HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY

ON

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BY

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

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PREFACE

Family centered maternity care study is a comprehensive, evidenced based learning solution built to help you enhance your ability to understand, diagnose and treat common clinical problems in maternity care of an expectant mother, her family and the entire community during pregnancy, labour and puerperium.

The care is individualized, based on identification and understanding of a client and family as unique people with specific needs and problems. These needs and problems could be psychological, physiological, emotional and spiritual which should be identified and solved. A comprehensive care is rendered based on the problems identified throughout pregnancy, labour and puerperium and solved using the nursing care plan. This helps to avoid complications which might arise during pregnancy, labour and puerperium.

The study gives the student the opportunity to choose and nurse a client and her family throughout pregnancy, labour and puerperium and also prepare the family to receive the newborn using the knowledge acquired in the study of midwifery.

It is also a requirement of the Nurses and Midwives council of Ghana, for the award of a professional registered midwifery certificate to students at the end of their three years study in school.

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I express my profound gratitude also to my parents Mr. Benson Takyi and Mrs. Esther Takyiwaa for their love, prayers, support and encouragement throughout my education. Special thanks to all members of my family for their support. May God bless you all abundantly.

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INTRODUCTION

Family centered maternity care study is a way of providing care for women and their families that integrates pregnancy, labour and puerperium and infant care into the continuum of the family life cycle as a normal, healthy life event.

Family centered maternity care is based on supporting the integrity of the family and individualizing the care given to promote individual and family health. Thus, it is possible for every setting and for every client and family, regardless of physical settings or characteristics.

This study was carried out on Madam Suah. a 33-year-old gravida 2 Para 1A expectant mother during pregnancy, labour and puerperium. I met her on 3rd of November, 2021 at the Koranteng Maternity Home Techiman when she was 36 weeks pregnant and was visiting the antenatal clinic for the 6th time. She was selected for the study after careful examination and explanation of the purpose of the study. A comprehensive care was rendered to the client throughout pregnancy, labour and the first seven days of puerperium through regular home visits and education. She was handed over to the public health nurse on the seventh day post-natal for continuity of care.

This write up is structured in four chapters; chapter one which consist of client particulars and histories that is the personal, social, family, medical, surgical, past and present obstetric history. Chapter two is about the antenatal care rendered to client at the clinic and home till the onset of labour.

Chapter three is the care given throughout labour, how labour was managed and the immediate care given to both mother and baby.

Chapter four entails the care and management given to the client and baby within seven days postpartum. A nursing care plan is drawn at the end of chapters 2, 3 and 4 to solve problems identified during pregnancy, labour and puerperium.

Finally, summary, conclusion and appendices on the study are attached

LITEREATURE REVIEW

Pregnancy is a state of being with a foetus from the time of conception to the expulsion of the foetus (Tiran 2008). The normal period is 280 days or 40 weeks or 9 months and 7 days counted from the first day of the last menstrual period. Normal physiology and psychological changes take place in the woman due to hormonal changes. These changes affect almost all the systems in the body resulting in minor disorders such as morning sickness, nausea, constipation, heartburns, ptyalism, excessive salivation to mention but a few. These minor disorders if left unattended to, can result in serious life threatening condition to both the mother and the foetus. It is therefore the responsibility of the midwife to educate the woman on the importance of antenatal clinic and ways of coping with the minor disorders as well as reporting any abnormalities detected for prompt intervention to help save lives of both the mother and the baby. Pregnancy is a period under three trimesters: The first trimester is from the first week to twelve weeks of pregnancy. The second trimester is from the twelve week to the twenty fourth week of pregnancy and the third trimester is from the twenty fourth week to fortieth week of pregnancy (a textbook for midwifes in the tropics 2nd edition). Ojo and Brigg (2006) said that when pregnancy occurs, menstruation ceases and returns some weeks or months after delivery. The hormones progesterone and oestrogen are produced in the large quantities which exerts some action on the various systems of the pregnant woman. The most outstanding of these changes is growth which occurs in the uterus. They also added, Pregnancy is divided into three (3) periods or trimesters namely; First trimester, second trimester and third trimester. First trimester begins from the day of conception to the 12th week. Second trimester begins from the 13th week to the 26th week and the third trimester begins from 27th week till birth. According to Fraser and Cooper (2009), Antenatal Care is given to a pregnant woman from the time conception is confirmed until labour begins. It is a type of preventive health

care with the goal of providing regular check – ups that allow midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefits both mother and child.

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

LABOUR

Is the process by which the product of conception that is the foetus, placenta and membranes are expelled through the birth canal (Margaret Myles' 15th edition of textbook for midwives). Normal labour therefore occurs when the foetus is born at term, present with vertex and delivered spontaneously by natural unaided effort of the mother, time not exceeding 18 hours without complications to the mother and baby.

Labour involves four (4) stages

First stage: It begins with the onset of regular rhythmic painful uterine contraction, descent of foetus, to full dilation of the cervical os thus 10centimeters. It takes 12-18 hours in the primigravida and 6-10hours in the multiparous. It is divided into latent, active and transitional phase. The latent phase is the gradual effacement of the cervix. The latent phase is prior to the active phase of labour and may last 6-8 hours in primigravida when the cervix dilates from 0cm to 4cm [Howie and Rankin 2010]. The active phase starts from 4cm to 8cm cervical dilatation and the transitional phase continues from the 8cm to 10cm of cervical dilatation. Woods [2006] describe this as being from inner calm to acute distress. The active first stage of labour is managed with a partograph .Tiran [2008] explained partograph as 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.

Second stage: Starts with full dilation of the cervix to the complete expulsion of the foetus and normally last for one hour.

Third stage: Starts with the separation and complete expulsion of placenta and membranes and the control of haemorrhage after delivery of the baby. It takes 5 to 15 minutes in multigravida and

10 to 30 minutes in primigravids. Fourth stage: It is the first six hours after the third stage in which both mother and baby are closely monitored to prevent or detect any abnormality such as postpartum haemorrhage. Vital signs that is temperature, pulse, blood pressure and respiration are monitored and recorded.

PUEPRERIUM

Marshall and Raynor (2014) stated that puerperium starts immediately after the delivery of the placenta membranes and continues for six weeks. In many cultures around the world 40 days for recuperation is a time-honoured practice. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the efforts of the pregnancy and recovered to their non-pregnant state. According to Ojo (1992), 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 to eight weeks postpartum is called puerperium and where the bruises are healing, 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 this said period. Tiran (2008), states that puerperium is the period from 6-8 weeks following child birth during which the uterus and other organs and structures are returning to their non-pregnancy state. National safe motherhood protocol (2008) also describes puerperium as the period from the end of the delivery to six weeks after delivery. It states further that the purpose of post-natal care is to maintain the physical and psychological wellbeing of the mother and the child. It includes education to the mother in the care of the child, detecting and treatment of referral of any abnormality for further management. The essentials of post-natal care are therefore;

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

5. Health education and counselling

6. Family planning and counselling

7. Immunization services for mother and baby

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

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

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

Fraser and Cooper (2009) also states that, regardless of whether women are breastfeeding, they may experience tightening and enlargement of their breast toward the 3rd and 4th day, hormonal influences encourages the breast to produce breast milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce discomfort. Henderson (2009) further states that, the falling progesterone levels affects the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburns the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period. Fraser and Cooper (2009) further states that it has been traditional to associate afterpain with multiparity and breastfeeding. However, women experience afterpain regardless of whether they have had

previous pregnancies and when they are not breastfeeding. Management of afterpain is by an appropriate analgesic.

The American Academy of Paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye newborn as well as well as cord dressing. From the above definitions, it can be deduced that, puerperium infection and also administering of vitamin K injection to prevent haemorrhage disease of the is the management to the mother and baby to exclude puerperal sepsis, other complications and establishment of lactation.

WHY I CHOSE MY CLIENT

Madam Suah was among the pregnant women who attended Antenatal Clinic (ANC) on Wednesday 3rd November, 2021 at Koranteng Memorial Clinic, Techiman. Madam Suah was seen eating without washing her hands. When approached kindly, she confessed she had not really done anything with her hands. She was taught on the importance of ensuring clean hands before and after eating. After which she was very grateful. Upon further conversation with her, she revealed that she did not practice exclusive breastfeeding to her first baby so I thought it wise to help her to see the benefits of practicing the six months exclusive breastfeeding to her children and the need to take the Tetanus Diphteria Injection to prevent Tetanus from entering the body through wounds and cut.

Familiarity was built between myself and her after glancing through her antenatal book, she felt within the criteria for the selection. She had a good obstetrical history. Her gestation age, parity, age and other information met the criteria needed by the Nurses and Midwives council for the study. After a comprehensive introduction to her, The In charge informed her about the idea of using her for the family centered maternity care study of which she gladly agreed.

She was educated on the care that will be rendered to her at the facility, her home and in the community she finds herself during pregnancy, labour and puerperium. Phone contacts were exchanged and she was thanked for accepting the request.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

Chapter One gives a clear and vivid history about the client used for this study, her family and her community as a whole. It also gives an insight into the general assessment that was performed on the client, her family and the community as well. This Chapter also comprises of the past and present obstetric history, medical, surgical, menstrual, and family histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Suah was born on the 6th March, 1988 and she is a 33 years old expectant mother who comes from Wenchi in the Bono East Region but lives at Jeruselem, a suburb of Techiman. She lives with her husband. She speaks English and Bono. Madam Suah has a nice looking face and displays her white teeth anytime she smiles. She is dark in complexion and is 164cm tall. According to Madam Suah she had both her primary and junior high school education at Akrobey-Wenchi. She is a hairdressing apprentice. Madam Suah is married to Mr. Kofi Mensah for about five years now. Mr. Mensah is 38 years of age and dark in complexion. He is a carpenter and a taxi driver as well.

Madam Suah is a faithful and a devoted Christian and attends Jeruselem House Of Heaven church at Jeruselem. Mr. Mensah is a supportive husband and her next of kin.

1.2 FAMILY HISTORY

Opanin Duodu and Madam Twumwaa are the parents of Madam Suah. They are all alive and live at Wenchi in the Bono East Region. Both parent of Madam Suah are farmers. Madam Suah, is the fourth and last born of her parent. According to her, there are no known hereditary conditions such as diabetes mellitus, sickle cell disease, mental disorder, epilepsy and asthma in her family. She further stated that there is a history of multiple pregnancy in her family. Her older siblings who are the third born of her parents are twins. There is no congenital abnormalities like cleft palate, extra digits, spinal bifida etc. Death in her family occurs natural.

1.3 MEDICAL HISTORY

According to Madam Suah she has never been admitted in a hospital before. Madam Suah further stated that she sometimes experienced minor illness which is treated on Out-Patient Department basis, and added that, she does not have any medical condition like asthma, hypertension, diabetes mellitus and tuberculosis. She has no known allergy to any drug or food and has never been transfused with blood before neither has she donated blood before. She is also not on any medication for any chronic illness.

1.4 SURGICAL HISTORY

Madam Suah said that she has never had an accident that has affected her pelvis, spine or her reproductive organs neither has she undergone any surgical operation before. There is no episiotomy done on her previous delivery.

1.5 MENSTRUAL HISTORY

Madam Suah has a regular menstrual cycle of 28days. Client had her menarche when she was 16 years old. She has six days duration of menses which flows moderately and has no dysmenorrhea. Madam Suah said she changes her pad twice daily which indicates she has a normal flow. According to her, her last menstrual flow was 25th February, 2021.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Suah goes to bed around 8:00pm and wakes up around 6:30 am. She washes her face and brushes her teeth with tooth brush and tooth paste. The next thing she does is to sweep her room, corridor and her entire compound then mop her room and prepares breakfast for her husband and herself. Though Madam Suah already have a daughter but she is currently staying with her grandmother at Techiman because of her work and even her current pregnancy she would not have much time to spend with her. But according to my client she visits them frequently. She takes her bath immediately she is done with the preparation of their breakfast then she takes in her food. She lives closer to her work premises with her co-workers so she sometimes comes to prepare supper around 3:00pm and then goes back to work and closes from work around 6pm. She eats three times and empty her bowel at least once a day. She neither smokes cigarettes nor take any alcohol or caffeine drink. On Saturdays, Madam Suah cleans her room, goes to the market to buy food stuffs and shops for the items that she would need in the up keep of the house for the next week. Her dirty clothes as well as that of her husband is washed up during the weekend and dried in the sun. Madam Suah's favorite food is banku and groundnut soup with beef. She enjoys reading her bible and listening to music during her leisure time. On Sundays, Madam Suah goes to church with her husband and closes around 12:00pm. She then comes home and prepares lunch for her husband and herself around 2pm and makes sure that her husband is served and see

to it that he eat.

1.7 HOME ENVIRONMENT

physical

Madam Suah lives in an uncompleted self- contained house with three bedrooms and she occupies a room. Each tenant has his or her own corridor that has a door that is locked. Madam Suah's room has two windows lined with mosquito proof net and on the trap door as well while the other window is made with tainted glasses. The house was built with cement blocks and is well roofed with Aluminium sheet. Madam Suah keeps her things at the uncompleted building and they are neatly arranged. Madam Suah has a clean plastic container with a cover in which she stores her water. The house has three uncompleted bathrooms and toilet facilities but there is a single temporal KVIP which is shared by the whole tenant. The source of water is a pipe borne which is situated at the back of Madam Suah's room. Client disposes her refuse at the backyard of their house which is burnt every evening. Madam Suah's room is well ventilated and has a good lightening system. The source of light is electricity. She sleeps on a latex foam mattress under a treated insecticide net.

psycosocial

According to Madam Suah, she enjoys her stay with her husband ever since they got married. She added that, her relationship with her co-tenant and the people around is very cordialand has never had any fights among them. If there is any misunderstanding they try to settle everything among themselves before it worsens. She then stated that they themselves as one family. Therefore they offer each and everyone a helping hand in times of difficulties and find possible solutions if there

are problems. Madam Suah attends occassions like funeral, marriage,and other festivals with her husband when the need be.

1.8 PAST OBSTETRIC HISTORY

Pregnancy

Madam, Suah gravida 2 Para 1, alive, went through her pregnancy without any ill-health and had a term pregnancy. The interval between the first and the current pregnancy is three years. There were no complications like ante- partum hemorrhage or abortion. She did not take any dose of the Tetanus Diphteria injections during her first pregnancy but she took the five doses of Sulphadoxine pyrimethamine as a prophylaxis against malaria in pregnancy. She was a regular attendant to antenatal care till she delivered.

Labour

She had spontaneous vaginal delivery to an alive female infant at the Wenchi Methodist Hospital. Her baby cried lustly as soon as she was delivered with birth weight of 3.0 kilograms and the labour lasted for 6 hours. The third stage was actively and properly managed without any complications. The perineum was intact. In the fourth stage, the condition of the mother and the baby were good. The estimated blood loss was 150mls, but she said she had no postpartum hemorrhage.

Puerperium

Madam Suah's puerperal period, according to her was also normal. She had no puerperal psychosis. She visited the postnatal clinic frequently. She and her baby were healthy throughout. She breastfed exclusively for only three months and started complementary feeds from the fourth

month till the baby was two years old when she weaned her. According to Madam Suah her daughter received all the immunization against childhood preventable diseases and still continued to visit the child welfare clinic. She also said she received support from her husband, her siblings and mother during the previous delivery. Her daughter was healthy. Madam Suah did not use any artificial family planning method but she only practiced the Lactational Amenorrhea Method (LAM).

1.9 PRESENT OBSTETRIC HISTORY

Madam Suah Gravida 2 Para 1 visited the antenatal clinic when she was 6 weeks pregnant on 8th of April 2021. Her expected date of delivery was calculated to be 4th December, 2021 whiles first ultrasound scan and second ultrasound scan was 1st December, 2021 and 10th December, 2021 respectively.

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

Hemoglobin Level	-	12.0g / dl
Sickling Test	-	Negative
Blood group	-	O
Rhesus factor	-	Positive
G6PD	-	No Defect

Syphillis (VDRL) - Negative

HIV status - Negative

Urine R/E - No abnormalties

Hepatitis B status - Negative

The following observations were made and recorded - ;

Temperature - 36.7^{O}_{C}

Pulse - 82bpm

Respiration - 22cpm

Blood Pressure - 120/70mmHg

Madam Suah had her 1st and 2nd dose of tetanus Diphtheria on the 8th of April, 2021 and 7th of May,2021 respectively. She had her first dose of Sulphadoxine pyrimethamine on 5th of August, 2021 at 24 weeks, second dose on 13th September 2021 at 28 weeks, third dose on 20th October, 2021 at 34weeks, and the fourth dose on 17th November, 2021 at 38 weeks. Client was unable to complete the five doses course of the Sulphadoxine pyrimethamine because, she was unable to report to the facility at the time there was quickenining but the she came to the faclity when she was 24 weeks pregnant. Upon enquiries client couldn't give any tangible reasons for not honouring her appointment so this also called for intensive education to the client and the need to select her as my client for this study.

Records on Madam Suah's antenatal card indicated that she was examined from head to toe and no abnormalities were detected. Madam Suah had no complains during her first visit. Therefore she was served with the following routine drugs;

Folic acid 5mg (1 daily) for 30 days

Tablet Ferrous Sulphate 200mg (1daily) for 30 days.

Madam Suah honoured all scheduled visit correctly and carried out all the investigations requested. And all findings has been within normal ranges until she was met on the 3rd November, 2021 when she was 36 weeks pregnant. Madam Suah made five visits to the antenatal clinic before she was met for the first time.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives an accurate information of the care rendered to Madam Suah during her pregnancy specifically from the 36 weeks. It highlights more on the first contact with client, various home visits and subsequent visits to the clinic and also the nursing care plan drawn to solve her problems during pregnancy.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Suah was met on the of 3rd November, 2021 at Koranteng Maternity Home at Techiman during the antenatal day when she was 36 weeks pregnant. It was her sixth visit to the facility. Introduction was made as Albertha Appiah Ansu, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum sent to Koranteng Maternity Home on clinicals to have a practical experience in midwifery. Her antenatal book was collected and found out that she fall within the criteria for the selection of clients for this study and she has been attending antenatal clinic regularly and have no abnormal condition which can be a threat to her pregnancy. A brief information was given to her about the care study and why she was chosen and she gave an assurance of full support and co-operation and she was happy as well. She was then taken through the general examination when it got to her turn after procedures were explained. She was encouraged to ask questions. Her vital signs, weight and urine were checked and recorded as follows;

Temperature - $36.5^{O}C$

Pulse	-	80bpm
Respiratory rate	-	21cpm
Blood pressure	-	100/60mmHg
Weight	-	102kg

Urine tested for protein and glucose were negative.

After the above procedures, education was offered to her on the following; warning signs in pregnancy like vaginal bleeding, hyperemesis gravidarium, increase body temperature, increase or decrease or no movement of the foetus, convulsive fits, then also on budgeting and layette, signs of forthcoming labour, taking of medication as prescribed and avoidance of self- medication, avoiding caffeineted drinks, sleeping under an insecticide net to prevent malaria and good nutrition.

Permission was obtained to perform physical examination from head to toe after an explained procedure. She was asked to empty her bladder, privacy was ensured and she was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with a clean dry towel. Madam Suah was examined from head to toe, under the supervision of the midwife in charge and no abnormality was detected.

Madam Suah's hair was examined and it was neatly braided with no dandruff or lice. The sclera and conjunctiva were normal with no yellowish discoloration. There were no discharge from the nose and ears. The mouth, tongue and teeth were clean. On neck palpation, no lymph nodes were felt. The breasts had no lumps, dimples or discharge during palpation. Madam Suah was taught how to do self -breast examination and she was educated to examine her breast five days after her

menstruation where the breast would have been free from any changes for early detection of any abnormalities. The hands and fingers were inspected and the nails were cut and neat. The lower extremities were examined and no abnormalities was detected. .The back was also inspected for oedema at the sacral region and the condition of the skin. There was no oedema at the areas inspected and the condition of the skin was good.

Abdominal palpation

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

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

Measuring of Symphysio-fundal height: The zero end of the measuring tape was placed on the fundus and the tape extended to the symphysis pubis of the uterus and the symphysio-fundal height measured 35centimetres and gestational age of 36 weeks.

On fundal palpation: Upon facing the head of the woman on her right hand side, the fundus was palpated with both palms and the foetal buttocks were felt.

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

On pelvic palpation: Upon facing the woman's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and in wards, the head was palpated. The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

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

On Auscultation; A fethoscope was placed at the back of the foetus to listen to the foetal heart sounds whiles comparing it with the maternal pulse; foetal heart beat was 136 beat per minute**.**

On vulva examination; Permission was sought to examine the vulva and it was granted. Hands were washed under running water with soap and dried with a clean towel and gloves were put on. The mons pubis was already well shaved; there were no scars, oedema, varicose veins and genital warts. Also, there was evidence of good vulva hygiene so she was applauded for that and was asked to continue with it. She was educated to wear cotton panties and avoid douching to prevent infectioms. Madam Suah was asked to lie laterally and sit up before getting out of the couch. She was congratulated for allowing the procedure to be done on her. Hands were washed and dried and all findings were communicated to her and recorded in her antenatal book.

She complained of lower abdominal pains which she thought would affect the baby during delivery and puerperium. She was reassured and educated that it was due to the pregnancy since the fetus is engaging into the pelvis thereby exerting pressure on other organs and nerves in the sacral region. She also complained of waist pain, and it was explained to her that it was due to the relaxation of the joints of the pelvic bone by pregnancy hormones and she was educated to bend from the knees and also rest in between activities. She was thanked for her cooperation. The stages

and true signs of labour were explained to her. That is first, second, third and fourth stages also show, painful rhythmic uterine contractions respectively. Madam Suah was educated to report to the clinic if she sees any of these signs.

She was served with below routine drugs;

- Tab Ferrous Sulphate 200mg 1daily for 30 days
- Tab Folic acid 5mg 1daily for 30 days

She gave me directions to her house and contacts were exchanged so that she can be visited at home. Madam Suah having agreed to be used for the study, arrangement was made to visit her house on the 5th of November, 2021 She was thanked and seen off to the entrance.

2.2 FIRST ANTENATAL HOME VISIT

On the 5th of November 2021at 4:30pm Madam Suah was visited at home. The main goal was to know where she lives and also talk about birth preparedness and complication readiness plan. The house was a bit far from the clinic. Madam Suah was very glad for the visit. Seat and a glass of water were offered after which interaction with her started. Introduction was made once again. The house is built with blocks and roofed with aluminum sheets. There are three rooms in the house of which Madam Suah and her husband occupies one. The house is painted green from the outside and white inside. Their surroundings were neat. The used water from the bathroom drains through a canal into a small gutter purposely created for the draining water and is poured out. She brought out the Items for delivery for inspection and it was neatly arranged and complete. She was congratulated for purchasing all the necessary items for the impending labour and she was advised

to add her National Health Insurance and keep some amount of money that will be needed for some things during the period of labour, which may not be settle with the NHIS.

Madam Suah was educated on the signs of labour, and the process of labour. She was also educated on the intake of a well- balanced and nutitious diets, the importance of having enough rest, lifting of light loads instead of heavy ones and wearing of loose cloths and low heel shoes as well. She was educated on the essence of practing exclusive six months breastfeeding and environmental and personal hygiene education was also given. Her husband arrived just as the discussion was about to be concluded and he was educated on the signs of labour and also the danger signs that when he sees from his wife that he must rush her to the hospital immediately. He was encouraged to give a helping hand to reduce tiredness and promote adequate rest and sleep. She was informed about the next visit which was on the 10th November, 2021. Permission was sought to leave. She was very grateful .She was thanked for her co-operation and willingness to adhere to the pieces of advice given.

2.3 SECOND ANTENATAL HOME VISIT

On the 10th November, 2021, Madam Suah was visited as she was promised. A cheerful welcome was given by the client. After pleasantries were exchanged, It was inquired how she is doing and the foetus as well. She was asked if she had been feeling some foetal movements and she said yes, enough of them. She complained of constipation, profused vaginal discharge and frequency of micturation but she was reassured and explained to her the physiological changes that occur in pregnancy and she was told it will disappear soon after delivery. Enquiries were made to know if the vaginal discharge was offensive or itchy but she said it was not offensive and itchy, so she was encouraged on good perineal hygiene and the use of panty liners and also washing and dyring panties in the sun or ironing them.

Madam suah was reminded on the true signs of labour. She was thanked for her co-operation. Permission was sought to leave

2.4 SUBSEQUENT VISIT TO THE ANTENATAL CLINIC

Madam Suah reported to the antenatal clinic on 17th November, 2021 around 10:00am. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature	-	36.5^{o}C
Pulse	-	80bpm
Respiration	-	21cpm
Blood pressure	-	120/70mmHg
Weight	-	104 kg

Madam Suah was asked to empty her bladder; midstream urine sample was tested for protein and glucose which were trace and negative respectively.

She was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination symphysio–fundal height was 37cm, her gestational age 38weeks, lie was longitudinal, presentation was cephalic with a descent of 5/5th above the pelvic brim. On lateral palpation, the position was right occipito-anterior. On auscultation; the fetal heart rate was 147bpm with regular rhythmic and good volume.

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

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

PROBLEMS IDENTIFIED DURING ANTENATAL PERIOD

On 8th April, 2021 Client complained of:

1. lower Abdominal Pain

On 7th May, 2021 Client complained of:

2. Waist Pains

On 5th August, 2021 Client complained of:

3. Constipation

On 13th September, 2021 Client complained of:

1. Non- offensive vaginal Discharge

On 3rd November, 2021 Client complained of :

5.frequency of micturition

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains within 48hours.
2. Client's waist pain will reduce within 48hours.
3. Client will have her normal bowel movement (at leas twice daily) within 24 hours.
4. Client will understand the reason behind the vaginal discharge within 48hours
5. Client will understand the physiology behind the frequency of micturation within 3 hours.

LONG TERM OBJECTIVE

Client will go through pregnancy successfully without any complication to mother and the fetus.

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
08/04/21 at 10.00am	Lower abdominal pains related to descent of the foetal head.	Client will cope with lower abdominal pains within 48hours as evidenced by client verbalizing that her pains has reduced. Midwife observing smiling facial expressions	1. Reassure client that her pain would be subsided after intervention. 2. Explain the cause of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client's sister to help client with household chores.	1. Client was reassured that her pain would be subsided. 2. Client was thought that the pain is due to pressure on the bladder and nerves of the pelvis. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client's sister helped client with household chores like sweeping and washing.	10/04/21 at 10.00am	Goals fully met as evidenced by client verbalizing that her lower abdominal pains has been subsided after intervention was given.	

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
7/05/21 at 10:00am	Waist pain related to relaxation of the pelvic joints due to actions of pregnancy hormones.	Madam Suah's waist pain will reduce within 48hours as evidenced by: Client verbalizing that she is being familiar with the waist pain. Midwife visualizing client expressing low pain after performing activities.	1. Reassure client that she will be relieved of waist pain. 2. Encourage her to always bend on the knee and not from waist. 3. Teach husband on how to do sacral massage for Madam Suah. 4. Encourage her to take enough rest in between activities. 5. Administer prescribed analgesic(paracetamol 1g).	1. Client was reassured that she will be relieved of waist pain. 2. She should bent from the knee and not from the waist. 3. Husband did sacral massage for client. 4. She took enough rest in between activities. 5. Prescribed analgesics were administered. (paracetamol 1g).	7/05/21 at 10:00am	Goal fully met as evidenced by client verbalized that waist pain has reduced and she is coping.	

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
05/08/21 at 10:00am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large bowel during pregnancy.	Client will gain her normal bowel movement within 24 hours as evidenced by Client verbalizing that she was able to pass stools (twice daily). Stating that she is relief of discomfort of constipation.	1.Reassure Madam Suah that she will have a free bowel. 2. Explain the physiology of constipation to her. 3. Encourage client to take at least 8 glasses of water daily. 4 .Educate client on the intake of roughages. 5. Encourage her to perform both active and passive exercises such as dancing and walking.	1. Client was reassured that she will have free bowel. 2.The physiology of constipation was explained to the client . 3. Client took about 8 glasses of water daily. 4.Client took a lot of roughages such as vegetables and fruits. 5. Client performed active and passive exercises such as dancing and walking.	06/08/21 at 10:00am	Goal fully met as evidenced by client verbalizing that she passed stool twice daily and relieved from discomfort of constipation.	

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/09/21 at 8:00am	Profuse vaginal discharge related to increased vascularity and mucus production of the genital during pregnancy.	Client will understand and cope with the profuse vaginal discharge within 48 hours as evidence by client verbalizing that she is coping and midwife noting that client is not complaining.	1. Reassure client that the discharge will reduce. 2. Explain the physiology of vaginal discharge to client. 3. Encourage client to wear cotton panties to allow aeration. 4. Encourage client to practice good personal hygiene to avoid the incidence of genital tract infections. 5. Instruct client to change panties frequently. 6. Encourage client to dry panties in the sun if possible or iron them before using.	1. Client was reassured that the discharge will reduce. 2. Client was taught that it was due to hormonal influence on the vagina. 3. Client wore cotton panties to allow absorption and aeration. 4. Client practiced good personal hygiene like washing her panties regularly and taking good care of the perineum 5. Client applied panty liner all the time 6. Client dried panties in the sun or ironed them to reduce the rate of infections when it was possible.	15/09/21 at 8:00am	Goal fully met as evidence by client verbalizing that her amount of vaginal discharge has reduce.	

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
03/11/21 at 10:00am	Frequency of micturition related to the growing uterus exerting pressure on the bladder.	Client will understand the reason for the frequency of micturition within 3 hours as evidence by client verbalizing: She is coping with the frequency of micturition. Midwife observing that client complains less of the frequent voiding.	1.Reassure client and remind her of the physiology of the frequency of micturition. 2. Encourage her to lean forward when voiding to help empty her bladder. 3. Encourage her to urinate immediately she has the urge. 4.Educate her on the use of panty liners. 5.Educate client on how to tightening the muscles(kegel exercise) around her vagina and anus.	1. Client was reassured and reminded the frequency of micturition is due to pressure on the bladder. 2 .She leaned forward when voiding. 3. Client urinated immediately when she has the urge. 4. Client used panty liners. 5. Client understood what was taught on how to tighten the muscles around the vagina and anus.	03/11/21 at 1:00pm	Goal fully met as evidence by client verbalizing that she has been relieved of frequency of micturition.	

CHAPTER THREE

INTRODUCTION

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

3.0 LABOUR

ADMISSION AND MANAGEMENT OF LABOUR

ADMISSION OF CLIENT

Madam Suah reported to Koranteng Maternity Home with her sister on the 23rd November, 2021 at 10:30am which was Tuesday with complains of waist and lower abdominal pains and a blood stained mucoid discharge from the vagina. They were warmly welcomed and were offered seats. Her antenatal card was collected and quickly a glance through her obstetric history with the midwife in- charge was made. Labour history was taken and according to her, she experienced severe lower abdominal and waist pains on the 22nd November, 2021 around 5:00pm. She and her sister were reassured and the sister was asked to wait at the reception. Her items for the delivery were collected and labelled. Madam Suah complained of lower abdominal pains. She was reassured and it was explained to her that it was engagement of the fetal head which was putting pressure on the sacral nerves. She was asked about the last meal, bowel action and any drugs taken since she started experiencing the pains. She was made comfortable in bed and all procedure to be carried out was explained to her and her permission was sought. She was reassured that she was in the hands of competent staffs. She was reminded on the physiology of the stages of labour was explained to her. She was then encouraged to ask questions which she did and tactful answers were provided. Her vital signs were checked and recorded as follows;

Temperature	-	36.2°C
Pulse	-	80bpm
Respiration	-	20cpm
Blood Pressure	-	120/70mmHg

Other observation recorded as

Hemoglobin	-	12.0g/dl

3.1 MANAGEMENT OF FIRST STAGE OF LABOUR

The Procedure for the abdominal and vaginal examination was explained to client. She was taken to the labour room and offered a bedpan to empty her bladder. The quantity of urine was 130 millimitres. The midstream urine was tested for protein and glucose and it was negative for both. She was reassured and all procedures to be carried out on her were also explained to her. She was helped onto the bed and pillow was put under her head. Hands were washed thoroughly with soap and water and dried with a clean dry towel. Permission was sought to examine her after emptying the bladder. Head to toe examination was done. The conjunctiva was checked for pallor, the skin for rashes, the leg for varicose veins and the feet for edema but no abnormality was detected. Inspection of the breast was done to check for any abnormality which might interfere with breastfeeding of the baby.

On abdominal examination, the abdomen was ovoid in shape and medium in size and there were no scars or rashes on it. The procedure was carried out since she had emptied the bladder earlier.

On fundal palpation, standing at the right hand of the woman whiles facing her head, the two palms were rubbed together and gently the fundus was palpated. The upper pole of the uterus was occupied with the buttocks of the foetus.

On lateral palpation the limbs of the foetus were palpated on the left side of the mother and back palpated at the right side of the mother.

Facing the woman's feet and still on the right side, pelvic palpation was done and the fetal head occupied the lower pole of the uterus. Descent was $4/5^{th}$ she was monitored every 4 hours.The symphysio-fundal height was measured from the fundus to the symphysis pubis and it was 37 cm and the gestational age was 38weeks. The foetal position therefore was right occipito- anterior.

On auscultation, the fetoscope was warmed and placed at the back of the foetus and each heart beat was counted for a period of one minute and in all 142 beats per minute were recorded with regular rhythm and was monitored every 30 minutes.

Contractions were timed for ten minutes and recorded as 3:10 lasting for 24seconds was monitored every 30 minutes which was being recorded on the partograph.

Procedure for vaginal examination was explained to Madam Suah. A mackintosh and towel was placed under Madam Suah's buttocks while and she was in a dorsal position with knees flexed. Hands were washed under running water with soap and dried with a clean dry towel and a sterile gloves was put on. Client was encouraged to part her legs. The vulva was clean and normal with varicose veins or oedema and also it was inspected for episiotomy scars, warts, sores and offensive whitish vaginal discharge with no itching was observed. The vulva was cleaned with sterile cotton

wool swabs soaked with savlon. With strokes from upwaerds to downwards starting with the labia, labia minora and the vestibule, the vulva was cleaned.

On vaginal examination, the vagina was warm and moist. The cervix was soft, thin, effaced and the presenting part well applied to the cervix. The cervical dilatation was 4centimeters and was also monitored 4 hourly. No moulding was noticed, no offensive odour. The sacrum was well curved. The sacral promontory was not reached, the Ischia spines were blunt. A fist was made and it fitted into the intertuberous angle. The perineum was cleaned and a clean pad was applied to the vulva. The gloves were immersed into 0.5% chlorine solution. Gloves were removed by turning them inside out and were disposed into a polythene bag placed in a blue plastic container. Hands were thoroughly washed with soap and under running water and dried with a clean towel. She was helped to lie on her left side. The findings were recorded on the partograph and progress of labour was explained to her. Soon after delivery client complained of waist pain, she was reassured that she would be relieved of waist pain. Client was encouraged not to sit for a very long period but encouraged to walk around also sacral massage was given. Madam Suah was encouraged to lie on her left side to prevent supine hypotensive syndrome if she wants lie down. She was also encouraged to pass urine frequently and change her perineal pad when soiled to prevent genital tract infection. Client was informed about the progress of labour and findings were recorded on the labour chart. She was told to assume any position comfortable to her but should not lie on the right side for long. Dilatation was explained to her using the dilatation board. Foetal heart rate, contractions and pulse were monitored every 30 minutes. Cervical dilatation, descent of the foetal head, moulding, membranes, blood pressure and temperature were also monitored every 4 hours.

At 11:00am

Cervical dilatation	4cm
Descent	4/5th
Contractions	3 in 10 lasting 24 seconds
Moulding	no moulding
Fetal heart rate	142
Membranes	intact
Blood pressure	120/80mmHg
Temperature	36.6^{o}C
Pulse	85cpm
Urine	130ml
Protein/Acetone	negative

At 11:30 am

Fetal heart rate	144
Contractions	3 in 10 lasting 40 seconds
Pulse	84 cpm

At 12:00pm

Fetal heart rate	150bpm

Contractions 4 in 10; 48 seconds

Pulse 84cpm

At 12:30pm

Fetal heart rate 144

Contractions 4 in 10; 50 seconds

Pulse 84cpm

At 1:00pm

Fetal heart rate 140

Contractions 4 in 10; 48 seconds

Pulse 85cpm

At 1:30pm

Fetal heart rate 137

Contractions 4 in 10; 48 seconds

Pulse 83cpm

At 2:00pm

Fetal heart rate 148bpm

Contractions 4 in 10; 50 seconds

Pulse 87bpm

At 2:30pm

Heart rate 130bpm

Contractions 4 in 10; 50 seconds

Pulse 82cpm

At 3:00pm

Vaginal examination was repeated and the cervix was 8cm dilated, with bulging membranes, vagina was moist and warm, moulding was (+), urine output was 110mls, acetone and protein were both negative.

Vital signs and other observations were checked and recorded as

Temperature - 36.4 degrees Celsius

Pulse - 84beats per minute

Blood pressure - 120/70millimetre per mercury

Fetal heart rate - 140beats per minute

Descent - $2/5^{th}$

Contraction - 4 in 10 lasting for 43 seconds

3.2 PREPARATION FOR BIRTH

A helper was identified (The Midwife In Charge) to help and supervise the delivery. Emergency plan was also reviewed; thus calling of a taxi driver to help in transporting the client to referral center when the need be. Client was reminded that she will be assisted to wash her hands and chest when second stage is eminent to prepare for skin-to-skin care to prevent infections to the baby. The room was well lighted and a portable lamp was also in place in case of lights out. Preparation of the area for ventilation and checking of equipment was also done by preparing a dry, flat and safe space for receiving the baby for ventilation when needed was also prepared and equipment to help for the baby breathe were checked for their function. The items included the suction device, ventilation bag and mask, stethoscope, scissors, timer, head covering, clothes and gloves. Delivery set and emergency drugs were available when checked.

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

- Artery forceps
- Cord scissors
- Gallipot with cotton wool swabs
- Episiotomy scissors
- Receiver
- Drape

Lower shelf containing;

- Cheatle forceps and its container

- Identification band
- 3 cot sheets
- Cord clamp
- Perineal pad
- Bowl of water with penguin
- Bedpan
- Receiver for used swabs
- An oxytocin drug
- Container with syringes and needles
- Fethoscope
- Local Anasthesia
- Antiseptic Lotion
- Disposable gloves
- Catheter and drainage bag
- Mackintosh
- Sterile gloves

At 3:30pm

Heart rate	144bpm
Contractions	4 in 10; 50seconds
Pulse	82bpm

At 4:00pm

Heart rate	150bpm
Contractions	4 in 10; 44 seconds
Pulse	86 bpm

At 4:30pm, client complained of bearing down, she was positioned and vaginal examination done which confirmed full dilatation of the cervix, membranes ruptured spontaneously and vaginal examination was done to rule out cord prolapse, amniotic fluid was clear, moulding was (+ +) descent was $0/5^{th}$ and contractions were 4 in 10 lasting 50 seconds, feotal heart rate was 138 beats per minute, Blood pressure was 120/70, temperature was 36.4, pulse was 81beats per minute and urine output 120mls. Madam Suah shouted that she feels easing and wanted to push. In-charge was informed about the progress of labour and also asked to confirm findings and she said Madam Suah was fully dilated after confirming the vaginal examination which marked the beginning of second stage.

The active first stage lasted 5 hours, 58minutes under my care from 11:00am to 4:30pm.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Suah was transferred from the labour room to the delivery room where she was assisted to positioned herself in a lithotomy position. A gown, mackintosh apron, masks and boots were worn. After that, hands were washed with soap under running water and they were dried. Sterile gloves were worn. The midwife in-charge who was supervising, checked the foetal heart rate and maternal pulse after each contraction. The vulva, perineum, pubis and the inner thighs of the client

were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent faecal matter from contaminating the delivery field. Client was encouraged to push with just contraction to prevent exhaustion and rest in between contractions. Client was given oral fluid and reassurance and encouragement during each contraction was provided. Her perineum was shiny and over stretched, so she was told to follow the instructions so that tears would be prevented. Fingers of the right hand were placed on the advancing head to aid flexion in order to allow the smallest diameter to distend the perineum. Descent of the foetal head continued till it crowned. As soon as the baby's head crowned, she was asked to pant and give only small pushes with contraction to prevent rapid expulsion of the foetal head which could result in perineal tears and intra cranial injury. The sinciput, face and chin swept, the perineum and the head was delivered by extension. The mouth and nose were gently cleaned with sterile gauze. The eyes were wiped with sterile cotton wool swab from the inside out as well as the face. The neck was quickly felt for cord around it. The mother was reminded that the baby would be delivered unto her abdomen whiles waiting for restitution and external rotation of the foetal head. This was accompanied by internal rotation of the shoulders. With palm on each side of the baby's head, client was asked to push with the next contractions. The anterior shoulder was delivered by downwards traction on the head and the posterior shoulder swept the perineum to be delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 4:47pm, baby cried lustly immediately after birth.

3.4 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from the inner canthus out. The mouth and nose were also cleaned withsterile gauze to enhance patent airway. The umbilical cord was clamped about 2 centimeters away The baby

was dried and placed on the mother's abdomen to continue skin to skin and both were covered with a warm cot sheet to maintain warmth and prevent hypothermia.the baby's Apgar score was assessed at the first and fifth minutes were 8/10 and 9/10 respectively.

APGAR SCORE

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

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

Client still in the lithotomy position, the clamped and cut end of the cord was placed in a receiver in between the thighs nearer to the perineum to receive the placenta, membranes and blood loss after putting on a new sterile gloves. Cord was reclamped closer to the perineum and the cord with the artery forceps were held with the right hand. The left hand was placed on the fundus to check for contractions. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and the forceps were also held firmly at the same time and a downward steady traction was applied. The steady traction on the cord and the counter traction on the uterus was maintainedv until the placenta became visible at the vulva . The placenta was cupped by both hands and twisted gently to reduce pressure on the fragile membranes. The placenta and membranes were delivered completely at 4:58pm. A quick examination of the placenta was done to make sure that there were no retained products. The

placenta was placed in a receiver for a thorough examination to be done later. The uterus was massaged to expel clots The perineum was cleaned and gauze was used to wrap two fingers of each hand to inspect the vagina and cervix but no tear or lacerations were detected. Client was taught how to massage the uterus and was asked to feel for the contracted uterus. She was educated to change the pad when soiled, urinate frequently and report immediately when there is excessive bleeding. Madam Suah was cleaned off the liquor and blood with a clean pad after the examination. A new perineal pad was applied at the vulva and she was made comfortable. She was asked to cross her legs to keep the perineal pad in position. Client was monitored at the second stage room for an hour before transferring to the lying-in. During that time baby was put to breast to improve lactation and to help in contraction of the uterus and also to improve bonding between mother and baby.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was sent to the sluice room for thorough examination. The cord was situated at the middle of the placenta with two arteries and a big vein in the cord with no knot. The maternal surface of the placenta was intact with no missing lobe and was also checked for infarcts and it was dark maroon in colur. The membranes were examined for any blood vessels, and both the chorion and the amnion were separated to check whether they were intact and they were. The foetal surface was shiny grey in colour and translucent, intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss measured was 150 milliliters. After the examination the instruments were decontaminated in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinsed, dried and made ready for sterilization.

She was asked to urinate when she had the urge for the uterus to contract and was told that if she should feel any changes, she should not hesitate to report. She expressed gratitude for the patience and care and she was inturn thanked for her cooperation.

3.7 PREVENTION OF DISEASES

Cord was dressed with Chlorhexidine gel. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorders. Tetracycline Hydrochloride 1% ointment was applied on each eye to prevent eye infections. Hands were washed under running water with soap and dried with a clean towel. Mother was also given vitamin A and was educated to wash her hands before and after breastfeeding the baby. it was further encouraged to breastfeed baby on demands at least (8-12 times per day).

3.8 EXAMINATION OF THE BABY

The procedure was explained to Madam Suah then hands were washed with soap and water and dried with a clean towel. Disposable gloves were put on and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. A detailed head to toe examination was carried out to detect any abnormality. The head was examined for bulging fontanelles, size and shape, oedematous swelling that is caput succedaneum and lacerations, 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 32cm.

The ear was examined for alignment, shape, size and patency and the cartilage in the pinna was checked for its softness. Eyes were also examined for colour, redness and conjunctiva 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. For the mouth, the little finger was used to feel the palate for any submucousa cleft then the gum was checked for presence of false teeth and the tongue for tongue tie and no cleft lip was observed. No abnormalities were detected. Sucking, rooting and swallowing reflexes were checked and found present.

The neck was examined for congenital goiter, swelling, growth and rigidity of the neck but no abnormality was present. The chest was inspected for shape and the chest wall for movement and expansion. Breasts were palpated for lumps and the nipple was checked for position and witches' milk and everything was normal. Apex beat was present (132 bpm).

Examination of the upper extremities was done and the hands were inspected for clubbing, extra or missing digits, nails over growth and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected and reflexes (grasping, moro) checked. Everything was normal.

The abdomen was inspected and the size and shape was normal. The cord was inspected for bleeding and signs of infection and two arteries and a vein were found. The liver, spleen, and bladder were not palpable, no tenderness and masses but no abnormality was detected.

The genitalia was examined, and they were well developed thus the vulva and the urethral meatus for location, and they were all in their rightful position. The anus was patent on palpation, while the baby also passed meconium and urine. With the lower limbs, the legs and feet were inspected for extra digits, webbing, symmetry, movement, clubbed feet, paralysis, but no abnormality was

found. The hip had no dislocation and the reflexes (knee jerk/patella, plantar) were present. The baby was turned on his back with the head turned on one side and the spine was checked for swelling, dimples or hairy patches (spinal bifida), and for missing vertebra, meningomyelocele, but no abnormalities were detected. On examination of the skin, there was no abnormality found. The gloves were removed and disposed off, hands were washed and dried with clean dry towel. Findings were then communicated to the mother and documented as well.

3.9 MANAGEMENT OF THE MOTHER AND BABY

Madam Suah and her baby were transferred into the lying-in room, made comfortable and also congratulated for her co-operation. Uterus was felt if contracted. The uterus measured 17cm and her vital signs together with bleeding were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour, 1 hourly till the end of the 6 hours. The baby's condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. The first post-delivery vital signs were checked and recorded as follows; and the rest recorded on the partograph.

Temperature - 36.5 degree Celsius

Pulse - 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 120/70 millimeters per mercury

She was advised to empty the bladder frequently to prevent postpartum complications such as postpartum haemorrhage. She was educated on personal hygiene and exclusive breastfeeding.

3.10 CONDITION OF MOTHER

Blood pressure - 120/800 millimeters per mercury

Fundal height - 17 centimeters

Uterus - Contracted

Lochia - Red (rubra)

Urine output - 100mls

Mother's condition was good.

3.11 CONDITION OF BABY

Sex - Female

Birth weight - 3.2 kilograms

Length of the baby - 42centimeters

Head circumference - 32 centimeters

Apgar Score

First minute score - 8/10

Fifth minute score - 9/10

Meconium - Passed

Urine - Passed

Baby's condition was very good.

3.12 DURATION OF LABOUR

Duration of first stage	-	5hours 30mins
Duration of second stage	-	17 minutes
Duration of third stage	-	11minutes
Total duration of labour	-	5 hours 58 minutes

3.13 NURSING CARE PLAN ON LABOUR
PROBLEMS IDENTIFIED

On 23rd November,2021 Client was observed being:

1.Anxious

0n 23rd November, 2021 Client complained of:

2. Lower abdominal pains

3. Waist pain

4. Fatigue

5. Possible perineal trauma

SHORT TERM OBJECTIVES

1. Client will be relieved of anxiety after knowing the outcome of labour within 30minutes.
2. Client will understand and cope with lower abdominal pains within 2hours.
3. Client will cope with waist pains within 30minutes.

4. Client's fatigue will resolve within 30minutes.

5. Client will have intact perineum within 45minutes and to the end of the delivery.

LONG TERM OBJECTIVE

Client will go through labor successfully and deliver an alive baby without complications to both mother and baby.

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 4:30pm	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 30minutes as evidenced by client verbalizing that she is no more anxious of the outcome of labour Midwife observing calm tone in client's speech.	1. Reassure client that she is in the hands of competent staff. 2. Explain the physiology of the stages of labor to client. 3. Allow client to ask questions and answer them tactfully. 4. Communicate findings to client. 5.Introduce client to other staffs	1. Client was reassured that she was in the hands of competent staff so labour will be successful without any complications. 2. The physiology of the stages of labour was explained to client in simple terms. 3. Client asked questions and appropriate answers were given. 4. Findings were communicated to client about the progress of labour such as cervical dilatation and descent. 5.Client was introduced to other staffs.	23/11/21 at 05:00pm	Goal fully met as client expressed a relaxed face and verbalized that she is relieved.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 3:00pm	Lower abdominal pain related to strong expulsive uterine contractions.	Madam Suah will cope with lower abdominal pain within 2hours as evidenced by Client verbalizing she is coping with the pain.	1. Reassure Madam Suah and explain physiology to her. 2. Provide diversional therapy. 3. Encourage client to adopt a comfortable position. 4. Encourage and supervise client to practice deep breathing exercise during uterine contraction. 5. Give Madam Suah a sacral massage to relieve pain.	1. Madam Suah was reassured and told that it is due to the uterine contractions. 2. Client was engaged in conversation during labor. 3. Client adopted a comfortable position like lying in a left lateral position to reduce pain. 4. Deep breathing exercises were preformed. 5. Sacral massage was given to Madam Suah when there were contractions.	23/11/21 at 5:00.pm	Goal fully met as Madam Suah verbalized that she coped with labor pains.	

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 4:30pm	Waist pain related to descent of the fetal head.	Client will be to cope with waist pain within 30minutes as evidenced by client verbalizing that she no longer has waist pain. Midwife observing client coping with waist pains.	1. Reassure client that she would be relieved of waist pain. 2. Encourage client not to sit for a very long period. 3.Give sacral massage to relieve her of pain. 4. Explain the physiology of waist pain to client. 5. Encourage deep breathing exercise along contraction.	1. Client was reassured that she would be relieved of waist pain. 2.Client sit for short period and walked around. 3. Sacral massage was given to client to relieve her of pain. 4. client was enlighetened the waist pain is due to pressure on the sacral nerves and give of the pelvis. 5. Madam Suah was assisted to perfomdeep breathing exercises.	23/11/21 at 5:00pm	Goal fully met as evidenced by client verbalizing that she is relieved from her waist pain.	

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 4:30pm	Fatigue related to pain and stress of labor.	Madam Suah's tiredness will resolve within 30minutes as evidence by: Client verbalizing that she feels less tired. Midwife observing Madam Suah being active during labor.	1. Reassure client that she would be relieved of fatigue. 2. Encourage client to rest in between uterine contractions. 3. Explain to her why she feels tired and be sure she understands and allow her to ask questions and answer them tactfully. 4. Encourage client to practiced deep breathing exercise. 5.Hydrate Client orally.	1. Client was reassured that she would be relieved of fatigue. 2. Client was seen resting in between uterine contractions to prevent further exhaustion. 3. Education on fatigue was given to client and she knew it was normal for her to be tired during labor. 4. Client was seen practicing deep breathing exercise. 5. Oral fluid (water) was given to client to hydrate her.	23/11/21 at 5:00pm	Goal fully met as evidence by Madam Suah verbalizing that she feels less tired. Midwife observing that client was active during labor.	

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 4:30pm	Potential for perinea trauma (over stretched and shiny perineum) related to delivery process.	Client will have an intact perineum after delivery as evidence by midwife observing an intact perineum.	1. Reassure client that she would have an intact perineum after delivery. 2. Confirm full dilatation of cervix before instructing client to push. 3. Deliver clent skillfully following the mechanisms labour. 4. Instruct client on when to push and when to relax. 5. Encourage client to adhere to all instructions given.	1. Client was reassured that she would have an intact perineum afte r the delivery. 2. Cervix was confirmed fully dilated before client was instructed to push in other to prevent any perineal tears. 3. Flexion was maintained until head crowned. Also client was asked to pant for head to be delivered slowly. 4. Client pushed when she has the urge and relaxed in between contractions in other not to sustain tears. 5. Client was encouraged to adhered to instructions given.	23/11/21 at 5:00pm	Goal fully met as evidenced by midwife observing an intact perineum after delivery.	

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 second postnatal visit (six weeks postpartum).

4.1 DAY OF DELIVERY

Madam Suah came to the Koranteng Maternity Home labour wad around 10:30am on the 23rd November; 2021. She had a supervised vaginal delivery around 4:47pm to a baby girl with Apgar score 8/10, 9/10 within the first and fifth minutes respectively. 10units of oxytocin was injected intramuscularly on her thigh after delivery of the baby. Placenta and membranes were completely deliverd by control cord traction around 4:58pm. Estimated blood loss was 150mls.

She was made comfortable in bed with her baby and was allowed to rest in the labour ward for about an hour for observation. She was later sent to the fourth stage room and made comfortable for six hours with close observation and monitoring. Breastfeeding was initiated. The mother's vital signs, contraction of the uterus and lochia were monitored every 15minutes for the first hour, 30 minutes for the next two hours and hourly for the next three hours.

Physical examination was carried out on the mother to rule out any abnormality. The purpose of head to toe examination was explained to her. She agreed and Madam Suah was examined from head to toe and no abnormality was detected. Client was taught to do postnatal exercises such as the Kegel's exercise and encouraged to ambulate early to prevent thrombosis formation and severe abdominal pains and also to empty her bladder frequently , change her perineal pad frequently and

must wash her hands after changing each pad and report quickly in case of heavy bledding. She was served with a warm milo and observatons continued. The symphysio fundal height was measured to be 17 centimeters.

Temperature	-	36.4ºC
Pulse rate	-	80bpm
Respiratory rate	-	20cpm
Blood pressure	-	120/70mmHg

Baby was examined from head to toe and no abnormality was detected. The skin colour was pink, respiorations were normal and baby could suckle and there was no bleeding from the cord. The baby was then given vitamin k 1mg intramuscular injection to prevent any bleeding tendencies.

Madam Suah was encouraged to eat good, nutritious 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 kegel. She was then informed of possible discharge the following day which was on 24th November, 2021.

SUBSEQUENT CARE OF THE BABY

4.2 EXAMINATION OF THE BABY

A detailed head to toe examination was carried out to detect any abnormality. The head was examined for bulging fontanelles, size and shape, oedematous swelling that is caput succedaneum and lacerations, 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 32cm.

The ear was examined for alignment, shape, size and patency and the cartilage in the pinna was checked for its softness. Eyes were also examined for colour, redness and conjunctiva 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 and congestion and the mucosa for colour and polyps and they were all normal. For the mouth, the little finger was used to feel the palate for any submucousa cleft then the gum was checked for presence of false teeth and the tongue for tongue tie and no cleft lip was observed. No abnormalities were detected. Sucking, rooting and swallowing reflexes were checked and found present.

The neck was examined for congenital goiter, swelling, growth and rigidity of the neck but no abnormality was present. The chest was inspected for shape and the chest wall for movement and expansion. Breasts were palpated for lumps and the nipple was checked for position and witches' milk and everything was normal. Apex beat was present (132 bpm).

Examination of the upper extremities was done and the fingers were inspected for clubbing, extra or missing digits, nails over growth and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected and reflexes (grasping, moro) checked. Everything was normal.

The abdomen was inspected and the size and shape was normal. The cord was inspected for bleeding and signs of infection and two arteries and a vein were found. The liver, spleen, and bladder were not palpable, no tenderness and masses but no abnormality was detected.

The genitalia was examined, and they were well developed thus the vulva and the urethral meatus for location, and they were all in their rightful position. The anus was patent on palpation, while the baby also passed meconium and urine. With the lower limbs, the legs and feet were inspected for extra digits, webbing, symmetry, movement, clubbed feet, paralysis, but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/patella, plantar) were present. The baby was turned on his back with the head turned on one side and the spine was checked for swelling, dimples or hairy patches (spinal bifida), and for missing vertebra, meningomyelocele, but no abnormalities wer e detected. On examination of the skin, there was no abnormality found.

Baby's vital signs were checked and the findings were communicated to the mother and documented as follows:

Head circumference	-	32 centimeters
Length	-	48 centimeters
Weight	-	3.2 kilograms
Apex beat	-	140 beats per minute
Temperature	-	36.0 degree Celsius
Respiration	-	40 cycles per minute

4.3 BABY'S FIRST BATH

Baby had her first bath after 6 hours of birth. Mother was informed that baby was going to be bathed so should come and observe so that she could do same after discharge. Items to be used for the procedure were assembled.

Top shelf contained;

- Sterile cotton wool swabs and gauze in a gallipot
- Sterile water in a gallipot

Lower shelf contained

- Sponge
- Towel
- Soap
- baby oil
- vasseline
- comb
- dress
- socks
- hat
- diappers
- a clean dry cot sheet
- cotton wool swab
- Chlohexidine gel for cord dressing
- 2 basins for the water
- a jug

Baby was kept on a safe place while the water for the bathing was mixed and the temperature was tested using the elbow. Plastic apron was put on, hands were washed and a sterile gloves worn. Baby was placed on a flat surface, the cot sheet was opened and baby was undressed and upon a

quick glance, baby had no abnormalities. The eyes were cleaned with sterile cotton wool swabs soaked with normal saline from the inner canthus outwards. The face was cleaned with wet towel and dried. While supporting the nape of the neck, the ears were plunged with the thumb and index finger to prevent water from entering the ears. The head was then washed with a mild soap and water. The hair was rinsed and dried with a clean towel. The rest of the body was washed with soapy sponge and water, paying attention to the skin folds of the armpit, groin and buttocks. Baby's back was washed by supporting the chest with the arm. The baby passed meconium and urine indicating that urethra and anus were patent. The baby was then immersed into a basin of water with head above water level and thoroughly rinsed. She was then placed on a big towel and dried with a small towel paying attention to the skin folds. Baby oil was smeared on the body and vaseline on the hair and combed. She was then dressed and wrapped in a dry cot sheet but the cord was exposed. Baby's cord was dressed using chlohexidinegel and exposed for some time for it to dry.

Madam Suah was also taught good position and attachment of the baby to breast. After that baby was placed beside the mother to breastfeed. The mother was educated not to apply cow dung and other items on the cord with the exception of chohexidine gel that will be given to her.

4.4 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

Mother and baby were seen in the lying- in ward at 7:30am to find out how they were doing. Greetings were exchanged and Madam Suah was asked about how they were doing and she said they were both doing very well, except that she had lower abdominal pains (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 of the baby triggers the release of oxytocin which causes uterine contractions and therefore causes lower abdominal pains. She was given paracetamol 1g

to reduce the pain. Madam Suah also complained of less sleep because the baby cried a lot during that night. She was advised to attend to the baby whenever she cries in the night and have enough sleep when the baby is asleep. She was urged to change baby's diapers when soiled. She had already emptied her bladder so a puerperal assessment was then made on her. The hair was inspected for dandruff and lice, conjunctiva was inspected for sign of anaemia and jundice but they were all absent. The breasts were lactating slightly. The uterus had contracted and the symphysio fundal height measured 17cm. The perinea pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive smell. She was given capsules vitamin A 200,000IU to take and another one for the next day.

Madam Suah's vital signs were checked and recorded as follows;

Temperature - 36.5 degree Celsius

Pulse - 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 120/70 millimeters per mercury.

Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanels, it was explained to her that the fontanels closes naturally. Baby's cord was dressed with chlorhexidine gel.

Baby's vital signs were taken and recorded as follows;

Temperature 36.4 degree Celsius,

Pulse 120 beats per minute,

Respiration	45 cycles per minute.
weight	3.1 kilograms

The baby was given Bacilli Calmette Guerin (BCG) 0.05ml intradremal on the right upper arm for protection against tuberculosis and two drops of oral Polio vaccine against poliomyelitis. The mother was asked not to rub the injection site. 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. The opportunity was taken to prepare them towards discharge in the presence of her relatives and her haemoglobin checked to be 12.1g/dl. Madam Suah and family were encouraged to come back to the hospital for the 7th day for postnatal visit to the clinic for assessment to ensure no abnormality has risen within this period. They were also told to report to the facility quickly if they notice any abnormality with the baby or the mother. Client was also told to register the baby at the birth and death unit and complete all the immunization schedules at the Child Welfare Clinic. Routine drugs were collected and served. The client was on the National Health Insurance Scheme so no bills were settled.

She was assisted by her sister, to pack her belongings. Prescribed drugs were given to her for the subsequent days as below;

Tablet paracetamol	1g tds for 3/7
Tablet folic acid	5mg daily for 7/7
Tablet Multivitamin	200mg tds for 7/7
Capsules vitamin A	200,000 IU for the next day

The dosage and time for taking the drugs were explained to her and she was educated to take them

as ordered. Madam Suah 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 11:00am and was escorted with her items into a car brought in by her husband. They were reminded of the visit to their house and bid them farewell.

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

Mother and baby were visited in the evening at 5:30pm and they were all doing good. Mother was doing better on inspection and her vital signs were checked and were within the normal range. She was examined from the head of which the hair was kept neat, the conjuntiva was red indicating no signs of jaundice and anaemia. The breast was normal and it was flowing with colostrum. The uterus had contracted and the perineal pad was inspected of which the lochia appeared to be bright red (rubra).

Upon the assessment of the baby it was observed that the baby was looking normal with a good suckling reflex, the abdomen was slack with no bleeding from the cord. Baby had passed urine and meconium. Mother and baby's vital signs were checked and recorded as follows;

MOTHER

Temperature	$36.7^{O}c$
Pulse	85bpm
Respiration	20cpm
Blood Pressure	120/70mmHg
Fundal height	16cm

BABY

Temperature	$36.5^{O}c$
Pulse	135bpm
Respiration	47cpm
Weight	3.1kilograms

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

4.5 SECOND DAY POST NATAL HOME VISIT

Madam Suah was visited in her house in the morning at 7:30am as scheduled on the 25th November, 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 bathed; the baby was then toped and tailed. The vital signs of the baby was checked and then she was bathed and dresed nicely. The cord was dressed with the chlohexidine gel. Baby had passed stool and meconium.

Madam Suah was also examined from head, and there were no abnormal changes but she complained of back pain. The fundal height measured 15cm. The perineum was inspected and was found to be cleaned, lochia was red (rubra) with moderate amount of flow. Her vital signs were taken and recorded as;

OBSERVATION	
Temperature	36.2 degree Celsius
Pulse	78beat per minutes
Respiration	21cycle per minutes
Blood pressure	110/70 millimeters of mercury

Baby was not pale but looking good and normal and was able to suckle well. Baby's vital signs were taken and recorded as follows;

OBSERVATION	
Temperature	36.5 degree Celsius
Pulse	120 beats per minute,
Respiration	44 cycles per minute
Weight	3.0 kilograms

Madam Suah was encouraged to exclusively breastfeed the baby on demands and observe baby's crying and sleeping pattern and change in stool. She was also advised to keep the baby warm and dry always. She was assured to be visited in the evening.

EVENING

Around 5:30pm mother and baby were seen in their house looking healthy. Greetings were exchanged where they offered a seat and enquiries were made about their well being and mother said they were doing good. Permision was sought from the mother in order to examine her and the baby. Hands were washed and the mother was examined from head to toe and everything was normal. Baby was also examined from head to toe and no abnormality was found. Vital signs for both mother and baby were taken and recorded as below;

OBSERVATION	EVENING
Temperature	$36.8^{O}c$
Pulse	80bpm
Respiration	21cpm
Blood Pressure	110/70mmHg
Fundal height	15cm

Baby's vital signs were checked and recorded as follows;

OBSERVATION	EVENING
Temperature	$36.0^{O}C$
Pulse	137bpm
Respiration	40cpm
Weight	3.0 kilograms

4.6 THIRD DAY POSTATAL HOME VISIT

On the 26th of November, 2021 around 7:30am, Madam Suah was visited as promised the previous day. Greetings were exchanged and a seat was offered. Enquiries were made about their general condition and she said they were doing well but client complained of pain on both breast. The procedure of head to toe examination was explained to her, permission was sought and she was examined head to toe. The hair, conjuntiva and mouth were found to be normal. During the examination the breast it was observed to be heavy and engorged which she admitted that it was painful and has caused her headache. She was told that it was as a result of improper attachment and incomplete emptying of the breast. She was encouraged to always wake the baby up to feed her and also proper positioning of the baby to breast allowing her to empty one breast at a time before changing to another breast.

Fundal height was measured and recorded as 14cm above the symphysis pubis. Perineal pad was inspected and the lochia was serosa with no offensive smell and with a moderate flow. Her vital

signs were checked and the findings were communicated to her and was recorded as;

OBSERVATION	MORNING
Temperature	36.2oc
Pulse	81bpm
Respiration	21cpm
Blood Pressure	120/70mmHg
Lochia	Serosa and moderate
Fundal height	14cm

Hands were washed and the baby was examined from head to toe and no abnormality was detected. Client's perrmission was sought to top and tail the baby and permission was granted. The mother was asked to observed the procedure so as to be able to do it herslf afterwards. Baby was topped and tailed; she appearred to be normal with no jaundice, and the cord was dressed with the Chorhexidine gel and the cord was exposed to dry. The baby passed urine and a dark green stool baby had a good sucking reflex. Her vital signs were checked and recorderd as follows;

BABY

OBSERVATION	MORNING
Temperature	36.5ºC
Apex heart beat	132bpm
Respiration	41cpm
Weight	2.9kilograms

Madam Suah was encouraged to do postnatal exercises like the kegel, eat a well balanced diet and have enough sleep a. She was also encouraged to practice exclusive breastfeeding which if properly done, it can be used as a family planning method (Lactational Ammenorreoa Method). She was encouraged to ask any questions if she has but she said no. Enquiry was made about the previous complains and she said she was doing fine. Her sister and the husband were asked to help client in her activities and also in the care of the baby. Permision was sought to leave and promised to come back in the evening was made.

EVENING

At 5:30pm, client client was visited. On arrival, she was breastfeeding the baby and had assume a good posture with the baby properly attached to the breast. Lactation was well established and she was congratulated as it will help reduce the breast engorgement. Client's home environment was noticed to be neat and she was congratulated for the good work done. She was examined from head, breast, the abdomen and the uterus and her perineal pad was inpsected for the lochia and the

flow was moderate and it was still rubra. Her vital signs were checked and recorded as;

OBSERVATION	EVENING
Temperature	36.8^{o}c
Pulse	80bpm
Respiration	21cpm
Blood Pressure	110/70mmHg

The baby's vital signs were checked and recorded as shown below. She was top and tailed and the cord was dressed and exposed to dry. The cord was dried and non-offensive on inspection. Baby passed stool and meconium.

OBSERVATION	EVENING
Temperature	37.0Oc
Apex heart beat	149bpm
Respiration	40cpm
Weight	2.9kilograms

Madam Suah was educated to eat adequate diet to help in the production of breast milk and also to enable her recover quickly from stress of pregnancy and labour. She was encouraged to take enough water to avoid constipation. Enquiries were made about the previous complains and she

said she was doing better. Permission was sought to leave.

4.7 FOURTH DAY POSTNATAL HOME VISIT

On the 27th of November 2021, a third day post delivery visit was made to Madam Suah's house at 7:30am in the morning. Mother and baby were doing well. Permission was sought to examine her from head to toe. Breasts were heavy and breast milk was flowing freely. Mother was encouraged to breastfeed the baby frequently to prevent the breast from engorging and also attach the baby well to the breast to prevent cracks in order to prevent sore nipples and infection of the breast. Symphysio fundal height was measured 13cm. Perineal pad was inspected and the lochia was observed to be pinkish- brown (serosa). The baby was top and tailed, she appeared to be normal without any discolouration, a good suckling reflex, the abdomen was slack. The cord was neatly dressed and was dry without bad any odour. The baby also passed brownish yellow stools and she passed urine as well. Mother and baby's vital signs were checked and recorded as follows;

MOTHER

OBSERVATION	MORNING
Temperature	$36.5^{O}c$
Pulse	80bpm
Respiration	20cpm
Blood pressure	120/60mmHg
Fundal height	13cm

BABY

OBSERVATION	MORNING
Temperature	$36.0^{O}c$
Pulse	137bpm
Respiration	41cpm
Weight	2.9kilograms

4.8 FIFTH DAY POSTNATAL HOME VISIT

Madam Suah and her baby were visited again on the 28th November, 2021, in the morning at 7:30am to continue with the postnatal care. They were physically examined and nothing abnormal was detected. The hair was neatly permed, no odour from the mouth and the conjuntiva was red with no signs of anaemia or jaundice. Symphysio fundal height measured 12cm. Lochia was pinkish- brown(serosa) on inspection, with no odour. Baby was bathed, and the general examination commenced. No abnormality was found. The cord was neatly dressed and had shrinked with no evidence of infection. The baby passed urine and dark yellow stools. Mother and baby's vital signs were checked and recorded as follows;

MOTHER

OBSERVATION	MORNING
Temperature	$36.7^{O}c$

Pulse	80bpm
Respiration	21cpm
Blood Pressure	120/70mmHg
Fundal height	12cm

BABY

OBSERVATION	MORNING
Temperature	$36.8^{O}c$
Pulse	140bpm
Respiration	49cpm
Weight	3.0kilograms

After the assessment everything w found normal. Permission was souht to leave and Madam Suah granted the permission to leave in the absence of question. She was very overwhelmed with the numerous visits. She was thanked for her cooporation as always.

4.9 SIXTH DAY POSTNATAL HOME VISIT

The fifth day postnatal home visit was on 29th of November, 2021. at 7:30am to continue with the post- natal care. Hands were washed and dried and the baby was examined after seeking mother's permission. No abnormality was detected on examination. The baby was then bathed and neatly

dressed. The cord had fallen off during the night as said by the mother. The umbilicus was inspected for bleeding or any abnormality but none was found. The stump of the umbilicus was dressed with the chlorhexidine gel and it was kept dry. Baby passed stool and urine as I observed. Client and her family were reminded about the termination of care on the seventh day and there was sadness written on their faces but they were assured that it is the official termination but they would be visited from time to time until the clinical period is over.

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

MOTHER

Temperature : $36.7^{O}C$

Pulse : 80bpm

Respiration : 20cpm

Blood Pressure : 120/70mmHg

Funda height : 11cm

Lochia : Serosa

BABY

Temperature : $36.5^{O}c$

Pulse : 138bpm

Respiration : 40cpm

Weight : 3.1kilograms

Madam Suah was reminded of the next visit and she said she was very grateful so the opportunity was taken to leave.

4.10 SEVENTH DAY POSTNATAL HOME VISIT

The sixth day postnatal home visit was made on the 30th of November 2021, at 7:30am. A warm welcome was given and a seat was offered. Enquiry was made about the well being of the mother and the baby and they were all doing good. Permission was asked to examine both mother and the baby. Hands were washed and dried and the examination of the mother commenced and no abnormality was detected. On abdominal examination the fundal height was 10cm; perineal pad was pinkish brown on inspection, she was congratulated on good perineal care.

Her vital signs were monitored as:

Temperature - 36.4^{o}c

Pulse - 78bpm

Respiration - 19cpm

Blood pressure - 120/80 mmHg.

Fundal height - 10cm

Head to toe examination was done and no abnormality was found. During the examination, it was realized that the cord had fallen off. The skin rashes had dried off completely. Baby's vital signs were checked. Baby was then bathed. Vital signs are as follows;

Temperature - 36.0^{o}c

Apex heart beat - 130bpm

Respiration - 48cpm

Weight - 3.2kilograms

Client was reminded about the termination of care on the seventh day and also about the birth registration of the baby. It was explained to her the need to complete all immunizations on the baby. Permission was sought to leave.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Suah and her baby together with her husband reported at the hospital on 1st December, 2021 accompanied by her husband. 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. Procedure was explained to the mother. With permission from mother head to toe examination of the baby was done, she was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. 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 abnormalities were detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical stump was completely healed. The extremities and the back were also examined and there were no abnormalities.

Baby's weight was 3.3kilograms and her vital signs checked and recorded as follows:

Temperature - 36.5°C

Pulse rate - 134bpm

Respiratory rate - 42cpm

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

Madam Suah 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. Hands were washed and dried.

On inspection, client's hair was clean and nicely braided, her conjunctiva and sclera were pink without any pallor or jaundice, she was engaged in a conversation so as to examine the mouth, the lips were moist and there was no offensive smell from the mouth. The neck had no palpable nodes. The breast was heavy with milk dripping; lactation was well established. The upper and lower extremities were examined without oedema and her back was normal.The lochia was pinkish brown (Serosa). The abdomen had almost returned to normal. The fundus was palpable and measured 9cm. She was helped to dress up after the examination. Findings were communicated to her and documented. She was encouraged to honour all appointments to the child welfare clinic.

Madam Suah was advised to maintain good personal and environmental hygiene in the care of herself, the baby and the entire family as well. She was asked to continue the postnatal exercises. Client was reminded of the six weeks postnatal visit to the clinic. Client's vital signs and other observations were made and was recorded as;

Temperature : 36.5oc

Pulse : 80bpm

Respiration : 20cpm

Blood Pressure : 120/70mmHg

Haemoglobin : 12.7g/dl

Weight = 90kg

Protein and Sugar were checked and they were both negative.

Client was congratulated for proper care of herself and the baby.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife In- Charge, on the 4th of January, 2022, Madam Suah came to the facility for six weeks postnatal visit. They were warmly welcomed and they both looked healthy. General examination was conducted on the client from head to toe with her permission and everything was normal by then. Her vital signs were checked and recorded as;

Temperature - 36.5oc

Pulse - 80 bpm

Respiration - 20cpm

Blood pressure - 120/70 mmHg

Haemoglobin - 13g/dl

Weight - 94kg

Madam Suah's urine was checked for protein and sugar and it was negative for both, 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**
OPV 1	2 drops	Oral
DPT-HepB+Hib 1	0.5ml	Intramuscular, left thigh
Pneumococal 1	0.5 ml	intramuscular, right thigh
Rotavirus 1	1.5ml	Oral

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

Temperature - 36.2degree Celsius

Respiration - 24 cpm

Weight - 5.5Kilograms

Mother was encouraged to continue with the breastfeeding exclusively for 6 months to inhibit ovulation and prevent infection or any disease to the baby and maintain growth and development. 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 the immunizations and continuity of care.

4.13 TERMINATION OF CARE

Client was told about the end of the care given to her from pregnancy, labour and some few days during her postnatal period. It was explained to her earlier that the care study will be brought to an

end a week after her delivery but that does not end the care in reality. Madam Suah was handed over to the Public health nurse and informed her about the completion of the immunizations and continuity of care. Both maternal and child health record books of client and baby were handed over to the public health nurse. She welcomed Madam Suah with a smile. Client was reminded about family planning services and where she could get access to them.

She was advised to report to the facility immediately she recognizes any abnormality in her condition as well as the baby for early management and prevention of any complications that may arise out it. She was encouraged to take good care of herself and the baby. Client was reminded of the registration of the baby within 21 days. She was promised to be called regularly to see how both of them are doing. Happily good bye to each other were exchanged. Client and her husband expressed an overwhelmed appreciation for the support received during Pregnancy, Labour and Puerperium.

4.14 NURSING CARE PLAN DURING PUERPERIUM
PROBLEMS IDENTIFIED

- On the 24 th November, 2021 client complained of;

  1.after pains

  2.Interrupted sleeping pattern during the night.

- On the 25th of November 2021 client complained of;

  3.Back pain.

- On the 26th of Nonvember 2021 client complained of;

  4.Fullness of breast.

SHORT TERM OBJECTIVES

- Madam Suah will be relieved of after pain within 48hours.
- Client will have at least 8hours uninterrupted sleep within 24hours.
- Client's backache will subside within 72 hours.
- Client's breast engorgement will resolve within 48hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 at 7.30am	After pain related to involution of the uterus.	Madam Suah's after pain will resolved within 48hours as evidenced by Client verbalizing the pain has reduced. Relatives observing that client is relieved of pain by her facial expression during breastfeeding	1. Reassure client that she would be relieved of after pain. 2. Explain the physiology of the after pain to client. 3. Encourage client to continue breastfeeding the baby on demand. 4. Encourage client to empty her bladder frequently. 5. Serve Client with prescribed analgesics.	1. Client was reassured that she is in competent hands. 2. Client understood that after pain is due to contractions of the uterus. 3. Client was breastfeeding baby on demand. 4. Client was emptied her bladder frequently. 5. Client was served with analgesics(Paracetamol 1g).	26/11/21 at 7:30am	Goal fully met as Madam Suah verbalized that her after pain had reduced.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 at 8:00am	Interrupted sleep related to baby crying at night.	Client will be able to have 1 hour sleep during the day and 6 hours sleep during the night as evidenced by client stating that she gets adequate sleep at night.	1.Reassure the client that it is normal during the first few days. 2.Encourage her to sleep during the day when baby is asleep. 3.Advice client to ensure that baby is well fed and dried before putting her to bed 4.Encourage the husband to assist her in the care of the baby.	1. Client was reassured that when milk comes in it will normalized. 2. Client was sleeping during the day timewhen baby is sleeping. 3. Client ensured that baby is well fed before putting her to bed 4.Client's husband assisted her in the care of the baby.	25/11/21 at 8:00am	Goal was fully met as client verbalizing that she is coping with sleep disturbance	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/21 at 8:00am	Backache related to poor feeding techniques.	Client's backache will subside within 72 hours as evidenced by client verbalizing that her backache has subside.	1.Reassure client that she would be relieved of backache. 2 Explain the physiology of backache to the client. 3. Encourage client to adopt a good posture when breastfeeding the baby. 4. Teach client other positions in breastfeeding. 5 Encourage client to apply warm compress to her back.	1. Client was reassured that she would be relieved of backache. 2.Client became enlightened that backache may be due topoor posture. 3. Client was encouraged to adopt a straight back posture when breastfeeding her baby. 4. Client used other positions in breastfeeding such as lying down. 5. Client applied warm compress to her back.	28/11/21 at 8:00am	Goal fully met as evidenced by client verbalizing that she is relieved of backache.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 at 8:00am	Heaviness of breast(breast engorgement) related to inadequate emptying of breast.	Client's breast engorgement will resolve within 48 hours as evidenced by Client verbalizing that she is relieved of breast engorgement The midwife observing the absence of breast heaviness and warmth.	1. Reassure client and explain the physiologyof breast engorgrment. 2. Teach her on how to fix baby correctly to the breast. 3. Demonstrate to client how to correctly position herself when breastfeeding. 4. Encourage client to empty one breast before the other. 5. Encourage client to continue breastfeeding the baby exclusively	1. Client was reassured and was taught that it is due to increased blood supply and inability of the baby to suckle well. 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 one breast before the other 5. Client was encouraged to continue breastfeeding the baby exclusively.	28/11/21 at 8:00am	Goal fully met as evidenced by breast becoming soft and non-painful on palpation	

SUMMARY AND CONCLUSION

This script is a Family Centered Maternity Care, given to Madam Suah, a 33 years old woman gravida 2 Para 1 alive. She lives in Techiman in the Bono East Region. She was met at Koranteng Maternity Home when she was 36 weeks pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Madam Suah went through pregnancy with some minor disorders which were managed successfully.

Madam Suah's labour and delivery were managed carefully without any complications. She had a spontaneous vaginal delivery to an alive female infant with birth weight of 3.2 kg on the 23rd November, 2021 at 4:47pm who cried immediately after birth.

Madam Suah's puerperium was successful, mother and baby were visited at home and finally handed over to the Public Health Nurse for further management on 1st december, 2021.

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

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

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 and mortality.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
8/4/21	Blood	Haemoglobin	12.0-16g/dl	12.0g/dl	Normal
		Blood group	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		HIV status	Negative	Negative	Normal
	urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
7/5/21	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	12.0g/dl	Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONT'D

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES
5/8/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.0-16g/dl
13/9/21	Urine Blood	Protein Glucose Hemoglobin (Repeated)	Negative Negative 11.0-16g/dl
20/10/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.0-16g/dl
3/11/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.0-16g/dl
17/11/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.0-16g/dl

APPENDIX II

PHARMACOLOGY OF DRUGS USED

DRUG NAME	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Tablet Fersolate	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 aneamia	Gastro intestinal disturbance	None observed.
Tablet Multivite	Vitamin preparation	One tablet three times for 30 days	Oral	Helps in the prevention and treatment of • Anaemia	• Nausea and vomiting	None observed

				• Improves appetite	• Abdominal discomfort	

PHARMACOLOGY OF DRUGS USED CONTINUED

DRUG NAME	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Tablet Vitamin B complex	Vitamin preparation	One tablet daily for 30 days	Oral	Helps in the metabolism of carbohydrate, protein and fat	Over dose can cause rough skin, dry hair, enlarge liver, increase erythrocyte sedimentation rate.	None observed
Capsule Vitamin A	Vitamin preparation	200,000 unit	Oral	• Prevent night blindness. • Help bone and teeth formation and enhance its integrity	• Gastro intestinal upset • Nausea and vomiting • Liver damage will occur as a prolong use	None observed
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	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	EFFECTS OBSERVED ON CLIENT
Tablet sulphadoxine pyrimethamine	Anti Malaria	3 tablet starts 16 weeks /after quickening and other 2 doses 4 weeks interval but not after 36 weeks	Oral	• Prevention of malaria.	• Nausea • Itching • headache	None
Injection Tetanus diphtheria	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 labor	• 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 m	Intradermal Injection	Stimulate production of anti-bodies against tuberculosis	Small pustules which persist for some weeks	Blister observed

Polio O Vaccine	Vaccine	2-3 drops	Oral	Stimulate production of antibodies against poliomyelitis	Nausea	None observed

APPENDIX III

ANTENATAL CHART

Date	Weight	Blood Pressu-re(mmHg)	Urine (protein and sugar)	Haemo-globin level (g/dl)	Gestati--onal age (weeks)	Fun--dal height (cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Rem-arks
8/4/21	92	100/70	Negative Negative	12.0g/dl	6	-	-	-	-	No complains	Tablet folic acid, multivitamin, Fersolate, Advise on good nutrition, insecticide treated net given.	Healthy
7/5/21	94	100/60	Trace Negative	12.1	10		-	-	+	No complains	Tablet folic acid. Fersolate Iron	Well
5/8/21	100	100/60	Negative Negative	12.0	24	18	-	5/5	+	Lower abdominal pain	Routine drugs served,2nd dose of SP	Well

											given under DOT, paracetamol 1g for 5days was served and educated on rest and sleep	
13/9/21	102	120/60	Negative Negative	12.0	28	24	-	5/5	+	No complains	Routine drugs served,3rd dose of SP given under DOT	Well
20/10/21	104	110/70	Negative Negative	12.0	34	30	Cephalic	5/5	+	No complains	To continue with routine drugs served, 4th dose of SP was given under DOT.	Well
3/11/21		100/60	Negative Negative	12.3	36	34	Cephalic	5/5	140	Lower abdominal pains and waist pains.	Routine drugs served 5th dose of SP was given under DOT. Client was educated to	Neat

											minimize frequent bending and also encouraged to wear low heeled shoes. Analgesics were served to client for the relieve of pain.	
17/11/21	106	120/70	Trace Negative	12.3	38+2	36	Cephalic	5/5	147	No Complains	Routine drugs served.	Healthy

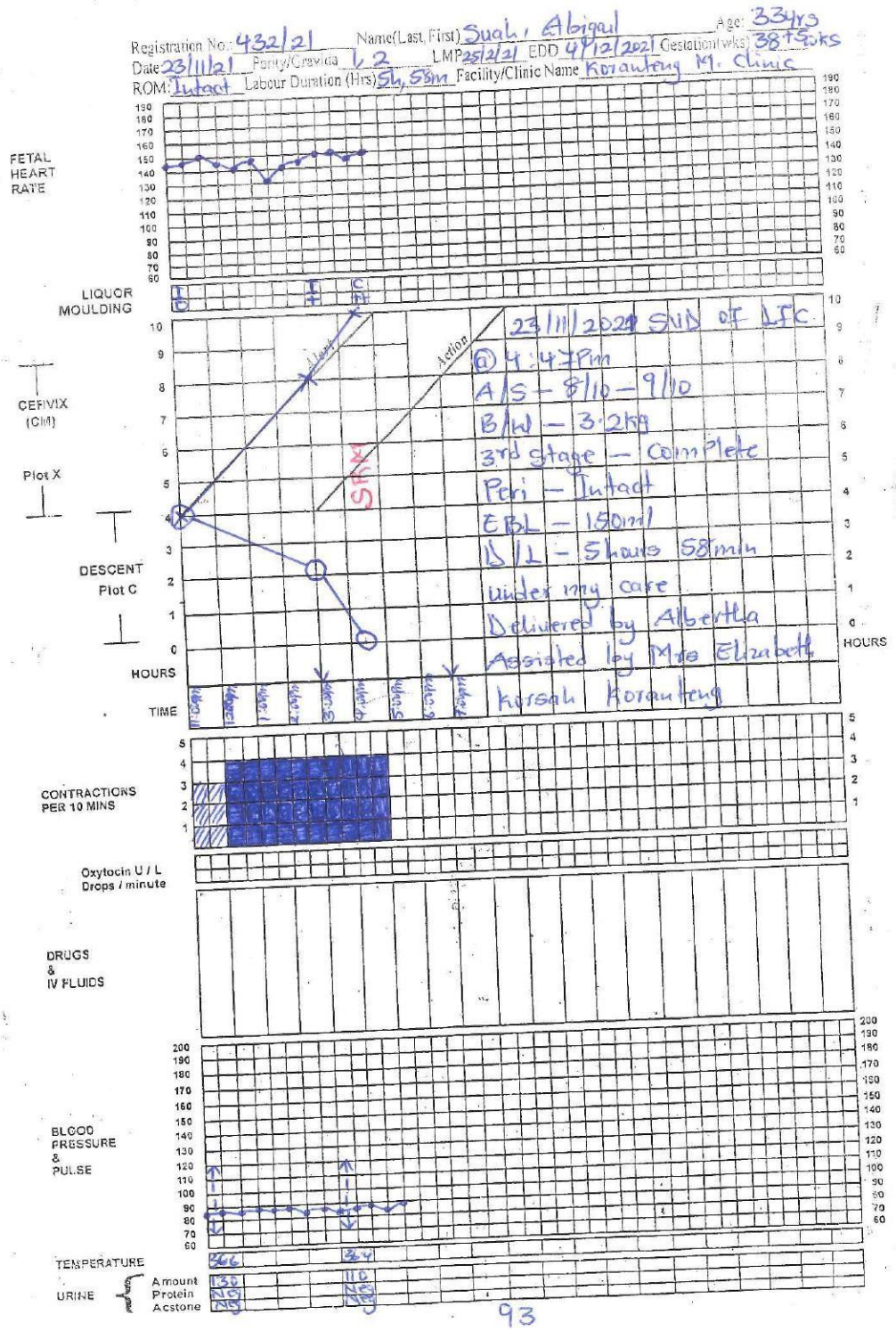
INTERMITTENT PREVENTIVE TREATMENT TABLE

<table>
<tr><td colspan="3">Insecticide treated (ITN) Given</td><td colspan="4">Date supplied 8/4/21</td></tr>
<tr><td rowspan="2">INTERMITTENT PREVENTIVE TREATMENT (IPT) FOR MALARIA</td><td rowspan="2">1st dose SP 3 tabs (Directly Observe Therapy)</td><td>Gestation in weeks</td><td rowspan="2">2nd dose (1month after 1st dose) (directly observed therapy)</td><td>Gestation age in weeks</td><td rowspan="2">3rd dose (1month) after 2nd dose(directly observed therapy)</td><td>Gestation age in weeks</td></tr>
<tr><td>24weeks</td><td>28weeks</td><td>34weeks</td></tr>
<tr><td colspan="2">4th SP Dose</td><td>38 weeks</td><td colspan="3">17/11/21</td></tr>
<tr><td colspan="2">5th SP Dose</td><td></td><td colspan="3"></td></tr>
</table>

TETANUS IMMUNIZATION TABLE

<table>
<tr><td rowspan="2">TETANUS IMMUNIZATION</td><td colspan="2">Previous TT</td><td colspan="2">Current TT</td></tr>
<tr><td>☐ Yes</td><td>☐ No</td><td>Date 8/4/2021</td><td>Date 7/5/2021</td></tr>
</table>

WHO Modified Partograph



93

LABOR NOTES

SVD of an alive female infant with a birth weight of 3.2kg On 23/11/2021 at 4:47pm. H.C = 32cm, L = 48cm. Perineum was intact. Third stage completed with AM'SL using Control Cord traction. Estimated Blood Loss = 150ml. first and fifth minute APGAR scores = 8/10, 9/10 respectively.

Please circle or write responses.

DELIVERY

DATE: 23/11/21 TIME: 4:47pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 4:49 Type/Dose 1 unit of Oxytocin

PLACENTA: TIME: 4:58pm (Complete) / Incomplete

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

BABY

Weight: 3.2kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	5:13	120/70	80 bpm	17cm	scanty	120ml
	5:28	120/70	80 bpm	firm	scanty	
	5:43	110/70	80 bpm	firm	scanty	
	5:58	110/80	84 bpm	firm	scanty	
	6:13	120/80	80 bpm	<U	scanty	Empty
	6:28	120/70	73 bpm	firm	scanty	
	6:43	110/70	80 bpm	firm	scanty	
	6:58	120/70	84 bpm	firm	scanty	
Every 30 minutes For 1 hour	7:28	120/80	80 bpm	firm	scanty	
	7:58	120/80	84 bpm	firm	scanty	110ml

Birth Attendant Albertha Appiah Ansu Date 23/11/21

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

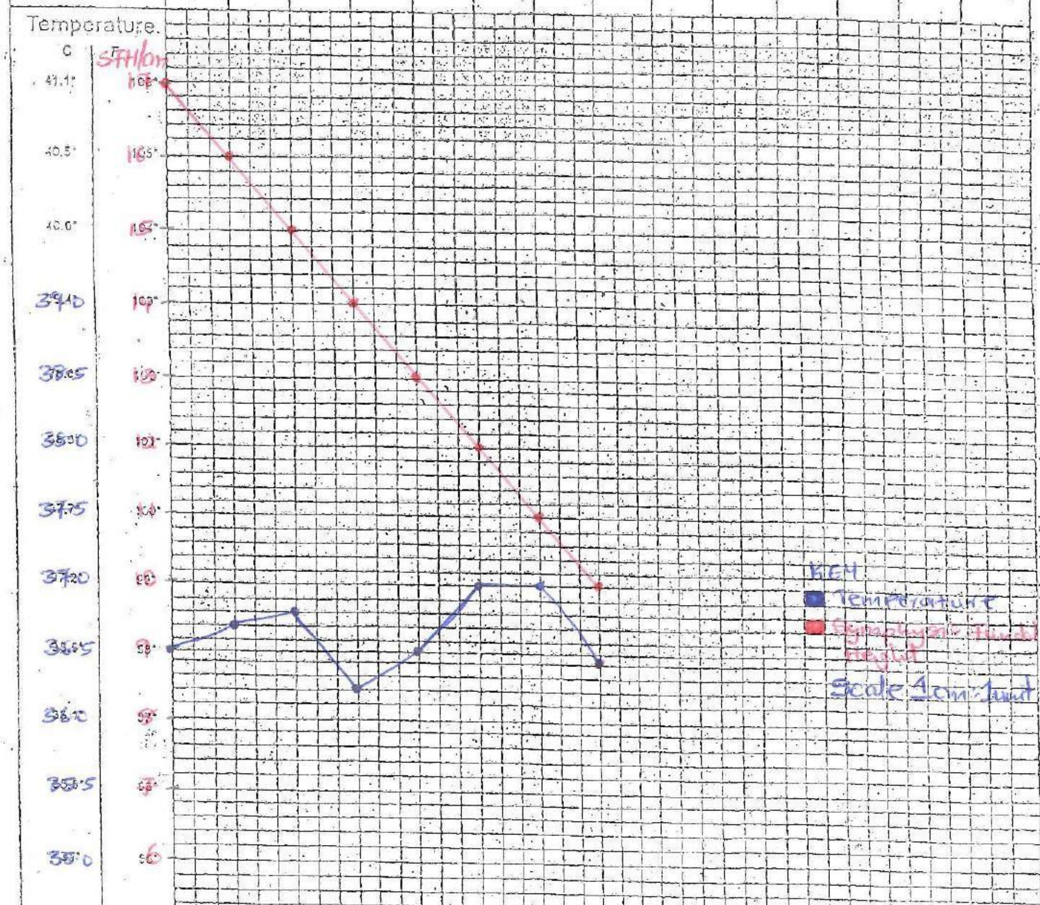
MATERNITY CHART

NAME: Madam Abigail Suah

AGE: 33 Years WARD: Lying - In

IP NO.: 432/21 BED NO.: 4

Date														
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7						
Days P. O.														
Hour AM		7:30	7:30	7:30	7:30	7:30	7:30	7:30						
Hour PM	5:30	5:30	5:30	5:30										



	DOD	D1	D2	D3	D4	D5	D6	D7
Pulse		82 85	85 78	80 81	80 80	80	80	78
Resp.		20 20	20 21	21 21	21 20	21	20	19
B.M.	—	—	—	—	—	—	—	—
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM		120/70	110/70	120/70	120/60	120/70	120/70	120/80
B. P. PM	120/70	120/70	110/70	110/70				

NEWBORN EXAMINATION FORM

Name: Baby Abena Guah Date of Assessment: 23/11/2021 Time: 5:58pm

Date of Birth: 23/11/21 Time of Birth: 4:47 Sex: ☐M ☑F Age at time of Assessment(days/hrs) 1hr

Gestational Age: 38+9wks Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section

APGAR: 1 min 8 ☐ 5min 9 ☐ Birth Weight: ☐ 3.2 Kg ☐ Length 48 Cm Head Circumference 32 Cm

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

Name of Assessor (Midwife/Doctor): Ansu Appiah Albertha

1.Respiration

Rate 40cpm
- ☐ Rate < 30 b/m*
- ☐ Rate ≥ 60 b/m*
- ☐ 30-60 b/m
- ☐ Retractions*
- ☐ Grunting*
- ☐ Stridor*

2.Activity Movement
- ☑ Spontaneous symmetric movement
- ☐ Reduce d/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*
- ☐ Jaundiee*

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

6. Cry
- ☑ Normal
- ☐ Shrill*
- ☐ Absent*

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent*

8. Head swelling
- ☐ Caput succedaneum
- ☐ Cephalhaematoma
- ☐ Subgalcal hemorrhage
- ☑ No swelling

9. Sutures
- ☑ Normal
- ☐ Overlapping
- ☐ Fused
- ☐ Widely separated*

10. Fontanelle
- ☑ 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:

14. Neck
- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other:

15. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

16. Chest
- ☑ Normal (shape/movement)
- ☐ Abnormal

17. Heart rate

Rate 140bpm
- ☐ Normal (100-160)
- ☐ <100*
- ☐ >160*

18. Femoral pulse
- ☑ Present
- ☐ Not palpable*

19. Abdomen
- ☑ Normal
- ☐ Distended*
- ☐ Scaphoid*
- ☐ Abdominal defect*
- ☐ Masses:
- ☐ Other:

20. Black (spine)
- ☑ Normal
- ☐ Abnormal Swelling*
- ☐ Hairy patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

21. Limbs
- ☑ Normal
- ☐ Abnormal

22. Genitalia Male Genitalia
- ☐ Normal
- ☐ Undescended tests
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other:

23. Female Genitalia
- ☑ Normal
- ☐ Pistula (meconium/urine through abnormal opening in vagina)*
- ☐ Large clitoris
- ☐ Other:

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

26. Service provided
- ☑ Vitamin K given
- ☑ Eye care provided
- ☑ Cord care provided
- ☑ Breastfeeding initiated
- ☑ Breastfeeding established
- ☑ BCG ☐ Polio Immunization
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnosis (if known)

Classification: (Overall assessment) ☑ Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice

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

NEWBORN EXAMINATION FORM

Name: _____ Date of Assessment: _____ Time: _____

Date of Birth: _____ Time of Birth: _____ Sex: ☐M ☐F Age at time of Assessment(days/hrs) _____

Gestational Age: _____ Mode of Delivery: ☐Vaginal ☐Assisted Vaginal ☐C-Section

APGAR: 1 min _____ ☐ 5min _____ ☐ Birth Weight: ☐ _____ Kg ☐ Length _____ Cm Head Circumference _____ Cm

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

Name of Assessor (Midwife/Doctor): _____

1.Respiration

Rate _____
- ☐ Rate < 30 b/m*
- ☐ Rate ≥ 60 b/m*
- ☐ 30-60 b/m
- ☐ Retractions*
- ☐ Grunting*
- ☐ Stridor*

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- ☐ Normal
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- ☐ Good
- ☐ Weak
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10. Fontanelle
- ☐ 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:

14. Neck
- ☐ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other: _____

15. Clavicle
- ☐ Normal
- ☐ Swelling/Fracture

16. Chest
- ☐ Normal (shape/movement)
- ☐ Abnormal _____

17. Heart rate

Rate: _____
- ☐ Normal (100-160)
- ☐ <100*
- ☐ >160*

18. Femoral pulse
- ☐ Present
- ☐ Not palpable*

19. Abdomen
- ☐ Normal
- ☐ Distended*
- ☐ Scaphoid*
- ☐ Abdominal defect*
- ☐ Masses: _____
- ☐ Other: _____

20. Back (spine)
- ☐ Normal
- ☐ Abnormal Swelling*
- ☐ Hairy patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

21. Limbs
- ☐ Normal
- ☐ Abnormal _____

22. Genitalia Male Genitalia
- ☐ Normal
- ☐ Undescended tests
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: _____

23. Female Genitalia
- ☐ Normal
- ☐ Pistula (meconium/urine through abnormal opening in vagina)*
- ☐ Large clitoris
- ☐ Other: _____

24. Anus
- ☐ Patent
- ☐ Imperforate*

25. Resuscitation provided
- ☐ None
- ☐ Suction/Stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Service provided
- ☐ Vitamin K given
- ☐ Eye care provided
- ☐ Cord care provided
- ☐ Breastfeeding initiated
- ☐ Breastfeeding established
- ☐ BCG ☐ Polio Immunization
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice

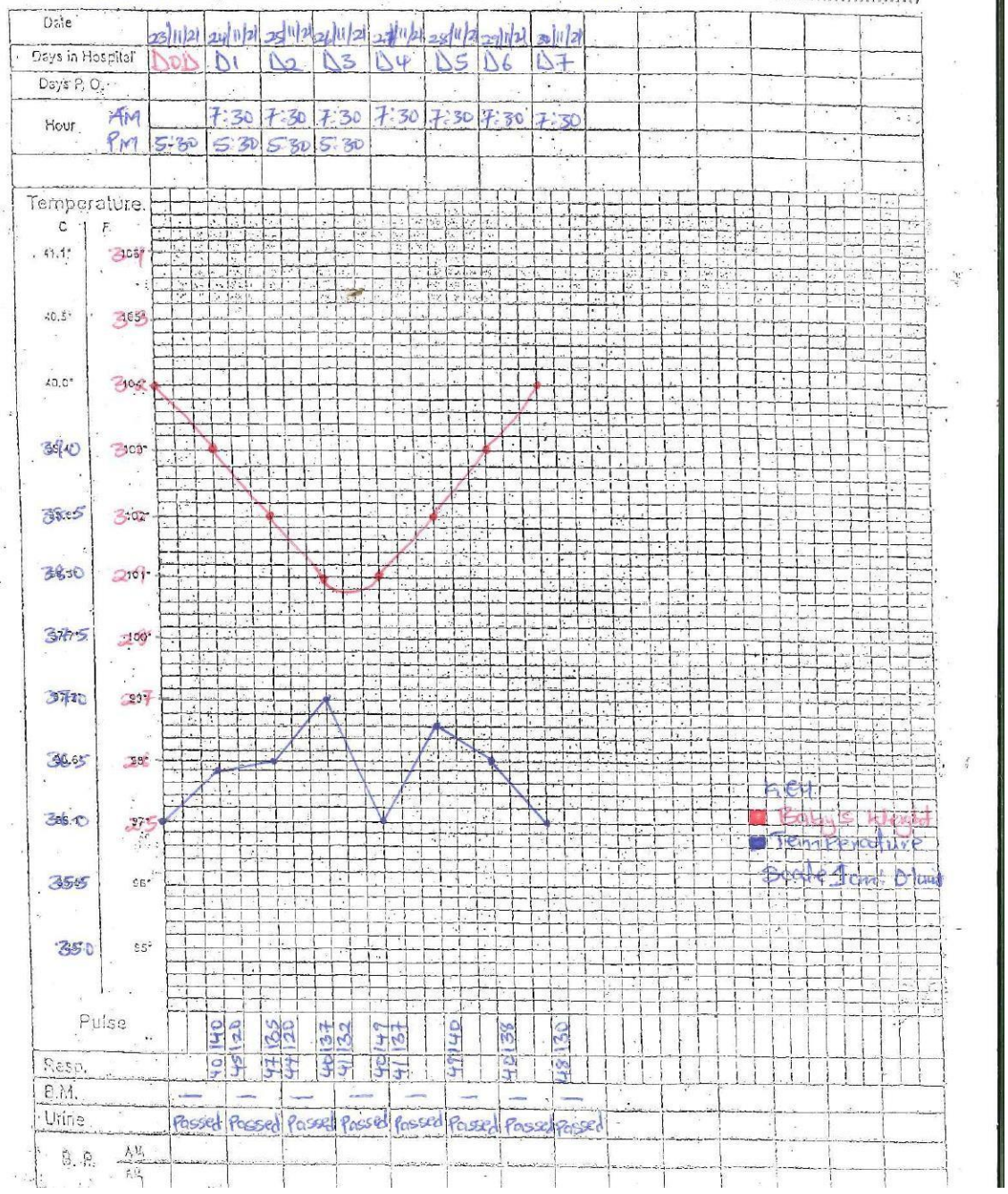
Plan: [ ] Routine Care [ ] Problem Continue supportive in-patient care [ ] Urgent Referral Advanced

TEMPERATURE CHART

NAME: Baby Abena Suah

AGE: Newborn WARD: Lying-In

IP NO.: 432/21 BED NO.: 4



NEW BORN CHART

ıme: Baby Abena Suah ..... No: ..... Birth Weight: 3.2kg .....

x: Female ..... Mother's No: 432/21 ..... Length: 48cm .....

ıture of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term baby .....

ıte of Birth: 23/11/2021 ..... Time: 4:47pm ..... Date of Discharge: 24/11/2021 .....

Date	23/11/21		24/11/21		25/11/21		26/11/21		27/11/21		28/11/21		29/11/21		30/11/21									
lo. of Days	DOL																							
Weight	3.2kg		3.1kg		3.0kg		2.9kg		2.9kg		3.0kg		3.1kg		3.2kg									
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
'emperature		36.0°C	36.4	36.5	36.5°C	36.0°C	36.5°C	37.0°C	36.0°C		36.8°C		36.5°C		36.0°C									
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed									
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed									
Remarks	Head Trunk Extremities Genitalia → NAD																							

SIGNATORIES

NAME OF STUDENT

ALBERTHA APPIAH ANSU

SIGNATURE: .....

DATE: 28/09/2022

MIDWIFE IN-CHARGE

MRS. ELIZABETH KORSAH KORANTENG

SIGNATURE: .....

DATE: 30/09/2022

NAME OF SUPERVISOR

MS ERNESTINA MENSAH

SIGNATURE: .....

DATE: 04/10/2022

THE PRINCIPAL

MONICA NKRUMAH

SIGNATURE: .....

DATE: 06/10/2022