HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY ON

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BAWA VIDA

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A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA ION PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICEE AS A PROFESSIONAL

(DIPLOMA).

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PREFACE

The family centered maternity care is a systematic approach used in nursing an expectant mother and her family through pregnancy, labour and puerperium. This is based on a thoughtful understanding and uniqueness of the client as an individual with specific problems and needs that should be addressed. The aim of this care study is to ensure that, the pregnancy results in a healthy mother, baby and a family. During this period of care, the physical, psychological, spiritual and social well-being of the client and family are taking into consideration.

The family centered maternal care study is an academic work which gives the student midwife an opportunity to nurse her client using the nursing process plan and the partograph to implement and evaluate her pregnancy, labour and puerperium using the knowledge and skills acquired during the training.

The report on the care study is compiled into a document which is part of the Nursing and Midwifery Council of Ghana's fulfilment in awarding professional certificate to the student midwife as a registered midwife after three years training.

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Finally, my sincere thanks to the authors of the various books used as references and from which I took inspiration for this care study.

INTRODUCTION

The family centered maternity care study is a study about the nursing care given to the expectant mother, and her family. The student midwife puts into practice knowledge acquired in the classroom to care for the pregnant woman and her family in solving any identified problem in the course of the interaction throughout pregnancy, labour and puerperium.

This study was conducted on Madam Janet, a 26 years old gravida 2 Para 1 alive. She is from Tanoso in the Ahafo Region of Ghana. She was met on the 12th November, 2021 at Tanoso Health Center with 36 weeks gestation and had come for her 6th antenatal care.

The study is in four (4) chapters beginning from pregnancy to puerperium. Chapter one talks about the client's general background including her social, medical, surgical, menstrual, past and present obstetric histories. It continues with chapter two which gives a detailed narration of how the study was conducted during the period of her pregnancy. Chapter three is on labour till the end of the first six hours after delivery. Chapter four is on the care during puerperium up to the seven days postnatal clinic visit. Chapter two, three, and four ends with a care plan drawn for her for the problems which were identified throughout the period of care this constitutes the appendices.

LITERATURE REVIEW

PREGNANCY

It is a period of having a developing embryo in the uterus and it is a time when women and their partners are especially open to reflecting on their lifestyles and healthcare options.

Myles (16th edition) added that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero. There are varieties of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness. The anatomical and physiological change in the uterus plays an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic fluid. At the time of labour, it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractility and elasticity.

Fraser & Cooper (2009) defines pregnancy as the fusion of the woman's egg and a man's sperm cell unite to form zygote. All changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the foetus, prepare her body for labour and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Its further states that, the woman's psychological state is also affected by hormonal changes. The gestational period is divided into three trimesters. The first trimester is from the time of conception to the 12th week. The second trimester is from the 13th week to the 26th week whilst the third trimester is from the 25th week to the38thweek. During pregnancy, antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby. This is why it is so important that, the midwife has the knowledge and understanding of the common disorders of pregnancy which include; constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramp, backache, insomnia increase vaginal discharge among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experiences.

Marie (2013) defines pregnancy as when the woman's egg and a man's sperm cell unite to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 26th week of pregnancy. The third trimester starts from the 25th week to the 40th week. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks

up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

Tiran (2008) stated that pregnancy is the condition of having a developing embryo or foetus within the body. It is the state from conception to the delivery of the foetus. The normal duration is about two hundred and eighty (280) days, forty (40) week or nine (9) months seven (7) days counted from the first day of the last normal menstrual period to delivery. During this period, psychological and physiological changes such as relaxation of the cardiac sphincter, relaxation of the smooth muscles of the intestines occur due to the effect of oestrogen and progesterone. These hormones provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

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 foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266) or thirty-eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks was limit of viability. The third trimester extend from 29 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

Weller (2009) states that, pregnancy is a state of being with a foetus from the time of conception to the expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the last

day of the normal menstrual period. Pregnancy is divided into three trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 26th week of pregnancy. The third trimester starts from the 25th week to the 40th week. During this period, a lot of physiological changes occur in the body under the influence of hormones which affect all the systems and organs with the greatest change taking place in the uterus as it has to accommodate and nourish the developing foetus, prepare the woman body for labour, develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Any disorder due to the physiological changes is managed to prevent further complications such as anaemia which can endanger the life of both the mother and growing foetus.

Ojo (1992) said that when pregnancy occurs, menstruation seizes and returns some weeks or months after delivery. The hormones progesterone and oestrogen are produced in large quantities which exert some action on the various systems such as the skeletal system, respiratory system, digestive system, and reproductive system etc. of the pregnant woman. The most outstanding of these changes is the growth which occurs in the uterus. The patient is usually the first person to suspect pregnancy. Her suspicion is often based on the fact that she has missed her period, the amenorrhea occurs because, following the implantation of the fertilized ovum.

LABOUR

Konar (2011) states that, labour is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. The date of onset of labour is very much unpredictable to foretell precisely the exact

date of onset of labour. It not only varies from case but even in different pregnancies of the same individual. Conventionally events of labour are divided into four stages: 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 primigravida and six hours (6) in multipara. 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 primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births) and control of haemorrhage. Its average duration is about fifteen minutes (15) in both primigravida and multipara. The duration is, however, reduced to five minutes (5) in active management. 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. 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 patient fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions. Under rest and ambulation, if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacava compression and encourages descent of the head. Ambulation can reduce the duration of labour; analgesia can improve maternal comfort. The transition from the first stage to the second stage is evidenced by the following features:

- Increasing intensity of uterine contractions.
- Urge to defecate with descent of the presenting part.
- Complete dilatation of the cervix on vaginal examination.

Varneys (2018) describes the onset of labour as the occurrence of regular painful contractions that promote dilatation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are hallmark of labour. There are four stages of labour that has being established; the first, second, third and fourth stages. The first stage of labour starts with cervical dilatation which begins with regular rhythmic uterine contractions until the cervix is fully dilated. During this stage, enquiry is to be made about the onset of labour pains or leakage of liquor if any through general and obstetrical examinations including vaginal examination are to be carried out and recorded. Records of antenatal visits, investigation reports and any specific treatment given if available are to be reviewed. There is an assessment of progress of labour and partograph recording. The second stage of labour begins with the expulsion of the foetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the foetus and ends when the foetus is born. The third stage of labour is the complete expulsion of the placenta and its membranes as well as the arrest of haemorrhage. The fourth stage of labour is 6 hours after the delivery of the placenta and membranes and continues with close monitoring of the client and baby.

Myles (16th edition), postulate that, labour purely in physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae.

This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last for six hours after delivery of the placenta.

The National Safe Motherhood Service Protocol (2008) states that normal labour begins with a regular painful uterine contraction lasting at least twenty (20) seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every ten minutes and with cervical dilatation of at least 3 centimeters. Signs that women may experience prior to labour includes show (pink mucous discharge from the vagina), engagement of the baby's head. The hormone oxytocin is responsible for the strong regular contractions of labour which when released cause the uterus to contract. Labour contractions feel very different from Braxton Hicks contractions that women experience during pregnancy but the most important difference is that labour contractions come regularly. Each one starts gradually, builds up to a peak and then fades away. Typically, when labour begins, contractions are short in length around 20 – 30 seconds long. As labour progresses contractions become gradually longer and stronger which dilates the cervix.

Tiran (2008) is defined as the process by which product of conception are expelled from the uterus through the birth canal. She continued that labour normally occurs spontaneously at term, that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until foetus, placenta and membranes are expelled by the maternal effort through the vagina. She further explained that, partograph is the graphical recording of labour progress obtained by assessment of visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and foetal wellbeing.

PUERPUERIUM

National Safe Motherhood Service Protocol (2008) states that the postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore:

1. Comprehensive screening to detect complications in both mother and baby.
2. Treatment of complications in mother and baby.
3. Assessment and support for infant feeding.
4. Malaria and anaemia prevention.

Some common discomforts of postpartum period in mothers are listed as after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, breast engorgement backache, headache, haemorrhoids and mood changes in the first week. Those associated with

the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds. The major causes of death in this period are infections, hypertensive complications, haemorrhage and thrombo embolism of which predisposing factors include:

1. Conditions or complications during the antenatal period.

2 .Complications of labour, related to duration of labour and mode of delivery

Myles (2014) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation, this is known as puerperium. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. It strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health.

Konar (2011) states that, puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 26 hours;(b) early-up to 7 days and remote-up to 6 weeks. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. At the end of six weeks, the weight of the uterus is almost similar to that of the non-pregnant state and weighs

about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

Dutta (2013) puerperium is the period following childbirth during which the body tissues especially the pelvic organs reverses back approximately to the pre- pregnant state. The period is arbitrarily divided into (a) immediate –within 26 hours; (b) early –up to 7 days and (c) remote- up to 6 weeks. In this book, the principles in management of puerperium are;

1. To restore the health of the mother.
2. To prevent infections.
3. To take care of the breast, including promotion of breast feeding.
4. To motivate mother for contraception

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

- Immediate –within 26 hours
- Early- up to 7 days
- Remote –up to 6 weeks

Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The

external os never revert back to the nulliparous state. During puerperium the number of muscles fibres is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: lochia rubra (red) 1 -4 days, lochia serosa (yellowish or pink or pale brownish) 5- 9 days, lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml. With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

Ojo& Brigg (1982) said at the end of labour, the uterus is still very large and mobile. The genital tract is greatly distended, bruised and perhaps lacerated. The abdominal muscles are flaccid and within a period of six weeks postpartum is called puerperium, and where the bruises are healed, the genital organs and any other organ which underwent changes during pregnancy return to their pregravida state. This process of readjustment is called involution. Lactation is also established during the said period. Lochia is the term used to describe the discharge from the uterus during the puerperium. During the puerperal period, the woman is educated on what goes on throughout the puerperal period and how to cope with these changes. Also, the puerperal woman needs a lot of rest and sleep, regular exercise, intake of adequate fluids and nutritious diet rich in protein, carbohydrate and vitamins. The mother is educated on how to care for the baby to prevent infections. Among this education include cord dressing, changing of napkins frequently and exclusive breastfeeding. Emphases are also laid on family planning within six weeks after childbirth.

WHY CLIENT WAS CHOSEN

Madam Janet was chosen as a client on 12th November, 2021 at Tanoso Health Center, during one of her scheduled antenatal visits. On arrival, she was received and offered a seat. During education that morning on the "Importance of Exclusive Breastfeeding", she had little knowledge so she could not contribute enough. The needed information on the topic she required was provided. On thorough examination from head to toe, no abnormality was detected. She was 36 weeks of gestation. After glancing through her antenatal card, decision was made to take her as a client since she had a previous delivery at the hospital and with spontaneous delivery per vaginum with no complication and also due to her current gestation she falls within the criteria, which include, she should be between para 1 to 4 all alive, and also be between 36 to 37 weeks and has spontaneously delivered per vaginum with no complications such as postpartum haemorrhage, retained product etc. Introduction was made as a student from Holy Family Nursing and Midwifery Training College Berekum and was at the clinic for practical experience. Permission was sought from her to be taken as a client for the care study which she accepted. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged. Client was thanked and she left.

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter gives information about the client, her family and her community characteristics. This includes client's social, family, lifestyle, medical, surgical, menstrual, past and present obstetrical histories.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Janet, gravida 2 para 1 alive is 26 years old. Client was born on the 25th December 1994 and lives at Tanoso, house number AB/0515/8768 within the Tano North district in the Ahafo region. She is 175cm tall and dark in complexion. Client was born at Tanoso and had her primary and Junior High education at Bethel Methodist at Tanoso in the Ahafo Region. She speaks Twi and is a seamstress. Madam Janet and her family are enrolled under National Health Insurance Scheme. Madam Janet is married to Mr. Shalie, a native of Tanoso. Client's husband is a potter and they have been married for four years. They are both Christians and attend Christ Apostolic churh in Tanoso. According to client, her next of kin is madam Adomah.

1.2 FAMILY HISTORY

Madam Janet is the second born of three children to Mr. Appiah and Madam Adwoa Pomaa. According to Madam Janet, both parents are alive and still married. She added that, there is no history of Hypertension, Diabetes Mellitus, Sickle cell disease, Asthma, Tuberculosis, Epilepsy, Leprosy and mental illness in her family. Again, they do not have any history of congenital abnormalities such as cleft lip or palate, spinal bifida or heart disease in the family. She admitted that, multiple pregnancies run through their family. She mentioned that death in the family are of

natural cause since she could not attribute any of them to any form of spiritual superstition whatsoever.

1.3 MEDICAL HISTORY

According to Madam Janet, she has no history of medical conditions such as hypertension, diabetes, hepatic disorders, kidney problems, pulmonary disorders among others. She had never been admitted to the hospital before. Even though she sometimes suffers from malaria, she is treated as an outpatient client, whenever she reports to the hospital for treatment. Throughout her life, she has never reacted to any drug given or a type of food taken. She is not on any lifelong medication currently except haematenics but hasn't been transfused before.

1.4 SURGICAL HISTORY

According to the client, she has never undergone any surgical operation such as hysterectomy, oophorectomy, salpingectomy, myomectomy, or caesarean section. She has not been transfused before neither has she had any accident that has affected or reduced the adequacy of her pelvis.

1.5 MENSTRUAL HISTORY

Madam Janet was 15 years when she had her menarche. Her regular menstrual cycle is 28 days, amount of blood loss is moderate each month and last for 6 days with mild dysmenorrhea prior to delivery of her first child. She uses sanitary pad during the flow and changes it twice daily. Her last menstrual period was on 5th March, 2021.

1.6 CLIENT HOBBIES AND LIFESTYLES

Madam Janet, usually rises from bed around 4:30 am and goes to bed at 9:00pm. Routinely, she does her morning devotion with her family before she steps out of her room to perform a few house chores like sweeping and dusting and prepares breakfast for the family. She then baths and

prepares her child for school. Madam Janet also prepares for work after making sure everything is in order in the house and her husband has left for work. She goes to work around 8:00am and comes home at 4:30pm to prepare supper for the family. All these are done from Monday to Friday. Weekend is exempted; that is when she washes dirty cloths, scrubs the house and also goes to church on Sunday. She loves to play ludo and watch local movies. She uses pepsodent toothpaste and V.I.P brush every morning to clean her teeth. Banku with Okro stew and fish is her favorite meal. She eats three times daily with frequent hydration and empties her bowel once daily. They watch movies together and have some fun until the day fades away. She neither smokes nor drinks alcohol.

1.7 PAST OBSTETRICAL HISTORY

Madam Janet Gravid 2 Para 1 alive has no history of spontaneous or induced abortions. The interval between the first pregnancy and this current one is four years. According to the Antenatal records, she never had problem during her pregnancy such as pre-eclampsia, antepartum haemorrhage, anaemia and gestational diabetes. She was a regular attendant at Antenatal session and took three doses of Tetanus Diphtheria as well as vitamin supplement. She was not able to take in sulphadoxine Pyrimethamine because she is G6PD defective. She also took all health education very serious. In trying to know what happen with the previous delivery (Labour), she said the mode of her first delivery was spontaneous vaginal delivery with some minor laceration on the perineal at the Regional Hospital. She further stated that the duration for her previous delivery did not exceed 18 hours. The outcome of labour was a life healthy male child with birth weight of 3.0kg, length of 53 cm and head circumference of 36cm. The baby cried immediately at birth. labour complications such as postpartum haemorrhage, retained

placenta, were not recorded. Her placenta was delivered soon after child birth and little amount of blood was loss.

During puerperium, she did not suffer any infection and psychosis. Madam Janet breastfed her first child for a period of three months and introduced child to supplementary feeding. The first child was fully immunized against the childhood preventable diseases as evidenced by the child's health record book. She mentioned that, her baby suffered malaria at the age of 2years which was treated on outpatient basis. Physical, social and emotional support was abundant from her beloved husband. She used Depo for 4years before this current pregnancy.

1.8 PRESENT OBSTETRIC HISTORY

Madam Janet Gravida two para one alive had her booking at Tanoso Health Center, in the Tano North District in the Ahafo Region on 21st May,2021 with the registration number 138/21, when she was thirteen (13) weeks pregnant. Client gave her last normal menstrual period as 5th March, 2021 and her expected date of delivery was calculated to be on 5th of December, 2021. However, ultrasound scan was done and it revealed the expected date of delivery to be 5th December, 2021. From her antenatal record book, social and personal, medical and surgical, family, present and past obstetrical history were taken and recorded. Vital signs and other investigations were checked and recorded as follows;

Temperature	36.0ºc
Pulse	78bpm
Respiration	20cpm
Blood pressure	110/70 mmHg
Height	175cm
Weight	69kg

Laboratory results revealed the following:

Haemoglobin level	13.4g/dl
Sickling	Negative
Blood group	A
Rhesus factor	Positive
Blood film for malaria parasite	Negative
HBsAg	Negative
G6PD	Full defect
VDRL	Negative
Stool R/E	No ova/ cyst
Urine R/E	Negative for both sugar and protein
Acetone	Clear
Appearance	Straw
Bile Pigment	Negative

These findings were used as base line recording for subsequent assessment of client's wellbeing. Provider initiated testing and counselling for human immune deficiency virus which was done to rule out mother to child transmission of HIV and client tested negative.

Head to toe examination was done which revealed no abnormality. On abdominal inspection, linea nigra was noticed and on palpation, the uterus was palpable and gestational age was 13 weeks. Symphysio-fundal heights was 14cm. Tetanoltoxid immunization third dose was also administered.

Client was advised to have enough rest and sleep, ensure personal and environmental hygiene to prevent infection and breeding of mosquitoes. Client was also educated on nutrition, danger

signs of pregnancy such as swelling of feet, severe headache, vagina bleeding and to report immediately to the clinic anytime she experiences any of them. The date for her next visit was communicated to her and recorded in her antenatal record book. Client prescribed drugs were served and were as follows:

Tablet ferrous Sulphate200miligram once daily x 30 days

Tablet Folic Acid 5miligram once daily x 30 days

Tablet Multivitamin 200miligram once daily x 30 days

Since then she has been honouring all appointments until she was met.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter elaborates the care that was rendered during pregnancy. This care started from the time of conception and continued throughout pregnancy 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 INTERACTION WITH THE CLIENT

Madam Janet was first met when she came to the antenatal clinic at Tanoso health center on 12th November, 2021 for her sixth [6^{th}] visit to the clinic and she was also thirty-36 weeks. She was warmly welcomed and a seat was offered to her and enquiry about her health and that of her family was made. She said they were all fine and that she was coming for antenatal care.

After the health education has been given to the clients on that day, which was the importance of exclusive breastfeeding to the mother and baby, her body language communicated that she was not willing to practice exclusive breastfeeding. She was approached and her antenatal book was collected and glanced through and then introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who came to have clinical experience and then wish to use her for care study and help her gain more knowledge on exclusive breastfeeding. All details of information and procedures involve in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. Various examination that would be conducted on her such as checking of vital signs, urine test for protein and sugar and physical examination from head to toe was

explained to her. She was told to empty her bladder to prevent discomfort and to give accurate findings which she accepted to do. Her history, weight and vital signs were taken and the findings recorded in her antenatal book were as follows;

Hemoglobin level	14 g/dl
Weight	80 kilograms
Temperature	36.5 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycle per minute
Blood Pressure	100/60mmHg

Urine Testing

Client was given a specimen bottle to provide midstream urine, with the aim of testing for protein and glucose. A chemically prepared strip was dipped into the urine sample. There was no change in colour of the strip indicating negative results for both protein and suger.

Client was made aware that head to toe examination was to be performed on her. The procedure was explained to her. The necessary equipment for the procedure were gathered and taken to the examination room. Privacy was provided. She was assisted to undress and wear a gown then asked to sit on the bed, lie lateral and then assume a supine position. Hands were washed and dried.

Physical Examination

On the head and Face, the hair was inspected for cleanliness, lice, ringworm, dandruff, alopecia or any scalp infection. Her face was inspected for oedema, chloasma and rashes but no

abnormality 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, the nose for any congestion and nothing abnormal was detected. The mouth for halitosis, the lips for pallor and cracks, the tongue for pallor, the teeth for tooth decay and cleanliness. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care of herself. The neck was examined for any distended neck veins, enlarged lymph nodes and thyroid gland. All these were absent.

Breast Examination: The breast was exposed to check for size, shape, signs of pregnancy, dimpling, nipple retraction and condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was reminded of self-examination. Nipples were squeezed gently for fluid (colostrum) and were examined for odour, blood and cleaned with cotton wool swab. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her previous child was breastfed.

She 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 legs were inspected for size and equality and palpated for oedema, tenderness in the calf muscles, varicose veins, size and equality and no abnormality was noted.

The back was examined for deformity of the spine (scoliosis), oedema of the sacral region, pain at the coast vertebra angle and no abnormality was detected. The condition of the skin was also noted to be normal.

Abdominal Examination

On **inspection,** the abdomen was inspected for scars, size, shape, striae-gravidarium, linear nigra and fetal movement. Linear nigra was present, the shape was ovoid with no scars, the size was average and there was a detection of fetal movement.

Measurement of the Symphysio-fundal height; the measuring tape was placed on the abdomen with zero end at the fundus and the tape extended to the symphysis pubis. The Symphysio-fundal height measured35cm and the gestational age was 36 weeks.

Fundal palpation, the hands were rubbed together to make them warm in order not to induce contractions. The palms were placed on either side of the fundus while facing the woman's head. Fingers were curved around the top of the fundus and a soft mass was felt, indicating that the buttocks were occupying the fundus.

Lateral palpation; the palms were placed on both sides of the uterus, midway between the symphysis pubis and the fundus. The uterus was stabilized with one hand and examined by the other hand. The palpation was started from the abdominal midline to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotational manner. The fetal back (the smooth part) was located at the right side of the woman's abdomen, and the limbs (the rough part) were at the left side.

Pelvic palpation; facing the woman's feet, she was asked to flex her knees slightly and breath in and out slowly to aid in the relaxation of the abdominal muscle. The palms were placed on either side of the uterus just below the level of the umbilicus and fingers directed toward the symphysis pubis, thumbs almost meeting. Presentation was determined to be cephalic as a hard mass was palpated, the lie was longitudinal.

Descent; the anterior shoulder was located to determine descent of the head. Two fingers were kept over the anterior shoulder and the symphysis pubis was located. The right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five finger breadths were accommodated and the descent was recorded as 5/5th.

Auscultation; Fetal stethoscope was warmed by rubbing it in the palm. The fetal heart was auscultated by placing fetal stethoscope on the area where the back was located. The ear was placed against the stethoscope, making sure hands were not touching the stethoscope when the fetal heart beat was being counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 146bpm with regular rhythm.

Vulva examination was performed on client. Permission was sought from Madam Janet to examine her vulva, which was granted. Her vulva was well shaved with no oedema or varicose vein on palpation. She was then helped to dress up after the examination and all findings were explained to her. She was thanked for her understanding and co-operation. Hands were washed and dried and all findings were recorded in her antenatal book. Permission was sought from her for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. She was informed on the next antenatal visit which was on the 14th November, 2021. Routine drugs were served as follows;

Tablet Folic Acid	5 milligrams daily for 7days
Tablet Fersolate	200 milligrams daily for 7days

She was again reminded on the home visit and said goodbye to her

2.1 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Janet's house was on the 14th November, 2021 at exactly 3pm.The aim of the visit was to find out how her environment looked like. The second aim was to see whether she was prone to infection and also check on her items for labour (layette). Greetings were exchanged and a seat offered. She was in the house with her child enjoying the weekends. Madam Janet, lives in a single boys quarters with a detarched bath room, toilet and kitchen. The house is built with mud and roofed with aluminum sheet. The house is made up of six rooms. She lives with her husband and her child and other family members and has a cordial relationship with them. Inside her room was a neatly laid bed with a treated mosquito net hanged around it. The room was well ventilated.

There is no tap in the house so client fetches pipe borne water from a nearby house for domestic activities. Electricity is the source of power used in the house. She has a kitchen which is made with mud which was clean. They share the bath house with the other family members. She gathers rubbish or waste in a container with a cover which she finally disposes every day at a refuse dump meant for public use. The compound was very nice because it looked very neat and the surroundings was neatly weeded There was no stagnant water and no choked gutters.

In the course of interactions she said that the whole family was with her ready to accept the new born into the family. She was encouraged to introduce her child to the pregnancy to prevent sibling rivalry. She was asked to continue with her routine drugs as prescribed. She was encouraged to maintain the neatness in her compound. Before leaving, her child's finger nails were inspected and they were nicely trimmed. Her layette was also checked, she had already packed her bag with items like; sanitary pads, cot sheets, toiletries etc. In this bag included purse

with money, insurance card and antenatal book. Her permission was sought to leave and promised to pay her another visit.

2.2 SECOND ANTENATAL HOME VISIT

The second home visit was made on 20th November, 2021 at 2:30pm. The visit was made purposely to check on the health status and educate her on birth preparedness and complication readiness plan. Client was doing well except that she complained of waist pains, backache and could not empty her bowels for the past two days. She was therefore encouraged to take in more fluids, fruits and vegetables rich in fiber such as pineapple, oranges, water melon and pawpaw, lettuce, carrot etc., which will aid in peristaltic movement. She was again educated on the true signs of labour such as rhythmic regular uterine contractions and 'show', and was told to report immediately to the clinic as soon as she sees any danger signs of pregnancy such as severe frontal headache, severe lower abdominal pains, bleeding per vaginum and excessive vomiting. She was also educated on birth preparedness and complication readiness plan by asking her the person who would accompany her to the hospital to deliver as well as take care of the house during that same period and she replied saying her husband and sister would take that responsibility. She was also encouraged to arrange with a taxi driver who would take her to the facility when labour sets in at an odd hour. Madam Janet was also told to pack items for delivery including her hospital card and (NHIS) so she will not find herself wanting when labour sets in. She was allowed to ask questions and appropriate answers were given. Client was thanked for her cooperation and reminded of her next visit to antenatal clinic on 3rd December, 2021.

2.3 SUBSEQUENT ANTENATAL VISIT TO THE HEALTH FACILITY

Madam Janet visited the clinic on the 19th November as she was booked to come in a week time. She was warmly welcomed and a seat was offered to her. Her health and that of her family was

asked and she complained of heart burns and lower abdominal pains. Observations were made as follows;

Temperature	36.5^0C
Pulse	78bpm
Respiration	22cpm
Blood pressure	110/70mmHg
Weight	81kg
Symphysiofundal height	36centimeters
Descent	5/5
Fetal heart rate	137beats per minute
Hemoglobin	11.7grams per deciliter

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

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

2.4 CARE PLAN DURING ANTENATAL PERIOD

Problems Identified During Antenatal

Madam Janet complained of the following;

12/11/2021 Heart burns

26/11/2021 Lower abdominal pains

3/12/2021 Backache

3/12/2021 Constipation

3/12/2021 Waist pain

Short Term Objectives

Client will be relieved for heartburns within 48hours.

Client will cope with and be relieved of lower abdominal pain by the end of pregnancy.

Madam Janet will be relieved of backache within 72hours.

Madam Janet's bowel action will be restored to once daily within 12 hours.

Client will be relieved of waist pain within 72hours.

Long Term Objectives.

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

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/2021 7:30am	Heartburns related to progesterone relaxing the cardiac sphincter	Client will be relieved for heartburns within 48hours as evidenced by client Verbalizing that the intensity of heart burns has reduced.	1. Support client emotionally 2. Explain the physiology of heartburns to the client. 3. Educate client to reduced fatty and spicy foods. 4. Educate client to eat in bits but at a frequent interval. 5. Educate client not to go to bed early after eating	1. Client was supported emotionally that she will be relieved of heartburns. 2. Physiology of heartburns was explained to client that it is due to the reflux of gastric content into the esophagus 3. Client was educated to reduce fatty and spicy foods. 4. Client was educated to eat bit at shorter intervals. 5. Client was educated to sit for sometimes before going to bed after eating.	17/11/2021 2:30am	Goal fully met as client verbalize, she has been relieved of heart burns.	

CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/12/21 7:30am	Lower abdominal pain related to descent of the fetal head.	Client will cope with and be relieved of lower abdominal pain by the end of pregnancy as evidenced by client verbalizing that the pain has reduced	1 Reassure client 2 Explain the cause of lower abdominal pains to the client 3 Encourage the client to reduce household activities 4 Encourage client to wear low heel shoes 5 Encourage client husband to help client with household chores	1.Madam Janet was reassured on the available measures which will decease her pain 2. Madam Janet had 2 hours of rest during the day. 3. Madam Janet understood and sat down in between activities 4. Madam Janet was educated to engage herself in tolerable works and moderate exercises 5 Client was educated to sit for sometimes before going to bed after eating.	17/11/21 2:30pm	Goal fully met as evidenced by client verbalized that she has been relieved of abdominal pains.	

CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/2021 7:30am	Lower abdominal pain related to descent of the fetal head.	Client will cope with and be relieved of lower abdominal pain by the end of pregnancy as evidenced by client verbalizing that the pain has subside.	1 Reassure client 2 Explain the cause of lower abdominal pains to the client 3 Encourage the client to reduce household activities 4 Encourage client to wear low heel shoes 5 Encourage client husband to help client with household chores	1.Madam Janet was reassured on the available measures which will decease her pain 2. Madam Janet had 2 hours of rest during the day. 3.Madam Janet understood and sat down in between activities 4. Madam Janet was educated to engage herself in tolerable works and moderate exercises 5 Clients husband was encouraged to help with household chores.	17/12/2021 2:30pm	Goal fully met as evidenced by client verbalized that she has been relieved of abdominal pains.	

CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/11/21 9:40am	Backache related to physiological changes in late pregnancy.	Client backache will reduced within 24hours as evidenced by; 1.Client verbalizing that the pain has subsided and midwife visualizing that client has a cheerful facial expression.	1. Reassure client. 2. Explain the physiology of backache to client. 3. Encourage client to sit down in between activities(sewing) 4. Encourage client to rest her back on a pillow when sitting. 5. Encourage client's family to help her with household chores. 6. Encourage client to sleep on a firm mattress.	1.Client was reassured she will be relieved of back ache after delivery 2 Explanation of the physiology of backache in late pregnancy was given to client. 3. Client sat down in between activities. 4. Client rested her back on a pillow when sitting 5. Client's family helped with her household chores. 6.Client slept on a firm mattress	17/11/2021 2:30pm	Goal fully met as evidenced by client verbalized that she has been relieved of backache.	

CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONS	SIGN
15/11/21 2:30pm	Constipation related to activity of progesterone causing decreased peristaltic movement and relaxation of the smooth muscles of the large intestine during late pregnancy.	Client will have a free bowel within 48hours as evidence by client verbalizing that she has been able to empty her bowel freely.	1. Reassure client 2. Explain the physiology of constipation 3. Educate her to take in foods rich in fiber 4.Take 1litre of fluids every 26hours 5. Educate the client to do exercise.	1. Client was reassured on the available measures to be implemented on her to facilitate easy pass of stools 2. Explanation of the physiology of constipation was given to client. 3. Client took food rich in fiber like fruits and vegetables. 4. She drank 3000ml-4000ml of fluids per day, and more fruits. 5. Client understood the health benefits of exercises and engaged herself in tolerable exercises. (walking)	17/11/2021 2:30pm	Goal fully met as 1. Client verbalizing that she passed stool once within 48 hours and is relieved from discomfort of constipation.	

CHAPTER THREE

3.0 INTRODUCTION

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

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE 0F LABOUR

Admission and initial assessment

Madam Janet, reported to the facility on the 5th December, 2021 at 2:00am accompanied by her mother and husband with the complains of lower abdominal pains and waist pains. They were offered seats after which greetings and introduction was made. Her ANC card was collected. She really looked anxious, so she was therefore reassured to allay anxiety and was asked to do deep breathing exercise. Her items for delivery were nicely and neatly packed in a bag and it contained all the needed items of which it was collected and labelled. She was asked about the last meal, bowel action and any drug taken. She was made comfortable in bed and all procedures such as vital signs, abdominal examination and vagina examination to be carried out were explained to her and her consent was sought. She was encouraged also to ask questions. Her vital signs were checked and recorded as follows;

Temperature	36.1 degrees Celsius
Pulse	88 beats per minute
Respiration	26 cycles per minute
Blood Pressure	110/70 millimeter per mercury

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

Client's abdomen was inspected, and it was ovoid in shape and medium in size. Striae gravidarum, linear nigra and fetal movement were present but no scar was found. The abdomen was palpated, symphysio fundal height was 36cm, and gestational age was 37weeks plus 5 days, the lie was longitudinal, presentation was cephalic and descent was 4/5th palpable abdominally. Contraction was 3 in 10 minutes lasting for 32 seconds. The heart rate was auscultated, and was 120beats per minute with good volume and regular in rhythm. Hands were washed with soap under running water and dried with a clean towel, sterile gloves were worn for vaginal examination at 4:34am. The vulva was then inspected for scars, sores, wart, clitoridectomy, and abnormal discharge but none was present. The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to it. The membranes intact, cervical dilatation was four (4) centimeters, presentation was cephalic, and promontory of sacrum was not reached at 10 centimeters. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Janet's perineum was cleaned and a perineal pad applied to the vulva. Client was encouraged not to sit for a very long period but encourage to

walk around to help manage the pain. Madam Janet was encouraged to lie on her left side when she felt tired. She was also encouraged to pass urine frequently and when she felt the urge as that will aid in the descent of the fetal head and effective contractions and also change her perineal pad when soiled to prevent infection. Client was covered with a cloth and made comfortable in bed and was educated on the progress of labour and findings were recorded on the observation chart. She was told to assume any position comfortable to her and sacral massage was done during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix oedematous and thereby prolonging labour. She was reminded of the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied she was okay. Client's husband was offered a seat outside and he was reassured of safe delivery.

Preparation for birth

The staff midwife on duty was chosen as the skilled personnel and informed to assist in case help is needed. Her husband who was the unskilled personnel was told to stay around in maybe he will be needed to run errands during the delivery.

The emergency plan was reviewed by making numbers of fellow midwives and obstetricians in the receiving hospital where referral cases can be sent . The taxi driver was also available as his service may be needed as a means of transportation to help with advanced care if the need arises.

The area of delivery was prepared by drawing curtains for privacy and warmth. Since the baby would be delivered unto the mother's abdomen, it was washed and cleaned with sterile gauze and her hands were also washed. The resuscitation area was prepared by assembling items like bulb

syringe, stethoscope, radiant heat bulb, cord clamp, ambubag, face mask, clean cot sheet, syringes etc. and their function too tested.

MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph when she dilated 4cm on vagina examination around 2:00am. Sacral massage was done for her during contraction to help relieve her of the pains. She was encouraged to walk around so that with the principle of gravity, the presenting part could easily descend to hasten cervical dilation. She was educated on perineal care and informed to also wash hands with soap and water to avoid infections.

At 6:00 am, there was spontaneous rupture of membrane and the liquor was clear with moulding of (++) and vagina examination was done to exclude cord prolapse. Cervical dilatation was 7cm, fetal heart rate was 138 beat per minutes, contractions were 4 in 10 lasting for 45seconds, descent was 1/5th and maternal pulse was 96 beats per minutes, Blood pressure 120/70mmgh. During this time, she complained of exhaustion and was sweating excessively, client was reassured and encouraged to rest in between contraction and 400mls of malt drink was served. Windows were opened to enhance fresh.

Setting of trolley

The trolley was set with the following instruments and items on top and button shelf;

The top shelf which contain the sterile instrument contain the delivery pack and is made up of

- Two sterile artery forceps
- One sterile cord scissors
- Sterile drape
- Membrane pierce

- Sterile receiver for placenta
- Injection tray containing 10 units of oxytocin
- Sterile Episiotomy Park containing scissors and suturing forceps

Button shelf also contains;

- Drum containing gauze and cotton wool
- Chettle forceps in its container
- Bulb syringe
- Sterile gloves
- Perineal pads
- Cord clamps
- Savlon
- Measuring jug
- Identification band
- Examination gloves
- Cot sheet

At 7:00am she complained of the urge to push. The already set delivery trolley was pushed to the delivery bed side. Vaginal examination was repeated to assess dilatation of the cervix, the midwife confirmed she was 10 cm dilated, moulding was (++), liquor was clear fetal heart rate was 135 beat per minutes, the contractions were 5 in 10 lasting 47 seconds and descent 0/5th, temperature 36.6 degrees Celsius. The staff midwife on duty confirmed full dilatation.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Janet, having successfully passed through the first stage was moved to the second stage room at 7:20am Protective clothing such as head gear, goggle, face mask, plastic apron and boots were worn. After hand washing, surgical gloves were put on to complete the sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexed as agreed earlier. The vulva was swabbed with the sterile cotton and savlon lotion. She was draped with 4 sterile towels; one each on the abdomen, under the buttocks as well as both thighs. Full dilation of the cervix was confirmed. A pad was applied to the perineum to prevent fecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contraction. Client was sweating profusely, windows were open to ensure proper ventilation and fans were also on to make client comfortable. As the pressure from the head thins out the perineum, the birth of the head was controlled with index and middle fingers placed on the fetal head to aid flexion to prevent perineal laceration. The pad placed on the perineum was equally supported and the head was allowed to crown slowly. After crowning of the head, client was asked to stop bearing down. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. Quickly neck was checked with a finger to rule out cord around it but was not felt then a clean gauze was used to wipe the eyes from the inner contours outwards. The face, mouth and nose were also wiped. There was restitution followed by external rotation of the head (internal rotation of the shoulders occurred spontaneously). With both hands on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 7:30am. The baby was placed on

the chest for skin to skin contact between the mother and baby and to provide warmth to the baby. The delivery time was noted as 7:30am by the midwife on duty and the sex confirmed as female.

IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, sterile gauze was used to clean the baby's face, eyes, mouth and nose. The baby was delivered onto the mother's abdomen. Thorough cleaning of the baby was done quickly as possible to prevent heat loss and possible hypothermia. The baby was kept warm by wiping off the liquor thoroughly and was covered with a clean dry cot sheet on the mother's chest .The baby was not suctioned because the airway was clear and baby cried immediately. The apgar score at the end of the first minute of birth was quickly assessed as 8/10.

First minute APGAR score was recorded as;

First Minute Apgar score:

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

The cord was then measured 2 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 2 finger breath above the clamp, the cord was cut. The baby was made warm by covering it with a warm dry sheet and was left on the mother's abdomen for skin-to-skin to prevent heat loss. Identification band was placed at the baby's wrist with the mother's

name, sex, date and time of delivery and breastfeeding was initiated. The condition of the baby was very good as she was actively crying and responding to stimuli.

3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Procedure involve in this stage was explained to client's understanding. Permission was sought before continuing with the third stage management. During the active management of the third stage, Madam Janet's uterus was palpated through the abdomen to exclude the presence of second twin. At 7:31am, oxytocin 10 units was injected intramuscularly on the upper outer thigh of the client within the first minute by the midwife to enhance uterine contraction. The cord was re-clamped closer to the perineum with artery forceps. The left hand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen (counter traction). The uterus was pushed upward to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and repeated until the placental tissues were visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act prevented the tearing of the membrane.

The placenta was delivered completely at 7:36am. A quick inspection was made to ensure that the membranes and lobes were intact and it was placed in the receiver. The cord had one big vein and two arteries. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted, blood clot was expelled from the uterus and measured 250mls. She was reassured and permission was asked to conduct examination to exclude any form of trauma to the cervix, vagina and the perineum. Fortunately, there were no cervical, vaginal, or perineal tears. All soiled materials were removed and she was properly cleaned with Dettol solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure

good contraction. She jubilated and glorified the name of the living God. Other family members were allowed to see Madam Janet and her baby

EXAMINATION OF PLACENTA

The placenta was sent to the sluice room and was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord insertion and was fully viewed, the lobes fitted together without any gap and edges also forming uniform circle at the maternal surface and this meant that there was no missing lobe, there was no white patches [infart] on the maternal surface, there was also no blood vessels radiating into the membranes which meant no succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries seen. There was no abnormality detected. The placenta was then discarded. The instruments and equipment's used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During the fourth stage, the client and the baby were under close observation for early detection of postpartum complication that arose. Madam Janet and baby were managed in the labour ward for 1hour 40mins and then transferred to the lying-in ward for the six hours for observation. Mother's vital signs were closely monitored every 15 minutes for 2 hours, every 30 minutes for an hour and every hour for three hours. The uterus was felt for contraction every 15 minutes to make sure it was well contracted. The first 15-minutes vital signs were recorded as follows;

Temperature	36.2 degrees Celsius

Pulse	80bpm
Respiration	20cpm
Blood Pressure	100/60mmhg

Madam Janet was also educated on how to feel for contraction and also massage her uterus. The symphysio -fundal height was measured and recorded as 17cm. Much attention was paid to the amount of blood loss during the lying-in period as the pad was regularly inspected. The lochia was red in colour, moderate flow and no odour. The client complained of lower abdominal pain which worsens with suckling. The physiology of this was also explained to the client. She took Milo and Bread which she ate well. Family members were also encouraged to visit Madam Janet and the new born baby.

Baby

The baby was observed for colour, breathing, bleeding from the cord and warmth but no abnormality was found. The baby was able to suckle the mother's breast.

Prevention of disease (prophylaxis for the baby)

This was done within the first 90 minute to prevent infections such as ophthalmic neonatorum a condition which is notifiable, neonatal tetanus and haemorrhagic disease of the new born. The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to outer canthus and chloramphenicol eye drop was instilled. The umbilical cord was clean with methylated spirit. Vitamin k_1 IM with the dose of 1.0 mg was given after the examination.

Examination of the new born

The procedure was explained to madam Janet and hands was washed and dried. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows closed and light switched on. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby's general condition was stable. A detailed head to toe examination was carried out to determine any abnormality.

The head and face: The head was examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial haemorrhage but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 35cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for colour, redness, discharge, placement and conjunctiva for haemorrhage but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps which were all normal. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and were present. The ears; the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected. The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good. The chest was examined, the respiratory movement was regular and the respiratory rate was 42cpm. Breasts were palpated for consistency, masses, and the nipples for position and milk. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with

no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver and spleen were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 136bpm.The limbs and digits were checked for length, movement and paralysis of the upper limbs. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, moro) checked. Everything was normal. The lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for disabilities such as talips and popliteal spaces were examined without any abnormality detected. The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebra, meningomyelocele but no abnormality detected**.** The labia, clitoris, vagina, and urethra were inspected for patency, foreign bodies, adhesions and discharge. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine. Baby's length was measured to be 50 centimeters, weight was 3.1kg and temperature was 36.7C.

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

SUMMARY OF LABOUR AND DELIVERY

DURATION OF LABOUR

1st stage	6 hours
2nd stage	20 minutes
3rd stage	6 minutes
Total	6 hours 26 minutes

CONDITION OF BABY AT BIRTH

Temperature	36.3 degree Celsius
Apex beat	132 beats per minute
Respiration	40 cycles per minute

The following measurements were recorded as;

Weight	3.1 kilograms
Head circumference	35centimetres
Length	50 centimeters

RECORD ON MOTHER

Date and time of delivery	5th December 2021 at 7:45am
Mode of delivery	Spontaneous vaginal delivery
Temperature	36.4^{o}C

Perineum	Intact
Pulse	82 beat per minute
Blood pressure	110/70 mmHg
Fundus	17 cm
Lochia	Rubra
Odour of Lochia	Not – offensive

CONDITION OF PLACENTA AND MEMBRANES

Placenta delivered	7:36am
Lobes and membranes	Complete
Maternal surface	Normal
Foetal surface	Normal

CONDITION OF BABY AT BIRTH

Abnormalities	None
Condition of baby	Satisfactory
Apgar score at First	8/10
Apgar score at fifth minute	9/10
Sex of baby	female
Meconium	Passed

Urine	Passed

Within few minutes after birth, baby passed urine and meconium.

The general condition of the baby was satisfactory.

3.7 CARE PLAN DURIG LABOUR

PROBLEMS IDENTIFIED DURING LABOUR

05/12/21 Anxiety

5/12/21 Lower abdominal pain

5/12/21 Sweating and feeling restless

5/12/21 Waist pain

SHORT TERM OBJECTIVES

Client will be relieved of anxiety at the end of labour.

Client's lower abdominal pains will be resolved within 24hours

. Client will be relieved of restlessness within 12hours at the end of labour

Client will be relieved of waist pain within 12hours at the end of labour

LONG TERM OBJECTIVES

Madam Janet will go through all the stages of labour successfully without any complications to her and the baby.

CARE PLAN DURIG LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/12/21 2:00am	Anxiety related to unknown outcome of labour	Client anxiety will reduce and cope with throughout labour as evidenced by 1. client verbalizing.	1. Reassure client 2. Explain every procedure to be carried on client. 3. Allow her to ask questions and answer tactfully 4. Update client with progress of labour	1. Client was reassured that labour will end safely. 2. Each procedure to be carried out on her was explain to her. 3. Client asked questions and answers were given tactfully. 4. Client was updated about progress of labour	05/12/21 7:30am	Goal was fully met as client's anxiety was allayed and evidenced by her relaxed facial expression and verbalization	

CARE PLAN DURIG LABOUR CON'T

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/12/21 2:04am	Lower abdominal pain related to uterine contractions of labour	Client's lower abdominal pains will be reduced and coped with throughout labour as evidenced by client's behavior	1. Reassure client 2. Explain the physiology of pain. 3. Encourage client to do deep breathing exercise in between contractions. 4. Perform sacral massage. 5. Engage client in conversation.	1.Madam Janet was reassured 2.Physiology of pain was explained to client. 2. Client was engaged in conversation during labour. 3. Client adopted a comfortable position like lying in a left lateral position to reduce pain. 4. Deep breathing exercises were performed. 5. Sacral massage was given to Madam Janet when there were contractions	5/12/21 7:31am	Goals fully met as 1. Midwife observed client cooperated during labour.	

CARE PLAN DURIG LABOUR CON'T

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/12/21 2:34am	Excessive sweating and restlessness related to stress of labour.	Client sweating will be reduced throughout labour as evidenced by observing skin turgor.	1. Reassure client 2. Encourage client to do deep breathing exercise. 3. Clean face and body of client with wet towel. 4. Provide fresh air to client by putting on fan.	1. Client was reassured of competent care to promote comfort. 2. Client continued deep breathing exercise. 3. Client face and body were cleaned with wet towel. 4. Client was provided with fresh air by putting on fans.	5/12/21 7:45am	Goals met as the 1. Midwife observed that client was not sweating and was comfortable. 2.Client verbalizing that she is no more sweating.	

CARE PLAN DURIG LABOUR CON'T

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/12/2021 2:04am	Waist pain related to descent of the fetal head	Client will cope with waist pain till the end of labour as evidenced by 1. client verbalizing	1. Reassure client 2. Allow client to assume a comfortable position but harmless. 3. Give sacral massage. 4. Explain the physiology of waist pain. 5. Encourage deep breathing exercise	1. Client was reassured that she would be relieved of waist pain. 2. Client was encouraged to assume harmless position such as left lateral position. 3. Sacral massage was given to client to relieve her of pain. 4. Physiology of waist pain was explained to client. 5. Madam Janet deep breathing exercises was encouraged and performed	5/12/21 7:45am	Goal fully met as evidenced by client verbalizing that she is relieved from her waist pain	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the six weeks postnatal visit. Then care plans drawn for the management of problems encountered during puerperium.

And also, health education, counselling, assessment, support for infant feeding and immunization service are part.

4.1 DAY OF DELIVERY

Madam Janet and baby were sent to the lying in room at 9:10am. They were closely observed for six hours postpartum. She was made comfortable in bed with baby. Both mother and baby were kept warm. She was encouraged to put the baby to breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also encouraged to empty the bladder frequently to help in fast involution of the uterus and also to prevent the occurrence of postpartum hemorrhage.

An opportunity was taken to educate her on exclusive breastfeeding for the first six months, emptying of one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and educated to change the baby's soiled napkins frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands with soap and water after visiting the lavatory, changing her perinea pad, removing the baby's

soiled napkins and also before and after touching the baby. It was explained to her the need to change her perineal pad frequently. Madam Janet took fufu and light soup for supper. Her vital signs were checked and recorded as follows;

Temperature	-	36.1ºC
Pulse rate	-	80bpm
Respiratory rate	-	25cpm
Blood pressure	-	100/60mmHg

The symphysio fundal height was measured to be 17centimeters. Lochia was also inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest and sleep. Client was educated to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage. She was also encouraged to try and walk about in order to aid in drainage of lochia. Again, she was advised to change her sanitary pad frequently since she was at risk of infection. She was educated on the importance of hand washing before and after changing her sanitary perinea pad.

Madam Janet was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and pelvic floor exercises. Madam Janet husband was advised to help his wife in the care of the baby and also the household chores. She was then informed of possible discharge on the next day which is on 6th December,2021 at 9:00am.

4.2 SUBSEQUENT CARE OF THE BABY

At 1pm, (6 hours) after birth, Madam Janet was informed about the need for baby bath and general examination of the baby and she responded positively. After the baby's bath, cord was checked for bleeding and also was dressed. Baby's breathing rate was checked and was within the normal range. Baby was also dressed and wrapped in a warm cot sheet to keep her warm to prevent hypothermia. Client was educated on the newborn care such as, cord care and also for any danger signs such as irregular breathing, jaundice, fever and report immediately to the nearest health facility.

BABY'S FIRST BATH

REQUIREMENTS

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

11. Mackintosh

12. 2 jugs containing hot and cold water each

13. Two receptacles for used water and dirty linen

14. A receiver for used swab

Procedure.

All windows and doors were closed, fans switched off and lights switched on to make the room warm. Procedure was explained to Madam Janet and was thanked for accepting. After gathering all items, the hot and cold water were mixed and temperature was tested with the elbow. Plastic apron was then worn, hands were washed with soap and under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a protected flat surface, she was undressed and covered with the towel leaving the face. The general condition was observed and the baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported with the hand, the ears were plugged with the thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinse, dried and covered with clean cap. The baby was placed back on the working surface and exposed arms and front of the trunk was washed to the feet paying attention to the skin folds then turned to the back and with one arm supporting the chest and the back, it was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warm water, with the head supported above the water and the body rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small cleaned dried towel was used to dry the body paying attention to the skin folds. Baby oil

was smeared on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution and was removed and discarded, hands were washed dried with clean towel. Mother was encouraged to observe bathing and dressing of the cord. She was educated to clean the cord as well as observed at home.

Cord Dressing

Before the cord dressing by mother was asked to protect her on the table. The tray containing six dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. Sterile gloves were worn and cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using five of the cotton wool swabs from the base upwards. One cotton wool swab was used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left expose to air dry. Baby was dressed nicely, wrapped and given to mother to breastfeed. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby. Observations were made and the findings were communicated to the mother and documented as follows:

Head circumference	-	35centimeters
Length	-	50centimeters
Weight	-	3.1kilograms

Apex beat - 135 beats per minute

Temperature - 36.1 degree Celsius

Respiration - 44 cycles per minute

Baby's condition was good.

At 1:30 pm mother and baby were seen to find out how they were faring, they were in good condition. They were both examined and their vitals were checked since they were not going to be discharged;

Temperature 36.4 degree Celsius

Pulse - 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 110/70 millimeters of mercury.

Observations were made on the baby and findings were communicated to her mother as;

Temperature - 36.3 degree Celsius

Respiration - 40 cycles per minute

Pulse - 134 beats per minute

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery was 6th December 2021. Mother and baby were seen in the lying- in ward at 8:00am to find out how they were faring. Greetings were exchanged and Madam Janet was asked about how she and the baby were doing and she said they were both doing well,

except that she had after pains while breast feeding the baby. She was reassured and educated on the physiology of after pain that is a normal physiology thus the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes after pain. Madam Janet was encouraged to apply warm compresses to her lower abdomen. She was given paracetamol 1g to reduce the pain. Madam Janet also complained of less sleep because the baby cried a lot during the night. She was encouraged to attend to the baby whenever it cried in the night and have enough sleep when the baby is asleep. She was urged to change baby diapers when wet. She had already emptied her bladder and taken her bath. So, permission was sought for head to toe examination.

A puerperal assessment was then made. The conjunctiva was inspected for sign of anaemia but it was absent. The breasts were lactating very well and the uterus was well contracted when palpated and measured, the symphysio fundal height measured 16cm. The perineal pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive smell. She was then encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she was served with hausa porridge and a loaf of bread as breakfast. Madam Janet vital signs was checked and recorded as follows;

Temperature - 36.6 degree Celsius

Pulse - 132 beats per minute.

Respiration - 40 cycles per minute.

Weight - 3.1kgs

The baby was given the first immunization Bacilli Calmette Guerine (BCG)0.05millimeters vaccine intra dermal on the right upper arm for protection against tuberculosis. Client was

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

Mother was educated on personal hygiene, postnatal exercise, keeping the baby's cord clean, dry and avoid the application of unprescribed medication on it, change baby's diapers or napkins frequently when soiled and wash and dry in the sun, take in nutritious diet and fruits which are available, provision of warmth to the baby and prevention of infection by changing her perinea pad whenever it was soiled and also she was educated on exclusive breastfeeding and the need to feed on demand and at night which will serve as family planning as well as aiding in involution. Client was informed about her discharge. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. Her belongings were packed, and her health insurance card was used to settle her bills. Prescribed drugs were given as below;

Iron III polymaltose complex capsule (daily) for30 days

Amoxycillin capsule 500mg (three times daily) for 7days

Metronidazole tablet 400mg (three times daily) for 7days

Paracetamol tablet 1g (three times daily) for 5days

The dosage and time for taking the drugs were explained to her. Madam Janet was also told that

she would be visited for one week to check on her condition and that of the baby and continued with their care. She was discharged home at 10:00am and was escorted with her items to the entrance of the clinic. On 15th December was scheduled as date for one-week visit. They were reminded of the visit to their house.

4.4 FIRST POST NATAL HOME VISIT (FIRST DAY POST DELIVERY)

Madam Janet was visited in her home in the evening at 5:00pm on 6th December, 2021. On arrival, greetings were exchanged with a warm welcome. She was neatly dressed and had already set the place for the baby to be bath; the baby was then toped and tailed. It was explained to her that physical examination will be done on her and the baby, dress the baby's cord and also check her vitals. The cord was dressed with cotton wool swabs soaked in methylated spirit. Mother was also examined from head to toe and there were no abnormal changes. The fundal height measured 16cm. The perineum was inspected and was found to be cleaned, lochia was red (rubra) with moderate amount of flow, breast were lactating small, small, uterus was well contracted. Her vital signs were taken and recorded as;

Temperature : 36.4 degree Celsius

Pulse : 78beat per minutes

Respiration : 21cycle per minutes

Blood pressure : 110/70 millimeters of mercury

Baby was not jaundiced or pale and was able to suckle well. Baby's vital signs was taken and recorded as follows;

Temperature : 36.1degree Celsius,

Pulse	:	134 beats per minute,
Respiration	:	38 cycles per minute.
Baby's weight	:	3.0 kilograms

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

4.5 SECOND POST-NATAL HOME VISIT.

On 7th December, 2021, the second visit was made to Madam Janet house at 7:30am in the morning as scheduled. Madam Janet said she has been relieved of the pains and now she can sleep for at least 4hours. Baby was also doing well. The family was pleased. She complained of backache. She was reassured and encouraged to adopt a good posture when breastfeeding the baby. Permission was sought from Madam Janet to inspect her perinea pad and perinea area was clean and the lochia was red (rubra), not offensive and the flow was moderate. She was asked to empty her bladder before the examination. She emptied her bladder and the head to toe examination was carried out and everything was normal. The breasts were firm and well lactating. Uterus was firm and symphysio fundal height measured 15cm.General examination was carried out on the baby from head to toe and no abnormality was revealed. Baby was toped and tailed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine. Observations were made on mother and baby and they were recorded as follows;

Observation on Mother

Observation	**Morning**
Temperature	36.2 degree Celsius

Pulse	78 bpm
Respiration	22 cpm
Blood pressure	110/60 mmHg
Lochia	Rubra
Fundal height	15cm
Condition of the uterus	Contracted
Breast	Lactating

Observation on Baby

Observation	**Morning**
Temperature	36.1 degree celcius
Apex beat	134 bpm
Respiration	42 cpm
Cord	No bleeding
Skin Colour	Pink
Suckling	Yes
Weight	3.0 kg
Stool Colour	Greenish

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

Evening

Family members were in good health on arrival at 4:30pm, greetings were exchanged and a seat

was offered. She was asked about her health and that of the baby of which she responded they were fine. The family was very cooperative which created a relaxed and lovely environment. Examination was done on the mother and baby and no abnormality was detected. Baby was wrapped in warm sheet and handed over to the mother to be breastfed. Madam Janet was thanked for her cooperation and permission was sought to leave, of which she granted and said she was very grateful and appreciated the care that was given to them.

4.6 THIRD POST-NATAL HOME VISIT.

On the 8th December, 2021, the second home visit was made to Madam Janet house at 7:30am in the morning. Mother and baby were doing well. She also said that she has been relieved of backache. Permission was sought to inspect Madam Janet perineal pad and the lochia was red(rubra) without offensive odour. Head to toe examination was also done. Madam Janet complained of fullness in the breast and rashes on baby's skin and she cries a lot. She was educated to continue breastfeeding the baby, apply cold compress on the breast to reduce the pain and also ensure that one breast was empty before the other one was given to the baby. She was reassured and encouraged to change baby's napkin before she sleeps and also educated to dress baby according to weather and use dusting powder on the baby's skin. Symphysio fundal height was measured 14cm. The baby was top and tailed, assessed and general condition was good and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed greenish yellow stools and urine. Observations made on mother and baby are as follows;

Observation On Mother

Observation	**Morning**

Temperature	36.6 degree Celsius
Pulse	80 bpm
Respiration	20 cpm
Blood Pressure	100/60 mmHg
Lochia	Rubra
Fundal height	14 cm
Condition of the uterus	Contracted
Breast	Lactating

Observation on Baby

Observation	**Morning**
Temperature	36.5 degree Celsius
Apex beat	140 bpm
Respiration	42 cpm
Skin colour	Pink
Cord	Clean
Suckling	Yes
Weight	3.0 kg
Stool colour	Greenish

Evening

At 5:00pm in the evening, both mother and baby were visited. Nothing abnormal was detected during the examination. She was reminded on exclusive breastfeeding and on demand,

maintenance of personal hygiene, eating of fruits and highly nutritious diet and warm saline sit-bath on each visit. Again, permission was sought to leave from Madam Janet of which it was granted. She was thanked and a bid was made.

4.7 FOURTH DAY POST-NATAL HOME VISIT

Madam Janet and her baby were visited again on 9th December, 2021 in the morning at 8:00 am sto continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected. Lochia was rubra on inspection with no odour. She also added that fullness of breast has reduced so therefore breasts were lactating and baby's skin rashes is gone. Head to toe examination was done and everything was normal. Symphysio fundal height measured 13cm Abdomen was also soft with no palpable masses. Baby had been bathed by client's mother on arrival so the general examination was carried out. No abnormality was found. The cord was neatly dressed and has shrinked with no abnormality detected. The baby passed dark yellow stools and urine. Observations made and recorded as follows;

Observation On Mother

Observation	**Morning**
Temperature	36.7
Pulse	80 bpm
Respiration	23 cpm
Blood Pressure	100/60mmHg
Lochia	Rubra
Fundal height	13cm
Condition of the uterus	Contracted

Breast	Lactating

Observation on the Baby

Observation	**Morning**
Temperature	36.8Oc
Apex beat	133bpm
Respiration	34cpm
Weight	3.1 kg
Cord	Dry
Suckling	Yes
Stool colour	Yellowish

Permission was sought to leave and client was very grateful and appreciated the care that was given to them.

4.8 FIFTH POST-NATAL HOME VISIT.

On the 5th day postpartum, Madam Janet was visited on 10th December,2021 at 8:30am to continue with the post- natal care. Mother and baby were both in a healthy condition. Breast were still lactating well. Inspection of the lochia was done and the colour was serosa (pink) with symphysio fundal height measured 12cm. After the head-to-toe examination, no abnormality was detected. Client's vital signs were checked and recorded as follows:

Observation On Mother

Observation	**Morning**
Temperature	36.5
Pulse	87 bpm

Respiration	22 cpm
Blood pressure	100/70mmHg
Lochia	Serosa
Fundal height	12cm
Condition of the uterus	contracted
Breast	Lactating

General examination was done and no abnormality was found on the baby. During the examination, it was realized that the cord had fallen off. Baby was bathed. The baby urinated and passed yellowish stool and was cleaned immediately. Vital signs and other observations were taken and recorded as follows:

Observation On Baby

Observation	**Morning**
Temperature	36.8
Apex beat	125 bpm
Respiration	35 cpm
Weight	3.2kg
Cord	Off clean
Suckling	Yes
Stool colour	Yellowish

Madam Janet was reminded of the next visit and she said she was very grateful. Permission was sought and she was thanked for her cooperation.

4.9 SIXTH POST-NATAL HOME VISIT.

The 6th day postnatal home visit was made on 11th December, 2021 at 7:00am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition. Symphysio fundal height measured 8cm. Inspection of the lochia was done and the colour was serosa (pink) with no odour and flow was scanty. She was educated to keep her perineum clean and change pad frequently to prevent infection and educated on family planning. After head-to-toe examination, no abnormality was detected. Client was not pale, breast were lactating. She was educated on the need to take adequate diet.

Client's vital signs and other observations were made and recorded as follows:

Observation On Mother

Observation	**Morning**
Temperature	36.8
Respiration	26 cpm
Pulse	90 bpm
Blood pressure	110/70 mmHg
Breast	Yes
Fundal height	11cm
Lochia	Serosa

Baby was bathed, head to toe examination was done and no abnormality was found on the baby. The stump was then dressed with cotton wool swab and the area was cleaned and kept dry. Stool was yellowish in colour. Baby looked healthy and active. Baby's vital signs and other

observations were taken and recorded as follows:

Observation On Baby

Observation	**Morning**
Temperature	36.7
Apex beat	145 bpm
Respiration	35 cpm
Weight	3.3 kg
Cord	Off Clean

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

4.10 SEVENTH POST-NATAL HOME VISIT.

The 7th day postnatal was made on 12th December, 2021, Madam Janet and baby was visited as usual in the morning at 7:30am. Mother and baby were in a healthy condition and client said the baby's crying had minimized. Inspection of lochia was done and the colour was serosa (pink), flow was scanty without any bad odour. Symphysio fundal height measured 10cm. After the head-to-toe examination, no abnormality was detected. Mother and baby's vital signs were as follows;

Observation On Mother

Observation	**Mornin**
Temperature	36.4

Respiration	23 cpm
Pulse	78 bpm
Blood pressure	110/60 mmHg

Baby

Observation	**Morning**
Temperature	36.5
Apex beat	130 bpm
Respiration	42cpm
Weight	3.4kg
Cord	clean

She was encouraged to continue adhering to all the advices and encouragement given to her especially on nutrition, exercise, rest and sleep and maintaining good personal and environmental health. Madam Janet was also encouraged to take good care of the baby and breastfeed exclusively. Client was also reminded to register the baby at the birth and death unit and complete all the immunization schedules.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Janet and her baby reported at the clinic on 12th December, 2021 at 9:00am accompanied by her sister. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal site and a seat was offered to them to listen to a health talk on immunization against the preventable childhood disease, exclusive breastfeeding and family planning. After the talk, client and baby were taken to the examination room to be examined. With permission from mother,

baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Janet and hands were washed and dried. The fontanels and sutures were examined for any bulging fontanels or widening sutures but there were none. The eyes, nose and ears were examined and no abnormality was detected. The abdomen was soft, not distended, and the umbilical cord was completely healed. The extremities and the back were also examined and there was no abnormality.

Baby's weight was 3.35kg and her vital signs checked and recorded were as follows:

Temperature	-	36.3°C
Apex beat	-	134bpm
Respiratory rate	-	42cpm
Weight	-	3.5kg

All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeeds well. Madam Janet was also examined and was asked to empty her bladder for physical examination after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Fundus was not palpable. Hands were washed and dried. Her vital signs checked and recorded as;

Temperature	-	36.5°c
Pulse rate	-	84bpm
Respiration	-	25cpm

Blood pressure - 100/70 mmHg

On inspection, client's hair was clean and nicely plaited her conjunctiva and sclera was without any pallor. The nose, mouth and ears were clean without any discharges. The breast was heavy, soft and lactating well with healthy nipples. The upper and lower extremities were without oedema and her back was normal. The lochia was scanty and creamy white. She was helped out of the examination couch after the examination. Findings were communicated to her and documented. Madam Janet was advised to maintain good personal and environmental hygiene in the care of herself and the baby. Madam Janet was again educated on her nutrition and was asked to eat foods that are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate rest and sleep. Madam Janet was encouraged to register her baby at the birth and death registry since there was none at the health center. Client was reminded of the six weeks postnatal visit to the clinic. Gratitude and thanks were expressed to Madam Janet and the entire family for their support and co-operation throughout the writing of the care study. She was finally handed over to the public health nurse in-charge to continue with the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge, Madam Janet six weeks postnatal visit was on 17th January, 2022. At 9:00am. She came to the facility with her husband. Head to toe examination was done on Madam Janet and nothing abnormal was present. Her vital signs, including the weight was checked and recorded as follows;

Temperature - 36.5

Pulse - 80 bpm

Respiration - 20cpm

Blood pressure - 110/60 mmHg

Weight - 67kg

Madam Janet urine was checked for protein and sugar and it was negative for both, and the haemoglobin was 12.0g/dl. Her fundus was not palpable and no lochia observed. The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

Vaccine	Dosage	Route of Administration
Polio 1	2 drops	Oral
Rotarix	2 drops	Oral
Penta	0.5 millimeters	intramuscularly on right thigh

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

Temperature - 36.2degree Celsius

Respiration - 26 cpm

Pulse - 142bpm

Weight - 5.1 kg

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. She also expressed her gratitude for all the support

offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

4.13 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. After pain. (6th December,2021).
2. Insomnia. (6th December,2021).
3. Backache. (7th December,2021)
4. Breast engorgement. (14th December,2021).
5. Rash on baby's skin. (9th December,2021)

SHORT TERM OBJECTIVES

1. Madam Janet will be relieved of after pain within 72hours.

2. Client will have at least 4hours sleep within 72 hours.

3. Client will be relieved of backache within 72 hours.

4. Client breast engorgement will reduce within 72 hours.

5. Baby skin rashes will go within 72 hours

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
6/12/2021 at 7.00am	After pain related to involution of the uterus.	Madam Janet will be relieved of afterpain within 72hours as evidenced by 1. Client verbalizing. 2. Midwife visualizing that client breastfeeds with relaxed facial expression.	1. Reassure client that the pain will reduce. 2. Explain the physiology of pain. 3. Educate client on postnatal exercises. 4. Encourage client to empty bladder frequently. 5. Serve prescribed analgesics.	1 Client was reassured 2 Physiology of pain was explaind to client. 3 Client was educated on postnatal exercise. 4 Client was encouraged to empty bladder frequently. 5 Analgesics were administered as prescribed.	9/12/2021 at 7:00am	Goal fully met as Madam Janet verbalized that she has been relieved of after pain. .	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
6/12/2021 at 5:00pm	Insomnia related to baby's crying and feeding at night.	Client will have at least 4hours sleep within 72 hours as evidenced by 1.client verbalizing that she can sleep.	1. Reassure the client. 2. Encourage client to sleep when baby is asleep. 3. Encourage support person to help in household chores. 4. Encourage client to rest-during the day.	1. Client was reassured. 2. Client was encouraged to sleep when baby sleep. 3. Client's relative was encouraged to help her in the care of the baby for her to sleep during the day 4. Client was encouraged to rest during the day.	7/12/21 at 5:00pm	Goal achieved as client verbalized that she's able to sleep.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/12/21 at 4:30pm	Backache related to physiological changes during pregnancy.	Client will be relieved of backache within 72 hours as evidenced by 1. Client verbalizing.	1. Reassure client. 2 Teach client how to position herself when breastfeeding. 3.Give body massage 4. Educate client against lifting heavy loads. 5. Encourage family members to - support in the care of the newborn.	1. Client was reassured. 2. Client was taught how to position herself when breastfeeding. 3.Client was massaged 4. Client was educated against lifting heavy loads. 5. The family members were - encouraged to help in the care of the baby.	10/12/21 at 4:30pm	Goal met as evidenced by client verbalized that she has been relieved of backache.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/12/21 at 4:30pm	Breast engorgement related to inadequate emptying of the breast.	Client's breast engorgement will be reduced within 72 hours. as evidenced by Client reporting that breast engorgement engorgement has reduced.	1. Reassure client. 2. Teach client on how to fix baby correctly to the breast. 3. Encourage client to empty breast when not feeding. 4. Encourage client to continue breastfeeding the baby exclusively. 5. Encourage client to apply cold and warm compress to the breast.	1. Client was reassured. 2. Client was taught how to fix baby correctly to the breast. 3. Demonstration was done to client on how to position baby during breastfeeding. 4. Client was encouraged to empty the breast. 5. Client was encouraged to continue breastfeeding the baby exclusively. 6. Client was encouraged to apply cold compress to the left -breast.	11/12/21 at 4:30pm	Goal fully met as client reported that breast engorgement has reduced	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/12/21 at 7:00am	Skin rashes on baby related to excessive dressing of baby.	Baby skin rashes will go within 72 hours as evidenced by **1.** client verbalizing that the baby skin rashes has resolved. 2. Midwife observing that baby- is having no rashes.	1. Reassure client. 2. Educate client on the need to clothe baby according to the weather. 3. Educate client not to scratch the rashes. 4. Educate woman to use dusting powder.	1. Madam Janet was reassured. 2. Client dressed baby in warm cotton cloths and according to the weather changes. 3. Mother was educated not to scratch the rashes as it would cause more pain and infection. 4. Client was educated to use prescribed powder for the rashes example dusting Powder.	12/12/21 at 7:00am	Goal met as Madam Janet informed the midwife that baby's skin rashes has resolved. 2. Midwife observed that baby has no skin rashes.	

SUMMARY AND CONCLUSION

This script is a Family Centered Maternity Care, given to Madam Janet Sarpong, a 26 years old woman gravida 2 Para 1. She hails from Tanoso within the Tano North district in the Ahafo Region. She was met at Tanoso Health Center, on 12th November, 2021 when she was 36weeks pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Client went through pregnancy with some sminor disorders which were managed successfully.

Madam Janet's labour and delivery were managed carefully without any complications. She delivered spontaneously to an alive female infant with birth weight 3.1 kg on the 5th December, 2021 at 7:30 am who cried immediately after birth. Madam Janet's puerperium was successful. Breast problem, sub-involution, puerperal psychosis and cord infection were not noticed. Education on good nutrition, personal hygiene, exclusive breastfeeding and family planning were given to ensure a comprehensive care to client and her baby as well as her family as a whole. Mother and baby were visited at home and finally handed over to the Community Health Nurse for further management on 17th January ,2022.

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

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

In conclusion, the client/family centered maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform them

and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
13/06/2021	Blood	Haemoglobin	11.0-16g/dl	-	
		Blood group	A, B, AB, O	A	Normal
		Rhesus factor	Positive/Negative	positive	Normal
		Sickling	Negative	Negative	Normal
		HIV status	Negative	Negative	Normal
		HBsAg	Negative	Negative	Normal
		VDRL	Negative	Negative	Normal
	urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
14/07/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11.0-16g/dl	-	
11/08/2021	Blood	Haemoglobin	11.0-16g/dl	11.2g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
9/09/2021	Urine	Protein	Negative	Trace	
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	-	

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
15/10/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11.0-16g/dl	-	
29/10/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11.0-16g/dl	12.0g/dl	Normal
12/11/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
26/11/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	HIV Status	Negative	Negative	Normal
03/12/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

APPENDIX 11(COMPLETE DIAGNOSTIC INVESTIGATION)

APPENDIX III

PHARMACOLOGY OF DRUGS USED

DRUG NAME	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Tablet Ferrous sulphate	Iron Preparation	200mg three times daily for 30 days	Oral	Helps in the formation of red blood cells. • Supplement Iron requirement of the body to iron deficiency anemia	• Gastro intestinal disturbance • Diarrhoea • Dark stool	1.Dark stool observed 2.Hemoglobin level increased
Tablet Folic Acid	Vitamin preparation	5mg daily for 30 days	Oral	• Helps in the formation of red blood cells. • Treatment of Iron deficiency anaemia	Gastro intestinal disturbance	None observed.
Tablet Multivite	Vitamin preparation	One tablet three times	Oral	• Helps in the prevention and treatment of	• Nausea and vomiting	None observed

PHARMACOLOGY OF DRUGS USED CONTINUED

DRUG NAME	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
		daily for 30 days		• Anaemia. • Improves appetite	• Discomfort	
Tablet Albendazole	Anthelmintic (Benzimidazole)	400mg single start dose	Oral	• To prevent and treat worm infections	• Stomach pain and headache • Nausea and vomiting • Liver problem will occur as a prolong use • Fever and dizziness	Observed vomiting

PHARMACOLOGY OF DRUGS USED CONTINUED

DRUG NAME	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Tablet Paracetamol	Analgesic Antipyretic	1000mg three times daily for 5 days	Oral	• To relieve pain • To reduce body temperature	Prolong use may result in liver damage.	None observed

PHARMACOLOGY OF DRUGS USED CONTINUED

DRUG NAME	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Injection Tetanus toxoid	Vaccine	0.5ml	Intramuscularly or subcutaneous	• Stimulate the formation of antibodies against tetanus organism • Given to prevent women to transfer infection to fetus	• Slight rise in temperature • Pain and tenderness at the injection site	-Rise in temperature -Inflammation occurred at the injection site.
Injection Oxytocin		10 units	Intramuscularly	• Stimulate uterine muscularly contraction and controls bleeding • Use for induction and augmentation of labour	• Uterine rupture if overdose is given	None observed

PHARMACOLOGY OF DRUGS USED CONTINUED (BABY)

DRUG NAME	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Injection Vitamin K	Group K vitamins	0.5 - 1 mg	Intramuscularly	• Help in clotting of blood • Help to prevent haemorrhage disease of the new born	Rashes on the face	None observed
Tetracycline Hydrochloride 1% eye ointment	Antibiotics	Applied on both eyes	Instillation	To prevent eye infection	Transient stinging, increase risk of aplastic anaemia	None
Injection Bacillus Calmette Guerin (BCG)	Vaccine	0.05 ml	Intradermal Injection	Stimulate production of anti-bodies against tuberculosis	Small pustules which persist for some weeks	Blister observed
Polio O Vaccine	Vaccine	2 drops	Oral	Stimulate production of antibodies against poliomyelitis	Nausea	None observed

APPENDIX III

ANTENATAL CHART

Date	Weig ht	Blood Pressu-re(mm Hg)	Urine (protein and sugar)	Haemo-globin level (g/dl)	Gestati --onal age (weeks)	Fun-- dal height (cm)	Prese nta-tion	Descen t (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Rem-arks
13/06/202 1	72	100/70	Negative Negative	11.2	13	12	-	-	-	No complains	Tablet folic acid, multivitamin, Fersolate, Advise on good nutrition, insecticide treated net given.	Healthy
14/07/202 1	77	80/60	Negative Negative	-	17	17	-	-	+	No complains	Tablet folic acid, multivitamin, fersolate. Advice on diet.	Well
11/08/202 1	78	110/60	Negative Negative	11.4	23	26	Cephal ic	-	+	No complains	Folic Acid, Multivitamin, Fersolate, 3rd dose TD given and educated to take more fluids, fruits and vegetables	Well
7/09/2021	75	100/60	Trace Negative	-	26+5	25	Cephal ic	-	+	No complains	Routine drugs served,1st dose of SP given under DOT and educated on personal hygiene	Healthy

15/10/2021	76	110/70	Negative Negative	-	28+9	27	Cephalic	5/5	132	No complains	Routine drugs served,2nd dose of SP given under DOT, paracetamol 1g for 3 days was served and educated on rest and exercise.	Well
29/10/2021	77	100/70	Negative Negative	12.0	31+4	32	Cephalic	5/5	138	No complains	Routine drugs served,3rd dose, albendazole given and educated on rest and sleep.	Well
12/11/2021	77	100/60	Negative Negative	-	35+	33	Cephalic	5/5	138	No complains	To continue with routine drugs and educated on birth preparedness and complication readiness	Well
19/11/2021	80	110/70	Negative Negative	-	36+1	35	Cephalic	5/5	138	No complains	Routine drugs served Client was educated labour and delivery	Well
26/12/2021	81	110/70	Negative Negative	-	37	36	Cephalic	5/5	138	Insomnia and lower abdominal pain	Continue treatment	Healthy

3/12/2021	80	100/70	Negative Negative	-	37+ 5days	36	Cephalic	5/5	136	Waist pain, constipation, backache	Routine drugs served. Educated to eat food containing fibres and drink more water	Well

TETANUS AND INTERMITTENT PREVENTIVE TREATMENT TABLE

TETANUS IMMUNISATION	Previous TT 2nd dose Current TT 3rd dose	Yes ☐ Date 11/06/21	No ☐ Date		3rd dose (1month) after 2nd dose (directly observed therapy)	Gestation age in weeks 13weeks

SIGNATORIES

THE STUDENT MIDWIFE

NAME; BAWA VIDA

SIGNATURE……

DATE……

THE MIDWIFE IN-CHARGE

NAME;MRS ABENA BOAHEMAA

SIGNATURE……..

DATE……

THE SUPERVISOR

NAME; MISS ERNESTINA MENSAH

SIGNATURE……

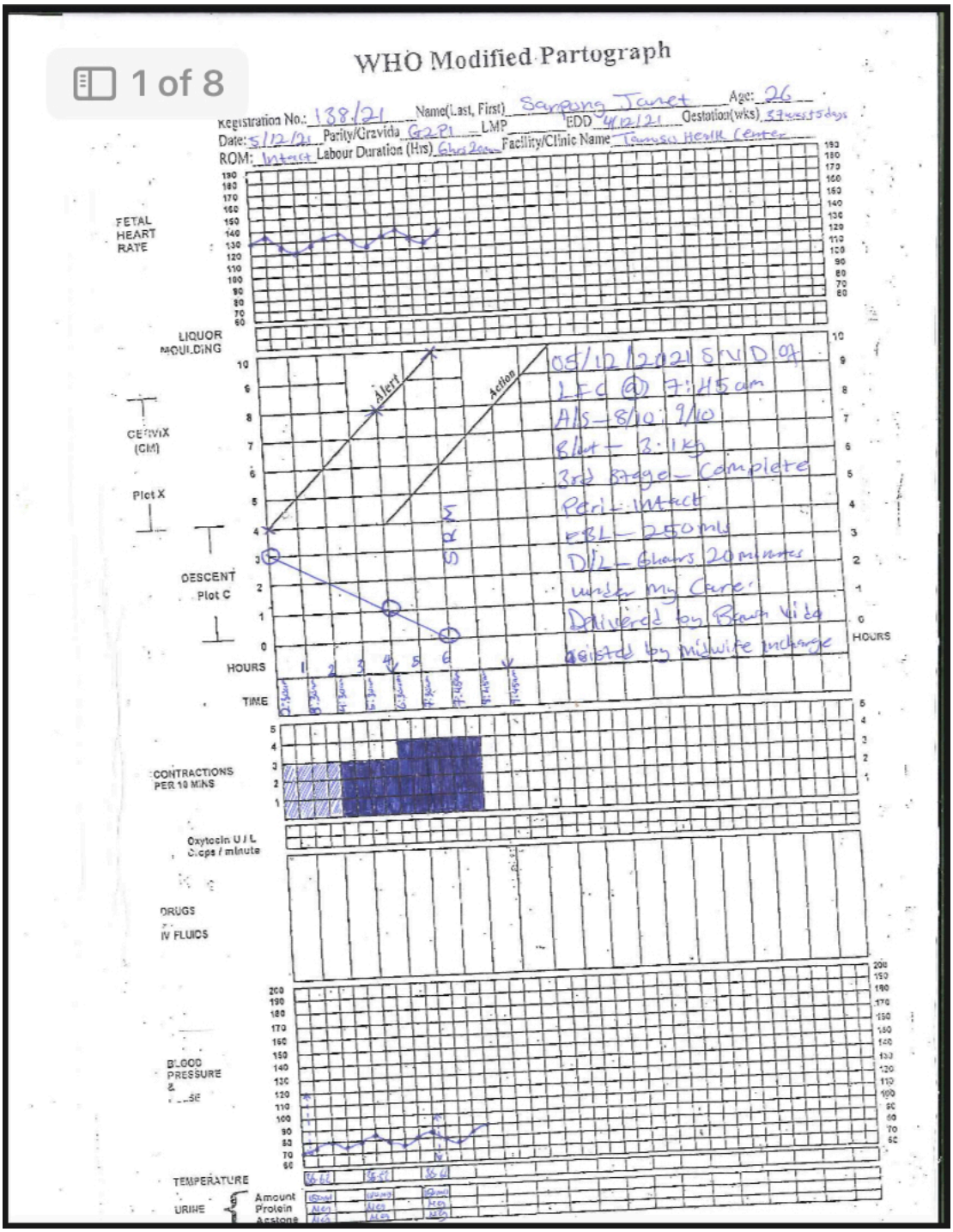
DATE…….

PRINCIPAL

NAME; MIS MONICA NKRUMAH

SIGNATURE……

DATE……



WHO Modified Partograph

Registration No.: 138/21 Name(Last, First) Sampong Janet Age: 26
Date: 5/12/21 Parity/Gravida G2P1 LMP EDD 4/12/21 Gestation(wks) 37 weeks 5 days
ROM: Intact Labour Duration (Hrs) 6hrs 20mins Facility/Clinic Name Tamale Health Center

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Plot X

DESCENT Plot C

Alert

Action

05/12/2021 SVD Of
LFC @ 7:45 am
A/S - 8/10 9/10
Bwt - 3.1kg
3rd Stage - Complete
Peri: Intact
EBL - 250mls
D/L - 6hours 20minutes
under my Care.
Delivered by Beauty Vida
Assisted by Midwife Incharge

HOURS

TIME

CONTRACTIONS PER 10 MINS

Oxytocin U/L Drops / minute

DRUGS

IV FLUIDS

BLOOD PRESSURE &

TEMPERATURE

URINE Amount Protein Acetone

LABOR NOTES

Client G2P1 was brought to the facility by her mother with the complains of lower abdominal pains. On examination FSH=38 gestation=37wks+5days Presentation=cephalic, descent=3/5, FHR=136bpm. Vital signs checked and recorded as BP=110/70mmHg, Pulse 72bpm, respiration 22cpm. Vaginal examination done, cervical OS 4cm dilated, Cervix=Soft and thin, membranes=intact. Labour progress @ 7:45am and Client had SVD to an alive female child. APGAR 8/10, 9/10. Injection Oxytocin 10units given @ 7:46am. Placenta and its membranes were completely delivered by CCT @ 7:50am. Uterus massaged till firmly contracted and blood clot expelled. Skin-to-Skin done, breastfeeding initiated

Please circle or write responses.

DELIVERY

DATE: 5/12/21 TIME: 7:45am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No · Medication: Time 7:46am Type/Dose 10 units

PLACENTA: TIME: 7:50am (Complete) / Incomplete

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

BABY

Weight:

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

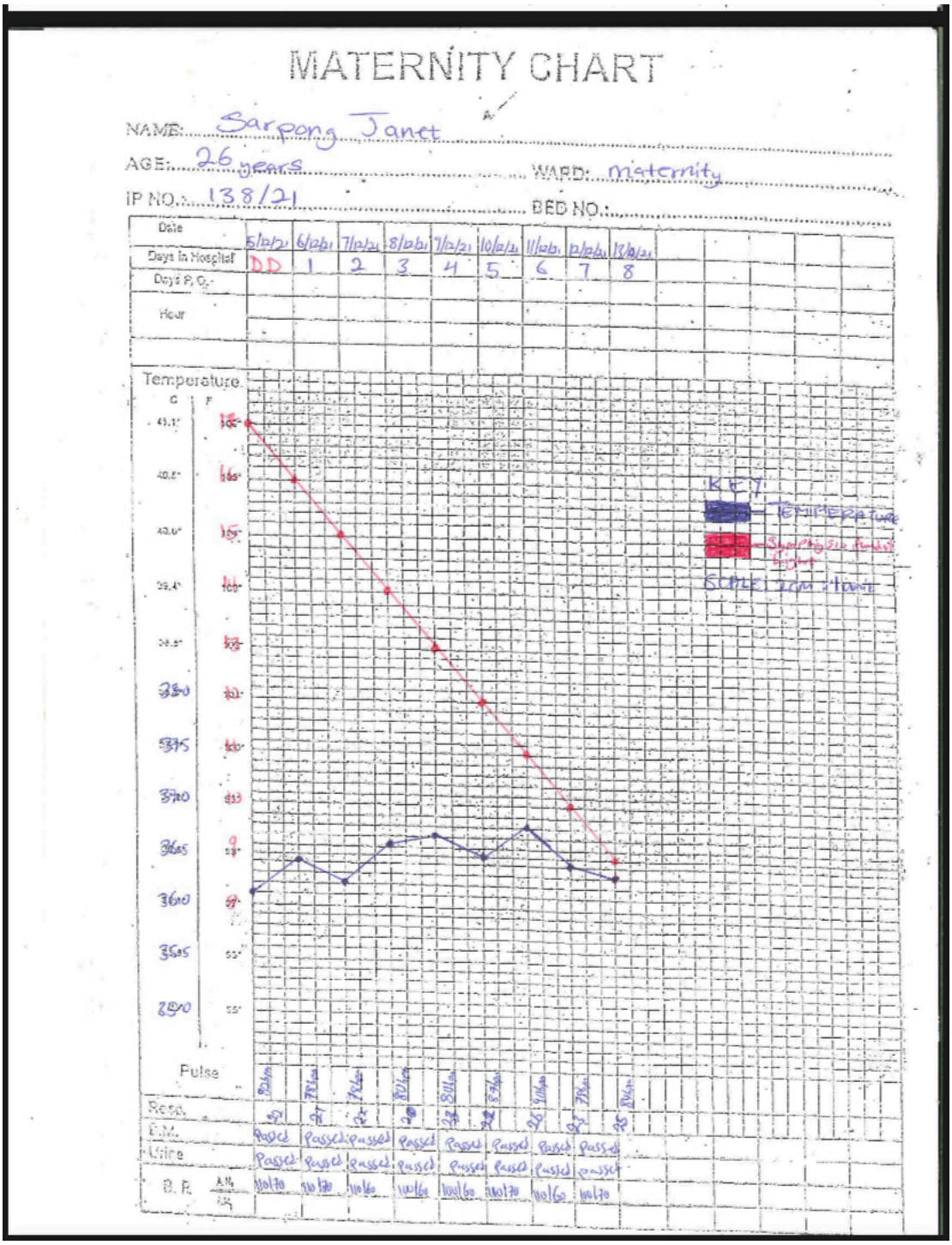
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	1	2	9/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	8:30am	110/70mmHg	72bpm	18	150mls	
	8:45am	110/60mmHg	75bpm			130mls
	9:00am	120/60mmHg	80bpm			
	9:15am	110/70mmHg	75bpm	firm		
	9:30am	120/60mmHg	73bpm			
	9:45am	110/60mmHg	80bpm			
	10:00am	110/70mmHg	80bpm			
	10:15am	110/70mmHg	82bpm			
Every 30 minutes For 1 hour	10:45am	120/60mmHg	76bpm	(20)	Moderate bleeding	
	11:15am	110/60mmHg	80bpm			

Birth Attendant Beira Vida. Supervised by Midwife Incharge Date 5/12/2021



MATERNITY CHART

NAME: Sarpong Janet

AGE: 26 years WARD: maternity

IP NO.: 138/21 BED NO.:

Date	5/2/21	6/2/21	7/2/21	8/2/21	9/2/21	10/2/21	11/2/21	12/2/21	13/2/21
Days In Hospital	DD	1	2	3	4	5	6	7	8
Days P. O.									
Hour									
Temperature C / F									
Pulse									
Resp.									
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
B. P. A/M / P/M	110/70	110/70	110/60	110/60	100/60	110/70	110/60	110/70	

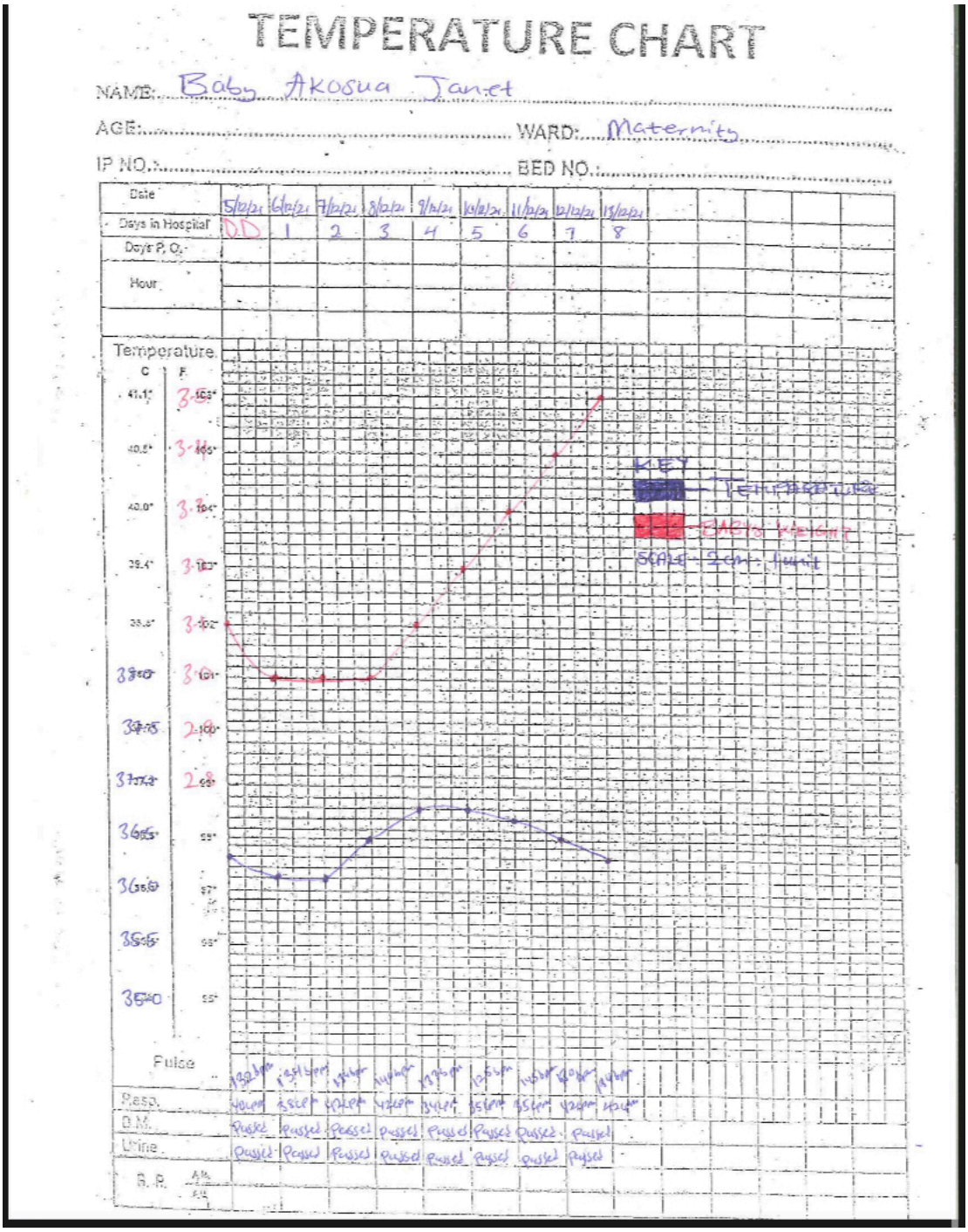
KEY
TEMPERATURE
SCALE: 2cm : 1unit

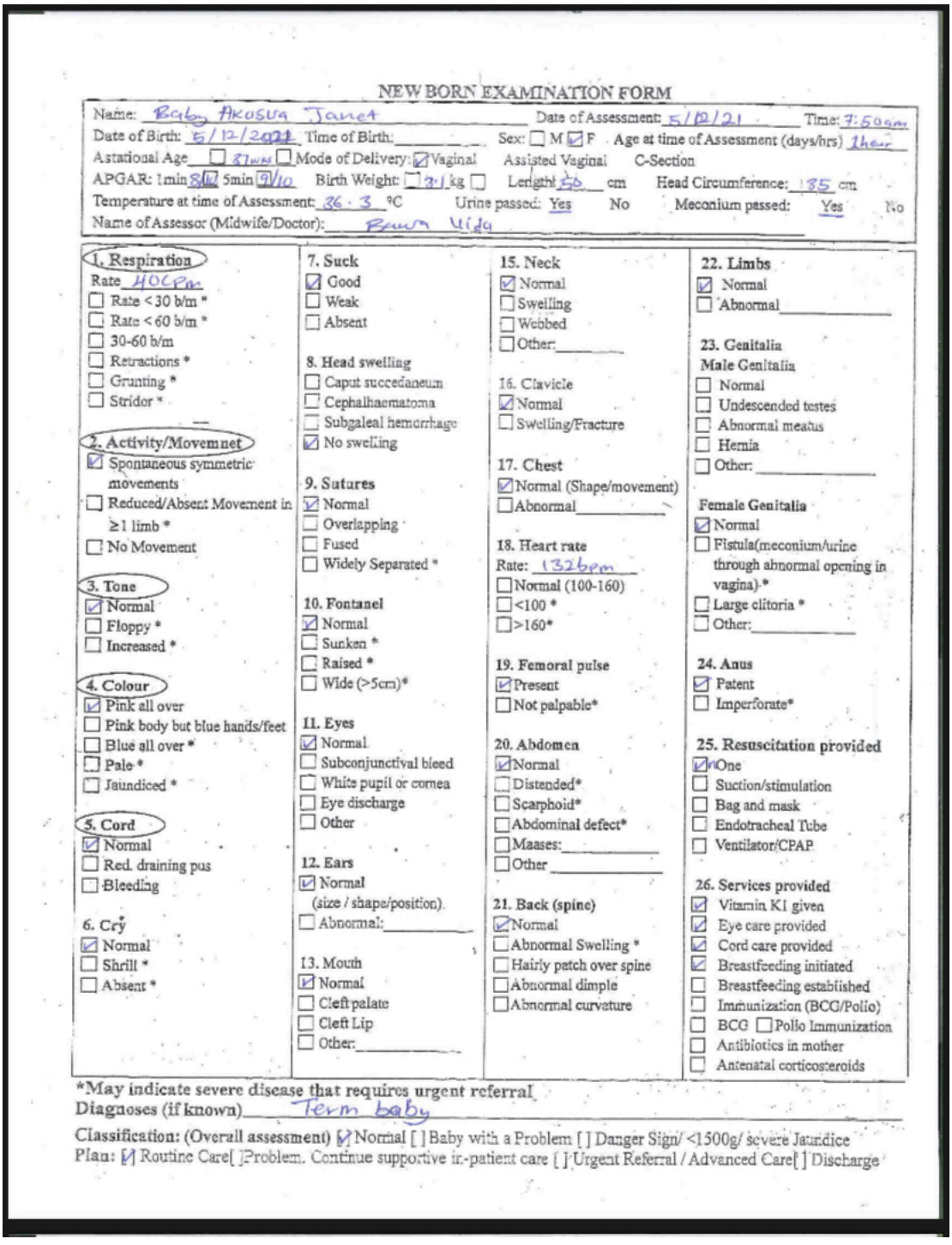
TEMPERATURE CHART

NAME: Baby Akosua Janet

AGE: ..... WARD: Maternity

IP NO.: ..... BED NO.: .....





NEW BORN EXAMINATION FORM

Name: Baby AKOSUA Janet Date of Assessment: 5/12/21 Time: 7:50am
Date of Birth: 5/12/2021 Time of Birth: _____ Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hour
Astational Age ☐ 37wks ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.1 kg ☐ Length 50 cm Head Circumference: 35 cm
Temperature at time of Assessment: 36.3 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Bawa Hida

1. Respiration
Rate 40cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

2. Activity/Movemnet
☑ Spontaneous symmetric movements
☐ Reduced/Absent Movement in ≥1 limb *
☐ No Movement

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

5. Cord
☑ Normal
☐ Red, draining pus
☐ Bleeding

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other: _____

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other: _____

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal _____

18. Heart rate
Rate: 132bpm
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases: _____
☐ Other _____

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

22. Limbs
☑ Normal
☐ Abnormal _____

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: _____

Female Genitalia
☑ Normal
☐ Fistula(meconium/urine through abnormal opening in vagina)*
☐ Large clitoria *
☐ Other: _____

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☑ None
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

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

*May indicate severe disease that requires urgent referral
Diagnoses (if known) Term baby
Classification: (Overall assessment) ☑ Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: ☑ Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

NEW BORN EXAMINATION FORM

Name: Baby AKOSUA Janet Date of Assessment: 6/12/21 Time: 8:00am
Date of Birth: 5/12/21 Time of Birth: 7:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) one day
Astational Age ☐ 37wks ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min ☐ 5min ☐ Birth Weight: ☐ 3.1 kg ☐ Length: 50 cm Head Circumference: 35 cm
Temperature at time of Assessment: 36.1 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Bawa Lida

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

2. Activity/Movemnet
☑ Spontaneous symmetric movements
☐ Reduced/Absent Movement in ≥1 limb *
☐ No Movement

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

5. Cord
☑ Normal
☐ Red, draining pus
☐ Bleeding

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other: _____

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other: _____

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal _____

18. Heart rate
Rate: 136 bpm
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases: _____
☐ Other _____

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
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22. Limbs
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*May indicate severe disease that requires urgent referral
Diagnoses (if known) Term baby

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

NEW BORN CHART

Name: Baby Akosua Janet ..No: .....Birth Weight: 3.1kg.....

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

Nature of Delivery: Spontanous Vaginal delivery .....Diagnosis: Term baby.....

Date of Birth: 5/12/2021 .....Time: 7:45am .....Date of Discharge: 6/12/2021.....

Date	5/12/21		6/12/21		7/12/21		8/12/21		9/12/21		10/12/21		11/12/21		12/12/21		13/12/21					
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	31kg		30kg		30kg		30kg		31kg		32kg		33kg		34kg		35kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.3°C		36.1°C		36.1°C		36.5°C		36.8°C		36.8°C		36.7°C		36.5°C		36.3°C					
Stools	Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed					
Urine	Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Truck Genitalia Extremities → NAD																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME; BAWA VIDA

SIGNATURE.....

DATE 5/10/2022

THE MIDWIFE IN-CHARGE

NAME;MRS ABENA BOAHEMAA

SIGNATURE.....

DATE 7/10/2022

THE SUPERVISOR

NAME; MISS ERNESTINA MENSAH

SIGNATURE.....

DATE 10/10/2022

PRINCIPAL

NAME; MIS MONICA NKRUMAH

SIGNATURE.....

DATE 12/10/2022

ACADEMIC COORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEPOSUM