A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM HANNAH OFORI

BY

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AT

ST. EDWARD'S HOSPITAL, ADUGYAMA

SUBMITTED TO THE NURSING AND MIDWIFRY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF THE LINCENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

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Contents

PREFACE........ Error! Bookmark not defined.
ACKNOWLEDGEMENT........ 5
INTRODUCTION........ Error! Bookmark not defined.
CHAPTER ONE........ 23
ASSESSMENT OF CLIENT/FAMILY........ 23
1.0 INTRODUCTION........ 23
1.1 PERSONAL AND SOCIAL HISTORY........ 23
1.2 FAMILY HISTORY........ 23
1.3 MEDICAL HISTORY........ 24
1.4 SURGICAL HISTORY........ 24
1.5 MENSTRUAL HISTORY........ 24
1.6 CLIENT'S LIFESTLE AND HOBBIES........ 25
1.7 PAST OBSTERTIC HISTORY........ 25
1.8 PRESENT OBSTETRICAL HISTORY........ Error! Bookmark not defined.
CHAPTER TWO........ Error! Bookmark not defined.
ANTENATAL CARE........ Error! Bookmark not defined.
2.0 INTRODUCTION........ Error! Bookmark not defined.
2.1 FIRST CONTACT WITH THE CLIENT........ Error! Bookmark not defined.
2.2 FIRST ANTENATAL HOME VISIT........ Error! Bookmark not defined.
2.3 SECOND ANTENATAL HOME VISIT........ Error! Bookmark not defined.
2.4 SECOND ANTENATALVISIT TO THE CLINIC........ Error! Bookmark not defined.
2.5 SUBSEQUENT VISIT TO THE CLINIC........ Error! Bookmark not defined.
2.6 NURSING CARE PLAN ON ANTENATAL........ Error! Bookmark not defined.
CHAPTER THREE........ Error! Bookmark not defined.
LABOUR........ Error! Bookmark not defined.
3.0 INTRODUCTION........ Error! Bookmark not defined.
3.1 ADMISSION AND MANAGEMENT OF FIRST LABOUR........ Error! Bookmark not defined.
3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR........ Error! Bookmark not defined.
3.3 IMMEDIATE CARE OF THE BABY........ Error! Bookmark not defined.
3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR........ Error! Bookmark not defined.
3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES........ Error! Bookmark not defined.
3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR........ Error! Bookmark not defined.

EXAMINATION OF THE NEWBORN .... Error! Bookmark not defined.
3.7 SUMMARY OF LABOUR .... Error! Bookmark not defined.
3.8 CONDITION OF MOTHER .... Error! Bookmark not defined.
3.9 CONDITION OF BABY .... Error! Bookmark not defined.
3.10 NURSING CARE PLAN DURING LABOUR .... Error! Bookmark not defined.
NURSING CARE PLAN DURING LABOUR TABLE .... Error! Bookmark not defined.
CHAPTER FOUR .... Error! Bookmark not defined.
PUERPERIUM .... Error! Bookmark not defined.
4.0 INTRODUCTION .... Error! Bookmark not defined.
4.1 DAY OF DELIVERY .... Error! Bookmark not defined.
4.2 SUBSEQUENT CARE OF THE BABY .... Error! Bookmark not defined.
4.3 FIRST DAY POST DELIVERY (AT HOSPITAL) .... Error! Bookmark not defined.
POST NATAL VISITS .... Error! Bookmark not defined.
4.4 FIRST POSTNATAL HOME VISIT .... Error! Bookmark not defined.
4.5 SECOND POSTNATAL HOME VISIT .... Error! Bookmark not defined.
4.6 THIRD POSTNATAL HOME VISIT .... Error! Bookmark not defined.
4 .7 FOURTH POSTNATAL HOME VISIT .... Error! Bookmark not defined.
4.8 FIFTH POST NATAL HOME VISIT .... Error! Bookmark not defined.
4.9 SIXTH POSTNATAL HOME VISIT .... Error! Bookmark not defined.
4.10 SEVENTH POST NATAL HOME VISIT .... Error! Bookmark not defined.
4.11 FIRST POST-NATAL VISIT TO THE CLINIC .... Error! Bookmark not defined.
4.12 SECOND POST-NATAL VISIT TO THE CLINIC .... Error! Bookmark not defined.
4.13 NURSING CARE PLAN DURING PUERPERIUM .... Error! Bookmark not defined.
CARE PLAN DUIRING PUERPERIUM .... Error! Bookmark not defined.
SUMMARY AND CONCLUSION .... Error! Bookmark not defined.
BIBLIOGRAPHY .... Error! Bookmark not defined.
APENDIX I: COMPLETE DIAGNOSTIC MEASURES .... Error! Bookmark not defined.
LABOUR .... Error! Bookmark not defined.
APPENDIX II: PHARMACOLOGY OF DRUGS FOR THE MOTHERError! Bookmark not defined.
PHARMACOLOGY OF DRUGS FOR THE BABY .... Error! Bookmark not defined.
APPENDIX III: ANTENATAL RECORDS .... Error! Bookmark not defined.
SIGNATORIES .... Error! Bookmark not defined.

PREFACE

Birth is a dynamic and transforming experience, both on an individual and the societal level, and has the power to profoundly affect the lives of those involved. It is a physiological process characterized by non-intervention, a supportive environment and empowerment of the woman.

A family centered maternity care is a tool that allows the student 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 helps the client to have a live and healthy baby after the delivery process.

Client and family are assured of confidentiality of information.

It again helps the student midwife to use tools such as the partograph in the management of labour.

The client/family centered maternity case study is a requirement by the Nursing and Midwifery Council of Ghana as a partial fulfilment for the award of a Professional Registered Midwifery Certificate.

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My heartfelt gratitude goes to the midwife in-charge, Ms. Evelyn Owusu Nyarko of St. Edward's Hospital, Adugyama and her staff for their support and tolerance given to me during my stay with them. To them I say a big thank you and God bless you all.

My profound gratitude and honor go to my family most especially my Mother Madam. Augustina Nsiah, my Dad John Nsiah and my siblings for supporting me both spiritually and financially through the three year course of study, I am forever indebted to you.

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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. 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.

A client and family centered maternity care study is a systematic holistic obstetric care to the expectant mothers, their family and community as a whole, based on thoughtful understanding of the client as a unique individual with specific needs and problems.

The client and family centered care study started from pregnancy, labour and puerperium and during this period the clients physical, psychological, spiritual and social changes were considered with the framework of her family and community. The care helps the student midwife to put into practice the skills and knowledge she has acquired during the training to care for the client and family to have safe mother and healthy baby at the end of pregnancy.

The client and family centered maternity care study was carried on Madam Hannah Ofori a 30 years old expectant mother, gravida3 Para2 all alive(G3P2) during pregnancy, labour and puerperium. The interaction with her started on 14th November 2022, during her 10th visit to

St. Edward's hospital, Adugyama at the Antenatal unit for review and selected for the care study since she qualified for the criteria. She was 38 weeks plus 2days of gestation during the first encounter.

Madam Hannah commenced antenatal clinic on 28th of April 2022 during which her gestation was 9 weeks plus 5 days. She had no history of any medical conditions such as hypertension, asthma, sickle cell, diabetes, heart diseases, epilepsy, allergies. Client's ANC card reveals that she had been screened on Hepatitis B, malaria parasite and HIV/AIDS and all revealed negative. Her haemoglobin level was good and she was feeling well. Various health education on the danger signs of pregnancy which includes, bleeding, excessive vomiting, severe headache and oedema were given to her.

The report of the study is compiled into a document in partial fulfillment for the award of a professional certificate to practice midwifery by the Nurses and Midwives Council of Ghana. There are four chapters outline in this script.

Chapter one talks about client's particulars such as social, family, medical, surgical, menstrual, lifestyle, past and present obstetrical history.

Chapter two talks about the antenatal care the client received and home visits made to client.

Chapter three talks about labour and its management.

Chapter four is about puerperium which involves an elaborate care given to Madam Hannah, the baby and the family after delivery. A care plan was drawn at the end of pregnancy, labour and puerperium to identify and solve problems of the client and also to prevent complication from occurring. Summary, conclusion, bibliography, appendix, antenatal records and signatories are also included.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defined pregnancy as from conception to delivery of the fetus; normal duration is two hundred and eighty days (280 days, 40 weeks or 9 months and 7 days), counted from the first day of the last normal menstrual period to delivery, or two hundred and sixty-five days (265), from conception to delivery.

King (2014) stated that, the prenatal period covers the time from the first day of the last normal menstrual period to the start of true labour, which marks the beginning of the intrapartum period.

Henderson (2009) stated that, Pregnancy may be suspected by the woman based on her knowledge of her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. Women may confirm their pregnancy using a home pregnancy test.

Henderson (2009) further stated that, confirmation of pregnancy may also be sought from midwife or doctor. This is established by a detailed history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhoea, breast changes, nausea and vomiting, increased frequency of micturition, enlargement of the uterus, skin changes and quickening. These signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive (Henderson, 2009).

King (2014) also stated that, the prenatal period is divided into trimesters, the first trimester is considered to be 1 to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time.

Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care techniques 28 weeks was the limit of viability. The third trimester extends from 28 to 40 weeks. The term 'post-date' or 'post term' is typically used to describe a pregnancy beyond forty (40) weeks.

According to King (2014), pregnancy is a time of profound anatomic and physiologic changes in a woman's body. In addition to the reproductive organs all maternal physiologic systems make adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis. Pregnancy lasts approximately two hundred and sixty six days (266 days) or thirty eight weeks (38 weeks) from ovulation.

Konar (2013) also added that, during pregnancy, there is 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 adaptations to the increasing demands of the growing fetus. Unless well understood, this physiological adaptation of normal pregnancy can be misinterpreted as pathological.

Konar (2013) further stated that, there is enormous growth of the uterus during pregnancy. The uterus which in non-pregnant state weighs about 60g with a cavity of 5-10ml and measures about 7.5cm in length, at term, weighs 900-1000g and measures 35cm in length. The capacity is increased by 500-1000 times and changes occur in all the parts of the uterus. There is increase in growth and enlargement of the body of the uterus. Not only the individual muscle fibres increase in length and breadth but there is limited addition of new muscle fibres. These occur under the influence of the hormones; oestrogen and progesterone limited to the first half of pregnancy but pronounced up to twelve weeks (12). Three (3) distinct layers of muscle fibres are evident; outer longitudinal, inner- circular and intermediate. Normal anteverted position is exaggerated up to eight (8) weeks. Thus the

enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequency of micturition. Afterwards, it becomes erect; the long axis of the uterus conforms more or less to the axis of the inlet.

Fraser and Cooper (2009) also added that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term.

Ojo and Brigg (2006) said that when pregnancy occurs, menstruation ceases and returns some weeks or months after delivery. The hormones progesterone and oestrogen are produced in the large quantities which exerts some action on the various systems of the pregnant woman. The most outstanding of these changes is growth which occurs in the uterus. They also added Pregnancy is divided into three (3) periods or trimesters namely; First trimester, second trimester and third trimester. First trimester begins from the day of conception to the 12th week. Second trimester begins from the 13th week to the 26th week and the third trimester begins from 27th week till birth.

Konar (2013) stated that, there is marked congestion with hypertrophy of the muscle and elastic tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6-8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. 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.

According to Konar (2013), 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 oesophagus 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. Atonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

According to Ghana Health Service (2008), Antenatal Care (ANC) is the health care and education given during pregnancy. Antenatal services are an important part of preventive and promotive health care. The objectives of ANC include:

1. To promote and maintain the physical, mental and social health of the mother and baby by providing education to the pregnant mother on nutrition, rest, sleep, personal hygiene, family planning, immunization, danger signals STI/HIV/AIDS birth preparedness and complication readiness.
2. To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical or obstetric.
3. To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
4. To help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.
5. To ensure safe delivery and postpartum health.
6. To ensure quality care, antenatal care services must be organised in such a manner that it will provide comprehensive and individualised care. As much as possible, all care activities for example history taking, physical examination

and treatment should be provided by the same care provider to the pregnant woman. (Focus Antenatal Care).

According to Ghana Health Service (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule.

1. First visit: From onset of pregnancy up to sixteen weeks (16) gestation.
2. Second visit: from the 24th to 28th week of pregnancy.
3. Third visit: at 32nd week of pregnancy.
4. Fourth visit: at 36th week.

FOCUSED ANTENATAL CARE is an individualized client centered on comprehensive antenatal care that places emphasis on disease detection rather than risk assessment. (Oduro Kwarteng, 2011)**.** Focused antenatal gives the client the opportunity to be cared for by the same skilled care provider, assured of confidentiality.

LABOUR

Henderson (2009) stated that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and descent of the fetus through the pelvis, culminating in the

spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes.

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

Fraser and Cooper (2009) also added that, 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.

Fraser and Cooper (2009) further stated that, human 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.

Fraser and Cooper (2009) stated that, traditionally, three stages of a labour are described the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely, the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effect observed in women during this time.

Konar (2013) also stated that, conventionally, events of labour are divided into three stages:

1. First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, the ‘cervical stage’ of labour. Its average duration is twelve hours (12) in primigravidae and six hours (6) in multiparae.
2. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravidae and thirty minutes (30) in multiparae.
3. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births). Its average duration is about fifteen minute (15) in both primigravidae and multiparae. The duration is, however, reduced to five minutes (5) in active management.

1. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. During this period, general condition of the patient and the behaviour of the uterus are to be carefully monitored.

King (2014) added that the term fourth stage of labour refers to the first postpartum hour following placental expulsion.

Fraser and Cooper (2009) stated the following about the First Stage

1. The latent phase is prior to active first stage of labour and may last 6-8 hrs. in first time mothers when the cervix dilates from 0 cm to 3-4 cm dilated and the cervical canal shortens from 3cm long to <0.5cm long.
2. The active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and, in the presence of rhythmic contractions, is complete when the cervix is fully dilated (10 cm).

3. The transitional phase is the stage of labour when the cervix is from around 8 cm dilated until it is fully dilated (or until the expulsive contractions during second stage are felt by the woman). There is often a brief lull in the intensity of uterine activity at this time.

According to Fraser and Cooper (2009), the onset of labour is process, not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contractions of pre-labour develop into the progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on the basis of this finding that decisions are made that will affect the intrapartum care and support subsequently provided.

King (2014) also stated that, the onset of labour is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are the hallmark of labour.

The onset of spontaneous labour cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labour. Common signs and symptoms suggestive of physiologic progress towards labour include descent of the fetus, cervical changes, increase in uncoordinated uterine contractions, rupture membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. (Henderson, 2009)

King (2014) also stated that, physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her fetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (fetus), and the passage (pelvis).

According to Henderson (2009), the aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable, fulfilling experience of child birth for the mother and her partner.

In order to give woman-centered care, the midwife should:

1. Assess the needs and expectations of each individual woman regarding labour and birth.
2. Plan care with each woman in labour that is tailored to meet her specific needs and expectations.
3. Put the care plan into practice, and
4. Evaluate the care given to measure its effectiveness

Henderson (2009) also stated that under emotional and psychological care, it is important for the midwife to have a good understanding of a woman's feelings in labour. Attitudes and reactions to childbirth vary considerably and are influenced by differing social, cultural and religious factors. Many women anticipate labour with mixed feelings of fear and excitement.

Henderson (2009) further stated that, throughout labour, there should be a free flow of information between the woman and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involve in decision-making helps the woman to retain a sense of autonomy and control. The midwife should be aware that not all individuals may feel sufficiently secure or able to express fear or anxiety during labour.

Konar (2013) further stated that under bladder care; patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterisation is to be done with strict aseptic precautions.

Fraser and Cooper (2009) also stated the following under bath or shower: Immersion in a warm bath or birthing pool can be an effective form of pain relief for labouring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. This midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour

According to Konar (2013), under rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labour, need of analgesia and improves maternal comfort. If, however, labour is monitored electronically of analgesic drug (epidural analgesia) is given, she should be in bed.

According to Konar (2013), assessment of progress of labour and partograph recording are also done. Partographs are the graphical representation of the salient features in the first stage of progress of labour which provides the opportunity for early identification of deviation from normal. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rates of prolonged labour, oxytocin use, caesarean sections and intrapartum morbidity/mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

Henderson (2009) stated the following under vaginal examination; this procedure is one of the options to help confirm the onset of labour. However, it is invasive and often very uncomfortable for the women and also poses a potential infection risk. Women may request it in seeking reassurance about the status of labour.

According to Konar (2013), the transition from the first stage to the second stage is evidenced by the following features:

1. Increasing intensity of uterine contractions.
2. Urge to defecate with descent of the presenting part.

3. Complete dilatation of the cervix as evidenced on vaginal examination.

According to Marshall and Raynor (2014), active management of the third stage of labour (AMTSL): An active management policy usually includes the routine prophylactic administration of a uterotonic agent, either intravenously, intramuscularly or (occasionally) orally, as a precautionary measure aimed at reducing the risk of post-partum haemorrhage. It is applied regardless of the assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth of the birth and delivery of the placenta by the use of controlled cord traction.

PUEPRERIUM

Marshall and Raynor (2014) stated that puerperium starts immediately after the delivery of the placenta membrane and continues for six weeks. In many cultures around the world 40 days for recuperation is a time-honoured 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 efforts of the pregnancy and recovered to their non-pregnant state.

Tiran (2008), states that puerperium is the period from 6-8 weeks following child birth during which the uterus and other organs and structures are returning to their non-pregnancy state.

National safe motherhood protocol (2008) also describes puerperium as the period from the end of the delivery to six weeks after delivery. It states further that the purpose of post-natal care is to maintain the physical and psychological wellbeing of the mother and the child. It includes education to the mother in the care of the child, detecting and treatment of referral of any abnormality for further management. The essentials of post-natal care are therefore;

1. Comprehensive screening to detect complications to both mother and baby

2. Treatment of complications in mother and baby
3. Assessment and support for the infant feeding
4. Malaria and anaemia prevention
5. Health education and counselling
6. Family planning and counselling
7. Immunization services for mother and baby

Konar (2013) states that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of discharge, it is named as;

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

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to be 250ml. Normal duration ay extend up to 3 weeks.

Fraser and Cooper (2009) also state that, regardless of whether women are breastfeeding, they may experience tightening and enlargement of their breast toward the 3rd and 4th day, hormonal influences encourage the breast to produce breast milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce discomfort.

Henderson (2009) further stated that, the following are some of the aims of postnatal care, the successful achievement of which will result from the contribution to care made by the midwife and other members of the multidisciplinary healthcare team.

1. To help the woman adapt to and successfully fulfil the role and responsibilities of motherhood.
2. To promote and monitor the woman and the infant's physical well-being.

3. To promote and monitor the woman's psychological well-being.
4. To assist the woman with the successful establishment of her infant feeding.
5. To foster the development of maternal-infant chosen method of attachment.
6. To foster good family relationships.
7. To educate the woman and her family in the needs and development of the infant.
8. To enhance the woman's confidence in her ability to fulfil her role as a mother to promote health education.

During the puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state:

1. Involution of the uterus and other soft parts of the genital tract.
2. Commencement of lactation.
3. 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.

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

Fraser and Cooper (2009) further states that it has been traditional to associate afterpain with multiparity and breastfeeding. However, women experience afterpain regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of afterpain is by an appropriate analgesic.

The American Academy of Paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye infection and also

administering of vitamin K injection to prevent haemorrhage disease of the newborn as well as well as well as cord dressing.

From the above definitions, it can be deduced that, puerperium is the management to the mother and baby to exclude puerperal sepsis, other complications and establishment of+ lactation.

WHY CLIENT WAS CHOSEN

Client came to the antenatal clinic late (10:29am) and was asked the reason for her lateness of which she said she has to attend to morning classes before coming for ANC. She was educated on the importance of attending ANC on time and was also advised to reduce the workload especially in her state of pregnancy. By observation from the abdomen, it was presumed that she will be in her late 3rd trimester. This was confirmed through her ANC card that she was 38weeks plus 2 days pregnant client was qualified to be used for the care study, thus, client has no complications in her previous Pregnancy. Labour, Puerperium.

She therefore fit into the criteria for selection of the study. Client was informed about the intention to use her for this study after explanation of the study was given. She gladly accepted but said the final decision would come from her husband after she has informed him. She therefore took my contact to be given feedback later.

Routine procedures were carried out, and the midwife in-charge after her assessment approved of client to be used.

At 06:30pm, a call was received from client and she said her husband had agreed for her to be used for the study. Direction to her house was given and home visit appointment was booked

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter entails information about the client, her family and community. It gives an account of the assessment on Madam Hannah Ofori, her family and the community in which she lived. Madam Hannah will be used throughout this case study.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Hannah is a 30 year-old teacher who comes from Adugyama in the Ashanti Region of Ghana. She stays near the Chief palace in Adugyama in the Ashanti region of Ghana with house number AY-0671-5232. She is dark in complexion and she is 161cm tall. She speaks Twi, and English. She has been in a relationship with Mr. Francis Ofori for 13 years but has been married for 10years now. She is blessed with two children, Felix Appiah Ofori and Norman Ofori. Madam Hannah had her education up to Tertiary level and now teaching for a living. Madam Hannah is a Christian and worships at Church of Christ and is very religious. She does not smoke or take in alcoholic beverages. Her next of kin is her husband Mr. Francis Ofori. Mr. Francis Ofori, her husband is 36 years old and also had his formal education up to Tertiary and a native of Adugyama. He is also a Christian and worships with Church of Christ and works as a mechanic at a mining company. His hobbies are watching football and listening to music whiles his wife watches television as her hobby and has Mentor of Adom TV telenovelas as her favorite program. The family lives together and patronizes health care services from St. Edward's hospital, Adugyama.

1.2 FAMILY HISTORY

Madam Hannah said there are no hereditary diseases like sickle cell disease, diabetes, hypertension, heart disease, asthma or mental illness in her family. She reported history of no

twin pregnancies in the family and no congenital abnormality in the family. Her parents are alive and her mother Madam Anita Yeboah, a farmer resides in with her husband, Mr. Kofi Anane who is a carpenter by profession. They are all Christians. She has four siblings, two boys and two girls of which she is the second child among them and they are all employed. Death occurs naturally in their family.

1.3 MEDICAL HISTORY

Madam Hannah said she has not been on admission at the hospital before but receives medical treatment on out-patient basis, whenever she is ill.

According to Madam Hannah she has no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, glucose 6 phosphate dehydrogenase (G6PD) defect and mental illness.

She has no known allergies to food or any drugs. She has never been transfused nor donated any blood.

1.4 SURGICAL HISTORY

Madam Hannah has not been involved in any road traffic accident neither has she undergone any surgical operation on the pelvis, spine, reproductive tract, caesarean section, laparotomy and infertility treatment before. She has no history of abortion. She has never undergone any blood donation exercise nor has been transfused.

1.5 MENSTRUAL HISTORY

Madam Hannah had her menarche at the age of eighteen (18). Her menstrual cycle is 28 days lasting usually for 5 days and she does not have dysmenorrhea during this period according to her. She uses sanitary pads during her menstrual period. She gave her last menstrual period as 19/02/2022.

1.6 CLIENT'S LIFESTLE AND HOBBIES

Madam Hannah wakes up around 5:00am and goes to bed around 9:00pm. She usually does her household duties as a wife every morning and then cleans up and prepares her son for school. After taking her son to school, she goes to school. Bathing and bowel movement is twice daily and empty's the bladder four to five times in her current state. She comes home around 3:00pm and rest before preparing supper for her family. She does a general cleaning on the weekends. She eats three square meals a day. She usually eats porridge and bread in the morning, rice and stew as lunch, and fufu with soup for supper. Her favorite food is banku with okro stew. Her hobbies are watching telenovelas on TV.

PAST OBSTERTIC HISTORY

PREGNANCY

Madam Hannah has had two pregnancies and two live male child (G2P2). She has no history of abortion. Madam Hannah began her first antenatal clinic session at St. Edward's Hospital, Adugyama during pregnancy at ten (10) weeks gestation for her first pregnancy and 12 weeks for the second pregnancy. She carried her pregnancies to term without any complication like ante-partum hemorrhage, urinary tract infection, malaria or anemia in pregnancy except some minor disorders of pregnancy like heart burns, frequency of micturition, lower abdominal pains for both pregnancies. She also had no pregnancy induced diseases like hypertension and diabetes. Her second child was four years when she had her current pregnancy. She had three doses of tetanus toxoid and five doses of sulfadoxine pyrimethamine for her first pregnancy and five doses of sulfadoxine pyrimethamine for the second pregnancy.

LABOUR

Madam Hannah said both sons were delivered spontaneously at St. Edward's Hospital, Adugyama. Client said her duration of labour for her first pregnancy lasted for about eight (8) hours and 6 hours 45minutes for her second pregnancy. Client said the placenta was

delivered few minutes after the baby was delivered and blood loss was moderate. There were no complications such as post-partum haemorrhage and she was in good condition after the delivery of her baby and breastfeeding was initiated not long after the delivery, before she was transferred to the lying- in- ward. The weight of her first baby was 3.0kilograms and second baby was 2.8kilograms. Client added that her children cried at birth with no congenital abnormalities and in a good condition

PUERPERIUM

Client claimed her puerperium was without any complications such as post-partum hemorrhage, infection and depression. She practiced exclusive breastfeeding for 4months for her children because of the nature of her work and its conditions and continued with complementary feeds like Nan 2, other foods taken by the family and weaned her babies for 2 and half years after which she stopped breastfeeding. Her children received care and all immunizations during her postnatal visits to the clinic. Both mother and babies did not suffer any ailment during puerperium. Client received support from her mother and sister during puerperium. According to her, she has never used any artificial family planning method but was practicing the natural family planning method.

PRESENT OBSTETRICAL HISTORY

Madam Hannah G3P2 reported to St. Edward's Hospital, Adugyama for booking on 28/04/2022 with 9weeks plus 5days cyesis. She said her last menstrual period was on 19/2/22, thus her expected date of delivery was calculated to be 26/11/22. Detailed information about her personal, menstrual, obstetrical, lactational, medical, surgical, family and contraceptive histories were taken. Her weight was 59kilograms and height was 161cm. Vital signs checked and recorded as follows.

OBSERVATIONS	VALUES
Temperature	36.3 degree Celsius
Pulse	87 beat per minute
Respiration	22 cycles per minute
Blood Pressure	120/80 millimetre of mercury

- Urine test showed negative for both protein and sugar.

  Client's laboratory investigations were also done and recorded below as;

- Haemoglobin level - 11.2 grams per deciliter.
- Blood group - B
- Rhesus factor - Positive
- HIV status (PMTCT) - Negative.
- Hepatitis B - Negative.
- G6PD - No defect.
- Sickling - Negative.
- Stool (cyst, protozoa, ova) - No abnormality detected.
- VDRL - Non reactive.
- MPs - No MPs seen.

Physical examination conducted revealed no detection of abnormalities. Symphysio-fundal height was not palpable. Madam Hannah had no complains. Client was served with routine drugs as below;

- Tablet folic acid 5mg daily for 30 days
- Tablet ferrous sulphate 200mg daily for 30 days
- Tablet multivitamin 200mg daily for 30 days

Client made her next appointment on 26th May, 2022.

CHAPTER TWO

ANTENATAL CARE

INTRODUCTION

This chapter elaborates the care that was rendered during pregnancy. This care started from the time of conception and continued throughout pregnancy. This include first contact with client, subsequent visit by client to the clinic, home visits during antenatal period and care plan drawn to solve problems encountered by client.

2.1 FIRST ENCOUNTER WITH CLIENT

Madam Hannah Ofori was welcomed to the ST. Edward's hospital for a medical review on the 14th of November, 2022. A brief introduction was made as a student Midwife from Nursing and Midwifery Training College, Berekum, stationed at the medical establishment for a period of 7 weeks to undergo clinical and write up a study plan on a chosen patient. Further explanation was done after the patient was offered a seat to expound on the nature of the study plan whiles going through her antenatal booklet and records. Madam Hannah met the criteria to become a subject in coming up with a study plan as she was a regular patient at the hospital, is multigravida and had good obstetric history. Madam Hannah was then informed of my interest to use her for my care study, of which she agreed. She had previously complained of heartburns to a fellow attendee and education was given prior to the introduction. Further procedures were done whiles explaining each one of them to her and with her consent, she was encouraged to ask questions or tell us to stop if she feels uncomfortable.

Madam Hannah was assisted through the routine laboratory investigation after vital signs checked and recorded. Her haemoglobin level was 12.4g/dl and her HIV screening result was negative. Her vital signs and weight were checked and recorded as:

OBSERVATIONS	VALUES
Temperature	36.7 degree Celsius
Respiration	24 cycles of minute
Pulse	80 beat per minute
Blood Pressure	121/74 millimetres of mercury
Weight	64 kilograms

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream urine to test for urine protein and glucose. Protective clothing like apron and gloves were worn. The quantity, color, odour and sediments were noted. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the strip was compared with the corresponding color on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container.

Findings were recorded and discussed with both midwife in-charge and client.

physical examination.

Under the supervision of the midwife in charge, head to toe examination was correctly done. All necessary equipment needed for the examination was gathered on a tray comprising of the following items;

- A sterile gallipot with sterile cotton wool swabs
- A receiver for used swabs
- A tape measures
- A fetal stethoscope
- A watch with a second hand
- Examination gloves

The procedure involved in physical examination was explained to her and she consented. Privacy was provided by closing doors and nearby windows and curtains drawn and hand washing was done and client was asked to empty her bladder. Madam Hannah was assisted to sit on the bed, lie on her right side and then assume a supine position after client has been assisted to undressed.

Head and neck.

The head was examined first during the physical examination. Client's hair was examined for cleanliness, lice, dandruff, ringworm, alopecia, skin infection and any other abnormalities and no abnormality was detected. Madam Hannah was congratulated and praised for keeping the hair clean and tidy and advised to keep it up.

Client's face was then inspected for oedema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected. The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for

dryness, cracks and infection of the lips. The gums and tongue for pallor, sores or lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and no abnormality was noted.

Breast examination.

The procedure was explained to client and consent sought before breast was exposed. The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction, and condition of the skin. On breast examination both breasts were present, the shape and size were normal, the areolar was very dark in color, and the skin of the breast were smooth with the nipple well projected. The breast nearer was covered and the other one farther was exposed to be examined. The client was asked to put the hand of the part to be examined under her head and with the left hand supporting the breast, the right hand was used to palpate the breast systematically in a circular manner using the inner aspect of the fingers for masses, enlarged axillary lymph nodes but no abnormality was detected. The nipple was also squeezed gently with cotton wool and expressed fluid (Colostrum) was examined for it color and it was clear and same procedure was performed on the other breast. While doing the breast examination she was told to be observant, since she would have to repeat what was done at home to detect abnormalities of the breast. Client's breastfeeding history was inquired and client verified desire to breastfeed exclusively for 6 months for her current child because she was not practicing exclusive breastfeeding. She was made comfortable and covered up. Findings were explained to client. Client was reminded to examine breast at home after she resumes her menses as it was done at the facility frequently and report any abnormalities.

Extremities

Upper extremities**:** Madam Hannah was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for oedema, pallor of palms and nail bed and no abnormality was noted. The finger nails were well trimmed and equal

Lower extremities: The legs were inspected for size and equality and palpated for oedema, tenderness in the calf muscles, size and equality and no abnormality was detected. Client was encouraged to rest in between sitting and standing, avoid prolonged standing and to perform mild exercise like walking to enhance proper circulation to prevent varicosity.

Back: The back was examined for deformity of the spine (scoliosis), oedema of the sacral region and no abnormality was detected.

ABDOMINAL PALPATION.

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

Inspection; There were no scars on the abdomen. The abdomen had an ovoid shape with the signs of pregnancy like striaegravidarum and lineanigra running through the midline of the abdomen. There were fetal movements.

Measuring of symphysio-fundal height: The zero end of the measuring tape was placed on the fundus of the uterus and the tape extended to the upper boarder of the symphysis pubis and the symphysio-fundal height measured 37cm and gestational age of 38weeks plus 2days.

Fundal palpation: Hands were warmed by rubbing them together to avoid inducing contractions. Standing on the right side of the client, both hands were placed just below the

xiphisternum and down the abdomen until the upper part of the fundus was felt. The fundus was occupied by a soft round mass indicating the buttocks.

Lateral palpation: With one hand stabilizing the right side of the uterus, the other hand was moved gently in a circular manner on the left side where rough parts were felt indicating the fetal limbs. This was repeated at the right side and a smooth round part was palpated indicating back of the fetus.

Pelvic palpation: The woman's feet were faced and she was asked to bend knees slightly in order to relax the abdominal muscle. She was helped to relax by guiding her to breathe out slowly. The palms of the hands were placed on either sides of the uterus, with the palms just below the level of the umbilicus and the fingers directed towards the symphysis pubis and thumbs almost meeting. A hard mass was felt at the lower pole of the uterus which indicated the head. On palpation the lie was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent: The anterior shoulder was located 2.5cm below the umbilicus and with the ulna border just above the symphysis pubis, five fingers occupied the space indicating descent of $5/5^{th}$.

Auscultation: The fetal heart was auscultated by warming and placing fetal stethoscope (fetoscope) on the area where the back was located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the fetal heart beat was counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 140beat per minute with regular rhythm.

Vulva Examination

Permission was sought to inspect her vulva after hand washing was done. Client's vulva was inspected after the examination light was turned towards the genital area for clear view. The

vulva was well shaved and clean. The perineum, labia and clitoris were inspected and it was clean, they had no abnormalities such as swollen tissue, rashes, warts or blisters and there was no indication of female genital mutilation, and no abnormal discharges found. Hands were washed and dried. Findings were communicated to her and she was congratulated for her co-operation. She was thanked and was helped to turn to her left side before getting off the bed and to do so any time she rises from bed. She was assisted to dress up. Madam Hannah was offered a seat and she was asked if she had any complains, of which she gave no complain. Client was encouraged to continue maintaining personal hygiene and also to have enough rest and sleep. She was told to get all her items needed for delivery ready and well packed. This was done after being educated on the signs of labour. Finally, education on the need to attend antenatal was reinforced. Danger signs of labour in pregnancy like severe headache, vaginal bleeding, swellings of the lower limbs, severe abdominal pains, excessive vomiting were explained to her so as to help her identify any danger signs and report immediately since she was in her late weeks. She was served with her routine drugs as below;

- Tablet folic acid 5mg daily for 7 days
- Tablet ferrous sulphate 200mg daily for 7 days
- Tablet multivitamin 200mg daily for 7 days

We discussed home visits and she gave directions to her house after which contacts were exchanged and she was seen off. The date for her next appointment (16th November, 2022) was given to her.

FIRST ANTENATAL HOME VISIT

The first home visit to Madam Hannah was on the 16th November, 2022 by foot according to directions given. Madam Hannah and the family warmly received me when they saw me in the house. After we exchanged greetings, she offered me a seat and introduced me to her household members and the family. This opportunity helps me to create an interpersonal relationship between myself and the rest of the family members. She was informed for the purpose of my visit, and it was to know where she stays, how she was fairing and to also assess the environment which she lives.

PHYSICAL ENVIRONMENT

Upon arrival at the vicinity, it was identified that Madam Hannah lives in a rented room, with house number AY-0675-5034. Client then led the way to her pouch and offered me a seat and a sachet of water. During our conversations, the following observations were made; it was observed that the room was a single room with a spacious veranda in front. Client stays there with her children. Client cooks in their kitchen which is in front of her room and her cooking utensils were well arranged on a table in one corner of the kitchen whilst her cylinder is on a table at another corner. In other to view the environment well client was asked to let us sit outside with the excuse that it was hot on the veranda.

Client lives in a compound house which contains nine rooms. The house was built with blocks and cement, painted violet and roofed with aluminum sheets. There is a standing pipe outside the compound which serve as their source of water from which all the family have access to. Client fetches water from the pipe and stores it in a large sized barrel with a well-fitting lid. The compound is very neat and their bathroom is located within the house together

with the bomber latrine detached from the house. She keeps her refuse in a dustbin without a lid and disposes it daily in the community refuse dump. Madam Hannah was educated to cover her dustbin to prevent flies from settling on the rubbish then on uncovered food which can cause infection. Client uses Charcoal as her source of fuel for cooking when her gas is finished.

Client’s room is divided into two by a curtain, part used as the bedroom and the other part used as the sitting room. The room was neat with items well arranged. She sleeps on a mattress under treated mosquito net. The room was a bit spacious with adequate ventilation. The windows were covered with net which prevented flies and mosquito from entering the room. Client was asked about who has been cleaning the bath house and the toilet and was told it was cleaned twice a week by sisters according to turns. She was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of urinary tract infection, and also to wash her hands with soap under running water after visiting the toilet. Client had her husband’s number which she can call when needed. Education was given to her on the signs of true labour which were, painful regular and rhythmic uterine contractions which will be felt as tightening discomfort or actual pain, a blood-stained mucoid discharge from the vagina, there may be rupture of membranes. She was encouraged to visit the hospital immediately she experienced any of these signs and take her drugs as prescribed. Later during our interactions her mother showed up from the market, an introduction was made again to her, she was very happy of my presence to educate her daughter on certain things. Client’s family was encouraged to support client in the performance of household chores. The family was encouraged to continue eating nutritious diet and to always drink clean and safe water.

PSYCHOSOCIAL

Client lives very well with her children, co-tenant and has a warm relationship with her neighbors. Her friends most of the time visit her and she also visit them with her leisure time. Client behaves nice and cracks jokes. She has respect for all manners of people. She also attends social gathering like wedding, naming ceremonies and funeral and client is also the women's leader in her church.

Client was thanked for her time and hospitality and permission was then sought to leave. Client was informed of the second visit to the house on the 18th November, 2022.

SECOND ANTENATAL HOME VISIT.

The second antenatal home visit to Hannah house was on the 18th November, 2022 at 4:30pm as scheduled where client has returned from work and rested for some time. The purpose of the visit was to inquire about their health. Madam Hannah and her family welcomed me warmly. Client received me in a hospitable manner and was made comfortable at home. An enquiry was made about client's health status and a positive response was given. Client also said the whole family was doing well. Client however complained of having constipation and fatigue. She was therefore encouraged to take in enough fluids (at least 8 cups daily) and eat diet containing fiber and roughages to manage the constipation. Education was given on personal hygiene to prevent infections. Client was again educated on the fatigue and it was explained to her that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained that, it was due to the weight of product of conception and inadequate rest related to gravid uterus. Madam Hannah was encouraged to take up a little work, have adequate rest during the day and avoid strenuous activities. Client was again reminded on the true signs of labour such as appearance of 'show', regular rhythmic painful uterine contractions and spontaneous rupture of membranes. Client was asked to report to the clinic any time she sees any of the signs mentioned to her. Client was asked about her preparations towards delivery and her layette was inspected, everything on the delivery list was intact and was neatly arranged in a luggage. Client was encouraged to arrange the items in a small bag and also to get contacts of drivers who could transport her to the hospital when labour sets in and support person was also identified as her elder sister who lived in the same house and her husband. Madam Hannah was encouraged to save money in her purse and add her antenatal book to her bag. Client's environment was clean and tidy and the refuse had been emptied. Inspection of the client's rooms was done and it was observed that everything was well arranged.

Madam Hannah was reminded of the next visit to the clinic on the 21st November, 2022. She was thanked and bid fare well.

SUBSEQUENT VISIT TO THE CLINIC

On the 21st November, 2022, Madam Hannah came to the clinic, which was the third (3rd) contact with her at the clinic but her twelve(12th) visit to the clinic. Client was warmly welcomed and offered a seat. Madam Hannah was asked about her general condition and she confirmed she was well. She was then taken through the routine care; urine sample was taken to test for the presence of protein and glucose of which was tested negative. Her vital signs and weight were checked and recorded as;

OBSERVATIONS	VALUES
Temperature	36.6 degree Celsius
Pulse	82 beat per minute
Respiration	22 cycles per minute
Blood Pressure	110/80 millimeters of mercury
Weight	54 kilograms

Permission was sought to examine her. Having urinated earlier, privacy was provided and she was helped onto the bed on her left side. Hands were washed with soap and water and dried. On physical examination from head to toe, no abnormality was detected. Hands was rubbed together to make them warm and abdominal examination were performed with the following

findings; the abdomen was spherical and fetal movements detected. The lineanigra running through the midline of the abdomen and the symphysio fundal height was measured to be 35cm. On fundal palpation an irregular soft mass was felt which indicated that the fetal buttocks of the upper pole of the uterus. On lateral palpation the right side of the abdomen revealed a smooth curved mass indicating the back of the fetus. On pelvic palpation a smooth hard mass was felt indicating fetal head at the lower pole of the uterus. It was therefore concluded that, the presentation was cephalic and position was right occipito-anterior with the descent of 5/5th. On auscultation the fetal heart rate was 142 beats per minute with regular rhythm. Client was assisted to get up from the bed and a seat was offered to her. Hands were washed and dried. Findings were documented and communicated to her. She was asked of any complaints or questions and client complained of lower abdominal pains and heart burns. she was educated on lower abdominal pains that it was normal for her to experience such as pains as she can be due for labour at any time. Client was educated to understand that, since she's getting to term the descent of the fetal head may put pressure on her pelvic ligament, so she should try to cope with it and have enough rest and sleep. Client was advice d to prevent prolonged standing when doing chores to prevent tension on the abdominal muscles. On Heart burns, it was explained to her that it was the action of progesterone on the smooth muscle causing relaxation of the gastric sphincter leading to reflux of gastric contents. Client was encouraged to avoid taken spicy and oily foods, stop bending down to work especially after eating and also lie on her side and lie down with many pillows to raise her up. In the absence of any further questions, she was encouraged to continue taken her routing drugs. Routine drugs were given to her as usual which included:

Tablets multivitamins 200mg twice daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate 200mg daily for 7 days.

Client was asked to come for antenatal visit in a week time if she had not delivered by then. The next antenatal visit schedule which was 23rd November, 2022 was reviewed.

Madam Hannah was thanked for cooperating, reminded of next home visit and escorted to the road side.

NURSING CARE PLAN ON ANTENATAL CARE.

PROBLEMS IDENTIFIED

1. On 16/11/22 Frequency of micturition.
2. On 17/11/22, Client complained of fatigue.
3. On 18/11/22, Client complained of constipation
4. On 20/11/22, Client complained of lower abdominal cramps.
5. On 21/11/22, Client complained of heartburns

SHORT TERM OBJECTIVES

1. Client will cope with frequency of micturition within 24 hours.
2. Client fatigue will resolve within 48hours.
3. Client will regain her normal bowel action (twice daily) within 24hours.
4. Madam Hannah lower abdominal pains will resolve within 24hours.
5. Client heartburn will subside within 24hours.

LONG TERM OBJECTIVES

Madam Hannah would maintain physical, social and emotional wellbeing throughout pregnancy without any complications to both mother and the foetus.

NURSING CARE PLAN FOR ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/1/2022 at 12:30pm	Impaired comfort related to frequency of micturition	Client will feel comfortable within 48 hours by understanding and coping with condition as evidence by client verbalizing that she can	1. Assure client that is a normal physiology of pregnancy. 2. Educate client on the causes of frequency of micturition. 3. Educate client to decrease intake of natural diuretics.	1. Client was reassured that it will resolve after birth. 2. Client was educated that it was due to the pregnant uterus competing space with the bladder causes frequency of micturition. 3. Client was educated to decreased intake of natural diuretics like coffee and	13/11/2022 at 12:30pm	Goal was fully met as client reported that she can cope with frequency of micturition.	N.C.G

		cope with the frequent micturition.	4. Encourage client to lean forward when voiding. 5. Encourage client to keep a clean covered chamber pot at bedside. 6. Educate client to use tissues to wipe vulva after urinating. 7. Encourage client to use panty liners if she can afford.	tea. 4. Client was encouraged to lean forward when voiding to help empty bladder completely. 5. Client was encouraged to keep a clean covered chamber pot at bedside to promote comfort at bedtime. 6. Client was educated to use tissues to wipe the vulva after urinating to prevent the occurrence of urinary tract infection 7. Client was encouraged			

				to use panty liners			

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS/ OUTCOME CRITERIA	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/11/ 2022 At 2:30pm	Constipation related to physiological changes in pregnancy.	Client will empty her bowel at least once daily within 24 hours as evidenced by 1. Client verbalizing that she has no difficulty in emptying her bowel. 2. Midwife Observing that client is free from constipation	1. Reassure client of relieve from constipation 2. Explain physiological basis of constipation to client that is due to relaxation of the intestines which is caused by progesterone 3. Encourage client to increase intake of fruits and vegetables. 4. Encourage client to take in least about 500mls of warm fluids on empty stomach preferably in the morning. 5. Encourage to engage in passive exercises to increase bowel movement	1. Client was reassured on free bowel movement. 2. Physiological basis of constipation was explained to client. 3. Client was encouraged to increase intake of fruits and vegetables. 4. Client was encouraged to take in 500mls of warm fluids on empty stomach preferably in the morning. 5. Client was encouraged to engage in passive exercises to increase bowel movement	15/11/ 2022 At 2:30 pm	Goal achieved as client said she had normal bowel movement and the midwife visualizing client is relieved of the constipation.	NCG

NURSING CARE PLAN DURING ANTENATAL CARE.

Date/ Time	Nursing Diagnosis	Objectives / outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
29/11/21 at 9:50am	Lower abdominal cramps related to pressure from the presenting part.	Madam Hannah will cope with lower abdominal cramps within 24 hours as evidenced by; 1. Client verbalizing that she is coping with the lower abdominal pains. 2. Midwife observing client with relax facial expression	1. Reassure client. 2. Educate client on the physiology of lower abdominal and waist pains. 3. Encourage client to wear low heeled sole shoes. 4. Advise client to	1. Client was reassured that pain will subside after delivery. 2. Client was educated that the lower abdominal pain was as a result of pressure from the presenting part and gradual intermittent contractions of the uterus. 3. Client was encouraged to wear low heeled sole shoes. 4. Client was advised to rest between activities or 2 hours rest during the day. 5. Client was given 1g of paracetamol tds x 7days to be	30/11/21 at 9:50am	Goal was fully met as client coped well with lower abdominal pain.	N.C.G

			have enough rest. 5. Serve client with prescribed analgesics.	taken home.			

ANTENATAL CARE PLAN

Date/ Time	Nursing Diagnosis	Objectives / Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
15/11/22 at 8:45am	Heart burns related to regurgitation of stomach content as a result of growing fetus.	Madam Hannah heartburns will resolve within 24 hours as evidenced by; 1. Client verbalizing absent of heartburns. 2. Midwife visualizing that client's facial expression is full of smiles as she used to be.	1. Reassure client. 2. Encourage client to elevate the head end of the bed by 6 inches. 3. Instruct client not to sleep or lie down immediately after eating. 4. Encourage client to minimize fatty and spicy meals and increase protein intake.	1. Client was reassured that her heart burns will be relieved. 2.Client was encouraged to elevate the head end of the bed with pillows. 3. Client was encouraged to sit up for at least 30 minutes after eating 4. Client was encouraged to minimize the intake of fatty and spicy meals and increase	16/11/21 at 8:45am	Goal fully met as client's heartburn was resolved.	N.C.G

			5. Encourage client to avoid the intake of food that triggers heart burns eg caffeinated drinks, chocolate	protein intake. 5. Client was encouraged to minimized the intake of caffeinated drinks, chocolate and acidic foods.			

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter consists of how Madam Hannah was admitted and managed during the first, second, third and fourth stages of labour. It emphasizes on the use of partograph and nursing care plan for the management of problems identified and also elaborates on the immediate care of the baby at birth.

ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

Madam Hannah reported to the St. Edwards Hospital at 4:40pm on the 24th November, 2022 accompanied by her co-tenant with complains of lower abdominal pains and backache. Client and co-tenant were warmly welcomed and offered a seat. She was asked to provide her antenatal health record booklet and it was read through with the help of the midwife in-charge.

According to her maternal health record book, her expected date of delivery was 26th November, 2022, haemoglobin level estimation at 38 weeks was 12.5g/dl and Human Immune deficiency Virus (HIV) status and VDRL were negative and she was 39 weeks and 5 days pregnant. Client complaint of pain but she looked calm and cooperative.

Client said labour started at 3pm with backache and lower abdominal pains. It was enquired from client if she had experienced any signs like blood stained mucous discharge (show), painful rhythmic contraction or rupture of membrane. Client replied that she had

seen “show” and experienced painful rhythmic contraction. Client’s items for delivery were checked and it was complete. Her facial expression and responses indicated she was in pain. An enquiry about her last meal was made and she said she had her last meal at 1:00pm and it was Rice with tomato stew and Client also said she moved her bowel later after eating.

Client was assured of being in the hands of competent midwives and that she would have a safe delivery. All procedures to be carried out on her were explained to her to gain her co-operation and consent.

Madam Hannah’s support person was asked to wait outside of the maternity unit and made comfortable. Client’s vital signs were checked and recorded as follows:

Temperature	-	36.3
Pulse rate	-	94bpm
Respiration	-	22cpm
Blood pressure	-	121/82mmHg

Madam Hannah was taken to the labour admission room for monitoring. Items needed for delivery were sent to the labour room and the remaining sent to her bed side. She was asked to urinate before the head to toe examination starts to prevent interruption. Midstream urine was taken for glucose and albumin to be tested and it was both negative. 115ml of urine was excreted which was amber in Colour and smelled like ammonia an intravenous cannula was passed as per facility’s protocol.

Client was assisted to undress and was draped with a cover cloth. Privacy was provided and client was helped onto the examination couch sideways then to a lithotomy position.

Hands were washed with soap and water, dried and warmed. The head-to-toe examination was done under the supervision of the midwife in-charge. The hair was free from dandruff and lice, it was clean, her face was a bit tensed because of the painful contractions. Her sclera was clear, conjunctiva was pinkish with no discharges found, her nose was with no discharges, Her mouth was with no dental carries and tooth decay . Her ears were clean with no discharges and the neck without any palpable lymph nodes. The breast was firm on the chest with no engorgement or inversion of the nipple and the arms were proportionate in length, the nails were also short and clean. edema nor jaundice. The hands were warmed again by rubbing them together.

Abdominal Examination

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

Palpation revealed the lie to be longitudinal, presentation was cephalic, descent was $3/5^{th}$ and the symphysio-fundal height was 36 centimeters. The fetal heart rate was auscultated and recorded as 136 beats per minute with good rhythm and volume. The contractions were 3 in 10 minute lasting for 35seconds.

Vaginal Examination

Permission was asked to perform vaginal examination of which she agreed. Procedure for vagina examination was explained to her in order to gain consent, promote comfort and seek her co-operation. A sterile tray was set containing two gallipots, one containing savlon antiseptic solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel.

Privacy was ensured. Hands was washed with soap under running water and dried with a clean towel.

Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves were worn and soiled pad removed and discarded with the left hand. Pair of surgical gloves was worn. The vulva was well shaved though soiled with the blood-stained mucous (show). The vulva was then inspected for scars, sores, warts, oedema and clitoridectomy, abnormal discharge but none was present, it had no abnormalities. A sterile cotton wool swab was picked with the right hand dipped into the gallipot containing savlon solution. The swab was dropped from the right hand into the left hand and used to swab the labia majora and the minora using a swab for each. With the left hand parting the minora, the last swab in the right hand was used to clean the vestibule from anterior to posterior. Client was informed that, the middle finger followed by the index finger will be put into her vagina to assess the condition of the

vagina and cervix and that she will feel a bit uncomfortable. With the labia minora still separated, the right middle finger was inserted into the vagina gently but firmly pressing downward whilst the index finger was added into the vagina in order to relax the vagina wall and muscles.

On vaginal examination, the vagina was warm and moist, the sacrum was well curved, the ischial spines were blunt, the sacral promontory was not reached and cervix was thin, soft, elastic and cervical Os was 5cm dilated. The presenting part was well applied to the cervix with intact membranes. Moulding could not be assessed because of intact membranes. The pubic arch was wide, and the rectum was empty. On withdrawal of the fingers, observation was made on the examining fingers and they were clear and not offensive. The vulva was cleaned and a clean perineal pad was applied. Client was covered with a cloth and made comfortable in bed. She was also encouraged to ambulate and to lie on her left when she felt tired. Client was then informed about the findings and after this, findings were recorded.

Madam Hannah was encouraged to empty her bladder when she felt the urge as that will aid in the descent of the foetal head and effective contractions. She was also asked to change her perineal pad when it got soiled. Her sacral region was massaged 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 educated on the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied in the negative. Client's support person was offered a seat at the waiting area and they were reassured. All instruments used were decontaminated in 0.5% chlorine solution. Hands were washed and dried after the gloves were discarded.

Preparation for birth

In preparing for birth, skilled and unskilled helpers were identified. The skilled helper identified was the midwife in-charge whiles client's support person served as an unskilled helper. She was told she would help by running errands when needed and be called in case of any emergency. The emergency plan which includes transportation in case of any referral, an obstetrician or a pediatrician was reviewed in case of emergency to advance care.

Emergency packs (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is delivered of which she agreed. Room was well lighted and ventilated. Madam Hannah was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin to skin care with the baby. The resuscitation pack had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Delivery items were also made available.

The light was tested to check if it was working and lamp was made available to be used in case of light out. The area for resuscitation and equipment were checked. The ventilation bag, sucker and mask were tested and they were in good shape for use. Delivery set, drugs and protective clothing (boots, goggle, face mask, cap and apron) were all made available for use. Head covering, scissors, cord clamp and sterile gloves were also made available. The equipment needed for resuscitation were assembled and tested for functioning and they were in good condition. The equipment included head cover, scissors, ambo bag and mask, timer, suction device, stethoscope, source of light,

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Hannah was given emotional support by reassurance that she is doing well, will soon have her baby and all conditions will resolve. She again complained of the lower abdominal and back pains sacral massage was given as she was also encouraged to void in order to enhance the foetal head to descend into the pelvis.

Madam Hannah was closely monitored and managed on the partograph throughout the first stage of labour. The fetal heart rate, maternal pulse and contractions were checked every 30 minutes. Temperature, blood pressure, vaginal examination descent and urine test were done 4 hourly and the results plotted on the partograph with findings communicated and explained to client. A bed pan was

provided for her and she was encouraged to urinate anytime she felt the urge to. Madam Hannah wanted to lie down so she was asked to lie on her left lateral side to prevent postural hypotension. Client was reminded about the deep breathing exercises as to conserve energy for the second stage. Sips of water were served to keep her hydrated. At 9pm, client was due for the next vaginal examination. The vagina was warm and moist, cervical Os was 9cm dilated, cervix was thin, soft, membranes were intact with moulding as two ++ . The descent of the head was $1/5^{th}$ above the pelvic brim. Contractions were 4 in 10minutes lasting 55 seconds, foetal heart rate was 140bpm and maternal pulse was 74bpm, blood pressure 109/64mmHg and temperature 36.7^{0}C whilst urine measured 98mls and protein and sugar in urine tested negative. Trolley was set for delivery.

Top shelve

- Sterile Cord scissors
- Sterile Artery forceps
- Sterile sheets
- Sterile gauze
- Sterile Cord clamp
- Two Sterile gloves
- Oxytocin; syringe/needle
- Sterile Drapes for the woman
- Sterile episiotomy pack

Injection vitamin K

Delivery sheet

Warm baby wrap

A Sterile galipot for antiseptic lotion

Sterile receiver for placenta

Sterile Perianal pad

Gown for the midwife

A galipot with sterile cotton wool swabs

Bottom shelve

- Two urethral Catheter — Disposable gloves
- Mucous extractor and a bowl with water — Goggles
- A jug to measure blood loss — Fetal stethoscope
- Extra cotton in a container — A swabbing lotion
- Cheatle forceps — Identification band
- Extra perianal pad
- Identification band — Savlon

At10:00pm there was spontaneous rupture of membrane and liquor was clear so vaginal examination was done to confirm cervical dilatation and to exclude cord prolapsed. Cervical Os dilatation was 10cm, molding was two++. Contractions were 4 in 10minutes lasting 55seconds, descent was 0/5, foetal heart rate – 146bpm with good volume and rhythm, pulse-80bpm BP – 126/74mmHg, The midwife in-charge was called to confirm full dilatation. All findings were communicated to the client.

She was informed that the baby would be delivered onto her abdomen to establish bonding and provide warmth so she will have to support the baby to which she agreed. The area for delivery was prepared by closing the windows to provide warmth and all fans were switched off to receive the new born into a warm room.

MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Hannah was assisted into the second stage couch covered with mackintosh and a clean sheet. Hand washing was done with soap under running water and dried with clean towel. Protective clothing (mackintosh apron, safety boots, goggles, face mask) were worn. Having washed client's abdomen and thighs with antiseptic solution, her thighs and under buttocks were draped and her hands washed. All these were done to keep her clean for the baby's arrival. A perineal pad was applied to the anus to prevent faecal matter from contaminating the delivery field hence infecting the baby.

Madam Hannah complained of severe bearing down sensations with the uterine contractions becoming more expulsive and stronger at around 10:15pm. The anus was gapping with the perineum bulging. Client continuously lifted her buttock off the couch due to intense pain. Client was instructed to keep the buttocks on the couch and to bear down with contractions and rest in between contractions while practicing deep breathing exercise as she was taught to prevent perineal tear. Maternal pulse and fetal heart rate were checked after each uterine contraction to know the condition of both mother and fetus. Uterine contraction was 4 in 10 minutes lasting 45seconds and descent of fetal head was $0/5^{th.}$

Labour progressed successfully as the head advanced gradually. Flexion was aided by gently pressing the occiput downwards with the right index and middle fingers in order to allow the smallest diameter of the head distend the vulva and the perineum. The vagina was roomy so there was no need for an episiotomy. Flexion of the fetal head continued till crowning of the head occurred, she was asked to stop pushing, and pant at this stage to prevent rapid expulsion of the head which could lead to perinea tear and intracranial injury to the baby. The head was delivered by extension by allowing the sinciput, the face and chin to sweep over the perineum to be delivered.

The baby's eyes were cleaned with sterile gauze swabs from the inner canthus to the outer canthus to prevent infection using one swab for each eye. There was no cord around the baby's neck when felt for.

Restitution took place and few seconds later there was external rotation of the head which indicated that there has been internal rotation of the shoulders. This brought the shoulders into the anterior-posterior diameter of the pelvic outlet. She was asked to push gently with the next contractions. The palms were placed on either side of the parietal bone and with gentle downward traction on the fetal head towards the anus the anterior shoulder escaped under the symphysis pubis. Upward traction was done for the posterior shoulder to sweep the perineum and was delivered. The rest of the body was delivered by lateral flexion following the curve of carus unto the mother's abdomen at 10:27pm to initiate bonding and provide warmth.

A female baby was delivered and she cried loudly soon after delivery. APGAR score for the first minute was checked and recorded as 8/10. Baby was shown to the mother to identify the sex. Madam Hannah was congratulated for her effort.

IMMEDIATE CARE OF THE BABY

As soon as the head was born, the immediate care of the baby began. Baby's face was wiped with sterile gauze. The eyes were swabbed from the inner canthus to the outer canthus with different sterile cotton wool swabs. The index and the middle finger of the dominant hand were slide around the neck of baby to feel for cord around neck which was absent. The mouth and nostrils were not suctioned because the air way was clear and patent. Baby was dried thoroughly as soon as it was delivered unto mother's abdomen to prevent heat loss.

The wet cot sheet was removed and was replaced with a clean cot sheet. The cord was clamped within 3 minutes. The cord was measured 3 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 2 finger breaths above the clamp, there was a second clamp this time around with a forceps.

The cord was cut in between the clamp and the forceps with sterile scissors covered with sterile gauze to prevent splashing of blood. Baby was separated unto mother's abdomen. The cut end of the cord with artery forceps was placed in a sterile receiver. Baby was shown to the mother to identify the sex. An identification band was placed on the baby's wrist with mother's name, sex, date and time of delivery to identify the baby. Baby was placed on the mother's abdomen to initiate skin to skin contact which will last for an hour as means of providing warmth.

APGAR	FIRST MINUTE	FIFTH MINUTE
Appearance	1	2
Pulse	2	2
Grimace	1	1
Activity	1	2
Respiration	2	2

TOTAL	8/10	9/10

MANAGEMENT OF THE THIRD STAGE OF LABOUR

Madam Hannah was informed and procedure was explained to her. The uterus was palpated for any undiagnosed twin, after which injection oxytocin 10 units was administered on her left lateral thigh at exactly 10:30pm after palpating the uterus. The cut end of the cord was re-clamped closer to the client's vulva with a forceps; a sterile receiver was placed close to the perineum to collect the placenta, membranes as well as blood. The non-dominant hand (left) was placed on the uterus to feel for contractions. When contractions were felt, the dominant hand (right) held the cord with the clamp. With contractions, the left hand was removed and placed just above the symphysis pubis with the palm facing the mother's umbilicus. The placenta was delivered by firmly grasping the cord and applying the controlled cord traction in downward direction while counter traction was applied with the left hand to prevent inversion of the uterus. Steady traction was maintained until the placenta became visible at the vulva.

Both hands were removed simultaneously to cup the placenta. In teasing movement to ease pressure on the membranes to prevent tearing, the placenta and membranes were completely delivered at 10:35pm

A quick assessment of the placenta was made with lobes intact and complete membranes. The placenta was put in the receiver for thorough examination later. The uterus was massaged and blood clots were expelled.

The client's vagina, cervix and perineum were examined after consent was sought from client under a good light source. The index and middle finger were wrapped with sterile gauze to view the cervix, the anterior and posterior vaginal walls in clockwise direction. The same was done laterally for tears at the vaginal walls but there was none. Client was cleaned, and a new pad placed at her perineum, she was transferred to detention room and made comfortable in bed. She was taught and encouraged to massage her uterus. She was encouraged to change her pad to prevent infection and urinate whenever she has the urge to prevent post-partum hemorrhage. She was congratulated for her cooperation. Baby was still maintained in skin-to skin with mother with breastfeeding initiated. She was asked to report to midwives in case she sees any changes.

EXAMINATION OF THE PLACENTA AND MEMBRANES

Protective clothing like Mackintosh apron, cap, sterile gloves was worn and a thorough inspection of the placenta and membranes was done in order to ensure no part of it have been retained during its delivery after it had been sent to the sluice room. The placenta was removed from the 0.5% chlorine solution and it was held by the cord allowing the membranes to hang loosely downwards. The cord was of normal size and the cut edge was cleaned with cotton wool which revealed two arteries and one vein. It was surrounded by Wharton's jelly. The cord insertion was central; it had no false or true knots. The foetal surface was shinny and smooth

with its color being bluish grey. The branches of the cord vessels were seen radiating on its' surface .The placenta was placed on a flat surface with the maternal surface facing upward. Through inspection, the colour was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface and neither was it oedematous. It was then disposed off appropriately. 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.

Findings were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also completed.

Delivery book and summary of delivery in the antenatal booklet were also recorded. The husband and mother in-law were informed about the safe delivery and sex of the baby that is a girl, for which they accepted and were very happy. They expressed gratitude for the patience and care.

MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Fourth stage of labour begins after delivery of placenta and membranes to six (6) hours of observing both mother and baby. During this period, the baby and mother are closely monitored for any changes. Vital signs of mother and baby were checked and recorded every 15 minutes for the first two hours and 30 minutes for an hour and hourly for three hours.

Prevention of Diseases

Hands were washed with soap under running water to prevent infection. The eye of the baby was treated by administering chloramphenicol eye drop (2 drops on each eye) to protect the eye against infection such as Ophthalmia Neonatorum. The cord was also dressed using 6 cotton wool swabs soaked with methylated spirit. Injection vitamin K (0.5ml) was given intramuscularly on the

right thigh to prevent the baby from bleeding disorders. Mother was educated to wash hands before and after breastfeeding baby, visiting the wash room and changing her perineal pad. The baby was covered to provide warmth.

EXAMINATION OF THE NEW BORN

Consent was sought from Madam Hannah as the procedure was explained to her that the baby was going to be examined from head to toe to identify any birth defects for the necessary interventions to be taken whiles the findings will be communicated to her after the procedure and was encouraged to observe.

Hands were washed, dried and examination gloves put on. Baby was put on a warm flat surface and undressed but covered with a clean cot sheet. A quick general inspection on the baby revealed; the skin colour was pink and the muscle tone was good, then baby was covered with a clean cloth and was examined systematically;

Skin

The baby was pink in colour. There were no rashes or birthmarks seen. Lanugo hair was present and skin was intact and smooth with little vernix caseosa.

Head and neck

The face was pink with no birth mark. The head was examined and there was no caput succedaneum. The fontanels were not bulging or sunken and were pulsating normally with no widened sutures. The mother was encouraged not to use any hot water on the head.

She was educated that the posterior fontanelle would close within six weeks and anterior fontanelle would also close within 18 months. The head circumference of the baby was measured using a tape measure to encircle the baby's head starting from the occipital protuberance to the supra-orbital ridges and it measured 35 centimeters.

The ears were normal sized and shaped and the cartilage of the pinna was medium in texture. The eyes were in normal alignment. The sclera and conjunctiva was pink in colour with no discharges or jaundice. The ears were patent. The nose was of normal size and shape with a normal central septum. The nostrils were patent. The lips and tongue were pink, no tongue-tie, no false teeth and no cleft `lip or palate were detected. Rooting, suckling and swallowing reflexes were evident. The neck was palpated for swellings and enlarged lymph nodes or congenital goitre but there was none.

Extremities

The upper extremities were equal with no extra digits, clubbing, webbing, or a missing digit. The capillary refill did not delay at all when finger was pressed. There were palmer creases and movement present. Grasping and Moro reflexes of baby were present. The lower extremities were equal. There were no extra digit, webbing, clubbing or forefoot adduction. There was no dislocation of the hip. Knee jerk and planter reflexes were normal

Chest and Abdomen

The abdomen felt soft and round not distended and without any palpable masses. The cord was situated centrally and no bleeding was seen. The abdomen was of normal shape and size. The cord had one vein and two arteries. On the chest the trunk had a normal size.

The breasts were normally situated with no engorgement or mass. The nipples were in alignment with no extra ones. Respiratory movement was normal.

Back

The back and spine were also examined for any abnormal curvature, swellings, and injuries but none was detected. There were no abnormalities of the back such as spinal bifida or meningomylocele detected.

Genitalia and anus

The genitalia was examined and the labia majora covering the labia minora. The clitoris was present. The urethra and anus were patent since the baby passed urine and meconium.

The length, head circumference, weight and temperature of the baby were taken and recorded. Finally, the gloves were removed and disposed of according to infection prevention protocol. Vital signs and other assessment checked were communicated to the mother and documented as follows:

Head circumference - 35 cm

Length - 46 cm

Weight - 2.7 kg

Apex beat - 136 bpm

Temperature - 36.7^0C

Respiration - 48 cpm

The baby was wrapped nicely and the findings were communicated to the mother that there were no abnormalities detected. She was educated on how to maintain good personal hygiene of the baby and herself by washing her hands with soap and water frequently, changing baby's diaper whenever soiled and not applying any herbs on babies cord to avoid any infection and also to keep the baby warm so as to prevent hypothermia.

MOTHER

Madam Hannah was sent into the detention room and made comfortable in bed. She was congratulated for her co-operation. She was served with mashed kenkey she complained of fatigue and hunger. Client was taught and encouraged to continue breastfeeding the baby exclusively and on demands to maintain lactation.

She was educated on the importance of breastfeeding such as it enhances the release of oxytocin which helps in the contraction of the uterus and drainage of lochia, control of hemorrhage and also as a form of family planning. She was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was palpated and it was well contracted. Symphysio-fundal height was 16cm. Vaginal bleeding was small and lochia was red (rubra). There was no offensive odour and perineum intact. Madam Hannah was encouraged to report if she experiences any profuse bleeding. She was also asked to change her pad when soiled in order to prevent

infection and wash hands afterwards. She was encouraged to urinate frequently as this will aid contraction of the uterus and involution. 60mls of urine was passed in about an hour later.

Vital signs were checked every 15 minutes for two hours, 30 minutes for one hour and one hourly for the remaining three hours and recorded in the observation chart. All findings were within the normal range. Her vital signs and assessment were checked and recorded as follows;

Temperature	-	36.4^0c
Pulse	-	87bpm
Respiration	-	23cpm
Blood Pressure	-	120/ 76mmHg

SUMMARY OF LABOUR AND DELIVERY

Date of delivery	24th November, 2022.
Time of delivery	10:27pm
Time of placenta expulsion and membranes	10:30pm
Type of delivery	Spontaneous vagina delivery
Estimate blood loss	150mls
Duration of labour	
First stage of labour	7 hours

Second stage of labour	27minutes
Third stage of labour	8 minutes
Total duration of labour	7 hours 35 minutes
Condition of baby	
Sex	Female
Birth weight	2.7kg
Apgar score at 1st minute	8/10
Apgar score at 5th minutes	9/10
Full lengths	46cm
Head circumference	35cm
Chest circumference	33cm
Meconium	Passed
Urine	Passed
Abnormality	None detected
General condition	Satisfactory
Condition of mother	
Blood pressure	122/63mmHg

Pulse		83bpm
Respiration		21cpm
Temperature		36.5^{o}C
Uterus		Contracted
SFH		16cm
Lochia		Rubra
Condition		Satisfactory
Condition of placenta		
Maternal surface	-	Normal (Dark red)
Fetal surface	-	Normal (Bluish grey)
Lobes and membranes	-	Complete and healthy
Blood vessels	-	2 Arteries, 1 vein
Cord situation	-	Central

NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

Client complained of:

24th November, 2022

- Lower abdominal pains

- Backache

- Fatigue

- Risk for perineal tear

- Risk for infection

Short Term Objectives

- Client will cope with lower abdominal pains within 3 hours

- Client will cope with backache within 3 hours of labour.

- Client will be relieved of fatigue within three hours.

- Client will go through 2nd stage of labour successfully without perineal tear.

- Client will be free from infections throughout labour.

Long Term Objectives

Labour will progresses normally and end successfully without any complication to both mother and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
24/11/22 at 5:04pm	Lower abdominal pain related to painful uterine contractions.	Client will cope with lower abdominal pains within 3 hours and throughout labour as evidenced by 1. Client verbalizing she is coping with the pain. 2. Midwife observing a relaxed facial expression in between contractions.	1. Reassure client. 2. Encourage her to adopt a comfortable position. 3. Encourage client to do deep breathing exercise. 4. Involve client in a conversation.	1. Client was reassured that pains would resolve after delivery. 2. Client was encouraged to lie on her left lateral to cope with the pain. 3. Client was encouraged to do deep breathing exercise during contractions. 4. Client was involved in a conversation to divert her mind off the pain.	24/11/22 at 7:18pm	Goal fully met as client said that she is coping with pain.	N.C.G

			5. Perform sacral massage for client.	5. Sacral region was massaged for client during contractions.			

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
24/11/22 at 5:05pm	Backache related to relaxed pelvic ligament and descent of the fetal head	Client will cope with backache within 3 hours of labour as evidenced by 1. Client verbalizing her ability to cope with backache. 2. Midwife	1. Reassure client. 2. Explain the physiology behind backache in labour to client. 3. Encourage client to adopt a suitable position. 4. Massage sacral region	1. Client was reassured that the backache will resolve after delivery. 2. It was explained to client that the backache was due to pressure on sacral nerves. 3. Client was encouraged adopted the left lateral position	24/11/22 at 8:35pm	Goal fully met as client reported that she has been able to cope with backache.	N.C.G

		observing client adapt coping mechanisms.	5. Teach and encourage client to do deep breathing exercise.	4. The sacral region of client was massaged during contractions. 5. Client was encouraged to do deep breathing exercise during contractions.			

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
24/11/22 at 8:38pm	Fatigue related to effects of labour pains and contractions.	Client will be relieved of fatigue within an hour as evidenced by; 1.Client verbalizing that she feels less tired. 2. Midwife	1. Assure client. 2. Explain to her why she feels tired.	1. Client was reassured that the situation can be managed. 2. Client was told her tiredness was due to the labour pains and contractions. 3. Client was encouraged to rest	24/11/22 at 9:10pm	Goal was fully met as client verbalized she was feeling less tired.	N.C.G

		observing client been refreshed.	3. Encourage client to rest in between contractions 4. Advice client to avoid shouting to prevent maternal exhaustion. 5. Encourage client to take in sips of malt beverage and water to replenish lost glucose stores and also for rehydration.	when no contractions to prevent further exhaustion. 4. Client was advised to avoid shouting to prevent maternal exhaustion and was encouraged to do deep breathing exercise 5. Client was encouraged to take sips of her favourite malt beverage and water to replenish lost glucose stores and also for rehydration.			

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIM E	EVALUATI ON	SIGN
24/11/22 at 7:35pm	Risk for infection related to	Client would be free from infections within 5 hours of	1. Assure client.	1. Client was assured that she would have no infection from the cannula passed.	24/11/2 2 at 9:45pm	Goal fully met as midwife	N.C.G

	invasive procedure.	labour as evidenced by; 1. Midwife observing client with no infection. 2. Client not exhibiting signs and symptoms of infection.	2. Practice aseptic technique during invasive procedures. 3. Encourage client on proper hygiene. 4. Encourage client to keep hands away from the cannula. 5. Educate client on the need to prevent infection as post- partum infection will have negative effect	2. Gloves were worn and site cleaned before the procedure was done. 3. Client was encouraged not to allow water get access to the cannula site when bathing. 4. Client's was encouraged to keep hands from the cannula and not to touch it to prevent dirt from entering the site. 5. Client was educated on the need to adhere to information given to prevent infection as post- partum infection will have negative effect on her wellbeing.		observing client had no infections.	

			on her wellbeing.				

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATI ON	SIGN
24/11/2 at	Risk for	Client will go	1. Assure client.	1. Client was assured that she is	24/11/22	Goal was	N.C.G

8:45pm	perineal tear related to overstretching of the perineum and perineal muscles	through 2nd stage of labour successfully for 1 hour without any perineal tear as evidenced by: 1. Midwife observing intact perineum at the end of the labour. 2. Client observing and verbalizing the absence of a tear at the end of labour	2. Encourage client to only push when cervix is fully dilated. 3. Encourage client to place buttocks on the couch 4. Encourage client to pant when the head crowns. 5. The midwife should aid flexion of the fetal head by placing the	in the hands of skilled and competent midwives. 2. Client was encouraged to push only when the cervix is 10cm dilated. 3. Client was encouraged to not to lift buttock off the couch during contractions. 4. Client was told to breathe through the mouth when the head crowns to prevent rapid expulsion of the fetal head. 5. The midwife placed her middle and index finger on the advancing head to aid flexion and	at 9:45pm	fully met as client expressed relaxed face and verbalized that she is relieved	

			middle and index finger on the advancing head.	allow the smallest diameter of the fetal head to distend the vulva			

CHAPTER FOUR

PUERPERIUM

INTRODUCTION

Chapter four gives an overview of activities and management of mother and baby from the first day to the sixth week postnatal. Outlines and care plans are drawn for controlling and supervising of problems encountered in the process of puerperium. In this process the reproductive organs return to their non-pregnant stage and lactation initiated. Sensitization and health education, counseling, assessment, aid for the baby feeding and immunization service for baby were carried out.

DAY OF DELIVERY

Madam Hannah Ofori delivered on 24th November, 2022 and was sent to the lying ward at 10:30pm where her baby was nicely wrapped and placed beside her. Madam Hannah was educated again on the need to ensure personal hygiene and empty her bladder more often and also prevent post-partum hemorrhage and uterine sub- involution. Madam Hannah was taught and made aware that changing of pad when soiled is very imperative to good health during her postpartum period.

Madam Hannah was taught to feed baby more often and practice an extensive breastfeeding and also taught how to fix baby to breast very well. There were other mandatory personal hygiene daily education like washing of hands properly after visiting the washroom

and changing the baby's napkins to prevent infections. Symphysio-fundal height and vitals were examined and recorded every 15minutes to two hours, below is a record of her vital signs, and it read[ioks as follows;

Temperature - 36.4 Degrees Celsius (^{o}C)

Pulse - 87 beats per minute (bpm)

Respiration - 23 cycle per minute

Blood pressure - 120/76 millimeters of mercury (mmHg)

Symphysio fundal height - 16centimeters (cm)

Client was again congratulated on her effort and was allowed to rest.

SUBSEQUENT CARE OF THE BABY

Madam Hannah was informed about the need to bath the baby and general examination of the baby, consent was sought and client agreed. The baby's cord was observed for bleeding but there was none. The color of the baby was pink. Urine and meconium were passed and all reflexes were normal. Below indicates baby's vital signs and weight;

Temperature - 36.5 Degree Celsius (^{o}C)

Apex heart beat - 132 beats per minute (bpm)

Respiration - 46 cycles per minute

Baby's weight - 2.7 kilograms (kg)

Baby's height - 46cm

The umbilical cord was dressed and kept clean. Some 10 hours 30 minutes later after birth the baby was bathed at the facility under the supervision of the midwife in- charge

BABY BATH AND CORD DRESSING

A trolley was set with the following

Top shelf

4 Sterile cotton wool swabs and gauze in a gallipot

Surgical gloves

Sterile water in gallipot

Methylated spirit

Baby's diaper

Baby dress

Baby’s towel and cot sheet to wrap the baby

Baby’s cap and socks

Soap in a soap dish

Baby’s sponge

Bottom shelf

Disposable gloves

Jug of hot water

A bowl for mixing water

Kidney dish for used gauze and swab

A receptacle for used water

Mackintosh apron

Cream (powder)

A warm bath is given to the baby to prevent hypothermia. The client was made to understand the process and reasons why it's necessary to prevent hypothermia. The warm water was prepared, it was mixed and tested for using the elbow to check its temperature.an apron was worn and hand washing was performed using soap and water and dried. Baby was carried and put on a flat protected surface to undress it and she was then wrapped in a cot sheet; Gloves were worn and eyes of the baby were cleaned, using cotton wool swabs dipped in sterile water and the face was cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand and plugging the ears with two fingers, the head and was washed with soapy sponge. Baby was lifted of the flat surface, and with the hand still supporting the nape of the neck and the body resting in the elbow to the edge of the bowl, the baby was laid on a protected flat surface. Baby's arm and front of trunk were washed, laying emphasis and paying attention to the skin folds. The baby's back was turned with one arm supporting the chest with one hand and holding the distal arm of the baby. From behind it was washed down to the feet, paying attention to the skin folds. Holding the baby firmly, baby was immersed in a basin of warm water with head above the water and rinsed thoroughly. The baby was covered with a clean sheet and was put on a flat surface. A towel was used on the baby to Dry and clean and pay attention to the skin folds, baby oil was applied on the skin. Gloves used in the above procedure were taken off and discarded.

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 and clean 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. 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 swap was used to clean the anterior part, two (one each) for the lateral sides and another one was also 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 and clean. Baby was dressed after diaper was put on. The baby was wrapped with clean Dry and clean cot sheet to maintain her temperature and given to her mother. Findings were communicated to the mother and she was thanked for her co-operation and she was accompanied to the bedside. The working surface and the instruments were decontaminated with 0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed and dried and the procedure was documented.

Mother was informed that the baby will be immunized against tuberculosis and poliomyelitis.

FIRST DAY POST DELIVERY AND DISCHARGE

On 25th November 2022, Madam Hannah woke up rejuvenated and healthy as well as baby. Client was informed she was going to be discharged that morning. Procedures and step to be taken on both mother and baby were explained. Perineal pad was inspected for the flow of lochia which was small and red in colour with no odor. Client took a warm shower and was served with porridge and bread. Afterward, a head to toe examination was done with no health abnormalities detected. Madam Hannah was asked about how she and the baby were doing and she said they are both doing well, except that client complaint of lower abdominal pain while breastfeeding the baby. She was reassured and educated on the physiology of after pain that, it is a normal physiology that is the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes after pain. She was given paracetamol 1gram to reduce the pain. Client had to be encouraged to breastfeed baby more often to aid involution. Client's vital signs were observed and recorded as;

Mother

Vital Signs	Morning
Blood pressure	110/60mmhg

Lochia	Rubra
Fundal Height	15cm
Condition of uterus	Well contracted
Pulse	86bpm
Respiration	20cpm
Temperature	36.7

Baby received an initial immunization which was Bacillus Calmette Guerine (BCG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine 0 (OPV0) 2 drops at the back of the tongue to prevent poliomyelitis which was administered by the a midwife in-charge. The baby was top and tailed and observed from head to toe with no abnormalities detected. Six cotton wool swab and methylated spirit was used to dress the cord in the presence of the client. Below are the baby's vital records;

BABY

Vital Signs	Morning

Temperature	36.4°c
Apex Heart Beat	130bpm
Respiration	40cpm
Condition of the cord	Dry and clean
Suckling	Good
Weight	2.7kg
Stool Colour	Greenish

The baby was wrapped in a clean and warm cot sheet and handed over to the mother for breastfeeding. Good positioning and attachment to the breast was encouraged. Mother was educated on the intake of a balanced diet. Several educations were given to client on the changes in perineal pad when soiled and the need to wash her hands after removal and before breastfeeding the baby to prevent infections. Mother was educated on postnatal exercises such as Kegel, ambulation and family planning, and the need for napkins or diapers to be changed frequently, wash and Dry and clean them in the sun and keep the baby warm always. Client was asked to register the baby at the birth and death registry. Client was informed on the first postnatal visit to the facility to be 1st

December, 2022. Client was informed that she may be discharged soon. The baby was assessed again and no abnormality noticed and confirmed they were ready for discharge and was giving the following medications;

Tablet Folic Acid	5mg daily for 30 days
Tablet Ferrous Sulphate	200mg bd for 30days
Tablet Multivitamin	200mg tds for 30 days
Tablet Paracetamol	1g tds for 3days

Client was assisted to pack up her belongings and was discharged at 10:30am after serving her medications. Her bills were settled by the national health insurance scheme. Client was reminded of the several home visits the next seven days and she agreed.

Client was congratulated and bid farewell.

FIRST POSTNATAL HOMEVISIT (SECOND DAY POSTNATAL)

On 25th November, 2022 at 4:30pm, client and family were visited as agreed. The general health condition of the baby and the mother was good. Client and baby were examined from head to toe and no abnormalities were detected. The evening home visit was at 4:30pm, after exchanging pleasantries both mother and babies were examined from head to and everything was fine, the cord was dressed with cotton wool swab and methylated sprit. The cord was Dry and clean and free from bad odor. Client complained of

headache and loss of appetite, madam Hannah was urge and encouraged to rest in a serene environment and also cut down some chores and avoid activities that will stress her. Client was asked about her afterpain and she asserted that the pain is becoming bearable with time. There were several recommendations for the client's husband after he requested for a blood pressure check. Below is the mother's and baby's vital signs;

MOTHER

OBSERVATION	MORNING	EVENING
Temperature	36.6℃	36.7℃
Pulse	78bpm	90bpm
Respiration	21cpm	18cpm
Blood pressure	114/78mmhg	121/84mmhg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of uterus	Well contracted	Well contracting

Breast	Lactating	Lactating

BABY

OBSERVATION	MORNING	EVENING
TEMERATURE	37.0℃	37.1℃
PULSE	138bpm	137bpm
RESPIRATION	45cpm	44cpm
WEIGHT	2.6kg	2.6kg

SECOND POSTNATAL HOMEVISIT (3RD DAY POSTNATAL)

On 26th November, 2022 at 7:30am and 4:30pm was another day of home visit as agreed and scheduled with Madam Hannah. Client and relatives of the clients were in good health when it was inquired. Inspection of perineal pad was done and the flow of lochia was small and red in colour. No abnormalities were detected. Head to toe assessment was carried out on the mother without any abnormality detected. Vital signs of Madam Hannah were recorded as follows;

Observation	Morning	Evening
Temperature	36.8°c	36.7°c
Pulse	82bpm	80bpm
Respiration	22cpm	20cpm
Blood Pressure	100/60mmhg	100/70mmhg
Lochia	Rubra	Rubra
Fundal Height	13cm	13cm
Condition of uterus	Contracted	Contracted

The baby was assessed from head to toe and no abnormality was detected. The babys had passed urine and meconium which was greenish in colour while breastfeeding.

Client was educated on the need to apply a warm compress on the breast, need to put on well- Clien complained of fullness of breast and she was urged to position the baby well to breast fitting brassier to help ease fullness and also ensure the complete emptying of each breast during breastfeeding. Madam Hannah was educated to continue breastfeeding. The cord was dressed with cotton wool swab and the mother was educated not to apply herbs on the cord. When asked about the after pain client said she was relieved as various recommendations helped. The baby was assessed again and no abnormality was found.

Below are the baby's vital signs, weight and other assessment made;

Observation	Morning	Evening
Temperature	36.7	36.8
Pulse	126bpm	126bpm
Respiration	51cpm	40cpm
Condition of cord	Dry and clean and clean	Dry and clean and clean
Suckling	Good	Good
Weight	2.5kg	2.5kg

Stool Colour	Greenish	Greenish

The baby was wrapped in a warm towel and was given to the mother for breastfeeding. Mother was reminded of next visit, thanked and permission was sought to leave.

THIRD POST NATAL HOME VISIT (4TH DAY POSTNATAL)

Client was visited again on the 27th November, 2022 at 7:30am and 4:30pm respectively. Madam Hannah was very hospitable. General condition of both mother and daughter was good. Madam Hannah's complaints of loss of appetite and headache during the first post natal visit have been resolved when asked. Hannah emphasized that she had a sound sleep as compared to the previous nights. The procedure of general examination was explained to mother and both mother and baby were examined from head to toe. The mother's perianal pad was inspected for lochia and it was bright red with no foul smell.

Below are the results accrued on assessments on the mother;

Observation	Morning	Evening
Temperature	36.5°c	36.7°c

Pulse	68bpm	74bpm
Respiration	20cpm	18cpm
Blood Pressure	100/60mmhg	100/70mmhg
Lochia	Rubra	Rubra
Fundal Height	12cm	12cm
Condition of uterus	Contracted	Contracted

Baby was assessed and examined and no abnormality was detected, baby was top and tailed and passed urine and greenish stool. Cord was examined and it was Dry and clean, the cord was dressed with sterile cotton and methylated spirit.

Below is the vital sign and observation record of the baby;

Observation	Morning	Evening
Temperature	36.4°c	36.5°c
Pulse	128bpm	124bpm

Respiration	42cpm	44cpm
Condition of cord	Dry and clean	Dry and clean
Suckling	Good	Good
Weight	2.5kg	2.5kg
Stool colour	Greenish	Greenish

FOURTH POST NATAL VISIT (5TH DAY POSTNATAL)

On the 28th November, 2022, the fourth visit was made to Madam Hannah's house at 7:30am. She was in a good health condition together with her family, her environment was well kept and tidy. Client's family was also lauded for taking good care of the baby. Madam Hannah laid emphasis on her complaint on the pain she felt in her breast had eventually subsidized immensely. Client was asked to top and tail baby under supervision and she executed it very well. Baby passed yellowish stool and urine. Cord was dressed with sterile cotton and methylated spirit. The cord was Dry and clean and had begun to detach.

The symphysio fundal height was measured and recorded as 11 centimeters and lochia was inspected and it was pink in color

Mother was assessed and findings were recorded;

Observation	Morning
Temperature	36.4°c
Pulse	78bpm
Respiration	16cpm
Blood pressure	100/78mmhg
Lochia	Serosa
Fundal Height	11cm
Condition of uterus	Contracted

Vital information and findings recorded for the baby were

Observation	MORNING
Temperature	36.6°c

Apex heart beast	130bpm
Respiration	50cpm
Suckling	Good
Weight	2.6kg
Condition of cord	Dry and clean
Stool colour	Dark yellow

Client was informed about the termination of care and the need to be handed over to the child health clinic for the continuity of care and monitoring of the baby's growth. Client was told the date was scheduled to be 5th December, 2022 during first post natal visit the clinic. Patient and the entire family was reassured of competent care.

After staying interactive for some time client together with her family was very happy and thanked for the visit.

FIFTH POST NATAL VISIT (6TH DAY POSTNATAL)

Client was visited again on the sixth day postnatal, 29th November, 2022 at exactly 7:30am. The health condition of Madam Hannah together with her family was good, head to toe examination was done and there were no abnormalities detected. Hannah lochia was pink in colour with moderate flow not offensive. Madam Mary was assessed and asked whether she was able to sleep at least six hours in the night and two hours during the day, her feedback was positive and clear, she had no issues in sleeping in both day and night. The family was urged to assist client on some domestic activities. Hannah husband agreed to assist her take care in instances' of changing diaper and etc.

Below is a vital sign and observations made of the fifth postnatal visit day

Observation	MORNING
Temperature	36.5°c
Pulse	92bpm
Respiration	16cpm
Blood Pressure	120/82mmhg
Lochia	Serosa

Fundal Height	10cm
Condition of Uterus	Contracted

The baby was examined and recorded as;

Observation	Morning
Temperature	36.3°c
Apex Heart Beat	136bpm
Respiration	51cpm
Suckling	Good
Weight	2.7kg
Condition of cord	Shrunken
Stool colour	Brownish yellow

Client said her both her headache and breast engorgement has been resolved. Madam Hannah was advised to breastfeed baby on regular basis. Permission was sort to leave and client's house was exited.

SIXTH POST NATAL VISIT HOME VISIT (7TH DAY POSTNATAL)

Client was visited again on 30th November, 2022 at 7:30am. There were no health complaints or issues associated with Madam Hannah, the baby and the family as well. Client complained of heat rashes on the baby's skin and client was assured through education to dress the baby in accordance to weather and use talcum powder on the baby's skin. Hands were washed and assessment from head to toe was done and no abnormality was detected, lochia inspection proved it was pink with no odor.

Vital signs were recorded as;

Pulse	70pbm
Respiration	21cpm
Blood Pressure	112/72mmHg

Lochia	Serosa
Fundal height	9cm
Conditions of Uterus	Contracted
Breast	Lactating
Temperature	36.7℃

The stump of the cord was dressed with cotton and methylated spirit and the client was again advised not to put anything on it to prevent infection. The vitals for the evening were all within normal range.

Vitals Signs of the baby were checked recorded as

Temperature	36.5°c
Apex heart beat	128bpm
Respiration	41cpm
Skin colour	Pink

Condition of Cord	Fallen off
Suckling	Good
Weight	2.8kg
Stool colour	Brownish yellow

The baby as handed over to the mother to cuddling with her for a while and dressed for breastfeeding. Madam Hannah was thoroughly educated on perineal care and the intake of a balanced diet and avoid hot application of fontanelles. Madam Hannah was asked to continue breastfeeding for six months. Client was thanked and reminded of her first week postnatal visit to the clinic which happened to be the next day. Client affirmed she would be in attendance.

FIRST POST NATAL VISIT TO THE CLINIC

Madam Hannah visited the facility on 1th December, 2022 for the first post-natal examination. Client and baby were healthy and well dressed. Client was welcomed at the hospital. Every process to be initiated was explained to the client.

Vital signs and other observation were recorded as well;

Temperature 36.6°C

Pulse	82bpm
Respiration	20cpm
Blood pressure	104/89mmHg
Lochia	Serosa
Fundal height	Not Palpable
Condition of uterus	Well Contracted
Breast	Lactating
Weight	59kg

Because it was her first postnatal clinic visit, it was very imperative that she needed to be sent to the laboratory for another investigation Madam Hannah was given a specimen bottle to collect midstream urine to test for protein and glucose. Blood sample was taken and client's hemoglobin level was tested.

Haemoglobin	13.5g/dl
Urine protein	negative
Glucose	negative

Madam Hannah was asked lie straight on the bed head to toe physical examination while maintaining privacy. Before the commencement of the examination hands were washed with soap under running water and dried with towel. On the head, the hair was

nicely and neatly braided. There were no sign of jaundice in the eye and no discharges and the ear too had no discharges. Tongue was neither coated or pale, no foul smell, no visible tooth decay was noted after the mouth check. The neck was palpated for inflammation of lymph nodes and goiter but nothing was detected .Client's chest and breast was examined for mass, engorgement and sore nipple but none was detected. After the abdominal examination, there were no tenderness, enlarged liver or spleen but the uterus was not palpated. The vulva was examined for infections, scars, and lochia but none was seen. With the permission of the mother, the baby was taken and examined from head to toe and nothing abnormal was detected.

The baby's vitals were observed as recorded as;

Temperature	36.7^{o}C
Apex heart rate	120bpm
Respiration	40cpm
Skin colour	Pink
Stump	Healed
Condition of cord	Fallen off and stamp healing
Suckling	Good
Weight	2.9kg
Stool colour	yellow

Explanation was given to Madam Hannah on the need to be handed over to the midwife in-charge for continuity of care on as discussed on 5th post natal visit at 5:00 pm. Explanation was made to her that our program had ended on the 23rd December, 2022 but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her mother together with her partner were thanked for their cooperation, information provided throughout the study, they were reminded to register the baby at birth and death registry. And also, to complete baby's immunization schedule.

SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, Madam Hannah came to the hospital on the 3rd of January, 2023 for her sixth week postnatal visit. The midwife indicated that client was welcomed and was offered a seat. Client and baby looked healthy and happy. As she was emptying her bladder, midstream specimen was taken for investigations. Rapport was established and permission sought for head to toe examination of both the mother and her baby and no abnormalities were found. Vitals of the mother was checked and recorded as;

Temperature 36.0^{0}C

Pulse 80bpm

Respiration 20cpm

Blood pressure 110/70 mmHg

Weight 65kg

The results from the laboratory were recorded as;

Haemoglobin	12.6.g/dL
Urine protein	Negative
Glucose	Negative

Madam Hannah and her baby were handed over to the child welfare clinic and family planning unit for the 6 weeks immunization.

Baby was immunized with the following vaccines; polio 1 to 2 drops, Rotavirus 1 to 2 drops, pneumococcal 1 0.5milligrams and pentavalent (diphtheria, pertussis, tetanus, hepatitis B,

Hemophilic influenza) . Mother was reminded on the family planning advice and breast feeding exclusively, rest and sleep, exercise and nutritious diet which would aid in lactation. She was encouraged to ask questions bothering her but there was none. Client was advised to visit the hospital for any health related issues and was handed over to the public health nurse for continuity of care.

CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

1. 25/12/22 - Client complained of after pain
2. 26/12/ 22 - Client complained of headache
3. 26/12/22 - Client complained of loss of appetite.
4. 27/12/22 - Client complained of fullness of breast

5. 28/12/22 - Skin rashes was observed on the baby

SHORT TERM OBJECTIVES

- Client will be relieved of after pain within 72 hours.
- Client will be relieved of headache within 24 hours
- Client will regain her appetite within 24 hours
- Client’s engorge breast will resolve within 48 hours
- Client’s baby rashes will resolve with 72 hours

LONG TERM OBJECTIVES

Madam Hannah will go through puerperium successfully without any complications to herself or the baby.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/12/ At 9:00am	After pain related to involution of the uterus	Client will be relieved of after pain within 72 hours as evidenced by a. Client verbalizing that she's no longer in pain. b. Client's husband saying his wife no longer complains of the said pain.	1. Assure client. 2. Explain the physiology of pain to client. 3. Encourage client to assume any comfortable position to help cope with pain. 4. Encourage client to empty her bladder frequently. 5. Serve her with	1. Client was assured that pain is temporal. 2. The client was told that the pain is as a result of the contraction of the uterus. 3. Client assumed a prone position with pillow under her lower abdomen. 4. Client emptied her bladder frequently to allow space for the uterus to contract. 5. Client was served with analgesic	28/12/22 At 9:00am	Goal fully met as client verbalized her pain has drastically resolved.	N.C.G

			prescribed analgesics	(paracetamol)			

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION EVALUATION	SIG SIGN
26/12/2\ at 7:40am	Headache related to stresses of puerperium.	Clients headache will be relieved within 24 hours as evidenced by a. client verbalizing that she is relieved from her headache. b. Client's husband	1. Assure client. 2. Educate mother to have some rest during the day. 3. Encourage support person to assists client in taking care of the baby. 4. Educate mother to	1.Client was assured that her headache will resolve 2.Mother was educated to sleep during day time while baby is asleep 3. Support person was encouraged to take care of the baby to allow client	28/12/22 at 7:40am	Goal met as client said that her headache has subsided.	N.C.G

		confirm that client stopped complaining of headache	limit number of visitors. 5. Serve prescribed analgesic e.g. paracetamol 1gram when necessary.	have some rest 4. Mother was educated to limit visitors so that she can rest a little. 5. Tab paracetamol 1g was served when necessary.			

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/12/22	Loss of appetite related to stresses of labour.	Client will regain her normal eating pattern within 24 hours as	1. Assure client. 2. Encourage her to practice oral hygiene to help increase her appetite	1. Client was assured that her eating pattern would return to normal. 2. Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her	28/12/22	Goal achieved as Client said she ate half of meal served. Support person	N.C. G

		evidenced by a. client verbalizing that, she is able to eat b. support person observing client eating half of meal served.	3. Serve client’s favorite food. 4. Serve clients food attractively 5. Administer vitamin supplements.	appetite. 3. Client’s was served with two balls of banku with okro stew. 4. Clients food was served attractively by garnishing the food. 5. Vitamin supplements such as folic acid, multivitamin were administered to client.		reported that client ate more than half of meal served.	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/12/22	Breast	Clients engorged	1. Assure client that	1. Client was assured that breastfeeding baby	29/12/22	Goal fully met	N.C.G

	engorgement related to inability to empty the breast completely.	breast will resolve within 48 hours as evidence by a. Client verbalizing that she feels comfortable in her breast and b. Midwife visualizing that the fullness has resolved.	breast feeding baby on demand help in resolving the fullness. 2. Encourage client to support the breast with well-fitting brazzier or breast binder. 3. Educate client on how to position and fix baby well when breastfeeding. 4. Educate client to apply cold compress on	on demand help resolve the fullness so she should always put baby to breast. 2. Cleint was encouraged to support the breast with well-fitting brazzier or breast binder. 3.Client was educated on how to position baby to breast thus more of the areolar should enter into baby's mouth, the baby's abdomen to touch mothers and also mother should support her back when breastfeeding baby. 4. Client was educated to take warm bath to aid in circulation and also to apply cold compress on the breast to help in resolving		as client said that she felt comfortable and midwife reported that fullness of client's breast has resolve.	

			the breast 5. Encourage client to do gentle manual expression of the breast.	pain. 5. Client was encouraged to do manual expression of the breast in to the cup and also to use breast pump to help in complete emptying.			

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/12/22	Skin rashes on baby related to excessive dressing of baby.	Baby will have no skin rash within 72 hours as evidenced by; a. Client verbalizing that baby skin rashes has resolved. b. Midwife observing that baby is having no	1. Assure client. 2. Educate client on the need to cloth baby according to weather. 3. Encourage mother not to scratch the rashes to prevent	1. Client was assured of competent care and she was comfortable. 2. Client was educated dress baby in warm cotton cloths and according to the weather changes. 3.Mother was encouraged not scratch the rashes as it would cause more pain and infection	30/12/22	Goal fully met as client informed the midwife that baby's skin rashes has resolved.	N.C.G

		rash.	infection. 4. Encourage and teach mother how to use prescribed powder. E.g. Listerine powder and Vaseline or Shea butter to protect baby’s skin. 5. Encourage mother to open windows for good ventilation.	4. Mother was encouraged use the medications given for the rashes. That is the Vaseline and Listerine powder. 5. Mother was encouraged windows for good ventilation.			

SUMMARY AND CONCLUSION

Madam Hannah Ofori 30-years gravida 3 para 2 alive and a native of Adugyama in the Ashanti Region was met when she was 38 plus 2 weeks pregnant on the 14th November,2022 at the St. Edward Hospital, Adugyama. She was chosen as a client to help her go through pregnancy, labour and early puerperium successfully without any complications after she consented to.

During her prenatal period her antenatal card was collected and glanced through and noticed client complained of heartburn. She was chosen for the care study so that she could be helped to manage her problem.

Her pregnancy was managed well and she cooperated throughout pregnancy. She went into labour and had spontaneous vaginal delivery to an alive Female child on 24th November,2022 with no complications like postpartum hemorrhage. She was visited at home during puerperium and cared for in their own environment. Client was managed throughout pregnancy, labour and puerperium until the fourth day puerperium when she was handed over to the public health nurse for continuity of care.

In undertaking this family centered maternity care study, I had enriched my experience since I was able to put the things being taught both knowledge and skills into practice. Scientific approach was used in the nursing care to collect data from her, identified her needs which enabled me to render a comprehensive care. It has also made me recognize the importance of family support, participation and choice in rendering total care to the client.

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DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA- TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAINS	SIGN
28/4/22	59kg	120/80mmHg	Positive/ negative	9 weeks plus 5days	Not palpable	-	-	-	Routine drugs	No complains	V.K
07/5/22	57kg	109/76mmHg	negative/ negative	13weeks	Not palpable	-	-	-	Routine drugs	Doing well	M.T
27/6/22	58.9kg	119/80mmHg	negative/ negative	20weeks	18cm	-	-	124bpm	Routine drugs.	Doing well	R.M
25/7/22	59kg	105/64mmHg	Negative/negative	22+2weeks	19cm	-	-	130bpm	Routine drugs.	Feels well	N.O

MOTHER'S ANTENATAL (APPENDIX I)

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN⁄SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
22/8/22	60kg	9O⁄60mmHg	negative⁄ negative	26 weeks	25 cm	-	-	132	Routine drugs.	Doing well	R.M
19/9/22	61kg	115/80mmHg	negative/ negative	30+2weeks	30cm	Cephalic	-	138	Routine Drugs	Waist pains	V.S
3/10/22	59.5kg	105/66mmHg	Trace/ negative	32+2weeks	31cm	Cephalic	5/5th	135bpm	Routine Drugs	No complaints	O.A

17/10/22	62kg	123/57mmHg	negative/ negative	33+2weeks	33cm	Cephalic	$5/5^{th}$	130bpm	Routine drugs	Vaginal itching	.S
31/10/22	62kg	136/81mmHg	negative/ negative	36+2weeks	36cm	Cephalic	$5/5^{th}$	135bpm	Routine Drugs	No complains	J.A

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
7/11/22	62kg	120/80mmHg	Trace /negative	37+2weeks	38cm	Cephalic	$5/5^{th}$	129bpm	Routine drugs	Doing well	V.S.
14/11/22	64.0kg	121/74mmHg	Negative/negative	38+2weeks	36weeks	Cephalic	$5/5^{th}$	143bpm	Routine drugs	constipation	N.C.G

21/11/22	64Kg	128/79mmHg	Negative/ negative	39+2 weeks	37weeks	Cephalic	5/5th	144bpm	Routine drugs	Doing well	N.C.G

ITN Given – 27/05/2022

INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 27/05/22	Gestation age In weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 22/08/2022	Gestation age In weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)19/09/22	Gestational age in weeks
		20weeks		26weeks		30+2weeks
	4th dose 3 tabs (Direct observed therapy)17/10/22	Gestation age in weeks 33+2weeks	5th dose 3 tabs (Direct Observed Therapy)07/11/22	Gestation age in weeks 37+2weeks		

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

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
21/04/22	1. Blood 2. Urine	Haemoglobin level Sickling status Grouping and Rhesus factor HIV status VDRL Hepatitis status G6PD status Sugar	12g/dl-16g/dl Negative A, B, AB, and O Positive and negative None reactive None reactive Negative None reactive	11.2g/dl Negative B Positive Negative Non-defect Negative Non-defect	Low Normal Normal Normal Normal Normal Normal Normal

		Protein	Negative Negative	Negative Negative	Normal Normal
7/05/22	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
27/06/22	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
25/07/22	1.Urine	Sugar	Negative	Negative	Normal

		Protein	Negative	Negative	Normal
22/08/22	1.Urine Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 10.0g/dl	Normal Normal Low
19/9/22	1.Urine 2. Blood	Sugar Protein	Negative Negative 12g/dl-16g/dl	Negative Negative 10.2g/dl	Normal Normal Low
31/10/22	1.Urine 1. Urine 2.Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 9.2g/dl	Normal Normal Low

31/10/22	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
7/11/22	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
14/11/22	1. Urine 2.Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16gdl	Negative Negative 10.2g/dl	Normal Normal Low

21/11/22	1.Urine 2.Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.5g/dl	Normal Normal Normal

Appendix III

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Ferrous Tablet	Haematinics	200mg daily	Orally	Aids in Red Blood Cell formation	Increase in haemoglobin level	Black stool, diarrhoea and constipation	None observed
Folic Acid Tablet	Vitamin preparation	5mg daily	Orally	Helps in the formation of blood cell	Increase in haemoglobin level	Nausea, vomiting, diarrhoea and constipation	None observed
Multivitamin Tablet	Vitamin	200mg	Orally	Increases	Increase in	Gastrointestinal	None

	preparation	daily		appetite and helps in the formation of Red Blood – Cells	appetite	disturbance	observed
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 observed
Tetanus Injection	Anti-tetanus drugs	0.5mg	Intra-muscular	Protect mother and foetus against infections	Client was protected against tetanus infection	Mild fever, Malaria	None observed
Metronidazole tablet	Anti-infective	400mg tds	Orally		Infection	Dizziness,headache,nausea,	None

		x 30		Prevention of infection	was prevented.		Observed
Sulfadoxinepyramethamine Tablet	Anti-malaria prophylaxis	3 start 16 weeks after quickening till delivery and it was given at 1month after last dose.	Orally	Prevention - of malaria	Malaria was- prevented	Urticaria rash, dizziness, nausea, stomatitis	None observed
Oxytocin injection	Oxytocin	10 units	Intra-	Increase	Client had	Vomiting, uterine spasm	None

	drug		muscular	uterine contraction and control bleeding	good uterine contraction	and raised blood pressure	observed
Vitamin A capsule	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development and proper vision	Normal vision and healthy skin	Vomiting	None observed
Amoxicillin tablet	Antibiotics	500mg for 7 days thrice daily	Orally	Treat all kinds of infections	Treated infections.	Nausea, vomiting, diarrhea, rash, vaginal yeast infection	None observed

PHARMACOLOGY OF DRUGS (BABY)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Vitamin K	Group K vitamin	1.0mg	Intra-muscular	Prevent haemolytic diseases	No bleeding	Risk of haemolysis in people with G6PD, rashes and brain damage	None observed
Chloramphenicol	Antibiotics	2 drops	Instillation	Prevent eye infection	Increase risk of a plastic anaemia	Ototoxicity and nephrotoxicity	None observed
Bacillus calmett Guerin injection	Antigen	0.5mg	Intra-dermal	Immunity against tuberculosis	Under observation	Mild fever, swelling of injection site and blister formation	Blister noticed
Polio O	Antigen	2 drops	Orally	Production of	Under	There may be	None

				antibodies to prevent poliomyelitis	observation	diarrhoea	observed
Hepatitis B vaccines	Antigen	0.5ml	Subcutaneous	Immunity against hepatitis B virus	Under observation	Fever	None observed
Diphtheria portussis tetanus	Antigen	0.5ml	Subcutaneous	Immunity against Diphtheria pertussis tetanus	Under observation	Fever	None observed
Haemophilus influenza Hepatitis B	Antigen	0.5ml	Subcutaneous	Immunity against Haemophilus influenza Hepatitis B	Under observation	Fever	None observed

WHO Modified Partograph

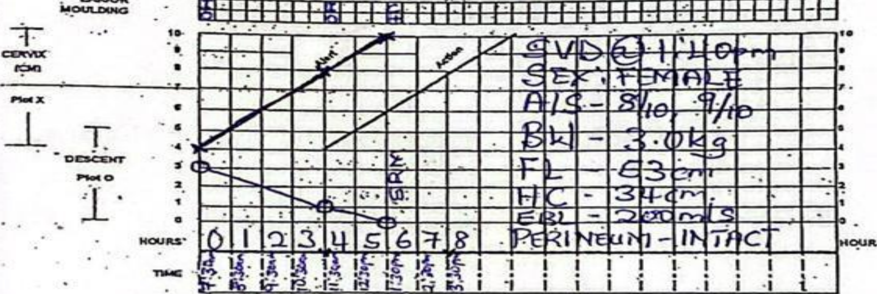
Registration No. 1857/22 Name (Last, First) Fosuaa Gloria Age 24
Date 27/11/2022 Parity/Gravida 1 . 2 LMP 14/2/22 EDD 28/11/22 Gestation (wks) 38+3
ROM (Time, Date) 27/21/11/22 Labour Duration (Hrs) 6'18m Facility/Clinic Name Pentecost Clinic

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM) Plot X

DESCENT Plot O



CONTRACTIONS PER 10 MINS

Oxytocin U / L Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE & PULSE

TEMPERATURE

URINE — Amount, Protein, Acetone

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LABOR NOTES

24/11/2022 at 10:27pm SVD of alive female neonate delivered with APGAR score 8/10 9/10 for 1st and 5th minutes respectively. Placenta delivered with membrane after IM oxytocin 10units administered. EBL-150mls. Essential care of newborn done. FL-46cm HC-35cm CC-33cm with no abnormality detected.

Please circle or write responses.

DELIVERY

DATE: 24/11/2022 TIME: 10:27pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / O

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No   Medication: Time 10:30pm Type/Dose Oxytocin / 10un

PLACENTA: TIME: 10:35pm (Complete) / Incomplete

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

BABY

Weight: 2.7kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladd
Every 15 minutes first 2 hours	10:30pm	129/76	83	16cm	No active bleeding	85ml
	10:45pm	118/64	82	contracted	No active bleeding	NiL
	11:00pm	124/61	84	contracted	No active bleeding	NiL
	11:15pm	120/75	75	contracted	No active bleeding	NiL
	11:30pm	115/67	70	contracted	No active bleeding	NiL
	11:45pm	118/70	77	contracted	No active bleeding	Voided
	12:00am	120/78	75	contracted	No active bleeding	NiL
	12:15am	121/72	80	contracted	No active bleeding	NiL
Every 30 minutes For 1 hour	12:45am	115/65	72	contracted	No active bleeding	NiL
	1:15am	114/65	81	contracted	No active bleeding	100ml

Birth Attendant Nsiah Cassandra Gyan / SM Felicia Adjei Date 24/11/2022

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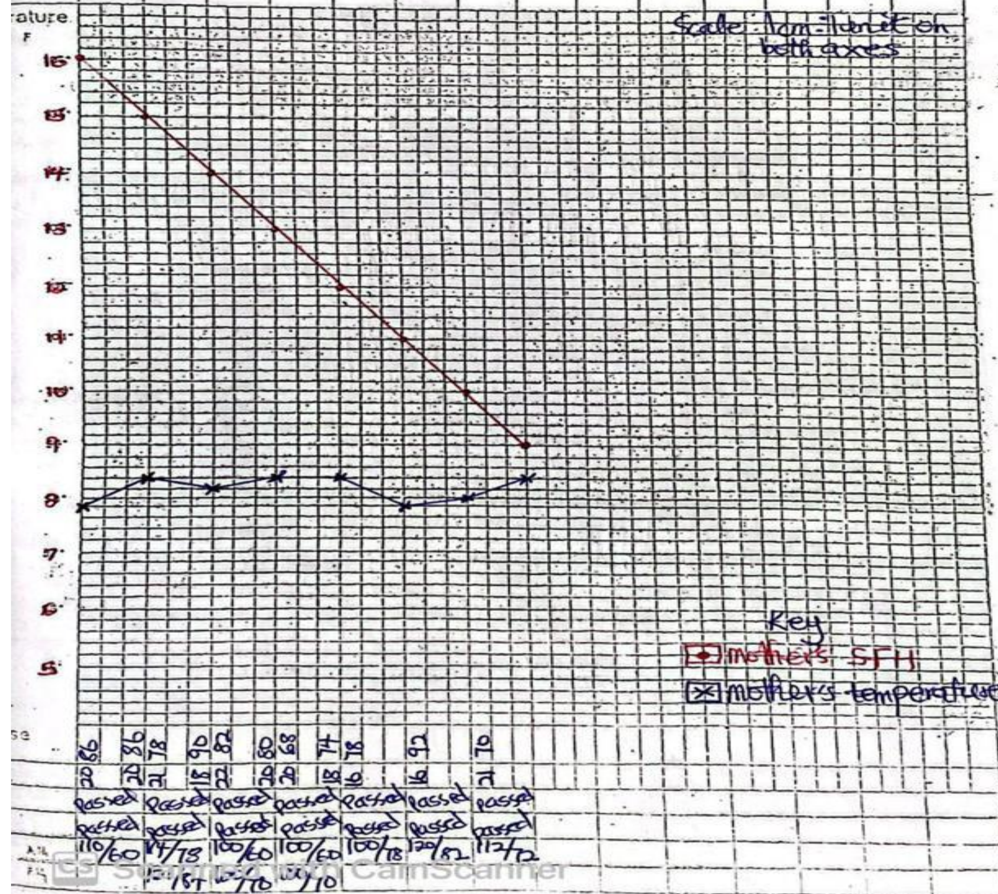
MATERNITY CHART

Hannah Ogori
30 years — WARD: Lying-In
918/22 — BED NO.: 1

	24/11/22	25/11/22	26/11/22	27/11/22	28/11/22	29/11/22	30/11/22	1/12/22	
Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
No.									
am		7:30	7:30	7:30	7:30	7:30	7:30	7:30	
pm	4:30	4:30	4:30	4:30					



TEMPERATURE CHART

Baby Yaa Ofori

918/22 .... WARD: Lying-In

BED NO.: 1

	24/11/22	25/11/22	26/11/22	27/11/22	28/11/22	29/11/22	30/11/22	1/12/22
Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
P.O.								
am		7:30	7:30	7:30	7:30	7:30	7:30	7:30
pm	4:30	4:30	4:30	4:30				

Temperature F

Scale: 1cm : 1 unit on both axes

Key
Baby's weight
Baby's temperature

Pulse: 40 130, 45 135, 44 137, 51 126, 40 126, 45 129, 44 124, 50 130, 136, 41 128

passed	passed	passed	passed	passed	passed	passed
passed	passed	passed	passed	passed	passed	passed

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NEW BORN EXAMINATION FORM

Name: Baby Yaa Ofori   Date of Assessment: 25/11/22   Time:
Date of Birth: 24/11/22   Time of Birth: Sex: [ ] M [ ] F   Age at time of Assessment (days/hrs)
Astational Age [ ]   [ ] Mode of Delivery: [ ] Vaginal   Assisted Vaginal   C-Section
APGAR: 1min 7/10 5min 10/10   Birth Weight: [ ] 2.7kg [ ]   Length: 46 cm   Head Circumference: 35 cm
Temperature at time of Assessment: °C   Urine passed: (Yes) No   Meconium passed: (Yes)
Name of Assessor (Midwife/Doctor):

1. Respiration
Rate 53cpm
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [x] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20. Abdomen
- [x] Normal
- [ ] Distended*
- [ ] Scarphoid*
- [ ] Abdominal defect*
- [ ] 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
- [ ] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other:

Female Genitalia
- [x] Normal
- [ ] Fistula(meconium/urin through abnormal open vagina) *
- [ ] Large clitoris *
- [ ] Other:

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

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

26. Services provided
- [x] Vitamin K1 given
- [x] Eye care provided
- [x] Cord care provided
- [x] Breastfeeding initiated
- [x] Breastfeeding establis
- [ ] Immunization (BCG/F
- [ ] BCG [ ] Polio Immun
- [ ] Antibiotics in mother
- [ ] Antenatal corticosteroi

*May indicate severe disease that requires urgent referral

Diagnoses (if known)

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[ ] Disch

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NEW BORN EXAMINATION FORM

...y) Yaa Gyan | Date of Assessment: 24/11/2020 | Time: 11:00pm
...24/11/20 | Time of Birth: 10:27pm | Sex: [ ] M [x] F | Age at time of Assessment (days/hrs) ______
...ge [ ] | Mode of Delivery: [x] Vaginal | Assisted Vaginal | C-Section
...in 8/10 [ ] 5min [ ] 9/10 | Birth Weight: [ ] 2.7 kg [ ] | Lenght 46 cm | Head Circumference: 35 cm
...at time of Assessment 36.4 °C | Urine passed: (Yes) No | Meconium passed: (Yes) No
...essor (Midwife/Doctor): ______

...ion ...pm ...b/m • ...b/m • ...s • • ...

Movemnet ...ous symmetric ...ts ...Absent Movement in ... • ...ment ... ...l • ... ...over ...y but blue hands/feet ...over • ...d • ... ...ining pus ... •

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

8. Head swelling
- [x] Caput succedaneum
- [ ] Cephalhaematoma
- [ ] Subgaleal hemorrhage
- [ ] 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
- [ ] Normal (Shape/movement)
- [ ] Abnormal ______

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

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

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

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

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

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

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

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

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

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

...dicate severe disease that requires urgent referral ______
...s (if known) ______
...tion: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

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NEW BORN CHART

Name: Baby Iaq Oponi No: .... Birth Weight: 2.7kg

Sex: Female Mother's No: 918/22 Length: 46cm

Nature of Delivery: Spontaneous Vagina Delivery Diagnosis: ....

Date of Birth: 24/11/2022 Time: 10:27pm Date of Discharge: 25/11/22

Date	24/11/22		25/11/22		26/11/22		27/11/22		28/11/22		29/11/22		30/11/22		1/12/22							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight		2.7	2.6		2.5		2.5		2.6		2.7		2.8		2.9							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.5	37.0	37.1	36.7	36.8	36.4	36.5	36.6		36.3		36.5		36.7							
Stools		passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							
Urine		passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							

Head
Neck } No abnormality detected

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SIGNATORIES

THE STUDENT MIDWIFE

NAME: NSIAH CASSANDRA GYAN

SIGNATURE: ....

DATE: 5th June, 2023 ....

THE MIDWIFE IN-CHARGE: (ST. EDWARD'S HOSPITAL, ADUGYAMA)

NAME: MS. EVELYN OWUSU NYARKO

IGNATURE: .... (for) ....

ATE: .... 14/07/2023 ......

HE SUPERVISOR

AME: MS. UBAIDA ABDUL-KARIM

GNATURE: ....

ATE: .... 6/06/2023 ....

HE PRINCIPAL

AME: MONICA NKRUMAH (f)

GNATURE: ....

ATE: 14/07/2023

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

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