemoglobin	-	12.3g/dl

A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. The abdomen was inspected.

Inspection: Client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear nigra and fetal movement were present but no scar was found.

Palpation: The abdomen was palpated, symphysio fundal height was 39cm, and gestational age was 41weeks+4days, the lie was longitudinal, presentation was cephalic. Contraction was 2 in 10 minutes lasting for 31 and 34 seconds respectively. Descent was $3/5^{th}$ palpable abdominally.

Auscultation: The heart rate was 145 beats per minute with good volume and regular in rhythm.

Vaginal Examination: Madam Debora was helped onto the lithotomy position at 4:30pm. Hands were washed with soap under running water and dried with a clean towel, sterile gloves were worn

for vaginal examination. The vulva was then inspected for scars, sores, warts, edema, clitoridectomy, and abnormal discharge but none was present.

The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to it. The membranes intact, cervical dilatation was four (4) centimeters, presentation was cephalic, promontory of sacrum was not reached at 10 centimeters. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Debora's perineum was cleaned and a perineal pad applied to the vulva. Client was encouraged not to sit for a very long period but encourage to walk around to help manage the pain. Madam Debora was encouraged to lie on her left side when she felt tired. She was also encouraged to pass urine frequently and when she felt the urge as that will aid in the descent of the fetal head and effective contractions and also change her perineal pad when soiled to prevent infection. Client was covered with a cloth and made comfortable in bed and was educated on the progress of labour and findings were recorded on the labour chart. She was told to assume any position comfortable to her and sacral massage was done during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix edematous and thereby prolonging labour. She was reminded of the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied she was okay. Client's husband was offered a seat outside and he was reassured of safe delivery.

PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan: The midwife in-charge who was supervising labour was chosen as a skilled helper and was informed that she may be called to help in case of emergency for the baby and mother during and after delivery. The husband of the client who was the unskilled helper was informed to be available in order to run errands when needed. Madam Debora had two of her relatives around who were going to donate blood in case of need. The taxi driver was also informed that his service may be needed when there is emergency. The area for delivery was prepared by drawing curtains down, testing of light and making provision for artificial lighting in case of lights out and switching off fans. Madam Debora's abdomen was washed and dried to prevent infection to the baby after delivery since the baby will be placed skin to skin on the mother's abdomen. She was assisted to wash and dry her hands. Preparation of an area for resuscitation and checking of equipment was also done by preparing a dry, flat and safe space for receiving the baby for resuscitation when necessary and equipments to help the baby breathe were assembled, checked and tested for their functioning and they were in good condition. The items included the suction device, ambu bag and mask, stethoscope, scissors, timer, source of light, head covering, clothes and gloves among others. Delivery set and emergency drugs were available when checked.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labour was established Fetal heart rate, constractions and pulse was checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done 4 hourly. She complained of fatigue and nausea .Sacral massage was done and she was reassured, the physiology behind the pains explained to her and educated on deep breathing exercise during contractions. She was encouraged to take light

nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second stage of labour. She was also encouraged to adopt left lateral position to prevent supine hypotension syndrome. A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive.

At 8:30pm, client vaginal examination repeated, cervix was 8cm dilated with descent $1/5^{th}$, contractions 3 in 10 minutes lasting between 40 ,41and 44 seconds respectively with membranes still intact, foetal heart rate was 138bpm. Client's vital signs was checked and recorded as follows:

Temperature - 36.4 degrees Celsius

Pulse - 62 beats per minute

Respiration - 23cycles per minute

Blood pressure - 101/62 millimeters per mercury

Fetal heart rate - 134 beats per minute

Descent - $1/5^{th}$

Contraction - 3 in 10 lasting for 40,41 and 44 seconds

All findings were communicated and recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during that period she will have the edge to bear down to defecate and therefore asked to call the midwife.

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

- Delivery pack containing; Four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots (with one containing cotton swabs soaked in savlon solution and the other containing gauze)
- One cord scissors
- Receiver
- Episiotomy set
- Cord clump
- Pair of sterile gloves
- 10 units of oxytocin
- Three cot sheets
- Vitamin k injection

Lower shelf containing;

- Bed pan
- A receiver for placenta
- Container with syringes and needles
- Fethoscope
- Placenta bowl
- Extra perineal pad

- ❖ Antiseptic lotion savlon
- ❖ Rubber mackintosh
- ❖ Small cup containing water and bulb syringe
- ❖ Bed pan
- ❖ Lidocaine
- ❖ Measuring jag

Labour progressed well, client complained that she wants to defecate. At 9:30am on 9th December, 2022 she ruptured membranes spontaneously, she had the edge to pass stools, vaginal examination was done and the cervix was 10cm dilated, descent was 0/5th, contractions was 4 in 10 minutes lasting 46seconds and fetal heart rate was 136bpm, the perineum bulged and the anus gaped. The in-charge was informed of the progress of labour and was asked to confirm my findings and she confirmed client was fully dilated which marked the beginning of second stage of labour. Client was helped to wash her hands and chest with soap and clean water and dried with clean towel to prepare for skin-to-skin care. Vital signs and assessment were recorded as follows;

Temperature	-	36.8 degrees Celsius
Pulse	-	90 beats per minute
Respiration	-	24 cycles per minute
Blood pressure	-	110/60 millimeters per mercury
Fetal heart rate	-	136beats per minute
Descent	-	0/5th
Contraction	-	4 in 10 lasting for 45,44,42, and 46 seconds

The first stage lasted for 6 hours.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labour starts from full dilatation of the cervix to birth of the foetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby. She was asked about the position she preferred to deliver her baby with and she chose the lithotomy position and was helped to assume that position. All windows were closed and fans were turned off. Protective clothing was then worn, that is plastic apron, boots and face masks. Delivery pack was opened by the midwife in-charge and sterile gloves worn. The vulva was cleaned with cotton wool balls soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the foetus. Madam Debora was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take rest when the contractions wear off. As she pushed and the head was advancing, a clean perineal pad was placed at the anal region to prevent the stool from contaminating the delivery field and getting in to contact with baby’s face.

The middle and index fingers of the right hand were placed on the fetal advancing head to aid flexion and to allow the smallest diameter of the fetal head to distend the vulva; this was done to prevent crack or tear of the perineum. With two contractions crowning took place and the woman was asked to pant with contraction in order to prevent sudden expulsion of the fetal head. Extension of the head occurred in which sinciput, face and the chins swept the perineum and the head was born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner contour of the eyes outward using a swab at a time.

The neck was felt for cord around the neck and there was none. Restitution occurred and external rotation of the head which indicated that internal rotation of the shoulders had occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and with lateral flexion, the trunk and the rest of the body was delivered onto the mother's abdomen. The sex of the baby was noticed to be a male.

The baby coughed and started crying out very loudly. The baby was left on the mother's chest to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 9:51pm.

3.3 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from within outwards, mouth and nose to enhance patent airway. The baby was placed on the mother's abdomen and dried thoroughly off the liquor and the first minute APGAR score was recorded as;

First Minute Apgar score:

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

Within 1-3 minutes, the cord was clamped 10 centimeters away from the baby's abdomen and the cord was again clamped 8 centimeters from the mother using the forceps. The cord was covered with gauze and cut in between the clamps to separate the baby from the mother. The cord was then measured 3 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 2 finger breaths above the clamp the cord was cut. The baby was made warm by wiping off the liquor and was left on the mother's abdomen for skin-to-skin to prevent heat loss and an identification band was placed at the baby's wrist with the mother's name, sex, date and time of delivery. The condition of the baby was very good as he was actively crying and responding to stimuli.

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

This stage of labour deals with the total delivery of the placenta and membranes and control of hemorrhage. The skilled helper was asked to give 10 units of oxytocin intramuscularly at the left lateral thigh of Madam Debora with the aim of contracting the uterus after palpating to exclude second twin. Controlled cord traction was the method used in delivering the placenta in order to prevent retained placenta or products of conception. The cord was clamped closer to the perineum, a receiver was placed in between Madam Debora's thigh to receive the placenta and membranes.

The left palm was placed on the uterus to feel for contraction. With counter pressure and with the palm facing the fundus of the uterus and at the same time, the dominant hand held the clamped cord. When the uterus contracted, control traction was applied on the cord in a downward motion to deliver the placenta in the direction of the curve of carus. The steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and was twisted to deliver the placenta and its membranes. The placenta and membranes were expelled completely at 9:59pm. The placenta was placed in the receiver after quick examination was done to know

whether the membranes and lobes were intact. The uterus was rubbed to stimulate contraction and expel clots. Client was taught how to perform uterine massage and also educated on how the uterus should feel after massaging. The perineum, vulva, vagina and the cervix were swabbed and examined for tears and lacerations under a good source of light but there was no tear. A clean pad was then used to clean the liquor and the blood from her body.

A clean perineal pad was also applied to the perineum and the client was asked to lie on her back and cross her legs so that any bleeding could easily be identified. She was thanked for her cooperation and efforts. She was informed to empty her bladder whenever she felt the urge in order to prevent bleeding. Her husband was informed of a safe delivery of a baby boy and he was happy.

Finally the placenta and membranes were sent to the sluice room to be examined, Placenta and membranes were immersed in 0.5% chlorine solution for ten minutes to minimize the risk of infection during examination, afterwards per the protocol of the facility placenta was discarded. Blood loss was measured or estimated as 260 millimeters.

3.6 EXAMINATION OF THE PLACENTA

The placenta was placed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination.

The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries were seen

in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility.

The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery to detect any deviation from normal. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

3.8 PREVENTION OF DISEASE

Chloramphenicol eye drops was instilled on the baby's eyes as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

3.9 EXAMINATION OF THE NEWBORN

The procedure was explained to client. Baby's weight was 2.6 kilograms. Measurements of the baby were done and the head circumference was 31 centimeters, full length of the baby was 47centimeters and chest circumference was 30 centimeters. Baby's vital signs were checked and recorded as follows;

Vital Sign	Value
Temperature	36.0 degree celsius
Apex heartbeat	146beats per minute
Respiration	54 cycles per minute

Examination gloves were worn and baby was examined in the presence of the mother in a clean and warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of the baby was checked to be normal. The colour was pink, chest was moving normally and baby was active. A detailed head to toe examination was carried out to detect any abnormality.

Head and Neck.

The head and scalp were normal with no caput succendaneum, bulging or sunken fontanelles. The eyes were examined for the presence of eye balls, jaundice, discharge and redness but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps. No abnormality was detected. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip or tongue tie. The ears were inspected, the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for its softness. The shape and size was also

noted and no abnormality was detected. The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

Chest and Abdomen.

The chest was examined, the respiratory movement was regular and the respiratory rate was 44cpm. The space between the nipples was checked and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

Extremities.

Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. The shape and colour of the fingers were inspected for reflexes (grasping, moro reflex) and they were normal. Hands were again examined and there were no abnormalities like clubbing, extra or missing digits, nail growth and webbing. The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The lower limbs were also examined for congenital dislocation for the hip and the feet were examined for any disability such talips equinovarus but no abnormalities were found.

Genitalia and Anus.

The genital area was examined. The scrotum was palpated and testes were descended and the penis inspected, and the urethra meatus was patent and its anus was also patent

Back

The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida.

The baby was weighed and the weight was 2.6 kg, head circumference was 31cm, length 47cm. Vitamin K 1milligram was given to baby intramuscularly to prevent bleeding disorders.

In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped.

3.8 MANAGEMENT OF THE MOTHER AND BABY

Madam Debora and her baby were transferred into the lying-in room, made comfortable and also congratulated for her co-operation. Uterus was felt for contractions and her vital signs together with bleeding were monitored every 15 minutes for the first 2 hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hours post- delivery. The baby's condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. The first post-delivery vital signs were checked and recorded as follows; and the rest recorded on the partograph.

Temperature - 36.4 degree Celsius

Pulse - 71 beats per minute

Respiration - 23 cycles per minute

Blood pressure - 110/78 millimeters per mercury

She was encouraged to empty the bladder frequently to prevent postpartum complications such as postpartum hemorrhage and measuring of the fundal height. She was further informed that, emptying her bladder would provide comfort and ensure accurate measurement. Afterwards, a new

perineal pad was applied to her vulva. She was advised on personal hygiene and exclusive breastfeeding. She was then helped to lie down comfortably.

3.9 CONDITION OF MOTHER

Blood pressure - 100/80 millimeters per mercury

Fundal height - 18 centimeters

Uterus - Contracted

Lochia - Red (rubra)

Urine output - 100mls

Mother's condition was satisfactory.

3.10 CONDITION OFBABY

Sex - Male

Birth weight - 2.6kilograms

Length of the baby - 47centimeters

Head circumference - 31centimeters

Apgar Score

First minute score - 8/10

Fifth minute score - 9/10

Meconium - Passed

Urine	-	Passed

Baby's condition was satisfactory.

DURATION OF LABOUR

Duration of first stage	-	5 hours
Duration of second stage	-	21 minutes
Duration of third stage	-	8 minutes
Total duration of labour	-	5 hours 29minutes

3.11 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

0n 8th December,2022 Client complained of

1. Excessive sweating
2. Anxiety
3. Risk for urinary tract infection
4. Fatigue
5. Nausea

SHORT TERM OBJECTIVES

1. Client excessive sweating will subside within 3 hours of labour.
2. Client will be relieved of anxiety within 30 minutes.
3. Client will show no sign of urinary tract infection within 72 hours after delivery.
4. Madam Debora will have energy to bear down within 4 hours and throughout labour.
5. Client's nausea will reduce within 2 hours and throughout labour.

LONG TERM OBJECTIVE

Client will go through all stages of labour safely without any complications to herself and the unborn baby.

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
8/12/22 at 3:00pm	Excessive sweating related to stress of labour.	Madam Debora excessive sweating will subside within 3 hours as evidenced by midwife observing that client is not dehydrated and with minimal sweating. 2.Client confirming She is no more sweating.	1. Reassure Madam Debora. 2. Provide fresh air to client by putting on fan. 3. Clean face and body of client with wet towel 4. Encourage and supervise client to practice deep breathing exercise. 5.Encourage client to take shower at the 1st stage of labour.	1. Madam Debora was reassured. 2. Fan was put on to provide fresh air to client. 3. Client face and body were cleaned with towel. 4. Deep breathing exercise was encouraged. 5.Client took shower during the 1st stage of labour.	8/12/22 at 6:00pm	Goal fully met as evidenced by client not sweating and was comfortable.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
8/12/22 at 3:00pm	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within30 minutes as evidenced by client delivering a healthy baby without any complication or trauma.	1. Reassure client. 2. Establish and maintain good interpersonal relationship between you and the client. 3. Explain every procedure before and after implementation. 4. Communicate all findings to client. 5. Introduce successful women to client.	1. Client was reassured. 2. Good interpersonal relationship was established. 3. Every procedure was explained to client. 4. Findings were communicated to client. 5. Successful women were introduced to client.	8/12/22 at 3:30pm	Goal fully met as client delivered a healthy baby with no complication. 2. Client observed to be relaxed in bed.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
8/12/22 at 8:00pm	Risk for urinary tract infection related to mishandling of perineal pad	Client will show no sign of urinary tract infection within 72hours after delivery as evidenced by; The midwife visualizing that she shows no symptoms of infections and recording normal body temperature.	1. Reassure client. 2. Encourage client to wash her hands before and after touching perineal pad. 3. Educate client on the need to change perineal pad whenever soaked to prevent infections. 4. Educate client not to reapply perineal pad when it falls. 5. Explain to the client the -need for proper handling of pad.	1. Client was reassured that she will be free from infections. 2. She washed her hands before and after touching perineal pad. 3. Client changed perineal pad when soaked to prevent infections. 4. Client changed perineal pad when it falls. 5. Client handed perineal pad well.	11/12/22 at 8:00pm	Goal successfully met as Midwife reported that client showed no signs of infections such as rise in body temperature.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
8/12/22 at 3:00pm	Fatigue related to physiological activities that occurred in labour.	Madam Debora will have energy to bear down within 4 hours and throughout labour as evidenced by 1.Client verbalizing that she is much stronger now. . 2.Midewife observing client been active during 2nd stage of labour.	1. Reassure client. 2. Encourage client to rest in between uterine contractions. 3. Encourage client to take in fluids to boost her energy. 4. Encourage client to practiced deep breathing exercise. 5. Give client oral fluids.	1. Client was reassured that she will be relieved of her fatigue. 2. Client rested in between contractions. 3. Client took in fluids to boost her energy. 4. Deep breathing exercise was encouraged. 5. Oral fluid (fruit juice) was given to client to hydrate her.	/12/22 at 10:30pm	Goal fully met as client was active throughout period of labour had a safe delivery.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
8/12/22 at 3:00pm	Nausea related to hormonal actions in labour.	Client's nausea will reduce within 24 hours and labour as evidence by client verbalizing that her nausea has stopped. 2.Midwife observing that client is not feeling nauseous.	1. Reassure client. 2. Encourage client to eat light foods in bits. 3. inform client to rinse the mouth with mouth wash 4. Educate client on the causes of nausea. 5.Remove nauseating objects	1. Client was reassured. 2. Client was encouraged to eat light foods in bits. 3. Client was informed to rinse the mouth with mouthwash. 4. Client was educated on the causes of nausea. 5. Nauseated objects removed.	8/12/22 at 12:30pm	Goal fully met as evidenced by midwife observing client nausea has stopped.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the six weeks postnatal visit.

4.1 DAY OF DELIVERY

Madam Debora and baby were sent to the lying-in after six hours for close observation when her condition was satisfactory. She was made comfortable in bed with baby. Both mother and baby were kept warm. She was encouraged to put the baby to breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also encouraged to empty the bladder frequently to help in fast involution of the uterus and also to prevent the occurrence of postpartum hemorrhage.

An opportunity was taken to educate her on exclusive breastfeeding for the first six months, emptying of one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and educated to change the baby's soiled napkins frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands with soap and water after visiting the lavatory, changing her perinea pad, removing the baby's soiled napkins and also before and after touching the baby. It was explained to her the need to change her perinea pad frequently. Madam Debora took fufu and light soup for supper. Her vital signs were checked and recorded as follows;

Temperature	36.7 degree celsius
Pulse	85bpm
Respiration	24cpm
Blood pressure	114/69mmHg

The symphysio fundal height was measured to be 16centimeters. Lochia was also inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest and sleep. Client complained of after pains. Physiology of after pain was explained to her, tablet paracetamol was served with good effect. Warm compresses were applied to the lower abdomen. Client was educated to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage. She was also encouraged to try and walk about in order to aid in drainage of lochia. Again, she was advised to change her sanitary pad frequently since she was at risk of infection. She was educated on the importance of hand washing before and after changing of her sanitary perinea pad.

Madam Debora was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and pelvic floor exercises.

Madam Debora's husband was advised to help his wife in the care of the baby and also the household chores. She was then informed of possible discharge the next day which was on 9th December, 2022.

4.2 SUBSEQUENT CARE OF THE BABY

After six hours, Madam Debora was informed about the need for baby bath and general examination of the baby and she responded positively. Head to toe examination was done and no abnormality detected and all findings were communicated to her.

BABY'S FIRST BATH

REQUIREMENTS

1. Soap
2. Sponge
3. Cream / powder
4. Sterile cotton in a gallipot or wrapped
5. Basin
6. Towels: 1 big towel and 3 small ones
7. Cot sheets 2
8. Apron
9. Gloves
10. A clean baby dress, cap and socks (if available)

11. Mackintosh

12. 2 jugs containing hot and cold water each

13. Two receptacles for used water and dirty linen

14. A receiver for used swab

Procedure.

All windows and doors were closed, fans switched off and lights switched on to make the room warm. Procedure was explained to Madam Debora and was thanked for accepting. After gathering all items, the hot and cold water were mixed and temperature was tested with the elbow.

Plastic apron was then worn, hands were washed with soap and under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a protected flat surface, he was undressed and covered with the towel leaving the face. The general condition was observed and the baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in sterile water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported with my hand, the ears were plugged with my thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinse, dried and covered with clean cap.

The baby was putting back on the working surface and exposed arms and front of the trunk was washed to the feet paying attention to the skin folds then turned to the back and with one arm supported the chest and the back was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warm of water, with the head supported above the water

and the body rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small cleaned dried towel was used to dry the body paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution and were removed and discarded, hands were washed dried with clean towel.

Mother was encouraged to observe bathing and dressing of the cord. She was educated to clean the cord as well as observed at home.

Cord Dressing

The cord was dressed by wrapping the baby in a towel to keep him warm. Mother was asked to protect him on the table. The tray containing six dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. Sterile gloves were worn and cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using four of the cotton wool swabs from the base upwards. One cotton wool swab was used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left expose to air dry.

Baby was dressed nicely, wrapped and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby.

Vital signs were also checked and the findings were communicated to the mother and documented as follows:

Head circumference	31 centimeters
Length	47 centimeters
Weight	2.6 kilograms
Apex beat	146 beats per minutes
Temperature	35.7 degree celsius
Respiration	54 cycles per minute

Baby's condition was good.

At 12:00 am mother and baby were seen to find out how they were faring, they were in good condition. They were both examined and their vitals were checked since they were not yet discharged;

Temperature	36.4 degree celsius
Pulse	82 beats per minute
Respiration	22 cycle per minute
Blood pressure	110/70 millimeters of mercury

The baby’s vital signs were also checked and findings were communicated to his mother

Temperature	36.3 degree celsius
Respiration	40 cycles per minute
Pulse	140 beats per minute
Weight	2.6kg

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery was 9^{h} December,2022. Mother and baby were seen in the lying- in ward at 8:00am to find out how they were faring. Greetings were exchanged and Madam Debora was asked about how she and the baby were doing and she said they were both doing well, except that she had after pains while breast feeding the baby. She was reassured and educated on the physiology of after pain that is a normal physiology thus the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes lower abdominal pain. She was given paracetamol 1g to reduce the pain. Madam Debora also complained of less sleep because the baby cried a lot during the night. She was encouraged to attend to the baby whenever it cried in the night and have enough sleep when the baby is asleep. She was urged to change baby diapers when wet. She had already emptied her bladder and taken her bath. Permission was sought for head-to-toe examination. A puerperal assessment was then made. The conjunctiva was inspected for sign of anemia but it was absent. The breasts were lactating very well and the uterus was well contracted when palpated and measured, the symphysio fundal height measured 15cm. The perinea

pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive odour. She was then encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she was served with hausa porridge and a loaf of bread as breakfast. Madam Debora's vital signs were checked and recorded as follows;

Temperature	36.2 degree celsius
Pulse	72 beats per minutes
Respiration	19 cycles per minutes
Blood pressure	111/67 millimeters of mercury

Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanelles that was explained to her that the fontanels close naturally. And also, how to position herself when breastfeeding, how to put the baby to breast were demonstrated to her to enable her breastfeed well and prevent breast sore.

Baby was also examined with permission from the mother after hand washing was done with soap and under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected. The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord dressed with methylated spirit. The baby was dressed nicely and wrapped in a clean warm sheet. Baby's vital signs checked and recorded as follows

Temperature	35.7 degree celsius
Pulse	146 beats per minutes
Respiration	54 cycles per minutes
Weight	2.6 kilometers

The baby was given the first immunization Bacilli Calmette Guerine (BCG)0.05millimeters vaccine intra dermal on the right upper arm for protection against tuberculosis. Client was educated that she should not apply anything on the injection site or massage it. She was told that there could be a tissue reaction over the area, a scar formation later indicating that the child had been immunized against tuberculosis effectively. Polio vaccine of 2 drops at de back of the tongue was also given orally to protect the baby against polio myelitis. Vitamin K giving to prevent bleeding. Chloramphenicol eye drop given to prevent infections. Client was educated to continue with baby's immunization schedule at well baby clinic. This would help prevent baby contracting any of the childhood preventable diseases. Client was also told to register the baby at the birth and death unit and complete all the immunization schedules.

Mother was educated on personal hygiene, post-natal exercise, keeping the baby's cord clean, dry and avoid the application of unprescribed medication on it, change baby's diapers or napkins frequently when soiled and wash and dry in the sun, take in nutritious diet and fruits which are available, provision of warmth to the baby and prevention of infection by changing her perinea pad whenever it was soiled and also she was educated on exclusive breastfeeding and the need to feed on demand and at night which will serve as family planning as well as aiding in involution.

Client was informed about her discharge. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. I was assisted by her mother, to pack her belongings, and her health insurance card was used to settle her bills. Prescribed drugs were given as below;

Iron III polymaltose complex capsule	30 days(daily)
Amoxycillin capsule 500mg	7 days (three times daily)
Metronidazole tablets 400mg	7 days (three times daily)
Paracetamol tablet 1g	5 days (three times daily)

The dosage and time for taking the drugs were explained to her. Madam Debora was also told that she would be visited for one week to check on her condition and that of the baby and continued with their care. She was discharged home at 10:00am and was escorted with her items into a car brought in by her husband. 16th December,2022 was scheduled as date for one-week visits and the circumcision for the baby of which she agreed. They were reminded of the visit to their house and bid them farewell as the car drove off.

4.4 FIRST DAY POST NATAL HOME VISIT

Madam Debora was visited in her home in the evening at 5:00pm as scheduled that is on the 9th December, 2022.On arrival, greetings were exchanged with a warm welcome. She was neatly dressed and had already set the place for the baby to be bath; the baby was then toped and tailed. It was explained to her that physical examination will be done on her and the baby, dress the baby's cord and also check her vitals. The cord was dressed with cotton wool swabs soaked in methylated spirit. Mother was also examined from head to toe and there were no abnormal changes. The fundal

height measured 15cm. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with moderate amount of flow. Her vital signs were taken and recorded as;

Temperature	36.4 degree celsius
Pulse	78 beats per minutes
Respiration	21 cycles per minutes
Blood pressure	110/70 millimeters of mercury

Baby was not jaundiced or pale and was able to suckle well. Client was told that during her first postnatal visit to the clinic her baby will be circumcised since he was a male. The need for circumcision was then explained to her as a means of preventing infection to child. Baby's vital signs were taken and recorded as follows

Temperature	36.8 degree celsius
Pulse	134 beats per minutes
Respiration	38 cycles per minutes
Baby's weight	2.5 kilograms

Madam Debora was encouraged to breastfeed the baby on demand. A promise was made to visit them again the following day and client said good bye and the family were bid farewell.

4.5 SECOND DAY POST-DELIVERY.

On 10th December,2022 the second visit was made to Madam Debora's house at 6:30am and 5:30pm in the morning and evening respectively as scheduled. Madam Debora said her condition had improved. Baby was also doing well. The family was pleased. Permission was sought from Madam Debora to inspect her perinea pad and perinea area was clean and the lochia was red (rubra), not offensive and the flow was moderate. She was asked to empty her bladder before the examination. She emptied her bladder and the head-to-toe examination was carried out and everything was normal. The breasts were firm and well lactating. Uterus was firm and symphysio fundal height measured 14cm in the morning and 13cm in the evening. General examination was carried out on the baby from head to toe and no abnormality was revealed. Baby was toped and tailed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine. Mother and baby's vital signs and weight were taken and recorded as follows;

Observation on Mother

Observation	**Morning**	**Evening**
Temperature	36.4degree celsius	36.4degree celsius
Pulse	78bpm	74bpm
Respiration	21cpm	23cpm
Blood pressure	115/66mmHg	110/70mmHg
Fundal height	14cm	13cm
Lochia	Rubra	Rubra

Condition of uterus	Contracted	Contracted
Breast	Lactating	Lactating

Baby was top and tailed while I asked both mother and father including the family member to observe the procedure. After which baby's cord was dressed with spirit. Cord was clean and dried with no offensive odour. Head to examination was done on the baby and nothing abnormal was seen. Baby's vital signs were checked and recorded as;

Observation on Baby

Observation	**Morning**	**Evening**
Temperature	36.5degree celsius	36.1degree celsius
Apex beat	134bpm	130bpm
Respiration	42cpm	44cpm
Stool Colour	Greenish	Pink
Cord	No bleeding	Clean
Skin Colour	Pink	Pink
Suckling	Yes	Yes
Weight	2.5kg	2.5kg

Baby was wrapped in warm sheet. He was handed over to the mother to breastfeed. Madam Debora was thanked for her cooperation and permission was sought to leave, which was granted.

4.6 THIRD DAY POST-DELIVERY.

On the 11th December,2022 the second home visit was made to Madam Debora's house at 6:00am in the morning and 5:00pm in the evening. Mother and baby were doing well. Permission was sought to inspect Madam Debora's perineal pad and the lochia was red (rubra) without offensive odour. Head to toe examination was also done and everything was normal. Breasts were heavy and breast milk was flowing freely. Symphysio fundal height was measured 13cm and 12cm in the morning and evening respectively. The baby was top and tailed, assessed and general condition was good and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed greenish yellow stools and urine.

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

Observation on Mother

Observation	**Morning**	**Evening**
Temperature	36.6degree celsius	36.4degree celsius
Respiration	22cpm	23cpm
Pulse	80bpm	82bpm
Blood pressure	100/70mmHg	100/65mmHg
Lochia	Rubra	Rubra

Fundal height	13cm	12cm
Condition of uterus	Contracted	Well contracted
Breast	Lactating	Lactating

Observation on Baby

Observation	**Morning**	**Evening**
Temperature	36.6degree celsius	36.5degree celsius
Apex beats	139bpm	140bpm
Respiration	40cpm	42cpm
Skin colour	Pink	Pink
Cord	Clean	Clean
Suckling	Yes	Yes
Weight	2.4kg	2.4kg
Stool colour	Greenish	Greenish

Again, permission was sought to leave from Madam Debora of which granted. She was thanked and a bid was made.

4.7 FOURTH DAY POST-DELIVERY

Madam Debora and her baby were visited again on 12th December, 2022 in the evening at 5:40 pm to continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected. Lochia was rubra on inspection, no odour and breasts were lactating. Head to toe examination was done and everything was normal. Symphysio fundal height measured 11cm. Baby had been bathed by client's mother on arrival so the general examination was carried out. No abnormality was found. The cord was neatly dressed and has shrinked with no abnormality detected. Madam Debora complained of fullness in the breast. She was educated to continue breastfeeding the baby, and to apply cold compress on them to reduce the pain. She was educated to ensure that one breast was empty before the other one was given to the baby. The baby passed dark yellow stools and urine. Mother and baby's vital signs were checked and recorded as follows;

Observation on Mother

Observation	**Evening**
Temperature	36.7 degree celsius
Pulse	80bpm
Respiration	23cpm
Blood pressure	110/mmHg

Lochia	Rubra
Fundal height	11cm
Condition of the uterus	Well contracted
Breast	Lactating

Observation on Baby

Observation	**Evening**
Temperature	36.7 degree celsius
Apex beat	132bpm
Respiration	38cpm
Weight	2.4kg
Cord	Dry
Suckling	Yes
Stool Colour	Yellowish

4.8 FIFTH DAY POST- DELIVERY.

The 5th postnatal home visit was on 13h December, 2022 at 5:30pm to continue with the post- natal care. Mother and baby were both in a healthy condition. Inspection of the lochia was done and the colour was serosa (pink) with symphysio fundal height measured 10cm. After the head-to-toe examination, no abnormality was detected. Client's vital signs were checked and recorded as follows:

Observation on Mother

Observation	**Evening**
Temperature	36.5 degree celsius
Pulse	85bpm
Respiration	22cpm
Blood pressure	100/72bpm
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

Head to toe examination was done and no abnormality was found on the baby. The cord was dry and not completely off so baby was topped and tailed. The baby urinated and passed yellowish

stool and was cleaned immediately. Vital signs and other observations were taken and recorded as follows:

Observation on Baby

Observation	**Evening**
Temperature	36.4 degree celsius
Apex beat	130bpm
Respiration	35cpm
Weight	2.5kg
Cord	Dry
Suckling	Yes
Stool colour	Yellowish

Madam Debora was reminded of the next visit and she said she was very grateful; permission was sought and she was thanked for her cooperation.

4.9 SIXTH DAY POST-DELIVERY.

The 6th day postnatal home visit was made on 14th December, 2022 at 5:00pm. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and client said fullness of breast has subsided except that there are rashes on baby's skin and he cries a lot. She was reassured and encouraged to feed the baby

well and change napkins before she sleeps and also educated to dress baby according to weather and use talcum powder on the baby's skin. Symphysio fundal height measured 9cm. Inspection of the lochia was done and the colour was serosa (pink) with odour indicating infection due to poor personal hygiene. She was educated to keep her perineum clean and change pad frequently to prevent infection and educated on family planning. After head-to-toe examination, no abnormality was detected.

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

Observation on Mother

Baby was bathed, head to toe examination was done and no abnormality was found on the baby. During the examination, it was realized that the cord had fallen off. The stump was then dressed with cotton wool swab and the area was cleaned and kept dry. Stool was yellowish in colour. Baby looked healthy and active. Baby's vital signs and other observations were taken and recorded as follows:

Observation on Baby

Observation	**Evening**
Temperature	36.7 degree celsius
Apex beat	145bpm
Respiration	38cpm
Weight	2.6kg

Cord	Off (Clean)

Madam Debora was encouraged to continue exclusive breastfeeding. She was thanked for her cooperation and time. And also remembered her of the one-week visit, interacted for a while and permission was sought to leave.

4.10 SEVENTH DAY POST DELIVERY.

The 7th day postnatal was made on 15th December, 2022. Madam Debora and baby was visited as usual in the morning at 5:00am. Mother and baby were in a healthy condition and client said the baby's crying had minimized. She complained of backache. She was reassured and encouraged to adopt a good posture when breastfeeding the baby. Inspection of lochia was done and the colour was serosa (pink), flow was scanty without any bad odour. Symphysio fundal height measured 8cm. After the head-to-toe examination, no abnormality was detected. Mother and baby's vital signs were as follows

Observation on Mother

Observation	Evening
Temperature	36.4 degree celsius
Respiration	21cpm
Pulse	77bpm
Blood pressure	110/62mmHg

Fundal height	8cm

Baby's Observation

Observation	**Morning**
Temperature	36.5 degree celsius
Apex beat	135bpm
Respiration	42cpm
Weight	2.7kg
Cord	Clean

She was encouraged to continue adhering to all the advices and encouragement given to her especially on nutrition, exercise, rest and sleep and maintaining good personal and environmental health.

Madam Debora was also encouraged to take good care of the baby and breastfeed exclusively. Client was also reminded to register the baby at the birth and death unit and complete all the immunization schedules. She was again reminded on the circumcision of her baby on the first postnatal visit to the clinic. They were told that day was the last visit.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Debora and her baby reported at the hospital on 16th December, 2022 at 9:00am accompanied by her sister. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal site and a seat was offered to them to listen to a health talk on immunization against the preventable childhood disease, exclusive breastfeeding and family planning.

After the talk client and baby were taken to the examination room to be examined. With permission from mother, baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Debora and hands were washed and dried. The fontanelles and sutures were examined for any bulging fontanels or widening sutures but there were none. The eyes, nose and ears were examined and no abnormalities were detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical cord was completely healed. The extremities and the back were also examined and there were no abnormalities.

Baby's weight was 2.8kg and his vital signs checked and recorded were as follows:

Temperature	36.5 degree celsius
Apex beats	142bpm
Respiration	50cpm

All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeed well.

Madam Debora was also examined and was asked to empty her bladder for physical examination after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Fundus was not palpable. Hands were washed and dried. Her vital signs checked and recorded as;

Temperature	36.7 degree celsius
Pulse	84bpm
Respiration	24cpm
Blood pressure	103/74mmHg

On inspection, client's hair was clean and nicely plaited her conjunctive and sclera was pink without any pallor. The nose, mouth and ears were clean without any discharges. The breast was heavy, soft and lactating well with healthy nipples. The upper and lower extremities were without oedema and her back was normal. The lochia was scanty and creamy white. She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Madam Debora was advised to maintain good personal and environmental hygiene in the care of herself and the baby. Madam Debora was again educated on her nutrition and was asked to eat foods that are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate rest and sleep. Client said the backache has subsided. Madam Debora was encouraged to register her baby at the birth and death registry since there was none at the health center. Baby was sent to the man-in-charge for circumcision for the baby to be circumcised. Client was reminded of

the six weeks postnatal visit to the clinic. Gratitude and thanks were expressed to Madam Debora and the entire family for their support and co-operation throughout the writing of the care study. She was finally handed over to the public health nurse in-charge to continue with the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in- charge, Madam Debora's six weeks postnatal visit was on 24th December, 2022. At 9:00am. She came to the facility with her husband. Head to toe examination was done on Madam Debora and nothing abnormal was present. Her vital signs, including the weight were checked and recorded as follows;

Temperature	36.5 degree celsius
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Weight	64kg

Madam Debora's urine was checked for protein and sugar and it was negative for both, and the hemoglobin was 12.0g/dl. Her fundus was not palpable and no lochia observed.

The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

Vaccine	Dosage	Route of Administration
Polio1	2 drops	Oral
Rotarix	2 drops	Oral
Penta	0.5 milliliters	Intramuscularly on right thigh

Baby's vital signs and other observations were checked and recorded as:

Temperature	36.2 degree celsius
Pulse	24cpm
Respiration	141bpm
Weight	2.7kg

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. She also expressed her gratitude for all the support offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

4.13NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. After pain. (9th December, 2022).
2. Sleeplessness. (9th December, 2022).
3. Breasts engorgement. (12th December, 2022).
4. Rash on baby's skin. (14th December, 2022)
5. Backache. (15th December, 2022)

SHORT TERM OBJECTIVES

1. Madam Debora after pain will be relieved within 48 hours.

2. Client will have at least 4hours sleep within 24 hours.

3. Client's breast engorgement will subside within 72 hours.

4. Baby will have no skin rashes on skin within 72 hours.

5. Client's backache will resolve within 48 hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/12/22 at 7.00am	After pain related to involution of the uterus.	Madam Debora's after pain will be relieved within 48hours as evidenced by client verbalizing her after pain has reduced. 2. Midwife visualizing that client is reduced of- after pain.	1. Reassure client. 2. Explain the cause of pain to client. 3. Encourage client to assume any comfortable position of her choice. 4. Encourage client to empty her bladder frequently. 5. Serve her with prescribed analgesics.	1. Client was reassured. 2. The cause of pain was explained to her. 3. Client assumed any comfortable position of her choice. 4. Client emptied her bladder frequently. 5. Client was served with analgesics (Paracetamol 1g).	11/12/2 2 at 7:00am	Goal fully met as 1. Madam Debora verbalized that her after pain has reduced. 2. Midwife visualized that client look cheerful on assessment.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
9/12/22 at 5:00pm	Sleeplessness related to baby's crying and feeding at night.	Client will have at least 4hours sleep within 24 hours evidence by client verbalizing that she now sleeps for at least 4 hours at night and 2 hours during the day. 2.Client's husband testifying that client is able to sleep.	1. Reassure the client. 2. Encourage client to practice kangaroo mother care. 3. Encourage client to sleep when baby is asleep. 4. Encourage her support person to help her in the household chores. 5. Encourage client to rest-during the day.	1. Client was reassured. 2. Client practiced kangaroo mother care. 3. Client slept when baby was asleep. 4. Her relatives helped her in the household chores like washing to enable her to sleep during the day. 5. Client rested during the day.	10/12/22 at 5:00pm	Goal achieved as client verbalized that she's able to sleep well at night.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/12/22 at 4:30pm	Breast engorgement related to inadequate emptying of the breast.	Client's breast engorgement will subside within 72 hours. as evidenced by Client verbalizing that she feels comfortable in her breast and the midwife visualizing that the fullness is reduced.	1. Reassure client. 2. Teach client on how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding. 4. Encourage client to empty breast when not feeding. 5. Encourage client to continue breastfeeding the baby exclusively.	1. Client was reassured. 2. Client was taught how to fix baby correctly to the breast. 3. Demonstration was done to client on how to position baby during breastfeeding. 4. Client emptied the breast. 5. Client to continued breastfeeding the baby exclusively.	15/12/22 at 4:30pm	Goal fully met as client reported that she has been relieved of breast engorgement.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/12/22 at 7:00am	Skin rashes on baby related to excessive dressing of baby.	Baby will have no skin rashes on skin within 72 hours as evidenced by client verbalizing that the baby skin rashes has resolved. 2. Midwife observing that baby- is having no rashes.	1. Reassure client. 2. Educate client on the need to clothe baby according to the weather. 3. Educate client not to scratch the rashes. 4. Teach client how to use prescribed powder for the rashes example Vaseline, shea butter and Listerine powder. 5.Client was encouraged to use mild soap to bath the baby.	1. Madam Selina was reassured. 2. Client dressed baby in warm cotton cloths and according to the weather changes. 3. Mother did not scratch the rashes as it would cause more pain and infection. 4. Client was taught on how to use the prescribed powder for the rashes example Vaseline, shea - butter and Listerine powder. 5.Client used mild soap in bathing the baby.	17/12/22 at 7:00am	Goal met as Madam Debora informed the midwife that baby's skin rashes has resolved. 2. Midwife observed that baby has no skin rashes.	

NURSING CARE PLAN ON PUERPERIUM.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/12/22 at 4:30pm	Backache related to poor posture during breastfeeding.	Client's backache will resolve within 48 hours as evidenced by 1. Client verbalizing that pain has relieved. 2. Midwife observing -client assume good posture during breastfeeding.	1. Reassure client. 2. Teach client how to position herself when breastfeeding. 3. Teach client other breastfeeding methods. 4. Encourage client to support her back with pillow when sitting to breastfeed baby. 5.Encourage family members to support in the care of the newborn.	1. Client was reassured. 2. Client was taught how to position herself when breastfeeding. 3. Client was taught other breastfeeding methods example; side line, cradle and cross cradle 4. Client supported her back with pillow when sitting to breastfeed baby. 5. The family members were - encouraged to help in the care of the baby.	17/12/22 at 4:30pm	Goal met as evidenced by client verbalizing that she is relieved of pain. 2. Midwife observing that client look cheerful on assessment and assumed good - posture change when breastfeeding.	

SUMMARY AND CONCLUSION

This script is a Family Centered Maternity Care, given to Madam Debora, a 28 years old woman gravida 4 Para 3. She hails from Ayimom in the Bono Region. She was met at Jinijini Health Centre, on 14th November,2022 when she was 38weeks +1day pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Client went through pregnancy with some minor disorders which were managed successfully.

Madam Debora's labour and delivery were managed carefully without any complications. She delivered spontaneously an alive male infant with birth weight 2.6kg on the 8th December, 2022 at 9:51pm who cried immediately after birth.

Madam Debora's puerperium was successful, mother and baby were visited at home and finally handed over to the Community Health Nurse for further management on 16th December, 2022.

The Family Centered Maternity Care has afforded me the opportunity to identify the various needs of the expectant woman during pregnancy, labour and puerperium.

The knowledge and experience acquired will be translated to other expectant mothers, their families and the community members during my practice as a midwife.

I n conclusion, the client/family centered maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform them and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity.

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APPENDIX I

COMPLETE DIAGNOSTIC MEASURES

Date	Specimen	Investigation	Normal Range	Findings	Remarks
16/05/22	Blood	Hemoglobin level	11-16g/dL	14.1g/dL Negative	Normal
		Sickling	Negative	Positive	Normal
	Urine	Rhesus factor	Positive/Negative	O	Normal
		Grouping	A, B, AB, O	Negative	Normal
		HIV status	Negative	Negative	Normal
		Hepatitis B Syphillis	Negative	Negative	Normal
			Negative	Negative	Normal
		G6PD	Negative		Normal
		Protein		Negative	
		Sugar	Negative	Negative	Normal
			Negative		Normal
15/08/22	Blood	Hemoglobin level	11-16g/dL	11.1g/dl	Normal
	Urine	Positive	Negative	Negative	Normal
	Sugar	Negative	Negative	Negative	Normal
4/09/22	Blood	Hemoglobin level	11-16g/dL	11.6g/dl	Normal
	Urine	Positive	Negative	Negative	Normal
	Sugar	Negative	Negative	Negative	Normal
17/10/22	Blood	Hemoglobin level	11-16g/dL	11.4g/Dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
14/11/22	Blood	Hemoglobin level	11-16g/dL	11.0g/Dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
29/11/22	Blood	Hemoglobin level	11-16g/dL	11.6g/Dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Ferrous Tablet	Haematinics	200mg daily for 30 days	Orally	Aids in Red Blood Cell formation	Increase in hemoglobin level	Black stool, diarrhea and constipation	None
Folic Acid Tablet	Vitamin preparation	5mg daily for 30 days	Orally	Helps in the formation of blood cell	Increase in hemoglobin level	Nausea, vomiting, diarrhea and constipation	None
Multivitamin Tablet	Vitamin preparation	200mg daily for 30 days	Orally	Increases appetite and helps in the formation of RBC	Increase in appetite	Gastrointestinal disturbance	None

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	**Classification**	**Dosage**	**Route**	**Actions and Uses**	**Actual Effect**	**Side Effect**	**Side Effects Experienced**
Paracetamol Tablet	Antipyretics/ Analgesic	1g tds x 3	Orally	Reduces mild to moderate pain	Client pain was relieved	Liver damage due to prolong use	None
Tetanus Injection	Anti-tetanus drugs	0.5mg	Sub-Cutaneous	Protect mother and fetus against infections	Client was protected against tetanus infection	Mild fever	None
Sulphadoxine Pyrimethamine Tablet	Anti-malaria prophylaxis	3 tablets start from 16 weeks interval/ quickening and repeated at 4 weeks intervals till delivery	Orally	Prevention of malaria	Malaria was prevented	Malaria was prevented	None
Oxytocin injection	Oxytocin drug	10 units	Intra-muscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting, uterine spasm and raised blood pressure	None

APPENDIX III

PHARMACOLOGY OF DRUGS (BABY)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Vitamin K	Group K vitamin	0.5ml	Intra-muscular	Prevent hemolytic diseases	No bleeding	Risk of hemolysis in people with G6PD, rashes and brain damage	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	Treatment of bacterial eye infection	To prevent eye infection	None	None
Bacilli Calmette Guerin injection	Antigen vaccine	0.5ml	Intra-dermal	Production of antibodies. Immunity against tuberculosis	Tuberculosis prevention	Mild fever, swelling of injection site and blister formation	Blister noticed
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent Poliomyelitis	Polio prevention	There may be diarrhea	None observed
Pneumococcal	Antigen	0.5milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, heamophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus vaccine	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

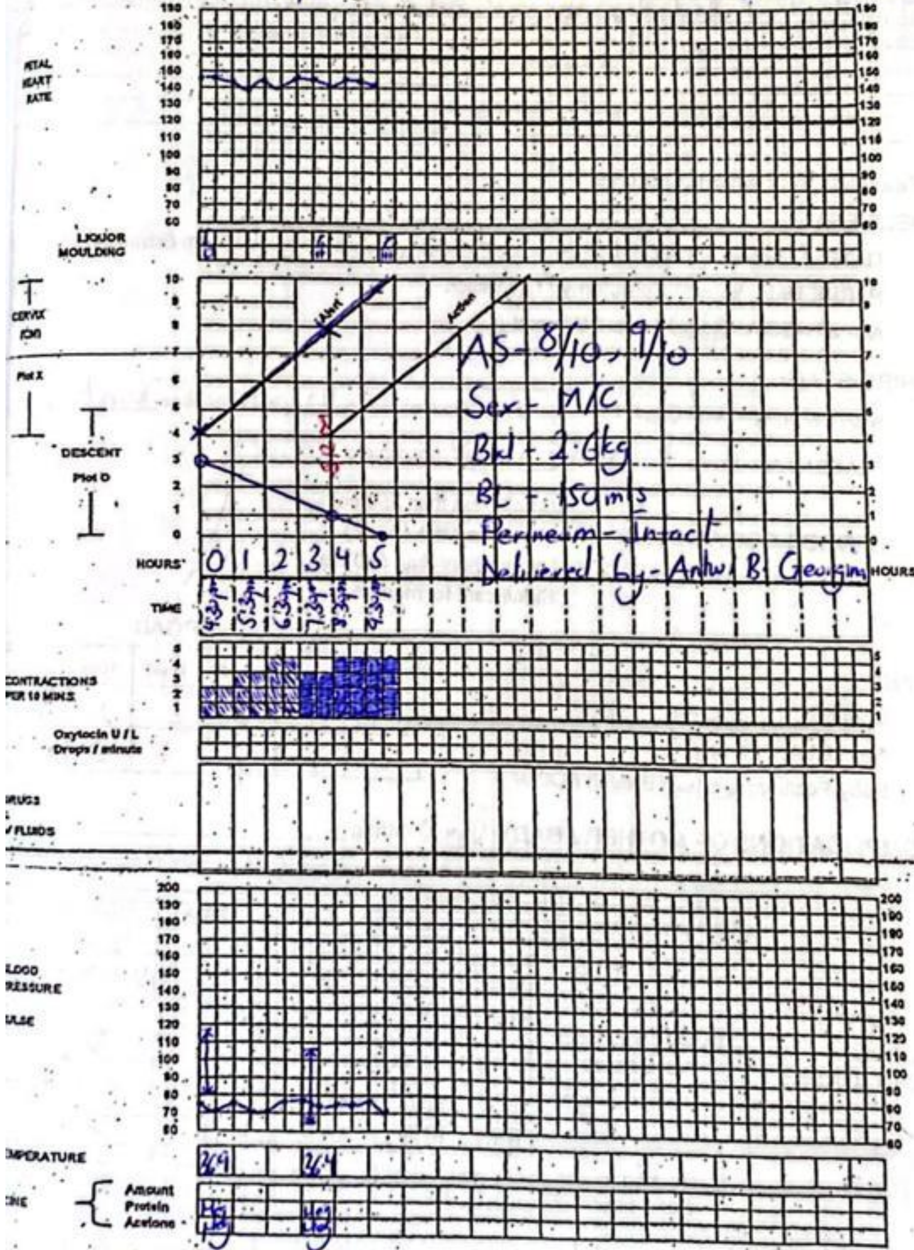
APENDIX 1

ANTENATAL RECORD FOR MADAM AYIWA

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/SUGAR	GESTA-TIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
16/05/22	55kg	91/64mmHg	Negative/ Negative	_	_	_	_	_	Routine drugs, Tab Paracetamol 1g	Headache and General body weakness	OAG
5/08/22	57kg	114/74mmHg	Trace/ Negative	23weeks+5days	21	_	_	_	Routine drugs	No complains	Mable
15/08/22	56kg	120/78mmHg	Trace/ Negative	25weeks+1day	24cm	_	_	156bpm	Routine drugs	Stomach pain and LAP.	Esther
19/09/22	55kg	117/76mmHg	Negative/ Negative	30weeks+1day	28cm	_	_	148bpm	Routine drugs	No complains	Vivian
17/10/22	61kg	112/72mmHg	Negative/ Negative	34weeks+1day	32cm	Cephalic	_	142bpm	Routine drugs	Doing well	Usman
14/11/22	63kg	113/77mmHg	Negative/ Negative	38weeks+1day	36cm	Cephalic	_	138bpm	Routine drugs	Waist pain	Gina

ANTENATAL RECORDS OF MADAM DEBORA CONTINUE

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATION-AL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
21/11/22	62kg	100/74mmHg	Negative/ Negative	39weeks+1day	36cm	Cephalic	_	137bpm	Routine drugs	No complains	Gina
14/10/21	69kg	112/60mmHg	Negative/ Negative	40weeks+2days	37cm	Cephalic	_	139bpm	Routine drugs	No complains	Gina



WHO Modified Partograph

Registration No. 118/22 Name (Last, First) Ofonwao Debora Age 28years
Date 8/12/22 Parity/Gravida 3, 4 LMP EDD 5/12/22 Gestation (wks) 41+3 weeks
ROM (Time, Date) 8:34 8/12/22 Labour Duration (Hrs) 5 hrs Facility/Clinic Name Sinjini Health Center

FETAL HEART RATE

LIQUOR
MOULDING

CERVIX (cm) Plot X

DESCENT Plot O

Alert
Action

AS - 8/10, 9/10
Sex - M/C
BW - 2.6kg
BL - 150mls
Perineum - Intact
Delivered by - Antw/ B. Georgina

HOURS 0 1 2 3 4 5

TIME

CONTRACTIONS PER 10 MINS

Oxytocin U/L
Drops / minute

DRUGS
I/V FLUIDS

BLOOD PRESSURE
PULSE

TEMPERATURE 36.9 36.4

URINE Amount Protein Acetone

CS Scanned with CamScanner

LABOR NOTES
At 9:45pm client complained of bearing down. She was positioned on a couch. Client pushed to an alive male infant. Baby was placed skin to mother. Cord clamped and cut. Third stage managed actively by controlled cord traction. Perineum was intact.

Please circle or write responses.

DELIVERY

DATE: 8/12/2022 TIME: 9:51pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 9:52pm Type/Dose 10units of oxytoc

PLACENTA: Time: 9:59pm (Complete) / Incomplete

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

BABY

Weight: 2.6kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	T
1 min	1	2	2	2	1	
5 min	2	2	2	2	1	

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

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bla
Every 15 minutes first 2 hours	10:10pm	110/78	71bpm	16cm	150mls	–
	10:25pm	100/80	70bpm	well contracted	No active bleeding	–
	10:40pm	110/75	75bpm	well contracted	✓	–
	10:55pm	98/70	68bpm	well contracted	✓	80
	11:10pm	90/66	62bpm	well contracted	✓	–
	11:25pm	110/88	70bpm	well contracted	✓	–
	11:40pm	100/80	73bpm	well contracted	✓	–
	11:55pm	115/82	70bpm	well contracted	✓	90
Every 30 minutes For 1 hour	12:25am	100/80	70bpm	well contracted	✓	–
	1:25am	100/70	72bpm	well contracted		

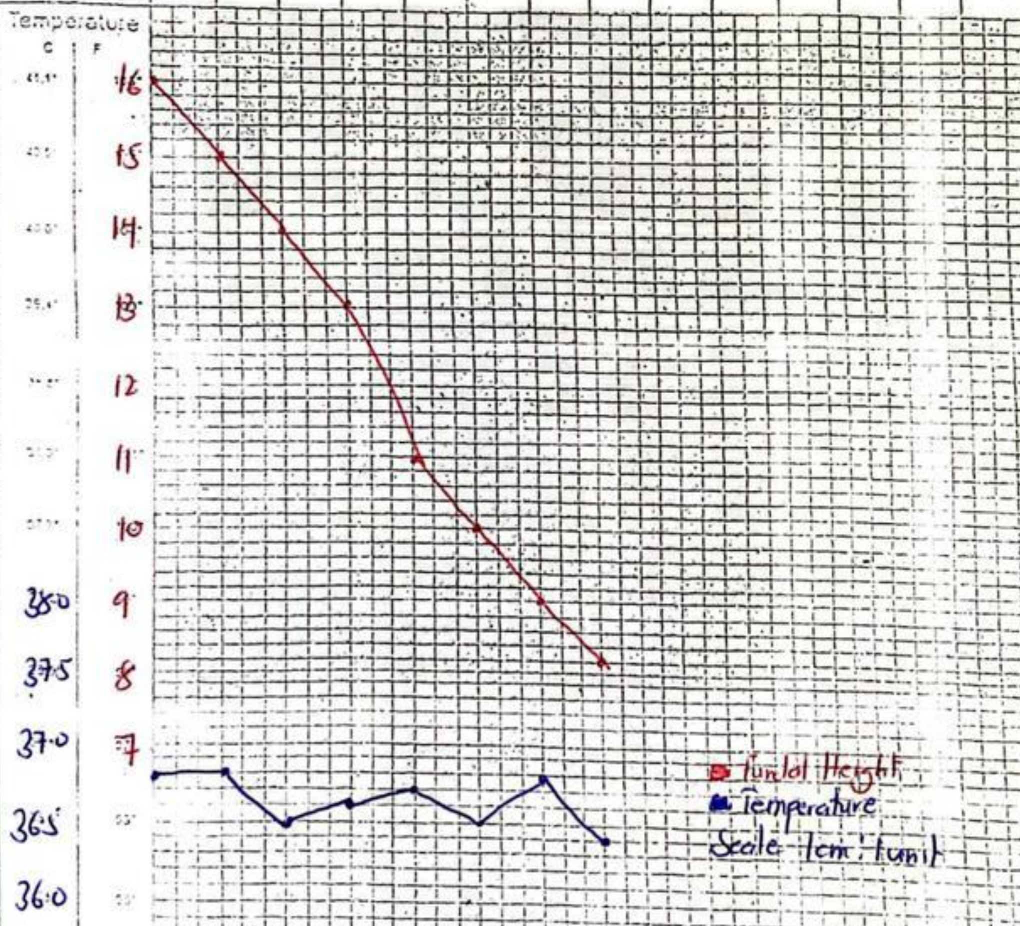
Birth Attendant Georgina Antwi Boasiakoh (Student midwife) Date 8/12/202

Assisted by Sarpomaa Priscilla (Staff midwife)

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

Scanned with CamScanner

MATERNITY CHART



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HOLY FAMILY HOSPITAL

BEREKUM

NEW BORN EXAMINATION FORM

Name: Baby Yaw Oforiwaa   Date of Assessment: 8/12/2022   Time: 10:34pm

Date of Birth: 8/12/2022   Time of Birth: 9:51 pm   Sex: [x] M [ ] F   Age at time of Assessment (days/hrs): 1:43mins

Gestational Age: 41wks +6 days   Mode of Delivery: [x] Vaginal   Assisted Vaginal   C-Section

APGAR: 1min 8/10   5min 9/10   Birth Weight: [ ] 2.6 kg [ ]   Length: 47 cm   Head Circumference: 31 cm

Temperature at time of Assessment: 36.0 °C   Urine passed: Yes No   Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Antwi Boasiako Georgina

1. Respiration
Rate: 54
- [ ] Rate < 30 b/m *
- [ ] Rate > 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

2. Activity/Movemnet
- [ ] 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: 146bpm
- [x] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

20. Abdomen
- [x] Normal
- [ ] Distended*
- [ ] Scaphoid*
- [ ] Abdominal defect*
- [ ] Masses ____
- [ ] 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
- [ ] Normal
- [ ] Fistula(meconium urine through abnormal opening in vagina) *
- [ ] Large clitoria *
- [ ] Other: ____

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

25. Resuscitation provided
- [ ] One
- [x] 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 [x] Polio immunization
- [ ] Antibiotics in mother
- [ ] Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known): Spontaneous Vaginal delivery

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

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

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NEW BORN CHART

Name: Baby Yaw Oforiwaa No: 120/22 Birth Weight: 2.6kg

Sex: Male Mother's No: 118/22 Length: 47cm

Nature of Delivery: Spontaneous Vaginal delivery Diagnosis: Term baby

Date of Birth: 8/12/2022 Time: 9:51pm Date of Discharge: 9/12/2022

Date	8/12/22		9/12/22		10/12/22		11/12/22		12/12/22		13/12/22		14/12/22		15/12/22		16/12/22					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	2.6 kg		2.6kg		2.5kg		2.4kg		2.4kg		2.5kg		2.6kg		2.7kg		2.8kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		35.7°C	35.7°C	36.8°C	36.5°C	36.1°C	36.6°C	36.5°C		36.7°C		36.4°C		36.7°C	36.5°C			36.6°C				
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed	Passed			Passed				
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed	Passed			Passed				
Remarks	Head, Neck, Limbs, Genitalia > Ho abnormality detected (H.A.D)																					

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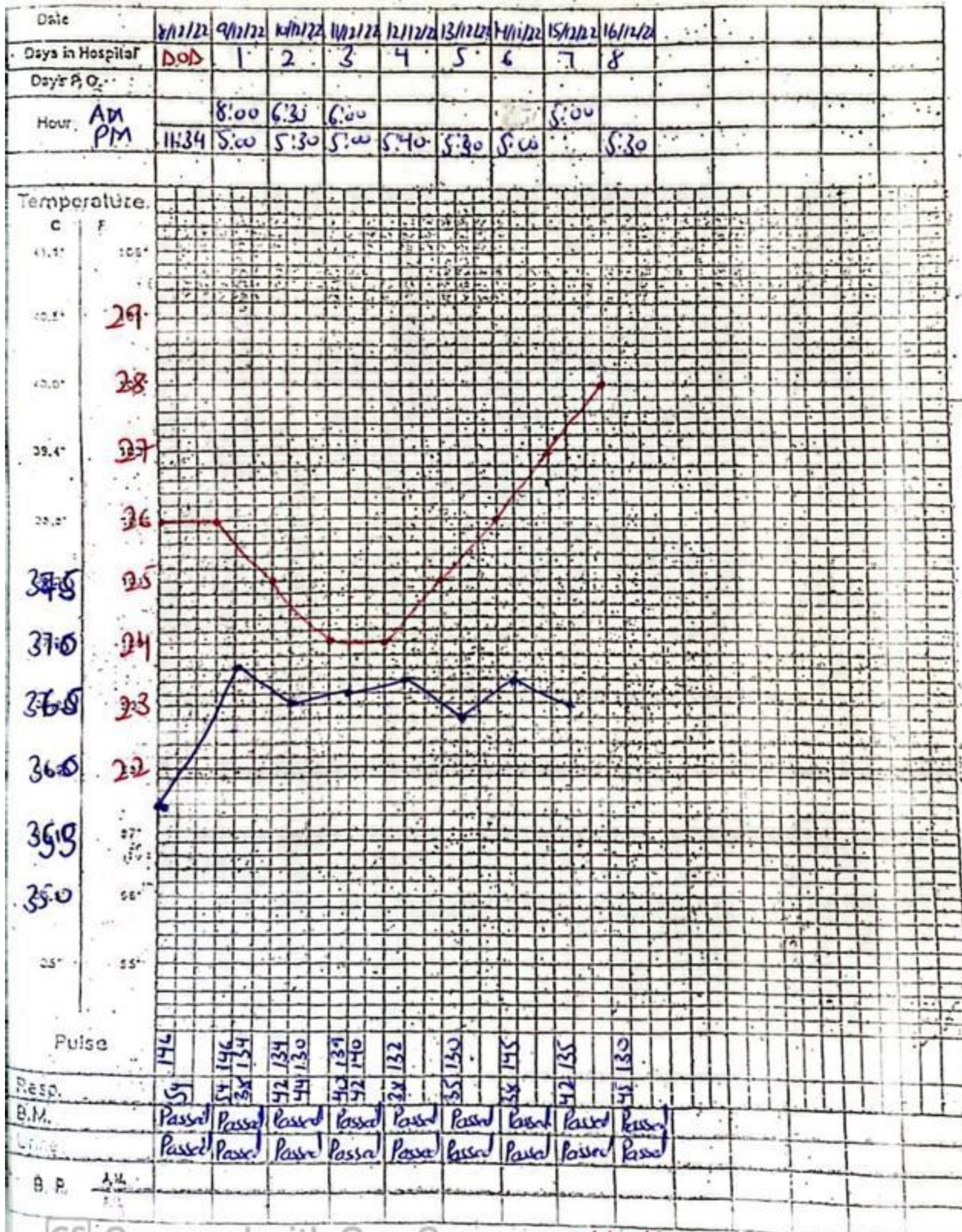
TEMPERATURE CHART

NAME: Baby Yaw Oforiwaa

AGE: New WARD: Lying-in

IP NO.: 118/22 BED NO.: 3



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Weight
Temperature

SIGNATORIES

THE STUDENT MIDWIFE:

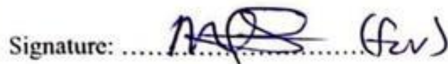
Name: MS. ANTWI GEORGINA BOASIAKOH

Signature:

Date: 22nd June, 2023

THE MIDWIFE IN-CHARGE:

Name: MS. PRISCILLA SARPOMAA

Signature: 

Date: 5/07/2023

THE SUPERVISOR:

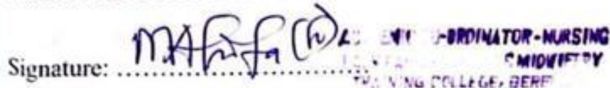
Name: MRS. CELESTINE AHIAWORNU

Signature:

Date: 24/06/2023

THE PRINCIPAL:

Name: MONICA NKRUMAH

Signature: 

Date: 5/07/2023

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